THE CONTRIBUTION OF HEALTH EDUCATION TO THE BASIC CONTENT OF TRAINING

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COMMUNITY DEVELOPMENT SECTION

The Contribution of Health Education to the Basic Content of Training

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(*Item* 4 *on the Provisional Agenda; see WP/B.* 1)

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(1) Health an integral part of Community Development :

1. The object of the Community Development Programme is to establish for the people the 'right to live' by exterminating the triple enemy—poverty, disease and ignorance. It is recognized that it is not possible to exercise the 'right to live' without creating conditions conducive for the promotion of positive health. As such, health has to form an integral and essential part of the Community Development Programme in order to raise socio-economic conditions of the people. The health of the people in a community is a measure of human resources available for production of food, operation of industries and for maintaining the standard of living. Poor health not only keeps away workers from the fields and other places of employment, but it generally burdens the low family income and brings suffering and unhappiness. Unless people are healthy they not only stand in the way of their economic development but also they cannot enjoy the true benefits of their improved economic status. Ancient Indian texts on the Science of Medicine always laid a great stress on the attainment and maintenance of health. In one of the texts, it is said.

> "For the development of the artistic, the ethical, and the economic and spiritual activities of man, the first essential is 'Arogya' (health)".

In another text, it is said,

> "Physical prowess is essential for any kind of development".

As such, success of the Community Development Programme will necessarily depend upon the satisfactory maintenance of the health of the community.

(2) Major Health Problems :

2. The Community Development Programme has an important role to play for the development of rural areas where majority of the people live in Asia and the Far East. In most countries of this region the village represents the growth of life and culture. In a country like India the village has remained the basic unit of the social organization and nothing has happened till now to change its fundamental character. It was in this context that Mahatma Gandhi said,

> "If the village perishes India will perish too. India will be no more India. Her own mission in the world will get lost".

3. It is in the rural areas that the medical and health facilities are most inadequate. It is in the rural areas that most of the communicable diseases are rampant. Epidemics generally start from the rural areas. In the field of environmental sanitation conditions are no better, particularly in regard to safe water supply and hygienic disposal of human excreta. The mortality and morbidity due to filth-borne diseases such as dysentery, diarrhoea, typhoid group of fevers and cholera are very high. Insect-borne diseases, particularly malaria, has been a problem of a very great magnitude. High infant and maternal mortality and morbidity have added to the problems.

Among the communicable diseases small-pox and cholera still remain problems in spite of control measures. Apart from millions of deaths, these diseases have been responsible for the retardation in the physical and mental growth of the people. Experience has shown that the response of the people and their participation in sustained development is closely related to their physical and mental health.

4. *Housing* in most part of this region needs special attention for the creation of healthful environment. There is over-crowding and lack of adequate light and ventilation. Very few houses have any provision for sanitary amenities. In most cases human beings and animals live under the same roof.

5. *Rapid growth of population* is another problem which is causing great concern to some countries, particularly India. All efforts for improving the socio-economic conditions of these countries will not achieve the desired results unless something simultaneously is done in respect to population control. Further, frequent births have an adverse effect on the health of the mother and the child. Statistics have shown that the mortality is low among well-spaced children as compared to infants born in rapid succession. Proper spacing gives time to the mother to regain her normal health in between pregnancies.

6. Another major public health problem common to countries in Asia and the Far East is *under-nutrition* and *mal-nutrition,* in spite of the fact that this happens to be an area which is predominantly agricultural. Mal-nutrition is responsible for the wide-spread impairment of human efficiency, inertia and for enormous amount of ill-health and disease.

7. *The effect of wide-spread indebtedness on health and nutrition* cannot be ignored. The question as to the extent to which the health workers, in conducting educational programme should be concerned with the basic economic problems needs consideration.

(3) Health Education—a basic approach :

8. To solve and minimise some of the health problems stated above, it is essential to have a continuous programme of health education.

> "Health education, like general education is concerned with change in knowledge, feelings and behaviour of people".
>
> "The importance of health education is to help people to achieve health by their own actions and efforts".
>
> "In its most usual form it concentrates on developing such health practices as are believed to bring about the best possible state of well-being. In order to be effective, its planning, methods and procedures must take into consideration both the processes by which people acquire knowledge, change their feelings, and modify their behaviour, and the factors that influence such changes".

