Health Education for Palestine Arab Refugees

By THERON H. BUTTERWORTH, Ph.D.

THE UNITED NATIONS Relief and Works Agency for Palestine Refugees (UNRWA) in 1951 requested the assistance of the World Health Organization in evaluating its activities and developing future plans for public health education. The World Health Organization met this request by loaning a health educator to the Agency for 2½ months during the summer of 1952.

The WHO health educator worked with the staff of the UNRWA headquarters office in Beirut and with Agency's country headquarters' staff in Lebanon, Syria, Jordan, and the Gaza strip, formerly under the Palestine mandate, now under Egyptian control. He visited representative field health programs of the Agency in all these countries and held discussions on health problems and health education with staff groups and with the Arab refugees from Palestine.

In most of this work the health educator had the valuable assistance of a refugee who was employed by the Agency and who had received some special training in health education from the Egyptian Government. This assistant had been a camp sanitation officer and a camp leader and was well acquainted with the refugees in the camps and with their problems.

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Clarification of the meaning of health education was a major objective in the consultant's day-by-day meetings with individuals and with various groups. In his survey he found some health education, recognizable as such, to be a part of the UNRWA program. However, the survey also found educationally significant situations, which were neither recognized nor utilized as health education. If health education were to be accepted as an integral part of the Agency's program, it seemed important to try to develop a broader concept of what health education is and what it can do.

It was felt that a written statement, concisely and simply presenting a broader educational approach to health, would be useful to the UNRWA staff, especially to the health, education, and welfare divisions. Such a statement was prepared during the summer of 1952 as a stimulation to continued thought and discussion, as a record of some of the thinking which had taken place in group discussions throughout the camps, and as a guide for future planning.

Believing that this statement, which was prepared for wide distribution among the UNRWA staff, may also be of some general interest to the public health profession, it is presented below with a few editorial changes which seem appropriate in this new setting.

The Statement on Health Education

Good health education aims to help more people make more free-choice decisions which will result in the maintenance or improvement of their health. The state of health of each

individual is basically the result of his own actions; or, putting it another way, our health is what we make it, to the degree that we are at all able to control our private and social condition. Other than small babies, mental defectives, and those incompetent to assume the normal responsibilities of life, there are few persons who are exceptions to this statement. Each of us inherits certain health strengths and weaknesses, sometimes serious health handicaps. Whether we use our inheritance and the environment in which we find ourselves most effectively for the maintenance and promotion of sound health is largely a matter of personal or group choice.

Society usually provides such health protection services as water purification, sewage disposal, food protection, or quarantine services. And even when these services are provided, their effectiveness is still dependent in large measure on individual and group choice of action. One may choose to drink from the pure water supply or from a supply of questionable potability. Clean safe food provided in a store can become contaminated because of bad health habits in the home. Sewage disposal systems must be used properly to be effective. Quarantine laws protect only to the extent that they are obeyed.

On the other hand, where governments have failed to take the necessary action to protect the health of the citizen, each individual can, through personal choice, and without the aid of government, act to protect his own health and that of his neighbor though his choice of action may be limited by the culture within which he exists. Water can be boiled. Foods can be washed, peeled, cooked, protected by refrigeration, and shielded from dust or insect contamination. Human excreta can be disposed of safely. Ill persons can be avoided and simple isolation practiced. Occasionally, individuals may be forced into situations injurious to their health, but even these situations often represent a group choice, which still leaves opportunities to choose a personal course regarding health.

Health Education Defined

The correct choice of action is most frequently made by those of us whose education regarding health is most complete. By education, we mean that aggregate of experience which enables us to live with the highest degree of efficiency, satisfaction, and service in the environment in which we find ourselves. The importance of sound health education is, therefore, obvious.

"Health education is the sum of all experiences which favourably influence habits, attitudes, and knowledge relating to individual, community, and racial health" (*1*), to quote one definition of health education, and "health," as defined by the Constitution of the World Health Organization, is "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity" (*2*).

