How can we bridge the gap between literacy and health in South Sudan?

China Mayol Kuot

Student at Kampala International University-Western Campus, Uganda

Correspondence:
China Mayol Kuot
china_mayolk@hotmail.com

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INTRODUCTION

Addressing the low literacy rates in South Sudan has been a longstanding priority for primary health care providers as a way to improve the country's poor overall health status. Improving the literacy rate by "ensuring that all girls and boys complete primary and secondary education" by 2030 is ambitious but achievable for optimum health and socio-economic development.[1] While general literacy is an important determinant of health, it is not sufficient to address the major health challenges facing the South Sudanese population. Effective health education at primary health care points can help ensure healthy lives while other sectors are improving literacy.

Literacy, defined as the ability to read and write, facilitates Health Literacy. Health Literacy simply means "being able to apply literacy skills to health-related materials such as prescriptions, appointment cards, medicine labels, and directions for home health care".[2] In a broader sense, it is "the degree to which people are able to access, understand, appraise and communicate information to engage with the demands of different health contexts in order to promote and maintain good health across the life-course"[2] or "the degree to which people have the capacity to obtain, process, and understand basic health information and services needed to make acceptable health decisions."[2]

The adult literacy rate is defined as the percentage of the population aged 15 years and above who can, with understanding, read and write a short, simple statement on their everyday life.[3] In South Sudan, the adult literacy rate was 32 % in 2015[3], up by 19.18 % from 2008(27%)[3,4] but is still one of the lowest rates in the world today. Hence, there are generally low health literacy skills among the population.

Literacy and health

People with low literacy skills have poorer overall health. They wait longer to seek medical help and as a result, health problems reach a crisis state. Low literacy is associated with poor disease prevention, misuse of medication, poor adherence to medication and poor follow-up.[4] Low education levels, poor physical and mental health exacerbate each other's impact on different factors including unemployment and other socio-economic parameters.[6] This leads to poor outcomes in common health indicators of the country, including core aspects of health status, control of risk factors, service coverage and the entire health system.[7]

The Government is making efforts to increase literacy rates in South Sudan. The Education sector was allocated 9.4% of the Fiscal Budget 2018/2019 (a 5.3% increase when compared with the previous year).[8] The budget for the Health sector, however, seems fixed. Despite this, we can still strive to maximise efforts and improve the health of communities within our capacity by doing our best through health education.

Health education is the alternative connection between literacy and health literacy. It is defined as "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".[5] As the key outcome from effective health education is health literacy to the literate, it can also improve knowledge and life skills conducive to individual and community health.

Table 1. Transtheoretical Model

Stage	Definition	Examples	Potential change strategies
Precontemplation	Has no intention of taking action within the next six months	"It isn't that I can't see the solution; I just can't see the problem"	Increase awareness of need for change; personalize information about risks and benefits
Contemplation	Intends to take action in the next six months	"I want to stop feeling so stuck"	Motivate; encourage making specific plans
Preparation	Intends to take action within the next 30 days and has taken some behavioural steps in this direction	"I just took out a membership to a fitness facility"	Assist with developing and implementing concrete action plans; help set gradual goals
Action	Has changed behaviour for less than six months	"I've started exercising and while I enjoy it, sometimes I find it a chore"	Assist with feedback, problem-solving, social support and reinforcement
Maintenance	Has changed behaviour for more than six months	"Exercising three times a week has become a part of my lifestyle"	Assist with coping, reminders, finding alternatives, avoiding slips/relapses (as applicable)

The World Health Organization (WHO) describes health education as including communicating the social, economic and environmental conditions impacting on health as well as individual risk factors and risk behaviours and how to use the health care system.[5] During health education, we should also focus on fostering the motivation, skills and confidence necessary to take action to improve health.[5] Knowledge, while necessary, is not sufficient to change individual or collective behaviour.[9] Motivation usually must come from sources other than, or in addition to, factual knowledge. Most individuals know that it is best to prevent disease but fail to put in efforts to stop unhealthy lifestyles. A broad purpose of health education therefore is not only to increase knowledge about personal health behaviour but also to develop forms of action that are the politically feasible and organizationally possible to address individual, social, economic and environmental determinants of health."[5]

