

The Place of Health Education in Health Administration

Report on a Working Group

Manchester
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This report is also available in French and Russian.

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1. INTRODUCTION

In its endeavours to increase the effectiveness of health education services, the Regional Office for Europe of the World Health Organization convened a Working Group with the aim of examining the place of health education in the health administration of various European countries. This Working Group met in Manchester, United Kingdom, from 29 March to 1 April 1976.

The meeting was opened by Dr A.P. Woudenberg, Regional Officer for Health Education and Social Sciences, who addressed the participants on behalf of Dr Leo A. Kaprio, Regional Director, WHO Regional Office for Europe. The participants were welcomed by Dr A. Yarrow, Senior Medical Officer, who represented the Department of Health and Social Security, United Kingdom. Dr E.A. Smith, Professor of Community Medicine, University of Manchester, welcomed the participants on behalf of the Dean of the Medical Faculty.

For each of the four main topics to be discussed a Chairman was elected, namely, Dr F. Görres, German Democratic Republic; Dr L.G. van Parijs, Belgium; Professor E.A. Smith, United Kingdom; and Dr B. Tomić, Yugoslavia. Dr L. Barić, United Kingdom, was appointed Rapporteur.

The agenda of the Working Group is given as Annex I, and the list of participants as Annex II.

2. SCOPE AND PURPOSE

In a number of countries in the WHO European Region the responsibility for all planning, guidance and coordination of health education activities rests with a unit (or section, or department) of health education at central health administrative level.

In other countries, governments are advised on health education matters by a health education council or a similar body, which may carry out health education activities itself in conjunction with or separate from other health education agencies.

In other countries again, health education is carried out by voluntary organizations which receive grants and subsidies from the national health administration but which otherwise have little contact with it.

Consequently, various charts could be drawn of the existing models of health education services in the Region, showing the degrees of integration of health education systems in health administration systems.

Each model would have certain advantages and disadvantages with regard to planning, implementation and evaluation of the health education components of national health programmes. The various models would have implications for training and job definition of health education personnel, strengthening of health services and disease prevention and control. In view of this, the purpose of the Working Group was to discuss the various models and comment on them in order to produce recommendations on the appropriate place of health education in health administration.

The subject was also considered in the light of the resolution on health education adopted by the World Health Assembly in May 1974 (WHA27.27), in which the Director-General of WHO was requested to bring to the attention of Member States the need for the inclusion of health education activities in all health and other related programmes.

3. WORKING PAPERS

Four working papers had been prepared for the meeting:

- (1) "Health education administration in the European Region";
- (2) "The theory and practice of health education as related to the place of health education in health administration";
- (3) "Health education in the North Karelia project: principles and recommendations"; and
- (4) "The place of health education in the health administration of Yugoslavia".

3.1 Health education administration in the European Region

The first paper, "Health education administration in the European Region", was given by Dr A. Yarrow. It described methods of central organization of health education in Europe, the relationship of organizations to government and the relative advantages and disadvantages of each method. The dominating factor in the relationship to government was the function of health education in relation to prevention and the consequent need for joint examination of priorities. Scarcely less important was the frequent reliance of health education bodies on government to provide research and intelligence. Those considerations made a close relationship essential.

The paper then listed the functions being carried out to a greater or lesser extent by centrally organized health education bodies, including (a) determination of priorities; (b) programme performance and evaluation;

(c) research; (d) support of field workers; (e) promotion of health education in professional training; and (f) coordination of agencies.

The four arrangements prevailing were listed in simplified form, namely:

- (a) a unit within the health department,
- (b) a council outside the health department,
- (c) autonomous agencies with a coordinating committee,
- (d) autonomous agencies.

The relative advantages and disadvantages of each method were examined. Clearly the unit benefited from its close relationship with government, but its performance might be inhibited in areas where government was inhibited and it might lack outside support. Conversely, the council had greater freedom of action and its membership implied outside involvement. Powerful autonomous agencies might exhibit great enthusiasm and drive but involve fragmentation of effort. A coordinating committee enabled priorities to be considered.

