Swasth Hind

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HEALTH EDUCATION NUMBER

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CONTENTS

Contributions to 'Swasth Hind' from Public Health and Social Welfare workers on public health topics are invited. Articles should be typewritten and suitably illustrated. They ordinarily should contain about 1000 words and sent in triplicate to the Central Health Education Bureau, Combined Councils Building, Temple Lane, Kotla Road, New Delhi—1.

PHOTO ON COVER—A properly conducted demonstration-cum-discussion is an effective tool to form healthy food habits.

TRAINING IN HEALTH EDUCATION

G.R. Amritmahal*

IT is being recognized increasingly that health education is a *sine qua non* of public health programmes. Recommendations of the Health Survey and Development Committee and the Planning Commission in the First and Second Five Year Plans have emphasised the importance of educating the people and obtaining their active participation in solving public health problems of the country. Most of the States in the Union have now established divisions of health education within their health departments. Health education is the pivot around which revolve the activities of health personnel in the Community Development Projects. This widespread recognition of health education as a force in solving public health problems has thrown into the forefront the need for health education specialists as also the need for in-service and pre-service training in health education for all workers who, in some way or the other, are in a position to influence the health behaviour of people.

New Situation

Health education as a discipline in public health teaching is comparatively new in India. Many of the older workers in the field who use health education methods in their day-to-day work have learnt it largely by trial and error, and in their studies in other countries especially in the United States of America. Otherwise, it was largely left to the information departments to give out such information to the people as the health departments considered necessary. In the training of health officers for the country at the All India Institute of Hygiene and Public Health, Calcutta, prior to 1953 only three hours out of a total of over a 1,000 were devoted to health education. Even in those three hours teaching was largely concerned with publicity methods. Since then, the situation has changed very much. At present students studying for the Diploma in Public Health get about 40 hours in the theory and practice of health education, and the subject forms an integral part of the curriculum of almost every course offered by the Institute. Thus, the public health nurses spend about 50 hours in health education and have some additional hours for practice teaching. Students for the degree of Master of Engineering in Public Health have 14 hours allotted to health education.

In-service Training

These developments and the trends created a demand for training persons, currently employed in health, education and development departments and voluntary agencies, in health education. To meet this need the Government of India instituted in June, 1956, a three months' in-service training programme at the All India Institute of Hygiene. Three courses have been offered since then, training 67 persons drawn from all over India and the neighbouring countries like Burma, Ceylon and Indonesia. Students who took these courses were from different professions—doctors, sanitary inspectors, teachers, social education officers, social workers, publicity officers and others. Three weeks out of the three months were spent in supervised field work where students put into practice ideas gathered in the lecture-discussions at the Institute. Sixty-eight hours were spent in basic public health subjects and 212 hours in health education.

The main objective of this course was to bring to persons working in the field an understanding of the modern concepts of health education, so that they could apply these in their day-to-day work; the course was not designed to train health education specialists. It was also felt that this diversity in the background-preparation of the students would help promote team spirit, so essential for success in public health programmes. With the experience accruing out of the first course and a review of the positions of trainees on their return, it was felt that it was essential (i) to train health education specialists, and (ii) to offer a course exclusively for doctors who have qualified in public health so that these could man the health education positions until more fully trained people become available. The Government of

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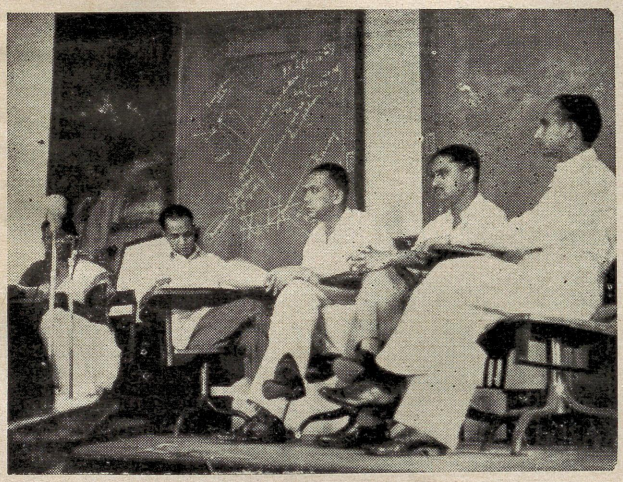


STUDENTS studying for tbe Diploma in Public Health course participate in a panel discussion which is a good method to adopt in solving a controversial problem

India approved of the latter suggestion and one such course was given from January to April, 1958.

Certificate Course

In June 1958, the Government of India sanctioned the institution of a ten months' certificate course in health education at the Institute. Designed to train health education specialists, the course caters to the need of both non-medical and medical personnel. University graduates in the natural or social sciences or education will be admitted to the first term of the course. During this period lasting for four months and a half, they will receive teaching in general public health to serve as a background on the need for health education. At the beginning of the second term persons with medical degree will be taken in and after a two weeks' intensive orientation to public health, will combine with the non-medical to form one class for the balance of five months. Fifteen students will be admitted in the first term and another 15 in the second.

The course-content in health education is divided into eight broad headings—meaning of health education, social sciences in health education, principles of education, methods and media of communication, programme development, school health education, evaluation of programmes and organisation and administration. Health education teaching to all courses is based on these eight divisions with emphasis related to the needs of the particular group. Interest-centred discussions make the subject more functional. Whatever be the length of the course, one major objective that if public health programmes are to succeed people's active participation in the programmes is essential is brought home to the students. For this purpose, a relatively larger proportion of time is spent in social sciences and methods of communication than in other subjects.

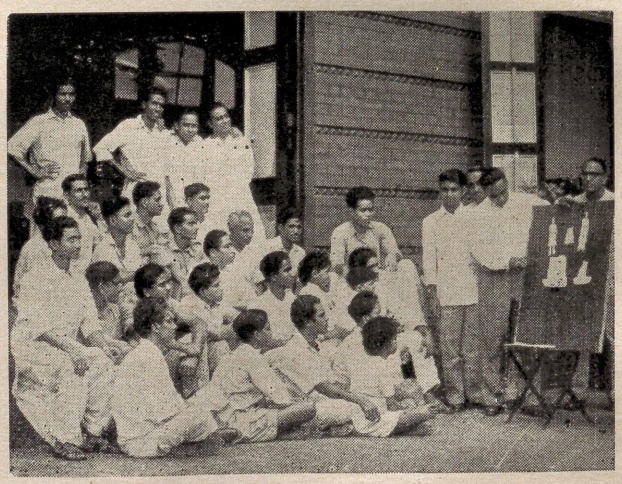
Teaching Method

Lectures, group discussions, panel discussions and seminars are some of the teaching methods used. Problems for discussion are sometimes set by the Faculty, but more often chosen by the students themselves. Students of the public health nursing course and of the health education course prepare a poster, pamphlet, flannelgraph and an exhibit design. Health education students, in addition, have to prepare scripts for a film and a filmstrip. Field trips to places of interest provide opportunities for valuable on-the-spot study. The field assignment for the health education students integrates the various theoretical concepts acquired into a practical process of solving problems. Students get experience in identifying and analysing health problems and in planning, developing, organising and evaluating a health education programme.

Re-orientation Centres

In addition to the training programmes at the Institute, limited training in health education is available in a few other centres. Principal among these are the three Re-orientation Training

A FLANNELGRAPH discussion is a helpful method to arouse audience interest



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EXPERIMENT IN TRAINING AND ACTION PROGRAMME IN HEALTH EDUCATION

Dr. G. Sen, Dr. N.B. Mahanti & A. Moarefi*

DURING 1957 we were intensively engaged in teaching health education to various groups of students who studied Re-orientation Training Course at Singur. In addition, several other courses were given by us to different groups who came to Singur for training and some occasional classes were also held at the All India Institute of Hygiene and Public Health, Calcutta.

The total hour spent in teaching of health education was 229, for 31 different groups consisting of village volunteers, dais, midwives, health assistants, sanitary inspectors, lady health visitors, public health nurses, N.E.S. Block workers, teachers, health educators, medical students, State doctors and specialists. The number of hours varied from 1 to 34 for each group depending on the needs and duration of training. In retrospect, we see a gradual change from a predominantly theoretical to a combination of theoretical teaching plus field work plus actual experience. The latter was arranged for 28 re-orientation training students consisting of doctors, sanitary inspectors, midwives and health assistants, who had their training in Singur in November and December 1957. From early 1957, each of the courses having 10 or more hours of health education was evaluated at the end and it was tried to apply the comments and suggestions made by the students in the future courses, as far as possible. The first special course in 1957 had 10 hours of health education in four weeks training and the first regular course of nine weeks, had a total of 19 hours of health education. Since the students expressed a need for more hours, the number was increased to 22 for subsequent batches and finally to 34 in the last batch excluding the work done by the students in their own time.

From the viewpoint of contents, the students always expressed a need for more practical training. To accomplish this, the students were assigned to work on various arbitrary projects which proved to be of some benefit. A number of students liked the opportunity they had for public speaking, learning the art and technique of group discussion, etc., but to them this was still operating in a vacuum.

Originally, we were teaching health education on the basis of the usually accepted method, giving the students an idea of the following points :

What is health education—definition and justification
What is the place of health education in a total public health programme ?
Learning and motivation
What are the approaches, methods and materials in health education ?
How could the methods and materials be made more effective ?
School health programme
Culture and cultural patterns
Community organisation and use of resources
Evaluation and follow-up

However, in the appraisal of these courses, we found that the students had liked the training received, but to them it was more of an appreciation course in health education rather than a training that they could adapt and apply in their day-to-day work. To them, use of health education was a conditioned one ; "if occasion arises", or "if situations permit", were the common conditions and remarks for application of health education.

