Regional Conference on Health Education

FINAL REPORT

PASB/WHO IN COLLABORATION WITH THE MINISTRY OF HEALTH AND WELFARE OF MEXICO

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REGIONAL CONFERENCE
ON HEALTH EDUCATION

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FOREWORD

The first Regional Health Education Conference to be convened in the Western Hemisphere was held in Mexico City from 18–30 September 1953.

For some time interest for more effective health education activities had been expressed in the countries served by Zones II and III of the Pan American Sanitary Organization in various ways: Individuals in a number of these countries had received fellowship grants providing for studies in health education in schools of public health in the United States and Puerto Rico; Ministries of Health in two of them had requested assistance from the World Health Organization in health education projects; health education aspects of other projects had received greater emphasis.

Taking these factors into consideration, representatives of the Pan American Sanitary Bureau and of the World Health Organization discussed in April, 1952, the possibility of a Regional Health Education Conference, sometime in 1953, comprising the countries of these two Zones. Favorable reaction to this suggestion resulted in arrangements for visits by consultants to these countries, late in 1952, in order to obtain reactions of public health officials to this proposed meeting; and the Conference was planned on the basis of these visits by health education representatives of the World Health Organization.

The general purpose of the Conference was to provide an opportunity for mutual discussion and exchange of experiences by public health leaders and persons engaged in health education work in the eleven countries concerned regarding health education needs and resources in their respective countries.

The program included such topics as planning and development of local health education activities; teamwork, coordination, methods and materials in health education, and health education training of public health personnel, as well as a number of field visits.

The general pattern of the Conference organization consisted of plenary sessions where the topics outlined served as a point of departure for group discussions. The groups were organized so as to be as truly representative of the Conference as possible.

Deep appreciation is extended to the hosts, the many agencies and individuals who contributed to the success of this Conference; to Dr. Ignacio Morones Prieto, Dr. Manuel E. Pesqueira, Dr. José Zozaya and Dr. J. Pilar Hernández Lira of the Ministry of Health and Welfare, and to Dr. Mauro Loyo Díaz of the Mexican Institute of Social Security for their sound council and constant cooperation during the Conference; to the Ministry of Health and Welfare, in general, for their efforts in providing personnel and equipment for the Conference; to the National University of Mexico for the facilities provided and the assistance received from the University staff; to the Institute of Social Security for the hospitality offered during the inaugural session and to the Inter-American Cooperative Public Health Service of the Ministry of Health and Welfare for the many services provided before, during and after the Conference.
PROGRAM

Friday, 18 September
6:00 P.M.: Inauguration of the Conference—General Session
Auditorium, Institute of Social Security of Mexico
Chairman: Dr. Ignacio Morones Prieto
Welcome Address: Lic. Francisco A. Urzúa
Welcome Address: Dr. Carlos Luis González
Keynote Address: The Importance of Health Education in Public Health Programs: Dr. Manuel E. Pesqueira
Opening Address: Dr. Ignacio Morones Prieto

Saturday, 19 September
9:00-10:00 A.M.: Registration. University City
10:00-11:00 A.M.: First Plenary Session: Chairman, Dr. Manuel E. Pesqueira
Activity Plan and Conference Program: Dr. J. Pilar Hernández Lira
Discussion of Conference Program by the Membership
11:00-12:00 A.M.: Preliminary Meeting of the four Work Groups

Sunday, 20 September
Free

Monday, 21 September
9:00-10:30 A.M.: Second Plenary Session: Chairman, Dr. Sherer Adrien
Symposium: Planning and Development of Local Health Education Activities
Chairman: Dr. Jorge E. Zepeda
Participants: Dr. Richard N. Adams, Mrs. Silvia Duncan, Mr. Salvador Sanley Gómez, Miss Catalina Lube
11:00 A.M.–2:00 P.M.: Work Group Meetings

Tuesday, 22 September
9:30 A.M.–2:00 P.M.: Work Group Meetings

Wednesday, 23 September
9:00-11:00 A.M.: Third Plenary Session: Chairman, Dr. Alberto Sevilla Sacasa
Work Group Reports on Planning and Development of Local Health Education Activities
Presentation and Discussion
Symposium: Teamwork and Coordination in Public Health
Chairman: Dr. Mario León
Participants: Mr. Edgar Arias Ch., Mr. José del Carmen Echevers, Miss Jeanette Pitcherella, Dr. Luis Ureña Hernández

11:30 A.M.-2:00 P.M.: Work Group Meetings

Thursday, 24 September

9:00-12:00 A.M.: Field Visits
School of Public Health of Mexico
"Beatriz Velasco de Alemán" Health Center

2:00-4:30 P.M.: Work Group Meetings

Friday, 25 September

9:00-11:00 A.M.: Fourth Plenary Session: Chairman, Dr. Alberto Bissot, Jr.
Work Group Reports on Teamwork and Coordination in Health Education
Presentation and discussion
Round Table discussion on Methods and Materials in Health Education
Chairman: Dr. Aníbal Herrera y Franchi de Alfaro
Participants: Miss Estela Herrera, Dr. Isabel Kelly, Dr. Federico Villaseñor

11:30 A.M.-2:00 P.M.: Work Group Meetings

Saturday, 26 September

9:00 A.M.-4:00 P.M.: Field Visits
Health Unit, Cuernavaca, State of Morelos
Rural Social Welfare Program, Tlaltizapán, Morelos

Sunday, 27 September

Free

Monday, 28 September

9:00-11:00 A.M.: Fifth Plenary Session: Chairman, Dr. Gabriel González Regalado y Acea
Work Group Reports on Methods and Materials in Health Education
Presentation and discussion
Symposium: Health Education Training of Public Health Personnel
Chairman: Dr. Ernesto Cofiño U.
Participants: Dr. Héctor Acuña, Dr. Gonzalo Aguirre Beltrán, Mr. Norman Craig, Engineer Carlos López Fuentes, Miss Hilda Lozier
REGIONAL CONFERENCE ON HEALTH EDUCATION

11:00–11:30 A.M.: Meeting of Rapporteurs to study summary of Work Group Reports on Topics 1 and 2
Planning and Development of Local Health Education Activities
Teamwork and Coordination in Health Education

11:30 A.M.–2:00 P.M.: Work Group Meetings
2:00–2:30 P.M.: Planning Meeting, Conference Editorial Committee

Tuesday, 29 September

8:30–10:00 A.M.: Meeting of Rapporteurs to study summary of Work Group Reports on Topic 3
Methods and Materials in Health Education

10:00–11:30 A.M.: Meeting of Rapporteurs to prepare and study summary of Work Group Reports on Topic 4
Health Education Training of Public Health Personnel

9:00 A.M.–1:00 P.M.: Meeting of Editorial Committee to prepare Joint Work Group Reports

1:30 P.M.: Placing of wreath at Monument to the Heroes of Mexico’s Independence

2:00 P.M.: Mexican Public Health Association Luncheon at the Maximino Avila Camacho Health Center

4:00–9:00 P.M.: Meeting of Editorial Committee to prepare Joint Work Group Reports

Wednesday, 30 September

9:00 A.M.: Sixth Plenary Session: Chairman, Dr. Mauro Loyo Díaz
Joint Work Group Reports prepared by Editorial Committee
Presentation by Dr. Ricardo J. Peralta
Discussion, amendment and approval of Final Joint Reports

1:30 P.M.: Closing Plenary Session
Chairman: Dr. Manuel E. Pesqueira
ORGANIZING COMMITTEE

Chairman: Dr. José Zozaya, Chief, Office of International Affairs of the Ministry of Health and Welfare of Mexico.

Technical Coordinator: Dr. J. Pilar Hernández Lira, General Director of Health Education, Ministry of Health and Welfare of Mexico.

Members:

Mr. Norman A. Craig, Health Education Consultant, Zone III, PASB/WHO.

Dr. Stanford F. Farnsworth, Representative, Zone III Office, Pan American Sanitary Bureau.

Miss A. Helen Martikainen, Chief, Health Education of the Public Section, World Health Organization, Geneva, Switzerland.

Dr. Guillermo E. Samamé, Representative, Zone II Office, Pan American Sanitary Bureau.
MEMBERSHIP

Honorary Chairman

Dr. Ignacio Morones Prieto, Secretary of Health and Welfare of Mexico.
Licenciado José Angel Ceniceros, Secretary of Public Education of Mexico.
Dr. Nabor Carrillo Flores, President of National University of Mexico.

Executive Chairman

Dr. Manuel E. Pesqueira, Under Secretary of Health and Welfare of Mexico.

Executive Vice-Chairman

Dr. Mauro Loyo Díaz, Assistant Medical Director General of the Mexican Institute of Social Security.

Delegates

British Honduras

Dr. George G. Smith, Director of Medical Services.
Miss Ivy Hall, Public Health Nurse.

Costa Rica

Dr. Oscar Vargas Méndez, Director General of Public Health.
Miss Ligia Carranza, Health Education Consultant, Inter-American Cooperative Public Health Service, Department of Health Education.
Miss Graciela Carrillo, Director of Health Education, Department of Health Education, National Department of Public Health.
Mr. Germán Sojo Arias, Chief, Audio-Visual Aids, Department of Health Education, National Department of Public Health.
Mr. Edgar Arias Ch., 4-S Clubs Supervisor, Inter-American Technical Service for Agricultural Cooperation, Ministry of Agriculture and Industries.

Cuba

Dr. Gabriel González Regalado y Acea, Medical Health Educator, National Public Health Department, Ministry of Health and Social Welfare.
Dr. Aníbal Herrera y Franchi de Alfaro, National Medical Health Adviser, Ministry of Education.
Civil Engineer Juan Luis Radelat Olivé, Chief of the Section of Public Health Engineering and Architecture, National Department of Public Health, Ministry of Health and Social Welfare.

Dominican Republic

Mr. Salvador Sanlley Gómez, Director, Division of Sanitary Engineering, National Department of Public Health.
MEMBERSHIP

Dr. Luis Ureña Hernández, Assistant Director, Division of Malariaology, National Department of Public Health.

El Salvador

Dr. Ricardo J. Peralta, Director of the Division of Social Hygiene, National Department of Public Health, Ministry of Health and Social Welfare.

Guatemala

Dr. Ernesto Cofió U., Director, Child Welfare Center.
Miss Margarita Glinz, Public Health Nursing Supervisor, Guatemala City Health Department.

Haiti

Dr. Sherer Adrien, Chief, Cayes Public Health District, National Department of Public Health.
Dr. Marc Fleurant, Chief, Gonaives Public Health District, National Department of Public Health.
Mr. Valès Jean-Louis, Health Educator, National Department of Public Health.

Honduras

Dr. Jorge E. Zepeda, Chief, Malariaology Section, Inter-American Cooperative Public Health Service.
Professor Filomena Carías, Director of the Rural Normal School of Villa Ahumada, Ministry of Public Education.

Mexico

Dr. Manuel E. Pesqueira, Under Secretary of Health and Welfare.
Dr. Mauro Loyo Díaz, Assistant Medical Director General, Mexican Institute of Social Security.
Dr. J. Pilar Hernández Lira, Director General of Health Education, Ministry of Health and Welfare.
Engineer Carlos López Fuentes, Director General of Sanitary Engineering, Ministry of Health and Welfare.
Dr. Manuel B. Márquez Escobedo, Director General of Public Health, Federal District of Mexico.
Professor Tomás Cuervo Ramírez, Director General of Federal Education, Ministry of Public Education.
Dr. Emilia Leija Paz de Ortiz, Director of the National School of Nursing.
Dr. Federico Villaseñor, Chief of Section, Department of Health Education, Ministry of Health and Welfare.
REGIONAL CONFERENCE ON HEALTH EDUCATION

Nicaragua

Dr. Alberto Sevilla Sacasa, Ambassador from Nicaragua to Mexico.
Miss Estella Herrera, Assistant to the Division of Health Education, Section VI, Ministry of Public Health.
Dr. Rodrigo Quesada, Chief of Section VI, Ministry of Public Health.

Panama

Mr. Félix A. Dormoi, Chief of the Health Education Section, Department of Public Health, Ministry of Labor, Social Welfare and Public Health.
Mr. José del Carmen Echevers, Sanitary Engineer, Chief of the Section of Sanitary Engineering, Department of Public Health, Ministry of Labor, Social Welfare and Public Health.