The paper concluded by pointing out that the quality of staff was as important as administrative structure; that health education was still relatively undeveloped; and that weaknesses in organization could be understood and overcome. Most important of all, the success of any method of central organization depended on the efforts of the field work health educators.

3.1.1 *Discussion*

The main topic of the paper was the difference in the way health education services were related to health services in various countries. The Working Group examined some advantages and disadvantages of that relationship.

One of the advantages of the close relationship between the two systems was considered to be the availability of health data collected by the health administration. Health education needed data to plan and execute its programmes. The kinds of data collected by the government were of use to the health administrators, but represented only one part of the data needed for health education which had, therefore, to be in a position to collect its own data. Whereas the governmental intelligence consisted mostly of mortality data (only in a few instances were morbidity data included) and data on available resources and their utilization, health education needed data on community values and norms, on individual behaviour and the process of change within a specific social system. That kind of information could rarely be found recorded on paper; it mostly represented a part of the knowledge and experience of field workers and had to be collected, classified and recorded for use in the planning and execution of health education programmes.

The most important area of interaction between health education and health administration was in the synchronization of behavioural changes and health regulations. In spite of tremendous efforts in the past, both on the part of health administrators and health educators, health programmes and their health educational aspects had tended to develop in parallel without coordination and synchronization.

Experiences in various countries concerning certain health threats had shown that health education programmes could be more successful if they were accompanied by formal norms (legal regulations). Such norms were necessary for the maintenance of behavioural changes achieved through health education (e.g., wearing of seat-belts in cars).

In a number of European countries there were three sets of bodies active in health education: health administration, health education services and voluntary organizations. The difficulties in cooperation between them often stemmed from the lack of trained health education planners who could participate on an equal footing with health service planners to set up nationwide health education programmes within the health services. One of the possible reasons for that was the absence of any evaluation of health education, which prevented health educators from insisting on the inclusion of health education interventions in health programmes since they would not be able to foresee the outcome of such programmes.

The difficulties that existed in cooperation between health/health education services and voluntary bodies were due to two main reasons: one was the lack of training of voluntary workers in health education; the other was their fear that any external intervention could jeopardize their existence.

Health education could not be successful without the participation of the people; changes needed to be accepted and promoted as part of the activities carried out by members of voluntary groups. In some countries, such participation, together with its control, had been successfully coordinated with the governmental activities by coopting government representatives into the voluntary organizations. In that way the voluntary bodies complemented the activities of the health and health education services.

3.2 The theory and practice of health education

The second paper, "The theory and practice of health education as related to the place of health education in health administration" was given by Dr L. Barić.

It dealt first with the theoretical aspects of various models existing in Europe concerning the organization of health education services. The various models were described in general terms according to the amount of centralization or decentralization of the health services. The second problem examined was that of the advantages and disadvantages of certain types of models according to the aims of health education, related to the problems in different

countries. Not only were there different models of organization of health education, but there were also different problems of health priority in different European countries and the organization of health education services had to be adjusted not only to the organization of the health care system but also to the needs for a solution of the predominant health problem. Special emphasis was placed on the need to rethink certain aspects of health education and on the need for professionalization of health education activity with the aim of protecting the client population.

It concluded:

(a) that a comparative analysis of health education methods was necessary with a view to achieving optimum effectiveness, bearing in mind the varying health priorities in different countries;

(b) that the existing high level of knowledge about the prevention and treatment of behaviour likely to lead to health threats was not fully reflected in the organization of health education services, nor were those services yet sufficiently professional;

(c) that an appropriate organizational framework for health education services therefore needed to be built up.

3.2.1 *Discussion*

It was generally recognized by the Working Group that there was an immediate need to train other professions in health education, as well as health educators.

The participants stressed the difficulties in achieving that aim. One reason mentioned was the difference in needs between the various professions such as doctors, social workers, nurses and teachers. Each of them had special requirements with regard to the need to complement their basic knowledge with certain aspects of health education.

Another reason concerned the state of existing health education knowledge. There was currently a substantial knowledge of the effects of health education and traditionally held beliefs on health and illness. However, that knowledge was at present dispersed, and in Europe no one profession could claim to possess it in full. Health educators might claim such expertise, but they were few in number and did not have a recognized professional status. In Europe there was a need for a recognized profession that would take the responsibility for that knowledge, collect and systematize it and act as its custodian.

