CHAPTER 1

© Jones & Bartlett Learning, LLC. NOT FOR SALE OR DISTRIBUTION. 9399

Introduction to Health Education, Health Promotion, and Theory

KEY CONCEPTS

- behavior
- certified health education specialist (CHES)
- certified in public health (CPH)
- code of ethics
- community-related terms
- health
- health behavior
- health education
- health literacy
- health promotion
- model
- terms related to antecedents of behavior
- theory

AFTER READING THIS CHAPTER YOU SHOULD BE ABLE TO

- Define health, health behavior, health education, and health promotion
- Identify the limitations of the traditional definition of health
- Differentiate between health education and health promotion
- Define terms related to antecedents of behavior
- Delineate community-related terms
- List the responsibilities of certified health education specialists
- Explain the role of theory in health education and health promotion
- Name different types of theories and provide examples
- Identify 10 national health education organizations

HEALTH, BEHAVIOR, AND HEALTH BEHAVIOR

Health is an age-old concept. In Old English the idea appeared as *haelen* ("to heal"), and in Middle English as *helthe*, meaning to be sound in body, mind, and spirit. The classic Greek definition of medicine was to "prolong life and prevent disease," or in other words to keep people healthy (Cook, 2004). Similarly, medicine in ancient India was called *Ayurveda*, or the science of life or health. By the 17th century, most medical

© Jones & Bartlett Learning, LLC. NOT FOR SALE OR DISTRIBUTION. 9399

textbooks commonly used the word *restoration*. By the end of the 19th century, the word *health* was considered colloquial and was replaced with the word *hygiene*, which was considered more scientific (Cook, 2004).

After the Second World War, the word *health* resurfaced with the formation of the World Health Organization (WHO), a global entity. Around the same time, the Hygienic Laboratory in the United States was renamed the National Institutes of Health. In 1948, WHO defined health in its constitution as "a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity" (WHO, 1974, p. 29). This definition of health has received a lot of criticism over the years for a number of reasons.

First, the use of the word *state* is misleading. Health is dynamic and changes from time to time. For example, a person may be healthy in the morning and then develop a headache in the afternoon and thus not be in the "state" of health. Second, the dimensions mentioned in the definition are inadequate to capture the variations in health. One such dimension is the spiritual dimension (Perrin & McDermott, 1997). Bensley (1991) has identified six perspectives related to the spiritual dimension of health: (1) sense of fulfillment, (2) values and beliefs of community and self, (3) wholeness in life, (4) well-being, (5) God or a controlling power, and (6) human–spiritual interaction. None of these concepts are included in WHO's definition. Another dimension that is not mentioned is the political dimension. Do the rich get sick more often, or do the poor? Who controls greater resources to health? Do the rich or the poor have a greater burden of mortality? All these and many other questions pertaining to the politics of health must be explicitly mentioned in the definition for it to be meaningfully complete.

Third, the word *well-being* is very subjective. A definition must be more objective, and subjectivity should be minimized. Fourth, the way in which health is defined makes it very difficult to measure. McDowell and Newell (1987) pointed out that "just as language molds the way we think[,] our health measurements influence (and are influenced by) the way we define and think about health" (p. 14); in other words, health and measurement are inextricably linked. Fifth, WHO's definition of health presents an idealistic or utopian view. It would be impossible to find anyone who embodies all the attributes presented in the definition. Thus the definition of health lacks practical applications.

> *Health is a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity.*
>
> —World Health Organization (1974, p. 29)

Sixth, in the WHO definition health is presented as an end product, whereas most people perceive health as a means of achieving something that they value more highly. For example, people want to be healthy so that

© Jones & Bartlett Learning, LLC. NOT FOR SALE OR DISTRIBUTION. 9399

they can raise their families. Finally, the WHO definition of health is written from an individualistic perspective in which health is defined for one person. It lacks a community orientation, which is much needed for something as complex as health. These limitations of the WHO definition are summarized in **Table 1.1**.

The original WHO definition has been modified in subsequent discussions at the world level. In November 1986, the first International Conference on Health Promotion was held in Ottawa, Canada (WHO, 1986). At that conference the Ottawa Charter for Health Promotion was drafted. In the charter, health was defined more broadly:

> [H]ealth has been considered less as an abstract state and more as a means to an end which can be expressed in functional terms as a resource which permits people to lead an individually, socially, and economically productive life. Health is a resource for everyday life, not the object of living. It is a positive concept emphasizing social and personal resources as well as physical capabilities. (WHO, 1986, p. 1)

Another important basic concept is **behavior**. *Merriam-Webster's Dictionary* defines behavior as "anything that an organism does involving action and response to stimulation." The key word is "action." A behavior is any overt action, conscious or unconscious, with a measurable frequency, intensity, and duration. "Frequency" refers to how many times the behavior occurs in a given time period. For example, we may classify someone as being active who participates in some sort of physical activity 5 days a week. "Intensity" refers to how intensely or how hard the behavior is performed. For example, we may say that a behavior is mildly intense, moderately intense, or vigorous depending on the effect it has on the heart rate or the number of calories burned.

TABLE 1.1 Limitations of the World Health Organization's Definition of Health
Health is dynamic, not a state.
The dimensions are inadequate.
The definition is subjective.
Measurement is difficult.
The definition is idealistic rather than realistic.
Health is not an end but a means.
The definition lacks a community orientation.

© Jones & Bartlett Learning, LLC. NOT FOR SALE OR DISTRIBUTION. 9399

"Duration" refers to the amount of time spent on each session. For example, physical activity may last for 20 minutes on any given day.

Any behavior is influenced by factors at five levels. The first level pertains to individual factors. For example, a person's attitude helps determine his or her behavior. A person who is partaking in physical activity may believe that physical activity is refreshing. The second level pertains to interpersonal factors. For example, the person may be exercising because his or her spouse requested it. The third level pertains to institutional or organizational factors. For example, there may be a policy at the workplace that requires every person to work out for an hour, and that may be the reason the person is performing the physical activity. The fourth level pertains to community factors. For example, if the only available parking is 10 minutes away from where the person lives or works, this may be the main reason the person is physically active. The final level in determining behavior is the role of public policy factors. For example, laws and policies requiring the use of seat belts while driving may make a person perform that particular behavior.

A behavior is any overt action, conscious or unconscious, with a measurable frequency, intensity, and duration.

Now let us focus our attention on defining **health behavior**. The World Health Organization (1998, p. 8) defines health behavior as "any activity undertaken by an individual regardless of actual or perceived health status, for the purpose of promoting, protecting or maintaining health, whether or not such behavior is objectively effective toward that end." David Gochman (1982, p. 167, 1997, p. 3) defines health behavior as "those personal attributes such as beliefs, expectations, motives, values, perceptions, and other cognitive elements; personality characteristics, including affective and emotional states and traits; and behavioral patterns, actions, and habits that relate to health maintenance, to health restoration, and to health improvement." Three key foci of health behavior are clear in these definitions: maintenance of health, restoration of health, and improvement of health.

These foci correspond to the three levels of prevention: namely, primary prevention, secondary prevention, and tertiary prevention (Modeste & Tamayose, 2004; Pickett & Hanlon, 1998). **Primary prevention** refers to preventive actions taken prior to the onset of a disease or injury with the intention of removing the possibility of their ever occurring. **Secondary prevention** refers to actions that block the progression of an injury or disease at its incipient stage. **Tertiary prevention** refers to actions taken after the onset of disease or an injury with the intention of assisting the individual with the disease or disability. The actions for primary, secondary, and tertiary level care are taken at individual, interpersonal, organizational, community, and public policy levels. Hence health behavior can be defined as all actions with a potentially

© Jones & Bartlett Learning, LLC. NOT FOR SALE OR DISTRIBUTION. 9399

measurable frequency, intensity, and duration performed at the individual, interpersonal, organizational, community, or public policy level for primary, secondary, or tertiary prevention.

