WORLD HEALTH ORGANIZATION

ORGANISATION MONDIALE DE LA SANTE

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BETTER EDUCATION FOR HEALTH

1. INTRODUCTION

The South-East Asia Region of WHO presents a challenging scenario to the health leaders of the countries in the Region. While diseases associated with poverty, illiteracy and an unhygienic environment are still major problems, ill-health linked to new and changing lifestyles as the result of social and technological changes as well as patterns of consumption have already become part of the disease burden of the Region. Morbidity and mortality due to cardiovascular illness, cancers and diabetes as well as tobacco and drug use, problem of drinking, violence, injuries and stress are rising. Irresponsible sexual behaviour has led to the pandemic of HIV infection/AIDS now affecting South-East Asia in a major way. With longer life expectancies, degenerative diseases and other health problems of aging populations are additional concerns witnessed in the health transition taking place in the Region. Fortunately, we have the scientific knowledge today on how most of the commonly-occuring diseases can be prevented. Our challenge lies in making this knowledge accessible to people who need it, within an environment that is supportive of use of this knowledge.

Education for health is recognized as an important and viable public health intervention to effectively meet this challenge.

2. HEALTH EDUCATION: CONCEPT AND PURPOSE

The revolutionary Alma Ata declaration of 1978 was a landmark not merely in the understanding of health care but also in providing a conceptual framework for health education. By stating that "people have the right and duty to participate individually and collectively in the planning and implementation of their health care", it provided the necessary impetus to help people to measure up to this task.

A WHO Expert Committee on Health Education met in 1982 to develop new approaches in health education in the context of primary health care. The Committee was convinced that the mandate and structure of health education developed over the years were no longer relevant. A mere outward and downward communication in health would not lead to community participation. It was necessary to give priority to the development of a people-oriented technology in contrast to adopting a paternalistic, commandment-like approach and to address problems that epidemiologically require urgent attention. It also implied involving lay resources in health care for the promotion of self-reliance.

This newer and broader social-scientific perspective replaces the former individual - and group - oriented approaches of health education with a social and ecological dimension called "Health Promotion". A WHO working group on "Health Promotion in Developing Countries" in 1989 broadened the focus of health education towards integrating it with other strategies such as advocacy - generating political commitment for health supportive policies and heightening public interest and demand for health; empowerment - equipping individuals and groups with the knowledge, values and skills that encourage effective action for health, and social support - developing alliances and social support systems that legitimize and encourage health-related actions as social norms. This conceptual development reflects the realization that health issues cannot be seen in isolation but must be seen as being embedded in people's social, cultural and ecological living and working conditions. Human behaviour is largely socially determined and to change it, it is not enough to merely inform and educate; social changes are also necessary. For this reason, there is a need for the health system, and especially for health educators, to work closely with all development sectors of the society.

3. FROM CONCEPT TO PRACTICE - SOME EXAMPLES

An analysis of the successes achieved with the *childhood immunization programmes* indicates quite clearly that the accomplishments were not the result of any one factor such as information or availability of vaccines. It was the outcome of a number of key complementary factors such as political will and support, educational campaigns, social mobilization, accessibility to appropriate technology, as well as sound management practices and logistics. To ensure its sustainability, these factors cannot afford to be overlooked and the place of health education must be seen within this framework.

Successful *nutrition education programmes* have also demonstrated that education must be combined with other back-up facilities such as easy access to affordable food elements. Similarly, *AIDS education* is known to be more effective when multidimensional and gendered in approach. It pays dividends when carried out within intervention programmes which are sensitive to people's culture and which take into account the multitude of forces - economic, social, religious, gender power relations, etc. - that influence the sexual behaviour of people. Innovative approaches in the Region which have taken into account such factors are leading to a significant reduction in sexually transmitted diseases, for example, through 100% use of condoms in brothels. When dealing with *lifestyle-related health problems*, it becomes abundantly clear that health behaviour needs to be seen within a whole range of other behavioural patterns related to demands made by the social, political, economic and cultural situations.

WHO's Inter-Health Project is based on the concept that diseases with common causes, namely unhealthy lifestyles, should be fought together rather than separately, through a common strategy of prevention. The emphasis is on healthy diets, physical exercise, non-smoking and reduction of stress.