The health education experiences most frequently referred to are (*a*) the conscious, formalized type of instruction, whether in the school class, university, or community study group, and (*b*) the exposure to one or more of the usual types of mass media. These kinds of experiences are related to the imparting of information and may or may not educate for action. Too frequently they do not. Individuals may become quite well informed about the ways to establish and maintain health, but until they freely choose to act in accordance with such information they are not really "educated" about health.

Many basic health attitudes and practices are developed without conscious instruction. Care of one's body, eating habits, patterns of sleep, care of the teeth, home remedy practices, actions in the face of oncoming illness, attitudes toward health and disease, choice and use of professional health and medical services—these and many other actions that daily affect health are much more the result of the experience of living in close contact with certain cultural patterns and social customs than of specific information acquired, no matter from what source.

It is true that present actions are dictated by past experience, notwithstanding the fact that one may possess information which indicates an entirely different choice of action.

The Bedouin mother who had had the experience of losing two children because, as she thought, they had got their heads wet, chose not to bathe her third child. She made this decision in spite of the information given her by the nurse as to the great benefit to the child of regu-

lar bathing and the careful explanation that wetting the head had not killed the other two children. The experience of daily visiting the baby center and seeing other mothers wetting their children's heads without harm finally convinced her that she should try it too. Another experience had been added to her life which helped her to make another free choice, that of washing her baby.

The word "favourably" in the definition of health education (*1*) is important. Some education in respect to health is unfavorable. Too often the unfavorable education is of the experiential type, and its importance is not recognized. A class may learn from the textbook that good ventilation is necessary for the promotion of sound health. Yet, because of a teacher's choice, this same class may sit daily for several years in a hot, poorly ventilated room. The members of the class may develop a liking for such an unhealthy condition despite the instruction in the book.

Or, a woman is urged to come to a maternity home for delivery. Once there, she is given the best medical and nursing care from a technical standpoint and is delivered of a fine baby. But, at the same time there may be so little human kindness and sympathy associated with the professional services that she "learns" that maternity centers are places to be avoided. The experiences of personal neglect and unhappiness will far outweigh the information concerning the usefulness of maternity centers which she may receive at the next antenatal class, if she attends one.

Experiences continually shape patterns of health habits. These experiences, being frequently repeated and usually touching personal lives closely, tend to outweigh the experiences of didactic teaching and information received from various sources. Those of us in public health have only to consider our own actions regarding health to recognize the truth of this statement.

Most of the experiences which educate positively or negatively for health can be controlled. Those of us who are in public health, in whatever particular professional group, need to train ourselves to recognize these experiences and to attach more importance to planning that the experiences be essentially favorable in effect. In our planning groups we would do well to include, whenever possible, the persons themselves who are to be educated. For it has been said that people usually act upon plans that they have helped to make.

Action is important. To know that vaccination protects against smallpox is to be informed, but to be vaccinated is to be "health educated" with respect to the control of smallpox. Health education, to be effective, must achieve desirable action.

Health Education in UNRWA

In studying health education in UNRWA, we noticed among the professional staff and the refugees themselves a general confusion between health instruction and health education. The aim of health education was most frequently considered to be informing people about health—specific situations which might be called "health instruction," situations in which people were being told what to do—rather than stimulating people to act wisely in regard to their health. The objective was arrived at through the fallacious reasoning that to know is to act.