Some health behaviors have positive attributes, such as promoting physical activity or eating five or more servings of fruits and vegetables. Other health behaviors focus on extinguishing negative attributes, such as smoking or binge drinking. These behaviors can be categorized as risk behaviors and protective behaviors. The World Health Organization (1998, p. 18) defines risk behaviors as "specific forms of behavior which are proven to be associated with increased susceptibility to a specific disease or ill-health." For example, indiscriminate sexual behavior is a risk behavior for sexually transmitted diseases, including HIV/AIDS. Protective behaviors aim to protect a person from developing ill-health or a specific disease. For example, a person may be immunized against tetanus and thus prevent the disease. Green and Kreuter (2005) divided protective behaviors into two categories: health-directed and health-related behaviors. Health-directed behaviors are actions a person consciously pursues for health improvement or health protection, such as seeking an immunization, getting a physical examination, eating a low-fat food, or using a condom. Health-related behaviors are actions performed for reasons other than health but that have health effects. An example is an individual who is trying to lose weight in order to improve his or her appearance.

HEALTH EDUCATION AND HEALTH PROMOTION

Health education professionals facilitate modification of health behaviors. Health education has been defined in several ways. Downie, Fyfe, and Tannahill (1990) defined it as "[c]ommunication activity aimed at enhancing positive health and preventing or diminishing ill-health in individuals and groups through influencing the beliefs, attitudes and behavior of those with power and of the community at large" (p. 28). The 2000 Joint Committee on Health Education and Promotion Terminology (Gold & Miner, 2002, p. 3) defined health education as "any combination of planned learning experiences based on sound theories that provide individuals, groups, and communities the opportunity to acquire information and the skills needed to make quality health decisions." The World Health Organization (1998, p. 4) defined health education as "compris[ing] 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." Green and Kreuter (2005, p. G-4) defined health education as "any planned

© Jones & Bartlett Learning, LLC. NOT FOR SALE OR DISTRIBUTION. 9399

combination of learning experiences designed to predispose, enable, and reinforce voluntary behavior conducive to health in individuals, groups or communities."

From these definitions some things are clear. First, health education is a systematic, planned application, which qualifies it as a science. Second, the delivery of health education involves a set of techniques rather than just one, such as preparing health education informational brochures, pamphlets, and videos; delivering lectures; facilitating role plays or simulations; analyzing case studies; participating and reflecting in group discussions; reading; and interacting in computer-assisted training. In the past, health education encompassed a wider range of functions, including community mobilization, networking, and advocacy, which are now embodied in the term **health promotion**. Third, the primary purpose of health education is to influence antecedents of behavior so that healthy behaviors develop in a voluntary fashion (without any coercion). The common antecedents of behavior are awareness, information, knowledge, skills, beliefs, attitudes, and values. Finally, health education is performed at several levels. It can be done one-on-one, such as in a counseling session; it can be done with a group of people, such as through a group discussion; it can be done at an organizational level, such as through an employee wellness fair; or it can be done at the community level, such as through a multiple-channel, multiple-approach campaign.

> Healthy People 2020 *reflects assessments of major risks to health and wellness, changing public health priorities, and emerging issues related to our nation's health preparedness and prevention.*
>
> —U.S. Department of Health and Human Services (2009)

Since the publication of *Healthy People: The Surgeon General's Report on Health Promotion and Disease Prevention* (U.S. Department of Health and Human Services [USDHHS], 1979), the term *health promotion* has gained popularity and continues to gain strength. This term has been used in the *Objectives for the Nation* (USDHHS, 1980), *Healthy People 2000* (USDHHS, 1990), *Healthy People 2010* (USDHHS, 2000) and *Healthy People 2020* (USDHHS, 2009) reports. **Table 1.2** summarizes the 38 focus areas in *Healthy People 2020*, which underscore the importance of health promotion.

Green and Kreuter (2005, p. G-4) defined health promotion as "any planned combination of educational, political, regulatory and organizational supports for actions and conditions of living conducive to the health of individuals, groups or communities." The 2000 Joint Committee on Health Education and Promotion Terminology (Gold & Miner, 2002, p. 4) defined health promotion as "any planned combination of educational, political, environmental, regulatory, or organizational mechanisms that support actions and conditions of living conducive to the health of individuals, groups, and communities." The *Ottawa Charter for Health Promotion* (WHO, 1986, p. 1) defined health promotion as "the process of enabling people to

© Jones & Bartlett Learning, LLC. NOT FOR SALE OR DISTRIBUTION. 9399

TABLE 1.2 Focus Areas in *Healthy People 2020*

Access to health services	HIV
Adolescent health	Immunization and infectious diseases
Arthritis, osteoporosis, and chronic back conditions	Injury and violence prevention
Blood disorders and blood safety	Maternal, infant, and child health
Cancer	Medical product safety
Chronic kidney diseases	Mental health and mental disorders
Diabetes	Nutrition and weight status
Disability and secondary conditions	Occupational safety and health
Early and middle childhood	Older adults
Educational and community-based programs	Oral health
Environmental health	Physical activity and fitness
Family planning	Public health infrastructure
Food safety	Quality of life and well being
Genomics	Respiratory diseases
Global health	Sexually transmitted diseases
Health communication and health IT	Social determinants of health
Healthcare associated infections	Substance abuse
Hearing and other sensory or communication disorders	Tobacco use
Heart disease and stroke	Vision

increase control over, and to improve their health." The Ottawa Charter identified five key action strategies for health promotion:

- Build healthy public policy.
- Create physical and social environments supportive of individual change.
- Strengthen community action.

© Jones & Bartlett Learning, LLC. NOT FOR SALE OR DISTRIBUTION. 9399

- Develop personal skills such as increased self-efficacy and feelings of empowerment.
- Reorient health services to the population and partnership with patients.

These action areas were confirmed in the *Jakarta Declaration on Leading Health Promotion into the 21st Century* in 1997 (WHO, 1997). In addition, the Jakarta Declaration identified five priorities for health promotion:

- Promote social responsibility for health.
- Increase investments for health development.
- Expand partnerships for health promotion.
- Increase community capacity and empower the individual.
- Secure an infrastructure for health promotion.

Once again, all these depictions of health promotion have some things in common. First, just like health education, health promotion is a systematic, planned application that qualifies as a science. Second, it entails methods beyond mere education such as community mobilization, community organization, community participation, community development, community empowerment, networking, coalition building, advocacy, lobbying, policy development, formulating legislation, and developing social norms. Third, unlike health education, health promotion does not endorse voluntary change in behavior but utilizes measures that compel an individual's behavior change. These measures are uniform and mandatory. Often the behavior change in health promotion comes from measures that an individual may not like, for example, an increase in insurance premium for a smoker. Finally, health promotion is done at the group or community level.

> *Health for all: The attainment by all people of the world of a level of health that will permit them to lead a socially and economically productive life.*
>
> —World Health Organization (1986, p. 4)

RESPONSIBILITIES AND COMPETENCIES FOR HEALTH EDUCATORS

The history of health education dates to the late 19th century, when the first academic programs emerged for training school health educators (Allegrante et al., 2004). The 2003 "Directory of Institutions Offering Undergraduate and Graduate Degree Programs in Health Education" listed 258 institutions offering baccalaureate, master's, and doctoral degrees in health education (American Association for Health Education, 2003).

As the profession of health education has grown, greater interest has arisen in establishing standards and holding professionals accountable to those standards.

© Jones & Bartlett Learning, LLC. NOT FOR SALE OR DISTRIBUTION. 9399

In February 1978, a conference for health educators was convened in Bethesda, Maryland, to analyze the similarities and differences in preparing health educators from different practice settings and to discuss the possibility of developing uniform guidelines (National Commission for Health Education Credentialing [NCHEC], Society for Public Health Education [SOPHE], & American Association for Health Education [AAHE], 2006; U.S. Department of Health, Education and Welfare, 1978). Soon after, the Role Delineation Project was implemented, which looked at the role of the entry-level health education specialist and identified the desirable responsibilities, functions, skills, and knowledge for that level. These were verified by a survey of practicing health educators. The process led to the publication of *A Framework for the Development of Competency-Based Curricula for Entry-Level Health Educators* (NCHEC, 1985).

In 1986, the second Bethesda Conference provided consensus for the certification process, and in 1988, the National Commission for Health Education Credentialing was established. In 1989, a charter certification phase was introduced, during which time health educators could become certified by submitting letters of support and academic records. From 1990 to the present, the NCHEC has conducted competency-based national certification examinations. An individual who meets the required health education training qualifications, successfully passes the certification exam, and meets continuing education requirements is known as a **certified health education specialist (CHES)**. In 2006, there were 12,000 certified individuals (NCHEC, SOPHE, & AAHE, 2006). **Table 1.3** summarizes the responsibilities for entry-level health educators (NCHEC, 1985).

