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Report on the

Intercountry meeting on health education

Cairo, Egypt
3–6 May 2010

World Health Organization
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CONTENTS

1. INTRODUCTION

The WHO Regional Office for the Eastern Mediterranean (WHO EMRO) organized an intercountry meeting on health education from 3–6 May 2010. Participants of the meeting were national health education officers. Nineteen countries of the WHO Eastern Mediterranean Region were represented. The meeting programme and list of participants are attached as Annexes 1 and 2, respectively.

The meeting was opened by Dr Haifa Madi, Director of the Division of Health Protection and Promotion, WHO Regional Office for the Eastern Mediterranean, who delivered a message from Dr Hussein A. Gezairy, WHO Regional Director for the Eastern Mediterranean. In his message, Dr Gezairy said that it was time to give health education the importance it deserved to ensure that individual and communities achieved the level of optimum level of health. Health education was a key vehicle for health promotion that had the ultimate goal of improving health literacy. It built on the internationally and regionally agreed instruments from the Ottawa and Bangkok charters, to the regional strategy for health promotion. Countries of the Region were witnessing demographic, social, economic and political transitions that led to easier access to tobacco and fast food products and busy working schedules, altering the ways in which individuals and communities organized their daily activities. The sharp increase in obesity among adults and children was another key challenge in the Region that had led to an increase in noncommunicable diseases. This could be addressed through behaviour change related to two main risk factors: diet and physical activity. He noted that the year 2009 had been marked by the emergence of a new type of influenza, pandemic H1N1 and the emergence of unprecedented new challenges. The H1N1 response showed the importance of health education and education on hygiene behaviours, which enabled the control of spread of the disease.

Dr Faten Ben Abdelaziz, Regional Adviser for Health Education, WHO EMRO, noted that in the area of health education, the Regional Office had produced two key documents: 1) a foundation paper that reviewed all the concepts related to health education, supported by a situation analysis of health education programmes conducted in the Region; and 2) a review of health literacy presented at the WHO seventh conference on health promotion in Kenya (2009). The former provided a description of concepts related to health education and promotion and was reviewed online by a group of international and regional health education and promotion experts. As for the report on health literacy, it provided examples of how to improve the health knowledge and skills in selected topics. The Regional Office had also conducted a review of health education activities in the four countries and produced a report. The meeting was organized based on the previously mentioned document with the following key objectives:

- Presentation of the regional health education foundation document, a review of health education concepts, approaches and tools and related concepts
- Consensus building on a proposed a regional strategic plan for health education for countries of the Region
- Development of draft nation action plans for health education.

2. TECHNICAL SESSIONS

Dr Jaffar Hussain, Regional Adviser for Healthy Lifestyles, WHO EMRO, presented the health promotion work in the Eastern Mediterranean Region. He highlighted the importance to ensure that any health education initiatives be conducted on the basis of the regional strategy on health promotion. Beside remarkable progress made in the area of health promotion since the commitment of WHO to the goals of Health For All (1977) and subsequent International Conference on Primary Health Care and health promotion, still after 25 years the concepts and principles of health promotion and protection are not well understood, probably due to the fact that there is a remaining lack of consistency in the use of concepts related to health promotion and the area seems to be facing an identity crisis even after 20 years of evolution, adding to it lack of political and financial support. Dr Hussain mentioned that some of the challenges that health promotion is facing are also due to the fact that being or staying healthy is left to the individual responsibility and insufficient effort is put in building supportive environment. Subsequently Dr Hussain presented the key objectives of the regional strategy for health promotion.

- Generating an information base for action
- Developing national capacity for health promotion including key partners and institutions
- Putting health promotion high on public agenda
- Developing a comprehensive multisectoral response
- Developing and updating legislation and regulations
- Putting community at the centre of health promotion
- Developing an integrated mechanism for health promotion at various levels including resource mobilization.