Representatives of Special Agencies and Organizations

Dr. Héctor Acuña, Medical Director, Inter-American Cooperative Public Health Service, Ministry of Health and Welfare of Mexico.
Dr. Richard Adams, Cultural Anthropologist, Pan American Sanitary Bureau, Regional Office of the World Health Organization, Zone III.
Dr. Gonzalo Aguirre Beltrán, Assistant Director, National Indian Institute of Mexico.
Dr. Sidney B. Clark, Medical Officer, Pan American Sanitary Bureau, Regional Office of the World Health Organization, Zone II.
Mr. Norman Craig, Health Education Consultant, Pan American Sanitary Bureau, Regional Office of the World Health Organization, Zone III.
Dr. Abraham Drobny, Medical Officer, Pan American Sanitary Bureau, Regional Office of the World Health Organization, Zone II.
Dr. Stanford F. Farnsworth, Representative, Pan American Sanitary Bureau, Regional Office of the World Health Organization, Zone III.
Dr. Carlos Luis González, Director, Division of Public Health, Pan American Sanitary Bureau, Regional Office of the World Health Organization, Washington, D. C.
Dr. Alonzo E. Hardison, General Director, Inter-American Cooperative Public Health Service, Ministry of Health and Welfare of Mexico.
MEMBERSHIP

Dr. Guy Hayes, Representative in Mexico of the Division of Medicine and Public Health, Rockefeller Foundation.

Dr. Isabel Kelly, Social Anthropologist, Inter-American Cooperative Public Health Service, Ministry of Health and Welfare of Mexico.

Miss Mary Jo Kraft, Health Education Consultant, Institute of Inter-American Affairs, Washington, D. C.

Dr. Mario León, Chief Medical Adviser, PASB/WHO Demonstration Area, El Salvador.

Miss Hilda Lozier, Nursing Adviser, Pan American Sanitary Bureau, Regional Office of the World Health Organization, Zone II.

Miss Catalina Lube, Health Education Consultant, Inter-American Cooperative Public Health Service, Ministry of Public Health and Social Welfare, Peru.

Miss A. Helen Martikainen, Chief, Health Education of the Public Section, World Health Organization, Geneva, Switzerland.

Dr. Pedro Daniel Martínez, Professor of the School of Public Health, Ministry of Health and Welfare, Mexico.

Dr. Luis Emilio Pinto, Health Education Consultant, PASB/WHO Regional Center of Fundamental Education for Latin America, Pátzcuaro, Mich., Mexico.

Dr. José Palacios Macedo, President of the Committee on Technical Efficiency, Institute of Social Security of Mexico.

Miss Jeanette Pitcherella, Nursing Adviser, Pan American Sanitary Bureau, Regional Office of the World Health Organization, Zone III.

Dr. Alfonso Pruneda, Consultant, Department of Health Education, Ministry of Health and Welfare of Mexico.

Mr. William Rost, Health Education Consultant, Inter-American Cooperative Public Health Service, Ministry of Labor, Social Welfare and Public Health of Panama.

Dr. Guillermo E. Samamé, Representative, Pan American Sanitary Bureau, Regional Office of the World Health Organization, Zone II.

Dr. Juan Sola Mendoza, Supervisor in Biology, Ministry of Public Education of Mexico.

Mrs. Mary B. Ugarte, Nurse, Society of Friends, Mexico.
Chapter I

INTRODUCTION

The first Regional Health Education Conference to be held in the Region of the Americas took place in Mexico City from 18 to 30 September, 1953. The Conference was sponsored by the Pan American Sanitary Bureau, Regional Office of the World Health Organization for the Americas, in collaboration with the Ministry of Health and Welfare of Mexico.

The Conference membership was composed of representatives of eleven countries in Zones II and III of the Pan American Sanitary Bureau, Regional Office of the World Health Organization: British Honduras, Costa Rica, Cuba, Dominican Republic, El Salvador, Guatemala, Haiti, Honduras, Mexico, Nicaragua, and Panama. The membership also included representatives of the Institute of Inter-American Affairs and the Mexican Office of the Rockefeller Foundation, in addition to World Health Organization personnel.

Professional workers participating in the Conference included public health administrators, sanitary engineers, public health nurses, health educators, educational psychologists, cultural anthropologists, representatives of public education, and a supervisor of agricultural extension work. The delegations from several of the countries were headed by their respective Directors General of Public Health.

Purpose of the Conference

The principal objectives of the Conference were:

1. To provide an opportunity for a representative group of public health leaders and professionals from related fields to consider health education needs and resources in their respective countries.

2. To determine the various possibilities for strengthening health education activities as an integral part of the different health services.

Preliminary Planning

Initial exploratory visits were made to every country in the two Zones between November 1952 and January 1953. These visits were made by health education representatives of the World Health Organization in cooperation with the Pan American Sanitary Bureau, Regional Office of WHO.

Ministers of Health, Directors General of Public Health, and other public health workers were interviewed to ascertain whether a regional
conference on health education was considered desirable and of interest. All of the persons interviewed were in favor of such a meeting and expressed interest in cooperating in the development of the Conference program. Several felt that the Conference could serve to focus attention on the necessity and importance of health education in public health work and on the need to intensify and make more effective the health education activities in their own countries.

Some preliminary suggestions regarding health education problems were received for consideration in planning the Conference program. In this connection, several directors of public health suggested that a series of meetings be held with personnel of the national health department and other interested agencies, in the belief that such meetings would make it possible to list major health education problems of common interest to these persons and their respective agencies.

It was agreed that a subsequent visit to each country by a health education representative of the Organization would be made to discuss the problems indicated. A tentative agenda could then be prepared that would express the needs and interests of all participating countries.

These visits were made in January and February of 1953, at which time each country submitted a tentative list of topics for the Conference agenda. A study of the topics submitted disclosed that these could be grouped under four main headings:

1. Planning and development of local health education activities. How this should be done, when and where, and by whom.
2. Possibilities for strengthening teamwork efforts and for integrating health education activities in all phases of health work. Principal problems involved.
4. Training of personnel, teachers and others, for their respective health education responsibilities. The need for such training, how, where and by whom.

A complete list of these tentative topics for discussion appears in Appendix B, p. 62.

Membership and Program Arrangements

On 8 July, the Director of the Pan American Sanitary Bureau, Regional Office of the World Health Organization, sent a formal letter of invitation to all participating countries, stating that Mexico was to serve as host country to the Conference. Government authorities were invited to designate technical representatives to participate in the Conference.

National Health Departments were likewise invited to forward, for
printing and distribution at the Conference, a brief statement listing the principal requirements for strengthening health education aspects of their health programs together with ideas and suggestions as to the future developments which might be undertaken in health education. They were also invited to send or take to the Conference samples of audio-visual materials used in connection with their health education activities.

Representatives of Zones II and III visited the Ministries of Health in their respective Zones in the latter part of July. Arrangements were completed for the formal designation of Conference participants and for the completion of fellowship applications for each nominee to the Conference. Travel arrangements and hotel reservations were also completed insofar as it was possible at this time.

A preliminary meeting of the Conference Organizing Committee was held in Mexico City from 17 to 21 August, and plans were completed to hold the Inaugural Session of the Conference in the Main Auditorium of the Mexican Institute of Social Security. Through the generous cooperation of the National University of Mexico, facilities for the work sessions of the Conference were made available in the Commerce Building of University City. The Ministry of Health and Welfare of Mexico, through the Inter-American Cooperative Public Health Service of Mexico, provided transportation for the participants to and from the hotel and the Conference site, as well as for the field trips featured in the Conference program.

During this same meeting of the Organizing Committee, further details were worked out as to Conference program and structure.

Conference Program and Structure

In order to provide maximum opportunity for discussion and exchange of ideas, the Conference Program provided for plenary sessions to be followed by meetings of the participants in Work Group sessions. It had already been agreed that the Conference Program would center around the four main topics based on suggestions received from the participating countries. (See Appendix B, p. 62.)

Certain aspects of each topic were presented in symposia or round table discussions featuring selected Conference participants. These presentations were outlined at separate plenary sessions. For example, on Monday, 21 September, the Second Plenary Session offered a symposium discussion on the topic: Planning and Development of Local Health Education Activities. During the Third Plenary Session of Wednesday, 23 September, discussion centered on the topic: Teamwork and Coordination in Health Education.
In order to derive in the smaller group discussions the greatest possible benefit from the exchange of ideas and experiences, the Conference Organizing Committee established four Work Groups, with as nearly an equal distribution as possible of all Conference members. To assure a broader viewpoint and a maximum interchange of experiences, every effort was made to include in each group a true representation of the participating countries and of the various professions represented.

The presentation of topics in plenary sessions was planned so as to submit questions, problems and viewpoints for consideration by the Conference membership in a manner as to stimulate the subsequent discussion of the topic by the Work Groups.

Following the symposium presentation the delegates met with their respective Work Groups to consider and analyze the problems presented through informal discussion, exchange of ideas, opinions, and experiences. Their purpose was not to offer solutions to local problems nor to outline a specific international formula to meet the needs and conditions prevailing in all the countries. Their main concern was to establish a set of principles, acceptable to all members of the Conference, that could serve as a basis for public health programs.

Each Work Group presented, at the following plenary session, a report of its findings to the total Conference membership for discussion, approval and amendment. When the first set of group reports was presented it was recommended that, in view of certain duplications, in addition to the individual group reports all rapporteurs should meet and prepare a joint report summarizing the conclusions and recommendations of all four groups.

At the last Plenary Session, joint reports of the Work Group conclusions covering the entire Conference were prepared by the Editorial Committee elected by the four Work Groups. (See Appendix C, p. 64.) These conclusions, as amended and approved by the Conference membership, appear in the chapter VIII of this report.

Conference Mechanism

Spanish was the official language of the Conference, with facilities for translations into French and English for the benefit of all participants. At plenary sessions, simultaneous translation equipment was provided to enable each participant to speak or hear the language of his choice.

Work Group sessions were conducted in Spanish. Interpreters were provided for those whose only language was English or French.

The Conference administrative staff maintained an even flow of documents and materials to the participants in the three Conference
languages. The results of each session were transcribed, translated and mimeographed for distribution on the following day. The quick processing of these documents was a real contribution to the effectiveness of the work sessions, and appreciation for the staff's efforts was expressed at the final Plenary Session.

Field Visits

The following field visits, arranged through the courtesy of the Mexican Ministry of Health; State and Local Health Officers, and the School of Public Health, featured in the Conference program:

1. To the School of Public Health of Mexico and to the Health Center “Beatriz Velasco de Alemán”, on 24 September.
2. To the Health Unit of Cuernavaca and to the Rural Social Welfare Program of Tlaltizapán, in the State of Morelos, on 26 September.
3. To the Health Center “General Manual Avila Camacho” of the Distrito Federal, in conjunction with a luncheon given by the Mexican Public Health Association to the Conference members, on 29 September.

Conference Library

A small reference library, containing a collection of materials and text books lent by the Library of the Pan American Sanitary Bureau in Washington, D. C. and by the Library of the Mexican School of Public Health, was provided at University City for the benefit of Conference participants. Health education materials used in the various participating countries were also on display in this library.

Special Function

The Conference members, in a formal ceremony, placed a wreath at the Monument to the Heroes of Mexico's Independence, on Tuesday, 29 September, pursuant to a motion presented and unanimously approved at the Third Plenary Session, Wednesday, 23 September.
Foreword

The Inaugural Session of the Regional Health Education Conference was held at 6:00 p.m., Friday, 18 September, in the Main Auditorium of the Mexican Institute of Social Security.

Dr. J. Pilar Hernández Lira, Director General of Health Education of the Ministry of Health and Welfare of Mexico, introduced to delegates and guests the Presiding Council of the Inaugural Session, which was composed of: Dr. Ignacio Morones Prieto, Secretary of Health and Welfare of Mexico; Dr. Manuel B. Pesqueira, Under Secretary of Health and Welfare of Mexico and Chairman of the Conference; General Demetrio Mayoral Pardo, M. C., Chief Clerk of the Ministry of Health and Welfare of Mexico; Licenciado Francisco A. Urzúa, Acting Director of the Office of International Organizations of the Ministry of Foreign Relations; Dr. Carlos Luis González, Director of the Division of Public Health, Pan American Sanitary Bureau, Regional Office of the World Health Organization; and Dr. Alberto Sevilla Sacasa, Ambassador from Nicaragua to Mexico, and Chief of the Nicaraguan Delegation.

Dr. Hernández Lira welcomed all the delegates of the participating countries and expressed his best wishes for the success of the Conference. He then called on the speakers who addressed the participants.

Welcome from the Ministry of Foreign Affairs

by Lic. Francisco A. Urzúa

Mr. Secretary of Health and Welfare and Delegates: On behalf of the Office of International Organizations of the Ministry of Foreign Affairs, I have the honor to extend to you a most cordial and warm welcome.

It is a sign of the times to observe that relations between States are no longer limited to embassies alone, and that it is becoming increasingly customary for the different ministries, departments and government agencies to take direct and active part in the relationships among peoples in their various fields of endeavor—social, technical, or other interests of their daily life. Consequently, on this particular occasion, the Secretary of Health and Welfare of Mexico has sponsored this Conference in direct collaboration with the respective international agencies.