9. Before starting a programme, it is necessary that the health educator must study the cultural, social and religious pattern of the people. He must have a full knowledge of their religious beliefs and dogmas. In fact he must try to find out as to *why people act and behave as they do*. People's beliefs and behaviour are determined by their past practices. They vary

from region to region. Since learning is a change in an individual's ideas and practices, this change can be brought about only through the individual's own efforts.

10. To accomplish his goal the educator should have a first hand knowledge and appreciation of the people with whom he plans to develop a health education programme. He should be familiar with the nature of the culture and the way of life of the people; their goal in life; and their values, beliefs, traditions, customs and taboos with respect to health and illness. He should understand the objectives for which the people are willing to strive, and, conversely, the aspects of life that mean very little to them or they are as yet unable to understand. He should gather what the people are willing to understand and what they will reject. Having once learned these facts the health educator can work with the people in planning and using educational measures which will harmonize with their life and character.

11. Any attempt ever made to ridicule or condemn an age-old existing practice or an idea in a community or traditional system of medicine and health is bound to have an adverse effect. A community development worker should attempt to start where the community is and then build on what exists. All people, including those with ancient cultures, have their own theories about maintaining health and curing sickness. These theories may provide feelings of as much security for those who hold them as do the explanations based on modern science.

12. The new ideas and concepts which health education introduces can produce good result only, if they can be integrated with the existing values of the people concerned. For the worker in the field of health education, as in any other programme for human development, the importance of good human relations cannot be over-emphasized. The field worker must remember the value of first impressions, when he makes contact with the people. The methodology of approach should be such that it makes the worker acceptable—it should be friendly and human and he should be ready to work with the people; the worker has to be exceedingly patient and should be able to talk to the people in a 'language' they understand.

13. Education in health should be an integral part of every type of education meant for the development of the people and the community; in fact it is a continuous programme and must be flexible so that it can be altered to suit the changing social and cultural pattern of the community. Health education should start in the home and should be carried through the school into the community.

14. The family or rather the joint family is an important basic unit in some of the communities in this region. The family institution is highly potent in preserving social and religious values, customs and habits that are transmitted from generation to generation. The attitude of the family towards health, disease and treatment and prevention of illness is an important factor in formation of health behaviour of the members of the family.

15. The scope of "school and the teacher" in health education is dealt with later in this paper.

16. Health education should be an important discipline in the content of the training of all field workers and others associated with any form of 'Human Development'.

17. *Methods* : There are different extension methods in the field of health education just as in the field of any education concerning 'Human Development'. There is no rigidity about these methods. The educator has to choose a method which will be suitable for the particular area keeping in view the social, cultural and religious patterns. Before using a particular method, it is best to carry out an 'audience test' to determine the utility of this particular method for mass use in that art.

18. Experience has shown the effectiveness of audio-visual aids. The most important point to remember is that the audio-visual aids should have local colour. Special mention may also be made of "method demonstration" technique. This method offers the field workers, engaged in health education, a unique opportunity of training people to do useful things by actual demonstration.

(4) Community Development Personnel—their role as Health Educators :

19. Having explained the importance of health as an integral part of the community development and having shown that health education is the first and foremost step towards the solution of health problems enumerated in the beginning of this paper, it is now appropriate to discuss how the various workers are carrying out or can carry out the health education programme as a part of their normal development activities. To appreciate this, it is necessary to review the different categories of personnel employed in this programme and some of their main duties and functions.

20. The personnel engaged in the Community Development Programme usually fall into the following categories :

(*a*) Supervisory and administrative officers;

(*b*) specialized auxiliary health workers, *i.e.*, public health nurses,

(*c*) specialized auxiliary workers;

(*d*) multi-purpose or generalist village level workers; and

(*e*) school teachers.

21. Of the categories of personnel mentioned above those who are intimately connected with the people in the field for the improvement of health services are :

(*a*) professional personnel, *i.e.*, medical and health officer;

(*b*) specialized auxiliary health workers, *i.e.*, public health nurses, health visitors, mid-wives, health inspectors and health assistants;

(*c*) multi-purpose workers, *i.e.*, village level workers (gramsevaks), home economists (gram sevikas) and social education organizers;

(*d*) school teacher.

22. In addition to the personnel employed by the Government in community development, there are workers of voluntary organizations and co-operative societies who are also engaged in similar activities. A brief statement about the role of these organizations is given later in this paper.

