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UVODNIK

IZOBRAŽEVANJE ODRASLIH NA PODROČJU ZDRAVJA: POMEN DRUŽBENOKULTURNIH DIMENZIJ IN INTERDISCIPLINARNOSTI

Izobraževanje odraslih na področju zdravja postaja vedno bolj obsežno polje v andragogiki ter drugih družboslovnih, humanističnih in medicinskih vedah (English, 2012; Nutbeam, 2019; Wang, 2014), kar se med drugim odraža v samostojnih revijah (npr. *Health Education Journal*), interdisciplinarno zasnovanih razpravah o raziskovanju, kot npr. v *Social Theory and Health Education* (Leahy idr., 2020), v mednarodnih projektih (npr. *Last Aid*), mnogovrstnosti praks in tudi v pestrosti poimenovanj: zdravstvena vzgoja, izobraževanje za zdravje, zdravstveno izobraževanje, vzgoja in izobraževanje za zdravje, razvoj zdravstvene pismenosti ali zdravstveno opismenjevanje, ozaveščanje o zdravju.

Temeljni namen vseh teh dejavnosti je razvoj zmožnosti, da ljudje ohranjajo zdravje in se ob težavah z zdravjem informirano odločajo. S tem mislimo na razvoj zmožnosti pri različnih skupinah (mlajši odrasli, starejši odrasli, splošna javnost), da pridobivajo, razumejo in uporabijo informacije, pomembne za odločanje in ravnanje, povezano z zdravjem (Nutbeam idr., 2019, str. 1). Z besedno zvezo *vzgoja in izobraževanje za zdravje* poimenujemo vse procese oblikovanja/vzgajanja in spodbujanja človeka-v-okolju z namenom, da razvija zmožnosti emocionalnega, kognitivnega in somatskega učenja ter ravnanja z zdravjem ali boleznijo. Vzgoja in izobraževanje za zdravje je holističen proces, vključuje celotno osebo in njeno okolje. To torej ni proces, ki bi bil ločen od okolja. Sodobne teoretske paradigme in praktične aktivnosti so osredotočene na to, da vzgoja in izobraževanje kot proces in kot dejavnost, ki naj prispevata k zdravju ljudi ali uravnavanju bolezni, izhajata iz družbenokulturnih okoliščin. To pomeni, da morajo izobraževalci poznati širši družbenokulturni kontekst, politične in ekonomske značilnosti posameznega okolja in tudi njegove biološke ter okoljske razsežnosti. Poleg makroelementov morajo tako poznati tudi tradicijo, znanje, navade tiste skupine, za katero pripravljajo izobraževalne programe, ter značilnosti posameznika (Gilbert idr., 2015; Leahy idr., 2020; Willis idr., 2014). Ker so vsi ti makro- in mikroelementi, odnosi in procesi del družbenokulturnega sistema, je treba o njih tudi kritično misliti. To implicira, da se zavedamo različnega razumevanja pojmov zdravje, bolezen in zdravljenje, na kar opozarjajo medicinski antropologi.

Doživljanje in razumevanje zdravja je torej odvisno od družbenokulturnega okolja. Prav tako pa je odvisno od teoretskih interpretativnih vzorcev. Za interpretativno ogrodje se

vedno pogosteje uporabljajo integrativni bio-psiho-socialni modeli, med katere uvrščamo model salutogeneze, ki v ospredje postavlja procese spodbujanja zdravja. To velja tudi za takšne situacije, ki so povezane s kroničnimi boleznimi, travmami, primanjkljaji, ovirami. V razpravah srečamo tudi koncepte, kot sta trdoživost (*resilience*) in blagostanje (*well-being*).