The Office of International Organizations, of which I am in charge, is
proud of the part it has played, although small, in the organization of this Conference which has culminated in this auspicious meeting, and hopes to serve, on this occasion, as liaison between the authorities directly responsible for the various activities and the international organizations here represented.

It is now my pleasure to express to you the best wishes for the success of the work you are about to undertake, and may the results of your endeavors prove most profitable to all the countries of the Americas. Personally, I hope that your stay in my country, which is ever ready to utilize insofar as possible the fruitful results of meetings attended by such prominent personalities, may be most pleasant and enjoyable.

Greetings from the PASB/WHO

by DR. CARLOS LUIS GONZÁLEZ

I feel highly honored by the opportunity to bring to you the most cordial greetings from the Director-General of the World Health Organization and the Director of the Pan American Sanitary Bureau, Regional Office of the World Health Organization for the Americas, as well as their expressions of appreciation for the courtesy of the Government of Mexico to serve as host for this Conference, to which it has given its invaluable moral and material support.

This meeting is but another expression of the fundamental interest of the Member Governments of the Organization in the activities of public health education as a constituent factor of all public health programs. This interest has been most evident at meetings of the directing bodies of the Organization, from which very sound recommendations have emanated, recommendations which the administrative staff is endeavoring to implement in the most effective manner in compliance with the expressed desires of the Member Governments.

The importance of the topics on the tentative agenda, which will be submitted for your consideration, together with the experience and technical knowledge of the participants and the preparatory work of the Organizing Committee, are indicative of the fruitful results that will ensue from the discussions that will take place during the next few days.

The Conference which is being inaugurated today is characterized by the fact that it is attended by a representative group of a wide range of diversified health activities: along with the general director of public health we see the public health nurse; with the health educator we find the officer in charge of special health programs. In addition, to enhance the value of the discussions, there are those distinguished members engaged in the educational phase of agriculture, anthropology, and
All this brings us to realize that we are in the presence of an authoritative group who will soon engage in an interchange of ideas and experiences, and will offer suggestions to meet the many problems encountered in their daily tasks. At the conclusion of this Conference each and every one of its participants will no doubt return to his post armed with a wealth of new knowledge and ideas, ready to put them into practice in order to attain that common objective to us all—the improvement of health in its fullest extent—as defined in the Constitution of the World Health Organization.

I deem it appropriate to express our appreciation for the work accomplished by the Organizing Committee in the preparation of this Conference. Likewise, I wish to express our most sincere thanks to the international organizations and agencies, particularly to the Institute of Inter-American Affairs, for their efficient assistance at this time.

In conclusion, I take great pleasure in conveying the sincere appreciation of the Director-General and the Regional Director of the Organization to the Government of the United States of Mexico, under whose auspices and gracious hospitality this Conference is being held. These expressions of thanks are likewise extended to the Ministries of Foreign Affairs, Health and Welfare, and Public Education; to the National University of Mexico and to the Mexican Institute of Social Security.

Conference members: your proficiency, devotion, sense of responsibility and interest in health education portend the benefits that will ensue from this Conference. The Organization, which I have the honor to represent, extends to you a most cordial welcome and expresses the hope that this Conference may constitute a new milestone towards the worthy objective of imparting to the peoples throughout the world a positive concept of health, as a source of happiness and fundamental factor to community living in a peaceful world.

Keynote Address
by DR. MANUEL E. PESQUEIRA

As a representative of the Ministry of Health and Welfare of Mexico and a member of the Mexican medical profession, I take great pleasure in expressing on this occasion our sincere appreciation to the World Health Organization for selecting Mexico as the seat for the Regional Health Education Conference.

This selection is most gratifying in that it also affords us the opportunity to discuss, in cordial and friendly terms, problems which are common to us all, whose solutions we seek with equal zeal.

I feel sure that the Central and South American countries which, together with our own, constitute the Latin American group of nations,
have been aware, for some time past, that the concept of health education differs but little from the general problem of education that exists in all our countries.

It is not therefore embarrassing, since it is true, frankly to admit that health education programs encounter in our countries such obstacles as illiteracy, poverty, and diversity of races. That is why we must acknowledge that any phase of community education, including that of health, requires persistent and constant effort in order that it may exert its favorable influence on public health in general.

It is toward this worthy objective that our governments are stressing the promotion and protection of health as one of the most important tasks of their administration. It is, therefore, most gratifying to us as well as a source of personal satisfaction to observe that health education is being emphasized in all public health programs.

In order to put into practice the objectives of this educational phase, we have directed our efforts primarily toward teaching children and adolescents the principles governing the preservation of health and longevity, inducing them to form health habits which, not only during their school life but in subsequent years, may represent to them a source of vigor and energy. Through the education of parents and other adults, we have tried likewise to create attitudes of understanding and cooperation with the health programs, attitudes that are fundamental for the harmonious development of family and community life.

Furthermore, we have directed our health education endeavors toward the schools in general, in an attempt to use the schools as a means to bring into the family and community groups the progress made in social development.

In our desire to improve the living conditions of the individual and of the community as a means of developing hardier future generations, capable of building a stronger and healthier nation, we have centered our efforts on the concurrent achievement of the aforementioned phases.

Experience has taught us that improved health conditions run parallel to progress in education in general and in health education in particular. This improvement has become evident during the past fifty years in which health education, as a part of the health programs, has proved its favorable influence, statistically expressed, in a decrease of morbidity and death rates, a decline or eradication of certain diseases, or in an appreciable increase of the average life span. Perhaps we should affirm, though our affirmation may not be expressed in figures, that health education has contributed likewise to increase the physical vigor, energy and endurance of the world population.
A health education program should not be limited merely to promote physical well-being. It should be stressed that health education includes all health aspects—physical, mental, social and moral. Its application should include all aspects of a child's normal development. The aim of any sound public health program should not be merely to liberate human beings from physical deformities or pathological disturbances, but rather to strive for the highest level of physical, mental and emotional well-being of the citizens of all the nations, regardless of race, color or creed.

There are certain phenomena related to mental health which should be considered as a sequence of physical deficiencies or disturbances of the individual. Health education should therefore be considered as the most effective means for parents and relatives better to understand the reasons for a child's behavior, peculiarities and problems.

Better to understand these psychological aspects the personnel, who is to have charge of health education programs, should be as carefully selected as the directors of education and even the teachers themselves. An indispensable requirement of those in charge of such programs should be not only a knowledge of teaching methods nor of individual and group psychology, but the ability to put these into practice as well.

In other words, the departments of health education in any Ministry of Health should exact from the personnel selected the same requirements and qualifications as those required of the teaching personnel, inasmuch as between these two groups there are but slight differences of specialization. Moreover, officials in charge of health education should be thoroughly familiar with all the activities of the Ministry of Health, if they are to succeed in their endeavors.

Even with the aid of such well-trained personnel, the specific programs of health education should be so directed as to attain the desired objectives. In this respect we must admit that, on occasions, due to failure to utilize adequate means of communication, time and money have been wasted. We are glad to acknowledge, on the other hand, the progress made through audio-visual devices, such as moving pictures, radio and television, on the educational value of which we are confident.

We earnestly hope that this illustrious conference may reach satisfactory conclusions regarding the problems at hand, and that it may find a way to teach, even in the uttermost corners of our nations, how to lead a healthier, happier, and more useful life.

To the best wishes for the success of the Regional Conference on Health Education, may I add my cordial and sincere congratulations to the Regional Office of the World Health Organization for taking the
initiative in promoting the organization of this meeting from which the nations here represented will no doubt derive much valuable information.

Inaugural Address
by Dr. Ignacio Morones Prieto

Delegates, ladies and gentlemen: The Ministry of Health and Welfare is most happy to have you as guests of the Government of Mexico and is very pleased that the World Health Organization and the Pan American Sanitary Bureau have chosen our country as the seat for this most important meeting. We extend to you our thanks and best wishes for the success of this meeting on health education in the Americas. And now, I solemnly declare formally inaugurated the Regional Conference on Health Education, being held under the auspices of the World Health Organization in cooperation with the Ministry of Health and Welfare and the Government of Mexico.
Chapter III

PLAN OF ACTIVITIES AND CONFERENCE PROGRAM

The First Plenary Session of the Conference, presided by Dr. Manuel E. Pesqueira, Under Secretary of Health and Welfare of Mexico and Chairman of the Conference, took place at 10:00 a.m., Saturday, 19 September, in the auditorium of the Commerce Building, University City. This session was designed to acquaint the participants with the procedures of the Conference.

The Chairman called on Dr. J. Pilar Hernández Lira to make a brief exposition of the events leading up to the Conference and to present the Plan of Activities and Conference Program for consideration by the membership. Dr. Hernández Lira emphasized that the purpose of the Conference was to assist the members to determine what could be done to strengthen health education activities in their respective countries through this opportunity to exchange viewpoints and experiences regarding health education. He reviewed the four major topics of the agenda and explained in detail the way in which the Work Groups would function in their discussions of symposia presentations, adding that the Conference structure had been planned by the Organizing Committee with the idea of providing maximum opportunity for active participation by all members. Opportunity was then afforded for discussion of the procedure to be followed.

Lists of the provisional membership of the four Work Groups, selected in accordance with the criteria described in Chapter I, having been prepared and distributed by the Organizing Committee, the Chairman announced the names of temporary Work Group chairmen proposed by the Committee to serve during the discussion of the first topic. He recommended that Work Groups elect different chairman and rapporteurs for each discussion topic in order that all Group members might share in the duties and responsibilities of these positions.

The session was then adjourned and the Work Groups met to elect rapporteurs and prepare for the second plenary session on Monday, 21 September.
Chapter IV

PLANNING AND DEVELOPMENT OF LOCAL HEALTH EDUCATION ACTIVITIES

The symposium featured at the Second Plenary Session dealt with the problems of planning and development of local health education activities; the main purpose being to present, for consideration by the Conference, some of the basic principles involved. Many of these problems had been suggested by the various participating countries as discussion topics.

Those participating in the symposium had had professional training in their specific fields and considerable experience in public health. Among these were a public health administrator, a public health nurse, a sanitary engineer, a health educator, and an anthropologist.

Summary of Symposium Discussion

Some of the points developed during the symposium discussion were:

The necessity to recognize cultural differences where different cultural patterns are present, and plans to adjust the programs to them. Each culture usually has attitudes and beliefs about disease and treatment; also traditional methods by which these attitudes and beliefs are passed on from generation to generation. Open or passive resistance may develop within the community when the public health program conflicts with the established cultural pattern.

As a part of the planning and development of an effective program it is essential, therefore, to obtain accurate preliminary information about a community. It is also essential that those who are to carry out the various related activities be well-trained and familiar with local conditions.

From the very beginning, all members of the public health team should participate in the planning. This should be accomplished by means of regular staff meetings, at which time each team member, through the opportunity thus offered to exchange ideas and experiences, becomes better acquainted with the professional and personal qualifications of other team members. These staff meetings ensure the development of public health team activities through the cooperative effort and coordination of all personal and professional capabilities.

After the presentation in the general discussion of contributions by the Conference members, the symposium participants suggested that the Work Groups give special consideration to the specific aspects of the questions listed under this topic in the tentative agenda:
1. Are local health education programs adapted to the needs and interests of the population served?
2. Where does program planning begin and who takes part in it?
3. Has a real effort been made to determine the local resources available?
4. What has been done and what can be done to prepare local people to participate in local health education activities?

Report of Work Group "A"

1. Health education is a fundamental part of all health programs and all efforts and activities should be coordinated towards this end.

The following points should be considered when planning a health education program at the local level:

(a) Preparation and effective utilization of the members of the community in order to engage their participation in public health activities.
(b) Health education must be adapted to the community needs, resources, customs and possibilities for improvement.
(c) Health education programs should be planned by the local public health team in collaboration with the community.
(d) In the development of health education activities, coordination of all departments, organizations and institutions should be stimulated.
(e) Periodical evaluation of health education programs and of the results obtained.

2. Taking into consideration a community's needs and interests regarding health matters, the following items should be given priority when planning and developing local health education activities with the participation of all health personnel:

(a) Previous studies of statistical data and other reports and surveys.
(b) Surveys and interviews with members of the community to determine the problems, opinions and attitudes of the people.

3. In health education, cultural factors are of primary importance since these are indicative of the community's recognition of existing health problems. In order to carry on health education at different levels of the social structure of a given population, sociological studies of the component groups of the community should be taken into account and programs planned to reach these levels, once established, with particular attention to:

(a) Problems of which the population is aware.
(b) Information obtained about such problems.
(c) Source of the problems.
(d) Possible solutions.
(e) Reliable means of communication.
(f) Individuals whose opinion is sought (key persons).
(g) Social, economic and cultural characteristics and religious beliefs of the population, as well as the standards, beliefs and work patterns which may influence their decisions.

