CHANGING CONCEPTS IN PUBLIC HEALTH EDUCATION*

LUCY S. MORGAN AND EUNICE N. TYLER

Determination of the exact events leading to the origin of any social movement is difficult; with public health education those factors which set the wheels in motion are hard to identify. In the late nineteenth century, schools in widely scattered areas introduced the first meager courses in physical education, home economics, and in an understanding of the evils of alcohol and narcotics. At the same time a few health departments began the superficial inspection of school buildings and medical inspection of school children;[15] and New York State prepared its first health pamphlets.[7] It is a far cry from this to the modern concept of a total health education program, and the intervening years are crowded with accounts of new activities, from the first groping steps of a few far-sighted individuals to the extensive programs under development at the present time.

Looking back on the period of exploration certain landmarks can be readily identified. In the early twentieth century, the organization of the National Tuberculosis Association with education as one of its major objectives,[8] the employment of the first school nurse in New York City,[15] and the inclusion of a school principal, in the city of Baltimore, as a member of the nurse-physician team to plan for the health of the school child,[9] stand out as major accomplishments.

Tragedy is too often the immediate stimulus for scientific or social progress, and when medical examinations for the armed forces in World War I trained a search-light upon the poor health of American youth, they undoubtedly influenced the development of the child health movement. In any event, the following years brought increased interest in this field. Almost immediately the Child Health Organization was formed,[9] and the National Education Association adopted health as one of its cardinal principles.[1] The term "health education" was also conceived at this time,[9] and during the following decade major emphasis continued to be placed upon school health education, accompanied by

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* From the Department of Public Health Education, School of Public Health, University of North Carolina, Chapel Hill, N. C.

a growing concern for tools and materials among both voluntary and official health agencies.

Interest in health education was increasing on all sides, but there was little opportunity for workers in this field to get together until a Health Education and Publicity Section in the American Public Health Association was organized in 1922.[14] This was a landmark in the history of the movement. Another major step was taken with the initiation of a series of nine Health Education Institutes, held prior to each annual meeting of the Association from 1934 through 1942.[6] During this period the Institute, which might serve as a barometer for the field in general, devoted major emphasis to the development, use, and evaluation of tools and materials. The last Institute, however, with its theme "Community Organization for Health Education," forecast a new trend, the signs of which had been visible, in a few scattered areas, during the previous decade.

The origin of community organization is as old as man himself, but it was not until the early 1930's that consideration was given to adapting such organization to the needs of the relatively new field of health education. Early men had found it imperative to live and work together in order to survive. Organization was vital, as it was in the later development of government, religion, health, welfare, industry, agriculture, education, and other aspects of community life. Until 1930, health education was comparatively untouched by the work of these varied groups, but at this time an idea evolved which was to have a tremendous influence on the development of the field itself, and which later enabled health education to become a working partner in the larger movement of community organization. The staff associated with the demonstration, sponsored by The Commonwealth Fund at the University of Tennessee, pointed to the need for a person well trained in public health and education in each county in the State to work with the schools, the health department, and the community.[11] Thus a new concept of health education began to take form and a new type of worker appeared on the distant horizon.

Between 1931 and 1941 many landmarks could be cited which indicate a growing interest in community organization for health education. Health Guilds were started in Michigan in 1933[3] to make health education available to people who were not "joiners." The first local health co-ordinator was employed in Tennessee in 1935.[11] In 1937 the American Public Health Association appointed the Committee on

Community Organization for Health Education. This committee investigated pioneer developments and prepared an outstanding report, published in 1941, which served as a guide and stimulus to future programs.[2] District Health Committees were started in 1937 in New York City, organized by the Committee on Neighborhood Development.[4] In 1938 a community health education program was initiated in Hartford, Connecticut, under the joint sponsorship of the Hartford Tuberculosis and Public Health Society and the Hartford Board of Health, and guided by a person well trained in public health and education. This program included careful analysis of the problems, training of leaders, co-ordination of agencies involved, organization of lay committees, setting up of short- and long-range objectives, and evaluation.[13] Around 1941 the Boston City Health Department began to add to its staff health educators who had graduate degrees in both health and education.[5]

In mid-1941, a program was started which brought immediate and far-reaching results. The United States Public Health Service assigned a Health Education Consultant to the North Carolina State Board of Health to explore the possibilities of developing a general, community-wide health education program in a defense area. Cumberland County was selected by the State and the Consultant was loaned to the County Health Department in Fayetteville. By May, 1942, the success of this project had prompted the Public Health Service to add four more Health Education Consultants to its staff. All were temporarily loaned to North Carolina and assigned to county health departments in defense areas.[12]

The most outstanding and unique feature of the Public Health Service demonstrations was the use of the block-type organization. This method was developed prior to the establishment of the nation-wide Citizens' Service Corps and was used to make health education available to all the people. More than this, it was a *two-way* channel through which flowed ideas and actions, the results of the joint thinking, planning, and programs of professional workers, lay leaders, and the people. New leadership developed as provision was made, not only for organized groups, but for *every* person in the community to participate. All of these community-wide demonstrations were of the "grass-roots" type, based on a belief in the value and importance of each individual, regardless of color, creed, or position, and on a belief that each had something to contribute. Each program began with a study of local

problems and resources. The health educator assisted both lay and professional groups to make plans, to take action for the solution of the problems, to appraise the results, and to decide upon future steps.