IMPROVING HEALTH LITERACY

Despite the challenges in effective health education in South Sudan, it is important to remember that community participation is the hallmark of primary health care, without which it will not succeed.[10] It may be practically difficult to educate the massive number of people who come to the health care centre daily, or to organise health-talk appointments with prisoners, refugees and students or even discuss health promotion strategies with community members and leaders. Even though most primary health care providers have limited time or inadequate resources, health education ideals can still be approached from the most basic level: interpersonal capacity level. This involves extending the consultation time to address individual characteristics that influence behaviour, such as awareness and knowledge, beliefs, opinions and attitudes, self-efficacy, intentions, and skills and personal power personality traits.[11] Motivational interviewing enables primary health care givers to identify cues to elicit change and promote healthy lifestyle while at the same time address a client's initial complaints.

Motivational interviewing

Motivational interviewing (history-taking) is a person-centred method to elicit and strengthen personal motivation for change.[12] Motivational interviewing was designed from the outset to be a brief intervention including the short-timed outpatient sessions. Motivational interviewing is effective across a variety of real-life clinical settings even within the context of larger health care delivery systems. It is also efficient in that even a single session can invoke behaviour change.[11] The core principles of motivational interviewing include respect for the autonomy and ambivalence. Motivational interviewing aims to elicit and explore discrepancy between current behaviour and broader life goals and values.[11]

The primary health care provider first stimulates a change talk and with reflective listening, understands, expresses empathy and encourages change talk. Then, he/she identifies the assertions for self-motivation and counter-motivation (resistance) correctly.[11] This is because motivation is a strong predictor of change.

He/she also gives adequate information and teaches skills for decision-making and problem solving but leave the actual choice and action - towards change - to the individual.[10]

A key challenge for many health care providers learning motivational interviewing is determining when and how to transit from building motivation to planning a course of action.[12] Different models have been proposed to address this problem. These include: the rational model, the health belief model, extended parallel process model (EPPM), the transtheoretical model, the theory of planned behaviour and the activated health education model.[14] No single theory dominates health education and promotion because the problems, behaviours, populations, cultures, and contexts of public health practice are broad and varied. One of the most extensively researched behavioural change models developed in recent years is the transtheoretical model of change.[5] Table 1 gives brief details of the transtheoretical model. [5,11,14]

Without Health Education or without motivation to be healthy, individuals may fall sick again from the same disease. The major reason for missed immunisations in the Republic of South Sudan was inadequate information. [13] Therefore, when treating an individual with a skin infection or malaria, clinicians should assess patients' ideas, concerns and expectations. It is also important to educate the patient about the cause of the illness, how to prevent it (if possible), alarm signs and symptoms to warrant return to the clinic, what to expect with the drugs, how and when to come for follow-up and other basic information.

For effective health education, we should develop health communication skills which involves the study and use of communication strategies to inform and influence individual decisions that enhance health.[10] Through health promotion we enable an individual to increase control over, and to improve, their health. Jonathan Izudi and his colleagues found that many mothers came for post-natal care when they receive health education after delivery in Mundri East County, South Sudan.[15] Therefore, it is possible to improve health-care delivery and lessen complications from common health issues affecting the immediate communities we are serving when they receive basic health information and are motivated towards better health. This also, is how to fulfil the goal for continuous medical education, and deliver practical, scientifically sound and socially acceptable essential health care.

This interpersonal approach creates ideal conditions for community participation in promoting lifestyles conducive to health which could involve change in an individual's personal characteristics/behaviour, social interactions, and socioeconomic and environmental living conditions or an interplay.[5] Community participation, in brief, involves assessing the prevailing health problems and encouraging people to choose the best solutions to their health problems.[10]

In primary health care, we can offer more than just enough to the communities by educating them about common health problems and practical methods to prevent and control them. We can bridge the literacy gap that undermines effective prevention of diseases, early seeking of health care, therapeutic follow up and adherence through effective health education strategies that best fit the immediate community. This is possible when we have intrinsic motivation and renew our commitment to primary health care.

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