When they were asked whether they liked the course and whether they can practise what they have learned, the answers were always in affirmative. But when they were asked specifically how they could apply this training,

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the answers were optimistic, but still very vague.

This made us analyse the reasons for inclusion of health education in the Re-orientation Training.

Was it to convert public health workers of various discipline to full-time health educators ? or was it to teach, motivate and stimulate the students to the extent that they would use educational approach in their everyday public health work ?

It was decided that the purpose was the latter and not the former. Because, if we were trying to train full-time health educators, more time would have been necessary both for the theoretical teaching as well as the field work, and that was not the purpose of the Re-orientation Training in Public Health. Then, if the purpose was to train the students so that they could integrate health education with their various activities, why not emphasise on that type of training ?

Central Theme

This gave us the idea of choosing one central point as a problem of public health, and to teach health education, philosophy, methods, materials, application, evaluation etc., but mostly using examples of ways of meeting this particular public health problem, enriching it with the actual experience in health education, together with the assistance in meeting that chosen problem, if it is so desired by the people.

This was done with the understanding that if the students could actually see the relationship between health education and other activities in a rural health centre and if they were given a chance to actually integrate health education with the services in connection with one special problem, they could normally adapt the same technique or similar techniques in facing similar problems. In addition they would be able to understand and appreciate the health education approaches for meeting a number of other public health problems. Also it was felt that if the students actually discussed, planned, practised and evaluated their activities, they would be more enthusiastic in applying it in their future career. On this basis, health education training was gradaully changed till in the last Re-orientation training the approach of health education-cum-vaccination was taken. It was a very encouraging experiment in which every student had a role to play.

Here are some comments made in the evaluation done by individual students at the end of the course. "This course was a new one. It is very important to the people of the villages to have ideas of health problems. You taught us fundamental things, but choosing one village, you demonstrated to us how to apply those principles in any health problem" ; "We learnt that to do any health work, we have to teach the people about that problem" ; "We have learnt a new technique for educating the people and eradicating the disease by their co-operation" ; "Every health personnel should have this orientation training"; and "The method followed by us in our previous work was didactic only and we failed to grasp the actual problem of a particular community. The Socratic method of approach, the technique learnt here, is the method of choice".

Vaccination was chosen as a theme for the following reasons :

It had cultural implications.

It was an important problem of the area.

It had an easy method of prevention and control.

It was relatively easy problem to cope with during the time at our disposal for the training.

However, the approach has a number of possibilities such as, campaigns in eradication of other diseases, practice in community organisation, etc.

It is interesting to note that as evident from the report of the four groups of students, the response from the people was not mainly due to the use of audio-visual aids, but to the individual and group contacts made by the students.

The students were informed of the work, the area, population status and the beliefs. The students were assigned to form groups, elect leaders and other workers, make contacts in the village, prepare necessary health education materials and proceed with the work the way they seem fit, write report and evaluate their own work. The time spent in vaccination was actually three hours in which they vaccinated 861 persons. This was done with the understanding that the purpose of the programme was primarily educational and they could vaccinate the people only if they (people) wanted.

The four groups have submitted reports. Many interesting and stimulating points have been mentioned in these reports, such as the stress on the need for follow-up of the programme.

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MEDICAL STUDENTS AND HEALTH EDUCATION

Dr. Donald T. Rice*

HAVE you ever found yourself as a patient or as a patient's relative sitting in a doctor's consultation room and wondering what the doctor is trying to tell you and why he does not tell you in the language you can understand. Medical education is designed to make doctors think in exact technical terms and too frequently it is difficult for them to translate that information into popular language.

This difficulty in communication is a source of much misunderstanding between the doctor and the average patient and is a hinderance to the emotional well-being of the patient. Patients and relatives are often baffled by the doctor's inability to get his ideas across to them and are, therefore, unable to put their full confidence in him.

In order to improve the communication between the doctor, the patient and the public, the Christian Medical College at Ludhiana teaches its students some of the principles and techniques of health education. This course is given in the second year, just before the medical students are assigned to their village families. It lays the groundwork for their contact with the families and improves communication with the villagers.

During these lectures and practical classes we first teach the psychology of learning so that the students will have an idea about the factors involved in teaching other people. We also teach group dynamics so that our students will know some of the techniques and advantages of teaching people in groups. The advantage of the discussion method of teaching is also emphasized although we have not yet organized a practical period in this method. The methods and techniques of community organization are also included.

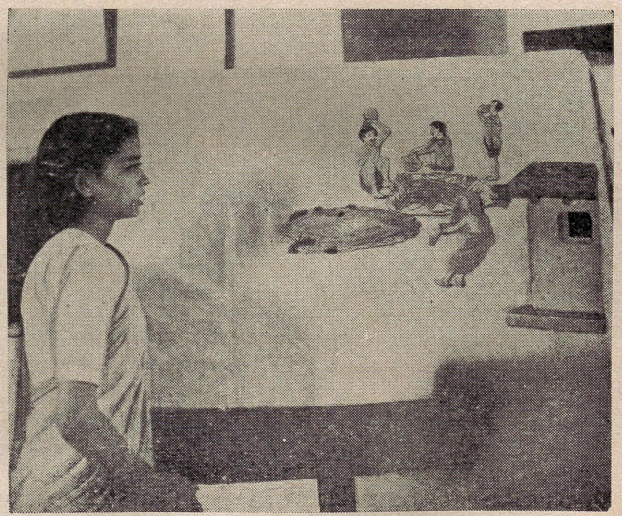
Audio-Visual Aids

Another valuable part of the course comes when the students have a chance to practice the use of some of the simpler audio-visual aids, such as flannelgraph, flashcards and puppets. It is amazing to see how quickly a group of students can prepare a creditable performance with any of these aids.

The time allowed for health education is limited in that we only have 10 lectures and six 2-hour practical periods. We would like to have a refresher course in one of the clinical years so that the students can learn how to use health education with his clinical patients.

How do we expect this course in health education to improve the relationship between the patient and doctor when he begins his practice? In the first place we, who practice allopathic medicine, often have difficulty in persuading Indian patients to undergo a full course of treatment or to submit to some operation which we feel is necessary for their well-being. If a doctor understands the psychology of individuals and groups and has at his

FLANNELGRAPH is a simple educational aid but one of the most effective



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Health Education and Environmental Sanitation

Shri K.S. Krishnaswamy & Dr. V. Ramakrishna*

IT is impossible to conceive of a human being apart from the environment in which he lives. He depends mostly on his environment for his basic needs such as air, water, food and shelter. The environment, which is so indispensable for his survival and development, also moulds his life and plays an important role in maintaining and promoting his health and eliminating and keeping the agents of disease under control. An unbalanced interaction of three factors, the host, the agent and the environment, results in a disease-process and the severity of the disease is directly proportional to the degree of maladjustment among these factors. Continued controlled adjustment of man's environment aimed at the eradication of the disease-producing agents has wiped out diseases like cholera, typhoid, plague, malaria, typhus etc., from many countries. The achievement of a state of complete well-being will be within the reach of all people if they live in a clean environment.

Clealiness has been a valued asset of all communities. Cleanliness is next to godliness – a truth upheld by almost all faiths and countries as a means to attain the ultimate aim of life. In India cleanliness has been given a high priority in the way of living of the people as it is the cheapest method of preventing and controlling disability, disease etc.

Education and Sanitation

This clean and pure way of life is sanitation and is the qualitative aspect of living. Sanitation must come from within the people ; it is nourished by knowledge and grows as an obligation and an ideal in human relations. What grows and develops from within the self out of knowledge and fellow consideration is the real education which conditions the entire mode of living. A mode of life, conditioned or controlled by the external force alien to the indigenous pattern at best lasts as long as the pressure operates and usually does not produce a permanent change in the behaviour of the people. So, sanitation implies self-control, self-reliance, self-effort and neighbourliness to attain a state of complete physical, mental and social well-being. But in actual practice sanitation has become a procedure of detecting sanitary offences, launching prosecutions and imposing penalties.

In a democratic set-up is it desirable to enforce a particular way of life by sanitary regulations and rules alone ? It has been the painful experience of sanitarians and other health workers that acceptance and following of sanitary codes by people is more an exception than a rule. The 'police method' of inspection and enforcement has not brought any change in people. People have either got accustomed to pay the small penalty grudgingly and violate the code again or effectively use ways and means to escape prosecutions. Even those who reluctantly introduce certain sanitary facilities like latrines in their houses may not use them. A recent survey in an area revealed that as many as 60 per cent of the families who were made to construct hand flush latrines in their houses did not use them. This is mainly due to the lack of public understanding and acceptance of positive responsibilities in the improvement of sanitation and partly due to the health workers not realising that sanitation is also a growing dynamic field in human relations and education. Here, health education assists the sanitarian to apply regulations effectively by a process of education.

Health education is an integral part of environmental sanitation programmes. All health activities have an educational component. It is essential that health education be an integral part of all branches of hygiene, preventive medicine and social medicine ; through it, activities in the field of health assume a more human aspect and become more effective. What is health education ? Health education is a process which aids people

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to find out their felt health needs leading to programme-planning, utilising available resources, modifying their health behaviour, breaking down barriers of ignorance, prejudice and misconception after an intelligent and thoughtful consideration of relevant health knowledge, and thus enable them to attain the highest possible standard of health by their own effort. It is the translation of what is known about health into desirable individual, family and community behaviour —patterns by means of educational process. It is an indispensable factor in improving environmental sanitation. Its aim is "to help people to achieve health by their own actions and efforts."