(h) Study and utilization of available resources.

4. Programs should be planned with the participation of individuals and specific groups from the locality with a view to consider the suggestions they may offer. Illustrative materials may also be used in health education programs developed at the different levels.

Report of Work Group "B"

1. The long range objective of health education is the improvement in living conditions of the community in its physical, social and emotional aspects, through the readjustment of the community’s social standards. The immediate objective is to have the community understand the purpose of a specific health program and to obtain active community participation in its implementation.

2. When planning a program the technical aspects as well as the community’s point of view concerning the problems involved should be taken into consideration in order to ensure community participation. A point to be stressed is the serious and frequent mistake, on the part of health authorities, to impose programs on the community.

3. Programs should be planned in accordance with the conditions of the area wherein the program is to be developed, without infringing upon the basic principles of the national public health program.

4. National and local health education activities should be stressed in accordance with the importance of the health problems.

5. When planning and developing health education in areas where public health services are available, the following procedure is suggested:

(a) To conduct a survey of the country’s cultural geography in order to determine the different cultural areas.

(b) To select a zone in one of the cultural areas in order to develop a local demonstration program.

(c) To make a complete study of the zone selected.

(d) To formulate a working program based on the results of this study.

(e) To develop the program planned and to evaluate periodically its progress and results.

6. Where only partial public health services are available, or such services do not exist, it is suggested that health authorities:

(a) Improve the training of public health personnel in health education methods.

(b) Avail themselves of the services of private physicians who practice in
the community and engage their cooperation in health education activities after adequate briefing on the subject.

(c) Engage the collaboration of teachers working in such localities, in order that they may develop some health education activities.

(d) Train "key persons", in places where there are neither physicians nor teachers, to develop health education activities directed at those fundamental problems of the community which have a possible solution.

7. The health educator should brief the personnel of the local health unit on the principles and methods of health education.

8. The technical personnel of a health unit should utilize, whenever possible, the "key persons" and the official and private agencies which have influence over community groups in order to develop local health education programs.

9. To strengthen local and national activities directed toward the improvement of health conditions, it is recommended that private initiative be encouraged in those communities where it is advisable to do so.

Report of Work Group "C"

1. Health education involves the mobilization and utilization of all factors which contribute to the improvement of the physical and mental health of the individual and the community.

2. The fundamental objective of health education is to cultivate in the individual and the community those habits and attitudes which promote better health. Such attitudes refer, of course, to what every individual must do by himself, for himself and for his family. He should, furthermore, take an active part in all public health activities sponsored by state and private agencies.

3. It is recommended that delegates from the participating countries emphasize to their governments the importance of establishing periodical meetings of all health personnel, in order that all may be acquainted with and participate in the over-all program of the Department of Public Health; and that a firm foundation for health education activities be established in accordance with the problems and programs of the various services.

4. Local public health programs should be planned in accordance with the needs, resources, and problems of the community, after careful study by well trained personnel or, when such personnel is not available, by regular staff trained as well as possible to make such studies.

5. The members of the health team should be reminded that they are all responsible for the entire public health program and that its success depends upon mutual respect, cooperation, and perfect coordination of all services.
6. All members of the health team should take an active part in the health education program. Health education should be stressed in Medical Schools, Teachers Colleges, Schools of Social Work, Nursing Schools, and others, in order that well trained personnel may carry on effective health education work in the communities where they perform their professional services.

7. When planning local public health programs, the needs recognized and stated by the community should be taken care of insofar as possible. The community should be stimulated through health education to take active part in long-term projects which are deemed necessary by public health personnel.

8. Health education should be adapted to the understanding of the individual and to the economic and social status of his group.

9. Health education should be directed to all age-levels of the population, with special emphasis on the teaching of children and young people, proportionally to the understanding of the individual and group.

10. It should be recommended that the different governments give immediate recognition to public health as a career and that due provision be made for job security, systematic advancement of trained personnel, and adequate remuneration, particularly for subordinate personnel.

Report of Work Group "D"

1. Health education comprises all that which tends toward man's development through the acquisition of health knowledge as a means to induce him to act and acquire habits which may help him to improve and maintain his health. From this viewpoint the scope of health education is vast, contributing as it does toward the guidance of man's development and adaption to his environment.

2. The social objectives of the education program are:

(a) To publish, broadcast and popularize protective health principles.
(b) To promote a community sense of responsibility for healthful living and thinking.
(c) To encourage the establishment and development of sanitary measures to be used against major diseases and epidemics.
(d) To arouse public interest and promote a desire fully to cooperate and support the work of the public health authorities.
(e) To combat the harmful effects of charlatanism.

Education is the most valuable basic measure to preserve health, and health is the highest aim of modern medicine, whose motto is: "to prevent, in order not to have to cure".

3. Summary: In planning any health education program, priority
should be given to the recognized needs of the community. The opinion of the majority must be respected.

4. In order to determine the acknowledged needs and interests of the community, the following steps should be taken:

(a) Representative leaders of all community groups should be consulted as to the problems, interests, and needs of the groups to which they belong.

(b) Surveys or studies should be made by trained personnel.

(c) Recent and reliable statistics should be used.

5. Any health program should include an educational phase.

6. The influence of the cultural factors on the health needs of a community is very strong and should be taken into consideration when health education programs are planned and developed.

7. In order to discover and deal with any resistance to the educational program the following factors should be taken into account:

(a) The habits, customs and interest of the various community groups in order to obviate any obstacles.

(b) The training of personnel in charge of health programs on the techniques of health education.

(c) The selection of persons in the community to be trained in the teaching methods of health education, since such individuals are accepted by their respective groups.

(d) Adaptation of the health education procedures and practices to the different social groups, and organization of medical services and preventive medicine for such groups.

8. The following principles should be applied in securing individual and community participation:

(a) Utilization of organized community groups or the organization of such groups in order that all may participate.

(b) Preliminary surveys of community resources, problems and interests before the program is initiated.

(c) Consideration for the customs and traditions of the individual regardless of his social status.

(d) Acknowledgment of the contributions by all participants.

(e) Priority accorded those problems considered of primary importance by the community.

9. In planning a health education program for a given area, it is recommended that:

(a) A survey be made of the general conditions of the area involved.

(b) The best health education techniques be applied in the planning and
development of a health education program, such as obtaining the largest possible number of participants.

(c) Periodic evaluation of the educational program in order to detect failures, correct errors and compare the health level prior to, and after the program has been in effect.

10. In order to strengthen health education activities in areas where few or no health services exist, it should be borne in mind that:

(a) The key to success of any health education program is the word more since education has no limits; more understanding and more acquiescence is required on the part of those responsible for the educational program.

(b) An evaluation of the work performed should be required in order to determine the progress made and what remains to be done.

(c) School teachers, civic leaders, and other organized groups should be recruited to help in health education work.

(d) Health authorities should be urged to organize health teams and to send them to areas where health services do not exist.

(e) Educational programs should be adjusted to the problems of the community, but without creating demands for services which do not exist.

(f) Educational programs which do not demand special services should be strengthened, for example, by giving greater emphasis to those aspects which tend to promote good health habits.

(g) Training programs should be planned for empirical workers (midwives, teachers).

11. Health education should be imparted simultaneously to children and adults.

12. The role of health education in basic educational programs may be defined as follows:

(a) To become acquainted with the health problems of the community in order to plan the work program.

(b) To combat ignorance, superstition and prejudices regarding health problems.

(c) To coordinate health education programs with other activities directed toward community improvement.

(d) To obtain public support of the idea that health is a public responsibility.

(e) To incorporate the basic principles of health education in fundamental educational programs.

(f) To impart health knowledge applicable to the daily life of the community.

(g) To make use of audio-visual aids and apply adequate methods to evaluate the results.

13. The administrative, technical and financial aspects involved in national and local health activities are:
14. For a proper distribution of local and national health activities it is recommended that:

(a) Statistics be used as a basis in planning health education programs.
(b) Priorities be established in accordance with the urgency of the problems
(c) Standards and regulations be established at the national and local levels

When problems are national in character, standards and regulations should be established at the national level. National authorities may supervise programs developed at the local level and provide counsel. Activities developed at the local level should be in accordance with priorities established at that level.

Summary of Work Group Reports

1. The long range objective of health education, based on established scientific principles, is the improvement of the physical, social and emotional aspects of the living conditions of the community, through a readjustment of the community's cultural values. The immediate objective is that of obtaining community understanding of a specific health program and active community participation in the development of such a program.

2. Local public health programs should be planned in accordance with the needs, resources and problems of the community, after careful study by well trained personnel or by regular staff, trained as well as possible, to undertake such studies. The health education program should be planned by the health team in collaboration with the community.

3. In order to carry on health education at different levels of the social structure of a given population, the sociological study of the component groups of the community should be taken into account, and programs planned in accordance with such levels. Individuals from the various levels should be trained and utilized in health education programs, since such persons are accepted by their group. It is also recommended that organized community groups be encouraged to participate or, in lieu thereof, that the community be organized.

4. To strengthen health education activities in areas with minimum health services or where such services are not available, it is suggested that:
(a) Teachers in such localities be encouraged to develop some type of health education activity.

(b) Advantage be taken of the services of private physicians, practicing in those areas, who may cooperate in health education programs.

(c) Teachers, civic leaders, "key persons" and organized groups in the community be recruited to help with the health education program.

(d) The education program be adjusted to community problems, but without creating a demand for non-existent public health services.

(e) Educational programs not requiring special services be strengthened, for example, by giving greater emphasis to the promotion of good health habits.

5. When public health problems are national in character, standards and regulations should be established at the national level. Local health education activities should be developed at the local level in accordance with established priorities at that level. Authorities at the national level may supervise programs developed at the local level and provide counsel.

The various members of the public health team should be reminded that they are all responsible for the entire health program, and that the program's success depends upon mutual respect, cooperation and perfect coordination of the various services.
Chapter V
TEAMWORK AND COORDINATION IN HEALTH EDUCATION

The discussion topic at the Third Plenary Session was presented in the form of a socio-drama. Participants included a public health administrator, a public health nurse, a sanitary engineer and an agricultural extension supervisor.

The socio-drama demonstrated to the Conference membership that the success of a public health program depends on: (a) coordination of the various activities of the members of the public health team, and (b) coordination of the entire program with the programs and activities of other agencies working indirectly in the field of public health.

Specific problems proposed by the symposium for consideration by the Work Groups were:

1. What is coordination and how may it be achieved by the public health team?
2. What must be done in order to attain effective coordination with other agencies concerned directly or indirectly with public health problems?

Work Groups then met to discuss these and other items listed under this topic on the Conference agenda.

When the group reports were read, a general discussion developed regarding the importance of the charlatan or quack in community health programs. It was recommended, as a result of this discussion that the four Work Group rapporteurs prepare and submit, for consideration by the Conference membership at the next session, a recommendation regarding the problem of charlatanism.

Report of Work Group “A”
1. The objective of teamwork and coordination is to expedite technical activities in order to obtain better results from the public health program. Since health education is a part of the educational system, its immediate objective is to engage the interest of the community in improved health; the long term objective is an over-all improvement of the community. In view of these objectives, it is recommended that:

(a) Every member of the health team be urged to collaborate fully in all public health programs.
(b) Local organizations and agencies be invited to participate in the planning and implementation of these programs.
(c) Proposed public health programs be explained to the community in order to obtain active community participation.

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2. Every health service has an educational effect, therefore everyone taking part in the development of a health program is partly responsible for the methods used and for the results obtained. It should be understood that health education is not limited to public health personnel alone, and that the health team should secure the cooperation of all persons working with the community.

3. The cooperation of school teachers in health education is essential and, in order that their work in this field may be more effective, it is recommended that the curriculum, at all levels, be revised and greater emphasis be given to health education.

4. Those in charge of group health education should adhere to the following principles:

   (a) To cooperate in the educational aspects of all community activities.
   (b) To develop appropriate methods.
   (c) To utilize adequate media to interest the community in health education programs.
   (d) To plan and develop specific procedures for educational programs.
   (e) To keep the community informed as to its health problems and what is being done to solve them.

5. The health educator, member of the team in charge of the program, should cooperate in the selection of educational methods and materials to be used, and should brief the other members of the team on the development of the program.

6. To promote a sense of teamwork and coordination, all health workers should be thoroughly familiar with the over-all public health program.

7. Permanent results in over-all improvement programs, developed in a rural area, can be obtained through teamwork and coordination, when participation of the Departments of Public Health, Education and Agriculture, as well as that of other organizations interested in the socio-economic improvement of the community, is ensured.