Dr Gauden Galea, Coordinator of Health Promotion, WHO headquarters, presented a global perspective on mainstreaming health education, outcomes, evidence and action. He gave examples of health education and promotion projects and their impact at the levels of individual, community, health services and physical and social environments. He noted that Member States use different strategies such as education, announcements and counselling. He drew the lessons learnt from the interventions and suggests that future interventions should consider:

- Applied evidence base
- Equity impact assessment
- Available health information systems (new evidence-based policies can be an outcome in themselves)
- Reduction in risk (can be fast, not slow, long-term)
- Development of a sustainable financing model.

Dr Wayne Mitic, University of Victoria, British Columbia, Canada, presented a theoretical framework that describes the relationship between health education, promotion, literacy and social determinants of health. The framework highlights the importance of

actions on two levels: individual capacities through educational, motivational, skills-building and consciousness-raising techniques; and building healthy public policies to provide the environmental support required for promoting healthy behaviour. By influencing both these intrinsic and extrinsic factors, meaningful and sustained change in the health of individuals and communities can be realized.

Dr Mayada Kanj, American University of Beirut, presented the key findings from a situation analysis on health education conducted in Bahrain, Egypt, Lebanon and Tunisia. The key areas studied were:

- Selection process of health education project
- Selection of target groups
- Funding
- Partnerships
- Implementation: process, mechanism
- Health education materials developed
- Evaluation process
- Documentation
- Profile of the health education staff.

The review showed that there was awareness on the importance of health education but no country had a national health education strategy. Teams of health educators were mostly composed of medical doctors who may not have the necessary public health expertise.

The coordination between health education unit and other government departments and private sector was weak. The type of activities conducted were mainly capacity building, generally one time lectures and/or health awareness sessions with a continuously changing audience. The community was generally not considered as an active actor, with needs assessment seldom conducted prior developing health education action. The type of training offered to health educators was generally on-the-job training through training of trainers. Health education materials produced are mainly brochures, pamphlets, posters, television and radio spots with little field-testing within the target group. The review was mostly done through an internal review process within health education team. Documentation is done mostly through reports writing and posting information on website, with limited information on details of activities only per donor request. Finally, regarding evaluation, interviewees were convinced that evaluation was important and it is per funders' request and only covers pre- and post-testing, implementation process but no impact or outcome evaluation. The reasons for not evaluating were lack of: knowledge and skills in the area of evaluation, time required to evaluate project impact and funds to cover the cost. A key recommendation from the situation analysis was to provide training to the health education concepts and tools as most respondents were unclear on what health education and health promotion comprise in terms of activities and scope.

Dr Abdulhalim Joukhadar, WHO Consultant, made a presentation on e-Health education. He said that e-Health covers five broad categories of e-solutions: electronic health

records, tele-health, secure electronic linkages, electronic health information, and other e-health applications such as surveillance and practice management systems. The e-health applications have enormous potential to support health promotion initiatives, particularly with regards to injury prevention. Internet users in the Region are typically under 35 years old and predominantly male, although there are indications that the digital gap between men and women is narrowing. The internet presents a high potential for promoting health literacy through rendering health information easily accessible and freely affordable for the general public. But caution should be taken as the internet contains mass information that varies in quality and not regulated. The institutional official sites and nonprofit organizations sites are side by side with sites fueled by commercial interests. Dr Joukhadar recommended that the health education website provide updated health/medical information and news in a consistent manner with search function and index to be more user-friendly and accessible to a broader audience and should include a glossary of technical terms in an easy language.

Dr Muhiuddin Haider, WHO Consultant, presented the topic of community engagement in response to public health emergencies. Dr Haider used the example of epidemics and pandemics to make the case of the importance of community active participation in health education. He said that epidemics and pandemics place sudden intense demands on national and international health systems and in some occasions have brought health and social systems to the point of collapse. Prepared communities tend to react differently to unprepared ones. Strong local level response and coordination supported by national level response is important to reduce the impact of a devastating event and unable it to recover quicker. He explained that the overriding goal of outbreak management is to minimize the public health impact of disease outbreaks. Early self-reporting of illness and consultation with public health officials should be encouraged so that adequate clinical care and treatment can be timely provided. Members of the community have the most to lose from being vulnerable to disasters and the most to gain from an effective and appropriate emergency preparedness programme. The positive gains of preparedness programmes can be best measured at community level. Social mobilization is defined as the process of mobilizing all societal and personal influences with the aim of prompting individual and family action. WHO ensures that communities and individuals engage and accept major disruptions of their lives if involved actively. Health educators should make use of strategic communication planning prior to materials production and conduct well-researched behavioural goals focus effort and result in clear, consistent messages to support uptake of sustainable behavioural practices. Dr Haider drew attention to the example of COMBI as a useful tool for assessing health needs and planning a response.