In 1992, the AAHE and SOPHE began to determine graduate-level competencies, and a Joint Committee for the Development of Graduate-Level Preparation Standards was formed. *A Competency-Based Framework for Graduate Level Health Educators* was

TABLE 1.3	Areas of Responsibilities for Entry-Level Health Educators
I.	Assess individual and community needs for health education
II.	Plan effective health education programs
III.	Implement health education programs
IV.	Evaluate the effectiveness of health education programs
V.	Coordinate the provision of health education services
VI.	Act as a resource person in health education
VII.	Communicate health and health education needs, concerns, and resources

© Jones & Bartlett Learning, LLC. NOT FOR SALE OR DISTRIBUTION. 9399

published in 1999 (AAHE, NCHEC, & SOPHE, 1999). **Table 1.4** summarizes the responsibilities for graduate-level health educators. Beginning in October 2011, the NCHEC will hold exams for the advanced-level credential, Master Certified Health Education Specialist (MCHES) (Rehrig, 2010).

In 1998 the profession launched the National Health Educator Competencies Update Project (CUP), a six-year project to reverify the entry-level health education responsibilities, competencies, and subcompetencies and to verify the advanced-level competencies and subcompetencies (Airhihenbuwa et al., 2005; Gilmore, Olsen, Taub, & Connell, 2005). The CUP model identifies three levels of practice: (1) entry (competencies and subcompetencies performed by health educators with a baccalaureate or master's degree and less than 5 years of experience), (2) advanced 1 (competencies and subcompetencies performed by health educators with a baccalaureate or master's degree and more than 5 years of experience), and (3) advanced 2 (competencies and subcompetencies performed by health educators with a doctoral degree and 5 years or more of experience). The CUP model contains seven areas of responsibility, 35 competencies, and 163 subcompetencies, many of which are similar to previous models. **Table 1.5** summarizes the responsibilities. Research and advocacy have been combined to form Area IV, and communication and advocacy have been combined in Area VII. The CUP model also identifies six settings for health education (**Table 1.6**).

TABLE 1.4 Areas of Responsibilities for Graduate-Level Health Educators

I.	Assess individual and community needs for health education
II.	Plan effective health education programs
III.	Implement health education programs
IV.	Evaluate the effectiveness of health education programs
V.	Coordinate the provision of health education services
VI.	Act as a resource person in health education
VII.	Communicate health and health education needs, concerns, and resources
VIII.	Apply appropriate research principles and techniques in health education
IX.	Administer health education programs
X.	Advance the profession of health education

© Jones & Bartlett Learning, LLC. NOT FOR SALE OR DISTRIBUTION. 9399

TABLE 1.5 Areas of Responsibilities for Health Educators in the CUP Model

I.	Assess individual and community needs for health education
II.	Plan health education strategies, interventions, and programs
III.	Implement health education strategies, interventions, and programs
IV.	Conduct evaluation and research related to health education
V.	Administer health education strategies, interventions, and programs
VI.	Serve as a health education resource person
VII.	Communicate and advocate for health and health education

TABLE 1.6 Settings for Health Education Identified in the CUP Model

Community
School (K–12)
Health care
Business/industry
College/university
University health services

Health education is an important and integral function of public health. The Institute of Medicine (1988) defined three core functions of public health in its *Future of Public Health* report:

1. *Assessment*: Every public health agency should regularly and systematically collect, assemble, analyze, and make available information on the health of the community.
2. *Policy development*: Every public health agency should assist in the development of comprehensive public health policies.
3. *Assurance*: Every public health agency should ensure that services necessary to achieve agreed-upon goals in communities are provided either directly or by regulations or by other agencies.

Building on these identified functions, the Public Health Functions Steering Committee (1994) identified six public health goals and 10 essential public health services.

© Jones & Bartlett Learning, LLC. NOT FOR SALE OR DISTRIBUTION. 9399

The six goals are to (1) prevent epidemics and the spread of disease, (2) protect against environmental hazards, (3) prevent injuries, (4) promote and encourage healthy behaviors, (5) respond to disasters and assist communities in recovery, and (6) assure the quality and accessibility of health services. The 10 essential public health services are to (1) monitor health status to identify community health problems; (2) diagnose and investigate health problems and health hazards in the community; (3) inform, educate, and empower people about health issues; (4) mobilize community partnerships to identify and solve health problems; (5) develop policies and plans that support individual and community health efforts; (6) enforce laws and regulations that protect health and ensure safety; (7) link people to needed personal health services and ensure the provision of health care when it is otherwise unavailable; (8) ensure the availability of a competent public health and personal health care workforce; (9) evaluate the effectiveness, accessibility, and quality of personal and population-based health services; and (10) research new insights and innovative solutions to health problems. It can be seen from both these lists that health education is a core and integral function of public health and that health educators are key public health functionaries.

The Institute of Medicine published *The Future of the Public's Health in the 21st Century* in 2002, which echoed the vision articulated in *Healthy People 2010* (USDHHS, 2000): healthy people in healthy communities. It emphasized the following key areas of action:

- Adopt a focus on population health that includes multiple determinants of health
- Strengthen the public health infrastructure
- Build partnerships
- Develop systems of accountability
- Emphasize evidence
- Improve communication

Once again, all of these functions underscore the inextricable linkage between public health and health education. Health education is an important subset of public health. Just as there is a NCHEC, since 2005 the National Board of Public Health Examiners (NBPHE, n.d.) has ensured that graduates from schools and programs of public health accredited by the Council on Education for Public Health (CEPH) have gained the required knowledge and skills related to public health. NBPHE is responsible for developing, preparing, administering, and evaluating a voluntary certification exam. People who pass this exam are called **Certified in Public Health (CPH).** The first exam was conducted in 2008 and certified about 500 individuals. The exam consists of questions from five core areas: biostatistics, epidemiology, environmental health sciences, health policy and management, and social and behavioral sciences

© Jones & Bartlett Learning, LLC. NOT FOR SALE OR DISTRIBUTION. 9399

along with seven cross-cutting areas: communication and informatics, diversity and culture, leadership, public health biology, professionalism, programs planning, and systems thinking.

CODE OF ETHICS FOR THE HEALTH EDUCATION PROFESSION

Ethics is a major area of philosophy that deals with the study of morality, and in recent years, interest in ethics has increased in all walks of life. Practicing ethical behavior provides a standard for performance in any profession. In the profession of health education, the earliest effort to develop a code of ethics was the 1976 code of ethics developed by the Society for Public Health Education (Taub, Kreuter, Parcel, & Vitello, 1987). A coalition of national health education organizations, composed of the American Academy of Health Behavior (AAHB), the American Association for Health Education (AAHE), the American College Health Association (ACHA), the American Public Health Association's (APHA) Public Health Education and Health Promotion (PHEHP) Section, APHA's School Health Education and Services (SHES) Section, the American School Health Association (ASHA), the Directors of Health Promotion and Education (DHPE), Eta Sigma Gamma, the Society for Public Health Education (SOPHE), and the Society of State Directors of Health, Physical Education and Recreation (SSDHPER) has developed a unified **code of ethics for health educators** (Coalition of National Health Education Organizations, 2004). The code of ethics has six areas, which are summarized in **Table 1.7**.

TABLE 1.7 Articles in the Code of Ethics for the Health Education Profession
Responsibility to the public: Supports principles of self-determination and freedom of choice for the individual
Responsibility to the profession: Exhibits professional behavior
Responsibility to employers: Accountable for professional activities and actions
Responsibility in the delivery of health education: Respects the rights, dignity, confidentiality, and worth of people
Responsibility in research and evaluation: Conducts oneself in accordance with federal and state laws, organizational and institutional policies, and professional standards
Responsibility in professional preparation: Provides quality education that benefits the profession and the public

© Jones & Bartlett Learning, LLC. NOT FOR SALE OR DISTRIBUTION. 9399

HEALTH EDUCATION ORGANIZATIONS

Ten health education organizations exist at the national level. The following subsections provide a brief description of each of these organizations.

