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PROJECT PROPOSAL

A FILM ON NON-FORMAL EDUCATION

A film on non formal education is being produced by Centre for Social Development (CSD) based on the experiences that the organisation has gained in working in this field.

Our non formal education programme addresses a particular class - children and adults of rural and urban areas who because of their socio-economic and politically underprivileged situation remain outside the ambit of the expanding formal education system.

The problem of growing illiteracy in this country, and specially female illiteracy, has confounded government policy makers and development activists. Despite enormous expansion of the formal education system since independence, the rural and urban poor, by and large, are left outside the boundaries of this system. Statistics relating to the problem of illiteracy on a nation-wide basis indicates quite clearly that our present education system remains class and gender discriminatory. Education is a commodity which can be bought by those with the purchasing power to do so to augment the power relations of the already privileged. In such a situation women, and specially poor rural and urban women, who enjoy the least privileged status in their families and in society, find no place in a system of education based on privilege. Children in poor rural and urban households are workers from a very young age, and therefore, do not enjoy the privilege of a childhood necessary to avail of the advantages of the formal education system.

The governmental response to the growing problem of illiteracy has been to promote and finance schemes for adult education and non formal education for children. By and large these programmes have been ineffective and have made no dent in the situation. The blame for the failure of schemes is being laid on the people - their lack of motivation and interest, on the workers employed to run such centres with little or no infrastructure or training available to them.

commensurate lack of faith in people's ability to learn, to acquire skills of awareness . In a sense we all subscribe in some way or the other to the larger educational culture which does not relate to the lives of the majority of our people and least of all to the overburdened, politically powerless female members of a poor household.

CSD began its programme in the context of all these problems. We soon identified the two main problems that we think need to be contended with in building a programme of education which serves this particular class and exercises positive discrimination towards women. Firstly, the educational needs of the learner. Secondly, the kind and quality of the human investment necessary to respond to the educational need of the learners.

Film being the most expressive form of communication in which it is possible to capture the innuendoes of experience has been selected as our medium - the learners and trainers - to highlight and pose questions about the meaning and significance of non formal education. The film is for us a learning experience and we feel that it will serve the larger purpose of helping all those interested and working in the realm of education for underprivileged groups to understand the meaning and content of the non formal approach, An approach which in its construction we have deliberately fashioned as a tool for the underprivileged sections of our society.

Who are our learners? Little children whose parents are menial workers and, therefore, are left in the care of older sibling for most of the day. Older children specially girl children who become part of the labour force from the age of 11 or 12; women who perform menial jobs in middle class households for a pittance and struggle at home to make ends meet. The main problem of these learners is time - to carve out some time in their busy work day for self development. Our main responsibility, therefore, is to devise strategies and curriculum which makes the best use of the learners' time and in return gives them the power of achievement. The motivation to learn is augmented by this growing power, by the collective nature of the learning pro$ess.

The film, therefore, tries to capture all these issues and also highlights the methodology to concretise literacy training which is not mechanistic and qualifies awareness education.

The making of the film was a participatory venture. Both learner groups and trainers articulated the content. However, since film making is a professional activity the direction of this documentary was entrusted to professional film makers. As is evident from the bio-data of the director, Rahul Bose, he is a committed film maker on social themes and has been an assistant to one of the foremost film makers in Bengal, Mrinal Sen.

Comm-33-8.

IDENTIFICATION OF LEADERS

IN HEALTH EDUCATION

Mere identification and involvement of leaders in health education programmes is not enough. More important problem is to sustain their interests in the assigned responsibilities. Herein lies the skills of a health educator in creating a situation to sustain interests of the leaders.

DR. K.S. SINHA

From time immemorial leadership has played a vital role in bringing about changes in the society. It is the human nature that people want to work together for solving community problems vital for the growth of the individual in particular and of the society in general. Indeed, the entire process of socialization is based upon the human interaction and acculturation. This process involves leaders in initiating desired change for human growth.

For bringing about a change from undesirable to desirable health practices through educational process, change-agents are required. These change-agents are primarily concerned with the identification and understanding of health needs of a specific community. They rank them in order or priority, find out available resources and develop a plan of action to meet the health needs. In this process, the entire community is involved and helped to help itself.

In the present day changing pattern of living, it is of significance to understand the multi-dimensional aspects of health and disease, i.e. preventive, promotive, curative and rehabilitative. It has been found that most of the diseases can be prevented. And through the process of health education, change in the knowledge, attitude and health behaviour of the people can be brought about.

Changing pattern of leadership

However, behavioural change requires understanding of the changing pattern of leadership and the role of leaders as change-agent. It is well-known that there are various types of leaders in our commu

Pre-requisites

It is essential to identify leaders in the community befor they are involved as change-agents. Here, it is worth mentioning that early as in 1949, L.D. Kelsey and C.C. Herne in their book, "Co-operati Extension Work" have pointed out that the pre-requisite for identificat of leaders is to know the following :

"1. What job is to be done?

2. What characteristics and skills this job requires?

3. Where the person possessing the needed qualitifation can be found?

4. What group will support or follow the person?

5. Of the qualities he has -

(a) Which of them may be improved by training

(b) Which may not be changed materially

6. Of the qualities he lacks -

(a) Which may be developed

(b) Which may not be developed.

7. The basis on which he can be induced to work".

In 1970, Dr. S.R. Mehta in his book, "Emerging Patter■ of Rural Leadership", has written that in the villages "there are possibly six distinctive areas of social life"and it is necessary"to identify leadership in each of these areas separately".

Six distinct areas are as follows

It is not enough to know the above mentioned criteria. It is also important to know the nature and magnitude of the health problem, and targets for education as well as services.

In some cases, targets for service as well as education may be the same; but in others, they may be different. For instance, in an immunization programme against smallpox, the service targets may be children whereas educational targets may be either the mother or the father or both.

Socio-cultural factors also play predominant role in decision-making process or selection of leaders. In certain situation health rituals based on misconceptions and deep-rooted value system and the role of priests cannot be ignored. But at the same time the fact that has to be kept in view is that "whereever traditionalism has given way for experimentation, social change has come". Thus there ar certain situations which require more than one type of leaders. The function of a health educator therefore is to understand such a situat and decide the specific type of leaders required to bring out a change in health practices. For example, in a family planning motivation programme for orthodox section of a community, it is worthwhile involv religious leaders, satisfied acceptors of family planning and symbolic leaders.

There is no denying the fact that symbolic and institutio leaders like "Sarpanchs" are very important. But, they can be more effective as change-agents provided they are also functional, i.e., po ing know-how in modern methods of agriculture. Such leaders are accep as change-agents for diffusion of innovation. Therefore, situations m be carefully examined, taking into consideration experiences of work i particular situation, finding out negative and positive forces at work etc., before actually identifying leaders for their active involvement in health programmes.

Methods

Based on the field experiences of organizing health education programmes in urban, semi-urban and rural areas through the

3. Group observer - This is anthropological way of locat leaders. In this method, the health educator works in a community f quite sometime and makes his observation regularly. On the basis of observations on various situations he prepares the list of potential leaders. Here, it is important for the health educator to create a siutation - where the community members do not get the impression tha they are being observed. This approach is action-oriented and the selection of leaders is based upon the actions taken by the potential leaders of the community.

4. Socio-metric method - This method is a little more technical than the other methods. This method is generally used by professional health educators, extension educators and trained social workers. The pre-requisite for this method is well thought out set o questions to be asked to the members of the different sections of a community. The questions for example may be "Whom do you consult when you fall ill?", "Whom do you consult for the marriage of your daughter", "Whom do you consult for purchasing particular variety of seeds?" etc. In this way, names of influential persons are listed fr different strata of a community and it is generally found that there are only five to seven common persons whose help is sought to find th solutions of various problems of different members of the community. These potential leaders are known as "initiators" or "spark plugs" fo other members of the community.

5. The election method - Many times leaders are identified through formal or informal election method. In this meth the health educator involves the entire community or section of a community in giving their opinion regarding their representatives to work as change agent.

6. Seniority and past experiences - Sometimes, leaders a identified on the basis of their involvement in health and welfare pr mmes for the community. Experiences of working with certain persons have proved useful in preventive and promotive aspects of health. Suc leaders are generally enthusiastic and energetic and in most of the ca are innovators.

The above mentioned methods of selection or identificatio of leaders are merely suggestive. However, selection of leaders deper considerably upon the situation and purpose for which they are selecte as change-agents.

Mere identification and involvement of leaders in health education programmes is not enough. More important problem is to sus tain their interests in the assigned responsibilities. Herein lies th skills of a health educator in creating a situation to sustain interes

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THE ADULT EDUCATION PROGRAMME

The urgency India is a vast country comprising 22 states an a population of 680 million . The vast majority of whom-80% - liv the villages in poverty, malnutrition, illhealth, illiteracy and stition.

The economic power is being concentrated in the hands of the powe the top 20% who own the land and industries, imposing a master-servant relationship with the 80%.

There is no true representation of the vast poor majorit . They h say in the decision-making of the country. The elections are cond by and for the power elite without any respect for democratic pri ples. Thus the so called political representatives are dominated by the money-power.

The caste system and the myth of untouchablity further aggravates sorrows of the poor. Thus religion becomes a tool of oppression.

The educational system is also geared to cater to the needs of th power-elite, where money can buy education and fit man into the structure making it a further tool of oppression, breeding unempl ment and keeping the 80% of the population silent and rural mass in total darknes.

Though the culture is rich and varied it is dying a slow death be of the dehumanising factors ever present stifling creativity.

In the final analysis, the caste system is the root cause of the socio-economical-political and educational oppressive forces wher the 20% of the population, [illegible], control the lives a destinies of the remaining 80%.

Our stand We stand for a just social order, where the poor have a say in the decision making, where there is a true represen of the now silent majority, where education creates awareness, dev skills and fosters the growth of talents, where culture is ever c

The adult education programme will contribute substantiall
making them socially aware, and critically conscious of the
which enslaves them and enable them to develop their skills
bilities and potentialities, giving expression to creativit
learning and sharing and growing together and finally chang
present oppressive, unjust and dehumanising powerstructure
humanising one.

Therefore We must therefore first of all liberate ours
in our thoughts, attitudes and behaviour, changing our pres
values, rejecting the old and discovering new values by bei
the people, ever learning from the people i a subject to
relationship, taking Jesus as our model. MY [illegible] IS THAT ther
in the present day context means the total liberation of man
dehumanising forces. This must be understood by all, in the
thereby helping to change the present structure and enabling
and effective participation of the laity in decision making
management.

Planing for action The present set up of the diocese is
that there is little or no active and effective participatio
the people in decision making. It is therefore not possible
adult education programme to be intergrated in to the presen
cture for a true social action.

A diocesan adult education team is therefore necessary to im
the adult education programme. Members of the team must be
dedicated and one with the people.

The team comprised the following .

1. Syllabus forum
Cultural forum(Aritists, Composers, Writers, Buscisions etc
3. Agriculture
4. Health "
5. Co-operative "

Motivation camps for adult education

The team moves to target villages for conducting preparato
for one to two days. The programme consists in presenting t
such as unity is strength, Organised action brings about su
evils of illiteracy, through cultural items like Adult Educ
songs Role Plays and Dialogical talks. During the programm
helps the people to form the Grammya Sangho for men and Mah
for women. They elect democratically the office bearers, Pr
Vice-president, Secretary and treasurer for the respective
sations. The whole village elects an Adult Education Instru
Village health Worker and if needed a n Agricultural animat
The above mentioned elected persons form the village commi
which is responsible for the planning and decision making o
developmental activities in the village.

The instructors of the 10 units form the adult education ce
adult education cells select animators for adult education,
and agriculture. All the Animators of all the cells togehte
the diocesan team form the diocesan central committee.

The training The team then concentrates on training the
instructors. The instructors will be trained in a village
be to experience the village situations gaining practical
sharing experience and finding solutions to crucial villag
Once in two months wil the animators together with the tea
meet in their respective cells.

Syllabus making During the preparatory and reorient
camps the team will also devote itself to finding out and

HEALTH EDUCATION C

FROM

CLASS I TO CLASS X

CO
VOLUNTAR
NE

SEPTEMB

HEALTH EDUCATION CURRICULUM

CLASS I

LEARNING OBJECTIVES	CONTENTS
(A)	(B)
1. To list out the good personal habits that helps to develop good health.	1. Clean habits are necessary for good health. 2. Personal hygiene habits should include: a. bathing every day b. cutting finger nails short, keeping them clean c. washing hands before eating d. burying feces with dirt e. cleaning teeth at least once a day

(A)	(B)
2. To recall clean places at home-school-playground etc.	1. What is cleanliness? 2. Why one must keep clean surroundings? 3. How places become dirty? 4. How to clean them?
3. To recall and recognize food items eaten by school children	1. Different types of food items a. eaten at home b. available locally c. what do they eat daily.

CLASS II

(A)	(B)
1. To inculcate in children good habits related to their sense organs.	1. The sense organs 2. How personal health habits relate to the parts of the body.
2. To list different parts of a housefly	1. Flies sit on all dirty matters like fecal matter, rotten foods etc. 2. Flies can spread diseases like diarrhoea. 3. Flies have eyes, head, leg 4. Through legs they can carr dirt from one place to other. 5. Food gets dirty when flies sit on them.

(A)	(B)
	6. To eat in dirty places wh create health problems
	7. Throwing banana peels all over will breed flies and flies can cause diseases like sore eyes, diarrhoea dysentry etc.
3. To make them aware of the importance of eating clean foods.	1. Food should be clean and from dirt and flies.
	2. Food must be clean and pprotected from flies.
	3. Hazards of eating food fr street vendors.
	4. Flies cause disease throu - dirty food,(eg.loose stools, diarrhoea et
	5. Dirt and flies make food unsafe for eating
	6. Hands should be washed bef eating and touching food

(A)	(B)

CLASS III

(A)	(B)
1. To develop the attitude that only clean water should be used for human life.	1. Sources of water in nature 2. How water can become unsafe for use 3. Methods of purification of water
2. To recall the diseases that spread through dirty water and to list how to prevent them.	4. What diseases are spread through it. 5. How to prevent them 6. Need of water in our body 7. Relationship of dirt/flies to diarrhoea.
3. To reinforce the good personal health habits taught in class I & II	1. Review the importance of a) bathing every day b) washing hands after toilet use c) washing hands before eating d) cleaning teeth atleast once a day. 2. An additional health habits should be learned a) taking proper care of eyes.

	(B)
4. To develop good food habits and hygenic practices. /especially after	1. Cleaning teeth and rinsi after eati ng helps prever dental caries and tooth- aches. a) What are caries? b) How is it caused? c) Food items related to caries and decay d) Better oral hygiene c prevent caries.

CLASS IV

(A)	(B)
1. To recall the diseases that can be spread through air and water. 2. To list the measures to prevent them	1. Common preventable diseases of child hood 2. Immunization schedule 3. All about loose motions, diarrhoea, jaundice and other disease spread through water. 4. What is done in diarrhoea? 5. How to make ORT? 6. How is malaria caused? 7. How mosquitos breed?
3. To develop an association of diseases with poor personal habits.	1. The child should begine to learn why these health habits are important through an association of poor health habits with poor health. a) a basic discussion on diseases b) during the review of the personal health habits the children will be taught the health consequences of self care. c) poor self care will be shown as a contributing factor in such illness as worms, cough, cold, sore eyes skin infections etc.

(A)	(B)
4. To be able to relate food to the need of the body.	1. Functions of the food item 2. Needs of the body 3. Digestion and assimilation of food. 4. Eating the right kind of foods and eating often is important - why food is essential to life. 5. Certain locally available foods keep us healthy. Som foods, not so useful. 6. Food is needed for growth energy and repair.

CLASS V

(A)	(B)
1. To list out disease one can suffer due to dirty surroundings.	1. All about various diseases like malaria, tuberculosis, diarrhoea, jaundice etc. 2. Life history of mosquitos 3. How malaria is caused? 4. Functions and structure of lungs.
2. To develop healthy attitudes towards self preservations.	1. Discuss body parts and functions of internal organs and skin. 2. Discuss basic functions of - a) respiratory system b) digestive system c) muscular skeletal system and protective function of skin. 3. Relate the importance of good hygiene to the proper functioning of these 4 systems.