Public Health is People

During the first quarter of this century, C.E.A. Winslow gave a comprehensive and scientific definition of public health. The important part of the definition is its operative portion *viz.*, to enable every citizen to realise his birthright of health and longevity through organised community efforts—for the sanitation of the environment etc. Evironmental sanitation, being the basic part of the local integrated health service, can only be truly effective with the understanding, the support and the participation of the people. It is the task of every health worker to encourage self-help among the people by making the health programmes as people's programmes. The success of the programmes depends upon the extent of active participation of the people either in their individual or group capacity. A control with consent imposed from within is more potent in changing the pattern of living than that superimposed from outside. Whatever progress has been made in the past to improve sanitation has been achieved without great popular support or demand and without considering the prevailing social and economic condition of the local communities. The public health engineers and sanitarians have done their job mostly by themselves and are realising that technical improvement of sanitation without public education in hygiene and sanitation is futile.

Human Factor

Then how can public understanding, support and participation be secured for the development and promotion of environmental sanitation programmes ?

The science of human behaviour can help sanitary scientists to build the sanitation projects on a sound foundation of human needs and values. In recent times, social sciences have made rapid progress and are becoming increasingly complex since the variables they have to encounter are too many. It is rather impossible for a busy health officer or public health engineer to keep himself abreast of the latest trends in these sciences. However, if he wants to function efficiently, he should always consider the human factors—their interest, customs, beliefs, attitudes, taboos, value system, past experiences and traditions, community structure, educational level, socio-economic status, leadership patterns etc.

Team Work

In order to obtain data relating to human behaviour—social, economic, cultural and religious characteristics—of the local people, the public health engineer or sanitarian will require the assistance of health education specialists and social scientists, who also form part of the health team. The spirit of team work should pervade the entire work from the very initial stages of the survey. Each member of the team accepts responsibility for that part of the survey or programme he can do best, and carries out his part in such a manner that it supports the work of all the other personnel. Unless the public health engineer or health officer actively practices the team approach in planning, programming, and evaluating, it will not be possible to provide comprehensive health service to the people. The team work conducted in democratic atomosphere will also be an effective educational tool in moulding the outlook and changing the knowledge of the members of the team.

BY DISCUSSING the unsafe features of handpumps and demonstrating the ways of avoiding them many families will learn to keep their water supply safe

Community Self-Survey

Along with the technical survey to be done by public health engineers and sanitarians it is necessary to organise a community self-survey to sensitise people to their sanitation problems and help them to recognise their needs. "The perceptions of the people to be 'changed' are basic to planning". A community self-survey planned with the local leaders should be quite simple and stimulating to the people. To arouse and awaken people from the age-long inertia and apathy is in itself an important task to accomplish first. People have their own reasons and beliefs for the prevailing insanitary situation. To them these beliefs are as true as they appear unscientific and superstitious to the sanitarian. A health worker will have to take note of the existing cultural background and then weave sanitary information suitably into their pattern of perception. In this process the health educator plays an important role.

Programme Planning

The educational and sociological data collected provides the foundation to build and develop environmental sanitation programme. It is logical and fruitful to build from where the people are, rather than to start reconstruction without knowing the nature of the existing structure. A house without a sanitary privy immediately suggests to health workers the need for providing a latrine but the family may not be ready for or interested in such a facility or may be even hostile to it. To insist on the introduction of toilet into such a house is not a wise move. It takes some time for lay people to understand the relationship of water supply and excreta disposal to disease. Even when they understand, the application of that knowledge for modifying their way of life requires the approval and support of the group of which the individual and family is only a part. The social control is so strong that the individual is afraid of taking an independent action which runs counter to the current and deeply ingrained practices and beliefs. In such instances, it would be profitable to list and determine the priority of the un-met wants, interests and goals of the families and the community. Co-operation for health begins with the problem of immediate interest, and in its solution, and then the family or community is ready to take up health problems considered important by the health workers. When the basic underlying pattern is known and the immediate un-met want is determined a programme of 'directed cultural change' can be initiated.

Even if the felt need is unrelated or related remotely to the topic of environmental sanitation, the people should be assisted and guided to attain it first (the felt need). For example, in a village the people's pressing problem is to obtain a particular type of manure or seeds in time. The sanitarian works with people to procure the commodity from the agriculture department. He thus wins the people's confidence. Later on, it will not be difficult for him to show the villagers the relationship between improved agricultural operations and improved health practices. "It should be considered axiomatic that environmental sanitation programmes in underdeveloped areas should be integrated with general community development, and particularly with the agricultural progress". Since health is only a part of the total human welfare, weaving a thread of environmental sanitation programme in the community welfare programme is both realistic and productive.

Communication of Ideas

Before programme-planning for environmental sanitation it is essential to have a clear knowledge of how information is transmitted among the people, what channels of communication operate in the community and what barriers exist for dissemination of health information. A health educator can help in assessing these factors.

Sanitary science information may be communicated effectively if suitable methods and materials are used by the trained personnel. Two-way or Socratic method which include individual, family and group discussions, etc. appears to prove useful in areas where illiteracy is high. The methods selected should be in consonance with the local educational and emotional levels and the religious and cultural traditions. These methods may be made more effective by the use of appropriate educational aids—flash cards, khadigraph, filmstrips etc. According to the local conditions, puppets, drama, role-playing may prove effective. A sanitarian trained in health education and who has the help and guidance of an health educator can make his own media utilising the local resources and discover what methods and which media are most suited to his work and people.

Two-way Traffic

Communication will be effective if it is a two-way traffic—flow of sanitary science knowledge from the health workers to the people and the local reactions, field experience, etc., returning to the top health worker. Government officials usually tend to form a class separate

from the village people, being isolated socially and culturally. In such a set-up the traditional behaviour of villagers towards officials (health) is that of passive verbal acceptance of whatever they say. This blocks the communication from the rural folks to the health authority which may be removed by identifying ourselves with the peasants and taking steps to win their confidence.

Role of Village Leaders

It is easier to approach the community through the key persons—leaders. The leaders may be religious heads, pandits, hakims, village doctors, chiefs or elders, landlords, teachers, village officers etc., who are held in high esteem and trusted by the people. In rural communities, family is a vital, closely-knit social unit. The family system has afforded security to its members for centuries and has become the 'core units of culture'. The 'open sesame' to most homes is through family elders who hold high social status. The survey, the preliminary planning etc., should involve the representatives of local institutions and the different social strata who can later serve as instruments of social action to carry on sanitation programme. The leaders get trained during their participation in survey and planning and can function as effective 'change-agents'. The health education specialists and social scientists will help detect the real leaders (natural, functional) of a community who can influence, motivate and mobilise people for the desired action.

Plan with People

Having known the needs and interests of the people, their systems and social climate, the stage is set for finding and designing solutions for the problems affecting them. Health workers are used to plan and render service to the people or for the people. People have all along been accustomed to remain as silent recipients of benefits with the traditional suspicious attitude. Perhaps villagers could not find much difference between the officials who collected tax, kept law and order and those who improved sanitation. In the past the sanitation measures have been mainly enforced by Government orders from the top. Further progress must come from the assimilation and use of scientific concepts by the villagers themselves and this can be done only by their involvement in the survey, planning and conduct of the programme.

Popular acceptance of a programme is in direct ratio to the degree the local representatives participate in the conception and formulation of the sanitation programmes. Participation should be from all segments of the community. To ignore opposition is a sure way for the increasing opposition and to talk with enemies is the best way of getting their consent, if not their co-operation.

All members of the health team should also be brought into the planning. The planning team should take particular care to see that the initial sanitation action programme is only a negligible variation of the local culture which had given people security and satisfaction for generations and tailored to fit in with the value system. The targets and aims fixed should be realistic enough to be within the easy reach of the people and the co-ordinated co-operative effort of the community and the local agencies.

Be Slow and Steady

As no single dose of programme will help to modify people's way of living, it is necessary to plan programmes in successive stages stretched to over a period of time. Achievement of each part of the programme should lead to the next stage maintaining the interest and motivation for action. People have worked out through centuries a mode of life which they feel as 'normal' and cling strongly to it and it takes time to change it.

"The planning process itself is an educational method which has the potentialities for stressing the major psychological factors to bring about 'change'. Planning provides the participants a situation for reducing tensions which can serve as a motivating force for learning and taking action. People who have undergone this

SKILLED FRIENDLINESS is one of the principles of health education

process are committed to the programme they have planned and they are bound to say : "We do not easily give up something which we have helped to plan".

Self-reliance

But some people may still show negative reaction, apathy and indifference due to various stresses and strains under which they have been living. Continued demonstration of our faith in people's ability to better their condition with the guidance of public health engineers and sanitarians will help to modify their attitude towards the programme. To obtain their acceptance and co-operation, there can be no one set formula which can show immediate results. However, environmental sanitation demonstration projects will be useful in this respect and in providing a field for scientific study of local sanitation problems and training lay and technical personnel for the programme.

Demonstration in Schools

The sanitation demonstration programme should start from the schools. Schools are channels for directing some social change and have the segment of the population that can be moulded easily to practise sanitary way of living. The questioning frame of mind of the school child and the experimental attitude are helpful in spreading the scientific knowledge of environmental sanitation. Learning by doing and learning through example are the two most effective methods by which children learn. This can only be done effectively if the school maintains the basic sanitary conveniences and the teachers themselves use them and practise sanitation. The sanitary facilities in the schools should suit the local socio-economic standard and values. Health education is necessary for the development and promotion of environmental sanitation programmes and in turn they are required for carrying on effective health education.