Professional jealousy prevented health educators from being recognized by other professions. They were not often accepted as teachers of health education knowledge, even where it had been systematized and collected.

A solution would be to raise the professional qualifications of the teachers of health education to at least the same, if not a higher, level than those of their pupils so that they could command the required professional recognition and respect.

The integration of health education into other professions could be dangerous without the simultaneous preparation of agents who could carry it out. Those agents would have to fulfil two tasks: integration into the basic training of other professions as well as into regular activities in their own field.

3.3 Health education in the North Karelia project

The third paper, "Health education in the North Karelia project; principles and recommendations", was given by Mr K. Koskela.

On the basis of experiences gathered so far in the North Karelia project it was concluded that the main emphasis in the practical implementation of a health education programme should be to organize a comprehensive and community-orientated activity on a local level, which would affect the conditions that regulated people's behaviour. The local health services, e.g., the health centre, should have a specific responsibility for being in charge of the activities aimed at the prevention of the major health problems in its area. That implied the allocation of necessary resources to preventive work.

To be able to accomplish its task, the local health centre needed systematic programmes with clearly defined objectives and practical tasks. The programme should be based on a systematic health education service-structure, take into account possible environmental changes, provide for the collection of general information and operate with the cooperation of various institutions in the area; in other words, it should take into account the actual social situation in the community. The necessary health education services should be integrated in the existing health care service-structure. The planning, management and evaluation of the services should be carried out in a practical way as part of the operation of the overall health care services.

3.3.1 Discussion

The facts set out in the working paper indicated that the experiences gained in the North Karelia project were of great educational value for the future integration of health education into the activities of the health services.

Following a petition from the population of a certain part of the country, who had become aware of the size and importance of one of their health problems, the top health administrators had provided an intensive programme to solve it. That had been achieved by the inclusion of health education in various activities of the health services, with the result that it was now its integral part. The effects had so far been only partly assessed but it was

already noticeable that the behaviour of the people was changing, that the services included units designed to support and help in the attainment and maintenance of behavioural changes and that the idea of social responsibility was growing. The North Karelia project's approach had been taken up in other parts of the country and at least one university (Kuopio) had made it a part of its teaching philosophy.

3.4 Health education in the Yugoslav health administration

The fourth paper, "The place of health education in the health administration of Yugoslavia" was given by Dr B. Tomić.

During the early nineteen-fifties, health educators in Yugoslavia had tended to underrate the importance of legislation for health education. That low opinion of the influence of legal norms on people's behaviour was due to previous experiences with so many health regulations which were rarely adhered to. The same applied to legislation concerning the activity of health education as being "compulsory" for every health worker. The existing experience was that, for the legal requirements to be satisfied, an educational process had to take place. It should be based on research findings, be well timed, supported by the appropriate organizational structure and backed up by the necessary services. One way to achieve that was to engage the decision-makers and health administrators in activities which would provide them with practical experiences.

Such a process resulted in health education holding an important position in general health care and one which was formally recognized and supported by laws and regulations.

The 1970 Law on Compulsory Public Health Protection and its Instructions contained a great number of references to health education and paid special attention to the role of the health visitor. The consequence had been a qualitative change in community health education activities, based on the experiences gained in special pilot areas.

3.4.1 Discussion

Analysis of the possible contribution of legal regulations to the integration of health education in the health services (with integrated curative and preventive services) showed clearly that in specific social systems such regulatory methods could be of great importance.

In a country where the budgeting of health services was based on the payments by the social insurance system for services provided by the health care system, health education activities would be carried out only if they were priced in the same way as any other health or medical services. Once that had been achieved, health education became a part of the regular services provided by the health care system.

However, in a country where the preventive services were detached from curative services that integration would be less likely to occur. If, for example, preventive dentistry were not included in the health insurance scheme, or the general practitioners did not have preventive work included in their contract, prevention in general and health education as its specific aspect would not be carried out on a regular basis.