Report of Work Group “B”

1. The role of the health educator in the public health team.

   As a fundamental principle, the qualified health educator should serve the public health team, and other organizations working in the community, as a consultant in and promoter of integration and coordination of the over-all community program.

   For this purpose, health educators should have experience in general public health programs in order that they may be able to develop and coordinate their activities in any program in which they are engaged.
2. Coordination of work of the health educator in health programs.

Since all public health programs should be developed around the cultural and environmental characteristics of the community, it is essential that there be coordination in the activities of each and every member of the team, including those of the health educator.

3. Coordination of health work with the over-all program of community improvement. Coordination should be based on:

(a) The recognition that cultural and environmental characteristics are decisive factors in the planning and development of a health program.
(b) The fact that the purpose of a public health program is to contribute to the over-all improvement of the community.
(c) The understanding that lack of participation by individuals and organizations with potential influence in the community can have disastrous effects on community improvement programs; and that continuous coordination of all elements, contributing to the development of community programs, is essential.

4. Some essential requirements for program coordination.

To ensure coordination among individual health workers and professional men, and among the various health agencies and other agencies, it is necessary that:

(a) relationship among the personnel of an agency and between the personnel of that and other agencies permit and encourage an exchange of ideas and services;
(b) mutual understanding and appreciation of the objectives, methods and problems of the various agencies and individuals be developed and maintained.

Moreover, effective coordination among agencies and professional men in different fields of endeavor requires the services of a coordinator, or coordinating mechanism, with autonomy over the personnel participating in the program, as well as over the material and equipment allotted for their use.

These principles emphasize the fact that coordination of activities at the local level is as important as at the regional or national level.

Report of Work Group “C”

1. Coordination is the process by which a public health team combines principles with action and, in agreement with the community, directs its activities in a joint effort to attain a definite objective. Successful coordination requires accurate information, effective channels of communication and mutual recognition of effort, in an atmosphere of tolerance and mutual respect.

The immediate objective of coordination is an effective joint action
by all participants in their respective fields, in accordance with the principles previously outlined; each participant providing maximum information to his collaborators as to the purpose and extent of his activities. In this way, a harmonious plan of action, useful to the community, may be put into effect. The long range objective of coordination is the application of the above principles by all health authorities and other branches of the Government.

2. Every public health worker should be convinced of the high ideal toward which he is cooperating and aware of the responsibilities involved in the educational aspects of his particular work.

3. Teachers, workers in extension services, and others cooperating in the public health program play an important part in such programs, particularly in communities where public health services are not available.

4. Health education activities are developed in accordance with the needs and programs of the various public health services.

5. The fundamental principle of teamwork is coordination, and the methods to obtain it are those outlined in the preceding paragraphs.

6. To obtain the collaboration of individuals and organizations, working in the Departments of Agriculture, Education and Public Works, it should be impressed upon them that their participation in health education activities will redound in the planning and implementation of health education programs that will benefit the entire community.

The major role of the full-time health education worker in the implementation of the principles previously outlined is to discharge his duties to the best of his ability and to assume responsibility in health education activities.

Report of Work Group “D”

1. The immediate objective of teamwork and coordination in health education is to attain greater efficiency and economy in the performance of the program. The long-range objective is to raise the community’s standard of living in all its aspects: better health, increased agricultural and industrial production, improved economy, better recreation facilities and a better adaptation to the social development of the nation.

2. To obtain coordination and efficiency in health education activities, all public health personnel should assume responsibility as health educators. Since it would seem impractical to assume that every community will have specially trained personnel in health education, it behooves the physician not only to treat disease, but also to educate the patient and his family. This same philosophy is applicable to other members of the public health team.

3. Teachers play an important role in health education programs by
promoting health habits in children and young people. It is therefore essential that such teachings be integrated in school curricula and that such instruction be practical and not merely theoretical. All teachers, extension service workers and others engaged in health programs should be familiar with the methods and techniques of health education in order that these may be incorporated in health education programs for community improvement.

4. Health education is an essential part of all public health programs, therefore every public health service should include educational activities.

5. The principles and methods, fundamental to teamwork and cooperation among public health workers, may be summarized as follows:

The chief of the local health unit should assume responsibility for the training of personnel and for arousing in them a sense of responsibility. He should also give the personnel an opportunity to participate in the planning and development of the program as a means to obtain their full collaboration. Staff meetings to consider the needs and problems of all personnel members are recommended as a means of achieving greater success in program activities.

6. To obtain greater collaboration from individuals and agencies working in Agriculture, Education, Public Works, etc., it is necessary:

(a) To invite those individuals and organizations to participate in the planning and implementation of health education programs, at the national as well as the local level.
(b) To promote the exchange of information among participants in the program concerning their respective activities.
(c) To hold periodical meetings at the local level, and if possible at the national level, to enable health education personnel as well as workers in other agencies to evaluate the progress made and to formulate future plans.

7. The major role and responsibilities of full-time personnel engaged in health education could be summarized as follows:

(a) To urge public health personnel to extend their activities to health education. To promote cooperation in the effective use of health education methods and techniques.
(b) To participate in the planning and development of a health education program, based on the needs and resources of the locality.
(c) To help establish and maintain good working relationship between the health center and other agencies engaged in health education of the public.
(d) To work through organized groups or to assist in the organization of such groups in communities where these do not exist, in order to expand the health education program.
(e) To provide technical advice in health education methods and techniques to schools, community groups and other agencies engaged in health programs.

(f) To serve as liaison between the local health unit and the community, and to explain to the public the services provided by the health center.

(g) To prepare, select and distribute audio-visual materials in accordance with the needs of the public health program.

(h) To participate in the periodic evaluation of public health programs and their health education aspects.

**Summary of Work Group Reports**

1. Teamwork and coordination are essential in the planning and implementation of a health program, as well as to expedite the educational activities of the program and to evaluate the results obtained. Coordination means the process by which members of a public health team, combining principles with action and with community cooperation, direct their joint efforts toward achieving a definite objective.

2. Immediate objective: To arouse community interest and active participation in the planning and implementation of a needed health program. To realize that respect for the cultural and environmental characteristics of the community is of vital importance if community cooperation is to be obtained.

   Long-range objective: To raise the standard of living (physical, mental, and economic) of the community through health education, and to engage the cooperation of the health authorities in extending such benefits to the greatest possible number of communities.

3. Every one engaged in public health should act as educator; he should, moreover, be responsible for the methods he uses and for the results obtained in the health program.

4. The cooperation of school teachers is essential, particularly in areas where public health services are not available. Through theoretical and practical instruction school teachers promote health habits in children and young people. To make such teachings more effective, it is recommended that curricula be revised, giving greater emphasis to health education. The same recommendations are applicable to extension services and other cooperating agencies.

5. Since health education activities are a part of the entire public health program, these should be developed in accordance with public health needs.

6. Among the essential basic principles for teamwork are: responsibility, self-evaluation, and coordination; all of which may be attained through accurate information, inter-communication, and appreciation of the capabilities of each individual worker in an atmosphere of tolerance and mutual respect.
7. To obtain greater collaboration from individuals and organizations working in Public Education, Agriculture, and Public Works, their participation in the planning and implementation of public health programs should be invited. The success of such a program depends upon the understanding, on the part of each worker, of the objectives to be attained and the responsibility of each particular task; as well as on periodical staff meetings to evaluate the work accomplished, analyze criticisms, and introduce necessary improvements.
Chapter VI

METHODS AND MATERIALS IN HEALTH EDUCATION

This topic, for discussion at the Fourth Plenary Session, Friday, 25 September, was presented in a symposium in which a medical advisor from a national ministry of education, a health educator, an educational psychologist, and an anthropologist participated. Each participant made a brief statement regarding criteria to be used in the selection of methods and materials for use in health education. These statements reflected the experience and training of the participants in their respective fields.

Attention was called to the psychological bases of education, the inherent factors which help determine how, why and when the individual may learn and put such learning into practice.

With reference to the principles established in a previous session, special attention was called to the need of adapting methods and materials to the habit patterns of the individual and to the cultural patterns of the community, so as to avoid any possible conflict with their traditional habits and attitudes. The need to determine first the people's present standing with regard to health habits and attitudes, was stressed. Their capacity to change socially, economically and psychologically must be carefully studied, before selecting the methods and materials that will lead to a gradual change acceptable to the community wherein the health workers are engaged.

Any attempt to effect an abrupt change, entirely different to their way of life, often meets with opposition, particularly when the members of the community are firmly convinced that their way of life is superior, better, or the only one possible within their social or economical status.

A common mistake is the use of health education methods and materials which present, through pamphlets, films or posters, attractive habit patterns of other cultures, in the belief that such means alone will stimulate people to adopt them in their own particular culture, and thus effect the desired change. "Education" is then erroneously reported as having taken place in terms of pamphlets and posters distributed or films shown.

The real test of any methods and materials used is not quantitative but qualitative—not how many times they are used, but rather the extent in which they have helped to bring about desirable changes in habits and attitudes which have raised the health level of the community.
As a part of the symposium discussion, a flannel-graph was used to demonstrate the fact that methods and materials employed in a health education program are necessarily influenced by such factors as planning, organization, staff, direction or administration, coordination, reporting, and budget.

After some general discussion by the Conference membership for clarification of certain points, the Work Groups met to consider all questions listed under this topic on the Conference agenda.

Pursuant to instructions received at the previous session, the four Work Group rapporteurs presented a recommendation on the problem of charlatanism which received Conference approval. This recommendation appears as Special Recommendation No. 1 in Appendix A, p. 59.

**Report of Work Group “A”**

1. Methods and materials used in health education should be based on the psycho-sociological principles which stimulate the individual and the community to adopt habits, attitudes and beliefs which tend to promote better health and social well-being. In the application of these principles, the following are recommended:

   (a) Adequate motivation toward acquiring a healthful behavior, based on needs and interests.
   (b) Maintenance of interest in such behavior.
   (c) Encouragement toward achieving higher standards.
   (d) Recognition of the importance of personal contact among the various elements of the community in accordance with their cultural differences.

2. The following points should be taken into consideration with reference to educational methods and audio-visual materials to be used:

   (a) The objective to be attained.
   (b) The group toward which the methods and techniques are directed.
   (c) Communication media.
   (d) The type of presentation to be employed.
   (e) Interpretation by the public.
   (f) Plans for reviewing and changing the methods and materials used.

3. The following approaches may be used in the evaluation of educational methods and materials:

   (a) Inclusion of the community in preliminary testing.
   (b) Intensive tests and demonstrations in selected areas.
   (c) Questionnaires, personal interviews and other survey methods, with careful analysis of results.
   (d) Production of materials on a small scale for experimental purposes and evaluation of the results of production and use on a large scale.
Report of Work Group "B"

1. To awaken the interest of individuals or socio-cultural groups to their own welfare requires the application of step-by-step education. Psychological principles and methods must be employed in an objective and experimental manner in order to form healthful habits and modify or eradicate unhealthful habits. These methods should be adapted to the cultural pattern of the individual and to the specific problems involved.

Active participation by the individual in group discussions is essential in determining and solving the problems which concern him.

2. The following principles should serve as a guide in the selection, preparation and use of the various educational methods:

(a) The socio-cultural group on which such methods are to be used should be carefully defined, taking into account its understanding, beliefs and customs regarding the educational objective.

(b) The training, personality, and experience of the educator must also be taken into consideration.

(c) The scientific accuracy in the interpretation to the community of the problem to be solved and the procedures to be followed should be given careful attention.

3. Technical personnel in public health work should include an expert in audio-visual aids who can collaborate with other workers or agencies in the selection, preparation and use of health education materials.

4. Adequate low cost materials should be prepared for the health education program when so required, for example: silk screen posters, mimeographed leaflets, exhibits and slides.

5. To evaluate the effectiveness of the educational methods and materials employed, it is necessary to carry on systematic studies and analysis of the results obtained. Such evaluation will permit continuous adjustment of methods and materials to the actual local situation.

Report of Work Group "C"

1. Personal contact is of fundamental importance in an educational program and it may be said that the success of a health education program is in direct proportion to its use of this procedure. However, this Group is aware of the importance of other educational methods and their use in coordination with the personal approach.

2. Language is a part of a culture and it is important that educational methods conform in terminology with the understanding and culture of the different social groups of which the community is composed.
3. Weak points of some educational methods and techniques now in use are:

(a) An attempt to use in one country or area an educational method which has had good results in another country or area, without first considering the peculiarities and customs of the people with whom that particular method is employed.

(b) Relying exclusively upon certain materials.

(c) Insufficient economic support of the health education program.

4. This group therefore recommends:

(a) That the characters, illustrations and cultural environment portrayed in audio-visual materials be those of the culture in which they are to be used.