Vzgoja in izobraževanje za zdravje sta namenjena različnim ciljnim skupinam: tako tistim, ki imajo težave z zdravjem, kot tistim, ki naj bi se izognile težavam na tem področju. Poseben izziv so programi za izobraževanje posebnih ciljnih skupin, kot so manjšine, migranti, starejši, ter posebne tematike, npr. izobraževanje za higieno ustne votline, promocija zgodnjega odkrivanja in zdravljenja raka dojk, detabuizacija težav v duševnem zdravju, ozaveščanje o rabi kontracepcije, izobraževanje pri pripravi na porod in druge vrste izobraževanja staršev (gl. Lauzon in Farabakhsh, 2014; Silberberg, 2020). S sodobnimi demografskimi spremembami, kot so migracije, se odpirajo še dodatne tematike, npr. vprašanja o izobraževanju za sporazumevanje, vprašanja o večkulturnih stikih s tujejezičnimi bolniki v zdravstvenih ustanovah (gl. Pokorn in Lipovec Čebron, 2019).

Izobraževanje za zdravje je v svojem razvoju prešlo različne faze. Najprej je bilo namenjeno predvsem preventivnim programom, s katerimi so se ljudje opolnomočili za odločanje in ravnanje pri ohranjanju zdravja (npr. spoštovanje pravil higiene, skrb za doječe matere in novorojenčke), pozneje pa se je razvilo v izobraževanje za zdravje, ki je zasnovano z namenom formiranja ali transformiranja navad in praks v vsakdanjem življenju (npr. zdrava prehrana in gibanje). Poleg preventivnih programov se razvijajo tudi programi, ki so namenjeni spoprijemanju z boleznijo ter razvoju novih veščin in navad (npr. razvoj prehranskih navad pri diabetesu). Naslednja značilnost v razvoju izobraževanja za zdravje je povezovanje različnih akterjev pri pripravi programov. Povezujejo se izobraževalni in zdravstveni sistem, sistemi politike in upravljanja, sistem dela. Nosilci izobraževanja, učenja in promoviranja so različni. Prav tako so zelo raznolike strategije izobraževanja, ki se približujejo skupnostnemu izobraževanju in načelom skupnostne psihologije (Francescato idr., 2020; Seedat idr., 2017).

Ob vsem tem se zastavlja tudi vprašanje raziskovalnih strategij. Raziskave so v preteklosti slonele predvsem na pozitivistični paradigmi, v sodobnosti pa se porajajo novi kvalitativni in postkvalitativni pristopi (Cardano idr., 2020). Sprašujemo se, kako v raziskovanju in razvoju izobraževanja odraslih na področju zdravja odsevajo t. i. obrati: narativni obrat, afektivni obrat. Kakšna je uporaba avtoetnografije, biografske metode, narativnih metod? Kakšna je vloga akcijskega raziskovanja in participatornega akcijskega raziskovanja glede na poststrukturalistično teorijo prakse? Kako na raziskovanje in razvoj vzgojno-izobraževalnih programov za zdravje vplivajo »neoliberalni časi« in težnje po komodifikaciji zdravja, izobraževanja? Kako na izobraževanje za zdravje vplivajo pritiski, da bi »šibkosti« nekaterih ljudi in skupin razumeli kot nekaj samoumevnega in odvisnega zgolj od njih samih? Če sprejmemo ugotovitve, da je znanje družbenokulturno umeščeno, kakšne so epistemološke, didaktične, etične posledice in implikacije za načrtovanje raziskav in izobraževalnih programov? Ali raziskovalne strategije dajejo glas vsem vključenim v

vzgojo in izobraževanje za zdravje? Kako na izobraževalne programe vplivajo intersekcijske neenakosti in ali jih v raziskavah zaznamo?

Družbenokulturni, politični in ekonomski vidiki so zelo pomembni za razumevanje odzivanja prebivalcev na bolezni, okužbe, epidemije ter za analiziranje ukrepov, na katere se skupine ljudi različno odzivajo. Nekatere skupine v času epidemije covida-19, ki povzroča velike kognitivne disonance in negotovosti, iščejo referenčne točke, ki bi pomagale pri urejanju kaotičnosti, tudi tako, da se zatečejo v popačeno interpretacijo znanstvenih spoznanj. Vsi ti izzivi implicirajo razmislek o razmerjih med zdravjem in znanjem, spretnostmi, navadami, učenjem, epistemološkimi sistemi ipd. Razmisliti je treba o temah, kot so: družbenokulturni vidiki zdravja, bolezni in zdravljenja, vloga skupnosti v izobraževanju odraslih za zdravje ter vloga skupnostnega učenja in izobraževanja pri spoprijemanju z zdravstvenimi težavami.