(A)	(B)
3. To be able to select appropriate food items and take balanced diet.	1. Various food items needed fo the body. 2. Balanced diet. Why it is needed? 3. Preservation and proper storage of food. 4. Some foods can be eaten raw while others need cooking before eating. Raw food shou be washed well. 5. Sprouting of grains and puls increases their food value.

CLASS VI

(A)	(B)
1. To develop habits of a) sleeping in good ventilated rooms b) to breathe in fresh air c) to use latrine instead of fields.	1. Structure of lungs - their functions, how we breathe. 2. Composition of sunlight how it can kill germs and bacteria. 3. How we get enough Vit.D from sunlight. 4. Why oxygen is needed by your body? Why we breathe faster after running and exercise (Physical) 5. Different types of latrine available in schools, urba and rural area. 6. Diseases spreaded through fecal matter - worms, hepatits and jaundice How can they be prevented. 7. Life history of eminent scientists? 8. Life cycle of round worm, 9. Why shoes, slippers must be used while walking on ground.

(A)	(B)
2. Same as in previous classes	1. Continued association of health problems that are caused by poor health habits 2. Increased understanding of how the body functions and its various systems 3. Explain in greater detail the various problems caused by poor hygiene 4. Further discussion of body anatomy and physiology and discussion of - i) circulatory system ii) nervous system
3. To develop habits of eating nutritious food.	1. Cheap locally available range of foods that promote growth, energy and repair. 2. Fats, sweet foods - their function 3. Cheap food can be as good as expensive foods for health and growth.

(A)	(B)
1. To develop an attitude to safeguard against accidents at home and on the road.	1. Different types of accidents at home/on the road/ in the school. a) injuries b) foreign body in the eye c) burns d) swallowing of coins e) bites by stray animals f) how to prevent them and how to deal with them.
2. To develop attractive and self confident posture in students	1. How a clean body and mind can create healthy attitude to life. 2. Relationships and associations of behaviour with personal habits 3. Development of personality and growth

(A)	(B)
3. To list out various food items and their functions in the body.	1. Food classification bas on function and nutrien content. The four grou with the various food are: (a) Energy foods- eg. Rice, Wheat, banan Ragi, Jowar. (b) Body building food eg. Dals, groundnu fish, meat, milk. (c) Protective foods - Greens, carrots, tomato, oranges. (d) Fats and sweet foo eg. Jaggery, sugar, oil, butter milk. 2. What happens if the righ foods are not eaten in proper quantities?

CLASS VIII

(A)	(B)
1. To develop correct attitude and knowledge about the common diseases and their prevention.	1. General weakness(malnutritio 2. Malaria, diarrhoea, Jaundice 3. Visionary 4. Hearing defect
2. To develop in students a sense of responsibility about themselves.	1. Continue discussion on natu of germs, pathogens in the environment. 2. Continue discussion on anat and physiology of different organs of body.

(A)	(B)
3. To recognise signs of nutritional deficiencies	1. Early signs of malnutriti 2. Weight for height

(A)	(B)

CLASS IX

(A)	(B)
1. To act as health guides and monitor for the class and family.	1. Management of minor health problems seen in the family and school. 2. It is necessary to spell cut the minor problems again.
2. To develop the confidence in students to exert influence on younger siblings for better health habits.	1. Good personal habits in rela to health.

(A)	(B)
3. To recognise signs of nutritional deficiencies	1. Other nutritional deficienci early signs: (a) anaemia (b) Vitamin A,B,C,D defi encies (-) goitre. 2. Ways in which diet can be ma more nutritious For good health and normal development, the daily meal should contain a combination food items from all food groups. 3. Green yellow vegetables, are very essential. 4. Carrot, papaya,mangoes conta Vit. A and are good for eyes 5. Palak, methi, sag are good for b[illegible].

CLASS X

(A)	(B)
1. To develop the right attitudes towards health and illness.	1. Health care system in In 2. How and what is being do to reach the poorest sec of society in India. 3. National health problems
2. To teach children to function as 'Health Monitors' for younger children for peer groups.	1. First aid, Bandaging, Treatment of Burns 2. Prevention of accidents 3. Helping the Health worke 4. Treatment of minor compla 5. Increased knowledge of diseases and their prever
3. To develop the right food habits and to inculcate rht the right attitudes towards foods. To be able to motivate the peer group for better food habits.	1. Possible reasons for sick and lack of growth and e foods. 2. Foods should be distribut according to the need of body. 3. Economic problems and foo habits. 4. Population and food.

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ACTIVITIES OF THE NUTRITION AND HEALTH EDUCATION UNIT AT THE VIKRAM A. SARABHAI COMMUNITY SCIENCE CENTRE.

C.H.E.T.N.A

(Centre for Health, Education, Training & Nutrit

This unit was started during March 1979 when CARE Gujarat requested the VASCSC to develop some Nutr and Health Education Activities for children whic be conducted in their supplementary feeding progr all over Gujarat. In order to do so, a similar s tion (a feeding centre) was created at the VASCSC in the activities developed during the week were out on 100-150 urban slum children every Saturday Sunday. These children on completion of the acti were fed a ration of milk and bread as actually d the feeding programmes. A set of 50 activities w field tested with the children who came for feedi twenty five activities were finalised and approve by CARE for replication to the rural feeding cent supported by CARE.

Encouraged by the positive results of the above pr gramme CARE decided to fund another pilot programm through the VASCSC "Integrated Nutrition and Healt Action Programme"(INHAP) in ten talukas all over G in hundred selected villages with the primary obje of ensuring qualitative improvement in feeding pro grammes through

Since the material was field tested it was found t
technically sound, easy to understand and presente
a simple manner. These posters and pamphlets deve
in the INHAP were replicated by the Government of
in large numbers. (20,000) for use in all their nu
tion centres all over the State.

The overwhelming success of the INHAP approach in t
talukas of Gujarat further initiated CARE Gujarat t
fund a low cost approach to larger areas to cover 2
villages in a whole district (Sabarkantha) for a pe
of 2 more years during which many more materials in
form of health care posters, balsevika kit (A kit f
the cresche worker) in the rural area and manuals f
ensuring smooth implementation of programme were de
loped by the INHAP nutrition and health team at the

Two research monographs were written by the NHE team
A comparative study of awareness among nutrition pro
gramme functionaries and in para medical functionari
of old and new INHAP talukas.

The Nutrition and Health team during the period of
three years continued to conduct various trainings
both orientation/inservice and also held various sem
and training workshops. The Vikram A. Sarabhai Commu
Science Centre was recognised by the Government of
Gujarat as a resource centre for the orientation tra

The nutrition and health team have also designed, developed and produced the following nutrition and health education materials in collaboration with the following agencies.

1. A complete set of nutrition and health education materials for use in upgraded SNP centres all over Gujarat (1200 centres, funded by UNICEF & CARE).

    1. A set of 10 laminated multicoloured posters printed on board.
    2. A manual for SNP workers.
    3. Immunization card.
    4. Growth monitoring card.
    5. ICDS manual in Gujarati.
    6. Rehydration spoon to be used to make ORS solution.

2. A set of 12 illustrated training flip charts on diseases commonly leading to malnutrition in children for use in community health programmes by health workers (2000 centres) (field testing done in interior areas of Gujarat. In collaboration with Gujarat Voluntary Health Association funded by Xaviers Kelavani Mandal. (In Gujarati/ Hindi/English)

3. A complete set of material to be used for CHILD CARE by h[illegible]th workers. This is a trial

A training manual to be used by the trainer is enclose in the kit which enables him to utilize the kit approp

PROJECT AT PRESENT WITH CHETNA

1. ICDS (Integrated child Development Scheme) Orientation/Inservice training for all the functionaries involved in the ICDS scheme in the area of health and nutrition for which a communication and training need assessment survey is in progress Funded by USAID through the Government of Gujarat.

2. Training for paramedics involved in delivering health care services to children in the upgraded feeding centres in Gujarat. In addition to the above the team is required to develop relevant nutrition and health education material for the training purposes. In collaboration with CARE Gujarat and funded by CARE.

3. Design/Development of material for the topic "Anaemia and Women's Health" funded by UNICEF, Delhi via the Directorate of Adult Education, Government of India.

4. Training for child survival - Ford Foundation

The Nutrition and Health team at VASCSC have been regu

Con

Bureau of Health Education and Training

The Bureau of Health Education and Training was reorganised in the as per guidelines issued by the Central Health Education Bureau Governme with the following functions.

1. To Plan, Organise and guide Health Education activities as an integ part of State Public Health Programme.
2. To provide Technical Assistance and guidance in Health Education me to Voluntary Health Organisations.
3. To procure, produce and Store Health Education, Aids and Equipments their distribution to pheripheral institutions and to organise meet Conference, Seminars, Exhibitions, etc.
4. Assist Programme Directors in implementing their programmes.
5. Drafting of guides for Health Education activities.
6. To assist in conducting foundation and orientation Training Courses the Medical and Para-Medical Personnel and through the different tr centres scattered all over the State and Country like, Selecting Ca tes for Basic Training of Multipurpose Workers at 5 Health & Family Welfare Training Centres located at Bangalore, Hubli, Mandya, Raman and Gulbarga conducting Health Inspectors Training Course of 1 year duration for in Service Candidates at the Health Inspector Training Centres located at Mandya, Mysore, Mangalore, Bellary, Belgaum, Dha Gulbarga. Conducting 4 months training in Leprosy for Para-Medical Workers 5 days orientation Training in Leprosy for Junior Non-Medic Supervisors and 7 days Orientation training in Leprosy for Para-Med Workers and 7 days Orientation training in Leprosy for Medical Offi at the Leprosy Training Centre located at Bangalore, Hubli, Kollega and Gulbarga.

Conducting integrated Training of 3 weeks duration and Administrati

Selecting and deputing Health Supervisors for Diploma in Sanitary Service Course at Gandhigram Institute of Rural Health and Family Welf Tamilnadu.

Collecting and forward application of Medical and Para-Medical Pe to the Government for deputation to Haz.

Sending the Service Particulars of Medical and Para-Medical Staff (Speciality wise) for considering them for award of W.H.O. Fellowship.

Providing Supervisory field training to the Diploma Students in H Education deputed from All India Institute of Hygiene and Public Healt Calcutta and the institute of Rural Health and Family Welfare, Gandhig

7. To conduct field study-cum-Demonstration of Health Education meth and Media.

8. To Organise implement and Supervise School Health Programme. To ordinate with the Education Department and Department of Adult Educatio developing Health Education Syllabus, Text book, Mannual etc, and to Pl conduct Teacher, Training Programme.

9. To Organise Health and Medical Library.

Sd/-
Joint Director
Health, Education and Train
Health & Family Welfare

Dr Hemma Reddy Jr D
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duration for in Service Candidates at the Health Inspector Training
Centres located at Mandya, Mysore, Mangalore, Bellary, Belgaum, Dha
Gulbarga. Conducting 4 months training in Leprosy for Para-Medical
Workers 5 days orientation Training in Leprosy for Junior Non-Medic
Supervisors and 7 days Orientation training in Leprosy for Para-Med
Workers and 7 days Orientation training in Leprosy for Medical Offi
at the Leprosy Training Centre located at Bangalore, Hubli, Kollega
and Gulbarga.

Conducting integrated Training of 3 weeks duration and Administrati
finance training of 3 weeks duration to the Medical Officers 30 days for

Send one copy of circular to UHAK, Feroke.

Selecting and deputing Health Supervisors for Diploma in Sanitary Service Course at Gandhigram Institute of Rural Health and Family Welf Tamilnadu.

Collecting and forward application of Medical and Para-Medical Pe to the Government for deputation to Haz.

Sending the Service Particulars of Medical and Para-Medical Staff (Speciality wise) for considering them for award of W.H.O. Fellowship.

Providing Supervisory field training to the Diploma Students in H Education deputed from All India Institute of Hygiene and Public Healt Calcutta and the institute of Rural Health and Family Welfare, Gandhig

7. To conduct field study-cum-Demonstration of Health Education meth and Media.

8. To Organise implement and Supervise School Health Programme. To ordinate with the Education Department and Department of Adult Educati developing Health Education Syllabus, Text book, Mannual etc, and to P conduct Teacher, Training Programme.

9. To Organise Health and Medical Library.

Cataract - op; space + Rs 60 per head
Next budget Rs 10 lakhs for space.

Sd/-
Joint Director
Health, Education and Trai
Health & Family Welfare

- Lack of achievement of literacy rates
- Awareness of people on health issues inadequate
- Trg + retraining of health personnel, 32 types of jobs

VOLUNTARY HEALTH ASSOCIATION KARNATAKA
REPORT OF THE FOLLOW UP WORKSHOP 'HEALTH FOR NON-HEALTH GROUPS' HELD ON 10th &11th NOVEMBER 1989 AT MONTFORT COLLEGE OLD MADRAS ROAD, BANGALORE -38.

Voluntary Health Association of Karnataka has organised the followup workshop on 'Health for Non-Health Groups' of 3rd and 4th Sept. 1989. This workshop was organised in Monfort college, Old Madras Road, Bangalore -38.

The session started at 11.00 A.M. with the analysis and consolidation of the answers to the questions given for homework to the participants, during the previous workshop. The questions given were-

I a) Common ailments found in your area which can be tackle by you.

b) Other ailments which can be tackled by others help.

II a) Common dietary pattern in your area, which are the foo stuffs that are easily available?

b) What Knowledge in required to enrich the diet in your area?

III Collaboration with Government

a) What are the Health needs of your area as per your Knowledge?

b) What are the Health facilities you are aware of? and h are they made use of?

c) What are the ways to pressurise the Govt. to fulfil th Health needs of your area?

d) How can you make use of the Traditional Health resourc

1. Skin diseases-13
2. Diarhoea-10
3. Fever-10
4. Cold & Cough -8
5. Headache & Body ache-6
6. Stomach ache-5
7. Diseases of the eyes-4
8. Anemia-4
9. Worm infestation-3
10. Defiencies-3
11. Common E.N.T. Problems-2
12. Measles-2
13. Malaria-2

B. Other ailments which can be tackled by others help:

1. Asthama-8
2. T.B.-4
3. Leprosy-4
4. Eye diseases-3
5. Typhoid-3
6. Malaria-3
7. Fever-2
8. Handigod syndrome-2
9. Delivery problems-2
10. Problems of stomach-2
11. Cancer-2

II. Common Dietary Pattern:-

available in plenty. Many of them are ignorant of the nutrit value of the foods for eg., Nowadays in rural areas sugar is used for beverages but jaggery which is rich in Iron in gradu given up.

b) Common food stuff/available:

a) Ragi-9
b) Cereals-6
c) Vegetables-10
d) Greens-5
e) Jower-4
f) Rice-3
g) Wheat-1
h) Fruits-2
i) Jaggery-1
j) Milk, Curds-1
k) Meat-1

III. Health needs.

1. Health education
2. Immunization
3. Primary health care
4. Trained Health Workers
5. Essential drugs
6. Sanitation
7. Mother and child health
8. Mobile health unit
9. Weaning(enriched)foods
10. National Health programmes

8. Safe drinking water
9. Anganwadis
10. Mobile health unit
11. Smokeless chulas.

C. Pressure on Governments.

a. Demanding for primary health centres by women
b. Pressure higher authorities in govt.
c. Involving govt. health workers in village activities.
d. pressuring govt. through mandal panchayats & voluntary Or

IV. Use of Traditional Health Resources:

1. Bringing awareness among people
2. Encouraging Traditional methods of treatments
3. Encouring cultivation of Medicinal plants in the back yar
4. Promoting home remedies.
5. Educating and training the masses
6. Training to cultivate medicinal plants
7. Training health workers
8. Encouraging naturopathy
9. Collection & dissamination of knowledge of local practice

The groups also discussed about the govt. programmes, require and training needs considering the above questions in the 2nd session. The 1st group comprised of the participants from Chickmagalur, Coorg, Mysore and Shimoga. This group falt tha is was necessary to be aware of-

a) Govt. programmes, Health budget, Grants-in aid and what could be claimed

Health workers manual in Kannada, training fresh groups and to make the existing group to under go intensive training an impart health education to family.