23. It must be emphasized that community development is a team work between all the personnel mentioned above. Each type of field worker has to supplement the effort of the other. There should also be coordination between a Government agency and the voluntary organizations and co-operatives that exist in the field.

24. The Block Development Officer (in India) is the coordinating authority at the block level for the multi-purpose programme. He is receiving orientation in the basic philosophy and concept of community development for effective coordination and administration.

25. *A. Professional Personnel* : According to the pattern adopted in most countries health units (primary health centres) are being established to render all medical and public health services including health education. This unit is under the charge of a medical officer who is responsible for giving an integrated medical care both curative and preventive with emphasis on prevention. Experience has indicated that the work-load of the out-patient, sometimes, is far too much for the doctor to carry out health education activities adequately. Otherwise health education conducted in a curative clinic and directly related to demonstrable cause and effect is more effective than education by itself. A patient who comes to a doctor suffering from an acute pain in the abdomen will be very much interested in the prevention of a similar attack of colic if his symptoms can be relieved quickly. The doctor is the head of the medical and public health team working in the health unit area and has to supervise the work of the public health nurse/health visitor, health inspector and health assistant. This means that some assistance to the doctor is essential to reduce his work-load and make his services more effective.

26. (*a*) *Specialized Auxiliary Workers* : This category includes (*i*) public health nurse/health visitor; (*ii*) mid-wife; and (*iii*) health inspector and health assistant.

27. (*i*) *Public Health Nurse/Health Visitor* is a multi-purpose worker in the field of public health and health education with emphasis on maternal and child care. She looks after the expectant mothers from the time of conception, through ante-natal, natal to post-natal periods. She conducts ante-natal and well-baby clinics at the health unit and carries out home visits. During these visits she works intimately with the people and is in a position to educate the women in essentials for improvement of the health of the family and the community.

28. Of all those engaged in health education, public health nurse/health visitor has an advantage in that they have an access into the homes of the people. They have to work intimately with the families and as such have a greater need of learning the extension technique of direct approach to the women on matters pertaining to preservation and improvement of health. For working with families, it is essential to acquire and maintain confidence and respect of all people at all levels. During home visits these women workers can educate the women about nutrition, personal and environmental hygiene, control of communicable diseases and family planning, in fact in this respect they embody the work of a social worker. During home visits these women personnel also demonstrate simple procedures to relieve conditions like scabies, lousiness, sore-eyes, etc. One of the major objectives of this category of personnel is to help reduce maternal

and infant mortality and morbidity and improvement of home environments. She has to supervise the work of the mid-wife and also participate in the training of dais. In some areas the health visitor is helping in the school health programme.

29. (*ii*) *Mid-wife* : She is responsible for domiciliary mid-wifery and for the care of the mother and the infant. Her work lies mostly with the women in their homes and as such she is in an ideal position to carry out individual health education.

30. (*iii*) *Health Inspector and Health Assistant* : The main functions of these personnel are :

a. Health education;
b. Improvement of environmental sanitation; and
c. Control of communicable diseases.

31. As a result of personal and group discussions and demonstrations, they are able to achieve their objectives. Improvement in environmental sanitation and control of communicable diseases are proportional to the success they achieve in educating the people to understand the new methods employed for the purpose; for example, the construction of a sanitary well is of little significance unless it is related directly to improvement of health and prevention of disease. Unless this aspect is explained adequately to the people, maintenance of a well in a sanitary condition is not possible Similarly construction of a soakage pit for disposal of sullage water has very little meaning unless the people realise that unless sullage water is adequately disposed of, it will result in accumulation and consequent breeding of mosquitoes and other insects, apart from creating insanitary conditions. In the improvement of environmental sanitation and control of communicable diseases, there is a great deal of the human factor. The worker has to ascertain what is the motive force behind acceptance of some new ideas for improvement of health and partial acceptance or rejection of others.

32. Experience in India has shown that in the community development areas the utility of safe water is increasingly becoming acceptable but the programme for the development of sanitary latrines is not meeting with the success it deserves. Strange as it may sound, even those people who observe a very strict ritual cleanliness often indulge in soil pollution. The rural people have no knowledge that there are sanitary latrines which can easily and inexpensively be constructed and where there is no smell, no danger of fly-breeding and water pollution and no scavengers are required. In India three Research-*cum*-Action Centres have been established in association with social scientists and research is going on in this field.