V tej tematski številki je odnos med izobraževanjem in zdravjem/boleznijo osvetljen *z dveh zornih kotov*. Prvi obravnava vpliv izobraževanja, vključenosti v izobraževalne programe na zdravje in dobro počutje. Vključenost mlajših odraslih in starejših odraslih v izobraževanje vpliva na dobro počutje in zdravje. Izobraževanje, ki ga izvajajo na švedskih ljudskih univerzah in je namenjeno ljudem z avtizmom, prispeva k rehabilitaciji in predstavlja podporno okolje. Hedegaard, Hugo in Bjursell v članku *Ljudska univerza kot spodbudno okolje za udeležence z visoko funkcionalnim avtizmom* ugotavljajo, da je izobraževanje za udeležence z avtizmom pozitivno z vidika udeležencev, zaposlenih in ravnateljev. Meulenberg v prispevku *Dvojezičnost in jezikovno izobraževanje za izboljšanje kognitivnega zdravja starejših ljudi* analizira vpliv dvojezičnosti in implikacije za jezikovno izobraževanje starejših, saj lahko k zdravemu staranju pripomore tudi aktivna raba več jezikov. Formosa v svojem članku *Zbiranje dokazov o vplivu učenja starejših odraslih na aktivno staranje: kvantitativna študija* pa predstavlja rezultate študije o tem, da ima učenje starejših močan pozitiven vpliv na dejavno staranje, saj učenje blaži socialno izolacijo in kognitivno slabitev. Izobraževanje v starosti prispeva k boljšemu zdravju, telesnemu in duševnemu blagostanju.

Drugi zorni kot razmerja med zdravjem in izobraževanjem odpira pogled na izobraževanje, ki je ciljno pripravljeno z namenom izboljševanja znanja o zdravju/bolezni. Prosen in Ličen v članku *Izboljševanje zdravstvene pismenosti nosečnic z uporabo sodobnih pristopov v zdravstveni vzgoji: integrativni pregled literature* razčlenita koncept zdravstvene pismenosti kot ključne socialne determinante zdravja ter razmišljata o sodobnih pristopih zdravstvene vzgoje za nosečnice v t. i. razvitem svetu. Ugotavljata, da je proces posodabljanja zdravstvene vzgoje prepočasen in premalo progresiven. Podobno ugotavlja tudi Švab o vlogi splošnih knjižnic, ki bi lahko bile zelo pomembni akterji pri ozaveščanju javnosti o zdravju in tudi o lažnih novicah, ki so z njim povezane. Avtorica članka *Zdravstveni kotički in izobraževanje za zdravje v splošnih knjižnicah* je v svoji raziskavi analizirala prednosti in pomanjkljivosti delovanja zdravstvenih kotičkov v slovenskih splošnih knjižnicah. Zapiše, da so poseben izziv pri načrtovanju in izvajanju izobraževanja za zdravje informacijsko slabše pismeni prebivalci, zato bi morali zdravstveni kotički razviti

nove strategije delovanja, ki bi se približale različnim ciljnim skupinam. Posebno področje za načrtovanje izobraževalnih programov so teme, ki so v našem kulturnem okolju še vedno tabuizirane. Taka tema je umiranje. Zelko, Jakšič in Krčevski Škvarč v svojem članku *Ozaveščanje javnosti o paliativni oskrbi: evalvacija tečaja Zadnja pomoč (Last Aid) v Sloveniji* opisujejo izkušnje iz mednarodnega projekta skupnostnega izobraževanja o paliativni oskrbi, ki ga izvajajo v 18 državah, in sicer podajajo predvsem evalvacijo programov Zadnja pomoč v Sloveniji. Pomembno vlogo v vzgoji in izobraževanju za zdravje imajo tudi zdravstveni delavci. Lipovec Čebron in Huber sta v članku *Evalvacija kulturnih kompetenc na področju zdravstva: Zakaj je potrebno vpeljati kvalitativne pristope?* predstavili različne poskuse merjenja kulturnih kompetenc v zdravstvu. Na podlagi primerov iz tujine in Slovenije sta dokazovali, kako pomembno je na tem področju dopolnjevanje kvantitativnih metod s kvalitativnimi ter kako potrebno je premakniti pozornost od merjenja kulturnih kompetenc posameznih zdravstvenih delavcev k evalvaciji celotnega izobraževanja in njegovih izvajalcev.