Social health education connected in a healthy environment will have a marked influence on the sanitary practices at home and in the community. Mere class-room teaching of sanitation without having a chance to live and enjoy healthy school environment has little effect on the students and is unfortunately common in many parts of our country. "Every effort should be made so that children during their school life should have inculcated in them the proper appreciation of sanitary standards both by teaching in the class-rooms and by the day-to-day familiarity with good sanitary practice.

In Health Centres

Next to the schools, the hospitals, clinics, dispensaries, health units and other public institutions, should have priority in the environmental sanitation demonstration programme. These places which have to be models of sanitary environment, providing example to those who visit them for matters of health are the ones usually neglected most.

Demonstration centres will have to be an important item in the planned sanitation action programme. In the actual conduct of the programme development of personal touch is perhaps the key for enlisting continued public support and participation. Eliminating or reducing the gulf between the health worker and the villagers, encouraging the community to discuss and take decisions on problems which are not too technical respecting the views of others including the opposition groups, using personal and friendly approach and adopting an attitude of sincere humility are some of the factors which strengthen and promote human relations

Evaluation

With improved relationship between the members of the health team, community leaders, local institutions and organisations, official and voluntary agencies operating in the area, there can be a co-ordinated and co-operative effort for the sanitation programme. But, the progress being made should be continuously observed, collecting and analysing the data and critically assessing the results against the base-line facts and the objectives. Periodically the people should also be involved in these appraisal to keep them informed of the reasons for modifying their programme. Usually the progress made in an engineering project is measured by the amount of money spent in the shortest possible period. The efficiency of the engineer is judged by his capacity to spend more in constructing structures in the least possible time. Neither the number of sanitary facilities created nor the amount of money spent indicate the extent of improvement of environmental sanitation. People may continue to lead an insanitary way of life in spite of possessing sanitary conveniences. Recently the chairman of a village panchayat (council) who had a hand flush latrine in his house for nearly a decade remarked that he got it constructed to complete the diary of the local health inspector and had not used it since then. In another village a leader informed with pride that this family has been using the latrine since 15 years and even earned some money by selling the manure. Incidence of hookworm continues to be high in the former village. This shows that sanitation is mainly a way of life and the provision of sanitary facilities is only a part of it.

CHANGING HEALTH BEHAVIOUR IN RURAL AREAS

Dr. B.S. Sehgal*

THE health behaviour of the present day villager has been formed as a result of long history, beliefs and traditions passed on to him from his forefathers. Scientific advancement having been kept out of the villages, these beliefs have continued with minor changes and they show alikeness throughout the country.

Basically, disease is still supposed to be a punishment from the Almighty, and cure and prevention are possible only through His pleasure, which may be secured by individual or community worship, or offerings in cash or kind to ward off the evil. However, lot of changes and new things have been taking place in our villages

New Ideas

Extension of education, provision of modern medical aid and the establishment of health activities have brought in new ideas, many of which are diametrically opposed to the present day thinking of the villagers. The average villager patiently hears to what these 'people of new outlook' have to say and quietly ignores most of the things, which everyone like them advocates and to which his experience has not been pleasant so far. The causes for this have been many, though the main reasons have been the low standard of general education and the attitude of the Government in the pre-independence days, which was hardly ever appreciated by the majority of villagers. Since Independence, earnest attempts are being made by the Government to change the attitude of the villagers to the Government services and the whole philosophy of Community Development is a bold endeavour to bring the people and Government nearer in all activities in which the villager is interested. Education is also making rapid strides in the countryside.

Health Behaviour

Health as a basic need, however, does not exist in any community in the world, though sickness forms an important item in every society. Every society has formulated traditional methods and techniques to overcome the prevalent disabilities. In the industrialised countries of the West these methods have during the last half of the century assumed a progressive preventive outlook based on scientific findings and have eradicated most of the common epidemic diseases. This has been possible by the people themselves acquiring health attitudes through education obtained, either at home or in the school or elsewhere, and most of the people strictly conform to these health habits. Economic prosperity has been probably at the back of all these developments, and these changes have been possible through a slow process extending over decades to which a number of factors must have contributed.

However, today health workers in India are faced with a major challenge. Most of the great killers in our country can be completely eradicated if we can make the people understand and follow health principles to their advantage, and give them the necessary financial aid. Though this appears quite simple, it is a formidable task which can only be achieved through a concentrated effort extending over a long period. Some serious thinking has to be done in this regard by all interested in the health and welfare of the people.

CHANGING HEALTH BEHAVIOUR

From the practical standpoint, this will have to be looked at from two aspects.

Long-term Aspect

It is here that seeds of modern scientific knowledge can be introduced amongst the rural people through two institutions which are rapidly extending in the villages—educational institutions and village-level workers.

Educational Institutions : The key to change health behaviour of the future generations would be to change the health attitude of the teachers going in for rural schools by an intensive training

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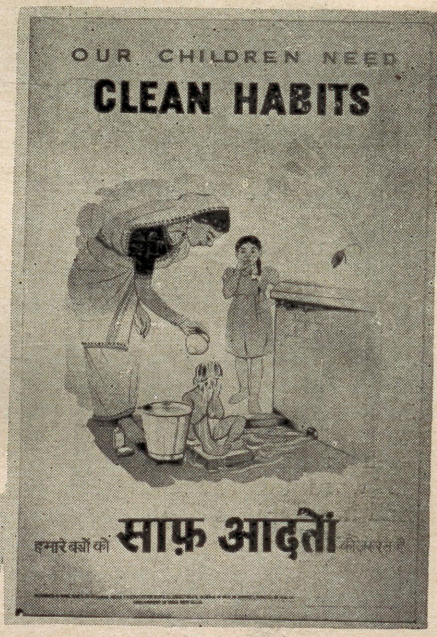

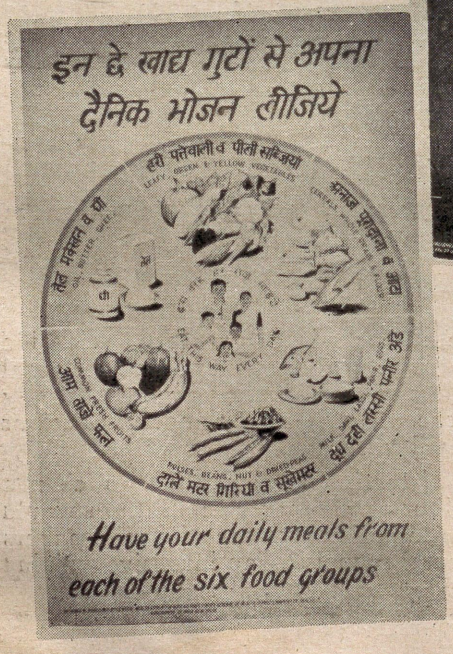

POSTERS AND PAMPHLETS PRODUCED BY

BY CENTRAL HEALTH EDUCATION BUREAU

programme. These teachers should be trained in the methods and techniques of imparting health education through practical demonstration, whenever possible. This would also require introducing health topics among the subjects being taught in the schools.

Village Level Workers : Here again there is an ideal opportunity by which villagers could learn from the behaviour of trained village level workers who live with them. These workers should be trained sufficiently to the extent of changing their own beliefs, which are no less deep-rooted than those of the villagers. But these workers get only a routine training in public health course and not much opportunity is offered to them to change their own outlook. Thus they go to the field with half-baked knowledge, expecting to do things in which their own faith is still not firm.

Short-term Aspect

Help from social sciences will have to be sought to bring about a change of outlook amongst the older groups. The sciences of Sociology, Cultural Anthropology and Social Psychology have developed techniques for analysing and understanding the people who live in a group. Health behaviour is a part of total behaviour and, therefore, the approach will have to be from that angle. Such studies will reveal the value system, local groupings, leadership positions and the channel of communication. The educational methods to change the health behaviour will have to be adapted to the existing local conditions. The main objectives of these methods will be :

To create awareness amongst the people about health problems prevalent in the locality and make the villagers realise that something better is possible and that they themselves can do something about it.

Resistance to Change

Man by nature shows a resistance to change for the fear that it may upset his normal way of living. This is especially so amongst people cut off from the outside world, and where the educational level is low and traditions and beliefs have religious and group sanctions. Furthermore changes based on theories and concepts far removed from the villager's own ideas will be greatly resisted. For example, it is possible that health facilities may be sold in the villages on principles other than the germ theory of disease.

Last but not the least is the fact that even if all the methods of changing people's health habits are adopted, it will be a rather slow process. Invisible change always goes on in every society, and any attempt to move it too fast will only put off the expected change still further. For this work every worker in the field of health should be trained in health education methods, and a sustained effort by all will no doubt produce permanent results in the course of time. Health education based on scientific findings should form an essential part of the curriculum for physicians, sanitation workers, health visitors, midwives and all other health workers. The ultimate success of the short term programme will depend upon the attitude of the local leaders in understanding and appreciating the benefits to be derived from the improved health habits and the sincerity of the workers.

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Centres at Najafgarh (Delhi), Poonamallee (Madras) and Singur (Calcutta). The Singur Centre, being located in the rural practice field of the All India Institute of Hygiene and Public Health, is greatly influenced by the Institute. In these three Centres health education forms a basic part of the eight weeks' in-service training for health workers of the Community Development Projects. The All India Institute of Family Planning, Bombay, and the West Bengal Government training scheme for family planning workers include health education as related to family planning in their curricula. Health education is also included in the training programmes for public health nurses, health visitors and sanitary inspectors.

Another important aspect of training in which the Institute has taken a lead is the in-service training for the staff of the rural and urban practice fields. Based on the principles of a workshop, they are essentially problem-centred discussions where health education methods are used in solving problems. Three such workshops have been conducted.

With the assistance of International Co-operation Administration (U.S.A.) and the World Health Organisation, a number of people have been trained in the U.S.A. and the U.K. Most of the health education positions in the country are being manned by such people and each State has at least one trained person or a person who is undergoing training.