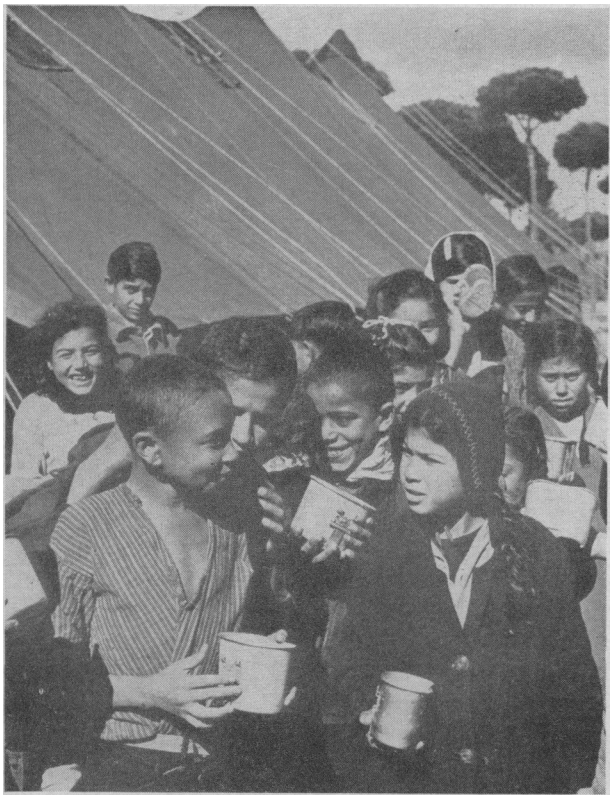
Health education found throughout the camps was being carried on by many different people in UNRWA. This is as it should be, for health education is, for the most part, an aspect of a program or service rather than a separate entity in itself. It should be carried on by all members of the staff, with the person designated as health educator having the responsibility of stimulating and facilitating the health education aspects of the work of others, as well as of carrying on some direct education.

The program contained many examples of health education and many more opportunities not yet put to use in the interests of health education. Some of the situations found in UNRWA camps more commonly recognized as involving health instruction are these:

Teachers in elementary schools give some health instruction.

Some sanitary inspectors during their daily work give talks to groups of people, explaining the reasons for sanitary regulations.

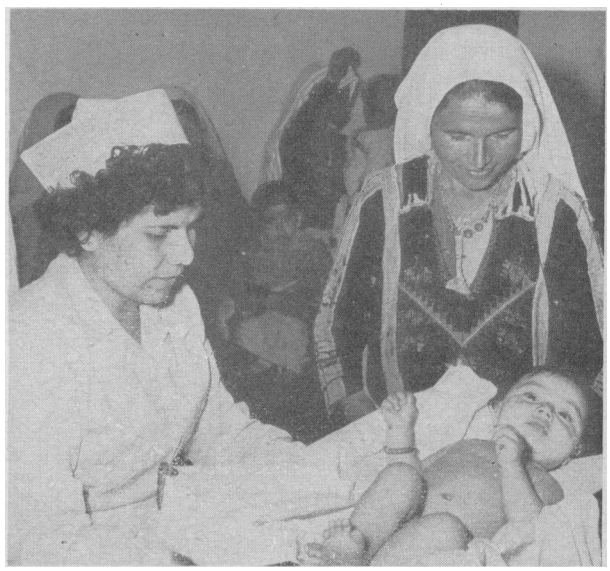
Health instruction is a part of the literacy training included in the work of one sewing class.