Although the opportunity for all people to take part existed, only a few were ready to take advantage of it. The majority were inexperienced in working and thinking together. They needed help, "moral support," stimulation, and practice. With these aids they did remarkably well. They began to see what they themselves could accomplish, but they lacked confidence. Experience in the demonstrations pointed to the fact that in any such program continued guidance and assistance are essential; that progress will be faster if guidance comes from the same individual; that with such help there is no question but that the people themselves will assume greater responsibility for leadership; that the assistance can and must be withdrawn as fast as this occurs; that the democratic method is slow but gains momentum with use and is fast in an emergency; and, finally, that the democratic method is the only sound approach to a total health education program.[16]

Since 1941 the North Carolina program has grown steadily, and at the present time there are thirty-four well-qualified health educators at work in the State. Locally ten are employed by health departments and two by voluntary agencies; eight are paid for jointly by the health department and the department of education or a voluntary agency; and two are teaching in local school systems. On the state level, four are with the Board of Health. Two are employed jointly by the Board of Health and the Department of Public Instruction, and one is employed by a voluntary agency. Five are teaching in colleges or universities, one of these is employed jointly by the health department and the college; and by September, 1947, it is expected that there will be forty-five well-qualified health educators working in various agencies throughout the State.

An important factor in the development of the total health education program in North Carolina was the organization, in 1942, of a graduate curriculum for training health educators in the School of Public Health at the University. This curriculum differed from those previously offered in Schools of Public Health in that one quarter of supervised field work was required for the Master's degree in addition to the usual three quarters of academic work, and graduate credit was given for the field quarter. In 1945 a similar curriculum for training

Negro health educators was begun at the North Carolina College for Negroes in Durham and is now in its second year of successful operation.

In the five years since the beginning of the pilot project the growth of this type of program has been phenomenal. By March, 1943, Oklahoma and South Carolina had each borrowed a Health Education Consultant from the Public Health Service and had initiated programs similar to those under development in North Carolina. Illinois, Indiana, Tennessee, Mississippi, and Louisiana soon joined the movement, and by 1945, California, West Virginia, Washington, Canada, and Puerto Rico also had programs under way.

The Puerto Rican program, more than any of the others under development at the present time, demonstrates the newer and broader concept of a "total health education program." While this project was initiated in January, 1944, by a Health Education Consultant loaned by the United States Public Health Service to the Insular Health Department, it soon came to include many of the other agencies that were concerned with health problems.

Through joint planning a comprehensive island-wide program has evolved in which the Department of Education, the University of Puerto Rico, the School of Tropical Medicine, the Polytechnic Institute of Puerto Rico, the Farm Security Administration, the Agricultural Extension Service, the Puerto Rican Department of Labor, and the Insular Health Department are all partners.

The over-all plan, already partially in operation, provides for: the training of forty-three health educators in schools of public health in the United States; the placement of the workers as consultants and teachers in the agencies listed above; the development of in-service and pre-service training programs for personnel in the health and education departments in Puerto Rico; and an island-wide action program in health and education designed to reach all of the people on the island within ten years.[10]

With this widespread interest in health education in the United States, Canada, and Puerto Rico, has come the acceptance of the health educator as a new professional worker. Local health departments have recognized the health educator as an indispensable member of the public health team, and there is a definite trend toward the "five-piece" unit. The United States Public Health Service has added Health Education Consultants in the district offices and to the field activities staff, and state and local health departments have employed them as rapidly

as they could be trained. Federal agencies, such as the Tennessee Valley Authority and the Farm Security Administration, also employ workers trained in this field, and departments of education and voluntary agencies have likewise been insistent in their requests for well-qualified health educators.

Because the demand for trained health educators far exceeded the supply an extensive recruiting and training program was necessary. More than 300 persons were sent to schools of public health between 1943 and 1946 on fellowships provided by the W. K. Kellogg Foundation, the National Foundation for Infantile Paralysis, the Commonwealth Fund, the General Education Board, and through federal grants-in-aid from the United States Public Health Service and the Children's Bureau. Recruiting is going on continuously, but even if the annual number of graduates remains at the present high level, the supply of trained health educators will be totally inadequate to meet the growing demand for such workers in health departments, public schools, colleges, universities, agriculture, industry, and the voluntary agencies. The minimum number of health educators needed in local areas alone is approximately 6,000, and when the "total health education program" becomes nation-wide an even larger number will be required.

In this brief review of public health education it has been possible to mention only a few outstanding programs which have given direction to the entire movement. Through fifty years the concepts have changed, from the first groping steps in school health and the early attempts to educate through publicity, to the present-day concept in which the forces of health, education, and community organization have been united to produce a "total" health education program designed to meet the health needs of all the people.

Today, more than ever before, public health workers are challenged to develop immediate action programs which will provide for the health needs of a people plunged overnight into an atomic era. The broad concept and philosophy of the "total" health education program are in step with this era, but action programs are relatively few. A vast, undeveloped territory lies ahead in which health education *must* meet the challenge, not only in a few areas but in every tiny hamlet, in every country town, and in every hustling city throughout the United States.

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