HEALTH PROMOTION AND DISEASE PREVENTION A Handbook for Teachers, Researchers, Health Professionals and Decision Makers	
Title	**Health Education in Practice a Bit Differently Than Usual**
Module: 4.4	**ECTS: 1**
Author(s), degrees, institution(s)	**Lijana Zaletel Kragelj,** MD, PhD, Assistant Professor University of Ljubljana, Faculty of Medicine, Chair of Public Health, Slovenia **Milan Krek, MD,** PhD Candidate, Teaching Assistant Regional Public Health Institute Koper and University of Ljubljana, Faculty of Medicine, Chair of Public Health, Slovenia **Ivan Erzen,** MD, PhD, Assistant Professor Regional Public Health Institute Celje and University of Ljubljana, Faculty of Medicine, Chair of Public Health, Slovenia
Address for correspondence	**Lijana Zaletel Kragelj,** MD, PhD, Assistant Professor University of Ljubljana, Faculty of Medicine, Chair of Public Health Zaloška 4, Ljubljana Slovenia Tel: +386 1 543 75 40 Fax: +386 1 543 75 41 E-mail: lijana.kragelj@mf.uni-lj.si
Key words	health communication, health education
Learning objectives	After completing this module students should: • recocgnize the importance of health communication and health education; • increase knowledge about health education and its uses in different target groups; • understand basic elements of health education.

Abstract	Health education is becoming more and more important approach to control various public health problems, epecially in the populations with high percent of older age groups. At the first sight this approach seems to be very easy to practice but to plan and to practice properly this approach in various target groups it is necessary to have certain knowledge and skills. On one hand there exist different target groups in the process of health education with different needs and with different level and capacity of accepting the information on health. Practice of health education in old age groups differs substantially from the practice in adolescents or preschool children. On the other hand health professionals with different undergraduate background could be involved in the process of health education among them also physicians. In Slovenia, physicians of different speciality, especially general practitioners and family medicine specialists could be involved in health education on different occasions. Getting certain skills in health education could be of enormous importance for them.
Teaching methods	Teaching methods include introductory lectures, extensive discussion on methods of health promotion in practice, discussion on core theme of the health education practice, and health education practice. Students after introductory lectures prepare themselves to practical approach in respect of methodology and core theme. Afterwards they realize health education workshop in practice in at least three different groups of target population.
Specific recommendations for teachers	• work under teacher supervision/individual students' work proportion: 50%/50%; • facilities: for preparational work a computer room; for health education workshop a room for about 20 pupils-learners, and students-educators; • equipment: for preparational work computers, LCD projection equipment, internet connection, access to the bibliographic data-bases; for health education workshop no special equipment is needed; • training materials: readings on health education methodology and on core theme of health education workshops; • target audience: undergraduate students of medicine.
Assessment of students	Written report on health education practice.

HEALTH EDUCATION IN PRACTICE A BIT DIFFERENTLY THAN USUAL

Lijana Zaletel Kragelj, Milan Krek, Ivan Erzen

Theoretical background

Health education definition

According to Last (1), health education is the process by which individuals and groups of people learn to behave in a manner conductive to the promotion, maintenance, or restoration of health, whilst according to World Health Organization (WHO) it is an activity which comprises consciously constructed opportunities for learning involving some form of communication designed to improve health literacy, including improving knowledge, and developing life skills which are conducive to individual and community health (2, 3).

The concept of health education is strongly related to several other concepts among which the following are important for understanding of this module:

- the concept of health behaviour and health behaviour change;
- the concept of lifestyle,
- the concept of health promotion;
- the concept of health communication;
- the concept of empowerment, and
- the concept of salutogenesis.

Concepts, related to health education

Health behaviour, risky health behaviour and health behaviour change

Health behaviour could be defined as a behaviour, which is related to health condition of an individual. There exist specific forms of health behaviour which are proven to be associated with increased susceptibility to a specific disease or ill-health and are as such designated as risky. Risk behaviours are usually defined as »risky« on the basis of epidemiological or other social data (2).