The Rural Group II had listed the following:

a) Govt. Schemes and resources
b) Duties and Responsibilities of the Govt Health Personnel
c) Knowledge of about govt. free services
d) Aims and structure of P.H.C. and P.H.U
e) Sharing of knowledge among other voluntary organisations
f) Legal laws related to health
g) Method of health education
h) Communication means
i) Means and modification of health education method to elde and children
j) Developing low cost health education materials
k) Nutrition Demonstration.

With respect to the training needs the group discussed under the following heads:

Training needs-

- Identification of training programmes their limitations
- Training of local health workers in nutrition and first a
- Health education regarding the affects of smoking, consump of Alcohol, Tobacco, Chewing of Betal leaves etc.,

- Diseases due to malnutrition
- Instant foods
- How to educate people regarding nutrition

The participants from Chitradurga, Dharwar, Bijapur and Belg came out with the following points in group discussion besid these mentioned in the above groups.

- Identifying the reasons for the failure of govt. progr
- Role of Voluntary organisations and people to pressuri the govt. to be more effective.

Training in health education:

- How to make health education more effective to reach t people.
- Major diseases prevalent in a particular area.
- Environmental sanitation
- Occupational Hazards
- Involving schools and local bodies
- Evaluation.

Training Needs: the areas identified by this group were-

- Causes of common illness
- Identifying symptom of common illness
- Home remedies and first aid for common illness.

Training needs to impart knowledge to people in the 3 above areas the group p opined that need may be to know the

a) Preventive measures

b) Causes, sumptoms and preventive measures to control

c. Change the believes

d. Simple book on health in local laanguage with pictures make it more effective.

This group emphasised on:

- Mother and child health
- Herbal medicines
- Intencification of medicines and knowledge about prepar and use of traditional medicines. With respect to nutrition was of the same opinion expressed in other group, neverthe this group highlited the importance of income generating programmes. Regarding the government programmes there was stress on the policies and health situation concerning slu areas.

Health education methods:(demonstration, group discussion, play, puppetry, street theatre, slides, films etc). Availa health education materials and listing of existing health resources was discussed in this group.

In brief the significant points regarding govt. and trainir needs are-

Government

1. Knowledge about govt. policies and programmes
2. Responsibilities of health personnel.
3. Health rights and legal laws related to health
4. Make govt. work more effective
5. Role of voluntary organisations
6. Peoples role to make health as a movement
7. Health education and communication skills
8. Resource centres
9. Health indicators
10. Evaluation.

Training need

9. Health education and communication skills.

Dr. Gerry Pais chairing the group report session consolidat and placed the following questions which would facilitate i planning the training programme. The questions were-

1. Who should undergo the training?
   a) Health workers
   b) Leaders of the people
2. Whether the training programme should be comprising both of only one group?
3. Is it feasible to create awareness among people?(people' movement)
4. Should the training be imparted to those who are interes or who are already working in the field?
5. What be the duration of the training programme? and in w areas

a. Problems tackled by ourselves	1. People
	2. Health workers
b. " " " Doctors	
c. Traditional Medicine	1. People
	2. Health workers
d. Govt	1. People
	2. Health workers
e. Health education	1. People
	2. Health workers

There was also a discussion of the role and functions of the voluntary organisations at regional level.

views regarding the same.

Dr. Pais briefed about the consultative committee where i
Development Commissioner as the Chairman involving variou
heads of the departments and voluntary organisations. Th
consultative committes would discuss & ensure the followi

1. Volgas are supported to play the role envisaged in the plan documents.
2. Volgas are effectively involved in the implementation programmes of several departments of government.
3. Problems encountered by the volgas are represented to concerned district level heads of the departments and problems sorted out.
4. The committee would serve as a bridge between governme and various volgas of the district.
5. The committee would provide information flow between vo and district level heads of the department in district
6. The committee would ensure the speedy implementation o issues of immediate concern.
7. The committee would provide feed back about certain pol and programmes.
8. The committee would provide linkage to the volgas to wo in close association with several departments of the go directly at the district level.
9. The committee would discuss and sort out problems which cannot be solved locally.

The names of the members of the each committee representing volgas was also presented and Dr. G. Pais called upon the volgas to keep in touch with the concerned person. If there are suggestions or problems related to specific sub-committe to be discussed uring the meeting.

Dr. H. Sudharshan briefed about the health sub-committee meeting and programmes of the govt. regarding health.

To evolve an Action plan based on the following areas
a. Common illness which cannot be tackled locally
b. Intensifying resources to overcome major diseases
c. Health education
d. Traditional medicine
e. Health as a movement.

The participants were posed with two questions:
1. What are the resources required to achieve these.
2. Identify the resources in your own area.

Hence, the participants were divided into groups for discus After an hour of discussion the participants came together plenary session. Each group came out with the following.

Rural-1: This group had identified only the resources, they
1. Elderly ladies of the village
2. Trained Dais
3. Experienced persons
4. Anganwadi workers
5. Volgas

4. Govt. drug resource centre.

Resources: Local persons aware of health education
2. Local volunteers who would initiate health as a movement
3. Communication skills
4. Writers
5. Health workers skilled in various aspects.
6. Govt. resources(D.H.D)
7. Medical, Nursing and Pharmacy colleges
8. Hubli hospital for the Handicapped
9. Maladahalli yoga skishana centre
10. Ghataprabha Health Institute
11. Rotary, Lions etc.,
12. Snehakunja-Kasarkod.
13. INSA-Bangalore
14. St. John's Medical college Hospital-Bangalore
15. SIBS-Anand Giri
16. ETCM Hospital-Kolar
17. Amoha Ashram

Urban Group:1.a. Gardens, ICDS, writers
Resources: Representatives of people(M.L.A., M.P., Corporat
etc.,)people's associations and those who are interested an
service minded.

categorised under 5 heads

1. We and beyond limits for health workers -3 days
2. Traditional medicin e Health workers & people -3 days
3. H ealth and education+nutrition+Govt. programmes -Health workers - 3 days
4. Drugs-Legal-People's movement -Health worker public-3 da
5. State level Health education for all.

It was suggested that each organisation be represented by o project holder and one worker in the field of health. To b more effective the concept of working at regional level was accepted by the participants as a result the state was divi into four region; they are

1. Raichur-Gulbarga, Bidar, Bijapur, Bellary, Raichur
2. Dharwar-Belgaum, Uttara Kannada, Chitradurga, Dharwar
3. Bangalore-Mysore, Kolar , Tumkur, Mandya, Bangalore
4. Mangalore- Shimoga, Chickmagalur, Hassan, Coorg, Mangalo

The action plan evolved was that 4 workshop are organised i four regions of 3 days consisting of 30 to 40 participants in the year 1990 and 1991 during the months agreed by the participants i.e., 1. March and August in Raichur region
2. May and November in Dharwar region
3. June and December in Bangalore region
4. April and October in Mangalore region

The participants expressed and proposed to have a one day state level workshop inviting the govt. health personel to

Brief evaluation was done and the workshop came to end by of thanks proposed by Dr. Pais, Hon-Secretary VHAK to one all.

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NATIONAL EDUCATION POLICY IN HEALTH SCIENCES

BACKGROUND

The draft of National Medical Education Policy formulated by the Ministry in 1978, was considered by the Joint Conference of the Central Council of Health and Central Family Welfare Council in October, 1978 and April, 1979 and later by the National Medical and Health Education Conference in August, 1979. A revised draft was again considered by the Joint Conference of Central Council of Health and Central Family Welfare Council in June, 1981, and also by the Consultative Committee of Parliament in September, 1981. It was later decided to postpone consideration of the National Medical Education Policy till the National Health Policy was finalised and also the recommendations of the Medical Education Review Committee becomes available.

The National Health Policy adopted by the Govt. in 1983 envisaged formulation of a separate National Medical and Health Education Policy taking into account the changes to be brought about in the curricular contents, training programme of medical and health personnel and to provide guidelines for production of health personnel on the basis of realistic assessment of manpower requirements etc. The Medical Education Review Committee in their report submitted in 1983 also recommended the formulation of a National Medical and Health Education Policy. The recommendations of Review Committee were examined by an Empowered Committee which submitted its report in May, 1984. The then Minister of Health and Family Welfare discussed the report with

DRAFT

NATIONAL EDUCATION POLICY IN HEALTH SCIENCES

Submitted by:
PROF. J.S. BAJAJ
Chairman, Consultative Group *

PREAMBLE

1.1 India has a rich heritage of medical and health sciences as is reflected in the antiquity of health care and medical education, practiced since the prehistoric time. The key to the philosophy of Ayurveda is *Prasannatmadriyamana* i.e. a sense of harmony between the spirit, senses and mind. The principles and practice of medicine and surgery are described in Sushrita and Charak Samhita which constitute the compendium of knowledge as enshrined in Ayurveda. Greek medicine was brought to India in the 13th century and established its roots as unani system. The blending of Ayurvedic and Unani systems resulted in the Tibbi medicine. With the co-existence of Yoga and Siddha, India has all these indigenous systems constituting our traditional heritage. The homeopathic and modern systems of medicine were introduced in the last Century. The practitioners of all systems of medicine provide health care to the people of India.

1.2 Since the time India attained independence, there has been a rapid expansion in the education and training of practitioners of all systems of medicine. However, it is being increasingly realised that there has been a dichotomous growth of health services and manpower, each developing in isolation and without proper linkages in temporal and spatial dimensions.

1.3 Large investments in the conventional, biomedical, and newly emerging high technology research areas, have considerably advanced our fundamental knowledge about the causes and mechanisms of disease processes. Paradoxically, this has also resulted in a further widening of the gap between what is known and what can be delivered in terms of health care.

1.4 The National Health Policy of 1983 was enunciated to facilitate the development of an integrated, comprehensive approach towards the futuristic development of medical education, research and health services so as to serve the actual

*Members : Drs. Harcharan Singh, O.P. Ghai, B.S. Chaubey, Mehdi Hassan; Member Secretary : Dr. Ira Ray

are socially motivated towards the rendering of community health services.

1.9 The need for a National Education Policy in Health Sciences is also expressed in the reports of Medical Education Review Committee, 1983 and Expert Committee on Health Manpower Planning, Production and Management, 1986.

1.10 National Policy on Education, 1986 brought into sharp focus essential interlinkages between health and education policies. It emphasized that health planning and health services management should optimally interlock with the education and training of appropriate categories of health manpower through health related vocational courses.

2. SITUATIONAL ANALYSIS

2.1 There is an increasing awareness that medical education in itself is only a means and not an end towards the achievement of health objectives, that advancements in medical education both in quantity and quality have not resulted in parallel achievements in the field of health care, and that the vast potential of human resource for health still remains to be harnessed through the functional interlinkage of health objectives and educational strategies.

2.2 There has been an exponential growth in the number of medical colleges in India since 1947 when the country achieved independence. In health sector, the first two Five Year Plans between 1950-60 mostly attempted to translate into action those recommendations of the Bhore Committee which pertained to the development of primary health centres, expansion of medical colleges and the establishment of All India Institute of Medical Sciences. The annual outurn of medical graduates from 17 medical institutions in 1947 was less than 1400;it increased to 5387 from 87 medical institutions in 1965. In contrast, the emphasis during the last two decades has been to slow down the pace of expansion of medical education, to consolidate and further develop such educational strategies and experiences that would impart national relevance to learning programmes, and to strengthen educational content of internship. In addition, efforts have been reinforced to make the country self-reliant in postgraduate

utilisation of health services, it is imperative that job description of each category of health care personnel is precisely delineated. Specifications of the tasks and responsibilities of the job should form the basis of both new appointments and promotions, in addition to the usefulness in facilitating performance evaluation. It is in this context that continuing education which aims at updating of existing skills and facilitates the acquisition of new skills and knowledge, considered essential for optimal performance becomes a key component of not only the process of education, but also of the management subsystem. Performance linked evaluation, and assessment of health-related programmes must provide essential inputs for the development of meaningful programmes of continuing education as the knowledge and skill acquired during basic training may rapidly become obsolete in view of the changing patterns of disease and the new demands posed by the national and state health care delivery systems. With rapid explosion of knowledge, it is now beyond the reach of any health care provider to keep abreast of the advances. Although several attempts are be ; made to develop a large number of continuing medical education programmes for medical practitioners and specialists, there is a need for cohesion and coordination in this area. Similarly, for the para-professionals, well considered programmes of continuing education of all categories of health professionals, need to be developed.

2.7 There is a general lack of awareness and non-availability of appropriate technology of education in institutions of health manpower training and education. Indeed, this holds true for several courses of instructions in other branches of higher and vocational education. While the teachers and instructors may be highly efficient professionals in their own branch of vocational specialisation, they continue to display extreme amateurism in fulfilling their responsibilities as educators. Although several fora in recent years have emphasised that education in health sciences must provide greater opportunity for independent and self directed study, no effort has been made to facilitate the acquisition by teachers and instructors of appropriate skills that would encourage and facilitate this

tion and training of students. A major lacuna has been the inadequate physical facilities available in such settings, thus creating frustration amongst students and teachers due to the prevalent logistic problems inherent in the residential postings of students in the community settings.

2.10 The role and place of one or more well equipped libraries in all institutions of health sciences is well recognised. There is a woeful inadequacy of such libraries due to lack of appropriate learning materials such as slides, audio tapes, video- tapes and other learning resource materials,both print and non-print,which are considered conducive for imparting requisite learning experiences.

There is a need of strengthening and updating of the National Medical Library in New Delhi. More importantly, there is a need of similar libraries at the regional levels with networking arrangements both with the central libraryas also with the institutions of health sciences within the region.

2.11 Appropriate technologies of education, relevant to the needs and demands, are generally lacking in most institutions, and non existent in ot rs. Well designed and validated self instruction materials in any branch of health sciences are non-existent. There is hardly any well organised and coordinated effort to design learning materials which could be used in distance learning. New technologies of education are not only relevant to the design and production of learning resource materials for regular courses of instructions at the institutional level, but are more appropriate for strengthening continuing education in health sciences with emphasis on the component of the self directed learning.

3. OBJECTIVES

3.1 The National Education Policy in Health Sciences seeks to achieve the following:

1) quantitative and qualitative development of appropriately trained health manpower for all categories of health care providers;

2) definition of educational strategies and curricular reforms considered essential for the community-oriented training of different categories of health personnel, with a view to establishing esential interrelation between functionaries of

medical education so as to make it more humanistic, nationally relevant and socially committed. The curricular contents and teaching-learning activities must therefore, be directed to achieve:

1) a proper balance between technological and humanistic medicine;

2) a more holistic approach covering promotive, preventive, curative and rehabilitative aspects of medicine;

3) a proper balance between the tertiary care hospital-based and primary care community-based education.

4) a shift of emphasis from the use of teacher-oriented to learner-oriented methods which would include self-initiated, self-directed learning and self-evaluation;

5) a progressive change from a narrow discipline-oriented teaching to a problem-oriented approach;

6) a shift from theoretically-oriented teaching to experimental learning;

7) a major change from the practice of factual memorization and recall to the acquisition and practice of professional skills; and

8) a major shift in the medical teachers' role from imparting a defined quantum of knowledge to that of a facilitator and motivator of community-based student learning.

3.4 FACULTY DEVELOPMENT

In order to be able to effectively implement the defined educational strategies, criteria for the selection and subsequent promotion of teachers should be so modified so as to aim at improving their competence in their role as facilitators and motivators for student learning. The social attitudes of teachers must receive consideration both during recruitment and promotion and opportunities must be provided so that the teachers, irrespective of discipline or affiliation, obtain first-hand experience in community health.

