

## Prescription 7: Health Education

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# HealthCorps Reader

### ***Part One: Overview***

No knowledge is more crucial than knowledge about health.

Without it, no other life goal can be successfully achieved.

-- *The Carnegie Foundation*

Health education as a profession is concerned with preventing disease and disability and promoting health through a variety of educational strategies.

HealthCorps members serving in a community health center may be involved with various health education activities. Some examples are:

- Facilitating classes for diabetes patients about how to manage their disease;
- Helping families in the community assess triggers for asthma in their homes;
- Educating a mother about the benefits of breastfeeding;
- Developing educational materials for the center that are culturally appropriate and have an appropriate literacy level;
- Planning a health fair or other community event to raise awareness about a particular health problem; and
- Working on a center's National Diabetes collaborative, collecting data to determine if the project interventions have been successful at improving the health outcomes of patients.

The purpose of such initiatives is to maintain healthy behavior patterns or to improve unhealthy ones. Sometimes this includes improving living conditions that are linked to health. "Healthy behavior" includes not only washing hands and eating well to prevent disease, but also preventing injury around the home, street, playground and sports field.

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The behavior of those who control resources or rewards—such as community leaders, employers, teachers, volunteers, parents, and even health professionals—are equally important in the process of planning and implementing health education efforts.

This Reader about public health education is not exhaustive, but it will give you a basic understanding of good health education practices and theories so that you will have some background to begin your site-specific training.

### *Definitions*

**Health** is a state of complete physical, mental and social well being, not merely an absence of disease or infirmity. (World Health Organization, 1947)

### **Health education**

- **Formal definition:** “The continuum of learning which enables people, as individuals and as members of groups to voluntarily make decisions, modify behaviors, and change social conditions in ways which are health enhancing.” (*Introduction to Health Education and Health Promotion*, Simons-Morton, Green, Gottlieb, 1995)
- **Informal definition:** Education intended to have a positive impact on health. Health education may be directed toward knowledge levels, attitudes, and/or specific behaviors. Educators are most interested in the behavior of people whose health is in question, either now or in the future.

### **Health promotion**

- **Formal definition:** “Any combination of health education and related organizational, political and economic interventions designed to facilitate behavioral and environmental supports for actions and conditions of living conducive to health.” (*Introduction to Health Education and Health Promotion*, Simons-Morton, Green, Gottlieb, 1995)

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- ***Informal definition:*** A broad concept that addresses the general process of advocating health. It may include education, environmental change to support improved health, legislation, or shifts in society's norms. Health promotion may focus on the individual, on groups, or on society at large.

**The profession of health education** is dedicated to promoting public health. Health education professionals might be involved with planning programs, teaching or training, developing community interest and/or resources, leading community, state or national coalitions, advocating for policies or policy change, or evaluating the outcomes of such efforts.

**Public health** is the field that shares the goal of improving health and preventing disease but is broader than community health. It also includes such activities as health assessment and surveillance procedures, technology, policy and environmental controls and protections, and health care services.

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### ***Part Two: Levels of Prevention Activities in Public Health***

Traditionally public health has concerned itself primarily with prevention of disease and its cure. Disease prevention begins with an identified threat to health such as a disease (*for example: SARS or HIV/AIDS*), environmental hazard (air pollution), or a documented risk factor (high cholesterol). The activities employed to prevent disease can be divided into three somewhat overlapping categories:

1. **Primary Prevention:** Activities to prevent disease or other forms of ill health *before* they occur. The more directly a health behavior is linked to a health problem as a risk factor, the better candidate it is for primary prevention efforts.
2. **Secondary Prevention:** Actions taken to enable early detection of a health problem and to stop or modify the risk, severity or extent of illness or injury. These activities target people at high risk for a particular illness or injury. The dominant activities in secondary prevention are screening, diagnosis, disease management and cure. Patient and public education are vital parts of secondary prevention.
3. **Tertiary Prevention:** Preventive measures aimed at disability limitation or rehabilitation. These come into play once a medical problem has progressed to the point of damaging the patient(s).

#### *Assumptions of Health Promotion*

The history of health care and related research has demonstrated the following facts. These are adapted from *Planning, Implementing, and Evaluating Health Promotion Programs*, by James F. McKenzie and Jan L. Smeltzer, 1997.

- Health status can be changed.
- Disease occurrence theories and principles can be understood.
- Appropriate prevention strategies can be developed to deal with identified health problems.