If the health behaviour of an individual or of a group of individuals is risky, the change of this behaviour to less risky or more healthy, is logical and reasonable. Changes in risk behaviour are major goals of disease prevention, and traditionally health education has been used to achieve these goals (2, 3).

Within the broader framework of health promotion, risk behaviour may be seen as a response, or mechanism for coping with adverse living conditions. Strategies to respond to this include the development of life skills, and creation of more supportive environments for health (2, 3).

In the process of health behaviour change existing behaviour is replaced with new one and as such relates to the adoption of innovations (3).

The health behaviour change could be individual or collective process.

In some population groups, e.g. in adolescents, strong collective risky health behaviour is present. Individual behaviour change in such a case is hardly to be efficient, and collective change is proposed (3).

Health education and health promotion

The term »health education« is often equated to the term »health promotion«. Certainly, on the other hand they overlap to the certain extent, but on the other hand they are definitely not

synonims. The debate about the overlap between these two terms, or better these two concepts, began in eighties when the range of activities of promoting health overgrew the narrow focus on lifestyle approaches (4). The problem of overlapping has historical origins, since in the past, health education was used as a term to encompass a wider range of actions including social mobilization and advocacy. These methods are now encompassed in the term health promotion, and a more narrow definition of health education is proposed by WHO to emphasize the distinction (2).

Health education and health communication

Today, health education is in many cases understood as one of the key methods of health communication.

Health communication is a key strategy in health promotion. It is aimed at informing the public about health concerns and to maintain important health issues on the public agenda (5, 6).

But health education is not only concerned with the communication of information, but also with fostering the motivation, skills and confidence (self-efficacy) necessary to take action to improve health (2). Health education includes the communication of information concerning the underlying social, economic and environmental conditions impacting on health, as well as individual risk factors and risk behaviours, and use of the health care system. Thus, health education may involve the communication of information, and development of skills which demonstrates the political feasibility and organizational possibilities of various forms of action to address social, economic and environmental determinants of health.

Health communication may take the form of discreet health messages or be incorporated into existing media for communication, from mass and multi media communications to traditional and culture-specific communication like story telling or songs. It encompasses several areas, including social marketing (2).

The main functions of communication are to inform, to persuade, to remind and to stimulate change behaviour.

Health education and lifestyle

According to Last (1), lifestyle is the set of habits and customs that is influenced, modified, encouraged, or constrained by the lifelong process socialization. In this process health education could have enormous impact in a positive manner if it is conducten in an appropriate way (corresponding to behaviours and needs of specific target group). In this process, it is extremely important to be aware, that if health is to be improved by enabling individuals to change their lifestyles, action must be directed not only at the individual but also at the social and living conditions which interact to produce and maintain these patterns of behaviour (2).

Health education and empowerment for health

Health education is extremely important in achieving greater empowerment, a process through which people gain greater control over decisions and actions affecting their health (2). It could take its part in empowerment for health in individuals as well as in communities. It is relevant in a number of contexts, including on one hand the dissemination of individual and population health risk information, and health professional-patient relations on the other (4, 7). Empowerment is among others a social, cultural, and psychological process. Again, it is

extremely important to be aware that empowered people as an outcome could be achieved only by considering all potential interactions.

Health education and salutogenesis

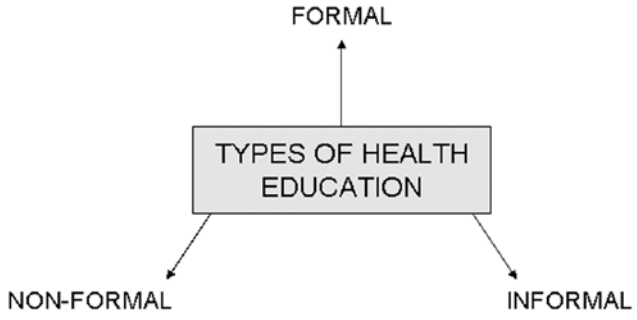
One of the key issues of modern curative medicine is the origin of diseases, since etiological treatment (i.einfluencing the cause of the disease) is the most effective. The mechanism by which a certain etiological factor causes disease is called pathogenesis (1). Opposite to this concept is a concept of salugenesis. Salutogenesis is a concept that focuses on factors that support human health and well-being rather than on factors that cause disease (8-10). Pathogenesis is thus related to biomedical comprehension of health, whilst salutogenesis to bio-psycho-social comprehension of health (4).