(b) That audio-visual materials be planned and produced in accordance with local economic possibilities.

(c) That other educational methods and techniques be employed.

5. With reference to the production of audio-visual materials, this Group discussed the possibility of recommending that the Pan American Sanitary Bureau produce educational films in accordance with the foregoing principles. However, after further discussion, it was decided instead to propose that each country produce its own audio-visual aids in the most economical manner (lantern slides, posters, etc.), in proportion to their economic possibilities.

6. Evaluation of health education programs should be constant, beginning with self-evaluation by the health educator and continuing through with the evaluation of the work done by other public health personnel. The long-term evaluation of the program shall include the public.

Report of Work Group “D”

1. In the application of psychological principles to encourage the adoption of favorable habits, attitudes, beliefs and customs, it is suggested that different approaches be used in dealing with the three following groups: well educated, with average education, with no educational advantages.

2. Programs directed toward the well educated group may feature statistics, facts and figures. A direct approach using such supporting facts will probably give the best results. Those who have had no education whatsoever should be approached in such a manner that they may be gradually persuaded to abandon certain beliefs and customs based on superstition. It is necessary to give them some accurate facts to take the place of the fixed ideas on which their old beliefs have been based. In
dealing with the latter group, it might be well to approach them with the theory that while their present customs and beliefs are good, the suggested new habits and attitudes, if tried, might prove to be better.

In substance, it is suggested that the psychological approach to the well-educated should be based on methods that are convincing; the approach to those with some education should include methods of persuasion and conviction; while the approach to those with no education at all should be based on methods of persuasion to adopt recommended habits and attitudes.

3. Community education cannot be accomplished from a desk. Those in charge of health education should be in personal contact with the individuals or groups which they are to educate. In selecting the educational methods to be used, it is necessary to consider the existing organization of the community, communication media, materials to be used, economic resources of the community and of the health department, and the personnel available for educational activities. The particular method employed may require either direct contact with the individual or groups, through "key persons", or some system of mass education in the more progressive communities.

In the opinion of this Work Group, a combination of all three approaches is recommended, with emphasis on the one that will give the best results in a given cultural environment. The educational level of the group concerned should be a determining factor in the selection, preparation, and use of the various educational methods. Distribution of printed material is ineffective in areas where the people are illiterate. In educational programs the language used should be at the level of the people for whom the program is intended.

4. The educational method selected should be designed to arouse and maintain the interest of the people in question and to make them feel that the program is theirs.

5. Health education activities are most effective in small groups, because of the greater opportunity provided for individual participation.

6. In preparing health education materials, the subject matter should be identifiable with actual situations in the everyday life of the people for whom the materials are intended. When selecting, preparing and using the various educational methods, careful consideration should be given to the local conditions, the educational background of the various individuals, the existing sanitary facilities, and the material resources available.

7. The strong points of a health education method are those which reflect due attention to the basic needs of the community and adaptation to local conditions. Weak points are those which indicate that the program has not been adapted to the needs of the community.
8. When planning and preparing audio-visual materials, the assistance of persons with training and experience in this field should be requested whenever such assistance is available.

9. All health education materials should be based on scientific facts. Other members of the health team, particularly available experts on the specific health problem involved, should collaborate in the preparation of these materials. It is necessary to consider the traditions, language, habits and other cultural factors of the people for whom the audio-visual material is intended.

10. Educational material should be regarded as an aid to the trained personnel and not as a substitute for the work of the educator.

11. Before widespread use is made of any illustrative material, it should be tested with various social groups in order to observe the effectiveness of the material. Such testing should be conducted with small groups. For greater economy, educational material should be produced in series and an effort should be made to convert purely visual material into audio-visual material. The possibilities of the health theatre as an economical audio-visual method should be explored.

12. The effectiveness of the health education materials employed may be evaluated as follows:

(a) Through questionnaires and individual or group interviews to find out whether the people have put into practice the ideas expressed in the educational materials.

(b) Through study of statistical reports to determine whether there has been a decrease in the morbidity rates of those diseases discussed in educational programs.

(c) By observing whether community resistance to the program has decreased. This could be evidenced in increased confidence, response and community support of the program, as manifested by the cooperation received from the community and the correction of undesirable habits.

**Summary of Work Group Reports**

1. To awaken the interest of individuals or socio-cultural groups to their own welfare requires the application of step-by-step education. Psychological principles and methods must be employed in an objective and experimental manner in order to form healthful habits and to modify or eradicate unhealthful habits. These methods should be adapted to the cultural pattern of the particular individual and to the specific problems involved.

   Active participation by the individual in group discussions is essential in determining and solving the problems which concern him.

2. It is most important that there be personal contact between health education personnel and individuals or groups interested in health
problems. It may be said that the success of a health education program is in proportion to the use of this method.

3. The factors and principles which should serve as a guide in the selection, preparation, and use of the various educational methods and materials are:

(a) A thorough knowledge of the socio-cultural group for which they are intended, taking into account their understanding, beliefs, and customs regarding the problem.
(b) Program objectives.
(c) Communication media.
(d) The education, personality, and experience of the person who will serve as educator.
(e) Presentation.
(f) The scientific accuracy in the interpretation of the problem to be solved and of the procedures to be used for its solution should be given special consideration.
(g) The facilities and material resources available.

The technical public health staff should include an expert in audio-visual aids who can collaborate with other workers or agencies in the selection, preparation, and use of health education materials.

4. It is recommended that adequate, economical material be prepared, for example: silk-screen posters, lantern slides, mimeographed leaflets, and exhibits. It is recommended that the Pan American Sanitary Bureau provide consultant services to these countries in the production of their own audio-visual materials. It is stressed that educational material should be used as an aid to the technical personnel and not as a substitute for the work of the educator.

5. The strong points of educational methods are those which respond adequately to the basic needs of the locality and which are adapted to local conditions.

The weak points in health education methods are those which are not adapted to the needs of the locality and to the peculiarities and customs of the community. Another weak point is the exclusive dependence upon certain materials.

6. To evaluate the effectiveness of educational methods and materials used in a program, it is necessary to study and evaluate at regular intervals the results obtained. This will permit a continuous adjustment of methods and materials to the actual local situation.
Chapter VII

HEALTH EDUCATION TRAINING OF PUBLIC HEALTH PERSONNEL.

This topic was discussed at the Fifth Plenary Session in a symposium composed of the medical director of a child welfare center, a public health administrator, an anthropologist, a health educator, a public health nurse, and a sanitary engineer.

The symposium discussion developed around a real-life situation involving the establishment of a rural health center in an area where:

(a) modern medical care and preventive medicine are relatively unknown;
(b) domestic medicine and quackery are widely practiced;
(c) language, customs, and standards are entirely different from those of the health center personnel.

In considering these and other problems which might develop later on this subject, the symposium members referred to principles established in previous plenary sessions. The need to include these principles in training programs was emphasized. In an exchange of ideas and experiences, the participants listed the immediate requirements of an in-service training program for the situation outlined above and then extended these recommendations to the broader needs of nation-wide training programs.

Through their presentation, they submitted to the Conference membership the following major questions which should be considered in planning a health education training program for full-time public health workers and other personnel in related fields.

1. What can be done to train personnel to work effectively in rural areas where the cultural pattern may greatly differ from that of the worker's background? Should separate training courses be established for rural and urban workers?

2. What steps can be taken towards creating among the local population a sense of responsibility for health education? To what extent can they be trained to do this work?

3. What can be done in the way of intensive studies by qualified persons who may give public health workers a true picture of the communities in which they will work? What are the possibilities of training persons who can render this service in each country?

4. What are the possibilities of introducing basic courses in the curricula of professional schools which would provide graduates with a
broader understanding of the sociological, economic, and general cultural aspects of the areas in which they will be employed?

5. What should be done and what can be done to strengthen health education aspects of present training in the various professions related to health?

6. Should training of auxiliary personnel in health education be limited to specific aspects of the program or to the whole program activity?

7. What should be done to direct training towards long-range permanent results rather than to short-term emergency measures which often fail to solve community problems?

8. Where training programs are not available within the country, what can be done to establish such programs? What can be done to modify some aspects of training in other countries which do not give the worker adequate preparation to adapt his training to his country's needs and resources?

9. To what extent should the community itself contribute to and participate in training programs of full-time and auxiliary public health personnel as well as of other personnel in related fields?

10. In view of the initial stage in which many health programs still are, should training be first directed toward educational aspects of therapeutics in order to create a more favorable atmosphere for preventive medicine campaigns which would logically follow?

11. In training health personnel, is there a tendency to think of health education in isolated terms, rather than to take advantage of the educational opportunities available to the doctor, the nurse and the sanitary engineer whenever they are performing a direct service to the individual?

12. When workers are sent abroad for health education training, is sufficient consideration given previously to the proposed programs so as to enable the student to acquire the knowledge needed in his country, or do the programs have to be adjusted later to conform to the knowledge acquired, which probably do not correspond to the country's needs and resources?

The Work Groups then met to consider these and other questions under this heading on the Conference agenda, and to prepare their reports.

Report of Work Group “A”

1. Health education training of personnel is fundamental in the development of health programs. Such training is necessary at all levels—national, regional and local. Training opportunities at the national level are offered:
(a) At teachers' colleges, where teachers should be made aware of their potential role in imparting health education through courses in methods and techniques;

(b) In field work, where training should be continuous to permit putting into practice the knowledge thus acquired.

2. The educational principles applicable to public health education programs should also be applicable to health education training of both professional public health workers and workers in related fields. Some of these are:

(a) The need to ascertain the beliefs, practices and attitudes, regarding health, of the workers to be trained.

(b) Those in charge of the training should themselves be members of a group or team, in order that the training may be coordinated with and adapted to the over-all program.

(c) The personnel receiving the training should participate in the planning of health programs in order to acquaint themselves with their country’s specific needs.

(d) The educational methods, techniques, and materials should vary in accordance with the educational level of the personnel and the specific tasks for which they are being trained. All available resources should be used in the training program.

3. To apply the foregoing principles, it is suggested that:

(a) A training committee be appointed, composed of representatives from the various organizations and agencies, to study the training needs and plan the necessary programs in accordance with the principles stated under section 2 of this report;

(b) The curricula of the various professional institutions be revised to include better training methods and techniques in health education;

(c) Courses in health education be included in the educational programs of the various agencies concerned with community improvement;

(d) A fellowship plan be established to permit for specialized training in health education;

(e) Personnel trained in health education, devoting full time to this activity, receive adequate compensation and be assigned to positions where they may be able to apply their special training.

Report of Work Group “B”

1. The main objective of health education is to arouse social interest toward the improvement of community sanitation. Since sanitation is an important problem in rural areas, students of engineering and architecture should receive some training in public health and be briefed on the cultural characteristics of the community in order that they may be
able to cooperate with public health personnel in the development of community health programs.

2. The training of public health personnel should include at least a study of:

   (a) the cultural characteristics of the community;
   (b) the public health problems of the locality;
   (c) the educational principles which are applicable in program development.

3. In view of the far reaching importance of environmental sanitation, it is recommended that all public health personnel develop an educational attitude toward the solution of this serious problem.

4. It is recommended that every effort be made toward the coordinated and continuous training of public health personnel, particularly of the health educator or auxiliary health educator with limited preparation, in order that they may perform their work effectively.

5. To work effectively, the health educator should have a general knowledge of cultural anthropology and of the various cultures which exist in his country.

6. In addition, the health educator should have a knowledge of psychological and pedagogical principles to enable him to serve as an educator; he should also have a knowledge of public health principles and problems and of health education methods and techniques. In view of the fact that there is a limited number of cultural anthropologists with professional training, it is recommended that directors of health programs consider the training of specialists in this field in order that they may serve as consultants to the program.

Report of Work Group “C”

1. The need to include courses on health education in the curricula of professional schools is recognized. It is recommended that the curricula be revised in order to provide practical training in health education and that these activities of the educational institutions be coordinated with those of the Department of Public Health.

2. Cultural anthropology contributes with its study of communities and is one of the liaison elements between the community and the public health workers, and permits the planning of public health programs in accordance with the cultural situations encountered.

3. It is recognized that the health center staff should include professional health educators who should extend their services to the teaching centers.

4. This group is not in a position to evaluate the facilities available in each country for the training of public health personnel, but it recom-
mends that training programs for teachers, extension agents and others be strengthened.

Report of Work Group “D”

1. Public Health workers at all levels should be well-trained in health education since their work is basically educational. They should not limit their efforts to the different technical aspects of their work, but promote health education principles which, generally speaking, do more to raise the health level of the given area than sanitary measures applied through coercion.

2. The possibilities for training public health personnel at the different levels depend on the enthusiasm and support given by those in charge of the program at these levels. It is recommended that these key officials coordinate training plans in order that these may complement one another at the different levels. In this way, public health personnel can assume the responsibility for health education which is inherent in their work.