It was for the government of a country to decide to make prevention a part of the general provision of health care. That decision, if made, should, however, be implemented on all the levels of the health services' structure to avoid a gap between policy decisions and their application in the field. To achieve that, the training of health personnel should include all the relevant subjects necessary for the fulfilment of such a task; each aspect of the task should receive the emphasis and amount of teaching appropriate to it. That followed from the awareness that doctors and nurses carried out the tasks for which they had been trained. If prevention and cure both became a part of their social reality, they would also become an integral part of their future professional role and it would not be left to their personal choice and conviction.

4. GENERAL DISCUSSION

The working papers and the discussion that followed raised a number of pertinent points concerning the interrelationship between health education and health services. The main aspects of this problem area may be summarized in terms of answers to a number of general questions: What is to be integrated in what? Where within the health system should health education be placed? How should this integration in the health system be achieved?

4.1 Description of the health education system

In countries where health education does exist as a separate recognizable system it is rarely fully developed in all of its aspects; usually one aspect tends to be dominant. The main emphasis may be either on the health or on the educational part of the system.

4.1.1 *Health education and health services*

The health education services can be integrated in the health care system to serve two purposes: to promote health on an individual or on a community level. In most cases they will be integrated in such a way that it will be possible to fulfil both tasks, although each one has very specific requirements.

Individual prevention. Health education dealing with the health behaviour of individuals will have different aims according to the need for primary or secondary behavioural prevention.

(a) Primary behavioural prevention will be concerned with the inculcation of routines, attitudes and knowledge appropriate for the maintenance and promotion of individual health as a part of the process of primary socialization of the individual.

(b) Secondary behavioural prevention will be concerned with behaviour modification of individuals, either through imparting knowledge; focusing attention on the risk from a certain mode of behaviour to an individual's health or his speedy recovery and thus provide the individual with alternatives of choice for his decision about prevention; or through legitimizing his "at-risk" status and pressurizing the individual to conform with the existing social norms relevant to the health risk in question.

Community prevention. Individual health education will be successful if it is supported by the social norms of the community or the group to which the individual belongs. The existence of appropriate and well defined social norms concerning expected behaviour is, therefore, a most important precondition for any lasting effects of health education. It can be a question of either reinforcing and publicizing the existing norms, modifying them if necessary, or creating new ones where no norms exist that are relevant to either the health threat or the population groups affected.

4.1.2 *Health education and the educational system*

The imparting of knowledge regarding the maintenance of health and the prevention of illness can also be a part of the process of secondary or formal socialization of individuals. However, a formal definition of the role of various educational agents and institutions does not as yet exist.

School health education. Primary education uses simple topics and methods appropriate to the relevant age-group, whereas secondary education includes health topics related more directly to the health problems of that age-group based on a rational explanation of the causes and consequences in each separate case. Considering the role of the school in imparting the legitimized knowledge of a society to its coming young generation, the problems of school health education are manifold. The prevention of some of the health threats relevant to that age-group cannot be defined as representing the "legitimized" body of knowledge in every case since there need not be full agreement among the educationists or the health profession as to what causal

relationship exists between the behaviour and the health threat. In some instances health education topics discussed in schools are more related to the value system of a specific group than to the existing scientific knowledge.

Adult health education. Health education of adults can be considered as a specific method of approach or a specific activity. In the latter case it is concerned with the many educational programmes designed for certain adult groups that already exist, or in the former case it will be concerned with adults who are being brought to a group setting for the specific purpose of receiving health education. The aim of adult education is mainly to impart new knowledge about health threats or to relearn the existing knowledge within a new context.

4.2 Types of health care systems

In the working papers prepared for the meeting descriptions were given of the different ways in which health care is at present organized in the various countries of the European Region. These include such systems as the practice of liberal medicine, the sickness insurance system, the national health system and the system of State medicine practised in socialist countries.

The extent to which a health care system is "open" or "closed" will determine how far it will be possible to make a centralized decision about the integration of health education services in that health care system. It will, furthermore, depend on the extent to which curative medicine and preventive medicine have been integrated, and to the place assigned to health education services within the health care systems. Ultimately, the level at which the health education services will be placed within the structure of the health care system will depend on the status and the reputation health education has as a special scientific discipline.