Today, salutogenesis with the concept of sense of coherence (SOC) represents a part of the theoretical background in health promotion (8), and as such also for the health education.

Types of health education

Like in education on general, we distinguish between different types of education, being formal, non-formal, and informal (11) (Figure 1).

Figure 1. Types of health education.



1. Formal education.
   Formal education is defined as regular schooling that follows a normal pattern and use of a curriculum that covers a wide range of knowledge, skills, values and attitudes. It is performed in educational settings.
   Formal health education is taking place in schools as well as in health settings (e.g. primary health care centres). It is a part of regular educational curricula in schools, or part of a regular preventive procedure in health care.
2. Non-formal education.
   Non-formal education is defined as any organized and sustained educational activities that do not correspond exactly to the defi nition of formal education. Non-formal education may therefore take place both within and outside educational institutions, and cater to persons of all ages. It may cover educational programmes to impart adult literacy, life-skills, work-skills, and general culture, as well as health and environmental education. Non-formal education programmes do not necessarily follow the »ladder« system like

formal education does, and may have differing durations, and may or may not confer certification of the learning achieved (12). The activities may include courses, workshops and apprenticeships that meet specific needs of population groups.

Education providers should consider enriching formal schooling with non-formal activities, since non-formal education may be a critical supplement for students enrolled in formal schools. For adolescents in particular, non-formal educational activities may greatly expand their opportunities for learning. Among others, health themes can be explored through non-formal courses to further students' understanding and to provide them with accepting social environments in which to discuss these issues.

Non-formal health education can place in schools as well as in health settings (e.g. primary health care centres), but outside the regular curricula, and can be performed by various parformers, also by specially trained peers.

3. Informal education.

   Informal education is defined as education through learning channels, such as mass media and mass publicity campaigns, where there is little or no possibility for attention to the individual.

Effective health education process in adolescents

When designing non-formal health educational activities, it is important not to overlook or underestimate learner concerns or needs. Some may be unrealistic, but none are unimportant. Learners should know that their concerns have been heard and that their ideas have been incorporated as far as is possible. Quality education is partly a result of gaining buy-in, trust, and participation/ownership from learners.

From this point of view, in health education process in certain population groups e.g. adolescents, specially trained peers could be important channel to distribute »healthy ideas« of any kind e.g. unhealthy behaviours (smoking, alcohol consumpiton, illicit drugs consumtion, unhealthy nutrition, insufficient physical activity, etc.), sexually transmited diseases, environmental health, etc. Peer education has proven to be quite successful in past efforts.

Peer-education is effective skills-based health education process, since children are benevolent to learn through social interaction with other children (11). Considering of involving youth in all stages of health education programmesis effective because:

- young people can use language and arguments that are relevant and acceptable to their peers;
- young people have credibility with their peers and may be able to offer applicable solutions to prevention problems. Especially students of medicine have credibility with a bit younger peers what secondary school students are. In many respects, students of medicine are a model, or better an ideal, to be reached in the future;

Also those, who are in role of peer educators may benefit from improved self-esteem and skills and attitudes with regard to health.

Case study - health education practice for undergraduate medical students at Ljubljana Faculty of Medicine/Slovenia
Health education in the curriculum of Ljubljana University Faculty of Medicine

Health education is introduced to medical students in Slovenia as one of public health methods in the frame of Social medicine in the second and third school year out of six school years of educational process:

- all students got acquainted with different types of health education, and different levels of health education (primary, secondary, tertiary) by attending the lectures in the second school year,
- students with special interest for public health approaches in medicine have opportunity to practice certain skills in health education by attending the elective module »Health education – A practical approach«, one of 23 elective topics in the frame of Social medicine in the third school year.