33. In the control of communicable diseases the value of immunisation is increasingly being appreciated by the villagers but a great deal of education has yet to be carried out to make the programme completely successful. In Asia we are nearly completing 100 years of anti-cholera inoculation and it is still not readily acceptable to all the villagers, until a large number of people begin to die from this disease. Similarly with regard to small-pox, not only the villagers, but some educated people still consider this disease as a visitation by the Goddess "Mata". This indicates that health education has to be combined with social education in order to ensure that people accept the improved practices. *This, therefore, calls for the co-ordination of work between the public health workers, the social workers and multi-purpose or general extension worker at the village level.*

34. (*b*) *In-service Training for Medical and Health Workers* : In order to be more effective the medical and public health staff even though professionally and technically fully qualified should be given an orientation in the basic concept and philosophy of the Community Development Programme. They should learn the extension technique of approaching the people so that they accept the new ideas about the prevention of disease and promotion of health and get involved in the programme. In India three Re-orientation Training Centres have been set up where medical and public health workers are given an in-service training before being posted to the community development area. It has been further decided to include this training in the curriculum for under-graduates in medicine, nursing and other health services, so that when they come out qualified they have already learnt what is being attempted in the Re-orientation Training Centres. In addition to this, further in-service training of these workers will have to be arranged periodically so that they are kept abreast with the changing concept in this programme, because community development is a dynamic ever moving programme.

35. (*c*) *Medical and health officers at higher levels* (corresponding to the district in India) have the responsibility for supervision, coordination and for *giving technical advice* in all matters pertaining to development of health services including health education. They also guide non-medical field workers like village level workers, home economists and social education organizers in the work pertaining to health programme. Further these officers have to co-ordinate government efforts with other similar activities which are being operated by social and welfare voluntary organizations in the field; as such the need for giving in-service training to the supervisory staff in extension technique and in correct attitudes related to field conditions and problems is essential for effective administration and supervision.

36. B. *Village Level Workers* : Among the non-medical persons working in the field, the village level worker, who is a multi-purpose functionary in India, is most important. In India his basic training is in agriculture but he is given special training in the extension technique for the multi-purpose Community Development Programme. He is a multi-purpose field worker responsible to develop 'felt-needs' of the people and help them to fulfil these needs by their own efforts and to inculcate in the people the desire for higher level of living. This desire is the motivating factor for the people to participate in the programme and to provide the necessary leadership to assure that development will become and continue to be a People's Programme. The village level worker is trained to guide the people in the expression of their needs for food, clothing, health, housing, recreation, etc. He is in day to day contact with the people; he lives with the people and is in an ideal position to develop in the people a desire for the creation of healthful environment. He can make an ideal health educator, if adequately trained.

37. The village level workers, who cover comparatively a small area of operation as compared to the public health workers whom most of the countries in this region cannot afford to provide for a long time to come, provides the best agency in the execution of health education. To illustrate, in India the village level worker covers from 5 to 10 villages as compared to the health inspector or public health nurse/lady health visitor who cover about 100 villages. This very fact shows the great utility of this multi-purpose worker in the field of health education.

38. Community development is a People's Programme. It has conclusively been established that the single most important extension method is to work through village leaders—good or bad, progressive or conservative, these individuals guide village thinking and actions. All village groups, both informally and formally organized, function through recognized group leaders. The existing leaders should be recognized and utilized in keeping with their capabilities. In most of the countries in this region there are small and large local bodies, village councils (panchayats), co-operative societies and they have generally an elected leader. The village level worker must be able to assist villagers in throwing up their natural leadership from amongst themselves and to inspire them individually and collectively to greater effort. The village level worker carries a two-way message :

(*a*) He translates the health needs of the villagers to those responsible for the development of health programme; and

(*b*) secure the participation of the villagers in the development of health programmes which are being initiated as a result of the 'felt-needs' of the people.

39. During his training in extension the village level worker should be given a thorough orientation in public health and for improvement of environmental sanitation. He should also receive training regarding essentials for the improvement of nutrition. Utilizing his extension technique he should be capable of explaining to the people the advantage of general cleanliness of the village and dangers of soil pollution. He should be in a position to help villagers to develop safe water supply and sanitary latrines as their 'felt-needs'. He can stimulate them to take advantage of the maternal and child health services available in the area and the advantages of immunisation.