American Academy of Health Behavior (AAHB)

The American Academy of Health Behavior was established in 1998. The mission of this organization is to advance the practice of health education and health promotion through health behavior research. Its specific objectives are to:

- Foster and disseminate findings of health behavior, health education, and health promotion research through sponsorship of scientific meetings, symposia, and publications
- Recognize outstanding achievements in the areas of health behavior, health education, and health promotion research
- Facilitate collaborative research efforts by bringing its members in contact with each other through a membership directory, professional meetings, professional publications, and electronic media
- Advance health education and health promotion by influencing health policy and allocation of resources (government agencies, private foundations, universities, etc.) by developing and disseminating a cohesive body of knowledge in the area of health behavior research

Its website is www.aahb.org.

American Association for Health Education (AAHE)

The American Association for Health Education was established in 1937, but its parent organization, the Association of the American Alliance for Health, Physical Education, Recreation, and Dance (AAHPERD), was established in 1885. The AAHE is a membership organization representing 7500 health educators and health promotion specialists and is the oldest and largest health education association. It advances the profession by serving health educators and other professionals who strive to promote the health of all people. Its specific objectives are to:

- Develop and promulgate standards, resources, and services regarding health education to professionals and nonprofessionals
- Foster the development of national research priorities in health education and promotion
- Provide mechanisms for the translation of theory and research into practice and the translation of practice into theory and research

© Jones & Bartlett Learning, LLC. NOT FOR SALE OR DISTRIBUTION. 9399

- Facilitate communication among members of the profession, the lay public, and other national and international organizations with respect to the philosophic basis and current application of health education principles and practices
- Provide technical assistance to legislative and professional bodies engaged in drafting pertinent legislation and related guidelines
- Provide leadership in promoting policies and evaluative procedures that will result in effective health education programs
- Assist in the development and mobilization of resources for effective health education and promotion

Its website is www.aahperd.org/aahe.

American College Health Association (ACHA)

The American College Health Association was established in 1920. The mission of the organization is to be the principal advocate and leadership organization for college and university health. The association provides advocacy, education, communications, products, and services, as well as promoting research and culturally competent practices to enhance its members' ability to advance the health of all students and the campus community. Its main objectives are:

- To support and promote systems and programs that produce optimum health outcomes for college students and campus communities
- To be the primary source of information, education, and consultation on health and health promotion issues affecting college and university students within the campus community
- To be the leading source of evidence-based knowledge about the field of college health
- To be the principal advocate for national public policy affecting the health of all college students and campus communities
- To develop and maximize the use of human, financial, and technological resources to ensure and sustain growth

Its website is www.acha.org.

American Public Health Association's (APHA) Public Health Education and Health Promotion (PHEHP) Section

The Public Health Education and Health Promotion Section was established in 1920. The parent organization, the American Public Health Association, was formed in 1872. The section has more than 3000 members. Its specific objectives are:

© Jones & Bartlett Learning, LLC. NOT FOR SALE OR DISTRIBUTION. 9399

- To be a strong advocate for health education, disease prevention, and health promotion directed to individuals, groups, and communities in all activities of the association
- To encourage the inclusion of health education, disease prevention, and health promotion activities in all of the nation's health programs
- To stimulate thought, discussion, research, and programmatic applications aimed at improving the public's health
- To improve the quality of research and practice in all public health programs of health education, disease prevention, and health promotion
- To provide networking opportunities for persons whose professional interests and training include, but are not limited to, the disciplines of health education, health communication, health promotion, social marketing, behavioral and social sciences, and public relations
- To provide section members with opportunities to become informed and engaged in all of the activities and matters of concern to the association
- To facilitate collaboration with all of the association's boards, committees, special primary interest groups, caucuses, sections, and affiliates
- To provide section members with such benefits as the annual meeting program, continuing education opportunities, newsletters, and a structure for exercising association leadership
- To identify and recognize individuals who make outstanding and substantial contributions to health education, disease prevention, and health promotion

Its website is www.jhsph.edu/hao/phehp/.

American Public Health Association's School Health Education and Services (SHES) Section

The School Health Education and Services Section was established in 1942 and has more than 300 members. Its specific objectives are:

- To provide a section within the association that works independently, with other association substructures, and with external organizations toward the improvement of early childhood, school, and college health programs
- To interpret the functions and responsibilities of health agencies to day care, preschool, school, and college personnel
- To interpret early childhood, school, and college health education and service objectives to other public health personnel and assist them in integrating the objectives in their community

© Jones & Bartlett Learning, LLC. NOT FOR SALE OR DISTRIBUTION. 9399

- To provide a forum for discussion of practices and research in early childhood, school, and college health
- To encourage the provision of health promotion programs within the school and college settings that address the needs of children and school personnel
- To encourage among interested association members the study and discussion of procedures and problems in early childhood, school, and college health services, health education, and environmental health programs

Its website is www.hsc.usf.edu/CFH/cnheo/apha-shes.htm.

American School Health Association (ASHA)

The American School Health Association was established in 1927 and has a membership of more than 3000. The mission of ASHA is to protect and promote the health of children and youth by supporting coordinated school health programs as a foundation for school success. Its specific objectives are:

- To promote interdisciplinary collaboration among all who work to protect and improve the health, safety, well-being, and school success of children, youth, families, and communities
- To provide professional development opportunities for all those associated with school health programs
- To provide advocacy for building and strengthening effective school health programs
- To advance a research agenda that promotes quality school health programs
- To fulfill these initiatives by acquiring human, fiscal, and material resources

Its website is www.ashaweb.org.

Directors of Health Promotion and Education (DHPE)

The Directors of Health Promotion and Education was established in 1946 and has more than 200 members. Its specific objectives are:

- To serve as a channel through which directors of public health education programs of states and territories of the United States may exchange and share methods, techniques, and information for the enrichment and improvement of public health education programs
- To establish position statements and make recommendations on legislation and public policy related to and having implications for public health education

© Jones & Bartlett Learning, LLC. NOT FOR SALE OR DISTRIBUTION. 9399

- To participate with the Association of State and Territorial Health Officials (ASTHO) in promoting health and preventing disease
- To identify methods of improving the quality and practice of education, public health education, and health promotion
- To elicit cooperation and coordination with national, public, private, and voluntary agencies related to public health programs
- To provide a forum for continuing education opportunities in public health education and health promotion

Its website is www.dhpe.org/.

Eta Sigma Gamma (ESG)

Eta Sigma Gamma was established in 1967. It is the national professional health education honorary society. The specific objectives of this organization are:

- To support the planning, implementation, and evaluation of health education programs and resources
- To stimulate and disseminate scientific research
- To motivate and provide health education services
- To recognize academic achievement
- To support health education advocacy initiatives
- To promote professional standards and ethics
- To promote networking activities among health educators and related professionals

Its website is www.etasigmagamma.org.

Society for Public Health Education (SOPHE)

The Society for Public Health Education was established in 1950, and has more than 4000 members. The primary mission of SOPHE is to provide leadership to the profession of health education and to contribute to the health of all people through advances in health education theory and research and excellence in health education practice, and to promote public policies conducive to health. The specific objectives of this organization are:

- To expand the reach and effectiveness of advocacy efforts beyond SOPHE membership
- To promote the use of health education to eliminate health disparities

© Jones & Bartlett Learning, LLC. NOT FOR SALE OR DISTRIBUTION. 9399

- To review, expand, and promote a dynamic research agenda for health education and behavioral sciences
- To support and enhance the professional preparation and training of health educators and public health professionals
- To proactively market health education
- To continually elevate SOPHE's performance in operations, governance, and resource development to achieve the strategic plan

Its website is www.sophe.org.

Society of State Directors of Health, Physical Education and Recreation (SSDHPER)

The Society of State Directors of Health, Physical Education and Recreation was established in 1926. The mission of SSDHPER is to provide leadership in facilitating and promoting initiatives to achieve national health and education goals and objectives. Its members supervise and coordinate programs in health, physical education, and related fields within state departments of education. Associate membership is available to individuals interested in the goals and programs of the society, but who do not work within a state education agency. Its specific objectives are:

- To help shape national and state policy defining and supporting comprehensive school health and physical education programs
- To link state health, physical education, and recreation leaders with their counterparts in other states
- To forge school–family–community linkages in support of school health, physical education, and recreation programs
- To foster professional growth and the development of leadership and advocacy skills
- To help resolve complex issues in education and health reform
- To provide leadership in the effort to link postsecondary institutions to school districts for improvement in curriculum, instruction, and assessment
- To provide a supportive network of professional and social relationships among members
- To provide training and workshops for members to help them increase capacity to improve comprehensive school health education and programs within their states

Its website is www.thesociety.org.