Wayne Mitic, University of Victoria, British Columbia, Canada presented on health education evaluation. Evaluation is defined as “the systematic assessment of the worth (value) or merit (quality) of some object or activity” (Scriven, 1994). The difference with research is that research looks at what “CAN HAPPEN” by studying controlled conditions (prove). Evaluation looks at “WHAT DOES HAPPEN” in the real world (improve). He said that the types of evaluation are various from needs assessment to effectiveness and outcomes evaluation, often leading to confusion among project and programme and implementers. The accepted standards for evaluation for health education programmes are as follows.

- Utility: serves the practical needs of users
- Feasibility: realistic, prudent, diplomatic, and frugal
- Propriety: conducted legally, ethically and with due regard
- Accuracy: technically adequate

He explained the importance for evaluating health programmes as the basis to decide whether to change, continue or cancel a programme or activity. Usually, programme implementers do not evaluate because they don't know how. They lack the necessary knowledge, expertise and techniques as well as the budget and time. They also fear that it may have a negative impact on their programme. Dr Wayne presented the logical framework as a useful tool for programme planning, monitoring and evaluation. He talked about process to select indicators and set an evaluation plan, methods of data collection and analysis.

Dr Mayada Kanj, Faculty of Health Sciences, American University of Beirut gave a presention on action research. Action research can be defined as "the study of a social situation carried out by those involved in that situation in order to improve both their practice and their quality of understanding" (Whitehead D, 2003). Action research is also called participatory action research, participatory/empowerment evaluation, collaborative action research etc. Action research has three key aspects:

- Participatory (participants perceive a need to change are willing to play an active role in the research process)
- Democratic (participants are seen as equals where the researcher is more of a facilitator of change)
- Contribution to social science and social change.

Dr Kanj compared traditional research and action oriented research highlighting that for the latter the starting point is usually research question or formal hypothesis while for action research it is a the description of a problem. In addition, in traditional research, communities and individuals are external observation while in action research the community participates from the start. Action research is suitable for health promotion and education activities as it fulfils the empowering and enabling goals of health promotion as well as the principles of participatory learning that are essential for health education approaches. The limitations of action research are that it is time-consuming and resource intensive.

3. COUNTRY PRESENTATIONS

3.1 Bahrain

Dr Amal Al Jowder, Director Health Education Directorate, Ministry of Health, presented the Bahrain experience. She said that health education is implemented by a team of health promotion specialists, family medicine physician, nurses, media personnel, religious leaders and volunteers. The team of health educators was trained on health education by the Health Science College in Bahrain and foreign universities. The sources of funding include Ministry of Health, WHO, UNDP, private sector and other ministries. As for evaluation,

although objectives are clearly stated prior developing health education interventions, the impact is not assessed systematically. Impact evaluation is conducted in individual programmes at health centres such as promoting mammograms or management of obesity or iron deficiency anaemia. The main challenges the health education unit faces are sustainability of the programme, capacity to evaluate health education programmes, coordination within and outside the Ministry of Health, sustainable sources of funding, human resources and capacity-building of workers. Opportunities for health education include the establishment of a health promotion directorate, establishing of new financing from other ministries, Bahrain Economic Vision 2030 and the creation of health promotion schools.

