

## Health Education in Timor Leste (East Timor): A Case Study

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The conclusion of the electoral process in April 2002, paved the way for the declaration of independence on 20 May 2002, making Timor Leste (East Timor) the world's newest democracy. The purpose of this study is to describe and analyse the status of health education in the world's newest democracy. The specific aims of this longitudinal study being carried out over 3 years were: to obtain a broad overview of the current health education curriculum in East Timor, to identify the professional development needs of teachers teaching health education at the primary and lower secondary level and to develop an health education module in Portuguese and Tetum for primary schools to be trialled in two schools in Baucau, East Timor.

The research used an interpretive case study approach in which multiple methods, sensitive to the context, included in-depth and focus group interviews, school visits, accumulation of documentary data and reflective narratives. This paper documents the challenges faced by teachers in the implementation of a relevant health education in a post-conflict transitional society.

### Background to the Study

*East Timor: A background to the world's newest nation*

The Democratic Republic of Timor Leste (East Timor) is in many regards a 'new' nation. From 1975 until an independence referendum in August, 1999, the nation was 'annexed' by the Republic of Indonesia. It is widely recognised that these decades were marked by violence, human rights abuses and an estimated 200,000 deaths throughout a long-term guerilla resistance (Dunn, 2003; WHO, 2000a). For the more than 450 years prior to Indonesian involvement, Timor Leste (East Timor) was a colony of Portugal (Dunn, 2003).

Immediately following the referendum vote, anti-independence groups led a violent assault on the nation's people and infrastructure, in which many East Timorese were killed, injured and the infrastructure destroyed (Adhikary, 2002). Up to three-quarters of the estimated population of 850,000 was displaced and health facilities were damaged or destroyed (Dunn, 2003; WHO, 2000). In addition, the emigration of core Indonesian health professionals caused the "total collapse" of the health system (WHO, 2000, p.1).

### Health Indicators in East Timor

Although currently 80% of the population has access to health services of some description (with an average walking time of 70 minutes) (WHO, 2003), there is an acute lack of trained health workers, and doctors. Continuing problems include:

- ♦ A strong potential for epidemics of malaria, dengue haemorrhagic fever, Japanese encephalitis, cholera, typhoid, tuberculosis and diarrhea (WHO, 2003).
- ♦ Maternal, infant and under-five mortality rates are at unacceptably high levels (WHO, 2003).
- ♦ Around half of all women and young children have anaemia and around half of all children under 5 are under-weight (WHO, 2003).
- ♦ Water supplies and sanitation reportedly remain very poor, with inadequate or non-existent systems for the formal collection of garbage and hazardous medical waste (Adhikary, 2002).
- ♦ 41% of the population lives below the national poverty line of 55 US cents per day (UNDP-HDR, 2002).

### Theoretical Underpinings

*Focusing Resources on Effective School Health (The FRESH approach)*

Good health and nutrition are both essential inputs and important outcomes of basic education. First, children must be healthy and well-nourished in order to fully participate in education and gain its maximum benefits. In addition, a healthy, safe and secure school environment can help protect children from health hazards, abuse and exclusion (WHO, 1996; UNESCO, 2002)

International agencies such as WHO, UNICEF, UNESCO and the World Bank believe that there is a core group of cost effective strategies for making schools healthy for children and so contribute to the development of child-friendly schools. These agencies have launched a new approach to health education called FRESH (Focusing Resources on Effective School Health). Through this approach health policies are adopted and implemented in schools that address the provision of safe water and sanitation, a skills-based health education and school based nutrition and health services

(UNESCO, 2002).

#### *School Health Education*

The arguments for using schools for the dissemination of health education and treatment are logical: there are invariably more schools than clinics in developing countries, and as schools effectively gather children together in one place, they provide an ideal environment for targeted health education. There are numerous reports of the effective use of school-based health programmes to diagnose and/or treat conditions such as malaria and schistosomiasis (Hall, Adjei & Kihamia 1996). Furthermore, children are accustomed to receiving instruction in classroom situations, and they are thus more receptive and responsive to specific health education messages, and more inclined to assimilate the information and relay it to other household members.

#### *The Child-to-Child Concept*

According to research conducted by Rohde and Sadjimin (1980), information conveyed by school children to other household members is generally perceived to be modern, reliable, and believable. This concept was also effectively used by schools in Uganda (Ministry of Education, Uganda, 1992). Indeed, school health programmes are so efficacious in influencing community perceptions and behaviours that they have been specifically identified by the World Bank (1993) as one of the six most cost effective public health strategies in use.

### **Research plan, Methods and Techniques**

#### *Using Multiple Research Methods*

In the context of Timor Leste (East Timor), the study was an enquiry into a complex transitional society. The case study used a multi-method approach using qualitative data with interpretative and critical ethnographic analysis to allow triangulation of methods and cross validation of the data (Denzin & Lincoln, 2000).

#### *Sample*

Qualitative data was collected from teachers, head teachers, education personnel and lower secondary students from schools in Dili and Baucau. 4 classroom health science lessons with 2 each in primary and secondary schools were observed. Focus group discussions on health issues were conducted with teachers and students. Documents on teaching health issues in schools were obtained from the Ministry of Education.

*The first phase of the study*, involved in-depth focus group discussions with primary teachers and lower secondary science teachers and secondary school students and addressed health related teaching and learn-

ing issues. This phase provided a broad overview of the health education taught in schools.

*In the second phase*, 4 health science lessons in primary and secondary schools were observed using a semi-structured class observation schedule, for the purpose of identifying classroom practices and professional development needs in East Timor.

*In the final phase*, teachers were introduced to primary health education modules. Teachers then identified those modules relevant to their context. The modules were then translated into Portuguese and Tetum. A manual was developed based on these modules and is currently being trialled in 2 schools in Baucau, Timor Leste.

### **Discussion and Conclusion**

Like the WHO, 1996 report on improving school health programs, this research also identified the challenges facing a post-conflict transitional society as an acute lack of infrastructure and resources, lack of trained teachers to teach health education, an impoverished population that struggles to survive, a shortage of funds to train teachers and buy resources. But meeting and talking to the teachers and students has given the researcher another lesson in resilience, endurance and hope: that teachers in the transitional nation of Timor Leste want to succeed against all odds.

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