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EDITORIAL

ADULT EDUCATION IN THE FIELD OF HEALTH: THE IMPORTANCE OF SOCIO-CULTURAL DIMENSIONS AND INTERDISCIPLINARITY

Adult education in the field of health is becoming increasingly relevant in andragogy as well as in other social sciences, humanities, and medical sciences (Nutbeam, 2019; Wang, 2014; English, 2012). This is also reflected in publications such as the *Health Education Journal*, interdisciplinary approaches to research such as *Social Theory and Health Education* (Leahy et al., 2020), international projects such as Last Aid, many diverse practices as well as a variety of terms including health education, education for health, developing health literacy, and health awareness.

The central purpose of all these activities is to develop people's abilities to take care of their health or to be able to make informed choices when it comes to health problems. This refers to developing the abilities of diverse groups (younger adults, older adults, the general public) to acquire, understand and use information that affects their choices and their actions when it comes to health (Nutbeam et al., 2019, p. 1). The term *education for health* refers to all the processes of forming/educating and encouraging a person within an environment to develop emotional, cognitive and somatic learning abilities as well as health or illness management. Education for health and well-being is a holistic process that includes the entire person and their environment. It is not a process that is separate from one's environment. Contemporary theoretical paradigms and practical activities are focused on the fact that education as a process and as an activity that benefits people's health or illness management stems from their socio-cultural circumstances. This means that educators must be knowledgeable about the wider socio-cultural context, the political and economic circumstances of a particular environment, its biological and environmental dimensions. Besides the macro elements, educators must also be familiar with the traditions, the knowledge and the habits of the group they are preparing educational programmes for, as well as the characteristics of individuals (Leahy et al., 2020; Gilbert et al., 2015; Willis et al., 2014). Because all of these macro and micro elements, relationships and processes are part of the socio-cultural system, they also need to be considered and given critical thought. As medical anthropologists have pointed out, this

implies that we are aware of the different ways terms like health, illness and treatment are understood.

How we experience and understand health depends on our socio-cultural environment as well as on theoretical interpretative patterns. An increasingly used interpretative framework is the integrative biopsychosocial model, which includes the salutogenic model, highlighting the processes that support health. This also applies to situations linked to chronic illness, trauma, deficit, and impairment. Studies in this field also feature concepts such as resilience and well-being.

Education for health is meant to serve various target groups: those facing health problems as well as those trying to prevent them. Specific challenges need to be addressed in health education programmes with target groups such as minorities, migrants, the elderly, as well as programmes on specific topics, for example, oral hygiene, promoting early detection and treatment for breast cancer, breaking the stigma attached to mental health problems, raising awareness about contraception, education about childbirth and other forms of education for parents (cf. Lauzon & Farabakhsh, 2014; Silverberg, 2020). Modern demographic changes such as migration open up questions, for example, about communication education, multicultural contact with foreign language speaking patients in health institutions (cf. Pokorn & Lipovec Čebron, 2019).

Education for health has gone through different phases of development. At first it was centred on prevention programmes, empowering people to make decisions and take action to stay healthy (e.g., following the rules of good hygiene, care for nursing mothers and new-borns), and later developed into education for health focused on forming or transforming habits and practices in everyday life (e.g., a healthy diet, exercise). Additionally, programmes for managing illness and developing new skills and habits (e.g., dietary habits for diabetes) were also developed. A significant element of education for health is also connecting the different actors involved in setting up these programmes: education systems and healthcare systems, the systems of politics and government, the systems of work. There are many educators and promoters in this field, as well as a variety of educational strategies that often come close to community education and the principles of community psychology (Francescato et al., 2020; Seedat et al., 2017).