© Jones & Bartlett Learning, LLC. NOT FOR SALE OR DISTRIBUTION. 9399

BASIC VOCABULARY IN HEALTH EDUCATION AND HEALTH PROMOTION

Health education and health promotion have their roots in several disciplines: biological science, behavioral science, economics, political science, and other social sciences. As in any other field, certain terms and jargon are common to health promotion and health education professionals. Some of these terms are presented in this section. These terms are used when we talk of the antecedents of health behavior change.

Awareness

A concept commonly used by health educators is developing awareness of health topics. To undergo any behavior change, the person first needs to become aware of what he or she is going to change. The *American Heritage Dictionary* defines being aware as "being mindful or heedful." The word *aware* implies knowledge gained through one's own perceptions or other means of information. **Awareness** refers to becoming conscious about an action, idea, object, person, or situation. An example of building awareness is a health educator screening a film about avian flu (bird flu) in a community in which there have been no cases of avian flu and no one knows about this disease. When people are already aware of an issue—for example, that smoking is harmful to health—there is no need to build awareness regarding that issue.

Information

After becoming aware of the need to make a behavior change, the person starts to gather facts about the change. The collection of facts related to an action, idea, object, person, or situation is called **information**. Health educators provide information on various health topics through pamphlets, brochures, flyers, compact discs, videos, and so forth.

Knowledge

After gathering information for making a behavior change, the person needs to learn facts and gain insights related to the action, idea, object, person, or situation. These facts and insights are called **knowledge**. Knowledge is part of the cognitive domain, and Bloom (1956) identified six categories of cognitive learning. The first level is knowledge, which entails recalling data or information—for example, reciting the symptoms of a disease or knowing safety procedures. The second level is comprehension, or

© Jones & Bartlett Learning, LLC. NOT FOR SALE OR DISTRIBUTION. 9399

understanding the meaning, translation, interpolation, and interpretation of instructions and problems. An example is the ability to state a problem in one's own words. The third level is application, which entails using a concept in a new situation. It also means applying what was learned in the classroom setting to novel situations in the workplace. The fourth level is analysis, in which the person is able to separate concepts into component parts so that their organizational structure may be understood. For example, a health educator collects information about a community and then prioritizes the needs to decide what program to offer in the community. The fifth level is synthesis, in which the parts are put together to form a whole, with emphasis on creating a new meaning or structure. The sixth and final level is evaluation, where one makes judgments about the value of ideas or materials. Knowledge can be tested using true/false or multiple-choice questions.

> *Science is organized knowledge.*
>
> —Herbert Spencer

Skills

Performing any action requires a set of psychomotor **skills**. Performance entails physical movement, coordination, and use of the motor skill. Development of these skills requires practice and is measured in terms of speed, precision, distance, procedures, or techniques in execution (Simpson, 1972). Seven categories, ranging from the simplest to the most complex skill, have been identified:

1. *Perception*. The ability to use sensory cues to guide motor activity.
2. *Set*. The readiness to act. It includes mind-set, which predetermines a person's response to different situations.
3. *Guided response*. Early stages in learning a complex skill, which include imitation and trial and error.
4. *Mechanism*. Learned responses have become habitual and the movements can be performed with some confidence and proficiency.
5. *Complex overt response*. Performance without hesitation; automatic performance.
6. *Adaptation*. Skills are well developed, and the individual can modify movement patterns to fit special requirements.
7. *Origination*. The person creates new movement patterns to fit a particular situation or specific problem.

Psychomotor skills are required in almost all health education programs. These are tested by demonstration and redemonstration. For example, in a cardiopulmonary resuscitation program, the instructor first shows the correct technique and then checks to see whether the participants have learned the technique correctly.

© Jones & Bartlett Learning, LLC. NOT FOR SALE OR DISTRIBUTION. 9399

Health Literacy

The 2000 Joint Committee on Health Education and Promotion Terminology (Gold & Miner, 2002, p. 5) defined **health literacy** as "the capacity of an individual to obtain, interpret, and understand basic health information and services and the competence to use such information and services in ways that are health enhancing." Zarcadoolas, Pleasant, and Greer (2003) have suggested a four-part model to understand health literacy.

1. *Fundamental literacy/numeracy*: Competence in understanding and using printed language, spoken language, numerals, and basic mathematical symbols or terms. This domain is involved in a wide range of cognitive, behavioral, and social skills and abilities.
2. *Literacy pertaining to science and technology*: Understanding the basic scientific and technological concepts, technical complexity, the phenomenon of scientific uncertainty, and the phenomenon of rapid change.
3. *Community/civic literacy*: Understanding about sources of information, agendas, and methods of interpreting those agendas. It enables people to engage in dialogue and decision making. It includes media interpretation skills and understanding civic and legislative functions.
4. *Cultural literacy*: Understanding collective beliefs, customs, worldviews, and social identity relationships to interpret and produce health information.

Beliefs

Beliefs are convictions that a phenomenon is true or real (Rokeach, 1970). In other words, beliefs are statements of perceived fact or impressions about the world. These are neither correct nor incorrect. For example, a student may enter a classroom and say that the classroom is big. She may be used to smaller classrooms, and thus from her perspective the current classroom seems big. Another student may enter the same classroom and say that it is small. He may be used to bigger classrooms and, thus, from his perspective the classroom is small.

Attitudes

Attitudes are relatively constant feelings, predispositions, or sets of beliefs directed toward an idea, object, person, or situation (Mucchielli, 1970). Put another way, attitudes are beliefs with an evaluative component. Attitudes have an affective component and demonstrate what one likes and what one does not like. For example, the student

© Jones & Bartlett Learning, LLC. NOT FOR SALE OR DISTRIBUTION. 9399

who found the room too small might qualify that belief by saying that it is "an ugly, small room." Since an evaluation has been made that the student dislikes the room, it becomes an attitude. Likewise, another student might find the same room to be a cozy, small room and thus demonstrate an attitude of liking the room.

Attitudes are usually measured by self-reporting scales, such as Likert scales. Likert scales list several sentences about an object and then ask respondents whether they strongly agree, agree, disagree, or strongly disagree with each statement. The scores are then summed to measure the respondent's attitude toward that object.

Values

A collection of beliefs and attitudes comprises a value system. **Values** are enduring beliefs or systems of beliefs regarding whether a specific mode of conduct or end state of behavior is personally or socially preferable (Rokeach, 1970). Let us take the example of the student who likes cozy, small classrooms. He also likes the students and the instructor in the classroom and likes the textbook that has been assigned by his instructor. He likes to read and to complete his assignments on time. Such a student can be said to have a value system that values education.

Community Mobilization

A **community** is a collection of people identified by a set of shared values. Working with communities is fundamental to the practice of health education. The first step in working with a community is **community mobilization**, which involves persuading community members to attend or participate in any activity planned by the health educator. The purpose of community mobilization is to enhance awareness on a given issue at the community level. Activities such as organizing a talk in the community, arranging a health fair, and bringing together key leaders of the community for a panel discussion are all methods used in community mobilization.

Community Organization

The second step for action at a community level is **community organization**. The term *community organization* was coined by American social workers in the late 1800s to describe their efforts with immigrants and indigent people (Minkler & Wallerstein, 1997). In community organization, community members identify needs, set objectives, prioritize issues, develop plans, and implement projects for community improvement in health and related matters. Green and Kreuter (2005, p. G-2) define

© Jones & Bartlett Learning, LLC. NOT FOR SALE OR DISTRIBUTION. 9399

community organization as "the set of procedures and processes by which a population and its institutions mobilize and coordinate resources to solve a mutual problem or to pursue mutual goals." Activities such as group discussions and committee meetings are common at this stage.

Community Participation

When community members actively participate in planning or implementing projects, it is called **community participation**. Community participation can take place regarding health-related matters or other civic matters. Community members must be in leadership roles for true community participation. Arnstein (1971) has identified eight different types of participation in a ladder of participation. At the bottom of the ladder there is no participation—only manipulation. Token participation entails the levels of information, consultation, and placation. Development of partnerships, delegation of power, and citizen control are levels of participation that are desirable.