40. Experience of working with the village level worker has shown that on more than one occasion, it was he who learnt of a case of an eruptive fever which was either small-pox, chicken-pox or German measles; again it was he who saw a case of Gastro-enteritis accompanied by vomiting which might have been anything from acute diarrhoea to cholera. It was the village level worker who after taking the preliminary steps of isolating the patient and asking the family members to keep the flies off the patient, collects the discharges of the patient in a broken earthen pot with ordinary lime thrown in it and instructing them to boil water before drinking, etc. rushed off to fetch the doctor to make diagnosis and take suitable preventive and curative measures. In other instances, it was the village level worker, who heard of a difficult labour case that had been further complicated by the untrained *dai* working in the village and rushed to fetch efficient medical aid to save the life of the woman.

41. The villager is very shrewd to realize what is good for him, his family and his community. All what is required is to create a method of approach—approach that must be 'problem-oriented' in the field of public health. In fact personal experience in India shows that the utility of the village level worker for improving the health of the villagers and for the prevention of disease cannot be over-emphasized.

42. Finally like every field worker the village level worker must set an example by observing the laws of personal hygiene and providing himself with all those amenities that help to create a healthful environment; which among others include a clean well-ventilated house, a smokeless chulha

(fire-place), storage of food grains to keep the insects and rodents away and a soakage pit for the disposal of house-hold sullage, a bath and a sanitary latrine. His appearance and personal habits should be such as to set an example for the villagers to copy. He is our 'unknown warrior' battling with our triple enemy—poverty, disease and ignorance. Mr. Arthur Raper, Consultant, Community Development Division of the United States Government, expressed the view that the "creation of this functionary "Gram sevak" will go down in history as one of the greatest social inventions of the present era". Gram sevak is the instrument of the economic and social revolution—a friend, philosopher and guide—which he can only be if properly oriented towards "Better Health".

43. C. *Home Economist* : In order to create a desire for better living in each family, the family must be the focal point for the beginning of this programme. Since village values, wants, the things which it considers important, have their origin with the family it logically follows that the driving force and motivation to do something about a given problem also comes from within the family. The family, therefore, decides what the village and the community finally agrees is important; gives priority to development programmes and determines the sacrifice and effort the village will exert in solving the problem or creating the thing which they want. As such, education for the family becomes an essential service which the Community Development Programme must provide if they are to meet the need of the majority of the population living in these countries. Education for the family primarily means the education for the woman and it is the woman, who is mainly responsible for the children and the home. Therefore, the need to educate women for effective participation in the all-round development programme particularly for improvement of the health and home become important and a pressing need. Not until the women assume greater and more positive leadership and work together in organized groups can the community development achieve its objective 'right to live'. To achieve this end, home economists (gram sevikas) are being appointed after they receive special training, so that they can stimulate women to accept new methods for a better and higher living.

44. The home economists are specially trained in the extension technique of involving the women in this programme. They are trained in rural sociology, psychology, and philosophy of community development. The home economists are trained in the basic principles of nutrition, values of available foods and of seasonal foods, requirements of the expectant and nursing mothers and children, defects in diet and how to remedy these through changes in diet. During training they learn about the fundamental of public health and environmental sanitation and health education, personal hygiene, first-aid and the need for family planning in the interest of health and welfare of the family. They are taught practical measures to improve the house and its surroundings, so as to provide healthy environment. The trainees practise these principles in their own lives, in their hostels, houses and families, and correlate them with practical work in the villages.

45. Apart from working in individual homes, the home economists also work through the women's clubs (Mahila Mandals) which are being organised in the villages where local women take upon themselves to teach other women.

46. It must be emphasized that her job is strictly in the field of health education and that too under the supervision of the medical officer, public

health nurse/health visitor and the sanitary inspector. She is there to supplement the effort of the medical and public health staff.

47. Considerable difficulties are being experienced in some of the countries in this region regarding the recruitment of suitable women in adequate numbers. This is partly due to lack of adequate education among women. To add to the problem are the prevailing social customs and religious feelings. Efforts made in various countries to overcome these difficulties will be of interest to the Seminar.

