MAIN OBJECTIVES

- To equip students and teachers to prevent diseases, both for their own well-being and that of their communities.
- To change risky health behaviours.
- To encourage coordination with relevant health

CONTEXT AND CHALLENGES

“Thousands of children are killed each year as a direct result of armed conflict and natural disasters. Many more, however, die from the increased rates of malnutrition and disease that typically accompany such emergencies ... The interruption of food supplies, the destruction of crops and agricultural infrastructure, the disintegration of families and communities, the displacement of populations, the disruption of health services, and the breakdown of water and sanitation systems all take a heavy toll on the health and nutrition of children. Many die as a result of severe malnutrition, while others become unable to resist common childhood diseases and infection.”

Source: UNICEF (2001)
In emergencies, primary health care is a priority response in order to avoid death from diseases such as measles, diarrhoea (including dysentery and cholera), acute respiratory infections, malnutrition, malaria (where prevalent) and other illnesses endemic to a region, such as yellow fever or typhoid, in addition to outbreaks of opportunistic diseases such as leptospirosis. Emergency-affected populations are particularly susceptible to these diseases due to their conditions of life: overcrowded spaces, inadequate quantities and quality of water, poor sanitation, inadequate shelter and inadequate food supply (Sphere Project, 2004). In situations where government systems and traditional social networks break down, there is an increased risk of sexually transmitted diseases, as well as an increased incidence of exposure to drugs, alcohol, and cigarettes. Where there is armed conflict, a military force on the move constitutes a health risk to the populations with whom it comes into contact.

Wars bring huge institutional challenges to national health systems. A country’s health infrastructure may have been specifically targeted during the crisis, destroyed or severely disrupted. Education service providers such as NGOs may not coordinate their efforts with health-service providers. Depending on the scale of the disaster, international organizations may be present and responding in the health sector. Therefore, educational authorities may need to coordinate health-education efforts with these health providers.

Refugees and IDPs will be unfamiliar with the local context and may not be accustomed to or equipped for local health threats. Therefore, they have less access to adequate health care and a higher morbidity rate than others in the same community. Refugees and IDPs often arrive in poor health due to problems encountered en route as well as having inadequate health care
prior to displacement. Refugee camps may not always be situated close to adequate clean water sources, and may be located in endemic disease-affected areas.

Once repatriation is under way, returnees from under-supported refugee or IDP camps may be in poorer general health, due to increased stress, poor hygiene practices in camps, and inadequate access to health care. Children whose families are returning from long-term exile may have less immunity to local diseases and be accustomed to good health care. Establishment of health services in insecure rural areas may be difficult and take time.

Education can play a critical role in supporting the efforts of primary health-care providers by teaching children about healthy behaviours, especially those most relevant to their current situation. Effective skills-based health education has two goals:

1. Children will change their own behaviours and adopt more healthy practices.
2. Children will share the information they learn in school with their parents and siblings, which may result in behaviour changes in their families.

For these reasons, inclusion of health and hygiene messages in the curriculum can be an effective means of transmitting information to a large segment of the emergency-affected population. Educational authorities should coordinate with other officials, such as those responsible for health services or water and sanitation, to ensure that appropriate messages are developed and incorporated into the curriculum. “Overall school health education seeks to help individuals adopt behaviours and create conditions that are conducive to health” (Aldana and Jones, 1999: 17).
Yet educational planners must go beyond awareness raising and ‘passing messages’. Assumptions about children’s capacity or willingness to change their attitudes, values and behaviours, based on ‘messages’ passed in class must be articulated in curriculum development and educational programme design. Similarly, the curriculum and instructional design must make explicit the manner in which children’s listening to messages will be transferred into behavioural change among adult members of their families. This implies understanding of modes of cultural transmission and intra-family communication. Developing skills is both more valuable and lasting, and much more difficult than merely passing messages.

**SUGGESTED STRATEGIES**

**Summary of suggested strategies**

**Health and hygiene**

1. **Conduct a review of health-education programmes being carried out under government auspices, through civil-society organizations and external agencies and NGOs, and establish a joint working group to prepare best practice guidelines for health education providers.**

2. **Health-education providers should assess health-education needs and develop skills-based health-education curricula/programmes using the assessment results.**
3. Educational authorities and providers should facilitate or conduct health-education campaigns, designed in collaboration with community members and teachers.

4. Consider developing an associated education strategy for security, protection, administrative and other personnel who come into habitual contact with youth.

Guidance notes

1. Conduct a review of health-education programmes being carried out under government auspices, through civil-society organizations and external agencies and NGOs, and establish a joint working group to prepare best practice guidelines for health-education providers.

   • Health education is often provided by schools, health services (especially primary health care programmes), youth programmes, women’s programmes, etc. Consider:
     • Which organizations are involved in delivering programmes? What health-education programmes are they delivering?
     • How is the education ministry involved?
       – Is it directly involved or in an advisory/consultative capacity with school programmes?
Is the education ministry involved with non-formal health education for youth and adults?