3. Among the acceptable possibilities for health education training of public health personnel, the following might be considered:

   (a) Health education training courses in official institutions organized for public health training.

   (b) Field training programs in places where the principles of health education are actually being applied and where such courses will be available to the public health worker at different levels.

4. Full-time health education personnel is needed to coordinate the activities of all the members of the public health team.

5. A diploma from a teachers’ college should be a minimum requirement for persons desiring to specialize in health education and it should be to their advantage to have had at least two years of actual teaching practice. In order that the health educator may serve effectively in coordinating the health education activities of the various agencies or persons working in community programs, he should have some basic training in principles of public health, psychology, sociology and anthropology.

6. For the development of any activity in the field of social improvement, it is necessary to strengthen the programs of health education training for teachers and others. The effectiveness of a community improvement program will depend upon the way in which such training is planned and developed.

7. Two basic aspects are involved in a training program:
(a) Professional training which includes specific programs on health education in the curricula of Normal Schools, Nursing Schools, Schools of Agriculture, and other training centers.

(b) Regular in-service training courses for teachers, nurses, social workers, etc.

Either type of training should conform to the needs and problems of the communities or areas where the training takes place or where a health education program will be developed. The training program should include, besides theory, field training under the supervision of an experienced health educator.

Summary of Work Group Reports

1. It is recommended that efforts be directed to the continuous, coordinated training of public health personnel in order that they may perform their duties satisfactorily. Preference should be given to the training of health educators and to limited training of auxiliary health educators in accordance with the needs and cultural characteristics of the area.

2. It is recommended that a candidate for health education training, in addition to a basic knowledge of anthropology, psychology and pedagogy that will enable him to work effectively as an educator, should have a knowledge of the basic principles of public health.

3. Emphasis is placed on the need to strengthen the health education training programs for teachers, extension service workers, and others.

4. The anthropologists' study of the communities constitutes a link between the community and the public health technician, which permits the latter to plan the programs in accordance with the cultural pattern. It is recommended that the directors of public health programs promote the training of specialists in anthropology to serve as consultants.

5. It is recommended that the professional health educator work full time in this activity, that he receive adequate remuneration, and that he be placed in positions where he may best apply the principles of health education. In addition, the desirability of obtaining fellowships from local or international organizations for professional training in health education is emphasized.
Chapter VIII

FINAL CONCLUSIONS AND RECOMMENDATIONS

The final Plenary Session of the Conference, on Wednesday, 30 September, was devoted to the study and consideration of the joint reports, conclusions and recommendations, as prepared by the Conference Editorial Committee. This Committee was composed of representatives elected by their respective Work Groups. (See Appendix C, p. 64.)

At the opening of the final Plenary Session each participant received copies of the joint reports and the Conference membership discussed the details of the summaries presented. Unfortunately, space does not permit for a detailed report of the interesting and gratifying discussions which took place in this meeting, but only for a record of the conclusions and recommendations of the Conference, which represent the principles accepted by the entire Conference membership, as amended and approved at the final Plenary Session. These basic principles, in summarized form, are included in this chapter.

It shall be noted that the Conference membership voted to change the title of Topic 4 of the Conference discussion from Training of Public Health Personnel and Related Personnel to read Training of Public Health Personnel in Health Education.

These and all other changes suggested by the assembly have been incorporated in the joint reports appearing elsewhere in this chapter.

Recommendations and Resolutions

Following approval of the joint reports as amended, opportunity was provided for special recommendations and resolutions from the floor.

The Costa Rican Delegation proposed the organization of a Society of Health Educators with representatives to be designated by the Ministry of Health in the various countries. The Conference decided that, since it was not empowered to make specific recommendations to the participating governments in this manner, a vote of acquiescence be given the proposal expressing the hope that all delegations present might work toward ideals similar to those expressed by the Costa Rican Delegation.

The Nicaraguan Delegation then moved that the Pan American Sanitary Bureau sponsor health education training centers. Following some discussion by the Conference membership, Drs. Pedro Daniel Martínez and J. Pilar Hernández Lira, of Mexico, were appointed by
the Chairman to draft a recommendation which would express the Conference opinion on this proposal. This recommendation, as prepared by the committee and approved by the Conference, appears as Special Recommendation No. 2 in Appendix A, p. 59.

At the Second Plenary Session the Cuban Delegation had proposed that the Conference draw up a set of principles which would confirm the need for and importance of health education. The Conference had voted at that time in favor of the appointment of a committee to work with the delegation in the drafting of such a set of principles. At this final session, the statement which had been prepared was read and approved by the Conference and appears in this report as Special Resolution No. 1 in Appendix A, p. 59.

At this final session, the Cuban Delegation moved that the Conference express thanks to all individuals, agencies, organizations, and corporations which had contributed toward the planning and presentation of the Conference. This motion was unanimously approved by the Conference membership and appears in final form as Special Resolution No. 2 in Appendix A. A similar motion, proposed by the Haitian Delegation and approved by the Conference, appears as Special Resolution No. 3, Appendix A, p. 61.

Formal Closure of the Conference

This first Regional Health Education Conference for the Americas came to a close at 1:30 P.M., Wednesday, 30 September. Dr. Manuel E. Pesqueira, Under Secretary of Health and Welfare of Mexico, presided at the Closing Plenary Session and addressed the Delegates as follows:

Members of the Conference: we have concluded the work planned for this meeting, for the success of which you have all contributed your warm enthusiasm. We hope that the results of this meeting will be of benefit to the different countries here represented and that this Conference will be the forerunner of other meetings with neighboring countries that will inspire a rededication to the work of finding solutions to our common problems. I thank you for your presence here and for the work you have accomplished, and hope that your stay in our country has been enjoyable. On behalf of Dr. Ignacio Morones Prieto, who regrets having been unable to be with you today, I declare this Regional Health Education Conference ended.
Joint Work Group Reports Prepared by the Conference Editorial Committee

(As amended and approved by the Conference in the Final Plenary Session)

PLANNING AND DEVELOPMENT OF LOCAL HEALTH EDUCATION ACTIVITIES

1. Definition: Health education is the process by which habits and attitudes favorable to the improvement of health are developed in the individual and in the community.

2. Objectives: The long-range objective of health education is the improvement of living conditions in the community in their physical, social, and emotional aspects through the readjustment, based on scientific principles, of the community’s cultural standards. The immediate objective is that of obtaining community understanding of a definite health program and active community participation in the development of such a program.

3. Planning and development: When planning a health education program, not only the technical requirements of the health problems involved but also the community’s viewpoint concerning these problems should be taken into account in order to ensure community participation in the planning and implementation of the program. It must be emphasized that the imposition of programs constitutes one of the most serious and most frequent mistakes.

When planning health education activities at the local level, the following points should be taken into consideration:

(a) Individuals and official or private organizations, having influence over the various community groups, should be trained and utilized in the development of health education programs.

(b) Health education must be adapted to the needs, interests, customs, and possibilities for community improvement.

(c) The health education program should be planned by the local public health team in collaboration with the community, without infringing upon regional and national programs.

(d) In the development of health education programs, the coordination of all official or private agencies interested in community improvement should be encouraged.

(e) Priorities should be determined and specific objectives established for the plan of activities in accordance with the public health programs already in effect.

(f) The methods employed in the periodic evaluation of the health education program should be planned in advance.

(g) Health education should reach all age-groups of the population.
(h) Health education programs should be an integral part of the general public health program and should not be planned independently of those programs as it has been observed in some cases.

Recommendations

1. That the countries participating in this Conference establish periodical meetings of public health personnel, in order that they may become familiar with and participate in the over-all public health program, and be able to coordinate their activities.

2. That in order to develop health education programs, organizations in the community be utilized or the development of such organizations be encouraged. The success of the program will depend upon mutual respect, understanding, and cooperation among these groups.

3. That all public workers take an active part in health education.

4. That every public health program should have adequate funds allotted in the budget for the effective development of health education activities.

Teamwork and Coordination in Health Education

1. Coordination is understood to be the process by which members of a public health team join in principle and action with the community and combine their activities in an effort to achieve a definite objective. Therefore, it is essential that the efforts of all participants be united toward the promotion of educational activities.

2. The immediate objective of coordination is the achievement of maximum results from available human and material resources in the development of an educational program. The long-term objective is the incorporation of this program in the entire plan for individual and community improvement.

3. Every public health worker should recognize that in order for his work to be effective it must be complemented by educational activity which should conform to the educational program established in his community.

4. Teachers play an important role in health education programs because they are in a position to promote healthful habits and attitudes. It is necessary that all teachers and other persons working in community improvement programs be aware of the needs and interests of the community and be acquainted with its health program.

5. The principles and methods necessary for achieving teamwork and cooperation among public health workers may be summarized as follows:
All personnel should take part in the planning and development of the activity program for the purpose of promoting individual and group understanding, active participation, and a sense of responsibility.

6. In order to obtain the greatest possible collaboration from persons and organizations working in Agriculture, Education, Public Works, etc., it is necessary:

(a) To request the participation of such persons and organizations in the planning and implementation of plans and programs on the national as well as the local levels.

(b) To provide for the interchange of information among the participants regarding their respective activities.

(c) To hold regular meetings at the local level and, if possible, at the national level, in order that public health personnel and participants from other agencies may be able to evaluate the results obtained and plan future activities.

7. The principal role and responsibilities of full-time health education personnel may be defined as follows:

The main contribution of the health educator, as a specialist in health education principles and methods, is to cooperate, within the possibilities and needs of the staff and the community, in making more effective the educational aspects of the work of the public health team.

**METHODS AND MATERIALS IN HEALTH EDUCATION**

1. With reference to health education methods and materials, the following principles are fundamental:

(a) The methods should be adjusted to the cultural and psychological characteristics of the individual and the community in which these will be used.

(b) Motivation should be based on the needs and interests of the community to attain healthful behavior.

(c) Interest must be maintained in the behavior patterns referred to in (b).

(d) Active community participation should be secured in determining and solving problems affecting the community.

2. To ensure the success of the health education methods used, personal contact is essential to establish a basis of mutual understanding and confidence between the health educator and the community. It may be said that the success of a health education program depends upon the extent of the personal approach.

3. Among the factors which should serve as a guide in the selection, preparation and use of different educational methods, special consideration should be given to the personality of the health educator, the terminology used, and the need to avoid dogmatic attitudes.

4. In order that the educational program may be most effective it
should be worked out through small groups because of the opportunities it provides for active individual participation.

5. It is recommended that audio-visual aids be used only as an auxiliary to trained personnel and not as a substitute for the work of the educator.

6. All audio-visual material should be developed in collaboration with representative persons of the community in order that the materials may be understood by the community.

7. It is recommended that particular effort be made to produce educational materials which are realistic, stimulating, and sufficiently economical to permit for continued production.

8. It is recommended that before educational materials are used they should be tested on various socio-cultural groups of the community. Subsequently, a systematic evaluation should be made of the results obtained.

HEALTH EDUCATION TRAINING OF PUBLIC HEALTH PERSONNEL

1. For a better understanding of and cooperation with health education programs the training of persons directly or indirectly involved in public health programs should require:

(a) That the Schools of Medicine, Engineering, Nursing, Agriculture, Architecture, Social Work, Normal Schools, and other educational centers develop in their students a positive attitude toward health, based on accurate knowledge of the social, cultural, and environmental characteristics of their communities.

(b) That public health personnel receive basic instruction on the principles of cultural anthropology, psychology, and pedagogy, which are deemed necessary for more effective participation in health education activities.

(c) That to make effective the recommendations in the preceding paragraphs (a) and (b), the directors of public health programs consult with those persons experienced in the methods of socio-cultural studies. In those countries where this assistance is not available, the professional training of such persons to serve as consultants to the program should be encouraged.

(d) That training programs for public health personnel be continuous in order to keep pace with scientific developments and social changes.

2. The extensive training of the health education specialist should include a sound knowledge of cultural anthropology, psychology, pedagogy, and biological sciences. Furthermore, he should keep abreast of current developments on these subjects and of social changes in order that he may understand the various social groups and be better able to work as a promotor and guide.

In view of the responsibilities implied in all the above recommendations, it is evident that the health educator should be employed on a full-time basis.
Appendix A

SPECIAL RECOMMENDATIONS AND RESOLUTIONS

SPECIAL RECOMMENDATION No. 1

WHEREAS the primary objective of a Health Education Program is that of improving the health of the individual and of the community.

IT IS RECOMMENDED that, with regard to the problem of charlatanism, the community be guided and instructed in accordance with the local situation and with the health laws and regulations of the country.

(Approved at the Fourth Plenary Session on 25 September, 1953.)