In a short span of a few years, interest in health education and the need for trained persons in the subject has grown in enormous proportions. As time goes on and as health education gets more and more closely integrated with the day-to-day work of every health worker this need is bound to increase.

Health Education—Tangible and Intangible

A. Moarefi*

ONE great mental barrier of some public health workers in integrating health education with everyday work in public health has been the intangible nature of the subject. Health education is aimed at maturity of thinking, reasoning and decision-making of individual in respect to his own health, health of his family and of his community; therefore education should be depicted in a favourable action on the part of the individual and of the community. This process of necessity has always been a slow one. It has been slow because it involves habit formation, but once the new habit is formed, it will continue till change of values demand further change of habit. But, this intangibility is not only in the field of health education. Any general improvement has always been a slow process. Health itself, if it is defined as the "complete state of physical, mental and social well-being", does not seem at all tangible at a casual glance. One cannot purchase health as easily as one can buy an aspirin tablet. However, assessment towards this improvement can be done by step-by-step evaluation of the activities rendered. This "complete state" cannot be attained by a single type of activity. It is a process which involves gradual improvement from prevention of premature death and control of disabling maladies to promotion of positive health and enrichment of life. A step-by-step analysis of the achievements made towards this ultimate goal can usually be done. Health education can also be assessed this way and therefore it can be proved that even though in terms of a short span ultimate goal may not have been reached, nevertheless, long steps towards the goal have been taken.

In many other cases, however, one can actually see what amazing results have been gained from health education. A case in point is the control of diphtheria in New York City from 1929-1939. From 1920 and onwards, each year this City had over 14,000 cases of diphtheria, of which about 1,045 died. In 1929, the City Health Department carried an intensive educational programme for immunisation which after 11 years resulted in reduction of cases from 14,000 to 543 and number of deaths from over 1,000 to only 22. In addition to saving human lives, it is interesting to note that in terms of financial gain for the family, Government and prevention of economic loss to the community, after spending $ 4,55,000 in health education and immunisation in the 11 years, $ 58,68,125 were saved only in 1939. To some people even this experience may seem a long-term gain. Tangible results can also be gained through a well planned health education work in shorter periods if the problems are easier in nature.

Singur Health Centre provides several examples to prove this point.

A study of the proceedings of the weekly staff meetings will show that during malaria spray, when people were educated in malaria control and the necessity for spraying prior to the advent of the spray team to the village, the percentage of the households refusing D.D.T. spray dropped to 1 per cent or even less, but when no prior health education programme was conducted, refusals normally ran from 6 to 10 per cent. This easily proves that a little effort and a timely educational activity can produce a surprisingly encouraging result which in this case has not only saved people from malaria and assisted in breaking the chain of transmission but has also minimised the effort of malaria workers in continued referrals to the houses unsprayed.

An interesting example can be given in regard to the use of books of Library of Singur Health Centre. It was felt by the staff that Singur should have a richer library. In order to answer this felt-need and to prove that each one should take part in promotion of the community by his own effort, a campaign as a technique in health education was chosen in July-October, 1957. All the staff were requested to send to the library the books they owned, had read and did not need. As a result of this campaign, not only more than 200 books and 3,000 copies of

*W.H.O. Health Educator, Rural Health Unit & Training Centre, Singur. [Extracts from bulletin of Singur Health Centre (Vol I No. 2)]

health magazines were received, but also the use of the library by the staff and the students was increased to a significant proportion.

As a result of a careful planning in health education work in connection with vaccination and as a means of training students in practical application of health education after proper planning, in one evening the group of students in Re-orientation Training was able to actually vaccinate 680 people or slightly less than 50 per cent of the entire population of two villages in Singur Thana. Later on the same type of experiment was conducted for cholera with a result of more than 50 per cent inoculation in two days. The experiment was later continued with joint planning of the public health nurse and the health educator in a small village and resulted in 100 per cent inoculation in one evening. This result, which in itself was a great success, proved that health education approaches should be adapted to local situations and problems, for gaining lasting results. Not always, however, health education will produce striking results in a short time. Those who do not find tangible results must, as it was said earlier, assess the activities step-by-step. Obviously, there are many cases in which improvements could be considered intangible in respect to time. It should also be realised that in these cases the problems themselves are not either readily solved or a particular community may respond differently to a particular situation. It must be reminded again that health education aims at maturity and growth and not achievements alone. Therefore, health education whether tangible or intangible should be considered as an integral part of every health activity, if lasting results are sought.

A time thus devoted to health education and funds thus spent in this type of activity will bring its dividends in terms of vast economic gain for the community and great satisfaction for the health workers. But as the most welcome dividends, it results in saving of lives and reduction of pains in a population mature enough to take intelligent decisions and willing enough to act accordingly.

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finger-tips aids which he can use, the chance of his getting across his ideas and reasons is better. Secondly, many patients and relatives need to know a great deal about the disease which is affecting them. For instance, a tuberculosis patient needs to know how he can protect his family and friends from this dread disease. A patient with diabetes needs to understand that he requires continual treatment and that we have no cure for this disease but that constant medical care will keep it under control. Heart disease patients have to realize that they have a deformity which limits their activities and they must learn to live within their capabilities. Patients suffering from any of the filth-borne diseases are ready to learn about how these can be prevented. In these instances the tendency is for the doctor to skip over everything except the specific medical treatment and hope that patient will find out about prevention some other way.

We know that a busy doctor does not have time to undertake all of this educational work with each of his patients, but if he knows how it should be done and what is available to help in getting it done, he can have materials on hand and can encourage his staff to become proficient in health education and to carry it on continuously.

A greater area of service is open to doctors trained in these methods in that they are ready and able to assume responsibility for the health education of the public. This community service can only be done when doctors are familiar with methods and techniques. We trust that when our students undertake their medical practice they will look out for the general welfare of the public and participate in the educational programmes which are necessary for the improvement in the health of the people of this land.

Health Education Programme in Uttar Pradesh

Dr. S.S. Bharara*

THE Uttar Pradesh State Hygiene Publicity Bureau was established in 1922 as a pioneer health publicity wing of any Directorate of Health Services in the country. Modern education has to bridge the wide gap that exists between what is scientifically known about health and what is actually believed and practised by the people. Recognising that this could be done only through a correct educational process, the activities of this Bureau are now being planned with greater emphasis on education than publicity. The Bureau has, therefore, been renamed as Health Education Bureau and steps are being taken to reorganise its activities in accordance with the scheme recommended by the Central Health Education Bureau.

Staff and Activities

The Bureau is under the charge of Assistant Director who is helped in its health education activities by two Health Education Officers, an Exhibition Assistant and a Film Librarian. The Red Cross and the St. John Ambulance activities are also conducted in conjunction with that of the Bureau. Jointly with these two organizations, the Bureau renders consultative services to other sections of the department and other Government and voluntary organizations in developing their health education activities, methods, material and media and organizes health exhibitions in the State with the help of very attractive models and translight exhibits.

The Bureau produces health education literature—pamphlets, posters, handbills, and disseminates knowledge on health topics through the various personnel of the department.

School Health Service

The Bureau conducts School Health Services through School Health Officers posted in 14 urban areas of the State. These officers examine male students for physical and other defects and give them necessary treatment at the school dispensaries. They also organize the Junior Red Cross groups and carry out health education programmes in schools.

Five Health Education Units, equipped with modern audio-visual aids, film projectors, film slide projectors etc. are working in five districts of the State doing intensive health education work in the rural areas on general local public health problems.

Other activities of the Bureau include the maintenance of a Health Museum in the Bureau and conducting of in-service and pre-service training programmes; maintenance of a film library and showing of films in the Museum Hall besides lending these to various districts for arranging shows.

It also helps the District Medical Officers of Health in holding health exhibitions during various fairs, conferences etc.

Field Study

The activities of the Bureau are now being supplemented by the field study and research in health education methods and media being conducted by the Planning Research-cum-Action Institute in the State. The department of Preventive Medicine and Public Health in the Lucknow Medical College is now developing a field study and demonstration centre in Sarojini Nagar, about nine miles from Lucknow, where cultural and social patterns of the community will be studied and health education methods tried.

W.H.O. Expert

The World Health Organization is shortly sending an international expert in Health Education to assist and advise the State Government in developing and expanding the activities of the Bureau. The W.H.O. expert will help in organizing conferences, seminars and training programmes, establishing a full-fledged library, developing audio-visual aids and producing literature scientifically.

*Health Education Bureau, Lucknow.

The activities of the Bureau are now being planned to be expanded. It is now known that it is no use just passing on information to the people unless their attitudes, beliefs, behaviours and practices of the people are changed by a process of education. The problem is huge when we consider that there are over 63 million people in Uttar Pradesh mostly living under very insanitary conditions, amidst poverty, low level of literacy and poor means of communication.

The Bureau is now actively considering steps to reorganise and reorient its activities with a view to follow scientific educational approach in raising the health consciousness of the people. Following steps have been proposed.

State Health Council

As recommended by the Central Health Education Bureau, the constitution of a State Health Council and a State School Health Education Committee are receiving active consideration. This will help involve local leaders and resource persons in planning programmes, coordinating and supporting the activities of the Bureau and in furthering the school health education programmes.

Fundamental to the achievement of any success in health education, it is imperative that all medical and public health field workers and personnel of other departments engaged in Education, Information, Social Welfare, etc. should be trained intensively in health education so that they could educate the people. Health education will thus become an integral part of every activity of the personnel of this department and of other allied agencies. Besides, the leaders among the communities have to be recognised, approached and organised in helping the people to solve their public health problems.