3.2 Egypt

Dr Abderraouf, Director General, Health Education Department, Ministry of Health, presented the experience of Egypt. The work of the health education department consists of organizing national public awareness campaigns, seminars and meetings on specific topics such as national campaigns for fighting poliomyelitis and blindness and world day for environment. The unit also develops health education messages, designing and producing television spots in close collaboration with concerned technical units at the Ministry of Health and scientific societies. The health education interventions are based on priorities expressed by governorates. The health education team receives various types of training: basic academic training in public health departments at the universities, on-the-job training through WHO, American University of Cairo (maternal and child health project), workshops outside Egypt in coordination with Johns Hopkins University and the public health department in Cairo University and national training programmes for women community leaders and health education. The source of funding is mainly a specified budget in the Ministry of Health budget and WHO. Impact assessment of the interventions is conducted through surveys. The main challenges concern financing support for the health education activities, especially for conducting training and research and implementing programmes.

3.3 Iraq

Dr Aliaa Hussain Ali Al Azzawi, Director of the Training Development, Health Promotion Department, Ministry of Health, presented the work of health education in Iraq. The health education activities cover workshops for health caregivers and those who are responsible for health promotion sections and units (medical and paramedical staff) in primary health care centres, hospitals and other health departments. Workshops are also organized for teachers and education supervisors in schools included in the WHO action-oriented school health curriculum programme. The health education unit organizes education regular campaigns and during outbreaks; develops educational materials production and disseminates health messages through various channels. She mentioned that usually the health education activities conducted centrally by health promotion department, composed of medical and paramedical staff, specialists in community medicine and public health. Health education interventions are generally based on a public health need assessment as well as political priority. Main challenges concern the security situations in Iraq, weak infrastructure,

shortage in health workers and migration of skilled human resources, lack of health literacy of the general public and economic challenges.

3.4 Jordan

Dr Basima Mustafa Isteiteih, Focal Point for Heath Education, Head of Health Awareness Department, Ministry of Health, explained that in Jordan the work of health education is done through the vision of “A health competent Jordan”. The mission of the health education unit is to “promote healthy behaviours among all Jordanians through capacity building and implementing efficient and effective awareness and communication programmes in coordination with related health programmes at the local community and across health sectors. The main function of the unit is to identify training needs and developing training plans and guidelines for health promoting staff and community members. It also provides information through a website. The main challenges the health education unit faces are the lack of coordination among health directorates and across sectors related to health communication programmes, a weak monitoring and evaluation system, limited communication skills among service delivery staff, lack of sustainable funds and high turnover of health promotion staff.

3.5 Lebanon

Ms Rasha Hamra, Head of Health Education Department, Ministry of Health, explained that health education activities at the government level are planned and organized by the Health Education Department, which is located under the Directorate of Preventive Health Care. National programmes work independently on health education activities (e.g. AIDS, diabetes). The main strengths of the department is the strong collaboration with different partners involved in health education and mini ministries, a strong involvement of nongovernmental organizations and international partners such as WHO, UNICEF as well as academic institutions and the media industry. Key weaknesses concern lack of human resources mainly at central level and financial resources from public sector health budget as most of the Ministry of Health budget is for curative services. In Lebanon there is also no national health education policy and strategy. Lebanon presents unique opportunities for health awareness campaigns due to a strong partnership with different parties and its strong partnership with the private sector. Indeed, Lebanon hosts major independent print and broadcast media outlets, which generally endorse public health efforts through coverage and free advertising placement. This effort is further supported by a media law that imposes the television broadcast free airing of health education messages. There are however, remaining challenges as health education activities are carried out in a fragmented and ad hoc basis and not as part of a national strategy leading to duplication of activities and waste resources.

3.6 Morocco

Dr Abdelhafid Rahmani, Head of Intersectoral Coordination Services, Ministry of Health, explained that health education units provides support to regional health departments in the domain of conception and production of information, education and communication

(IEC) material. The unit conducts studies and surveys for IEC material production. Prior 1995 most funding was from international organizations (70%) and the funds were used for equipment acquisition and training. After 1995 the mains source of funding was from the government budget (70%).

