



Learning and Teaching Health

Educational traditions in most countries have changed little. At primary, secondary, and tertiary levels, teachers still lecture from the front of the room, replicating the only methods they themselves have ever been exposed to. Whatever the rhetoric, in practice education's actual objective is the transfer of information, and students are evaluated according to whether they can remember and re-state facts and formulas. The teacher's skill is not measured by whether 40, 50, or 80% of learners learn. Rather, the assumption is that the teacher's job is to present the facts; bright and willing students will learn and those who do not are stupid or lazy. Classroom observers recognize when learning is occurring: The room is still except for the teacher's voice.

The influence on education of mass communication and some behavior change theory has not been much help. The media communicate messages, and it has been documented that we can put simple ideas and images into people's heads that shape their behavior. The problem is that it is easier to get many people to try Coke than it is to get a much smaller number not to try coke. Health attitudes and behaviors are complex, social, and often emotional. People of all ages actively interpret their experiences and construct their beliefs and behaviors, often unconsciously and without critical examination, and in the context of the strengths and weaknesses of their upbringing and community. They are not independent and empty vessels to be filled by discrete, creatively-packaged bundles of messages. They are complex learning organisms.

Most of the world is only starting to find a place for active, learner-centered, participatory education. In the sciences, lab-based instruction is becoming more common in well-resourced schools; in other subjects, students rarely get to "handle" the material. Of course, many schools have large class sizes, inadequate facilities and few resources; but the single greatest impediment to student-centered learning is the maintenance of didactic traditions among educators and those who train them.

Students can probably learn biology from the front of the room, but health learning must be active and participatory. Medicine is individual – everyone has his or her own body. But health is social and depends on norms and environments that support or undermine healthy choices. So much of what we do through peer education is to help, coax, tempt, trick, and even force young people to think things through, to question and probe, examine and reconsider together. In education, sequence always matters. It is certainly the job of peer education to provide scientifically accurate information about how to stay healthy – but it makes a big difference if we provide the "right" answers before, or after, learners have had the chance to puzzle and reason and dispute over the questions. Peer educators are educators, and the most important thing educators do is to ask good questions.

Perhaps we can best describe learner-centered, active and social health learning metaphorically: We are helping youth to build a stronger foundation for a house they will feel is their own and



hopefully choose to live in. Even more important, we are helping them learn to build, not asking them to move into some pre-fabricated model - and we are insisting that they cannot build alone, that the building and living in this house is a community affair. This sort of health learning, while it is only one goal of peer education, cannot be done from the front of the room. It requires small-group work not usually practical without peer educators.