It is, therefore, proposed to intensify training in health education for all in-service and pre-service personnel, who are being trained at the Provincial Hygiene Institute, and other training institutions of this department and that of the Planning, Education, Social Welfare etc. It is also proposed that conferences, seminars and short-term training programmes should be organised at least twice a year at the State headquarters and at the four Range Headquarters, each lasting for a week.

It is proposed that a mimeographed newsletter should be brought out from the Bureau every quarter, which will be a very effective tool for in-service training.

Except at Lucknow, the medical colleges at Kanpur and Agra do not have a full-time professor in Preventive Medicine and Public health. Till these are provided, the Bureau could conduct at least 10 hours teaching in health education (including two hours in cultural anthropology and two hours in social psychology, to the undergraduates.

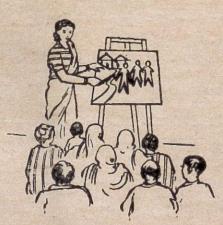
The five health education units will now be utilized in the collection of data on health education needs, interests, value systems, cultural, patterns, attitudes, beliefs, practices of the people as far as health and sickness are concerned. They will also pre-test material and evaluate health programmes.

It is proposed that the Bureau should utilize all media of mass communication effectively. A weekly programme on the All India Radio to be incorporated within the village programme should be developed. The newspapers should be further utilized effectively. The Bureau should publish an annual report in the form of profusely illustrated brochure to interpret State health programmes, services and policies to the different sections of the people and thereby win public interest and support. This Bureau may thus become a liaison agency between the Directorate and the people.

The Bureau is now extending consultative service to other sections of the department and other governmental and voluntary organizations to develop and execute health education programme. This will help in co-ordinating health education activities in the State.

A gradual revision of the material and literature etc., produced by the Bureau long time back has been planned.

The activities that have been proposed do not envisage any increase in the present finances or personnel. These will put the working of the Bureau on scientific pattern and will help fitting in with future plans of expansion easily. The Centrally-assisted scheme and the WHO project, now in the offing, will help a great deal in furthering the cause of health education. nay the cause of public health.



HEALTH EDUCATION BUREAU IN BOMBAY

THE Government of Bombay has decided to establish an Health Education Bureau in the State as it was realised that health propaganda and dissemination of health information was not sufficient to change the health habits of the people. The aim of health education is to change attitudes, beliefs and behaviour related to health, if necessary; in the interest of individual or public health. By sound health education people can be motivated to act in the interests of their own health and that of the community. It will also lead to their active participation and co-operation in health schemes and programmes.

The Bureau will be organised on the lines of scheme prepared by the Central Health Education Bureau. There will be number of schemes pertaining to health education administration, materials, stores and distribution training and students health education and field study and demonstration. To begin with the administration and material section are intended to be set up and the remaining sections will be started with minimum staff and built up gradually.

Tasks Ahead

The Bureau of Health Education should provide leadership in techniques and procedures with a view to accomplish an improvement in health conditions. To get a basis for successful work, it will be essential to ascertain the existing health picture and to understand the various factors responsible for it, that is, to study the health habits, attitudes and beliefs of the people.

Field Workers

With this background, health education work has to be done in the field, and it is necessary to have a large number of field workers. Therefore, the Bureau initially intends to train, in the basic principles of health education, the existing field staff of the Public Health Service and other agencies working already at the village level. Similarly sanitarians, health visitors, midwives and those still under their training will also be given short courses in health education. In the long run this is expected to provide a substantial number of field workers in health education with sufficient background to do the job. The question of giving specialised training to some of these will be considered as the Bureau develops. Teaching and visual aids play an important role in health education. The visual aids will be collected from the existing sources, modified to suit local condition, and if necessary, they will also be developed by the Bureau and made available.

Health Museum

The State Government is shortly establishing a Health Museum at Nagpur in the near future. The Bureau and the Museum supplement each other and combine their efforts in providing information and education on health.

The present staff of the Bureau comprises an Assistant Director of Public Health, a health propagandist besides the ministerial staff. The World Health Organisation has provided an expert on health education who will assist the State for two years. The health educator provided by the World Health Organisation will act as the chief technical adviser to the State Government. He will be stationed at Nagpur.

It is expected that the technical and operational direction will gradually be transferred to the Indian counterpart assigned by the Government while the international expert would continue in an advisory capacity.

Training

Short pre-service training courses have been conducted for sanitarians and medical graduates. Similar courses for under-graduates have been started and are planned for health visitors. A beginning has been made in conducting lecture-cum-discussions on health education to village level workers. Seminars are held every week with medical college interns attached to the Health Unit at Saoner for three months to study public health. The Seminar helps to familiarise the participants (interns, the guests staff) with the technique of group discussion as a method to

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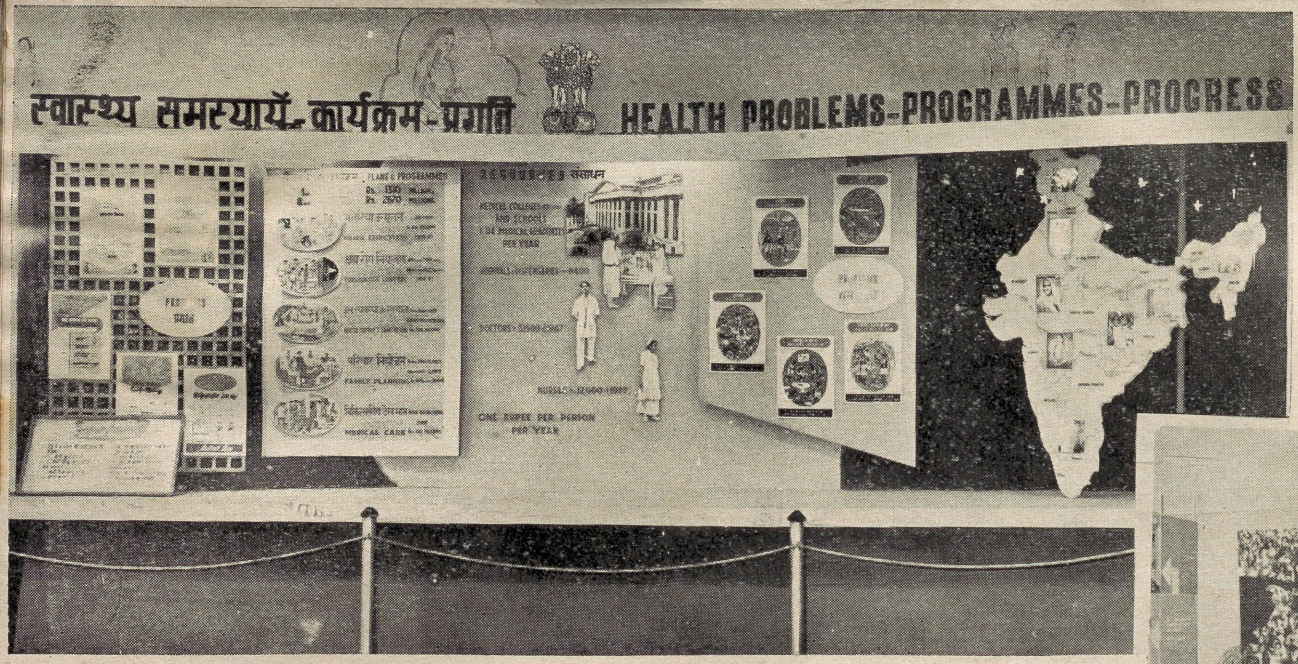
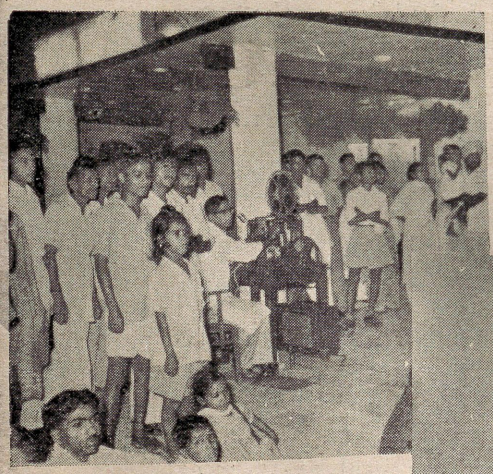