SPECIAL RECOMMENDATION No. 2

The Conference recommends that the participating delegations stimulate their respective governments, as members of the Pan American Sanitary Bureau, to promote through that organization the need to utilize all material resources for training in health education.

(Approved at the Final Plenary Session, 30 September, 1953.)

SPECIAL RESOLUTION No. 1

WHEREAS health education is a process which consists of developing in the individual and in the community habits and attitudes favorable to health;

It is accepted that community recognition of the principal health problems is a basis for the introduction of health education; and

It is well known that the major health problem confronting our countries is that of contamination of the environment,

THEREFORE the Cuban Delegation invited to this Regional Health Education Conference submits to the consideration of this Plenary Session for study and approval the following

MOTION

That the Regional Health Education Conference, held in Mexico City from September 18 to 30, 1953, recommend to all those working in health education in the participating countries that they specifically concentrate their educational efforts on the importance that environmental sanitation has in raising the health level. That in their educational activities they use all available means to inculcate in the people the conviction that the best way to help improve their health is to carry out their activities in sanitary surroundings.

By the Delegation of the Republic of Cuba

(signed) Dr. Aníbal Herrera y Franchi de Alfaro
Civil Engineer Juan Luis Radelat Olivé
SPECIAL RESOLUTION NO. 2

WHEREAS a perfect coordination has been observed in all aspects of this Regional Health Education Conference;

The Regional Health Education Conference has received full cooperation from all officials, institutions, associations, the press, etc.; and

In this Regional Health Education Conference the documents and materials have reached the delegates in a rapid and efficient manner,

THEREFORE the Delegation of the Republic of Cuba invited to this Conference proposes to this Plenary Session for study and approve the following

MOTION

That the delegates to the Regional Health Education Conference, gathered in Plenary Session, extend:

First: A vote of congratulation to the Organizing Committee of the Regional Health Education Conference.

Second: That the Regional Health Education Conference express its appreciation to—

His Excellency, don Adolfo Ruiz Cortines, President of the United States of Mexico;
The Honorable Minister of Foreign Relations;
The Honorable Minister of Health and Welfare;
The Director General of the Institute of Social Security of Mexico;
The Director of Public Relations of the National University of Mexico;
The members of the Mexican Delegation and the Chiefs of the Rural Social Welfare Program;
The Public Health authorities of the Federal District of Mexico;
The School of Public Health of Mexico;
The Director of the Inter-American Cooperative Public Health Service;
The officials of the Ministry of Foreign Affairs and the Ministry of Health and Welfare of Mexico, as well as to the personnel of the National University which has facilitated the work of the Conference;
The State and Municipal authorities of the State of Morelos and to their public health officials;
The Mexican Public Health Association;
The press, radio, and television of Mexico;
The Directors and personnel of the Pan American Sanitary
Bureau and of the World Health Organization;  
The Director of the Institute of Inter-American Affairs.

Third: A vote of thanks to all the personnel of the Regional Health Education Conference for their efficient work.

By the Delegation of Cuba

(signed) Dr. Aníbal Herrera y Franchi de Alfaro  
Civil Engineer Juan Radelat Olivé

Special Resolution No. 3

WHEREAS this Conference has been made possible through the whole-hearted cooperation of all governments, organizations, and agencies which have taken part or contributed to it, and

The work of the Conference has been made particularly effective through the efficient and consistently excellent work of the Conference personnel, particularly those who have been responsible for interpretation and translation and for the preparation of documents,

THEREFORE the Delegation of the Republic of Haiti proposes the following

MOTION

That the membership of the Regional Health Education Conference go on record officially as being most appreciative of the efforts of the sponsoring organizations, cooperating elements, and Conference personnel which have been a real contribution to the success of this meeting.

By the Delegation of Haiti

(signed) Dr. Sherer Adrien Dr. Marc Fleurant  
Mr. Vales Jean-Louis
Appendix B

TENTATIVE GROUPING OF TOPICS FOR DISCUSSION

1. Planning and Development of Local Health Education Activities.— An Important Focal Point

1.1 Nature and scope of health education objectives (immediate and long-range).

1.2 How can the health needs known to health authorities and staff be brought into harmony with the needs as recognized by the people?

1.3 How to determine the health needs and interests of people in any given community.

1.4 What are some of the priority health problems requiring educational methods for their solution, e.g. food problems, intestinal parasites, tuberculosis, malaria, environmental sanitation, etc.?

1.5 How do cultural factors affect community recognition of needs?

1.6 How can health education be carried out at different levels of the social structure in a given community?

1.7 Principles and methods involved in enlisting individual and community participation, approach through key people.

1.8 What can be done to demonstrate health education through work in a definite area rather than on a nation-wide scale?

1.9 What can be done to strengthen health education activities in local areas with at least minimal health services. What can be done in areas lacking health services?

1.10 Toward which age groups of the population is it most useful to direct health education?

1.11 What is the role of health education in fundamental education?

1.12 What are some of the principal administrative, technical, financial, and related considerations involved in strengthening both local and national activities in education for better health?

1.13 What is a good balance and distribution of activities in health education?

2. Teamwork and Integration in Health Education

2.1 Immediate and long-range objectives.

2.2 Role and responsibilities in health education of various health personnel.

2.3 Role and responsibilities in health education of teachers,
extension workers, and others whose work brings them in contact with the population.

2.4 Integration of health education developments with the needs and services of the total health program.

2.5 Principles and methods for fostering educational teamwork and integration among workers of the health team.

2.6 Recognizing that health is of vital importance in dealing with people, what can be done to extend the contributions to be made by individuals and agencies engaged in Agriculture, Education, Labor and Industry, Public Work, Social Welfare and others?

2.7 Principal roles and responsibilities of full-time workers in health education.

3.—Methods and Materials in Health Education

3.1 What psychological principles are involved in encouraging people to adopt desirable attitudes, beliefs, habits and practices?

3.2 The importance of personal contact with the individual, families, key leaders, and community. The importance of recognizing local variations and environmental factors.

3.3 Guiding principles involved in development, selection and use of various educational methods.

3.4 The strengths and weaknesses of various educational methods used most often in current programs.

3.5 Selected guiding principles involved in planning, development and use of various illustrative and audio-visual materials.

3.6 What are some possibilities for planning, production and use of more economical and suitable educational aids and materials?

3.7 What are the possibilities for testing and evaluating the effectiveness of the educational methods and the illustrative material used?

4.—Personnel Training Needs and Requirements

4.1 What are the needs and possibilities for training health personnel at various levels for their functions and responsibilities in health education?

4.2 Need for and training requirements of full-time personnel in health education.

4.3 Needs and possibilities for strengthening training programs in health education for school personnel, extension workers, and others.
Appendix C

Section I—Membership of the four Work Groups

Section II—Work Group Chairmen and Rapporteurs for the four Conference Topics

Section III—Editorial Committee

SECTION I

Work Group A

Aguirre Beltrán, Dr. Gonzalo
Beleño C., Mr. Guillermo E.
Clark, Dr. Sidney B.
Echevers, Mr. José del Carmen
Hernández Lira, Dr. J. Pilar
Herrera, Miss Estela
Herrera y Franchi de Alfaro, Dr. Aníbal
Kraft, Miss Mary Jo
Leija Paz de Ortiz, Dr. Emilia
Pareja, Dr. Víctor M.
Pitererella, Miss Jeanette
Ugarte, Mrs. Mary B.
Ureña Hernández, Dr. Luis
Vallecciillo, Dr. Gaspar
Vargas Méndez, Dr. Oscar

Work Group B

Adams, Dr. Richard
Cuervo Ramírez, Prof. Tomás
Dormoi, Mr. Felix A.
Duncan, Mrs. Silvia de
Hayes, Dr. Guy
León, Dr. Mario
Martikainen, Miss A. Helen
Martínez, Dr. Pedro Daniel
Palacios Macedo, Dr. José
Pesqueira, Dr. Manuel E.
Samamé, Dr. Guillermo E.
Sanley Gómez, Mr. Salvador
Sevilla Sacasa, Dr. Alberto
Sojo Arias, Mr. Germán
Zepeda, Dr. Jorge E.

Work Group C

Acuña, Dr. Héctor
Adrien, Dr. Sherer
Bissot, Jr., Dr. Alberto
Carrillo, Miss Graciela
Cofiño U., Dr. Ernesto
Craig, Mr. Norman
Drobny, Dr. Abraham
González Regalado y Acea, Dr. Gabriel
Hardison, Dr. Alonzo E.
Jean-Louis, Mr. Vales
Kelly, Dr. Isabel
López Fuentes, Ing. Carlos
Loyo Díaz, Dr. Mauro
Lozier, Miss Hilda
Peralta, Dr. Ricardo J.
Rost, Mr. William

Work Group D

Arias Chávez, Mr. Edgar
Carías, Prof. Filomena
Carranza, Miss Ligia
Cortés, Miss Aura Leyda
Farnsworth, Dr. Stanford F.
Fleurant, Dr. Marc
Glinz, Miss Margarita
Hall, Mrs. Ivy

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Lube, Miss Catalina
Márquez Escobedo, Dr. Manuel B.
Pinto, Dr. Luis Emilio
Pruneda, Dr. Alfonso
Quesada, Dr. Rodrigo
Radelat Olivé, Ing. Juan Luis
Smith, Dr. George G.
Sola Mendoza, Dr. Juan
Villaseñor, Dr. Federico

SECTION II

Work Group Chairmen and Rapporteurs

Topic 1—Planning and Development of Local Health Education Activities
Work Group A—Chairman: Dr. Luis Ureña Hernández
Rapporteur: Dr. Emilia Leija Paz de Ortiz
Work Group B—Chairman: Dr. Jorge E. Zepeda
Rapporteur: Dr. Mario León
Work Group C—Chairman: Dr. Alberto Bissot, Jr.
Rapporteur: Miss Graciela Carrillo
Assistant Rapporteur: Mr. Norman Craig
Work Group D—Chairman: Dr. Manuel B. Márquez Escobedo
Rapporteur: Miss Catalina Lube
Assistant Rapporteur: Dr. Rodrigo Quesada

Topic 2—Teamwork and Coordination in Health Education
Work Group A—Chairman: Dr. Luis Ureña Hernández
Rapporteur: Dr. Emilia Leija Paz de Ortiz
Assistant Rapporteur: Dr. Aníbal Herrera y Franchi de Alfaro
Work Group B—Chairman: Dr. Jorge E. Zepeda
Rapporteur: Mrs. Silvia de Duncan
Work Group C—Chairman: Dr. Ernesto Cofiño U.
Rapporteur: Miss Hilda Lozier
Assistant Rapporteur: Dr. Gabriel González Regalado y Acea
Work Group D—Chairman: Dr. Manuel B. Márquez Escobedo
Rapporteur: Miss Catalina Lube
Assistant Rapporteur: Dr. Rodrigo Quesada

Topic 3—Methods and Materials in Health Education
Work Group A—Chairman: Dr. Luis Ureña Hernández
Rapporteur: Dr. Emilia Leija Paz de Ortiz
Assistant Rapporteur: Dr. Aníbal Herrera y Franchi de Alfaro
Work Group B—Chairman: Dr. Jorge E. Zepeda
Rapporteur: Mr. Félix A. Dormoi
Work Group C—Chairman: Dr. Ricardo J. Peralta
Rapporteur: Dr. Héctor Acuña
Assistant Rapporteur: Dr. Isabel Kelly
Work Group D—Chairman: Dr. Manuel B. Márquez Escobedo
Rapporteur: Dr. Rodrigo Quesada
Assistant Rapporteur: Miss Ligia Carranza
Topic 4—Health Education Training of Public Health Personnel

Work Group A—Chairman: Dr. Luis Ureña Hernández
   Rapporteur: Dr. Emilia Leija Paz de Ortiz
   Assistant Rapporteur: Dr. Aníbal Herrera y Franchi de Alfaro

Work Group B—Chairman: Dr. Jorge E. Zepeda
   Rapporteur: Mr. Germán Sojo Arias

Work Group C—Chairman: Dr. Sherer Adrien
   Rapporteur: Ing. Carlos López Fuentes
   Assistant Rapporteur: Mr. William Rost

Work Group D—Chairman: Dr. Manuel B. Márquez Escobedo
   Rapporteur: Dr. Rodrigo Quesada

SECTION III

Editorial Committee

Work Group A—Dr. Aníbal Herrera y Franchi de Alfaro
   Dr. Oscar Vargas Méndez

Work Group B—Dr. Pedro Daniel Martínez

Work Group C—Dr. Ricardo J. Peralta (Chairman)

Work Group D—Dr. Manuel B. Márquez Escobedo
   (Dr. Héctor Acuña, Work Group C—assisted in the absence of the representatives of Group A)