- Are existing health-education programmes delivered through timetabled curriculum periods for health education?
- Are programmes taught by specially trained teachers or are health programmes included in other elements of the school curriculum?

To achieve the best results for emergency-affected populations, the educational authorities and organizations providing health education should form a working group to develop health education guidelines and materials suited to local needs, adapting existing materials from the country/countries concerned as well as from international sources.

2. Health education providers should assess health education needs and develop skills-based health-education curricula/programmes using the assessment results.

(See the ‘Tools and resources’ section of this chapter for ways to assure health promotion through education.)

- In coordination with health authorities, assess the health needs/issues in the community, and prioritize areas of greatest urgency. (See also the Guidebook, Chapter 5.1, ‘Assessment of needs and resources’.)
  - What are the leading causes of morbidity and mortality within the community?
  - What important health issues are affecting:
    - Younger children?
    - Adolescents?
    - Mothers (particularly lactating mothers and pregnant women)?
    - The elderly?
Chapter 4.2: Health and hygiene education

- Do these health issues have varying impacts on different segments of the population?
- What do health professionals consider to be the priority health issues? What does the community consider to be priority health issues? Are they the same or different?
  - If they are different, what communication mechanisms are necessary to bridge this gap between the health authorities and the population?
  - Such differences indicate areas for particular focus in the design of materials.
- What are the social taboos or other barriers to young people regarding education for reproductive health? Do young people have suggestions for overcoming them?
- Make sure to consider the following key areas:
  - Access to clean drinking water.
  - Waste disposal – including latrines.
  - Nutrition.
  - Drug use.
  - Reproductive health.
  - Immunization.
  - Psychosocial needs (See the Guidebook, Chapter 3.5, ‘Psychosocial support to learners’, for additional information.)
  - HIV/AIDS (see the Guidebook, Chapter 4.3, ‘HIV/AIDS preventive education’).
- Develop skills-based health-education curricula/programmes based on the assessment.
  - What are the behaviours that the health programme seeks to change?
  - What pedagogical techniques, partnerships, and/or other resources will help make behaviour change more realistic?
  - Who are the different target audiences (e.g. primary-age schoolchildren, adolescents, etc.)?
LESSONS LEARNED FROM A HEALTH-EDUCATION PROGRAMME IN GUINEA

In 1994, the International Rescue Committee (IRC) initiated an adolescent health-education programme for Liberian and Sierra Leonean refugees living in the Republic of Guinea. The programme was integrated within IRC’s general education programme through the use of formal health-education classes. Additional activities included the formation of voluntary after-school ‘health clubs’ and young women’s social clubs that were involved in promoting positive reproductive and general health practices.

IRC reported that given the chance to repeat the programmes the following changes would be made:

- A needs assessment would be carried out to enable more efficient targeting of activities and messages.
- Programme activities would be initiated earlier after the arrival of the refugees.
- Increased involvement of the programme recipients in programme planning.
- Better monitoring and evaluation of programme activities.
- Increased training for staff.

Source: Pfeiffer (1999)

- How will differences in age, gender, religion and cultural specificity affect the type of information students will require and the way it should be delivered?
- Have health-education materials been developed in the multiple languages present in the community? If this is impractical or too expensive, consider developing clear visual representations, such as posters, or short skits or mimes that do not require language to convey the desired message.
DEVELOPING SCHOOL HEALTH-EDUCATION PROGRAMMES

“School health-education should be a planned, sequential course of instruction from the primary through the secondary levels, addressing the physical, mental, emotional and social dimensions of health. It can be taught as a specific subject, as part of other subjects or as a combination of both.”

Source: Aldana and Jones (1999: 21)

- How can multiple approaches, or a ‘comprehensive approach’ be used to convey the information/skills?
  - Are there implications for teacher training if a different pedagogic style is to be employed?
- Are there sufficient resources available to meet the desired programme design? (For example, if teaching about safe sex, are there sufficient condoms available? If teaching about waste disposal, are there shovels to dig latrines? Is there safe drinking water if the lesson is to be about preventing water-borne illnesses?)
- Have programme designers accessed the existing teaching materials and other educational resources available through national governments and international organizations? These may be used for reference in local materials development, or made available directly to teachers, if appropriate in terms of content and language. See ‘Tools and resources, section 2’ for a list of health-education tools available from the INEE Technical kit (INEE, 2004b).
- Have emerging (or pre-existing) risk factors (such as trafficking or HIV/AIDS) been considered?
- Has the health and hygiene curriculum been developed multi-sectorally?
HEALTH-EDUCATION IN AFGHANISTAN

Under the Taliban regime, Afghanistan had “one of the worst child health records in the world. Because of the urgent health needs of Afghan children and obstacles to working with the Taliban school system, Save the Children focused on out-of-school structured learning activities. A programme of child-focused health education was developed to promote the rights of Afghan children – girls in particular – to health, education and participation. Activities took place both in refugee camps in Pakistan and within Afghanistan itself.