Developments in medical education are not only a response to scientific and technological advances but also reflect changes in community patterns of disease, social dynamics underlying community development and the demands posed by the social functions of medicine. It is , therefore, essential to develop and implement staff retraining programmes which would enhance the role of teachers in the training and education of students

from barely 17 at the time of independence to more than 120 at the present moment. The annual out turn of the doctors today is a formidable number of about 14-15,000 doctors per year. It is unfortunate that the training of doctors in India is not related to the health needs of the country. Serious efforts are being made to correct this malady. A basic doctor, to effectively deliver health care to the country, must be an astute clinician, a good communicator and educator, and a sound administrator, so as to effectively lead an ever expanding health team for a positive health action work and action domain of the doctor has crossed the boundaries of drugs and dispensaries and presently extends to a large extent to the families and to the communities - hence the need for the basic doctor to be a community physician. The National Education Policy in Health Sciences aims at and strives towards the production of basic doctors equipped with adequate knowledge, requisite skills and appropriate behavioural attributes to meet the health needs of the country.

4.1.2 First level specialists:

Specialisation is the order of the day. The major specialities needed to manage the Indian health problems are the ones which have been identified at the first level of referral in the National Health System, i.e. the Community Health Centre/ Taluk Hospital/Sub-district hospitals. Five specialities have been identified at such level of intermediate care. All out efforts will have to be made in the coming years to produce these specialists in adequate numbers and wholesome quality. Specialities identified are :

1) General Medicine
2) General Surgery;
3) Paediatric (child health)
4) Obstetric and Gynaecology;
5) Public health/ Community health.

The National Education Policy in Health Sciences will have to focus on the development of these specialists both from the professional point of view as also with regard to the societal needs. Uptil now about 1500 community health centres have been established which are likely to grow to a formidable number of about 1600 by the 8th and 9th Plan. The whole area of their training and education needs a close and critical examination.

edge and skills as envisaged in the Health Manpower Planning, Production and Management Report (Bajaj Committee report) wherein it is proposed to be taken up as a part of vocationalization of general education at the 10+2 level. The National Policy will have to seriously consider this issue.

4.1.6 Post-basic nurse

The number of post-graduate nurses in the country is very small. With the ever increasing specialities and super-specialities, specialised post-basic nursing education programme will have to be increased. Yet another area which needs attention is the area of public health nursing and the production of well groomed public health nurses.

4.1.7 Graduates in Dentistry:

Dental health in India is seriously threatened by inadequacy of dental services as also the ignorance about the principals of dental health in the community. India has barely 10,000 dental doctors in the country. This number is grossly inadequate to meet the dental health care needs. Over the years much more rational policy for development of dental education both for dentists as well a para-dental persons will have to be pursued.

4.1.8 Postgraduates in Dentistry

The number of postgraduate courses in dentistry is very small, with only a few Dental Colleges in the country imparting post-graduate dental education. With an era of specialists and super specialisation, dentistry cannot lag behind. In the coming years proper attention will need to be given to the development of postgraduate courses in dentistry.

4.1.9 Other categories of health care providers; first level and middle level: It is being increasingly recognised that professional people are too far important and far too expensive to be used for routine rituals of medical and dental health care. The vast number of paramedical and Auxilliary health professionals are being trained in the country who are going to play a very dominant role in the provision of health services to our people. The number of categories of various kinds of professionals and paraprofessionals would be more than 100. Ten core para-professionals have been identified by the Bajaj Committee. These categories will need to be developed on priority

sised under 2.10 However, it must be reiterated that the mechanism for dissemination of new information expeditiously to health care providers so as to translate such information into action for delivering health services, is almost non-existent. To build up a viable medical information network, it would be essential to pool the existing resources and services, with regional postgraduate Institutes acting as information clearing houses, and National Medical Library assuming a coordinator's role for monitoring the network activities and programmes. A major effort needs to be launched during the 8th Five Year Plan for the establishment of the proposed MEDINET network.

5.0 MECHANISMS OF IMPLEMENTATION

5.1 Education Commission in Health Sciences

There is a need for a central organisation in relation to professional education in health related fields. As recommended by the Medical Education Review Committee, and accepted by the Government in principle, a Medical and Health Education Commission, on the pattern of University Grants Commission, needs to be urgently established,. It shall be general duty of such an Education Commssion in Health Sciences to take, in consultation with the universities and professional councils concerned, all such steps as it may deem appropriate for the promotion and coordination of education in health sciences. The Commission would deal with all branches of health sciences, including medical sciences at all levels, as also nursing, pharmaceutical and dental sciences and other categories of health care providers.

The broad objectives for the Commision would include :

1 Continuing review of national health manpower requirements in the context of evolving socio-epidemiological needs and demographic requirements.

2 Ensuring the creation of educational institutions and facilities, or strengthening of such facilities in already existing educational institutions, that would facilitate the production of projected health manpower, and to consider the establishment of one or more Universities of Health Sciences.

5.2 Universities of Health Sciences

fessionals, such a structure needs to be considerably strengthened to fulfil its role and objectives.

5.5 National Apex Body

The National Policy in Education, 1986 envisages the establishment of a National body covering higher education in general, agriculture, medical, technical, legal and other professional education, for greater coordination and consistency of policy, sharing of facilities, and developing inter-disciplinary research. The need for the establishment of such an apex body stems from the fact that presently, the responsibility for development of higher education is met through seperate structures without any coordination. Such a separation in the decision making and funding mechanisms is not conducive to respond to the needs for the growth and development of new emerging disciplines such as biophysics, biotechnology, molecular genetics etc. where there is an acute need for developing compatible interfaces with other related disciplines. The National Education Policy in Health Sciences, taking cognisance of the decisions already taken with respect of development of a national apex body, strongly endorses the need for such a coordinating mechanism.

6. LINKAGES BETWEEN HEALTH CARE DELIVERY AND EDUCATION IN HEALTH SCIENCES

A formidable health infrastructure for health care delivery is being established in the country. This infrastructure suffers from suboptimal performance. One of the important reasons is the poor quality and inappropriateness of the education and training of health care providers. As such, it should be mandatory to establish innovative linkages between the health care delivery and the education in health sciences to make the whole system efficient and effective.

7. PRACTITIONERS OF INDIAN SYSTEMS OF MEDICINE AND HOMEOPATHY

India has the maximum number of manpower in Indian Systems of Medicine and Homeopathy (ISM&H), of whom a significant proportion is institutionally qualified and certified. This potential manpower resource is yet to be effectively drawn and optimally utilized for delivery of health care in the

faculty development so as to make education in health sciences relevant and responsive to the technological advances in this area.

9. RESOURCES AND FINANCIAL MANAGEMENT

For making the education Policy in Health Sciences a reality, adequate and appropriate resources are a must. The deleterious consequences of non-investment or inadequate investment in edcuation in general, and health sciences education in particular, are indeed very serious. As such, it is imperative that health in general, and education in health sciences in particular, must be treated as a crucial area of investment for national growth and developement. Education in health sciences will have to be appropriately funded through Central/State/N G.O/Private efforts. Innovative approaches for additional resource mobilisation will have to be thought of for augmenting the resources, particularly through community participation at the Panchayati Raj Institutions so as to inculcate a sense of public participation and to ensure community acceptability of a variety of health care provic s.

10 REVIEW MECHANISM OF NEPHS

The mechanisms for continuing review and monitoring of the implementation of the proposed National Education Policy in Health Sciences and the programmes and activities that shall be undertaken to fulfil the objectives of such policy, must be intimately built into the review process. It is further suggested that although appraisals at shorter intervals through agencies such as Education Commission in Health Sciences and any other independent organisation need to be undertaken so as provide remedial mid-course corrections, long term reviews both of the policy and of the programmes must be undertaken at regular 5-10 years intervals.

11 THE FUTURE

With a rich centuries-old heritage of medical and health sciences, the ancient medical system of India was of a holistic nature encompassing all aspects of human health and diseases. With the dominant influence of western medicine, there

APPENDIX

LEARNING OBJECTIVES FOR UNDERGRADUATE MEDICAL EDUCATION

1. The undergraduate medical education aims at producing medical graduates who would have the capability of providing comprehensive health care to both rural and urban communities. Such care should not only be curative but also include promotive, preventive and rehabilitative aspects of health services in an integrated manner. In order to be able to perform the tasks mentioned above the medical graduates should be able to demonstrate the requisite competencies so as to :-

   1.1 diagnose common disorders with the help of such diagnostic facilities as are likely to be available in the average community settings.

   1.2 perform simple laboratory tests and operative procedures, including surgical methods of fertility control.

   1.3 perform methods of first level management of acute emergencies, promptly and efficiently.

   1.4 work effectively in a community setting by acquiring proper attitudes and skills in order to improve the quality of life of that community.

   1.5 conduct scientific enquiry and critical analysis.

   1.6 establish communication and good working relationship with medical colleagues, members of allied health professions, and the community.

   1.7 provide advice about promotion of health, prevention of disease and rehabilitation of health.

   1.8 plan implement and evaluate health education activities.

   1.9 continue self education and be a life long learner.

   1.10 train other health professionals.

   1.11 organise and effectively manage health services.

3.3 legal and ethical implicati

3.4 local patterns of diseases, occupational health hazards family welfare programmes, and nutrition.

3.5 special problems of vulnera and urban community.

3.6 the basis of human behaviou factors both in health and

3.7 principle of management.

3.8 methods of effective use of

3.9 method of scientific enquir

* Modified and adapted from Indian

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If Doctors Learnt From Architects.....

by

F M Shattock

I would liken present health services to large buildings, the doctor replacing the architect. In too many health services the doctor believes he is pre-eminent and that if there is to be such a thing as a health team then its members are only accepted by his consent and toleration. He will decide on the work they will do, he will select them for training, will dictate the type of training, will oversee their examinations, assess their field performance and be their final (if not only) judge.

Over the years he has contracted out a few of his previously allembracing rights, such as optometry, dentistry and pharmacy, but this took years to achieve. Now he is stirring to consider one further contracting out (in which case he loses not only the responsibility but also the judgement) but delegation. Delegation of some of his responsibilities to paramedicals and auxiliaries so that by a process of delegation he retains final absolute control. This is the result of his training, the accepted standard of conduct of his peer group and in line with the t history of medicine.

Do we know of an architect who acts in a similar manner? A man who draws up the blue-prints, undertakes the carpentry, brick building, plumbing and electrical installations? Do we know of an architect who will draw up the blue-prints and then delegate the actual construction work to men whom he has selected for training, whose training he dictates and over whom he retains final and absolute control of their actions?

Why should not the brick-layers, the carpenters, the plumbers and the electricians be the paramedicals and auxiliaries of a health team? Persons who have a definite job, status and securit rather than being regarded as 'second - best' make-dos until such time as enough doctors are trained. Are we aiming to train more architects to replace the second-best carpenters, brick-layers, etc.?

The paramedical and auxiliary should be a first class medical worker with a definite job designed for them, a defined training, controlled by peer judgement, vital members of our health team and welcomed as such. They should also have a considerable say in the work they can and should do and in their training. In the same way that the architect may intervene when he believe that something done is not quite safe, so the physician would exercise a similar control in professional matters.

Their place in the overall medical structure is two-fold. Firstly as assistants to personnel in a hospital and secondly, their role of the provision of primary health care. In this second role will provide primary medical care from the grass roots of the villages through Aid Posts and Rural Health Centres up through the hospital system to the University Teaching Hospital where they serve in the out-patient departments.

The responsibilities and supervision of the 'primary care provid and of the 'assistance' providers will be vastly different. If they are to play their full role in the rural areas they must be prepar to operate quite independently of doctors in the more isolated areas with little supervision. Thus their training will of necessity be different.

Excerpts from

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Continuing Education for the Health Team in Developing Countries

Dr David C Morley

In the third world, continuing or lifetime education for the doct working in rural areas is not yet available. Perhaps this is not surprising; if the Professor of Medicine moved out from the tea hospital and attempted to take over the crowded daily outpatient of the up-country doctor, he would hardly know how to be effect Although, sixty percent of the patients attending would be childr neither the Professor of Pediatrics, nor the Professor of Comm Medicine would fare much better. The majority of the holders these posts have had no experience working in effective progra appropriate to the circumstances and resources of rural areas. The doctor who is trying to supply the enormous needs of the ru areas in developing countries will receive little help by more in depth study of those subjects he studied in his undergraduate da His requirements are more in the fields of communication, management and self reliance, as well as an up-dating on the management of common conditions. Unfortunately, the experti required to manage community services and run a small distric hospital with hospital teams that move out into the community i not considered important in university training.

To quote from a recent Indian Central Government Committee report: "Today the process of systematic learning stops once a doctor gets out of his medical college. On the other hand there is a great need that he should be continuously educated in orde to keep in touch with the advances in medical science that are taking place very rapidly." The committee has therefore emphasized the need to "develop an organizational pattern for t continuing education of physicians..." This education "must concern itself with those issues that are of deep significance to the health of the community and also with the educational

Such teaching is now more possible. We have some excellent books, for example, David Werner's "Where There is no Doctor" or Maurice King's "Primary Child Care," appropriate for the who health team. Equally important is the new expertise in distance teaching, once known as correspondence courses. This method of teaching now involves many other media, such as the television radio, tape-recording, short cassette film, and slides. Experien in this form of teaching has multiplied in many countries; in the United Kingdom, we are particularly proud of the 60, 000 students in our Open University, the largest university in the #o9d3

The organization of such a training course, developed for those working up-country, would depend on a team including an enthusia doctor and nurse, as well as those specifically trained in educatio who are so frequently missing in present undergraduate and post-graduate training schools. Perhaps, the course would be structur so that the doctor would start by playing the role of "teacher" as he would expect, but he would soon find that he had to start studying himself in order to keep up with his students. As the cou progressed, more time would be spent on discussion, and the heal team would be analyzing what work it undertook, how the unit mad of its resources, and its impact on the health of the whole comm In time the team would come to see how the community resources could also be mobilized to become involved in providing health car for all. Those teams who were able to bring together the resourc available from central government with those generated within the local community and create an effective system of health care unit would be the appropriate resource for the future field training of medical students and other health workers.

Organizing such a program will be a useful step towards raising th morale and image of those undertaking work in rural areas. On th will depend the success of the present drive toward appropriate pr health care and, through this, an overall improvement in the healt the largely rural communities of the developing world. Those

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HEALTH EDUCATION AND COMMUNITY HEALTH BEHAVIOUR

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Theory and Practice of Health Education:

Health educators have taken great pains in asserting that health educat is fundamentally different from propaganda or high pressure salesman ship; they also do not consider it to be synonymous with mass commun cation. Health education, according to them, seeks to bring about cha within a person in relation to his individual and community health goals

Every community, responding to the health problems faced by it, form its own health goals which determine the pattern of its health behaviou Changes in the health goals of a community and of individuals are requ when there is a gap between the pre-existing health goals and the goals ought to have in the context of the current knowledge concerning the he problems and the accessibility and availability to the community of ser that are based on such knowledge.

Three considerations emerge from the above approach to health educa

Firstly, as it involves persuading individuals and communitie to shift from some of the pre-existing health goals to newer health goals that the health educators consider to be more desirable for them, it involves value considerations. There thus always a danger of health educators becoming, unwitting or otherwise, instrumental in imposing certain preconceived

> of ensuring that the natural science essentials of health practices are separated from what are called the social, cultural and political overcoatings which these practices have acquired in the course of their development in the western countries. It is the responsibility of the health educators to ensure that the natural science essentials of the health practices are inserted into a new "envelope" or "coating" that will harmonise better with the social, cultural and economic environment of India.

Because of the above considerations, a sound understanding of the response of communities to their health problems and their response to the various services that are made available to them is of crucial importance for formulating a strategy of health education. Unfortunat this cardinal principle - the principle of basing a health education strategy on community diagnosis - has not received due attention in the actual practice of health education in India.