Elective Module »Health Education – A Practical Approach«

Historical background

The health education approach could be properly introduced to medical students only through practice, but we should be aware that only certain percent of medical students (in Slovenia about 20%) are susceptible to public health approaches.

At Medical faculty of University of Ljubljana the need for searching for the appropriate opportunity to transfer health education topic from theory to practice was identified few years ago. Since this topic is incorporated in the subject Social medicine, we started to think about how to realize it. The solution was to try in the frame of elective part of this subject. There were several options possible.

Opportunity

At one of the Ljubljana general secondary schools (gymnasiums) – »Gimnazija Ledina« secondary school – the personal contact was established. The idea was introduced to responsible persons and the response was more than positive. Together we have identified the common need for collaboration, being:

- from the point of view of »Gimnazija Ledina« secondary school, the need to transfer certain health topics to adolescents, and
- from the point of view of Faculty of medicine of University of Ljubljana, the need to transfer certain skills in health education to the students.

Identification of needs

At »Gimnazija Ledina« secondary school identified the need for establishing the supportive environments for health through skills-based health education process.

Health supportive environments is extremely important, since it offers people protection from threats to health, and enable people to expand their capabilities and develop self reliance in health, and opportunities for empowerment. Furthermore, in empowerment, life skills are extremely important. According to WHO, life skills are defined as abilities for adaptive and positive behaviour that enable individuals to deal effectively with the demands and challenges of everyday life. Transmission of life skills from peers, who are specially trained, thus could represent to other peers could be used for empowerment.

Focusing the health topic to be transmited

As previously described, many different health topics could be peer transmitted. We decided first to concentrate on one of the urgent health problems in Slovene adolescents – the problem of drugs and alcohol consumption.

Workshop course in practice – Drugs and adolescents

Aim of the workshop

The main aim of the workshop is to become familiar with the methods of health education with target group, and collecting basic experiences of how to pass on health educational contents, with intention to get acquaintance with all phases of the process, from planning to evaluation. For the last, methods of qualitative analysis were supposed to be used.

Methods

1. Health education (HE) method.

   The method of group discussion with peers is used (3, 13). With this method, several aims could be achieved (3):

   - increase of knowledge:
     - it assist the process of transferring knowledge from an expert (in our case from the trained peers) to the group,
     - it help people assimilate knowledge by giving the participants an opportunity to ask questions,
     - it help participants of the discussion to relate the new information to what they already know and to revise their attitudes,
     - it can be of great use in providing information about how to cope with problems discussed in every day life;
   - change in frame of reference:
     - it can help in creating awareness of problems and feelings (it is sometimes easier to acknowledge one's feelings in a group where other members openly discuss their own feelings too,
     - it can help to arrive at concrete formulation of a problem (the more clearly a problem is defined, the more likely the solution is found),
     - it can help to form an opinion about problem discussed,
     - it can lead to a change in norms (if the group itself concludes that they should change attitudes and norms, they indeed do change);
   - behaviour change:
     - it has an important role in individual decision making, what was demonstrated long ago in a series of experiments by Lewin (3),
     - it leads to collective decisions,
     - it can have an important role in helping people become aware of their collective interests, and in deciding how they can best protect these interests,
     - it generally strengthen a person's decision to implement the choice already made, and thus leading to a confirmation of the choice

Discussion with peers has several advantages. As already discussed, the adolescents have no positive relation towards classical presentation of health-educational contents and that is why classical lectures are almost not appropriate educational method. In guided group discussion

with peers we try in the group of pupils:

- to remove secrets, why some young people use legal and illegal drug, (especially alcohol), consequence they see and their relations with adults in view of drugs,
- to encourage young people in the process of discussion to think about negative consequences of drinking alcohol and taking drugs,
- to send positive messages – messages how to protect their own health in every aspect of drugs.

This method has also some disadvantages. For group methods to be effective, group size is important. When the group is too small, there will be insufficient input for discussion. When the group is too large, several participants will not take their part in the discussion. Generally it is recommended that a group size is between five and fifteen participants. Some other disadvantages are:

- problems/themes are discussed less systematically than in a lecture,
- there is a danger that some participants dominate the discussion while some others do not participate in it,
- a good discussion assumes participants have at least minimal knowledge about the theme of the discussion,
- there is a chance that incorrect information given by one participant will not be corrected,
- the socio-emotional climate has a great influence on the effects of a group discussion (it is not always easy to influence this climate to be a positive).