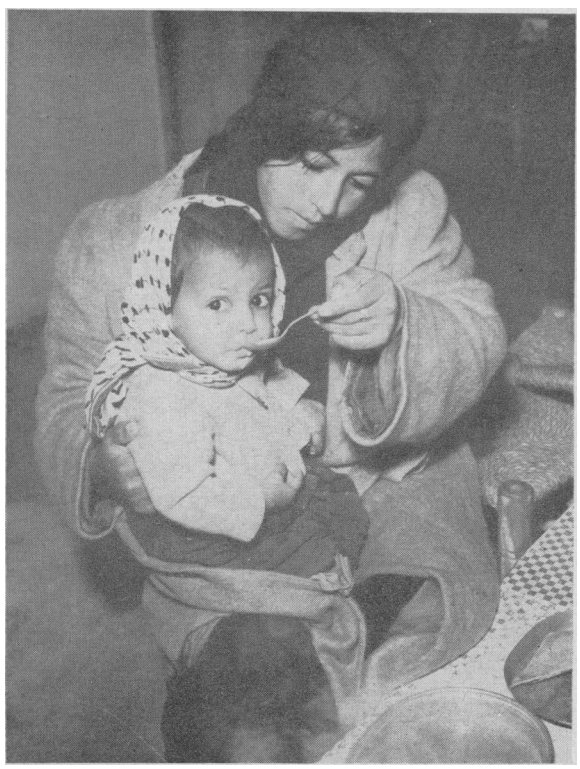


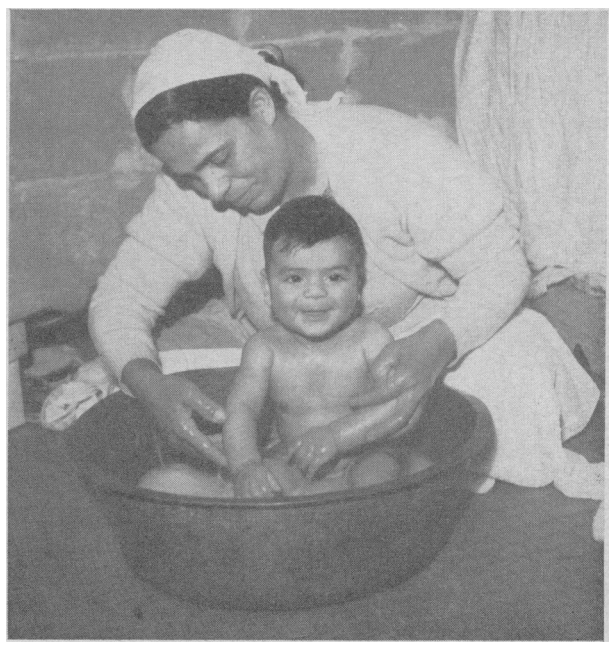
Positive Education for Health

WHILE as many as 6,000 Palestine Arab refugees are still living under canvas in a refugee camp, most of the camp populations have now been housed in huts of concrete or lumber, which give much better protection against winter storms and hot desert wind. From more than 30,000 tent units in 1950, UNRWA has reduced

the tent housing to approximately 10,000 in 1954. The present number in all UNRWA refugee camps is 340,000. Each camp has a supplementary feeding center, which serves milk and a daily cooked meal to all babies and children recommended by the camp physician. From early pregnancy, mothers are encouraged to attend the antenatal clinics. They learn to make their own baby clothes. They are urged to come to the maternity home for delivery of their child. Once a baby is born, his mother is encouraged to bring him regularly to the infant health clinic. She learns how to bathe her baby. Both mothers and children are having experiences which daily help them to learn the value of good food, carefully prepared and served.







Posters are displayed on the walls of schools, offices, clinics, feeding centers, and similar places.

Some films on health subjects have been shown to school children and to community groups.

Nurses and midwives teach mothers how to wash and dress their babies.

Suggestions for improving health education in UNRWA, made by staff and refugees, included motion picture shows, posters, talks to mothers, additional hours of instruction in schools, use of pamphlets, lectures to young girls, and special classes on health. All of these ways of instructing are important but of little effect if they are not made an integral part of a planned, broad-based education program which includes, in addition, those kinds of personal experiences which influence individuals to action.

The following are a few experiences of those in the camps of UNRWA, which may be having an even deeper effect on the formation of individual health habits but which are not always recognized as having health education significance:

Mothers and children at feeding centers enjoy meals which daily help them to learn the value of good food, carefully prepared and served.

In the feeding centers where young girl volunteers are assisting, good habits are formed with respect to the preparation and care of food.

In some areas it was reported that nurses and midwives were making at least a few visits to their patients' homes, a most effective form of health education.

The experience of being a part of the well-regulated community life of camps and compounds, with available sanitary services, pure water supplies, clinic services, feeding and recreation centers, and reading rooms may be the most important single factor responsible for changing for the better the health habits of the refugees.

The observable good effects of early diagnosis and treatment, of immunization and professional medical care, in reducing or entirely preventing illness, are a potent educational experience.

Hospitalization, when it is a satisfying experience, increases respect for health practices.

In one feeding center, sick mothers and babies, by being placed in isolation, learned to attach importance to the communicability of disease and to the practice of simple isolation.