Community Development

At the stage of **community development** local initiative and leadership in a community has been organized and stimulated so that changes in health or other matters are occurring. The key word in the concept of community development is *change* at the community level. Change can be measured by assessing changes in services or the provision of new services or by replacing existing policies or by incorporating new policies.

Community Empowerment

The concept of **community empowerment** is closely related to the Ottawa Charter definition of community action for health. The World Health Organization (1998, p. 6) defines it as "a process through which people gain greater control over decisions and actions affecting their health." In essence, empowerment is a process whereby individuals gain mastery over their lives in the context of changing their social and political environments. Empowerment can be a social, cultural, psychological, or political process. Individual empowerment is different from community empowerment. Individual empowerment is mainly about an individual gaining control over his or her personal life. Community empowerment entails individuals collectively gaining greater influence and control over the determinants of health and the quality of life in their community.

© Jones & Bartlett Learning, LLC. NOT FOR SALE OR DISTRIBUTION. 9399

Networking

An important function of health promotion is to establish a network. Creating interdependent relationships with individuals, groups, and organizations to accomplish mutually set objectives in health or other matters is called **networking**.

Coalition Building

No single organization can effectively achieve changes in the health status of a community; collaboration between agencies, groups, and organizations is needed. A grouping of separate organizations in a community united to pursue a common goal related to health or other matters affecting a large number of people is called a **coalition**. It takes time and concerted effort to develop such coalitions; this art is called *coalition building*, and it is a vital function for achieving health promotion goals.

Advocacy

Advocacy is active support of an idea or cause that entails especially the act of pleading or arguing for something. Green and Kreuter (2005, p. G-1) define advocacy as "working for political, regulatory, or organizational change on behalf of a particular interest group or population." Advocacy in health is about creating a shift in public opinion and mobilizing the essential resources to support any issue or policy that affects the health of a community or a constituency. It is a vital function for achieving health promotion goals.

Lobbying

Lobbying is working with and influencing policy makers to develop an issue or a policy affecting the health of a community. It is an important activity in health promotion. Oftentimes health lobbyists have to compete with more powerful and resource-rich lobbyists from business or industry.

Policy Development

Policies are made by institutions or governments (local, state, or federal). Health promotion professionals work with institutional heads or other lawmakers to develop health policies. The process of developing a policy with ramifications for the health of communities is called **policy development**.

© Jones & Bartlett Learning, LLC. NOT FOR SALE OR DISTRIBUTION. 9399

Legislation

Legislation are the laws passed by elected officials at the local, state, or federal level. Legislation has ramifications for the health of a large number of people. Health promotion professionals work at every step of the way to influence laws that foster healthy behaviors and help in extinguishing negative and unhealthy behaviors.

Development of Social Norms

Creating social acceptance for a practice, behavior, condition, policy, law, or environment that may affect the health in a community is called **development of social norms**. Health promotion professionals develop social norms so that healthy behaviors become acceptable and normative.

ROLE OF THEORY IN HEALTH EDUCATION AND HEALTH PROMOTION

Health education and health promotion have multiple influences from several disciplines. But the primary influence on health education is derived from the behavioral sciences, and health promotion is deeply embedded in the social sciences. It is from these behavioral and social sciences that the practice of health education and health promotion borrows the strategic planning of its methods.

The core concepts in behavioral and social sciences are organized in the form of theories. Theories are developed a result of research. Kerlinger and Lee (2000, p. 8) have defined theory as "a set of interrelated, concepts, definitions, and predispositions that present a systematic view of events or situations by specifying relations among variables in order to explain and predict the events or situations." In health education and health promotion, we are primarily interested in predicting or explaining changes in behaviors or environments. A theoretical foundation is becoming almost mandatory for practitioners of health education and health promotion. These days, even for entry-level health educators, competency in developing a logical scope and sequence plan for health education is a requirement (NCHEC, SOPHE, & AAHE, 2006). Graduate-level health educators must base their practice on accepted theory. Theories help us articulate assumptions and hypotheses regarding the strategies and targets of interventions (National Cancer Institute, 2005).

Polit and Hungler (1999) have classified theories into three types. Macro theories, or grand theories, purport to explain and describe large segments of the environment or human experience. Talcott Parsons's (1951) theory on social functioning is an

© Jones & Bartlett Learning, LLC. NOT FOR SALE OR DISTRIBUTION. 9399

example of a macro theory. Middle-range theories describe or explain phenomena such as specific behaviors. Albert Bandura's (1986, 2004) social cognitive theory is an example of a midrange theory. Finally, descriptive theories describe or explain a single discrete phenomenon, such as Hans Selye's (1974) explanation of general adaptation syndrome.

Glanz, Rimer, and Lewis (2002) have classified theories as explanatory theories, or theories of the problem, and change theories, or theories of action. Explanatory theories help describe and identify why a problem exists and search for modifiable constructs. Change theories guide the development of interventions and form the basis of evaluation.

Theories start from discussing concepts or ideas that are abstract entities. These are not measurable or observable. The concepts are adopted into theories and become known as constructs. For example, in social cognitive theory (Bandura, 1986, 2004), "self-efficacy" is a construct. When specific properties are assigned to the construct, it becomes an indicator. For example, a questionnaire examining self-efficacy may contain 10 items, which constitute what the construct means. A variable or quantitative score can be derived from each indicator, and this will vary from one individual to other. For example, in the 10-item questionnaire each item may be ranked from 1 to 5 and the summation may yield a score between 10 and 50. The constructs of a theory are constantly refined by empirical testing. A theory must be able to demonstrate predictive power. Behavioral theories must be able to make significant changes on affect (feelings or conation), thought (cognition), and action (volition). Ideally a theory provides practical guidance on what, why, and how. An ideal theory must be testable and must be generalizable. The constructs of the theory must be able to explain phenomena, which for health education and health promotion are behaviors or environmental conditions. **Figure 1.1** shows a generic depiction of a behavioral theory.

Theories derived from behavioral or social science help the practice of health education and health promotion in several ways. First, it helps in developing program objectives that are measurable. For example, if the health education program uses social cognitive theory (Bandura, 1986, 2004) to change physical activity behavior in elementary school students, then the objectives can be based on the following three constructs derived from the theory: (1) At the end of the program 80% of the participants are able to demonstrate positive change in their physical activity expectations score from before to after the intervention, (2) at the end of the program 80% of the participants are able to demonstrate positive change in their physical activity self-efficacy score from before to after the intervention, and (3) at the end of the program 80% of the participants are able to

There is nothing so practical as a good theory.

—Kurt Lewin

© Jones & Bartlett Learning, LLC. NOT FOR SALE OR DISTRIBUTION. 9399

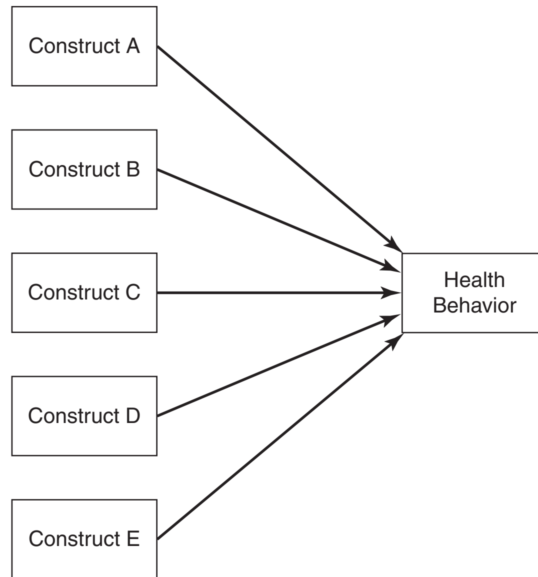

FIGURE 1.1 Generic depiction of a behavioral theory.

demonstrate positive change in their physical activity self-control score from before to after the intervention.

Second, the theory helps in identifying the method to use in health education or health promotion. For example, to change self-efficacy, the behavior must be taught in small steps, so demonstration could be used as a method. Third, the theory helps in deciding the timing of the intervention. For example, interventions that prevent use of tobacco should be implemented at the middle school level because that is when the behavior is beginning. Fourth, the theory helps in choosing the right mix of strategies and methods. In the earlier example, we were able to choose three constructs of the social cognitive theory because the theory suggests that those three constructs are important for early-stage adolescents.