3.7 Oman

Dr Halima Alhinai, Acting Director Health Education, Ministry of Health, said that the health education activities at central level mainly consist of coordinating health education activities with related health programmes, producing printed material, coordinating with mass media, developing and disseminating health messages, and planning and implementing health campaigns. At regional level, the work of health educators mainly consists of conducting lectures in health institutions and the community, interviews and focus group discussions in health institutions and the community and home visits. The health education work is not based on any models but recently it started to apply COMBI approach. In some health institutions, health education is conducted by health staff such as nurses and medical orderlies. Most health educators received training in health education and public health from Oman public health institute as well as on-the-job training. The main source of funding is the Ministry of Health, private sector and international partners for specific programmes including WHO, UNFPA and UNICEF. With regard to evaluation, it is conducted through annual health education reports without any evaluation of health education impact. Health education activities are part of a national 5-year plan with stated objectives, but no expected outcomes. The main challenges are shortage of health educators in the regions, no specific health education strategy, lack of training in the area of media communication and social marketing and systematic conduct of baseline data collection and subsequent evaluation of health education impact.

3.8 Occupied Palestine territory

Dr Lubna Sader, Director of Health Education, Ministry of Health, Nablus, explained that priorities depend on governorates, the emergency situation, funding of projects and health problems. Types of health education activities include health education campaigns, lectures, workshops, training activities, organization competitions, activities in schools, dissemination of health education messages in the mass media and counselling. The health education department is under public health and primary health care directorate. Models and framework used mainly concern the health belief model and social learning theory. The team of health educators is mainly composed of health educators, nurses, community health workers, doctors and specialists such as nutritionists. The training of health education educators covers IEC standards and procedures, communication skills, health education techniques and media communication. The source of funding is mainly from external support from international agencies and sometimes by local companies or nongovernmental organizations. The impact of health education interventions is assessed through KAP studies when funds are available and through national surveys such as the family health survey. Health education activities are initiated based on public health need and scientific evidence and political desire. The main challenges concern shortage of equipment e.g. television, LCD,

human and financial resources and the possibility to reach certain target audiences such as men.

3.9 Pakistan

Mr Mazhar Nisar Sheikh, Health Education Adviser, Ministry of Health, mentioned that health education unit conducts media campaigns (electronic and print), IEC, health forums, capacity development in health education through training, provision of materials, guidance, emotion-based communication (true stories of affected populations) and advocacy. The health education interventions are developed based on a logical framework. The health education units are responsible for planning, implementing and monitoring health education activities at the federal, provincial and district levels. Generally, health educators have graduated with a postgraduate degree in social sciences and public health (MPH) and other staff received professional training from health services academy at the federal and provincial levels. The source of funding is from specific programme and budget from federal and provincial levels. Evaluation of health education interventions is developed based on planned SMART objectives, third party evaluations and surveys. The main challenges refer to having health education programmes based on research and target, as well as training the health workface in health education and communication techniques.

3.10 Qatar

Mr Jassim Ibrahim Fakhrou, Director, Communication and Media Department, Supreme Council of Health explained that health education unit conducts public health awareness and health develops health education programmes including:

- “The Clean Student Programme”: on personal hygiene
- “Healthy Steps to Doha”: promoting proper nutrition and combating obesity
- “Premarital Medical Screening”: explaining the provisions of the applicable related law
- “I have Grown Up”: dealing with the physiological and psychological changes during adolescence.

The unit produces printed materials such as posters, booklets and brochures targeting schools, health care centres and governmental organizations; training workshops for persons employed in the health field. School nurses receive health education training on annual basis on the new programmes and the related scientific materials. The health education programmes depend on the social learning theories (social cognitive theories). The team is composed of health education specialist; research specialist; training coordinator and health educators. Source of funding is from the Supreme Council and from a private partnership. The department will work to broaden the scope of work to cover population groups speaking no Arabic. Some of the challenges include a shortage of qualified staff, high cost of producing educational materials and lack of coordination with other government councils such as Supreme Council of Education.