4.3 Types of health education systems

All the background papers dealt with different ways in which health education services are at present organized in the European Region. In general, the existing health education systems can be grouped according to their relations with the health care system into the "dispersed", "specialist", "coexisting" and "cooperative" models of organization. It would be wrong to assume that the different models of organization of health education services directly correspond to the type of health care system in that country. However, the status of the health education services will depend on a number of factors, such as the effectiveness of health education interventions, the degree of specialization of its agents and the amount of theoretical background on which health education activities are based.

4.4 Health education and health problems

Although health education is meant to deal with a wide variety of problems related to health (the state of physical, mental and social wellbeing), when integrated in health services it is mainly concerned with the prevention and cure of illness. Consequently, the problems health education has to deal with will depend on the development and the priorities of these services. These will range from the prevention of infectious diseases and the reduction of infant mortality to problems of chronic diseases and old age.

In addition to the problems peculiar to each country, there are at present problems of a European character which are not limited to one country or one health service. These are problems such as migration, tourism, traffic accidents, etc.

New problems demand a new coordination of health education services on a European scale, the planning of joint programmes and the adjustment of methods followed by cross-national evaluation.

At the same time, changes in health problems within countries demand new approaches in health education since, as has been seen in the North Karelia project, the existing methods can achieve only limited results even under optimal conditions.

Both the newly emerging problems and the limitation of existing methods demand that the organization of health education services be reconsidered within the health care system of each country.

4.5 Health education agents

This reconsideration of the place of health education services within each health care system must take into consideration the type of health education agents that are available as well as the type to be produced in the future.

There is a clear need for job definition and educational requirements concerning health education agents. The basic training and the type of specialization will define the place and the level at which health education agents will be integrated in the health services. Job definition will have to specify the degree of professionalization required, which in turn will decide the type of educational institution appropriate for obtaining the necessary qualifications.

The professional status of the health education agent is closely related to the type of services he can provide: for individuals or on a community basis.

4.6 Methods of development of health education services

The present state and the future development of health education services will depend on a number of factors: the perceived needs, the available resources and the existing mechanisms for introducing change.

4.6.1 *The perceived needs*

There is no doubt that in Europe today health education is necessary for the solution of present as well as future health problems. This can be achieved either by developing a specialist service, or by integrating the activity in the existing services; a combination of both approaches is also possible.

Experience has shown that specialist services should not be isolated from the rest of the health care system but should be regarded as a specialization within that system. On the other hand, integration of the activity in the existing system should be done during the undergraduate training of the personnel of that system so that it becomes a part of their general outlook and a skill to be executed during their daily activities.

4.6.2 *The available resources*

The need for either a specialized service or an integrated activity will require a clearly definable and academically respectable body of knowledge specific to the scientific discipline of health education.

In some countries attempts are being made to achieve this status for the subject matter of health education, whereas in others the view is still that health education is a part of the existing system of preventive and curative medicine and that only a few additional topics and skills should be sufficient.

It is only in some countries that health education has gained academic recognition and is being taught at present in some medical schools. Even in these countries health education is more often taught on a postgraduate level and not always to undergraduates.

During the discussion it was stressed that the body of knowledge relating to health education does exist but is dispersed and needs to be collected, systematized and recognized as a specific subject.

Once the subject matter has been recognized as having an academic standard, it can be taught either in its theoretical form or as an applied subject on an intermediate or practical level. It is becoming obvious that the teaching of practical skills without any theoretical backing is in general not acceptable as a serious subject meriting the time and effort required by a formally recognized subject.

To achieve scientific respectability the teaching of a subject must be based on tested theories for which research facilities are needed. So far research in health education, where it does exist, has been mainly concerned with studies of the problems, their etiology and distribution in a population as well as with behavioural causality. Health education is an applied aspect of medicine and as such requires research into the possible consequences of its application. This means that research must be concerned with the study of solutions (or evaluation) as well as the study of problems and their causes.

To achieve this standard of teaching and research it is important that health education gains academic recognition, since it will be mostly in academic institutions that this approach will be possible. On any other level, the need for practical solutions is too immediate and acute for time to be available for basic research.