For instance, health educators in India very willingly and actively participated on a massive scale in "selling" family planning to the masses -- to a hungry and poverty stricken population with very poor health status (particularly of mothers and children) and with extensive unemployment, social exploitation and illiteracy[1]. Neither the health educators in India nor the numerous health education consultants from abroad made any significant efforts to base the family planning health education strategy on sound community diagnosis. Again, in the case of practice of health education in the Indian tuberculosis programme, instead of making community diagnosis, health educators chose the easier and much more "rewarding" path of imitating their western counterparts and kept on the refrain of "educating the ignorant, superstitious and illiterate" public of India about tuberculosis. Later on, a community diagnosis, which was made for some other purpose, reveal that because of weaknesses in the services, a very large number of tuberculosis cases, who were actively seeking help, were not even being diagnosed as cases of tuberculosis and are being turned back wit a bottle of useless cough mixture[2]. These findings indicated that mu

educators in India have taken a very untenable value position. Findings from a recent study of health behaviour of rural populations in India appear to be very relevant in the context of the present crisis in the practice of health education in India. This effective study has provided data for developing a more effective framework for the practice of health education in India.

Health Behaviour of Rural Populations in India:

Considering the activities of a primary health centre as a purposive intervention to change for the better some aspects of the pre-existing health culture of the community served by it, a research study was designed to examine the current status and the nature of this interactio between the health services that are introduced through the PHCs and the pre-existing culture of rural population in India. A report on this study has been published elsewhere [3]. Only a broad outline of the study design and the principal findings are being summarised here.

In order to get data on health behaviour of rural populations under relatively more favourable conditions, a deliberate effort was made to select, in the first instance, primary health centres and villages whic are much above the average. The study has been completed in 19 villages, 11 of which also serve as the headquarter village of a Prima Health Centre. These primary health centres are from seven states of the country which belong to the different regions.

Considerable care was taken to develop a methodolical approach that was specially tailored for studying the health behaviour of villagers (including their behaviour in relation to the primary health centre services) against the background of the total village culture. Researcl investigators lived in these villages for three to five months. Apart from making special efforts to get themselves accepted by all the segments of the village community and collecting data through village informants, the investigators identified informants and some "ordina members from each segment of the village community and made observations and conducted depth interviews to understand the health

visited the village and when the villagers visited the primary health centre. Apart from these efforts to ensure that in-depth qualitative data are obtained from all the segments of the entire village communit according to well defined work procedures and check lists and that they were, as far as possible, checked and cross-checked, a quantitative dimension was given to the main qualitative data by framing an unstructured interview schedule on the basis of these data and administering it to a twenty per cent stratified random sample of the village households.

As an additional safeguard, after completion of the field work in the villages of a primary health centre, some of the data concerning the health behaviour of the community were cross-checked with the personnel of the primary health centre and the concerned personnel at the level of the corresponding seven state directorates of health services. An additional four states were added to the original seven to examine how far the findings from these seven were applicable to the others. These eleven states covered over 80 per cent of the population of the country. Recognising that the complex nature of the problem for this study calls for a new and rather exacting methodological approach, an effective monitoring system was developed by the research director to ensure that the data collected by all the investigators were of a minimum accepted quality.

Taking into account the social and economic status of the people, the epidemiology of health problems and the nature of the health services available, it was not surprising that problems of medical care should be by far the most urgent concern among the health problems in rural populations. But the surprising finding was that the response to the major medical care problems was very much in favour of western (allopathic) system of medicine, irrespective of social, economic, occupational and regional considerations. Accessibility of such services and capacity of patients to meet the expenses were the two major constraining factors. These findings seriously call into question the prevailing views of social scientists and health educators on this subject.

RMPs use allopathic medicines rather than aurvedic or unani medicines. When these RMPs prove ineffective, depending on the economic status of the individuals and the gravity of his illness, villagers actively sought help from government and private medical agencies in the adjoining (or even distant) towns and cities .

There were, however, numerous instances of adoption of healing practices from qualified or non-qualified practitioners of the different Indian systems of medicine and homeopathy and from other non-professional healers. This aspect of health behaviour has received much more than its due share of attention from health educators and social scientists. In their preoccupation with writing in details about some of the "exotic" aspects of health behaviour, they seem to have overlooked the fact that among those who suffer from major illnesses, only a very tiny fraction preferentially adopted these practices, by positively rejecting facilities of the western system of medicine which are more efficatious and which are easily accessible and available to them. Usually these practices and home remedies were adopted: (i) side by side with western medicine; (ii) after western medicine failed to give relief; (iii) when western medical services were not accessible or available to them due to various reasons; and, (iv) most frequently, when the illness was of minor nature.

Another very significant finding of this study is that the family planning programme had ended up in projecting an image which was just the opposite of what was actually intended by health educators and social scientists. The image of the family plannin g workers in rural areas was that of persons who use coercion and other kinds of pressure tactics and who offer bribes to entice people into accepting vasectomy or tubectomy. Because of this approach to family planning and failure of family planning workers to develop a rapport with the villagers, sometimes the villagers were unable to meet their needs for family planning services. There were several instances of mothers who, failing to get suitable family planning services from the primary healt centre, took recourse to induced abortions to get rid of unwanted pregnancies. This not only pointed to the failure of the programme to meet felt need of individuals for family planning services but it also

who is distant from them -- meant only for special people or for those who can pay for her services. She is not for the poor. She can be called only when there are complications and then also she should be paid. Because of the inability of the ANMs, the majority of the deliveries even in the villages where the primary health centre is located were conducted by dais and relatives and neighbours. In villages with no primary health centre, their sway was almost complete

As in the case of the Registered Medical Practitioners, confinement by relatives and friends and by indigenous dais was popular among the villagers not because of their intrinsic merits but in the absence of suitable services from the ANM/Lady Doctors, they were compelled to settle for something which they considered to be inferior but which was all that was accessible to them.

The only two programmes which can be stated to have reached the grass roots level in the villages were those concerning malaria and smallpox. Despite several complaints regarding the sincerity of these workers, there was almost a universal agreement among the villagers that these workers did pay visits to them. A significant finding was that these workers did not encounter any major obstacle in getting participation of the community in these programmes. Except when there were understandable compulsions, such as prospect of a poverty stricken mother losing wages for 4-5 days at the peak agricultural season due to the child's vaccination reactions, and some cases of orthodoxy, there was general acceptance of smallpox vaccination in village communities. The number of children who were left unvaccinated due to lapses of the parents appear to be a very small fraction of those who remained unvaccinated due to lapses of the vaccinators and their supervisors.

Patients suffering from tuberculosis, leprosy and trachoma got very little services from the corresponding national programme. It was remarkable that despite this, these patients actively sought help from elsewhere -- from the nearby towns or even big cities. Such help was not only much more expensive and bothersome but it was also

problems. When, however, epidemics of cholera and diphtheria struc separately three of the study villages when the field work was going on the primary health centre and the district health authorities encounter little difficulty in getting community participation in the anti-epidemic measures. There were also instances of villagers, on their own, seeking triple antigen immunization from the primary health centre. Very often even this need was not met by the primary health centre.

Extensive prevalence of abjectpoverty, as a result of which more than half of the population was unable to meet even the minimum dietetic calorie needs,and appalling conditions of sanitation, water supply, housing and education presented an ecological setting which was conducive to a widespread prevalence to various types of health problems in the community. These health problems formed only a component of the overall gloomy picture of the way of life in Indian villages. Ignorance, superstition, suspicion, apathy and fatalism should thrive in such a milieu. It is, therefore, a tribute to the strength of the culture of the rural populations in India, that despite these overwhelming odds, their health behaviour has retained so much of rationality. It is doubly unfortunate that health educators overlooked these obvious realities and uncritically set out to "educate" the people of the country at the behest of equally uninformed health administrators.

As in the country as a whole, as indeed in the international fields, in the villages also, the conditions of acute poverty and helplessness was associated with a political system which was dominated by a tiny group of highly privileged persons. This political power, in turn, vested this group with additional power to further exploit the weaker sections. Over and above, they got support and sustenance from similar power elites higher up in the hierarchy which extended right into the international arena. Each one of the villages studied thus presented a picture of a rather stable equilibrium in which a vast majority of the village population was kept effectively subdued by a small privileged group which had acquired political power by controlling land, trade, cooperatives, industry, money lending, education and the law and order and the judicial systems. Experience had

work for rural populations, they took advantage of the village power structure and confined themselves, as far as possible, to satisfying the privileged gentry of the village. In doing so they (a) won approbations and rewards from the so-called community leaders who had the ear of their superior officers and of the political leaders at the higher scales; (b) dealt with the least disagreeable segment of the village community; and (c) got a freee hand to "tackle" the rest of the community.

The findings of this study brought out a number of key issues which are of far reaching significance for the future development of a sound strategy for the practice of health education in the country:

1. It brings out clearly that there is no significant cultural resistance to acceptance of modern medicine as long as they are efficacious and they are accessible and available to them. This finding, therefore, seriously calls into question the belief of a very significant sector of health administrators, social scientists a health educators that there is considerable cultural resistance to the acceptance of modern medical practice in rural populations in India;

2. That the existing health services are working at a grossly low level of efficiency, which has led to considerable under-utilisation of these services. Priority should therefore, be given to ensuring that this problem is overcome;

3. There is also considerable scope for bringing about qualitative improvements in the existing health service and bringing it more in tune with the social and cultural setting of the village communities; and

4. Finally, after ensuring a reasonable level of utilisation of the existing capacities and after bringing about the

belonging to all the segments of rural populations from the different regions of the country have, on their own, brought about significant changes in their health behaviour in curative, preventive as well as promotive fields when the health services that were available to them had fallen far short of the requirements.

2. These remarkable shifts in health goals of the community and of individuals had been brought about without any intervention of health educators. If anything, health educators have to take the blame for being instrumental in diverting attention away from the central issues of community diagnosis by raising issues which are peripheral, if not blatantly counter-productive and irrelevant.

3. The most urgent task before health educators in India will, therefore, be to "catch up" with the already accepted individual and community health goals by emphasising that the needed services be made available to them.

4. As more effective health services are made available on a larger scale, health educators will be called upon to motivate people to make more effective use of these services. Motivating patients of tuberculosis and leprosy to take the medicines regularly, dispelling rumours concerning alleged illeffects of contraceptives and ensuring adequate coverage of the different immunisation programmes, are instances of such fields of action3

5. As additional resources are made available to the people, health educators will be required to promote more effective participation in the more extensive programmes that are developed in such fields as

elaborate interdisciplinary effort for formulating and implementing effective community health services for the country and for evaluating them. Acting as a "spokesman" for the community, practitioners of health education will be called upon to marshal the relevant social science data and fit them into the bigger process of programme formulation so that it is possible to promote participation of the community in these programmes.

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VIHAI - 220

HOW TO SCIENTIFICALLY PREPARE OUR OWN FLASHCAR

Health Education begins with local beliefs.

1. Choose an important local health problem (for which no visua aids already exist).

2. Collect local beliefs and practice about this problem. Write out these questions in the local language:

   What are all the local words and names used to describe this disease? List them all. Find out what each word means.

   What do they think causes it?

   What do people usually do when this disease comes?

   What do people think usually makes it get better?

   What do people usually think makes it get worse?

   Is anything forbidden as part of the treatment?

Write the answers exactly as said in the local language, or u a casette tape recorder to note all their answerss. In tervie village women especially.

If there are tribals interview some of them also.

Try and get the ideas of at least 20 women.

Collect all the answers together. Do not in terpret or summ

Present helpful belief.	Teaching objectives.
tuberculosis spreads from person to person.	that they will know that spitting spreads tuberculosis.
(flashcard story begins with this).	(flashcard story goes on to teac this. Some may know this alrea
(1)	(2)
Present harmful practice	Teaching objective
they spit on the ground	that they will spit into a rag or handkerchief but not on the gro
	(flashcard story goes on to tea
	(3)

Note: We only mention germs or bacilli if necessary to achieve our teaching objectives. If we have to mention germs, we do so a first mentioning their present beliefs.

5. Describe the illustrations needed and number these. Divide up into say 10-15 pictures, and number one part of the story for ea

6. Sketch and colour the picture, 22 x 26 cm will be economy si

7. Next day test the pictures on a group of women.

   (a) What does the story teach them?
   Are these things the same as in (3) above?
   If so the story is clear.

   (b) Do the pictures help to tell the same story?
   If they say so, then the pictures are helpful. (But check whether they recognise the different things in the picture

8. Then if you can afford it, get a good local artist to improve the

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VHAI - 45

USE OF FLASHCARDS

Flashcards are simple, portable visual aids that can be used to intr new ideas and lead into productive discussions.

The VHAI's flashcards have been developed to include important hea ideas and if properly communicated, can lead to the actual saving o many lives. The smaller card sets have been developed in the mar proved to be most effective among illiterate rural peoples - that is, line drawings, one idea per card with no extraneous background mat such as trees, flowers and grass. The smaller sets are purposely coloured to eliminate visual confusion. This will allow the villager personal identification with the people on the drawing.

These flashcards should be used in groups of 10-20 in village home schools, clinics, OPDs, wards, panchayat meetings, teacher's mee tea stalls, etc. The content of the flashcards should be read before presenting - it is certainly fair to embellish the script but not to cha the basic content ideas.

If you have any questions about the use of these flashcards, please w to the agency which produced your flashcards. Below are some step follow and common mistakes to avoid.

Before using the Flashcards.

1. Put the flashcards in the correct order
2. Read the script
3. Practice holding the cards
4. Practice changing the cards and telling the story.

During the Use of the Flashcards.

An effective way to teach a group of health workers how to use t flashcards properly is to first demonstrate the proper use of th flashcards, divide into small groups of 2-3 people and then have them teach the flashcard messages to each other.

After spending 1-2 hours (or time necessary to do this) have th group come back together for discussion in regard to points to in using the flashcards.

Some of the points that came out of a staff meeting after such a training seminar included the following:

1. First read the script yourself (each time).
2. Look at the pictures in the right order.
3. Know the subject.
4. Involve the audience (Question and Answer)
5. Show picture to the Audience.
6. Keep the pictures quiet. (Don't move the pictures around.)
7. Be ready to repeat.
8. Show two times and review.
9. Tell one message per picture.
10. Don't drop the pictures.
11. Know the language of the audience.
12. Tell the story. (Don't read).

These suggestions come from CHP programme , Kathma
Their help is gratefully acknowledged.

Scripts are provided in English Nepali- Hindi or English - Ta

If your language is not provided for, you may like to write it o back of the card or, in the case of flipcharts, on back of the p

HEALTH EDUCATION

smallpox eradication have reached a stage where more and more ind
participation and decisions are required for the achievement of t
Many governments are now beginning to realize that the services a
facilities they provide to improve the socio-economic and health
of the people will not be fully effective unless the people not
make use of these services but also undertake various practical
measures to improve their own health status and that of the commu
in which they live. This is a main objective of health educatio

APPROACHES TO PUBLIC HEALTH:

There are three well known approaches to public health:
(1) REGULATORY APPROACH: The regulatory or legal approach seeks
protect the health of the public through the enforcement of laws
regulations, e.g, Epidemic Diseases Act, Food Adulteration Act, e
The best laws are but waste of paper if they are not appreciated
understood by the people. They may be useful in times of emerge
in limited situations, e.g, fairs, festivals and epidemics; but t
not likely to change human behaviour. In areas involving persona
(e.g., giving up smoking, family planning) laws have no place in
society. The legal approach has also the disadvantage that it re
vast administrative machiery to enforce laws and also involves co
expenditure. (2) SERVICE APPROACH: The service or administrati
approach aims at providing all the health facilities needed by t
in the hope that people would use them to improve their health.
service approach proved a failure when it was not based on the "f
of the people. For example, when water seal latrines were provid
of cost, in some villages in India under the Community developm
pregramme, people did not use them. This serves to illustrate th
may provide free service to the people, but there is no guarantee
the service will be used by them. (3) EDUCATIONAL APPROACH: The
educational approach is a major means today for achieving change
practices and the recognition of health needs. It involves motiv

Education	Propaganda or Publicity
1. Knowledge and skills actively required	Knowledge instilled in minds of people
2. Makes people think for themselves	Prevents or discourages by readymade slogans
3. Disciplines primitive desires	Arouses and stimulates primitive desires
4. Develops reflective behaviour. Trains people to use judgement before acting	Develops reflexive beha aimns at impulsive acti
5. Appeals to reason	Appeals to emotion
6. Develops individuality personality and self-expression	Develops a standard pat attitudes and behaviou to the mould used
7. Knowledge acquired through self-reliant activity	Knowledge is spoon-fed passively received
8. The process is behaviour centred - aims at developing favourable attitudes and habits and skills.	The process is informat centred - no change of or behaviour designed.