3.11 Saudi Arabia

Dr Khalid Marghlani, General Health Communication, Directorate of Health Communication and Health Education, Ministry of Health, said that the department reports directly to health education the Minister of Health and has three departments, the department of health awareness, the department of public relations and the department media communication. The health education activities cover mass awareness, interpersonal activities, publications and electronic health education activities. The models and frameworks vary from health belief model to consumer-provider interaction and social marketing models. The team of health educates composed of specialist of health communication and health promotion, a consultant of public health and health education, a specialist of public health and health education, a general practitioner and technicians of health education. The training is mainly conducted through training of trainer (TOT) programmes supported by step-down training for the field health educators. The source of financing is governmental, through an annual fund directed to the administration of health education. Programmes are initiated either based on public health needs, prevalence and incidence and proven risk factors. Monitoring and evaluation of health education programmes outcome is incorporated at the planning process, and the implementation phase of every health education activity to ensure that pre-stated objectives were achieved, needs of target groups were fulfilled, and health education tools were assessed. Many types of health education programme monitoring are being used including context evaluation, reporting system, process evaluation and impact evaluation. Some of challenges include limited funds, lack of competencies at the field level and lack of coordination leading to duplication of health education efforts.

3.12 Sudan

Dr Kamal Hanafi Mansour, Director of Health Promotion and Education, Federal Ministry of Health, explained that in Khartoum health education interventions are implemented within the framework of health promotion at primary health care level by a team of health educators, promoters and communicators. The work mostly covers awareness-raising activities focusing on key risk factors. It also seeks to develop skills of communities at large and specific vulnerable groups.

3.13 Syrian Arab Republic

Dr Yahya Bozo, Director of Information, Health Education and Communication Department, Ministry of Health, explained that in his country, all health programmes on television and radio spots and newspaper are disseminated free of charge. Health education activities are based on various theories including the health belief models and the behaviour change model. He said that at the central level, a national committee for health education was established, and its function is to coordinate activities of mass media and others parties, including nongovernmental organizations, to ensure consistency in use of language and avoid conflicting messages. At the governorate level, there are about 14 health education teams responsible for implementing campaigns and planned health education activities that respond to local needs. The training of health educators have a pre-initial training in public health and

health education in five health institutes affiliated with the Ministry of Health. On-the-job training is carried out periodically to upgrade and update health educator's capacity. The main source of funding is from regular budget from the Ministry of Health and other key ministries, e.g. information and education. The department also receives seed funding from UN agencies including WHO, UNICEF, UNFPA and foundations such as Aga Khan. Main challenges are lack of financial resources and high turnover of health education staff, particularly their migration to the private sector.

3.14 Tunisia

Ms Raja Mazzouza, Health Department, Ministry of Public Health, presented the experience of Tunisia. She said that there is no designated department of health education. Each directorate has its own staff responsible for health education. At central level, the unit organizes training of trainers and awareness-raising campaigns, produces print and video health education material, and plans activities for World Health Day. The source of funding is mainly the Ministry of Health budget, with occasional support from WHO and other technical cooperation agencies. Health education activities are not based on any theoretical model. A key strength of the unit is a strong multisectoral partnership through national committees including ministries of social affairs, education, health and interior and local communities. The main challenges are the lack of a national health education strategic plan with clear objectives, no designation of a specific department for health education, duplication of activities, lack of coordination, material resources and human resources. In Tunisia, there are no health education specialists with academic training in this field. In addition, evaluation is conducted only for some particular courses and depends on the organizing committee.

3.15 United Arab Emirates

Ms Maysoon Alshaer, Head of Clinical Nutrition and Acting Head of Health Education, presented the experience of her country. She said that health promotion, education, prevention and care services can be provided at the same place, as a high percentage of the population use primary health care services (80%). The health educators have limited skills in health education and promotion areas and complementary training is weak and mostly targets health professionals. Guidelines and tools are lacking and health education activities are not assessed.

