1
CHAPTER

Introduction

- Pat is conducting a mandatory in-service workshop on HIV prevention for new correction personnel at the local jail.
- Michael is conducting a five-part workshop on health and safety for 45 physical plant employees at a local factory.
- Maria is performing a one-time presentation on the Pap smear and pelvic examination for a group of 15 Hispanic women in a local community center.
- Natalie is conducting an individual birth control session for a sophomore student at a university health center.
- William is teaching a 10-part unit on family life to a class of 25 ninth-grade high school students.
- Tanya is performing a patient education session for two hypertensive middle-aged men at a local hospital.
- Peter is working with the residents of an assisted living community to implement an intervention designed to keep seniors physically active.
- Dwayne is lecturing to 500 college students about sexually transmitted infections and safer sex as part of a series on contemporary sexual issues.
- James is podcasting a presentation on breast self-examination that can be downloaded directly via the Internet.
- Delores is speaking to a congressional panel on the importance of comprehensive health education.

Although these **health educators** are dealing with very different audiences—from very large groups to individuals, from high school students to elected national officials, from young to old, from the workplace to the classroom, from the community to the House of Representatives—they all share one crucial factor that will invariably determine success or failure… how well they actually educate. The philosophy presented in this text is based on the premise that the core of **health education** is the **health education process**, composed of factual information, effective delivery, and motivational impact. This means that what is most important is how well and effectively we perform the function of educating people and motivating them to make good health decisions.

Many tools are available to health educators, such as epidemiology, statistics, and program planning, but the essence of being a health educator is the actual "doing" of health education—that is, the conveyance of clear,

appropriate health information. As educators we may have access to the best knowledge available, but unless we are skilled and effective deliverers of this information, the usefulness of our work is clearly compromised. Anyone who has sat through a poorly prepared, often boring, and uninspired presentation or class should question the thought processes that resulted in such a negative experience. Health educators, therefore, need a systematic approach to the selection of educational interventions.

Our goal is to favorably influence the voluntary health decision making of our clients.

This text is intended to assist the health educator or would-be health educator in developing sound, effective, and appropriate presentation methods to create learning experiences that facilitate voluntary changes leading to health-enhancing behaviors. It is founded on the proposition that we must be good at the doing… the health education. Our goal is to favorably influence the health decision making of our clients. Further, it is our belief that health educators need a systematic approach to the selection of methods of intervention.

The authors of this text strongly believe the skills necessary to plan for and deliver effective health education programs are fundamentally the same, regardless of where they are practiced—in a classroom, workplace, Internet/online, hospital, or community setting, as shown in **Figure 1-1**. The fundamental duties of health educators, regardless of setting, are as follows:

- **A**ssessment of target population needs, which includes all the actions used to gather information about the needs of the target population. An accurate needs assessment provides direction for the focus and direction of the health education process.
- **P**lanning for intervention strategies, which involves the actions necessary to develop appropriate intervention strategies.

Figure 1-1
Health Educator Duties
Courtesy of Thomas Hanna, School Health Educator.

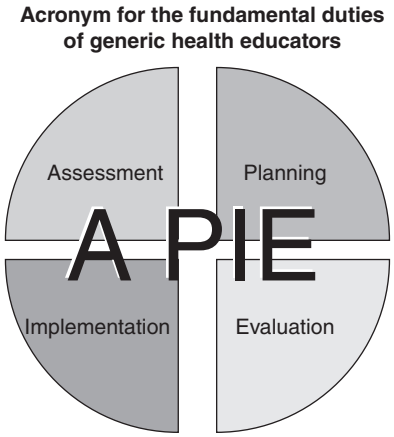

Figure 1-2
Mnemonic for Fundamental Duties of Generic Health Educators

- **I**mplementation of interventions, which includes the events associated with the delivery of the intervention.
- **E**valuation of success, which includes all requisite strategies use to analyze the impact and outcomes of the intervention.

These basic components, best remembered by using the mnemonic A PIE, can be used in any setting (**Figure 1-2**). Consequently, this text is designed for multiple settings and addresses the needs of the so-called "generic" health educator.

The *generic health educator* concept has important ramifications for the training of health educators because it puts more emphasis on the acquisition of skills than on health content. Health educators practice in a variety of settings, including school health education, community health education, worksite health education, and patient health education. Clearly, some skills are used more in some settings than in others, yet the basic tools are generic to all settings. Health educators, therefore, need to acquire these basic skills. It is ludicrous, for example, for an individual to believe he or she can function well as a health educator without training in educational principles. This text is organized and presented to facilitate the acquisition of many of these basic skills.