48. D. *Social Education Organizer* : This is a new category of field worker which is being employed in the Community Development Programme in India. At present one male and one female social education organizers are being posted in each development block. These workers possess the basic qualifications of a graduate, preferably in Social Science, and are then given six months special training in centres specifically organized for this programme, in basic principles of extension. It must be remembered that extension is education and its purpose is to change attitudes and practices of the people with whom the work is to be done. Social education organizers are specially trained in the preparation and use of audio-visual aids. He is to be a specialist in the art of communicating ideas to the people. In this connection he assists the various subject-matter specialists by changing the attitude of the people and creating a mental climate so that the people may accept new ideas as put forth by the subject-matter specialists. Therefore, the success and acceptance of the new ideas by the people depend on the extent of the support from these social education organizers.

49. Some of the main functions of the social education organizers are :

(*a*) To help create healthy institutions to take up the programme and make it a People's Programme. He is responsible to help people organize youth, children and women's clubs and to help provide projects and activities in which these groups can profitably participate.

(*b*) To arrange educational programmes aimed at removal of illiteracy, promotion of health education and education in citizenship. These programmes are carried out through demonstrations and actual life experiences.

(*c*) To stimulate local leadership and to utilize it where it exists.

(*d*) To organize voluntary agencies in development areas for carrying out social education activities on self-help basis.

(*e*) To organize community centres and gradually to develop them as focal centres of social services and other amenities for the community.

50. Experience has shown that majority of these workers have endeared themselves to the people who seek their help for solving some of their problems. In a number of cases they have succeeded in overcoming the resistance of the people to immunisation against small-pox and cholera and in seeking participation of the people in our National Malaria Control Programme which basically consists of spraying the inside and outside of the houses.

51. E. *School and the Teacher* : Health habits and attitudes once acquired die hard; therefore, it is vital to inculcate healthy habits and attitudes from the very beginning. Such an opportunity is provided in the primary schools. Health education in schools should be integrated with the general education. "School health education is concerned with the child's growth and development, physical, emotional, intellectual and social". It is recognized that improvement in health habits and attitudes is more likely to be attained through practical experiences concentrated around day-to-day activities of the individuals.

52. Children of school age represent an important segment of the population. The Community Development Programme is laying increasing emphasis on the development of primary schools throughout the region and in most countries primary education has already been made compulsory. This will mean that school going population will definitely increase in the near future. As such, it is imperative that these children, while still growing and developing, should receive health education adapted to their needs and culture. Emphasis must be placed on the formation of desirable health practices, particularly on personal hygiene and nutrition.

53. Care must be taken to see that the environments in which the children study, play and live are conducive to healthful living. Adequate provision must be made for safe water supply and sanitary latrines and urinals. Doctors and other health personnel, particularly the school nurse have a special contribution to make to health education. Opportunity should be taken during vaccination or immunisation, health examination or treatment, for health education.

54. Experience has shown that in some villages school children after they had imbibed the knowledge between the relationship of soil pollution and gastro-intestinal diseases had urged their parents to provide them with sanitary latrine at home of the type used by children in the school. Therefore, working through the school children is an effective media to approach the parents.

55. To accomplish successfully the above objectives, it is necessary that the school teacher should be adequately trained in the principles of health education during the period of his training as a teacher. No health education programme can be completely successful without the active co-operation of the school teacher. He is in close and continuous touch with the pupils in their daily routine. Further the teacher must set an example to the pupils by his personal cleanliness and by his scrupulously observing the laws of personal hygiene. An observant school teacher can bring to the notice of the doctor or the nurse certain facts about a boy's indifferent health and indifferent attitude towards studies and games or other factors that may be interfering with his study and his play. The teacher has further the advantage of being in close contact with parents and community health personnel. The teacher can work through the parents to bring about the correction of any abnormal condition. If the village teacher is to operate effectively in this programme his socio-economic status in the village must be upgraded. In India there is a special programme in operation to give orientation to the teachers to equip them to fulfil their role adequately.

56. It has been noticed that majority of the primary schools that have been set up during the Community Development Programme have seldom

been provided with satisfactory sanitary amenities for students to practise what is preached to them in the class-room. It would be interesting to discuss what are the reasons standing in the way of provision of sound environmental sanitation in the school.