3.16 Yemen

Dr Nasser Hassan Al-Absi, Director General, Health Education Centre, Ministry of Public Health and Population explained that the centre's function is to conduct national awareness-raising campaigns for communicable diseases and other health issues and periodic awareness-raising campaigns at the community level, producing health education manuals for health educators, health workers and community volunteers, designing and producing television and radio spots targeting the community. Health education is provided at many levels: district level, health facilities, school students, women and men in the community (mosques, markets and military camps), young people in clubs and university and community

leaders. At central level and district level, health education is provided by health care providers, media personnel (television, radio, press), teachers, religious leaders and community volunteers (male and female). The type of training provided depends on the literacy level but generally the training covers communication skills, behaviour change concepts and planning, monitoring and evaluation skills. With regards to health services providers, the training mainly covers health counselling and communication skills. The media, religious leaders and volunteers are trained on priority health messages.

Health education interventions are triggered by political will and population strategy and/or priority health issues/public health needs. The funding is from the government and international organizations. The impact of behavioural changes is rarely assessed. Challenges are various and include geographic and economic challenges, poor quality of health services and lack of coordination internally and externally.

4. STRATEGIC PLAN OF ACTION FOR HEALTH EDUCATION IN THE EASTERN MEDITERRANEAN REGION

Dr Faten Ben Abdelaziz presented the proposed regional strategic plan of action for health education for the coming five years that should be implemented as part of the regional health promotion strategy. Participants of the meeting worked in groups to review the proposed strategic plan for health education for the Region and mechanisms. In plenary, participants reached the following consensus.

Participants agreed to a common vision for health education “Healthy individuals and communities in health promoting environments” and mission should be to “Provide technical support and expertise to Member States in developing effective health education programmes and initiatives across all sectors.” The strategic plan sets five year strategic directions for a regional health education agenda to be implemented by the Regional Office.

The regional plan of action for health education has 6 strategic goals.

Goal 1: Strengthened intraministerial and interministerial coordination among key technical programmes and collaboration with private sector

Key objectives:

- There is one inter ministerial committee within the Ministry of Health in each country by mid 2011
- There is one intra ministerial task force by end 2013
- There is an agreement with nongovernmental organizations involved in health education at national level.

Goal 2: Core competencies in health education are reinforced

Key objectives:

- A training package on core health education skills for health planners at the Ministry of Health is developed by end 2011
- 4 countries have undergone the training programme by mid 2013.

Goal 3: Monitoring and evaluation skills in the area of health education programmes and initiatives are developed

Key objectives:

- There is trained core team of trainers on monitoring and evaluation by end 2012
- Training is provided in 4 countries by end 2013.

Goal 4: Enhanced community engagement

Key objectives:

- 2 countries are trained on community mobilization by end 2012
- A project focusing on community mobilization for a selected health topic is implemented and documented in 2 countries by mid 2013.

Goal 5: Enhanced health literacy

Key objectives:

- Accessibility of health information is improved through the creation of a website and a blog for health educators by end 2013.

Goal 6: Research in the area of health education is improved

Key objectives:

- Training on action research is provided by end 2012
- Action research implemented by mid 2013.

Participants suggested that the regional strategic plan of action for health education be implemented through the following mechanisms.

- Establishment of a network for health education
- Creation of an online platform for regular consultation and information sharing
- Conduct of an intercountry meeting every 2 years

5. RECOMMENDATIONS

To Member States

1. Finalize national plans of action on health education and advocate for and implement them.
2. Establish national mechanisms for intersectoral collaboration to address upstream determinants of health.
3. Establish national mechanisms for mainstreaming health education within priority health programmes.
4. Conduct a national assessment of health education programmes and available resources.
5. Develop a country profile on health education using a template to be provided by the Regional Office.
6. Ensure that health education activities are in line with the strategic objectives identified in the regional strategic plan on health education.
7. Report to the Regional Office every six months on progress in the implementation of national plans of action.
8. Advocate for sustainable resources to be allocated to health education and health through earmarking taxes on tobacco, or direct appropriation from central government funds.

To the Regional Office

9. By the end of 2010, develop a business case to establish an online platform for consultation, information sharing and as a resource for trusted health information, targeting the end of 2011 as the official launch if the trial period is successful.
10. Develop training packages on core skills targeting 1) national focal point health educators and 2) field health educators. The packages should be competency-based and certified and should include topics such as health behaviour models, planning tools, action research and monitoring and evaluation. They should cover evidence-based interventions targeted at priority health outcomes relevant to each country.
11. Develop templates for the country profile and for progress reports on implementation of country plans of action.
12. Follow up with countries on the progress of implementation of the regional strategic plan on health education.
13. Organize an intercountry meeting on a yearly basis subject to availability of resources.