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- An individual's health is affected by a variety of factors, not just his or her chosen lifestyle. Other factors include heredity, environment, and the health care system.
- Improvements in individual and societal health behaviors will affect an individual's health status positively.
- Individuals, families, small groups, and communities can be taught to assume responsibility for their health, which in turn changes their health behaviors.
- Individual responsibility should not be viewed as victim blaming.
- For a change in health behavior to be permanent, an individual must be motivated and ready to change.

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**Part Three: Goals & Objectives for Health Education**

All but the smallest educational projects must be carefully planned to be optimally effective. A necessary part of the planning is identification of specific goals and objectives. The following definitions will clarify any confusion about how a goal differs from an objective — and about the different kinds of objectives:

Term & Definition	Example
<p><b>Goal:</b> A broad, general statement of the long-term change a program is designed to bring about. Goals are “timeless statements of aspiration.</p>	<p>“To reduce the cases of lung cancer caused by exposure to secondhand smoke.”</p>
<p><b>Objective:</b> A specific statement of desired change in terms that are measurable, time-limited, and specific to a given target population.</p>	<p>“By December of 2005, 100 families in Neighborhood A will have attended a one-hour educational session on reducing their environmental risk for lung cancer.”</p>
<p><b>Outcome Objective:</b> A specific statement of desired outcome of a program in terms of change in rate, knowledge, attitude, behavior, policy or environment.</p>	<p>“By March of 2007, there will be a 50% reduction in the number of children under 6 years of age in Neighborhood A who report being exposed to secondhand smoke in the home compared to baseline data.”</p>
<p><b>Process Objective:</b> A statement detailing the level of activities designed to produce these outcomes.</p>	<p>“By March 2003, the project Coordinator will have developed a one-hour educational session for use in neighborhood meetings and submitted it to designated experts for approval.”</p>

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### *Guiding Principles of Health Education*

Many years of experience have taught professional health educators some fundamental principles to apply in their work. Members can use this list of principles as a checklist when planning their own projects.

- ✓ **Start with where the people are:** This approach affirms a commitment to self-determination and reflects our inherent faith in people's ability to assess their own strengths and needs, as well as their right to act on these insights in setting goals and determining strategies for achieving them.
- ✓ **Recognize and build on community strengths:** This can be described as the *asset approach* in comparison to the more familiar *deficit approach* which focuses on what people and communities *don't* have.
- ✓ **Foster high-level community participation:** People support what they help create. If the community's religious leaders, for example, worked with the health center to start a series of health education meetings, they are more likely to provide the space and refreshments for such meetings.
- ✓ **Laughter is good medicine — and good health education:** Incorporate humor in your work with individuals, communities, and colleagues.
- ✓ **Health education is educational - but it is also political:** The education of policy makers is an important aspect of health education, because people's health is deeply impacted by public policy.
- ✓ **Remain open to all parts of the picture:** Look at how race, economic class, religious affiliation, gender, ethnicity, sexual orientation, and academic experience (to name a few human characteristics) interact to determine how health care, lifestyle choices, and longevity are differently distributed.
- ✓ **Think globally, act locally:** Health educators often have to work on the macro (community) and micro (individual) levels simultaneously.
- ✓ **Foster individual and community empowerment:** Community health means community members and health providers working together,

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contributing equally. It means respecting and partnering with those served, resulting in the community building its *own* assets through learning.

- ✓ **Work for social justice:** Steer public attention away from disease as a personal problem and toward health as a social issue. *For example*, fighting alcohol and cigarette ads that target young people of color or working against the normalization of violence in movies.

### *Health Education Program Planning*

“Our success as health professionals is dependent on effective planning.”