CONTENT OF HEALTH EDUCATION:

Health education is as wide as community health. In practice content of health education may be divided into 8 main divisions: (1) HUMAN BIOLOGY: Much of the teaching pertaining to human biolo done in schools. We teach children the structure and functions of body, and how to keep physically fit. Each system of the body is naturally and without emotion. The need for exercise, rest and sle taught. The effects of alcohol, smoking, resucitation and first ai also taught. (2) NUTRITION: The aim of health education in nutrit guide people to choose optimum and balanced diets which contain nut

and ventilation; hygienic storage of foods; hygienic disposal of
need to avoid pests, rats, mice and insects. In community hygien
teach the desirability of safe water, the benefit of drainage, cl
good housing, town-planning - in short, everything about the envi
in which people live. (4) CARE OF MOTHERS AND CHILDREN: here ou
is with the physiological and psychological care of expectant an
mothers and of children. A large number of young women are relat
unprepared for child bearing. They start their family with fear
birth of a child. Their fear is dispelled by health education
Mothers are taught about the need for a balanced diet, rest and a
care; about certain ailments during pregnancy; about the care of
young child and elder children, i.e. feeding, weaning, clothing,
and baby care, immunization, prevention of accidents, burns, fall
poisoning; about the psychological aspects of child care, i.e., t
of children for love and security; and the need of children for l
security; and the need for a small family and family planning met
short, the care of mothers and children is an important area for
education. If we educate the mothers, we educate the whole famil
(5) PREVENTION OF COMMUNICABLE DISEASES: In this we confine to d
which are prevalent among the people among whom we work. Informa
disseminated about the mode of spread of disease from person to p
the need for immunization and protection of children. People are
to participate in programmes of disease control and health protec
promotion. (6) MENTAL HEALTH: Mental health problems occur ever
They become more prominent when major killing diseases are brough
control. There is a tendency to an increase in the prevalence of
diseases when there is a change in the society from an agricultur
industrial economy, and when people move from the warm intimacy
village community to the isolation found in big cities. The aim
education is mental health is to help people to keep mentally hea
to prevent a mental breakdown. People should enjoy their relati

factories, railways and mines. Management must provide a safe en and promote general order and cleanliness. There should be a pla everything, and everything should be in its place in the factory, home and in the office. The predominant factor in accidents is ca the problem can be tackled through health education. (8) USE OF H SERVICES: One of the declared aims of health education is to infor public about the health services that are available in the communi how to use them. They should not be misused or abused. Further, should be encouraged to participate in the various national health designed to prevent disease or promote health.

PRINCIPLES OF HEALTH EDUCATION:

Before we come to the practice of health education, we must principles involved. Health education brings together the art and of medicine, and the principles and practice of general education. link is to be found in the social and behavioural sciences -- socio psychology and social anthropology.

Health education cannot be "given" to one person by another among other things, the teaching, learning and inculcation of habi the objective of healthful living. Psychologists have given a gre of attention to the learning process. Every individual learns and learning develops the modes of behaviour by which he lives. Lear teaching is a two-way process of transactions in human relations, teacher and taught. The teacher cannot teach unless the pupil want learn. Learning takes place not only in the class room, but also in the wider world. There is internal learning by which a man gr an adult individual. It is possible to abstract certain principles and use them in health education.

(1) INTEREST: It is a psychological principle that people to listen to those things which are not to their interest. It is to remind ourselves that health teaching should relate to the inte

lead to personal acceptance. (3) KNOWN TO UNKNOWN: In health edu
work, we proceed from the known the unknown i.e., start where the
are and with what they understand and then proceed to new knowledg
use the existing knowledge of the people as pegs on which to hang
knowledge. In this way systematic knowledge is built up. New kno
bring about a new, enlarged understanding which can give rise to a
into the problem. The way in which medicine has developed from re
modern medicine serves us as an illustration, the growth of knowl
the unknown to the known. It is a long process full of obstacles
resistance, and we must not expect quick results. (4) COMPREHENSI
health education we must know the level of understanding, educatio
literacy of people to whom the teaching is directed. One barrier
communication is using words which cannot be understood. A doctor
the diabetic to cut down starchy foods; the patient had no idea of
starchy foods. A doctor prescribed medicine in the familiar jargo
ful three times a day"; the patient, a village women, had never se
teaspoon, and could not follow the doctor's directions. In healt
we should always communicate in the language people understand, an
use words which are strange and new to the people. Teaching shoul
the mental capacity of the audience. (5) REINFORCEMENT: Few peop
all that is new in a single period. Repetition at intervals is ex
useful. It assists comprehension and understanding. Every health
needs reinforcement; we may call it a "booster dose". (6) MOTIVAT
every person, there is a fundamental desire to learn. Awakening t
desire is called motivation. Tgere are two types of motives - prim
secondary. Primary motives (e.g., sex, hunger, survival) are drivi
initiating people into action; these motives are inborn desires.
motives are based on desires created by outside forces or incentive
of the secondary motives are praise and love, rivarly, rewards and
punishment, and recognition. In health education, motivation is an
factor; that is, the need for incentives is a first step in learnin
change. The incentives may be positive or negative. To tell a lad
with the problem of overweight to reduce her weight because she

soil, the health facts the seed and the transmitting media the s
Prior knowledge of the people - customs, habits, taboos, beliefs
needs - is essential for successful health education. The seed
health facts must be truthful and based on scientific knowledge.
transmiting media must be attractive, palatable and acceptable.
these three elements are carefully and satisfactorily interrelat
message will not have the desired effect. (10) GOOD HUMAN RELAT
Studies have shown that friendliness and good personal qualities
health educator are more important than his technical qualificat
human relations are of utmost importance in learning. The health
must be kind and sympathetic. People must accept him as their
(11) LEADERS: Psychologists have shown and established that we
from people whom we respect and regard. In the work of health e
we try to penetrate the community through the local leaders - th
headman, the school teacher, or the political worker. Leaders a
of change, and they can be made use of in health education work.
leaders are convinced first about a given programme, the rest of
of implementing the programme will be easy. The attributes of
are: he understands the needs and demands of the community; provi
guidance, takes the initiative, is receptive to the views and su
the people; identifies himself with the community; self-less, hon
impartial, considerate and sincere; easily accessible to the peop
control and compromise the various factions in the community; pos
requisite skill and knowledge of eliciting cooperation and achiev
of the various official and non-official Organisations.

AUDIOVISUAL AIDS:

All education is based on learning experiences. Edgar Dale
learning experiences into 10 stages - the first three stages invo
and the next seven stages are based on observation.

Audio-visual aids are increasingly being used in modern edu
has been found that audiovisual aids, when properly used in the t

PRACTICE OF HEALTH EDUCATION:

Health education is carried out at threemain levels: indivi
and general public through mass media of communication. For effe
changes in attitudes and behaviour, we rely on individual and gro

Learning Experiences	A. V. aids used
1. Direct purposeful experiences	-
2. Centrived experiences	Models, specimenks
3. Dramatised experiences	Plays, puppetry, role
4. Demonstrations	Apparatus, Chalkboard, graph
5. Field trips	-
6. Exhibits	Posters, displays, bul
7. Motion pictures	Films, television
8. Stillpictures	Slides, flash cards,ph
9. Spoken words	Radio, tape recorders
10. Visual symbols	Maps, sketches, diagra material

1. INDIVIDUAL HEALTH EDUCATION:

There are plenty of opportunities for individual health educ
may be given in personal interviews in the consultation room of th
or in the health centre or in the homes of the people. The indivi
to the doctor or health centre because of illness. Opportunity is
educating him on matters of interest - diet, causation and nature
and its prevention, personal hygiene, environmental hygiene, etc.
for health counselling may be selected according to the relevance

It provides opportunities to ask questions in terms of specific
The limitation of individual health teaching is that the numbers w
are small, and health education is given only to those who come in
with us.

2. GROUP HEALTH EDUCATION:

Our society contains groups of many kinds - school children,
industrial workers, patients, etc. Group teaching is an effective
educating the community. The choice of subject in group health te
very important; it must relate directly to the interest of the gro
example, we should not breach the subject of malaria eradication t
who has come for delivery; we should talk to her about child birth
have to select also the proper methods of health education - meth
bring in active participation of the people.

METHODS OF GROUP TEACHING:

Many different methods of education are necessary in workin
groups. The methods employed will depend upon local factors, and
method can be applied effectively in all circumstances. The metho
group teaching may be classified as below:

1. ONE-WAY METHODS:

(a) Lecture (b) Films (c) Charts (d) Flannelgraph (e) Exhibits

2. TWO-WAY OR SOCRATIC METHODS:

(a) Group discussion (b) Panel discussion (c) Symposium (d) Wor
(e) Institute (f) Role Playing (g) Demonstration (h) Programmed

1. ONE-WAY METHODS:

The one-way or didactic methods enable systematic presentati
to the group, but provides little opportunity for the group or audi
participate actively in learning. (a) Lectures: Lectures are the
method of health teaching. It is not a good method because communi
mostly "one-way". There is no opportunity for the group to partic

at once when put on the flannel. Flannelgraph offers the advanta pre-arranged sequence of pictures displayed one after another hel continuity and adds much to the presentation. The other advanta that the flannelgraph is a very cheap medium, easy to transport a promotes thou ht and criticism. (d) Exhibits: Objects, models, etc. convey a specific message to the viewer. They are essential media of communication, which can also be used in group teaching. Cards: They consist of a series of cards, approximately 10 by by each with an illustration pertaining to the story or talk to be g Each card is "flashed" or displayed before a group as the talk is given. The message on the cards must be brief and to the point. cards are primarily designed to hold the attention of the group.

2. TWO-WAY OR SOCRATIC METHODS:

(a) Group Discussion:

Group discussion is considered a very effective method of h It is a "two-way" communication; people learn by exchanging their experiences. This changing their views and experiences. This me useful when the groups have common interests and similar problems effective group discussion, the group should comprise not less th more than 20 people. There should be a group leader who initiat subject, helps the discussion in the proper manner, prevents side encourages everyone to participate and sums up the discussion in If the discussion goes well, the group may arrive at decisions wh individual member would have been able to make alone. It is als to have a person to record whatever is discussed. The "recorder a report on the issues discussed and agreements reached. In a gr the members should observe the following rules: (a) express ideas concisely (b) listen to what others say (c) do not interrupt when speaking (d) make only relevant remarks (e) accept criticism grac (f) help to reach conclusions. Group discussion is successful i know each other before hand, when they can discuss freely. Ther deal of evidence that group discussion is a very effective method

depends upon the chairman; he has to keep the discussion going and
the train of thought. After the main aspects of the subject are ex
by the panal speakers, the audience is invited to take part. It is
the discussion should be spontaneous and natural. If members of th
unacquainted with this method, they may have a preliminary meeting,
the material on the subject and decide upon the method and plan of
Panel discusion can be an extremely effective method of education,
it is properly planned and guided.

(c) Symposium:

A symposium is a series of speeches on a selected subject. E
or expert presents an aspect of the subject briefly. There is no d
among the symposium members unlike in panel discussion. In the end
audience may raise questions and contribute to the symposium. The
makes a comprehensive summary at the end of the entiresession.

(d) Workshop:

The workshop is the name given to a novel experiment in educat
consists of a series of meetings, usually four or more, with emphas
individual work, within the group, with the help of consultants and
personnel. The total workshop may be divided into small groups and
will choose a chairman and a recorder. The individuals work, solve
of the problem through their personal effort with the help of consu
contribute to group work and group discussion and leave the worksho
plan of action on the problem. Learning takes place in a friendly,
democratic atmosphere, under expert guidance. The workshop provide
participant opportunities to improve his effectiveness as a profess

(e) Institute:

The "institute" has become a tradition in America. It is a s
meetings designed to convey specific instruction and information in
areas of work. Such meetings are usually scheduled over several da
The most common objective of an institute is to present information

at about 25. Role playing is a useful technique to use in previ discussion of problems of human relationship. It is a particula educational device for school children. Role playing is followe discussion of the problem.

(g) Demonstrations:

Practical demonstration is an important technique of healt We show people how a particular thing is done -- using a tooth br a child, feeding of an infant, cooking etc. A demonstration lea impression on the minds of the people and is more effective than word.

(h) Programmed Instruction:

It is a method of teaching based on the Socratic method of by easy stages. The material is presented to the learner in gra one step at a time. The learning steps are called instructional Each frame requires students' active participation. This may in filling up blanks, solving a problem, answering a question, comp diagram or carrying out any other instructions.

3. EDUCATION OF THE GENERAL PUBLIC:

The mass media of communication for educating the general posters, press, health magazines, films, radio, television, heal health museums, etc. Mass media are generally less effective in human behaviour than individual or group methods because communi "one-way". Nevertheless, they do have quite an important value large numbers of people with whom there is no contact. The cont dissemination of information and views about health through all contribute in no small degree the raising of the general level o in the community. For effective health education, mass media sh not be used alone, but in combination with other methods.

(1) Posters: The first job of a poster is to attract attention; the material needs artistic preparation. Motives such as humour

of all forms of literature. They are an important channel of co
to the people. The local health department ought to establish g
relationship with the local press. (3) Health Magazines: Some a
and some bad. Good magazines can be an important channel of com
The material needs expert presentation. The Swasth Hind and the
of Health from Poona are good health magazines published in Indi
(4) Films: Films are very expensive to produce, and they get out
very quickly. It is also difficult to get films suitable to the
audience. (5) Radio: It is found nearly in every home, and has
into even the remotest villages. It is a potent instrument of e
Radio talks should not exceed more than 15 minutes. (6) Televis
Television bids fair to become the most potent media of all. We
public attitudes through television. Once television is establi
will be the cheapest media of mass education. (7) Health Exhib
exhibitions, if properly organised and published, attract large
people who might otherwise never come into contact with the vari
ideas in health matters. Small mobile exhibitions are effective
keypoints of interest, e.g., fairs and festivals. Health exhibi
the local health service to arouse public consciousness. (8) He
Museums: Health museums display material covering various aspect
A good museum can be a very effective mass media of education, s
one at Hyderabad in Andhra Pradesh.

PLANNING AND EVALUATION:

Planning and evaluation are essential for effective health
The logistics for planning and evaluation are:

(1) ESTABLISHMENT OF OBJECTIVES: The health problem should
identified in terms of its public health importance and economi
The objectives (immediate and ultimate goals) should be clearly
undertaking health education. This comprises taking into accoun
specific information the public should be given (b) what misconc

people towards these programmes and (g) availability of funds and pe

(4) DEVELOPMENT OF IMPLEMENTATION OF THE PLAN: This takes int (a) target groups to be reached (b) knowledge to be imparted (c) att be built (d) facts that need emphasis (e) methods to be used (f) mat be procured - audiovisual aids, transport etc. (g) tracing out local (h) enlisting support of the official and non-official agencies (i) roles to different persons participating in the programme. For succ a health education programme planning should be done with the people representatives.

(5) EVALUATION: All health education work requires continuous in order to find out the success or failure of the programme. Evalu should not be left to the end but should be made from time to time s if the programme is not progressing successfully, modifications can made. It is also necessary to establish a baseline at the beginning programme against which to measure the results. Evaluation should b along practical lines and in terms of specific objectives. Three ap to evaluation have been described: (a) Evaluation of structure and o Items of concern in this approach are such data as number of staff m case load, organisation charts, salaries and training of personnel of the Process: That is, what process were used by the organisation, good or how bad were they. Perhaps the best index is how well the p participate. (c) Evaluation of the results or the product: This co changes in the behaviour of the people. To evaluate in statistical t objective has to be clearly defined, the units of measurement need t developed so that results can be checked against the aims of the hea health programme.

ADMINISTRATION AND ORGANISATION:

Governments have a responsibility for assisting and guiding the education of the general public. For this purpose, the Central Healt Bureau was established in the Ministry of Health in 1956 at Delhi wit

(5) to represent the Central Health Services and work with or interested in health on a country-wide basis particularly on projec which education is the principal method likely to be used in reachi objects of health education.