Once a recognized body of practical knowledge exists, supported by tested theories, it will be possible to cater either for the needs of specialization or for the integration of the subject matter in existing training programmes.

4.6.3 *The existing mechanisms*

The Working Group agreed from the outset that it is not possible to produce a recommendation of one "best" model of health education services, in the same way that there is no "best" way of organizing the health care of a nation. Health education must be organized to fit the value system, organizational structure and health problems of each country in the Region.

As far as the value system is concerned, it is reflected in a country's sociopolitical subsystem. It can range from an individual to a communal approach, with various combinations of both in between. This will also influence the way any changes will be achieved if they should be deemed necessary. In some countries the emphasis will be on a gradual evolvement of awareness among politicians and administrators that the future health of the people depends on a successful and developed health education service; in other countries the change will be achieved through legislation and pressure to reduce the gap between top-level decisions and field-level implementation.

The existing organizational structures of the teaching institutions as well as the services will represent a further constraint on the development of health education. There are countries where health education is not a recognized subject in the teaching institutions. Even when the body of knowledge becomes academically respectable, it will be necessary to understand and take into consideration the procedures in such institutions that can be utilized in gaining acceptance of a new subject. The same applies to the existing organizational structure of the health services in a country. To avoid the sad situation where the need for health education only receives occasional lip-service from administrators and politicians, it is necessary to make definite provision for a career structure and job definition for health education agents. Where no specialists are being envisaged, the duties of existing agents must be spelled out, included in their job definition and even included in their contracts where this applies.

Probably the most important influence in selecting the type of health education service needed will be exerted by the health problems which must be solved. Different dominant problems will require that provision should be made for specific approaches and different priorities. It seems, however, that whatever the problems are, the types of intervention required have certain

shared characteristics: the need for a sound theoretical basis, professional responsibility towards the client population and well planned and evaluated programmes.

The health problems of the countries in the WHO European Region can no longer be considered as stages in a continuum ranging from simple to complex. Even in countries where infant mortality and infectious diseases are still dominant, problems of chronic diseases and old age exist; and vice versa, in developed industrial societies there is a constant threat of an epidemic breaking out. The enormous proportions of population migration and movement between and within various countries pose shared "European" health problems and dictate the need for shared "European" standards of health care, including prevention, with health education as its important aspect.

4.7 General implications for future developments

There was agreement among the participants of the Working Group on the importance of health education for the solution of present as well as future health problems in the European Region. It was further accepted that because of the different sociopolitical systems in the various countries the organization of health education services must be system-specific: there is no optimum model suitable for all European health care systems.

There was, however, one aspect of the health education delivery system which was not explicitly mentioned nor discussed. It concerns the ideological basis of the health education approach, whatever the organizational structure of the services.

4.8 Present needs

It could be argued that there are certain dangers involved in a drastic change from an individual to a societal approach in health education. So far this danger has been avoided by merely changing the emphasis placed on the approach of choice instead of excluding one on the account of the other.

Present theoretical knowledge, although still scarce, leads us to believe that the societal approach is more economical in terms of manpower and time than the individual approach. At the same time it is recognized that the individual approach should be available for those cases where a person can be described as "deviant" from societal norms and will need individual behavioural treatment.

In conclusion it seems that the integration of health education services in the health services of a country, in whatever form, will have to be able to achieve the following:

- (a) to create, change or reinforce social expectations concerning health-related behaviour;

(b) to provide back-up services for those who need professional help in changing their behaviour;

(c) to maintain a high level of professionalization, which implies responsibility for the protection of the rights of the clients, whether they be individuals or whole communities.

5. CONCLUSIONS

There was general agreement among the participants on the following points.

1. Health education structures are to a large extent governed by existing sociopolitical structures and are the most suitable initial positions from which to develop. An increased awareness among decision-makers of the implications and potential of health education should make it more likely for resources to become available for such development.

2. Health education should be integrated in a planned way in the total health service; in other words, health education programmes as separate entities should give way to national health programmes of which health education is a part.

3. Coordination of activities is necessary if direction is to be gradually achieved without wasteful overlapping of effort.