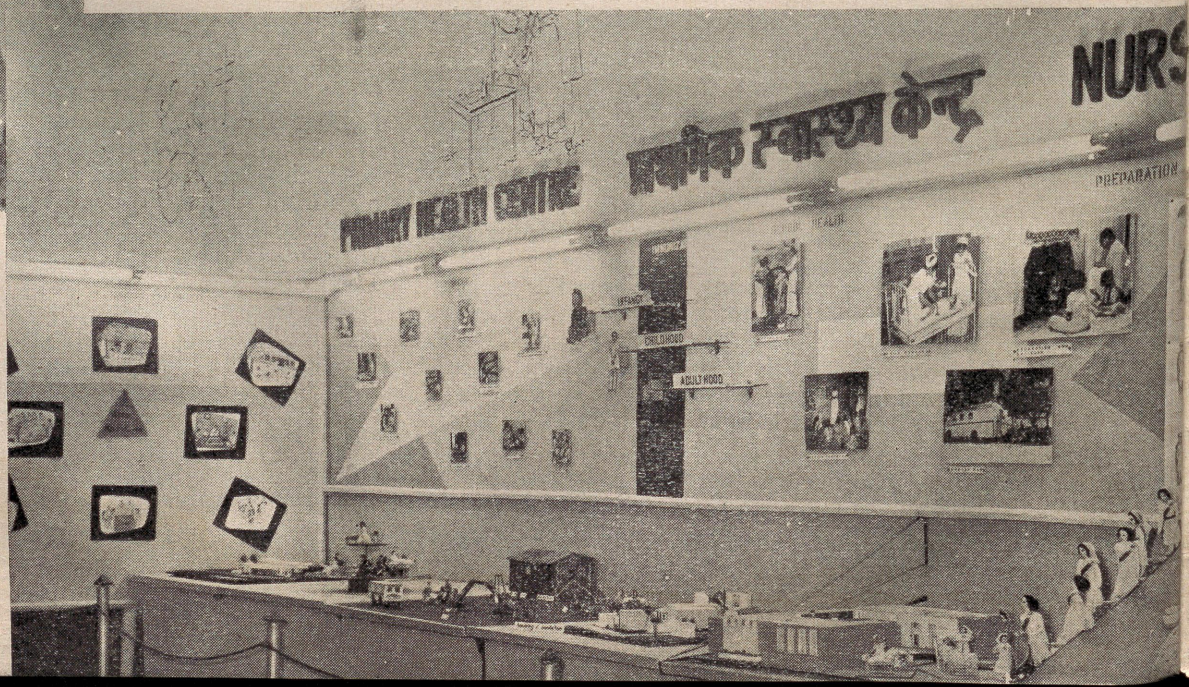
VISITORS TO HEALTH PAVILION

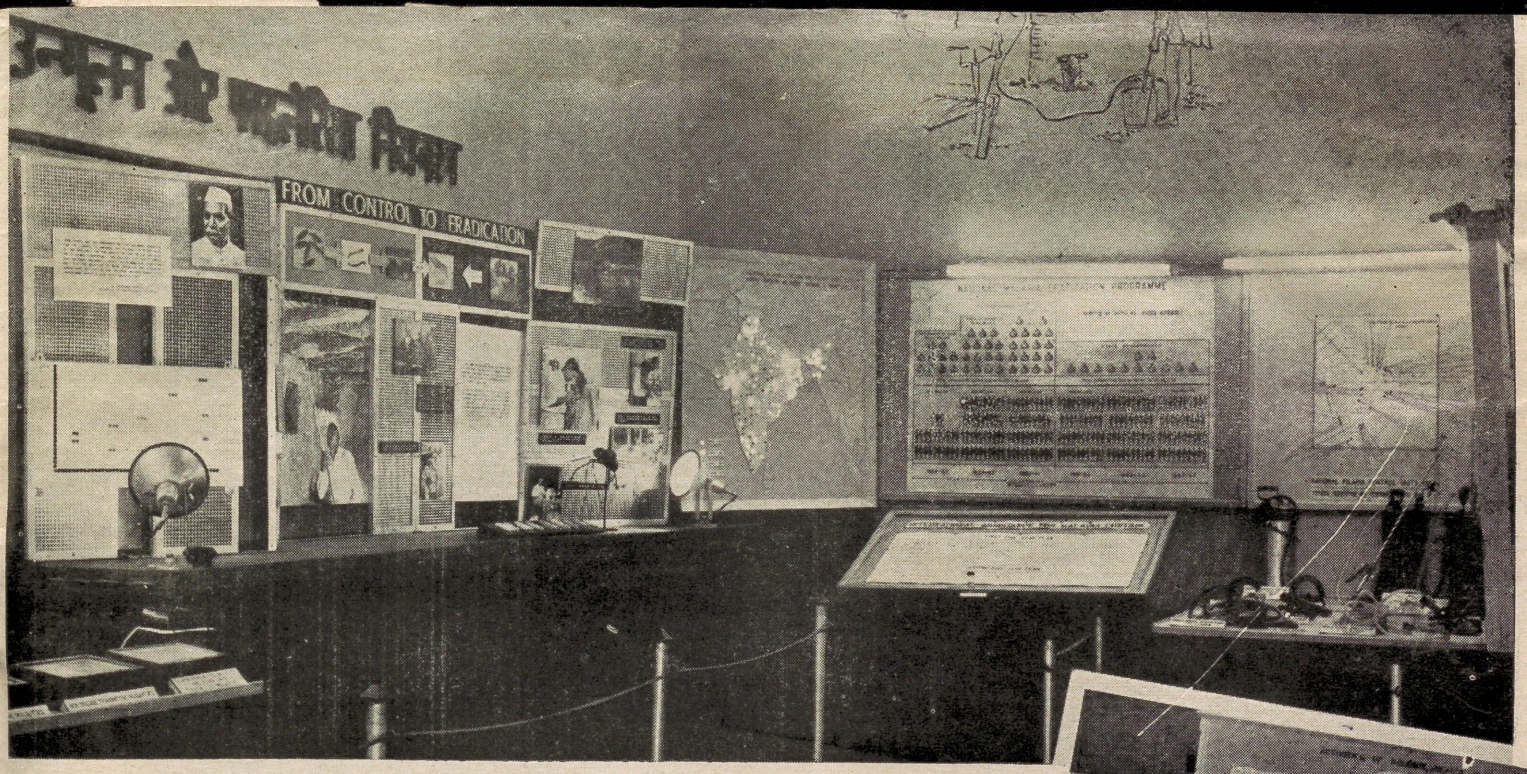
Health Pavilion, where models, pictures and other visual aids speak of the major health problems of the nation, the resources, the programmes and the progress in the field, is drawing a large crowd. Up to November, over two lakh persons visited the Pavilion, where the progress of the malaria control programme, that of the control of tuberculosis, that of maternal and child health services etc. are depicted pictorially.

A good number of visitors evinced keen interest in the health education literature produced by the Ministry of Health and over 4,500 of them have asked for the supply of publications on various health subjects.

The family planning stall had a good draw of visitors. The family planning workers at the stall faced a barrage of questions on the subject. About 1,500 persons have been referred to the various family







planning clinics. An attractive folder summarising the plan, and the progress of the family planning programme is being distributed free to the visitors.

At the maternal and child health stall a weighing machine has been installed for the benefit of the visiting mothers to have their children weighed. This facility was availed of by about 27,000 children.

Three film shows on health subjects have been arranged at the Pavilion daily. Over 30,000 persons attended the shows up to the end of November, 1958.

Children's Day Celebrations

CHILDREN'S DAY was celebrated throughout the country on 14 November 1958. Programmes of dance, music and drama by children marked the celebrations throughout the country. The importance to be given to the education and health of children and the need for co-ordinated effort of the governmental and non-official agencies in this regard was stressed at a number of meetings organised on the Day by Child Welfare and Social Organisations.

In the Capital, the Prime Minister, Shri Jawaharlal Nehru, inaugurated a children's train presented to Bal Bhavan, New Delhi, by the Union Ministry of Railways. Stating that it was the birthright of children to have all the love and regard one could give them, Shri Nehru expressed the hope that the towns and villages in India would have similar Bal Bhavans where the children could play, work, learn and grow up in a spirit of camaraderie.

Some of the Contributory Health Service Scheme dispensaries in New Delhi celebrated the Day. The programmes included baby shows, sports, health-exhibitions, variety entertainments and film-shows. Prizes and sweets were distributed to thousands of children who attended the functions. Shri D.P. Karmarkar, Union Minister of Health, who took part in the celebrations urged the parents to pay greater attention to the health and care of children.

Special Publications

The Central Health Education Bureau brought out special publications for the Day and assisted various child welfare and social organisations in organising the Day's celebrations.

Swasth Hind, its monthly journal, was a special Children's Day Number, carrying illustrated articles from experts on the theme of the Day—"The child that is sick must be nursed; the child that is physically or mentally handicapped must be helped".

Two booklets in Hindi—'Bachhon Ke Khel Khilone' (Children's Games and Toys) and 'Bachhon Ki Vyavaharik Samasayayin' (Practical problems of children)—were also brought out on the Day. Two posters captioned "Handicapped Child must be Helped" and "Prevent Diphtheria and Whooping Cough by Timely Immunisation" were designed and displayed at the Health Pavilion of the India 1958 Exhibition. Films on child welfare were shown at the Health Pavilion.

About 2,000 copies of the Special Number of Swasth Hind and over 4,000 copies each of the two Hindi booklets were distributed by the Bureau to C.H.S. dispensaries and child welfare organisations in the Capital and to all the State Directorates of Health and Education, State Councils of the Indian Council for Child Welfare for distribution among various district medical officers, schools and child welfare organisations. Besides the publications, sets of posters including the four of "Our children need" (series) were supplied to over 100 schools in Delhi and New Delhi and to State Directorates of Health and Education. The poster series comprised: Our children need protection from disease-carrying insects; healthy recreation; nutritious food and clean habits.

The Bureau also lent films on child welfare to organisations celebrating the Day.

The Health Minister broadcast a talk on the Day's theme from the Delhi Station of the All India Radio.

NEWS

Seminar on Malaria

THE annual informal meetings of the Malaria and Filaria Workers was inaugurated by Lt. Col. Jaswant Singh, Director General of Health Services, Government of India, at the Malaria Institute of India on 21 November. Dr. C. Mani, Regional Director of the World Health Organisation, South East Asia Office, Dr. Alvarado, World Health Organisation Adviser on Malaria Eradication and Dr. D.K. Viswanathan Regional Malaria Adviser, World Health Organisation, South East Asia Region were present.

Lt. Col. Jaswant Singh said: "This is a memorable day in the history of malaria eradication in this country. Indeed this is an occasion which will mark the eradication of malaria from this country within a foreseeable future." Malaria Eradication Programme, he said, had come into existence largely as a result of discussions held under the Indian Council of Medical Research, over a number of years, culminating into the World Health Organisation participating, advising and assisting us in its different aspects. Other agencies particularly International Co-operation Administration (U.S.A.) have contributed a major share in the development of this programme. It was the World Health Organisation, United Nations International Children's Emergency Fund who started the first demonstration for malaria control. For effective supervision and co-ordination of the Malaria Eradication Programme necessity has arisen for establishing regional centres, he said, adding that there were now six Regional Deputy Directors functioning in the States. They will take up the training programmes in hand in addition to other duties.