“Volunteer facilitators, supported by local partner organizations, formed children’s groups and took the groups through a series of child-focused health-education modules. Topics included diarrhoea, coughs and colds, worms, hand washing, safe water, and flies. Each module [had] a booklet, cloth flipchart, cloth poster and a carry bag. The modules [took] two to three months to complete. The project emphasized partnerships with NGOs and local authorities in order to deliver education messages … Since the project began, improvements in children’s health-related behaviour were noted. Children were visibly cleaner in appearance and some children took responsibility for cleanliness within their home environments.”

Source: Nicolai (2003: 43)

- Consider establishing links between health, protection and psychosocial services, education and vocational training, and community-based organizations for young people.

• Pre-test the health-education materials that have been developed.
  • Are there small groups of students who are representative of the larger target audience who can participate in the pre-test?
• Did the pre-test group understand the message conveyed?
• Were combinations of approaches used? Which approaches seemed to be the most effective?
• Were the results from the trial group used to modify and revise the curriculum?
• Was the trial group followed up to determine whether the information had been merely received as opposed to understood and then practised?

• Build flexibility and sensitivity into the programme.
• Have contingency plans been developed to allow for a rapid education response to sudden epidemic outbreaks? Have the types of diseases that provoke sudden outbreaks been identified (measles is a prime example)?
• Are there issues that, due to social taboos, would be better discussed separately by male and female students? Are there sufficient teachers available for same sex classes of this kind? In other words, if the topic is sensitive, what can be done about creating a ‘safe’ or ‘secure’ environment in which to discuss it? Cooperation in this area could include:
  - Creating opportunities for group discussions.
  - Confidential counselling.
  - Other creative activities for young people to consider reproductive health issues in schools or other places of learning and interaction.
• Consider setting up a confidential reporting system for young people to report gender-based violence. Ensure that data are continuously monitored and used to inform protection and other services for survivors as well as for education and other prevention efforts.
3. Educational authorities and providers should facilitate or conduct health-education campaigns, designed in collaboration with community members and teachers.

- Education providers should form a committee with representatives of health organizations, community members and teachers to design a health-education campaign.
  - Consider including youth representatives on this committee as peer education has proven to be quite successful in past efforts.
  - Do the committee participants have experience in designing community or school health campaigns? If so, what have they found to be most effective in the past?
  - Are committee members representative of the community in terms of age and social group, language group, gender, ethnicity, etc.?
  - Have young people from the target population and from the surrounding local communities been asked to express their concerns in the development of the curriculum?
  - Does the committee have clear terms of reference?
  - Does the committee have a way of communicating its priorities to funding agencies?
  - Will there be a comprehensive approach including school-based, non-formal and informal health education using multiple channels of communication?

- Consider developing a mechanism for data collection that continues to identify and involve young people, and monitor their health and education needs.
  - Can gaps in the provision of and access to health services be addressed?
  - Does the way in which young people engage in destructive and constructive activities change over time?
CHILDREN CAN TAKE ACTION IN DIFFERENT PLACES:

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<th>IN THE COMMUNITY</th>
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<td>• Learn together actively</td>
<td>• Describe and demonstrate what</td>
<td>• Pass on messages through plays and</td>
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<td>• Help and teach their friends</td>
<td>they learn</td>
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<td>• Help and protect younger children</td>
<td>• Help their families with good</td>
<td>• Act as messengers and helpers</td>
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<td>• Help to make their surroundings</td>
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Source: UNHCR and Save the Children (2001)

4. Consider developing an associated education strategy for security, protection, administrative, and other personnel who come into habitual contact with youth.

- Are community authorities sensitized to the particular health needs of youth?
- Has it been recognized that threats to young people, including rape and other forms of sexual violence relating to reproductive health, may come from international and local humanitarian and educational staff?
• Have clear guidelines for interaction with adolescents been established and disseminated? Are there mechanisms for reinforcing the guidelines?
• What education programmes are needed in this connection?

TOOLS AND RESOURCES

1. Assure health promotion and education

“The promotion of healthy practices and positive behaviour through education takes on added urgency in an emergency. Health-education efforts in the initial emergency phase should be simple, focused and directly related to immediate public health problems. Other health concerns can be part of broader awareness-raising efforts as the situation evolves. Critical initial messages include:

• Proper personal and food hygiene.
• Safe water and hygiene and sanitation practices.
• Measles immunization.
• Oral rehydration therapy.
• Recognition and referral of childhood diseases.
• STD/HIV/AIDS prevention.

Health-education strategies will depend on communication channels and culture-specific means with which information is transmitted and received. Those from within the affected community are usually more effective, especially over outsiders without knowledge of the local culture. It is useful to involve
respected local citizens, such as teachers, religious leaders, traditional healers, or traditional birth attendants (TBAs), who can disseminate health messages through their daily contacts with the community. Female communication agents, including community health workers, should be mobilized to ensure women access to basic health information.”

Source: UNICEF (2001)

2. Tools on health education available from the INEE Technical kit

These tools are available from the INEE Technical kit, which can be ordered by e-mail (coordinator@ineesite.org) or from their website: www.ineesite.org.


Source: INEE (2004b)
REFERENCES AND FURTHER READING