In 1958, the Ministry of Health established a School Health E Division in the Central Health Education Bureau. This division see help bring about desirable changes in health knowledge, attitudes a of the school population. Since health education of the various so groups of population can only be undertaken by State Governments, a formulated in 1959 for the establishment of State Health Education with central assistance. Many States in India now have Health Educ in their health directorates. Besides the Central and State Health Bureaus, there are other official agencies such as the Directorate Advertising and Visual Publicity (DAVP), Press Information Bureau a India Radio which are engaged in health education work. The Direct Advertising and Visual Publicity is producing printed material on t subject, under the guidance of the Directorate General of Health Se The A.I.R. is broadcasting health programmes covering subjects such nutrition, maternity and child welfare and family planning. Volunt such as the Indian Red Cross are also engaged in health education a At the international level, there is the International Union for He Education, a non-governmental agency whose main task is to promote of national committees and societies for health education. Founded Paris, it collaborates closely with the WHO with which it is in off relationship.

Health education is a complex activity in which different ind and organisations play a part. It is carried on by a variety of pe just educational specialists. Among them are parents, teachers, fr workers, physicians, nurses and numerous others. Furthermore, vari aspects of health education are carried out by different organisati education is incorporated in the programme of comprehensive medical

HEALTH EDUCATION

One dictionary definition of education is that it is in to prepare for the work of life, and for most education, this is of However, Health Education presents particular difficulties, for whi forms of education consist of teaching facts and ideas, to an audie may, or may not, want to remember them, at least these make no deep upon the audience. The principle of Health Education is however of acceptable, since not only does Health Education strive to teach fa should be remembered, but these facts, if acted upon, should change attitudes, and most important of all the way in which they act. He in the food industry is concerned with altering the attitudes and t of people with regard to their work, by instilling in them, the pri food hygiene. Unfortunately, it shares the basic obstacle which fa of Health Education, which is that the sermon which it preaches, no require people to change their deeply ingrained habits, but may als them to take considerable trouble in conforming to a new way of wor if questioned, one must admit that all this labour may be expended prevent some event (often in the remote future) which might well no anyway, even if unchanged attitudes and methods persist!

A parallel may be drawn from the immunization of child D-htheria, a procedure which is undoubtedly effective in protectin immu-ized against the disease. However, to achieve this protectio the m-ther must take him or her to the Family Doctor or Family Heal severa- separate occasions, and bear with the brief illness which m any immu-zation, and all this for protection from an improbable f which alth-ugh occasionally fatal, is not infrequently fairly mild lasting ill-ffects.

This is enough of a difficulty for Health Education to but there are others. Health Education work suffers from three fu lacks (and there may be others).

1. Lack of Money

Both public and private organizations, very properly, seek va spent on behalf of those who ultimately foot the bill or invest in a result, proposals which obviously increase immediate efficiency,

In contrast, health educators have little if any access to, or exp
consumer research methods and they labour under this further handi
their messages are acted upon they involve those who comply with t
and trouble and may require a complete change of established pract
the evaluation of success or failure is much easier in the commerc
it can soon be calculated whether sales increase, remain static, o
after a particular promotion campaign. The value of almost all he
however, remains unquantifiable in most instances. Thus, an appare
notifications of food poisoning, following a "clean food" campaign
this effort, but could also be caused, in part at least, by less c
a colder than usual summer leading to less bacterial growth in con
refrigerated food, a changed approach to notification by local doc
finally a change in public attitudes leading to more self treatment
gastroenteritis, so that fewer cases are seen and notified by doc$

3. Lack of Communication

Communication with staff presents an everyday problem in much
industry, and stems commonly from two difficulties, although those
course may well be able to add to this pair from their own experien
difficulty is, that many of those employed in the menial levels of
industry, have little capacity or motivation to change their habits
Many such jobs are hard physically, and involve working long hours
conditions for a relatively small reward, and additionally many are
workers, who, if pressed, will move elsewhere to situations where f
are made upon them. The second obstacle is one of language, and al
particular immigrant groups tend to cluster together, nonetheless m
of the 1970s are veritable Towers of Babel, in which a lack of lite
their mother tongue, limits communication with many employees, to t
understood spoken word-

So far this note has had a depressing theme, and deliberately s
the existing obstacles to education for clean food are realized, no
however strenuous will surmount them. The picture is not entirely
for, given enthusiasm, coupled with the knowledge that this course
slow persistence, habits can be changed, and standards thereby impr
health education in the food industry must of necessity be a series
efforts, for except in large factories, it is in a sense a cottage

3. Keep it small

Small groups of three or four (or even a single person) are much influence than a large audience. In a small group too, those liste more likely to ask questions - it takes a bold person to admit that not understood in front of twenty colleagues!

4. Precept before preaching

Nowhere does exemplary behaviour pay more dividends than in food not only does it produce a three-dimensional active demonstration o but of equal importance perhaps, it demonstrates one's own belief i as opposed to the "wrong" method.

Finally, do not expect instant success. Few things that of attainment, are easily achieved, and to alter peoples' attitudes struggle, as any educator (or politician even!) will testify but, half, or less, of the goal for which one strives is reached, then t only have been worthwhile. Legislation, and regulations, and disci together bring about superficial compliance, but the only dependabl alteration in food-handlers' habits that can be effective is one th from whithin, and the only way that such a change can be effective springs from within, and the only way that such a change can be mad Education.

Source - The Royal Institute of Public Health & Hygiene

prk* 3.2.80

PRINCIPLES OF HEALTH EDUCATION

(By Dr.S.Nagaraj)

1. WHAT IS HEALTH EDUCATION ?

"The focus of Health education is on people and on action. I its aims are:

(1) to encourage people to adopt and sustain healthful lif

(ii) to use judiciously and wisely two health services available to them and

(iii) to make their own decisions, both individually and col to improve their health status and environment.

WHO - EXPERT COMMITTEE - TPR SERIES 1969,

II. PRINCIPLES OF HEALTH EDUCATION:

" Principles are defined as laws, truiths and bases for life - for practice "by Dr Luis Philips. Principles stem either fro or philosophy.

Principles by nature are :

(i) universal in application irrespective of time p

(ii) with two componenets - a concept componen
- an action or appli

Principles (some) from which health education practices emanate,

(i) Group affecting the belief in the dignity and Humanbeings (origin both science and philoso

(a) A knowledge of the people, their felt need and interests is basic to effective health

(b) Active participation of well in formed pub

DAY	8.30-9.30 a.m.	9.30-10.30 a.m.
THURSDAY 5th May	Public Health Administration in India and Coordination with Govt Health Programme - DR.S.V.RAMA RAO	Maternal Health Services -DR.V.RAHMATHULLAH
FRIDAY 6th May	Staffing Patterns - Cadres and functions - DR.S.V.RAMA RAO	Epidemiological Methods of investigation -DR RAVI NARAYAN
SATURDAY 7th May	Evaluation as a tool in health planning and management -DR.S.V.RAMA RAO	Community participati in Health Care -MAJ GEN B MAHADEVAN
SUNDAY 8th May	OPTIONAL	SIGHT SEEING

N.B.: All teaching sessions will include group discussions on the subject. Participants will be given opportunities to speak so that the faculty gets to know their problems and find solutions to the same.

There will be lectures by guest speakers. The time and date will be informed in due course.

changes are to be made

(e) Leaders influence on the attitude and behavio

(f) Most individuals tend to conform with the accepted sanctions of their family and friends.

Source (1) WHO Expert Committee 1950 - Edn of the public

(2) Article by Dr(Mrs)Dois Philips - All & P.H.Calcutta

(iii) Group reflecting the belief in total development

(a) Edn be integrated with the other social, economic and edu efforts - an integral part of health programme

(b) Health education is only one of the factors in improving and social conditions

(c) Working (not for people) principles of Extension Education

(d) People - have individual human personalities
- extensive mutual power
- possess emotional powers - "Matters of the Heart"
Mothers Heart
- capacity to feel various emotions
- capacity to resist amy acts and conditions
- desire to improve many things
- extensive capacity to develop and shape t

III Steps in planning of a Health Education Programme

1. Knowing the area and know your population
(a) Gathering information of the area
(b) Collection of analysis of data about people

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"HEALTH EDUCATION SYMPOSIUM"

Friday the 16th June 1972
Student Lecture Hall
St. Martha's Hospital.

1. Principles and Aims of Health Education : Dr. Ravi Narayan
2. Methods and Media : Satish Kashyap
2. Demonstration of Methods :
   - i. Film show : ~~Insects~~
     - 1. A great Problem (English) : Cartoon
     - 2. Carriers of Disease (Telugu) : Disney Cartoon
   - ii. Slide Projection : Story of Johnny Voy : Thomas Chandy
   - iii. Film Strip : The Village Well : M.G. Thomas
   - iv. Flash Card : Better Nutrition Healthier Nation. : Meena Pereira
   - v. Booklet : Population Problem of India : Sr. Leah
   - vi. Model : Rat proofing of Godown : Gopalakrishna
   - vii. Pamphlet : Cancer is curable : Vijay Fernandez
   - viii. Posters :
     - i) Nutrition - (Hindi)
     - ii) Diet of Baby 1-12 months (Kannada)
     - iii) Eat Greens - (English)

     : Krishnamurthy
   - ix. Flannel graph : Scabies : Gladys D'Souza
   - x. Wall chart : Haemorrhage - (First aid) : Errol Rasquinha

the urge the greater the effort. Good health is one such desire th in civilised educated people and not so much in primitive, illitera because for them (the latter) illness and disease become ineritable objective of Health Education therefore is this ie to make people d "Good Health"

AIMS :-
1. To make "Good Health" an asset valued by a community
2. To encourage the full use and development of health se
3. To teach people how to achieve good health
4. To encourage them to achieve it by their own action or

In practice it involves :-
1. It supplies a person with enough new knowledge about a disease to make th measures, required by scientific med appear reasonable.
2. It makes a patient feel sufficiently about the importance of his own heal him alter his behaviour and adopt th measures
3. It makes him concerned for the healt
4. (The hardest) It tries to make him f strongly about the first three that and even initiates preventive action community.

Process of Health Education :- Health education does not always vacuum. The right health knowledge often has to displace the patie earlier beliefs and practices. It involves the follow 5 stages :-

e.g Dysentery

1. Change in knowledge - It is infectious
2. Change in attitude - It can be spread by one
3. Change in behaviour - Excreta not indiscriminately
4. Change in habit - Latrine habit
5. Change in custom - Latrine in house (cultural ch

Requirements of Health Education :-

- both during course of their activities and in their other activiti
- both within the walls of the hospital and in the community outside

Rules of (Teaching) :- For maximum success the health educator s

1. Be brief and to the point
2. Clear speech
3. Language of the people
4. Pleasant manner and informality
5. A sense of humour
6. Genuine love of people and a sence of involvement.
7. Must proceed always from - known to unknown
   - particular to general
   - Concrete to abstract
   - Simple to complicated

Motivation :- In order to help people change their habit through hea education one or more of the following motivating factors should be

1. Prestige
2. Envy
3. Experience
4. Repetition of ideas
5. Something for nothing
6. Self satisfaction
7. Making things easier.

Major areas of Health Education :- There are (9) areas of Health in education has proved to be of great benefit and these are :-

1. Hygiene
2. Nutrition
3. Child care
4. Immunization
5. Mental Health
6. Prevention of accidents
7. Rehabilitation following injury or disease
8. Teaching of Human Biology
9. Improvement of Doctor-patient relationship.

Opportunities for Health Education :- As students all of you will h opportunities for health education.

1. In your own homes

METHOD AND MEDIA

Health education can be made an easy and interesting subject by t special methods and media.

Under Methods we have talks, group discussions, Buzz groups an role acting.

Talk should last not more than 30 minutes, it should deal with than 5 main points. It should always be followed by questions time the person concerned must be prepared.

Group discussion :- ensures the participation of all present. Is i small number. Here there is sharing of experiences, and participat decision making.

Buzz Group :- When a large number of is involved. Many sub grou each discusses the point, and later the sub group leaders or spokes forth the view of their sub group.

Panel discussion :- The participation of the members of the panel important as the participation of the audience. Chairman's job is one.

Role playing and dramatic methods :- The person takes on differen he is talking - this must be done naturally - i.e. spontaneous rol important. All the same preparation is necessary.

MEDIA

Film :- Most of them are documentaries, are the best media availabl films are liked but expensive. The aim is to render factual instr influence the attitude as well as the cultureal aspect of the viewe

Film slide :- Topics like health services, air pollution, and lung cancer, food hygiene, can be effectively illustrated by sl It is better if the person photographes his own slides.

Before doing the photography the script has to be written, and interesting patients could be illustrated. The advantages are - tha

Sound film strip - comprise a film strip with a recorded comentary recorder with which is synchronized. Role playing of the scenes in conveying the point better.

Tape recorder

It stimulates, participation, it can capture an experience lik it can also be used to record disucssions which may be analysed at when a of an recording of a person's speech is being played - it is very m effective if the photograph of the speaker is also displayed.

If it is long - it may be interrupted by a discussion.

Wall chart

Must be introduced after a discussion, and left on the wall f period of atleast a month. At the end of the display a mention of made again. It should be displayed at a convenient placetop of a p

Flannel graph

Most careful and flexible media in H.E. Flannel graph make a p of which are mobile and can be easily placed anywhere over the flan Advantages - requires no artistic skill, the speaker does not lose the group when placing the pieces as happens, with a blackboard. I only on a small graph. Not more than 40, as it (visible) should be,

Poster

It should attract attention by its design, position, wording, and challenge. It should carry its message at a glance.

It may reinforce its message - once the glance of the passerby caught - by giving further inform. This can be done by overprintin a separate poster in small type.

LEAFLETS AND BOOKLETS

Leaflet, folded publications not more than 800 words usually i with symbolic drawings.

Plastigraph

Something like Harry's office. in the college

Models

Three dimensional models provide an opportunity to see and feel - new material. Model used must be strong - can be handled by everyone. Whenever possible the actual specimen must be used and models avo$ded.

IDENTIFICATION OF LEADERS

IN HEALTH EDUCATION

Mere identification and involvement of leaders in health education programmes is not enough. More important problem is to sustain thei interests in the assigned responsibilities. Herein lies the skills of a health educator in creating a situation to sustain interests of the leaders.

DR. K.S. SINHA

From time immemorial leadership has played a vital role in bringing about changes in the society. It is the human nature th people want to work together for solving community problems vital fo the growth of the individual in particular and of the society in gen Indeed, the entire process of socialization is based upon the human interaction and acculturation. This process involves leaders in ini tiating desired change for human growth.

For bringing about a change from undesirable to desirab health practices through educational process, change-agents are requ These change-agents are primarily concerned with the identification understanding of health needs of a specific community. They rank th in order or priority, find out available resources and develop a pla action to meet the health needs. In this process, the entire commun is involved and helped to help itself.

In the present day changing pattern of living, it is of significance to understand the multi-dimensional aspects of health a disease, i.e. preventive, promotive, curative and rehabilitative. It has been found that most of the diseases can be prevented. And throu the process of health education, change in the knowledge, attitude a health behaviour of the people can be brought about.

Changing pattern of leadership

However, behavioural change requires understanding of th changing pattern of leadership and the role of leaders as change-ager It is well-known that there are various types of leaders in our commu nity. In most of the cases, leadership shifts from situation to situation and the leadership quality or traits are not hereditary. I other words, leadership is not a personality trait and it can be acquired. Every situation has potential leaders and the leadership quality can be developed. For example, a person who

Pre-requisites

It is essential to identify leaders in the community bef they are involved as change-agents. Here, it is worth mentioning tha early as in 1949, L.D. Kelsey and C.C. Herne in their book, "Co-opera Extension Work" have pointed out that the pre-requisite for identific of leaders is to know the following :

"1. What job is to be done?