Dr. C. Mani said that the Indian Programme of Malaria Eradication was definitely the largest programme launched not only in this country but also in the entire world. The programme has a tremendous degree of importance because the whole world was watching India's efforts, and the results would have repercussions in many parts of the world. He assured that the WHO will place its support and assistance at the disposal of every worker of this programme."

Dr. Alvarado said that India's Malaria Eradication Programme was the biggest ever adopted in the field of public health in the world because it aimed at affording complete protection to the country's entire population of 390 million. "It is a question of the prestige of the man of science against the disease," he added.

LT. COL. JASWANT SINGH

Dr. B.A. Rao, Director of the National Malaria Eradication Programme, welcoming the delegates and others present, said that the inestimable value of such meetings lay in the opportunity afforded for a frank appraisal of the progress, drawbacks and finding remedies fo them. Dr. Rao announced that the Government of India had agreed to give 50 per cent cash subsidy towards the conversion of the control programme into one of eradication by the participating States and other organisations in the country.

Referring to the training of personnel, Dr. Rao stated that they would need to train 190 medical officers, 832 inspectors and 620 technicians. Facilities for training the medical officers were being augmented at the Malaria Institute of India. Arrangements for training the inspectors and technicians were being made in the States and at the Regional Centres with the co-operation of Directors of Public Health/ Directors of Health Services of the States.

THE annual informal meetings of the Malaria and Filaria workers was inaugurated by Lt. Col. Jaswant Singh, Director General of Health Services, Government of India in Delhi on November 21, 1958.

Dr. Rao emphasised the importance of total coverage in residual spraying and said, "The programme and its objectives should be explained to the people ; every citizen should be requested to participate in the programme. Refusals will have to be totally eliminated."

Dr. Rao said that though spraying operations had been in progress in different parts of the country; in some places for over 10 years past, no resistance had been observed in the vector mosquitoes. He, however, cautioned the workers "to be alive to this problem of resistance and to be on the look-out to detect any such resistance at its early stages."

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solve health problems, to learn and to stimulate action. This group of young physicians has a unique opportunity to study health education since they have close contacts with the villagers. The Bureau and the Health Unit help them to know the methods of learning and teaching and how health education fits in into the general public health work and medical practice.

A questionnaire to study the health habits, attitudes and beliefs of the people has been prepared after discussions at the seminar. It will be used by the interns as a basis for health education work in the villages and it is hoped that the information thus collected will be useful for the future work of the Bureau in preparing health education material.

A small pilot project has been taken up within a particular village. At several meetings in the village it was found that the people needed a new well. Then a decision was taken on the possible site for the well.

It is proposed to work out the details regarding the finances and labour. It is hoped that common planning and co-operative effort will bring about the desired result.

The Bureau, with assistance from World Health Organisation has started a library and is collecting material. It is hoped that the activities of the Bureau of Health Education and the Health Museum will enjoy individual and public co-operation and contribute to the progress of Public Health in the State.

HEALTH EDUCATION MATERIAL

NEW ADDITIONS

THE Central Health Education Bureau has brought out the following pamphlets, folders and posters on health topics during the first ten months of the year 1958. Fourteen pamphlets and folders are under print. Forty new films were added to the film library of the Bureau.

Publications

Bachhon Ke Khel Khilone
(Children's Games and Toys)
Backhon Ki Vyavaharic Samasyayin
(Practical Problems of Children)
Contributory Health Service Scheme
Cholera—How to prevent it
हैजा और इसकी रोक थाम
Delhi—A Plan in the Making
Filariasis
Malaria Unmulan
(Malaria Eradication)
Malaria Eradication—A symposium of messages
Nutrition for you
Slum Clearance and Urban Renewal in Delhi

Under Print

Compendium of the Activities of the Ministry of Health in the Second Plan
Eye
Eye Bank
Handbook for Mothers
Leprosy (Illustrated)
Leprosy
Low-Cost Balanced Diets (Suitable for South India)
Malaria
Maternal & Child Health
Medical Education conference Proceedings
Nursing Mirror (*Series*)
Training of Dais
Your Health—How to improve
Your First Visit to the Doctor

Posters

Our Children Need—(*series*)
- Protection from Disease-carrying Insects
- Healthy Recreation
- Nutritious Food
- Clean Habits

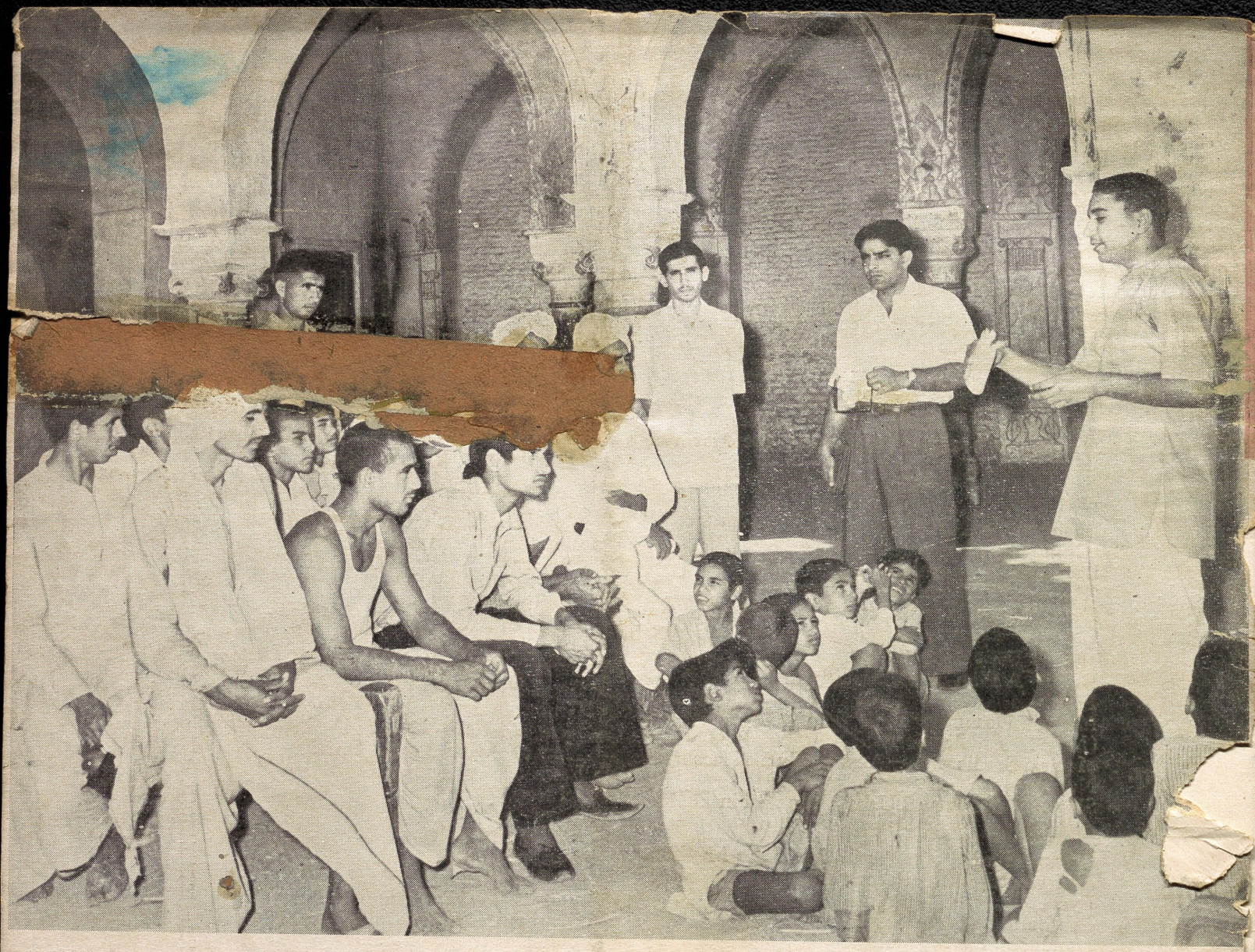
Have Your Daily Meals from Each of the Six Food Groups
Eradicate Malaria by Spraying

Films

Films	*Version*
All About Teeth	H
Along the Testa	H
Cholera	H
Crow and the Fox	H
Digestion of Food	E
Eyes and their care	E
First Aid	H
Getting Together	H
Good Health	H
Gram Safai	H
How Mosquito Spreads Disease	Silent
How to Avoid Muscle Strains	H
Human Development	E
Jaldeep	H
Jyoti	H
Killing the Killer	H
Lesson for Life	H
Lu Brothers	H
Maa	H
Mechanism of Breathing	E
Magic of the Mountains	H
Mental Slavery	H
Mission of Mercy	H
Nervous System	E
Nutrition in Pregnancy	E
On Road to Welfare State	H
Our Duty	H
Our Panchayat	H
Our Prime Minister	H
Planned Progress	H
Spring Comes to Kashmir	H
The Blood	E
Tomorrow is Ours	H
Training of Men	H
Vicious Enemy	H & E
Villages and Women	H
Welfare for the Workers	H
With Your Hands	H
Women and Education	H
Youth Activities	H

H=Hindi
E=English

Albion Press, Delhi.



Involving villagers in planning a health programme by group discussion and decision method

ON INDIA GOVT. SERVICE

BOOK POST

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