Group discussion needs a lot of preparation and planning, and it is not in any case a process, which will »just happen« (13). There are many ways of triggering it off and providing structures which help every member of a group to participate in the discussion. There are several methods, two of them being:

- brainstorms – this is a useful way to open up a subject and collect group members' ideas. An open question to which there is no single right answer e.g. »Why do people dring alcohol?«. Every suggestion should be accepted, without comment or criticism;
- rounds – a round is a way of giving everyone an equal chance to participate in the discussion. Each member of a group is invited to make a brief statement.

2. Insight in the workshop theme.
   Students should be familiar with the theme of health education workshop, in the case of the workshop Drugs and adolescents with the problem of drug abuse in Slovenia (14).
3. Methods of evaluation of the workshop.
   Evaluation means making a judgement about a health education activity (13). The judgement could be posed:
   - about the outcome, i.e. whether the objectives, which were set, were achieved (e.g. if the pupils at the end of the workshop know how much alcohol would put them »over the limit«), and
   - about the process, i.e. whether the most appropriate methods were used, or if theye used in the most effective way.

Organizing groups of students

A group of three to four students visits an individual group of 16 pupils. Each student visits at least three groups of pupils, so he/she can become aware of diversity among target groups.

There are two kinds of roles within each student group: a leader of a discussion, and a keeper of the minutes. How the students share the roles within the group depends completely on them. It is suggested that one out of the three (or two out of four students) takes care to write down everything about what is happening, the other two lead a discussion/interview (but it can also be vice versa).

Summary of the workshop and consclusions (the lesson learned)

When the students are finished with the workshops, they sit together (first alone, if they want, and then with the teacher) and try to evaluate the process, and the outcome e.g. assessing:

- pupils' relation towards drug abuse at the beginning and at the end of the workshop, and
- their knowledge abot self-preventive measures.

Exercise

Task 1:

Carefully read selected chapters of the textbook about health education methods, about evaluation of health education process, and selected papers on the theme of health education process (e.g. about illicit drugs), and discuss these issues with the teacher.

Task 2:

Arrange yourself in groups of 3-4 students and allocate your role within the group: a leader of a discussion, or a keeper of the minutes.

Task 3:

Make a visit to a group of about 16 pupils at least three times. Perform a guided group discussion on selected theme. In continuation you will find some valuable suggestions on how to run a workshop.

In order that the workshops would be unified for the groups of pupils as much as possible, each group of students should follow the same principles, and try to follow the similar course of the workshop:

1. At least one student within the group has to be a punctilious observer of what is happening and be a keeper of the minutes. His/her role is to follow if the course of the workshop sticks to the schedule. Other students should focus on asking questions.
2. Establish a positive atmosphere, an atmosphere of trust and first try to explain to the pupils what the subject matter of your visit is in a simple and clear way. Maybe it would have the best effect on reciprocal relation, if you ask them for help. Give them to know, that they are the one, who is going to help you by fulfilling your task, and that you are not there to moralize. Explain them it is your task to find out their opinion about drug abuse.
3. Ensure them secrecy of data and that you will not use any personal names. For this purpose may every participant temporally use a false name, so it would be a bit easier for you to follow and write down stories of individual participants.
4. You may use a dictaphone, but in that case you must not use personal names neither fictitious name.