Fifth, theory aids communication between professionals. The constructs of each theory remain the same in different applications, so readers can understand what was done across the studies. Sixth, the use of theory helps in replication of the program because the same constructs can be used from one intervention to the other. Finally, behavioral and social science theories help in designing programs that are more effective (have greater impact) and more efficient (take less time). These benefits are summarized in **Table 1.8**.

© Jones & Bartlett Learning, LLC. NOT FOR SALE OR DISTRIBUTION. 9399

TABLE 1.8 Benefits of Theory in Health Education and Health Promotion
Helps in discerning measurable program outcomes
Specifies methods for behavior change
Identifies the timing for interventions
Helps in choosing the right mix of strategies
Enhances communication between professionals
Improves replication
Improves program efficiency and effectiveness

APPLICATION EXERCISE

Go to your library webpage and see if you have access to MEDLINE, CINAHL, and ERIC databases. If you have access, then conduct this exercise using those three databases. If not, go to the following website which has public domain Medline (PubMed): http://www.ncbi.nlm.nih.gov/sites/entrez.

Choose a health behavior that interests you, such as a physical activity behavior or a behavior of eating fruits and vegetables. Then choose a target population such as schoolchildren or worksite. Add the key words "theory," and "intervention" to your key words for a "behavior" and a "target population" and conduct a search for a theory-based health education or health promotion intervention. Choose one article from your library or Internet search and summarize it in 500 words.

SKILL-BUILDING ACTIVITY

Think of either a positive behavior or a negative behavior amenable to modification by health education. Choose a target population for whom this behavior would be most relevant. Now, using the SMART way of writing objectives shown in **Table 1.9**,

TABLE 1.9 The SMART Way to Write Objectives
S = Specific (what exactly is being changed and in whom)
M = Measurable (percentage of participants who will change)
A = Action verb (list, describe, identify, explain)
R = Realistic (must be achievable)
T = Time frame (end of the session, end of one year)

© Jones & Bartlett Learning, LLC. NOT FOR SALE OR DISTRIBUTION. 9399

write at least three program objectives that would help bring about positive change in this behavior in your target population.

SUMMARY

Health is a means to achieve desirable goals in life while maintaining a multidimensional (physical, mental, social, political, economic, and spiritual) equilibrium that is operationalized for individuals as well as for communities. Health behaviors are actions with potentially measurable frequency, intensity, and duration performed at the individual, interpersonal, organizational, community, or public policy level for primary, secondary, or tertiary prevention. Health education is the systematic application of a set of techniques to voluntarily and positively influence health through changing the antecedents of behavior (awareness, information, knowledge, skills, beliefs, attitudes, and values) in individuals, groups, or communities. Health promotion is the process of empowering people to improve their health by providing educational, political, legislative, organizational, social, and community supports.

Health education and health promotion professionals assess individual and community needs; plan health education strategies, interventions, and programs; implement health education strategies, interventions, and programs; conduct evaluation and research related to health education; administer health education strategies, interventions, and programs; serve as health education resources; and communicate and advocate for health and health education. All these functions can be aided by the use of theories from the behavioral and social sciences. Theories help to discern measurable program outcomes, specify methods for behavior change, identify the timing for interventions, choose the right mix of strategies, enhance communication between professionals, improve replication, and improve program efficiency and effectiveness.

IMPORTANT TERMS

advocacy
attitudes
awareness
behavior
beliefs
certified health education specialist (CHES)
certified in public health (CPH)
coalition
code of ethics for health educators
community
community development
community empowerment
community mobilization
community organization
community participation
development of social norms
health
health behavior
health education
health literacy
health promotion

© Jones & Bartlett Learning, LLC. NOT FOR SALE OR DISTRIBUTION. 9399

information
knowledge
legislation
lobbying
networking
policy development
primary prevention
secondary prevention
skills
tertiary prevention
values

REVIEW QUESTIONS

1. How has the World Health Organization defined health? Discuss the limitations of this definition of health.
2. Differentiate between health education and health promotion.
3. Differentiate among primary, secondary, and tertiary prevention.
4. What are the areas of responsibilities for entry-level health educators?
5. What are the differences in responsibilities for entry-level health educators and graduate-level health educators?
6. Identify at least five settings for health education.
7. Discuss at least five areas in the code of ethics for the health education profession.
8. Discuss the objectives of any one national-level health education organization.
9. Differentiate between attitudes and beliefs.
10. Differentiate between community mobilization and community empowerment.
11. Define theory. What are the benefits of using theory in health education and health promotion?

WEBSITES TO EXPLORE

American Alliance for Health, Physical Education, Recreation, and Dance (AAHPERD)

http://www.aahperd.org/

AAHPERD is an alliance of five national associations: American Association for Physical Activity and Recreation (AAPAR), American Association for Health Education (AAHE), National Association for Girls and Women in Sport (NAGWS), National Association for Sport and Physical Education (NASPE), and National Dance Association (NDA). The American Association for Health Education (AAHE) serves health educators and other professionals who promote the health of all people. AAHE encourages, supports, and assists health professionals concerned with health promo-

© Jones & Bartlett Learning, LLC. NOT FOR SALE OR DISTRIBUTION. 9399

tion through education and other systematic strategies. The website has information on interest areas, programs and events, professional development, issues and action, and publications. *Explore this website and locate internship and leadership opportunities*.

American Public Health Association (APHA)

http://www.apha.org/

The American Public Health Association (APHA) is the oldest and largest organization of public health professionals in the world, representing more than 50,000 members from more than 50 public health occupations including health education. APHA is an association of individuals and organizations that works to improve the public's health and to achieve equity in health status for all. APHA promotes the scientific and professional foundation of public health practice and policy, advocates the conditions for a healthy global society, emphasizes prevention, and enhances the ability of members to promote and protect environmental and community health. *Visit this website and read about the latest public health news*.

Eta Sigma Gamma (ESG)

http://www.etasigmagamma.org/

Eta Sigma Gamma was founded on the campus of Ball State University in Muncie, Indiana, on August 14, 1967. It is the national health education honorary society. The principal purpose of Eta Sigma Gamma is to elevate the standards, ideals, competence, and ethics of professionally trained men and women in and for the health science discipline. *Visit this website and find out more about the national officers of this organization. Does your university have a chapter? Find information on starting a chapter at your college or explore the criteria for joining an existing chapter*.

National Board of Public Health Examiners (NBPHE)

http:// http://www.nbphe.org/

The mission of NBPHE is to test the knowledge and skills of students and graduates from schools and programs of public health accredited by the Council on Education for Public Health (CEPH). *Explore this website and find the date of the next exam. Evaluate what you need to do to become eligible for this exam*.

National Commission for Health Education Credentialing (NCHEC)

http://www.nchec.org/

© Jones & Bartlett Learning, LLC. NOT FOR SALE OR DISTRIBUTION. 9399

The mission of NCHEC is to improve the practice of health education and to serve the public and profession of health education by certifying health education specialists, promoting professional development, and strengthening professional preparation and practice. This organization credentials health educators in the United States. Requirements for the Certified Health Education Specialist (CHES) examination, dates for examinations, requirements for continuing education, and a forum for job seekers and employers are presented on the website. *Explore this website and find the date of the next exam. Evaluate what you need to do to become eligible for this exam.*

Society for Public Health Education (SOPHE)

http://www.sophe.org/

SOPHE was founded in 1950 and is an independent, international professional association made up of a diverse membership of health education professionals and students. Its mission is to provide leadership to the profession of health education and health promotion to contribute to the health of all people through advances in health education theory and research, excellence in health education practice, and the promotion of public policies conducive to health. The website presents news and announcements, benefits of joining, opportunities for continuing education, and advocacy. *Explore this website and find the date of the next SOPHE midyear or annual meeting. Visit the resources and links and learn about other health education organizations.*

World Health Organization (WHO)

http://www.who.int/en/

The website has information about the formation and organization of WHO, health information about all countries, alphabetical information about common health topics, a list of WHO publications, and a database of all WHO publications and WHO sites. *Read the constitution of the World Health Organization. Reflect on the successes and failures of this organization since its inception in 1948.*

REFERENCES AND FURTHER READING

Airhihenbuwa, C. O., Cottrell, R. R., Adeyanju, M., Auld, M. E., Lysoby, L., & Smith, B. J. (2005). The National Health Educator Competencies Update Project: Celebrating a milestone and recommending next steps to the profession. *American Journal of Health Education, 36*, 361–370.