Process of Health Education

Remember always to be grateful for the millions of people everywhere whose despicable habits make health education necessary.
—Mohan Singh

It is important to remember health education is, as the name implies, education about health. Health education has its roots in education and public health. Although it draws on various disciplines, including psychology, sociology, education, public health, and epidemiology, it is a unique discipline in many ways. One of the challenges for the health educator is that although the principal tool is education, the sought-after outcomes are often behavioral adaptations. Other disciplines in education focus almost

exclusively on knowledge, which is a critical component of health education. Knowledge alone is unlikely to be robust enough to cause behavior change. John Dewy, a dominant figure of education reform, suggests learning is more than assimilating information: It is the development of habits (or behaviors) to deal effectively and most intelligently with one's environment (Gaido, 2005).

The complexity of human behavior requires that approaches to health education target three key influences for behavior change:

- *Knowledge* about the behavior
- *Attitudes* associated with the behavior
- *Skills* necessary to enable behavioral adaptation

Health education strives to provide knowledge, as well as the requisite skills necessary to apply that knowledge—while developing appropriate attitudes—to result in healthy behavior choices or behavior changes as needed (**Figure 1-3**). Failure to address these three components will likely result in marginal outcomes. Health education is called on to lower cholesterol, alter drug-taking behavior, and improve fitness—to name a few of the many complicated expectations. The dissemination of knowledge alone clearly is not sufficient to accomplish such lofty goals.

Although all three key influences are critical to address when targeting health behavior change, it is important to realize they are not always targeted in a balanced approach, as represented by the equilateral triangle in Figure 1-3. For example, if a needs assessment reveals the target population of newly diagnosed diabetes patients has extensive knowledge about the

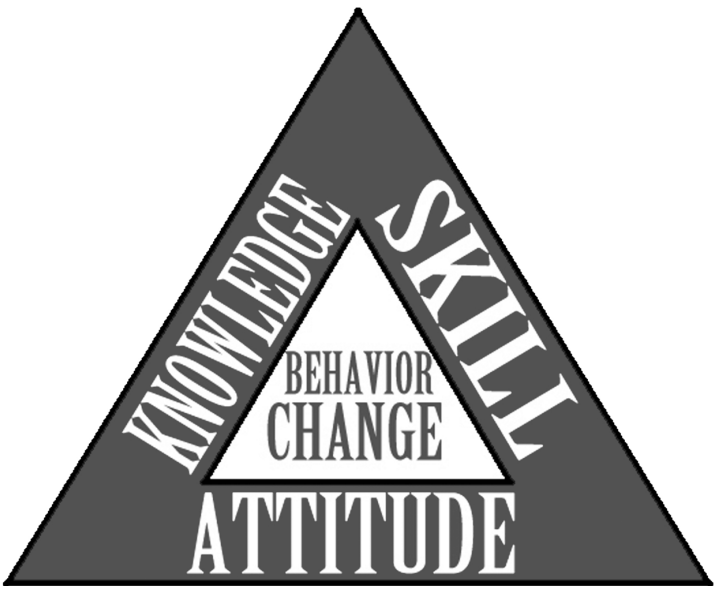

Figure 1-3
Triangle of Influences on Behavior Change
Courtesy of Thomas Hanna, School Health Educator.

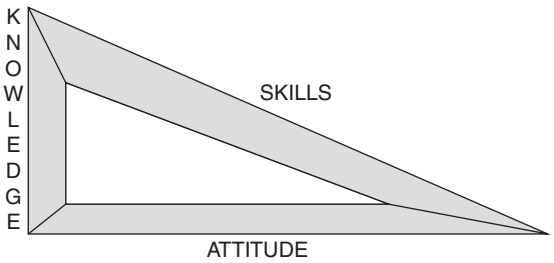

Figure 1-4
Scalene Triangle with Skills Emphasis

need to regularly monitor blood glucose levels but lacks the skills necessary to properly perform the procedure (behavior), a greater emphasis on skill development is needed. When planning intervention strategies, the health educator should select strategies that allow for practice to develop skills. The greater concentration on targeting skills will result in a scalene triangle in which the hypotenuse, or greatest side, is overly represented. **Figure 1-4** represents the ratio of focus in an intervention that primarily targets skills.

If the needs assessment also reveals the target population does not believe it is important to monitor glucose levels, the health educator should also implement strategies to address attitudes associated with the behavior. **Figure 1-5** represents a program that has a balanced focus on skill and attitude development but minimizes the focus on expansion of knowledge.

To effectively accomplish the process of health education, health educators must learn to set meaningful, appropriate, and achievable goals and objectives that address the needs of the target population. After setting clear, high-quality objectives, the health educator must seek to meet those objectives through appropriate ethical methods.