*--Dignan & Carr, 1992*

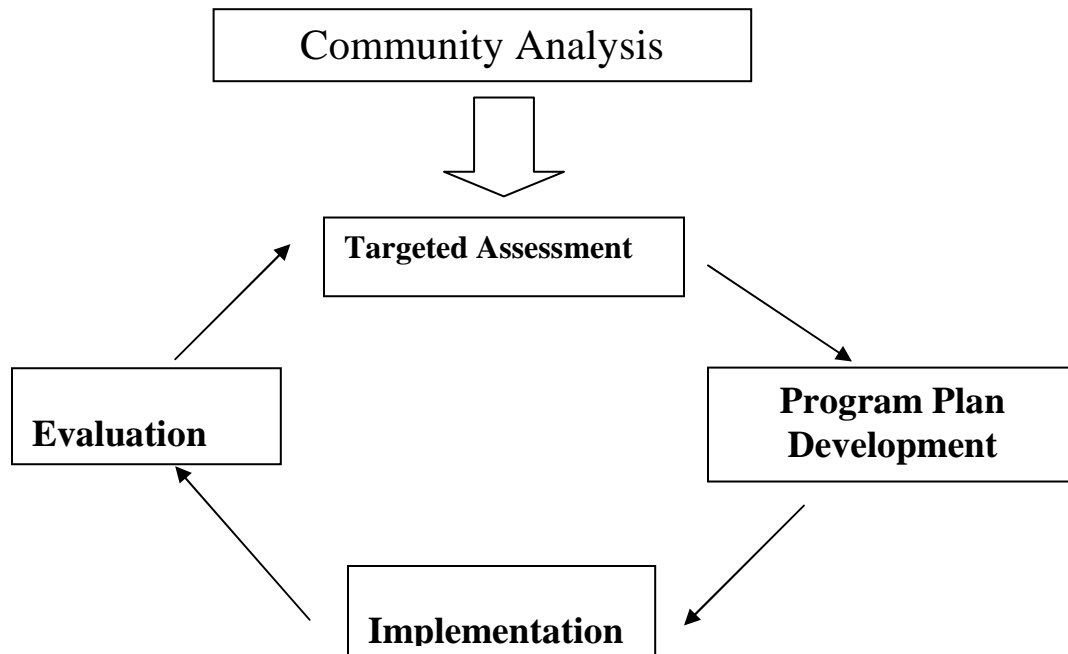
Health educators sometimes work in communities as part of a pre-existing program. They step into an educational initiative that is well underway, learn its contents and methods, and carry it forward. At other times, they are members of the initial team that determines what educational goals are appropriate and which approaches will be most effective.

In either case, health educators benefit from understanding the entire planning process, from beginning to end. After all, we can teach more successfully when we know how our piece of the program fits into the whole.

The process of program planning for community health education is comprised of a series of interconnected steps, as illustrated by the following diagram:

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Each step of the process is explained below:

**Community Analysis** provides overall descriptions of those health problems that can most likely be improved through health education. Many aspects of the community are analyzed, such as its general health status, its health care system, its social services system, the physical environment, and so on. This analysis is based on information developed by other organizations. Sources of information include Census data, state or non-profit agency reports, the Federal *Healthy People 2010*, and CDC state surveillance data. The community analysis enables program planners to identify health problems within sub-groups of the community and other issues related to health.

**Targeted Assessment.** With the results of the large-scale community analysis, program planners begin to focus on a targeted population (perhaps the home-bound elderly or overweight children) and/or a targeted health problem (perhaps circulation problems leading to stroke or obesity leading to diabetes) to define the specific health issues to be addressed. During the targeted assessment, it is most advantageous to involve community

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members. Having the target population participate in identifying and describing health concerns is educational for both the community and the health planners.

**Program Plan Development** involves a series of smaller steps. The planning group, ideally including members of the target audience:

- a. Develop program goals,
- b. Develop objectives for their goals,
- c. Explore resources that will help and constraints that might reduce success,
- d. Select the best possible methods and activities,
- e. Plan for implementation, and
- f. Plan for evaluation.

**Implementation** is putting the program into action. The planning group works to:

- a. Gain acceptance for the program within the target population,
- b. Specify tasks and estimate their resource needs,
- c. Develop specific plans for each program activity, and
- d. Establish a mechanism for managing the entire program.
- e. Put plans into action.

**Evaluation** is the formal process of assessing accomplishments and identifying limitations of the education initiative. Types of evaluations are:

- *Process*: evaluating the methods and activities of the program that are designed to produce behavioral changes in participants.
- *Impact*: evaluating the specific effect of the program on the behavior and current health of participants.
- *Outcome*: evaluating the effects that the program may have on participants over time.

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As shown in the planning diagram, the results of evaluation can be added to the original targeted assessment to improve the next round of planning and implementation.

### *Health Education Theory*

Public health and health promotion programs can help to improve health, reduce disease risks, manage chronic illnesses and contagious diseases, and improve the general well being of individuals, families, organizations, and entire communities. However, not all programs and initiatives are equally successful. The programs most likely to succeed are based upon a clear understanding of the targeted health behaviors and their context. Theories and models of health behavior can play a critical role in making a health education/promotion program effective, because they help us understand the processes for achieving behavior change.