All this also raises the question of research strategies. Past research was predominantly based on the positivist paradigm, while contemporary research has also utilised new qualitative and post-qualitative approaches (Cardano et al., 2020). Another question concerning adult education in the field of health is also how its research and development reflect the narrative and the affective turn. How does it use autoethnography, the biographical method, narrative methods? What is the role played by action research and participatory action research in the frame of poststructuralist theory? How are research and development of health literacy programmes affected by neoliberalism and the tendency to commodify health and education? How is education for health affected by the pressures to understand the ‘weaknesses’ of certain people and groups as something that is taken as a

given and as dependent solely on themselves? If we accept the idea that knowledge is embedded in society and culture, what epistemological, didactic and ethical consequences and implications does this have for planning research and educational programmes? Do research strategies give a voice to everyone involved in education for health? How does the intersectional nature of inequality affect educational programmes and is it detected in research?

Socio-cultural, political and economic aspects are all very important when it comes to understanding how people respond to illness, infection, pandemic, and in order to analyse the measures which different groups of people react to in different ways. In the time of the pandemic, which has caused a great deal of cognitive dissonance and uncertainty, some groups of people seek out reference points in order to make sense of the chaos – also by finding refuge in inadequate or inappropriate interpretations of scientific findings. All of these challenges urge us to contemplate the relationship between health and knowledge, skills, habits, learning, epistemological systems, etc. We need to consider issues such as the socio-cultural aspects of health, illness and treatment, the role of community in adult education for health, and the role of community learning and education when facing health problems.

The thematic issue before you explores the relationships between education and health/illness *from two perspectives.* The first perspective deals with the effect that participating in educational programmes on health and well-being has on younger and older adults. Swedish folk high schools provide education for people with autism that contributes to their rehabilitation and provides students with a supportive environment. Hedegaard, Hugo, and Bjursell's article *Folk High School as a Supportive Environment for Participants with High-Functioning Autism* finds that students with autism respond well to this type of education and that the students, the staff as well as the head teachers view this form of education as positive. Meulenberg's article concerns *Bilingualism and Language Education to Improve the Cognitive Health of Older People* and analyses the effect of bilingualism and the implications it has for adult language education. The active use of more than one language beneficially contributes to healthy ageing. Formosa's *Building Evidence for the Impact of Older Adult Learning on Active Ageing: A Quantitative Study* presents the results of a study on how learning positively affects active ageing in older people. Learning helps avert social isolation and cognitive impairment; as one gets older, learning contributes to better health, physical and emotional well-being.

The second perspective on the relationship between health and education centres around education that aims to improve knowledge about health/illness. In *Improving the Health Literacy of Pregnant Women Using Contemporary Approaches in Health Education: An Integrative Literature Review* Prosen and Ličen identify the concept of health literacy as a vital social determinant of health and examine the contemporary approaches to health education for pregnant women in the so-called developed world. They find that the process of modernising health education has been too slow and insufficiently progressive. In a similar vein, Švab discusses the role of public libraries as important actors

in raising awareness among the general population on issues of health and specific issues such as health-related "fake news". Her article *Health Zones and Health Education in Public Libraries* is based on research that analyses the advantages and disadvantages of health zones in Slovenian public libraries. She writes that planning and delivering health education to less information literate users is a particular challenge, and that health zones should develop new strategies to attract different target groups. *Raising Public Awareness of Palliative Care: Evaluating a Last Aid Course in Slovenia* addresses the evaluation of educational programmes on a topic that still remains taboo – dying. In this article Zelko, Jakšič and Krčevski Škvarč focus on evaluating a Last Aid course that was run in Slovenia and is part of an international project of community education on palliative care conducted in 18 countries. An important role in education for health is also played by healthcare workers, and this is the topic of Lipovec Čebron and Huber's *The Evaluation of Cultural Competence in Healthcare: Why Is the Introduction of Qualitative Approaches So Needed?* The authors present different attempts at measuring cultural competences in healthcare. Based on examples from abroad and from Slovenia they show how important it is to supplement quantitative methods with qualitative ones. They also highlight the need to shift attention from measuring the cultural competences of individual healthcare workers onto the evaluation of educational courses and education providers.

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