57. F. *Voluntary Organizations—their role in Health Education* : Voluntary organizations must be people's organizations created by the people and led by the people. Development and full utilization of voluntary community organizations in planning and execution of village programmes will greatly assist the government agency to educate the villagers and involve them in a continuous village self-help development programme. Each voluntary group is composed of persons who have common ideals and recognized leaders.

58. Voluntary organizations can be effectively used for certain village activities such as youth programmes, programmes for village women, recreational programmes, etc. Health education can be initiated by these groups through these programmes. These and many other activities are developed and serviced by the village leaders and the organized groups they represent.

59. Voluntary organizations should be made responsible for certain type of action which is important for balanced community development. The greater the recognition by the group of the responsibility which the community assigns to it, the more intense will be the group's efforts to meet the challenge. The community development personnel engaged in the field work should take full advantage of these organizations, securing their support and involving them in the programme.

60. Taking an overall view of these voluntary organizations, their utility has been accepted in the development work. In India various training camps have been started for *village leaders*. These leaders after training have done useful work in the communities. During the training they are being given an orientation in simple language about the fundamentals of health and nutrition, and facts pertaining to the improvement of environmental sanitation. During their training period sanitary amenities are provided for them, so that they can appreciate their advantages and when they go back to the villages they can help the villagers to change their attitude and habits and popularize their use, especially of the sanitary latrines.

61. G. *Role of Co-operatives* : Success of the Community Development Programme is primarily judged by the qualitative changes expressed in the attitudes and relationships, which add to human dignity and increase the continuing capacity of the people to help themselves to achieve goals which they determine for themselves. It is thus a co-operative endeavour. Co-operative development, it is true, has usually been primarily directed to economic objectives, but it has, where successful, invariably gone far into the social life of the community as well.

62. With the establishment of co-operative associations, there is ensured a continuity of progressive effort based on the sum of acquired experience contributed by its old members. The new members when they come in, are automatically introduced to the latest methods and techniques as they become available.

63. In India rural industries are being developed on co-operative basis, the number of co-operative societies is increasing and rural trade will undoubtedly prosper along these lines. The communities will be able to derive from these co-operative activities resources necessary to secure cultural, health and other social services now out of their reach. In the field of public health, to supplement government's efforts, co-operative societies can help greatly in the development of health services by setting up co-operative health centres, maternity and child welfare centres, housing societies, etc. These institutions are ideal for health education activities. A beginning in this direction has been made in India in West Bengal and Orissa. Other countries may have started similar ventures.

(5) Summary :

64. An effort has been made to indicate in this paper the necessity of health as an integral part of the Community Development Programme, a mention has also been made of some of the major health problems in Asia and the Far East and it has been stated that the foremost step in the solution of these problems is health education. A brief description has been given of the role of various categories of workers, both professional and non-professional field workers; their duties and functions and the utility of the teacher and voluntary people's organizations. In the Community Development Programme, every worker and particularly the field worker has to be a social educator which term should be taken as co-terminus with health educator. The improvement of socio-economic conditions of the people will depend greatly on how effective the health education programme is.

65. It must be recognized that good health cannot be forced upon the public. To achieve our objective we must continue the health education programme and also try to help people discover leadership in the community. It is the primary function of the official and voluntary agencies to encourage and develop this leadership so that communities will be in a better position to provide their own health services in an increasing manner.

66. When people are aware of the needs and have been educated as to the various methods of meeting such needs, they are willing and anxious to participate in helping to solve their health problems. The objective of health education is to create an environment in which solutions to health problems may be developed. No country can have good public health without health education.

67. To make an effective contribution in health education, it is essential that all categories of personnel employed in community development should work as a team. In addition, full co-ordination should be maintained between the government agency and the voluntary and co-operative organizations in the field. This implies the planning and organization of health education programme, *viz.*, that each person is assigned a job he can do best and carries out his part of the programme in such a manner that it supports and supplements the work of other persons. As such it is vital that they all be well-equipped with basic knowledge and skills in the propagation of health education. This means that the content of the training should be such that the field workers know what public health is, what it attempts to do and the use of various techniques and methods of imparting such knowledge to the people to

motivate them to feel the need for adoption and acceptance of improved health practices for a fuller and healthier living. Above all they must practise what they preach.

68. Further, all the community development workers must identify themselves with the programme and develop a sense of dedication in their activities. It is the only way they can help the people to achieve the 'right to live'.

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