There are many theories that come from social science fields — including sociology, psychology and public health — that help educators plan the content of their education/promotion activities. Two different theories are described here that best apply to the service which HealthCorps members perform.

**Health Belief Model (HBM)** is a frequently used model in health behavior; it was developed in the 1950's by a group of psychologists to help understand and predict health behaviors. Research has suggested that the HBM is one of the most effective models for sexually transmitted infection interventions and to increase condom use.

HBM is a framework for health education based on what people think about their own health. By asking people questions or using other methods to get them to think about health issues, the educator helps people identify any barriers that are preventing clients from making beneficial changes and recognize the benefits of possible changes. There are five components to the model:

- *Perceived susceptibility*: How a person views his/her potential risk for the particular health condition, such as AIDS. “Why bother? I’ll never get it!”

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- *Perceived seriousness of disease*: How the person views the nature of that health condition and its effects. “What would AIDS do to me if I had it?”
- *Perceived benefits of change of behavior*: Any positive results the person associates with changing his/her own behavior, that is, outcomes that make the behavior change worthwhile to the individual. “I always *wanted* my boyfriend to wear condoms, because I don’t want to get pregnant.”
- *Perceived barriers to change*: Any reasons why the individual has not changed his/her behavior or hesitates to try. “Condoms? Nah. Lousy sex!”
- *Self-efficacy*: The level of confidence the person has in his/her ability to change behavior successfully. “The last time I tried talking to a boy about using a condom was a year ago. Maybe I *could* make it work this time.”

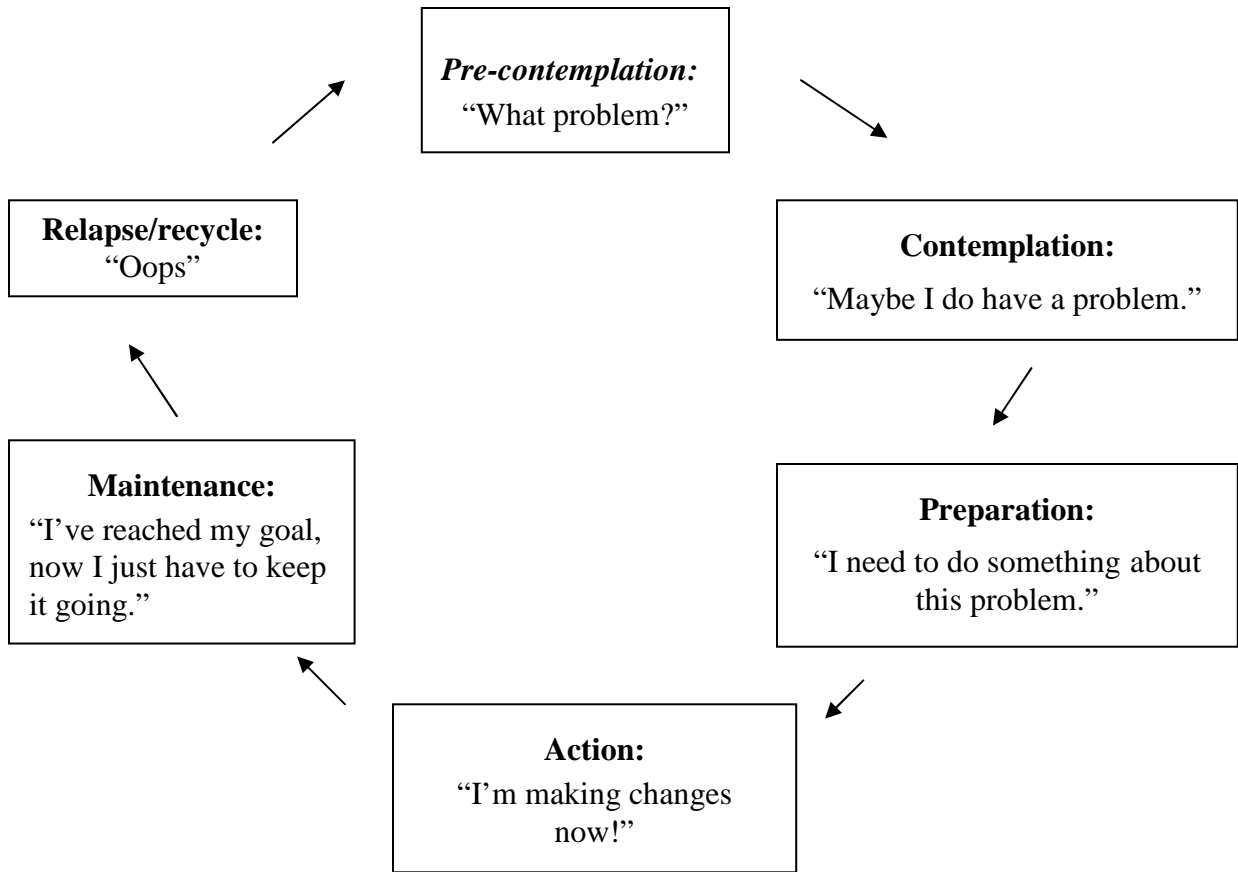
This model works on the principle that behavior change can only occur when a person believes there is a need to change and is ready to take action. Helping people perceive the benefits of change is often the hardest part. The health educator works to make the steps of behavior change as simple as possible.