4. Centralization in so far as it relates to organization, finance and staffing is advisable when it is compatible with the sociopolitical structures of a country and takes into account the valuable contribution that voluntary and statutory organizations, including the mass media, have to offer.

5. It is very important to educate and influence the policy-makers.

6. It is also important that health educators should not raise the expectations of the public without being able to meet them.

7. Evaluation should be a necessary component of all health education programmes, at all levels (including field level). Budgeting should take proper account of this need. This evaluation should interact with the evaluation of health services in general. Both long-term and short-term evaluation are important and make a necessary contribution to the identification of effective measures and as an aid to the decision-makers.

8. The development of health education will be facilitated by the provision of qualified health education personnel who would have a function in:

- (a) maintaining the quality and standards of health education;
- (b) gaining access to existing post-secondary education institutions in order to have a teaching input for undergraduates and postgraduates in related disciplines; and
- (c) contributing to the development of internationally acceptable standards regarding the theory and practice of health education.

9. The possibilities for training depend upon the present stage of development of health education in each country.

10. The achievement of attractive career possibilities is essential if people with the requisite qualifications are to be attracted to and retained in the health education field.

11. Where the organization of health education is at an early stage, immediate training requirements may vary, but the long-term development of training in this field is an advisable objective.

12. The credibility of longer-term training and the acceptability of the graduates are enhanced when the training is carried out in a recognized educational institution.

13. A primary function of the qualified health educator is the initiation of a "percolation" system, i.e., the teaching of the teachers.

14. The long-term training of health educators is dependent upon the political will to guarantee adequate and continuing resources.

15. It is essential that health educators should be brought into the health planning process at the initial stage.

6. RECOMMENDATIONS

The following recommendations were made by the Working Group.

1. Health education should be carefully integrated in the total health service; thus, health education programmes would become a part of health

programmes. This recommendation does not exclude health education initiatives. The integration of health education in overall health programming will have implications for the planning, execution and evaluation of such programmes: there will be a need for appropriate data either from existing sources or from those specially created for the purpose.

2. To achieve direction and avoid wasteful overlapping of effort by a variety of agencies the coordination of, and pooling of resources for, health education activities is desirable.

3. Regardless of what type of central administrative organization of health education is adopted, the concerted and educated support of policy-makers and health administrators is essential.

4. Recalling that health education of the population and the involvement of people in all health programmes is a collective responsibility of all elements of society, health administrators should assume responsibility for initiating health education where no health education services exist.

5. While the role and objectives of the health education component of health programmes should be determined by the administrator who shares the responsibility for the whole programme, the health education component should be planned by the health education services. To make full use of health education possibilities, health educators should be brought into health programme planning at the initial stage.

6. In view of the growing importance attached to the mass media by health administrations as well as health education services and the considerable financial resources involved, the WHO Regional Office for Europe should undertake appropriate measures to establish the role and effects of the mass media in health education and make the findings available to Member States.

7. Since health education services affect people's life style and behaviour it is considered of the utmost importance that adequate checks be built into the system to ensure a high degree of professional responsibility for the consequences of each health education intervention.

8. Professional responsibility for health education activity requires both long-term and short-term planned evaluation as a component of all health education programmes at all levels (including field level). The aim of this is to provide data for decision-makers, protect the clients and contribute to the deepening of knowledge. Budgeting of health education programmes should take proper account of this need. The evaluation of health education should be linked with the evaluation of health services in general.

9. To raise standards and quality in health education and achieve greater efficacy, a continuing effort to enlarge the already existing body of knowledge is to be made. Systematization of knowledge and the creation of internationally comparable scientific methodologies in health education would greatly facilitate the basic and advanced training of health education personnel.

10. Recruitment and teaching of health education personnel is closely linked to career structures and possibilities. The WHO Regional Office for Europe should study the existing career profiles and make recommendations as to the strengthening of health services by the development of health manpower in health education.

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Annex I

AGENDA

1. Various models of relationships between health education and health administration
2. Theory and practice of health education as related to the place of health education in health administration
3. The health education programme of the North Karelia project, Finland
4. Health education through the Health Visitors Service, Socialist Republic of Serbia, Yugoslavia
5. Discussion and recommendations

Annex II

LIST OF PARTICIPANTS

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