Profitable and healthy use of leisure time was learned at welfare centers where games are available.

Other examples of health education were found in UNRWA camps, but an extension of the list would serve no useful purpose here. The amount and quality of the health education found were, to a large degree, proportionate to the interest and conviction and capacity of the professional worker responsible. Although there were some who were notable exceptions, many members of the professional field staff of the health division seemed to hold the opinion that medical service—the treatment of disease—was of first importance and that since caseloads and the scarcity of equipment and supplies made it almost impossible to meet demands in this area, it was useless to attempt health education. Health education they considered to be an extra duty, not seeming to understand that through effective health education a crushing caseload might eventually be lightened.

Another attitude which must be considered in these particular health education activities is the refugee's conviction that under present living conditions he can do nothing to protect or improve his health. To the question, how can we help the refugee improve his health? the answer was repeatedly: Supply him with more and better food, a better house, more clothes, and he will take proper care of his health; he knows how but is prevented from doing so because of his living conditions.

Since even the most highly developed and health-educated people still need further health education because they do not always act for their own best interests, it seems improbable that the refugee would become sufficiently health-educated simply by being given clothes, a better home, and better food. In fact, in this part of the world a look at any group which is not composed of refugees refutes the argument. That these people can learn to change health habits for the better has been demonstrated.

Many refugees in only these few years have

changed lifelong habits. Many a desert dweller who had never before used latrines now uses them.

Many a refugee who never gave a thought to his water supply now chooses to use the safe supply provided for him.

Many a mother is washing and dressing her baby in a more satisfactory manner and is submitting her children to immunization, a procedure to which she objected vigorously a few years ago.

People—all kinds of people—can be helped to learn how to make good choices respecting their health. The first step is to help them want to make the change.

Program Development and Planning

The creation of trained leadership is the first need for the further development of health education on a wider basis among the Palestine refugees. Once there is trained leadership, the priority steps in developing the type of health education defined in the foregoing might take the form of the following suggestions:

1. Assist the UNRWA staff to make use of existing opportunities for health education as these are recognized and help the staff stimulate and create new situations where necessary so that refugees will have more opportunities to acquire positive health habits.
2. Assist in the training of additional leadership in health education of the public.
3. Develop, with the assistance of the Palestine Arab refugees, a broad, planned program of health education which can serve as a foundation for the continuation of health education services wherever the refugees may eventually live.
4. Develop an apprenticeship program whereby the kinds of effective health education now being carried on by some staff members can be learned by others.
5. Assist in obtaining or developing simple health education materials, to be tested for effectiveness before being given wide distribution.

Before a year passed the United Nations Relief and Works Agency for Palestine Refugees had started acting on these suggestions for future planning. The Agency entered into negotiations with the World Health Organization for specific assistance in developing the health education program. The two organizations signed an agreement in August 1953 whereby, under the United Nations expanded program of technical assistance, the World Health Organization would assign a qualified public health educator to the Agency, would underwrite training fellowships in health education for 10 persons, and would provide a modest sum for teaching equipment and materials.

In November 1953 the World Health Organization assigned a public health educator to UNRWA on a 2-year contract. Through his coordination with members of the UNRWA staff and the staffs of other agencies, a course of instruction in health education was established at the Agency headquarters office in Beirut. The course consists of 6 months of academic work, which is integrated with some field work, and 6 months of full-time supervised field training. Ten Palestine refugees, 7 men and 3 women, were recruited for the training from the areas served by UNRWA and reported on February 22, 1954. The 9 members of the class who completed their academic work in August 1954 and their supervised field work in February 1955 have been employed on a full-time basis by the Agency and are working in the 4 countries in which they did field work.

Thus far the training course has been successful. The Agency requested an increase in fellowship funds, which WHO granted, to assist in the support of a second class of 11 persons who commenced their academic work in November 1954. This group is now on supervised field work in Lebanon, Syria, Jordan, and Gaza. They will complete the year's course in October 1955, at which time it is anticipated they will also be employed by the Agency. It is hoped that eventually they will be utilized as health education leaders by governments and voluntary agencies in the eastern Mediterranean area.