Follow up after the educational intervention is important, too. This may involve one-on-one meetings with participants, “check in” phone calls to them, or getting the group together again a month later.

**Stages of Change Model** evolved from work with smoking cessation and the treatment of drug and alcohol addiction. It has recently been applied to a variety of other health behaviors as well. The theory reflects the belief that behavior change is a *process* (not an event) and that individuals are at varying levels of readiness to change. People at different points in the process of change can benefit from different interventions, matched to their stage at that time.

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The following diagram illustrates this model. The intervention appropriate to each step is summarized in the following table:



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<b>Patient Stage</b>	<b>Intervention</b>
<b>Pre-contemplation</b>	Plant seeds of doubt. Increase patient's perception of risks and problems with current behavior.
<b>Contemplation</b>	Tip the balance: educate. Evoke reasons to change, risks of not changing; strengthen patient's self-efficacy for change of current behavior.
<b>Preparation</b>	Planning helps the patient determine the best course of action to take in seeking change. Anticipate barriers.
<b>Important: Don't Rush the Planning Stage!</b>	<b>Important: Don't Rush the Planning Stage!</b>
<b>Action</b>	Help patient take steps towards change and reward him/herself. Continue to discuss barriers.
<b>Maintenance</b>	Help patient identify and use strategies to prevent relapse.
<b>Relapse/recycle</b>	Help patient to renew the process of contemplation, preparation and action without becoming stuck or demoralized because of the relapse. "A slip is not a fall."
<b>Important: Everyone relapses. Help patient see it as an opportunity to learn how to do it better next time!</b>	<b>Important: Everyone relapses. Help patient see it as an opportunity to learn how to do it better next time!</b>

*\*From Miller, W.R. & Rollnick, S. Motivational Interviewing: Preparing People to Change Addictive Behavior. The Guilford Press, 1991*

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Both of these theories focus on the individual factors affecting a person's behavior change. Other theories take into account how the physical and social environment in which someone lives can impact that person's health behavior. The following are examples of how a person's environment can affect his/her health behavior:

- A patient has been instructed to walk every day in order to lose weight but lives in a neighborhood where it is not safe to walk alone.
- A child is obese, but the only choices for snacks in his school are vending machines with candy and pop.
- A child with asthma does not use her controller medications, because she is teased by the other children.
- A woman is trying to quit smoking, but all of her family members and co-workers are smokers.
- A person's workplace adopts an employee wellness program where all the staff take walking breaks.

As you work in your site placement on asthma management or diabetes management or smoking cessation, think about how the physical and social environment might be affecting the individual's behavior and how those issues can be addressed.

### *Challenges in Health Education*

As in any profession working with human behavior, there are many challenges that come with implementing a health education program. The following are common challenges faced by health educators:

- Working with people who don't yet see any reason to change their health behavior.
- Motivating people to attend educational programs.
- Involving community members/patients in program planning.

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- Determining if a program has changed behavior and/or improved the health of the patients (i.e., outcome evaluation).

But the presence of challenges is no reason to believe that successful health education — leading to substantive changes in client/patient behavior — is impossible. In fact, the opposite is true. A good health educator enjoys solving such problems as s/he moves through the cycle of project planning, evaluation, and revision.