Allegrante, J. P., Airhihenbuwa, C. O., Auld, M. E., Birch, D. A., Roe, K. M., & Smith, B. J. (2004). Toward a unified system of accreditation for professional preparation in health education: Final

© Jones & Bartlett Learning, LLC. NOT FOR SALE OR DISTRIBUTION. 9399

report of the National Task Force on Accreditation in Health Education. *Health Education and Behavior*, *31*, 668–683.

American Association for Health Education. (2003). Directory of institutions offering undergraduate and graduate degree programs in health education. 2003 edition. *American Journal of Health Education*, *34*(4), 219–235.

American Association for Health Education, National Commission for Health Education Credentialing, & Society for Public Health Education. (1999). *A competency-based framework for graduate-level health educators*. Allentown, PA: National Commission for Health Education Credentialing.

Arnstein, S. R. (1971). Eight rungs on the ladder of citizen participation. In E. S. Cahn & B. A. Passett (Eds.), *Citizen participation: Effecting community change* (p. 70). New York: Praeger.

Bandura, A. (1986). *Social foundations of thought and action*. Englewood Cliffs, NJ: Prentice-Hall.

Bandura, A. (2004). Health promotion by social cognitive means. *Health Education and Behavior*, *31*, 143–164.

Bensley, R. J. (1991). Defining spiritual health: A review of the literature. *Journal of Health Education*, *22*(5), 287–290.

Bloom, B. S. (1956). *Taxonomy of educational objectives. Handbook I: The cognitive domain*. New York: David McKay.

Coalition of National Health Education Organizations. (2004). *Code of ethics*. Retrieved from http://www.hsc.usf.edu/CFH/cnheo/ethics.htm

Cook, H. (2004). Historical keywords. Health. *Lancet*, *364*, 1481.

Downie, R., Fyfe, C., & Tannahill, A. (1990). *Health promotion: Models and values*. Oxford, UK: Oxford University Press.

Gilmore, G. D., Olsen, L. K., Taub, A., & Connell, D. (2005). Overview of the National Health Educator Competencies Update Project, 1998–2004. *Health Education and Behavior*, *32*, 725–737.

Glanz, K., Rimer, B. K., & Lewis, F. M. (2002). *Health behavior and health education. Theory, research, and practice* (3rd ed.). San Francisco: Jossey-Bass.

Gochman, D. S. (1982). Labels, systems, and motives: Some perspectives on future research. *Health Education Quarterly*, *9*, 167–174.

Gochman, D. S. (1997). Health behavior research: Definitions and diversity. In D. S. Gochman (Ed.), *Handbook of health behavior research: Vol. 1. Personal and social determinants.* New York: Plenum Press.

Gold, R. S., & Miner, K. R., for the 2000 Joint Committee on Health Education and Promotion Terminology. (2002). Report of the 2000 Joint Committee on Health Education and Promotion Terminology. *Journal of School Health*, 72, 3–7.

Green, L. W., & Kreuter, M. W. (2005). *Health program planning: An educational and ecological approach* (4th ed.). Boston: McGraw-Hill.

Institute of Medicine. (1988). *Future of public health*. Washington, DC: National Academy Press.

Institute of Medicine. (2002). *The future of the public's health in the 21st century*. Washington, DC: National Academy Press.

Kerlinger, F. N., & Lee, H. B. (2000). *Foundations of behavioral research* (4th ed.). Fort Worth, TX: Harcourt College.

© Jones & Bartlett Learning, LLC. NOT FOR SALE OR DISTRIBUTION. 9399

McDowell, I., & Newell, C. (1987). The theoretical and technical foundations of health measurement. In I. McDowell & C. Newell (Eds.), *Measuring health: A guide to rating scales and questionnaires* (pp. 10–42). New York: Oxford University Press.

Minkler, M., & Wallerstein, N. (1997). Improving health through community organization and community building. A health education perspective. In M. Minkler (Ed.), *Community organizing and community building for health*. New Brunswick, NJ: Rutgers University Press.

Modeste, N. M., & Tamayose, T. (Eds.). (2004). *Dictionary of public health promotion and education. Terms and concepts* (2nd ed.). San Francisco: Jossey-Bass.

Mucchielli, R. (1970). *Introduction to structural psychology*. New York: Funk and Wagnalls.

National Board of Public Health Examiners. (n.d.). *National Board of Public Health Examiners*. Retrieved from http://www.nbphe.org/about.cfm

National Cancer Institute. (2005). *Theory at a glance: A guide for health promotion practice* (2nd ed.). Washington, DC: U.S. Department of Health and Human Services. Retrieved May 20, 2006, from http://www.nci.nih.gov/theory/pdf

National Commission for Health Education Credentialing. (1985). *A framework for the development of competency based curricula for entry-level health educators*. New York: Author.

National Commission for Health Education Credentialing, Society for Public Health Education, & American Association for Health Education. (2006). *Competency-based framework for health educators—2006*. Whitehall, PA: Author.

Parsons, T. (1951). *The social system*. New York: Free Press.

Perrin, K. M., & McDermott, R. J. (1997). The spiritual dimension of health: A review. *American Journal of Health Studies*, *13*(2), 90–99.

Pickett, G., & Hanlon, J. J. (1998). *Public health: Administration and practice* (10th ed.). St. Louis, MO: Mosby.

Polit, D. F., & Hungler, B. P. (1999). *Nursing research: Principles and methods* (6th ed.). Philadelphia: Lippincott.

Public Health Functions Steering Committee. (1994). *Public health in America*. Retrieved from http://www.health.gov/phfunctions/public.htm

Rehrig, M. (2010, Winter). The long awaited advanced credential, MCHES, Don't miss out. *The CHES Bulletin*, *21*(1), 1.

Rokeach, M. (1970). *Beliefs, attitudes and values*. San Francisco: Jossey-Bass.

Selye, H. (1974). *The stress of life*. New York: McGraw-Hill.

Simpson, E. J. (1972). *The classification of educational objectives in the psychomotor domain*. Washington, DC: Gryphon House.

Taub, A., Kreuter, M., Parcel, G., & Vitello, E. (1987). Report from the AAHE/SOPHE Joint Committee on Ethics. *Health Education Quarterly*, *14*(1), 79–90.

U.S. Department of Health, Education and Welfare. (1978). *Preparation and practice of community, patient, and school health educators: Proceedings of the workshop on commonalities and differences*. Washington, DC: Division of Allied Health Professions.

U.S. Department of Health and Human Services. (1979). *Healthy People: The surgeon general's report on health promotion and disease prevention*. Washington, DC: Author.

U.S. Department of Health and Human Services. (1980). *Promoting health—preventing disease. Objectives for the nation*. Washington, DC: Author.

© Jones & Bartlett Learning, LLC. NOT FOR SALE OR DISTRIBUTION. 9399

U.S. Department of Health and Human Services. (1990). *Healthy People 2000. National health promotion and disease prevention objectives*. Washington, DC: Author.

U.S. Department of Health and Human Services. (2000). *Healthy People 2010* (Vols. 1–2). Washington, DC: Author.

U.S. Department of Health and Human Services. (2009). *Healthy People 2020: The road ahead*. Retrieved from http://www.healthypeople.gov/HP2020/default.asp

World Health Organization. (1974). Constitution of the World Health Organization. *Chronicle of the World Health Organization*, *1*, 29–43.

World Health Organization. (1986). *Ottawa charter for health promotion*, *1986*. Geneva, Switzerland: Author.

World Health Organization. (1997). *The Jakarta Declaration on leading health promotion into the 21st century*. Geneva, Switzerland: Author.

World Health Organization. (1998). *Health promotion glossary.* Retrieved from http://www.who.int/hpr/NPH/docs/hp_glossary_en.pdf

Zarcadoolas, C., Pleasant A., & Greer, D. S. (2003). Elaborating a definition of health literacy: A commentary. *Journal of Health Communication*, *8*, 119–120.

© Jones & Bartlett Learning, LLC. NOT FOR SALE OR DISTRIBUTION. 9399

© Jones & Bartlett Learning, LLC. NOT FOR SALE OR DISTRIBUTION. 9399