2. What characteristics and skills this job requires?

3. Where the person possessing the needed qualitifation can be found

4. What group will support or follow the person?

5. Of the qualities he has -

(a) Which of them may be improved by training

(b) Which may not be changed materially

6. Of the qualities he lacks -

(a) Which may be developed

(b) Which may not be developed.

7. The basis on which he can be induced to work".

In 1970, Dr. S.R. Mehta in his book, "Emerging Pattern of Rural Leadership", has written that in the villages "there are possibly six distinctive areas of social life"and it is necessary"to identify leadership in each of these areas separately".

Six distinct areas are as follows

(a) Persons most influential

It is not enough to know the above mentioned criteria. It is also important to know the nature and magnitude of the health problem, and targets for education as well as services.

In some cases, targets for service as well as education may be the same; but in others, they may be different. For instance, in an immunization programme against smallpox, the service targets ma be children whereas educational targets may be either the mother or t father or both.

Socio-cultural factors also play predominant role in decision-making process of selection of leaders. In certain situatio health rituals based on misconceptions and deep-rooted value system and the role of priests cannot be ignored. But at the same time the fact that has to be kept in view is that "whereever traditionalism ha given way for experimentation, social change has come". Thus there a certain situations which require more than one type of leaders. The function of a health educator therefore is to understand such a situa and decide the specific type of leaders required to bring out a chang in health practices. For example, in a family planning motivation programme for orthodox section of a community, it is worthwhile invol religious leaders, satisfied acceptors of family planning and symboli leaders.

There is no denying the fact that symbolic and instituti leaders like "Sarpanchs" are very important. But, they can be more effective as change-agents provided they are also functional, i.e., p ing know-how in modern methods of agriculture. Such leaders are acce as change-agents for diffusion of innovation. Therefore, situations be carefully examined, taking into consideration experiences of work particular situation, finding out negative and positive forces at wor etc., before actually identifying leaders for their active involvemen in health programmes.

Methods

Based on the field experiences of organizing health education programmes in urban, semi-yrban and rural areas through the involvement of local leaders and community participation, some of the methods adopted for identification of leaders are as follows :

3. Group observer - This is anthropological way of loc leaders. In this method, the health educator works in a community quite sometime and makes his observation regularly. On the basis o observations on various situations he prepares the list of potentia leaders. Here, it is important for the health educator to create a siutation - where the community members do not get the impression t they are being observed. This approach is action-oriented and the selection of leaders is based upon the actions taken by the potenti leaders of the community.

4. Socio-metric method - This method is a little more technical than the other methods. This method is generally used by professional health educators, extension educators and trained soci workers. The pre-requisite for this method is well thought out set questions to be asked to the members of the different sections of a community. The questions for example may be "Whom do you consult when you fall ill?", "Whom do you consult for the marriage of your daughter", "Whom do you consult for purchasing particular variety o seeds?" etc. In this way, names of influential persons are listed f different strata of a community and it is generally found that there are only five to seven common persons whose help is sought to find t solutions of various problems of different members of the community. These potential leaders are known as "initiators" or "spark plugs" f other members of the community.

5. The election method - Many times leaders are identified through formal or informal election method. In this met the health educator involves the entire community or section of a community in giving their opinion regarding their representatives to work as change agent.

6. Seniority and past experiences - Sometimes, leaders identified on the basis of their involvement in health and welfare p mmes for the community. Experiences of working with certain persons have proved useful in preventive and promotive aspects of health. Su leaders are generally enthusiastic and energetic and in most of the c are innovators.

The above mentioned methods of selection or identificati of leaders are merely suggestive. However, selection of leaders depe considerably upon the situation and purpose for which they are select as change-agents.

AUDIO-VISUAL AIDS IN HEALTH EDUCATION

1. What is an Audio- Visual Aid ?

An instrument or a device to assist the instructor in transmitting facts, skills knowledge and understanding to a learner.

Audio Visual aids are the materials and devices used in learning situations to supplement the written or spoken word in the transmission of knowledge, attitudes and increase the retentive power.

II. Value of Audio-Visual aids:

1) Help to give correct concepts or impressions.
2) Stimulate interest
3) Promote better understanding
4) Supplement other sources of learning.
5) Add to variety to teaching methods.
6) Make economy of time.
7) Promote intellectual curiosity.
8) Tend to reduce verbalism or the repetition of words.
9) Contribute to longer retention of learning.
10) Can give new concepts of things outside of the range of ordinary experience.

III Types of Audio-Visual aids:

Audio Visual aids are broadly classified as two brand division

a) Projected:

1) Films
2) Film strip
3) Film Slide

B) Non-projected aids:

1) Black board
2) Charts, Graphs, Maps
3) Posters
4) Flash Cards
5) Flip charts
6) Flannel graphs
7) Puppets
8) Models and specimens
9) Radio
10) Tape recorder
11) Folder
12) Leaflet
13) Booklet

Films:- A motion picture is a series of still pictures, taken in rapid succession, developed and finally projected combined with sound.

Advantages:

1) Provide real life experiences
2) Attract and hold audience attention
3) Combine sight and sound thus acting on two senses

Film Strip:

A filmstrip is related sequence of transperent still pictures or immages on a strip of 35 mm. film.

Advantages:

1) Lessexpensive
2) More useful
3) Can be operated by the speaker-Easy to handle
4) Can be produced to meet the local situation
5) Can be operated both by electricity as well as petromax.

Disadvantages:

1) When too long it will not be interesting.
2) Rough handling may result in damage.

Film-Slide: A slide is an individually mounted transparent picture or immage projected by passing a strong light through it.

Common size:- 2" x 2" or $3\frac{1}{4}$" x $3\frac{1}{4}$" or 31/3 x $4\frac{1}{4}$.

Advantages:-

1) Attract the attention of the audiance, and arouse interest in them.
2) Assist for lesson development.
3) Helps for review of instruction.
4) Could be prepare locally without much financial resources

Disadvantages:-

Advantages:

1) The material is comparitively easy to prepare.

2) A variety of materials could be handled.

3) The instructor can face the audiance.

4) The instructor can point to or write on the material while it is being projected.

Disadvantages:

It may become difficult to use effectively if the instructor has not prepared the lesson plan.

Epideoscope:

A projected aid in which the printed material could be made use of for projection.

Advantages:

1) Easy to handle

2) Less work to the instructor.

3) Dual advantages i.e., we could use both slides and printed matter.

Disadvantages:

In the absence of electricity it cannot be used.

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AIMS:- ① To ensure that health is valued.
② To equip people w skills/knowledge to solve health problems
③ To promote knowledge/dev & use of Hlth ser
APPROACHES to public Hlth Problems - ① Regulatory ②
③ Educational

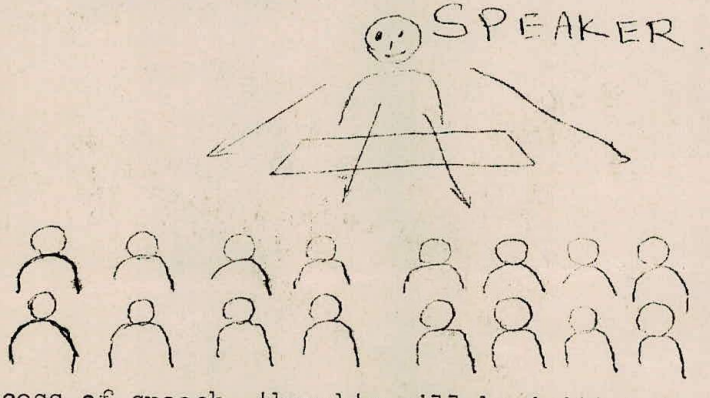
METHODS OF HEALTH EDUCATION

In the implementation of Health Programme, Health of Edu is of paramount importance and in the process of Health Education, va methods are employed. When we are dealing with human beings, the met methodology is very important in achieving the end results. If the methods are good and sound the people accept and act in the direction want them to change.

The following are some of the common and practical metho Health Education which could be employed by the P.H.C. field staff in educating the community for the successful implementation of any Heal Programme.

I. Lecture Method:-

The lecture is an oral presentation by a speaker to deli organised thoughts and ideas.



In this process of speech, thoughts will be initiated, problems will b identified and the audience may be moved to action.

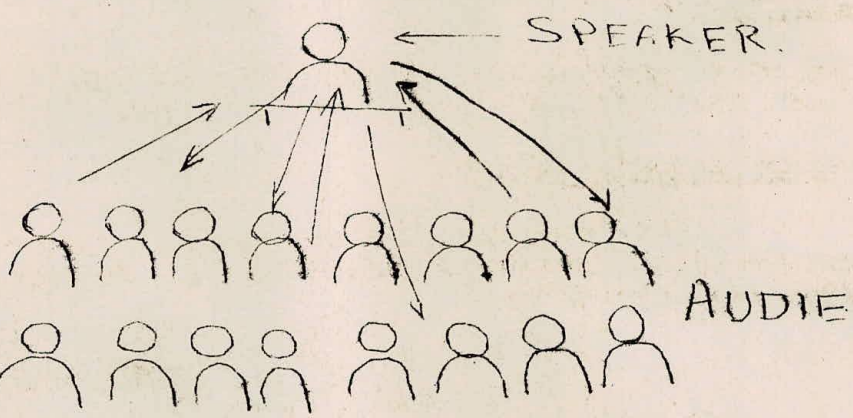
Advantages:-

1. Could present the material in a logical sequence.
2. Appeals to the audience since it is easy to hear than
3. Easy to impart large number of facts in the shortest t possible to a large group of audience.
4. Simple to organise lectures.

II. Lecture-cum-discussions method:-

- It is a process by which the speaker and audience participate both in lecture and discussion.

- In the process, thoughts will be initiated, problems will be identified to seed solutions.



Advantages:-

1. Learning will be more meaningful and effective
2. Material could be presented in a specified time
3. Could know that is in the minds of the people
4. Doubts may be cleared
5. Two way method
6. Feeling of satisfaction to the audience

Disadvantages:-

1. Communication may fail in case the Lecturer/Speaker has not prepared properly.

2. May result in the wastage of time, if the audience is asked to disc subject/topic not relevant to that particular occasion.

III. Personal or individual contact method:-

Method of discussion/talk/conversation with a person individually.

Advantages:-

1. Feels freely to discuss the problems.
2. Doubts could be clarified.
3. Personal Health problems could be discussed.
4. Health matters could be discussed in Confidence.

Disadvantages:-

1. May not be practicable to discuss with other six.
2. Uncomfortable to the persons who are shy type.

IV. Group discussion method:-

It is a participation of a group of persons in the discussion of some subject or problem for which further informationor action is mutually desired.

Group discussion

(a) Chairman - lead the discussion:- CHAIRMAN - The Chairman will be the person who leads the discussion and helps the group not only for s running of group discussion, but also, for its productivity in terms o arriving at decisions. He will see that there will be no scope for gr conflicts and provide opportunities to all the members to participate the discussions. He will be the person who must be in a position to command the respect of the group and he must be polite and courteous in his dealings with the group.

(b) Rapporteur - Establishing rapport and recording

(c) Resource person - Guide the group

(d) Members - participants

- Group discussion provides each participant an opportunit to experss his or her view point.

Advantages:-

1. A valuable educational method which provides opportunity to all th members to participate
2. Stimulate people to become aware of mutual problems.
3. Help them to identify problems.
4. Help to explore the other possibilities of solving the problems.
5. Provides an opportunity for them to place programmes of action.
6. Assist them to find out solution to problems.
7. Easy to implement because of group support.
8. Learning will be more effective as the members discuss elaborately and clearly.
9. Bring together the opinions of all the members to conclusion.
10. The contribution of each member in the group discussion will add t the group knowledge.

Disadvantages:-

1. If there is no planning, it will not reach the desired success.
2. If all the members do not participate, group discussion will not be a success.
3. The leader, if he is not well-versed with the topic/problem, the discussion will not be effective.

V. Seminar Method:-

Advantages:-

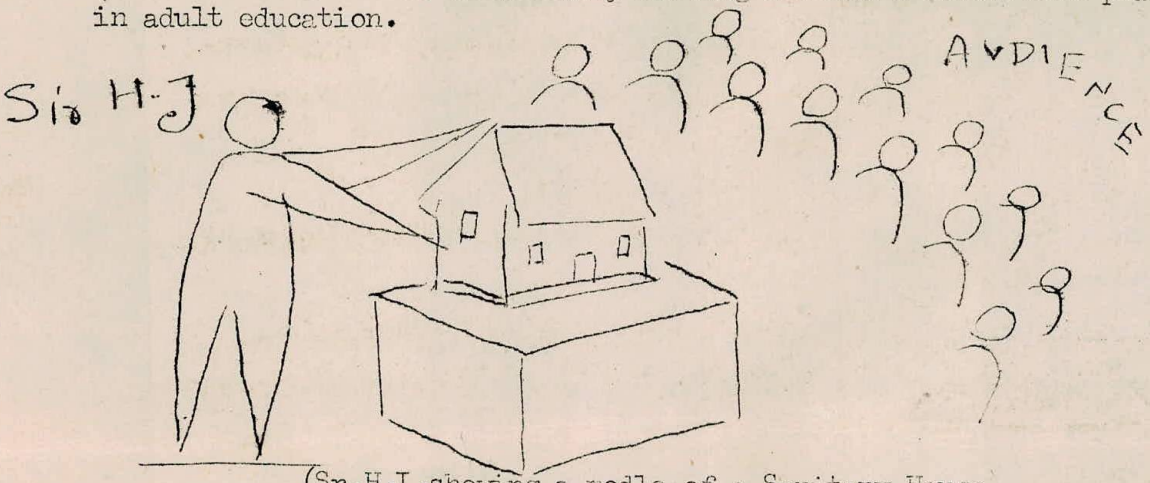
1. Learning is great, as the members speak different aspects.
2. Creates interest among audience
3. Practicable to any situation.

Disadvantages:-

1. In the absence of pre-planning , the entire show may be ineffective.
2. Members may have to be well prepared for the probable questions from the audience.

VI. Demonstration Method:-

It is a method of actually showing and has a favourable place in adult education.



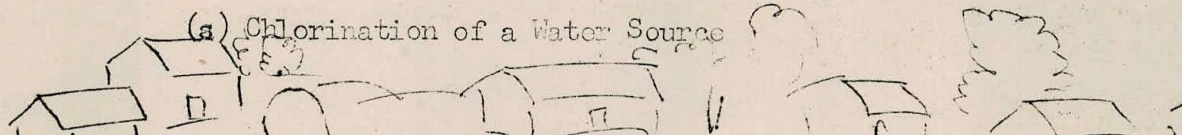
(Sr.H.I.showing a modle of a Sanitary House)

Two types:-

1. Method demonstration:-

Actually demonstrates the method of doing

(a) Chlorination of a Water Source



2. Result Demonstration:-

Actually demonstrating the results with evidence after practice.

Example:- (1) A baby attending the well baby clinic with that of a baby not attending. The baby who is attending the Clinic naturally will be more healthy than the one not attending.

(2) A pregnant lady who attends the Antenatal Clinic regularly with that of another pregnant lady who is not attending the Antenatal Clinic. In this case, the Lady who attends the Antenatal Clinic will have a safe delivery and healthy Child.

(3) Regular primary vaccinations and periodical revaccinations lead to Erradication of Small Pox &

Advantages:-

1. Attracts and holds attention and it is interesting
2. Can present subject matter in a way that can be under- stood easily.
3. Convince those who may have doubts
4. Objective and concrete
5. Proves the example of practical application and knowledge
6. Permits both theory and practice.

Disadvantages:-

1. Very difficult to make good demonstration
2. This method is restricted to certain kinds of teaching situations.
3. Requires a large amount of preliminary preparation.

VII. Field trips and tours:- It is planned to visit places outside the Class room or the meeting place of the Organisation. Field trip involves the taking of a group to a specific place for a specific purpose. Short duration of 1 to 3 hours.

OXFORD

BOOK FORM REFILL

HEALTH EDUCATION 26-P

9p

Ref. No. 62MN

Standard Rulings
9x7 40 Leaves

62P	Plain
62F	Feint
62FM	Feint and Margin
62N	Narrow Feint
62MN	Narrow Feint and Margin

Patent No. 919854