4. STRATEGY CONSIDERATIONS

4.1 Safeguarding Human Rights

Education for health is a fundamental human right to enable individuals to make informed choices. It is necessary that this is implemented within a framework that respects non-discrimination, individual and community values and priorities, equity and justice. The plight of poor women, indigenous people, street children and other marginalized groups makes education for health mandatory for such sections of society.

4.2 Mobilizing Specific Population Groups

In the implementation of health education programmes it is always useful to build alliances with specific population groups, particularly organized bodies such as youth and women's groups, worker's organizations etc. This provides double benefits, as it not only promotes healthy practices in individuals who belong to priority groups but also stimulates such groups to mobilize themselves to act as health advocates and help create conditions for healthy living.

(1) Youth

The idealism, creativity and unbounded energy of youth provides an excellent opportunity for enlisting their participation in the promotion of lifestyles conducive to health. Youth have a vested interest in health. Rapid socioeconomic changes witnessed in the Region, breakdown in value systems and traditional social controls, rapid urbanization etc. are all changing the lifestyles of youth, making them vulnerable to life-threatening diseases. Examples of youth organizations taking on leadership roles in dealing with problems of drug abuse, alcoholism and HIV/AIDS are well known in the Region.

(2) Women

There is greater awareness today of women's health issues that span across her entire life cycle, beginning from birth and extending to old age. There is also greater awareness today of women's contribution to the productive, reproductive and household maintenance requirements of the family and its impact/toll on her health. Activation of women's groups has led recently to an enhanced awareness of such issues within broader developmental concerns and how these can be addressed. There is, however, an urgent need to make information on women's sexuality, reproductive health and occupational health easily accessible to adolescent girls and women to empower them to take decisions and to exercise choices to improve their health and well being. Moreover, since women are the guardians of their family's health and transmitters of health information to the next generation, educating and mobilizing women for health leads to multiple beneficial efforts for family and community health.

(3) Workers

The application of unsafe technologies together with environmental changes has produced new concerns in occupational health. Organized workers are another category who have great potential as advocates for health, both at their place of work and in the society at large.

(4) School Children

Educating children on health in schools is yet another area that deserves high priority. When this is carried out within a school health service and medical check-up programme, its impact is limited in terms of enabling children to acquire health-related knowledge, values and skills, to pursue a healthy life as well as to work as agents of change to improve the health of their families and communities. A more comprehensive school health education programme is called for which includes a broad spectrum of activities that take place within and outside of schools and in the surrounding communities, to empower children and youth as well as their families to act for healthy living and to promote conditions supportive of health. In the South-East Asia Region of WHO, not many children have access to such comprehensive school health education programmes and their implementation remains a major challenge. Even though health teaching in schools has been a long established practice in the Region, there is a need for a stronger collaborative arrangement between ministries of health and education to strengthen existing school curriculum to cover topics related to health.

4.3 Working Intersectorally

Working intersectorally is a strategic approach for empowering people for health action. Examples of the successes achieved by such collaboration are well documented. Partnerships with the education, media, environment, food, housing and community development sectors have led to the development and implementation of effective health education programmes involving a multiplicity of intervention methods. These include community organization and development, legislative and policy development, social marketing and other health communications strategies and training.

It is important that alliances are strengthened with all political and societal forces and strengths of various organizations, both government and nongovernmental, drawn upon, especially those organizations representing women, youth, workers, school teachers and religious and political institutions.

4.4 Health Communications

Health communications is a major component of the health education strategy involving media support as well as interpersonal communication skills. The past decade has seen a growing awareness of health issues highlighted

through the media. Press, radio and television can be very effective not only in informing and educating people about health, but also in helping to create a political will by forming public opinions and by fostering community involvement through facilitating a dialogue between the community and health care providers.

Apart from mass media, there are other ways of communicating with people. Interpersonal communication using the small media or group media is very effective when participatory in nature. The use of folk media is a time-tested technique and is especially popular among rural communities. Whatever the medium and channel selected for communicating, it is important that health communication is planned to lead to interaction, dialogue and action.

To sum up, it must be recognized that to meet the health challenges of the Region, education for health will remain a vital public health intervention.

To achieve its full potential as an integral component of development, education for health must function in an environment that is supportive of health for all in the spirit of equity and justice.