Annex 1

PROGRAMME

Monday, 3 May 2010

08:00–08:30	Registration
08:30–09:00	Opening ceremony Message of the Regional Director, WHO/EMRO By Dr Haifa Madi, Director of Health Protection and Promotion
09:00–09:20	Introduction of participants
09:20–09:30	Election of meeting officers
09:30–10:00	Objectives, expected outcomes, proceedings
10:00–10:15	Group picture
10:45–11:10	Health promotion strategy for the Region *Dr Jaffar Hussain, WHO/EMRO*
11:10–11:30	A framework for implementing health education *Prof. Wayne Mitic, WHO Temporary Adviser*
11:30–12:00	Plenary discussion
12:00–12:20	Report from the situation analysis on health education in selected countries *Dr Mayada Kanj, WHO Temporary Adviser*
12:20–12:35	Plenary discussion
13:30–14:45	Country presentations Bahrain, Djibouti, Egypt, Islamic Republic of Iran, Iraq
14:45–15:00	Q&A
15:30–16:45	Country presentations (cont.') Jordan, Kuwait, Lebanon, Libya, Morocco
16:45–17:00	Q&A

Tuesday, 4 May 2010

08:30–11:30	Country presentations Oman, Palestine, Pakistan, Qatar, Saudi Arabia, Sudan, Syrian Arab Republic, Tunisia, United Arab Emirates, Yemen
11:30–11:45	Q&A
11:45–12:15	Introduction to the strategic plan for health education for the Region *Dr Faten Ben Abdelaziz, WHO/EMRO*
13:15–13:35	Coordinated heath education across public health programmes *Dr Gauden Galea, WHO/HQ*
13:35–14:15	Capacity building for effective health education E-Health education *Dr A.Halim Joukhadar, WHO Temporary Adviser* Core competencies for health education *Dr Wayne Mitic, WHO Temporary Adviser*

14:45–16:00	**Group work:** Review of the strategic plan on health education **Group 1:** Mainstreaming health education into public health programmes How can we integrate health education ion within technical programmes? **Group 2**: Building capacity building core competencies for health education How can we enhance core competencies of health educators? **Group 3:** Increasing the level of health literacy How can we use new information technology to enhance health literacy of the public?
16:00–17:00	Group reports

Wednesday, 5 May 2010

08:30–09:50	Engaging community in responding to public health emergencies (20 min) *Prof. Muhiuddin Haider, WHO Temporary Adviser* Monitoring and evaluation (20 min) *Prof. Wayne Mitic, WHO Temporary Adviser* Conducting research for health education (20 min) *Dr Mayada Kanj, WHO Temporary Adviser*
10:30–12:00	Group work **Group 1:** Assessing community health needs What are the mechanisms in place for engaging the community? What are the type of tools in use for assessing needs and capacities? **Group 2:** Monitoring and evaluation If you could measure only **three** things, what would they be? How can capacities in monitoring and evaluation be strengthened? **Group 3**: Strengthening research What are the main challenges and opportunities in conducting research in the area of health education?
12:00–13:00	Group report
13:30–15:30	Development of country plans based on the regional health education strategic plan Working groups **Group 1:** GCC countries **Group 2**: Djibouti, Morocco and Tunisia **Group 3**: Egypt, Libya, Sudan **Group 4**: Iraq, Islamic Republic of Iran, Pakistan **Group 5**: Jordan, Lebanon, Palestine, Syrian Arab Republic
16:00–17:00	Presentation of country plans (2 groups)

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08:30–10:00	Presentation of country plans' continued (3 groups)
10:00–10:30	Presentation of the revised strategic plan for health education
11:00–12:00	Recommendations and next steps
12:00–12:30	Closing remarks

Annex 2

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