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A section (pp. 8–14) in the 1955 annual edition of the publication, Health Educators at Work, has been devoted to program planning in health education for the Palestine Arab refugee. Written by Dr. Louis Findlay and William A. Darity, the article tells what came after Mr. Butterworth's article and describes the actual

training program in health education. Dr. Findlay is the WHO medical officer assigned to UNRWA as chief of the health division, Beirut headquarters office, and Mr. Darity is the WHO health educator on loan to the same office. Health Educators at Work is published by the Department of Public Health Education, School of Public Health, University of North Carolina, Chapel Hill, and the Department of Public Health Education, North Carolina College, Durham.

REFERENCES

(1) American Public Health Association: Report of the Committee, Health Education Section. New York, The Association, 1934.

(2) Constitution of the World Health Organization. Pub. Health Rep. 61: 1259–1279, Aug. 20, 1946.

PHS film

Functioning of Gas Feed Chlorinators

Part 1: Visible Vacuum Chlorinator.

Part 2: Volume Metering Chlorinator.

35 mm. Filmstrips, color graphics, Part 1—12 minutes, 57 frames; Part 2—10 minutes, 42 frames. 1954.

Audience: Sanitary engineers, sanitarians, and others interested in water chlorination.

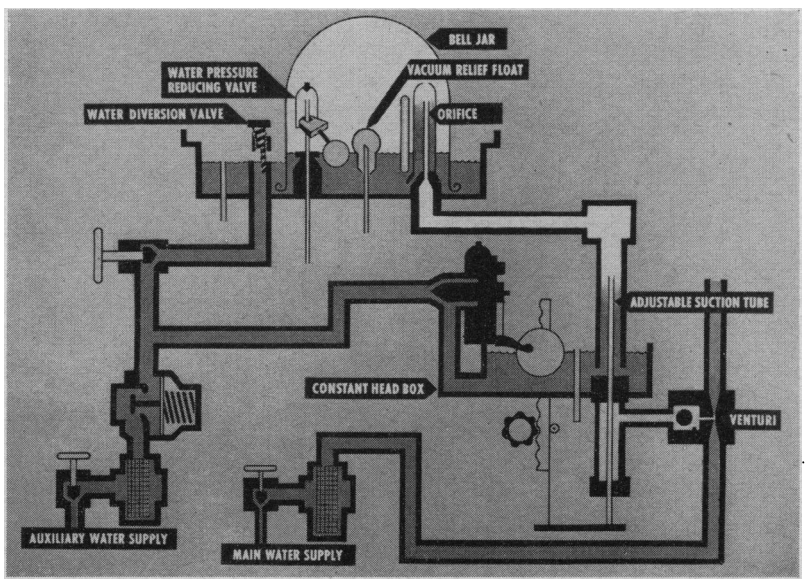
Available: Loan—Public Health Service, Communicable Disease Center, 50 7th St., NE, Atlanta 23, Ga. Purchase—United World Films, Inc., 1445 Park Avenue, New York 29, N. Y.

The primary parts of visible vacuum and volume metering chlorinators and their functions are illustrated in these filmstrips.

Points to be checked at each inspection for assurance of proper operation of the machines are also depicted. For the visible vacuum chlorinator in part 1, the scale inside the bell jar that indicates the amount of chlorine being fed, the weight of the chlorine cylinder to tell how near it is to being empty, the chlorine gas, water supply, and auxiliary supply pressure gauges are shown as operation check-points.

For the volume metering chlorinator, part 2, the water pressure gauge, the pulsations-per-minute, the chart for checking the amount of chlorine fed per day, and the weight of the chlorine cylinder are emphasized.

The basic principles and inspection check-points pictured in these filmstrips aid in the understanding of the functioning of the general types of the machines featured.



A cross section of a visible vacuum chlorinator. Its function is to apply chlorine gas to water in an accurate and continuous flow.