5. We suggest you start with common questions, which refer to spending free time, where they have spent their vacation, pressure in school, etc. In that way, you loosen the pressure among pupils, before you start with hard questions.
6. After the introduction, you start with first complex of questions that refer on basic question, why young people take drugs. You can connect that question with a whole bunch of questions. It depends in which way the conversation will develop itself.
7. Now comes the question about place of youth in current society and how is that connected with drug abuse. Here you have to pay attention to that, how they spend their spare time, what are the possibilities the society has to offer to young people, are they allowed to speak up and share their opinion, what do they think about school (as a constraint or something that carries them on and represents a nice experience).
8. You may ask them how they solve their own problems and where with reference to that do the drugs step in. Do not avoid the questions about use of alcohol and tobacco and try to connect that kind of drugs with use of illicit drugs. Do those, who take drugs, also often drink alcohol? Was alcohol a primary drug and it was proceeded with use of other drugs?
9. How do the teachers look on the drug abuse among pupils. What would happen, if someone would have publicly used drugs in school or if would get known, that someone has been taking drugs. What are their suppositions about the reaction of teachers (or other school personel)?
10. What kind of relation would they, as schoolmates, have towards a pupil, who is on drugs? What should be done with him? Would they want him to get expelled? Clear up the relation among pupils, who do not use drugs, and the drug-taker, who would appear in the class.
11. How do their families look upon the problem of drug abuse? What would happen at home, if their parents found out, they use drugs? What kind of relationship would their parents have towards them and what kind their brothers or sisters or their peers.
12. Speak about problem of drugs on parties. How does it look like, if one of their friends in having a party? Can they imagine a party without alcohol or do they think it would not go without it. What kind of drugs do people usually take on parties? What do they think about drugs abuse on parties? Why is it necessary to take drugs on parties, if they think it is necessary (does alcohol help them to make contacts with other people, does it enable them a relaxed atmosphere, etc., or are there other reasons)? Do they drink alcohol beverages, when they go out with friends?
13. You can find out what do the pupils, teachers and parents think about marihuana.
14. Nowadays, is it necessary to take drugs, if you want to be a part of society? Is taking drugs a status symbol? Are you more important, if you take drugs?
15. How much do they know about consequences of drug abuse? Do they know enough or too little? Would they lessen the consumption of drugs and alcohol, if they knew more about consequences?
16. In their opinion, what are the chances to prevent the drug abuse among youth? What do they think, the society should do? What would they do? What their parents and school should do? Maybe in discussion you will find others, who could do something in this aspect.
17. What do they think is an effective therapy? Do they have a preventive in the field of drugs in school? Does it work? If not, what would have to be fixed? In what way would the preventive be effective?

18. How much do they know about prevention by adults, and what is their point of view of it? Do they know the „alcohol law"? Do the adults respect that law? If they order a drink in a bar, does the waiter ask them to show the ID (or other document) or do they serve them with alcohol drink without questioning? What about in stores, can they buy a drink in a store? Have they seen anywhere a warning, that selling alcohol to underage persons is forbidden? Do older companions buy alcohol for them (18 years or more)?
19. What about self-preventive? What do they do on parties, where drugs are being used, to protect themselves from eventual noxious consequences?
20. In discussion, you keep looking for new dilemmas and then you try to talk about them and to pass positive messages. At the same time, you carefully take notes of their opinion and their answers. Throughout, you conscientiously take notes about the answers.
21. In the end, you thank them nicely for their cooperation and make an arrangement to present them the results of the discussion they had with you, of course if they are interested in it.

Other important suggestions

1. In discussion, every time you get the answer to previous question you will find yourself before new challenges and before a dilemma, how to set a new question, because with the help of questions you will step by step reveal the structure of phenomenon.
2. When you will be asking questions, you will be opening new dilemmas and new questions all the time; that will not be dilemmas only for you, but mostly for the one who is answering.
3. You will build questions on previous answers, but in spite of all that you should try to keep on primary outlined path
4. Thoroughly you conscientiously have to write down the answers, so in the end you work with interpretation of the process would be easier.
5. Leader of discussion should keep close a reminder with questions (annexed file) as a help by guiding the discussion.
6. The student, who is putting down the answers, prepares for himself sheets of paper for putting notes for separate complex of questions (annexed file) in advance. With that kind of help you will have less trouble with writing down, it will go easier and faster.

Task 4:

When three visits are accomplished discuss your experiences (positive and negative) with your teacher. If necessary, the discussion can take place after every visit.

Task 5:

Write a report on your visit, including your opinion on importance of this kind of health promotion activities.

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Recommended readings

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