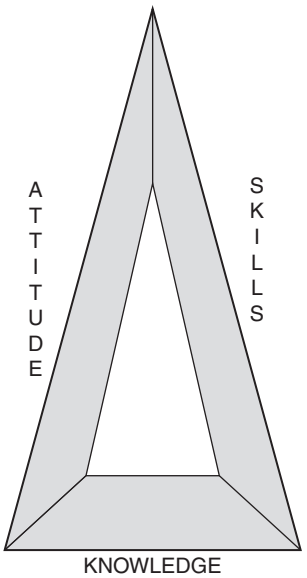

Figure 1-5
Isosceles Triangle with Attitude and Skills Emphasis

History of Health Education

Health education has been offered in some form since the beginning of time. Humanity has always sought to lead a longer and healthier life. Means's classic text, *A History of Health Education in the United States* (1962), reviews early health education activities in the United States. It is interesting to note that in 1818 Harvard College required hygiene in all seniors (Means, 1962, p. 36). The American Public Health Association was formed in 1872, and the National Education Association started a Department of Child Safety in 1894 (Means, 1962, pp. 46–48). The American School Health Association was formed in 1927 as the American Association of School Physicians. The American Association for Health Education began as the American Association for Health and Physical Education in 1937, which is now part of the American Alliance for Health, Physical Education, Recreation and Dance (AAHPERD). In 2013, AAHPERD became the Society of Health and Physical Educators of America or SHAPE America. Professional organizations serve a role in helping educators keep current on new research findings and evidence-based practices in the field.

Education about health became more common in the 1800s and early 1900s with numerous reports and advocates. Some noted advocates included Horace Mann, Thomas Denison Wood, the American Academy of Medicine, the Metropolitan Life Insurance Company, the U.S. Public Health Service, and the U.S. Office of Education. The first reported academic department of health education was located at Georgia State College for Women around 1917. The first known recipient of a health education degree was Cecile Oertel Humphrey, who, after additional course work at Harvard during the summers of his program at Georgia State College, received a bachelor of science in health education. A thesis was required, and his was entitled, "The Inferiority Complex—Its Relation to Mental Hygiene." No report is available on what has become of Mr. Humphrey (Means, 1962, p. 144). Teachers College, Columbia University, began an undergraduate degree in 1920 and was one of the early granters of graduate degrees in health education.

Health education has functioned as a separate discipline for approximately the last 40 to 70 years. As a relatively young discipline, it has always struggled for a strong sense of identity. One illustration of this is the large number of health education professional organizations, each with overlapping goals. Another is the odd fact that health education degrees are sometimes offered at higher education institutions with few or, in some extreme cases, no health educators on the faculty. Despite these problems, health education continues to evolve into an important discipline with a unique orientation to addressing the health education needs of the world.

The demand for health educators is presently on the rise. The U.S. Department of Labor Statistics predicts an employment market growth of 36% over the next decade (Bureau of Labor Statistics, 2012). This is considered to be much faster than the average for all other occupations (Bureau of Labor Statistics, 2012). According to the National Employment Matrix, in 2006

approximately 62,000 health educators were employed in the United States. The Bureau of Labor Statistics (2012) predicts that number will increase to 86,6000 by 2020. Much of this growth is attributed to the rising cost of health care. The limitations of medicine and pressures to contain high medical care costs have resulted in a social and political climate emphasizing self-help and individual control over health; thus the need for community health educators is becoming more and more evident (Siminerio, 1999). Insurance companies and governmental agencies are recognizing the cost-effectiveness of preventive health measures. It appears these entities are embracing the important contributions of the health educator in prevention efforts.

The passing of the Patient Protection and Affordable Care Act (PPACA), signed into law by President Barack Obama on March 23, 2012, has helped to highlight the role of professional health educators. In a review of the PPACA using simple word searches, multiple references to a variety of health professionals are made. Although the term "certified health educator" is never used, the term "health educator" is stated one time, "public health professional" five times, "health professionals" 94 times, and "health promotion" 42 times (Patient Protection and Affordable Care Act, 2010). The term "health education" is used 52 times, suggesting a realization of the need for educational approaches to promote healthy behavior.

Throughout the history of health education, numerous agencies have recognized its potential to address health problems. Federal agencies have supported many studies and projects designed to improve the quality and impact of health education. In the 1980s the Centers for Disease Control and Prevention (CDC) created an eight-component strategy for improving the health and learning outcomes of students. Academic success is strongly linked to the health of young people, and the converse is also true: Academically successful youth are healthier (Dunkle & Nash, 1991). Because schools have direct contact with more than 95% of youth aged 5 to 17 for approximately 13 critical years, schools can play an important role in improving students' health and social outcomes. The coordinated school health (CSH) model is a systematic approach to enable schools to minimize gaps and redundancies in funding streams; to focus efforts on helping students engage in protective, health-enhancing behaviors while building partnerships among professionals in the field; and to provide the capacity for communication and collaboration among schools and communities (CDC, 2011). CSH may be one of the most efficient means to prevent or reduce risk behaviors and prevent serious health problems among students (Harper & Lynch, 2007).

Another important effort was the Role Delineation Project begun in 1978 (funded by the then U.S. Bureau of Health Manpower and carried out by the National Center for Health Education), which examined the role of the entry-level health educator and generated a defined role. This defined role was based on surveys of practicing health educators in 1978. The end product was a defined role for the entry-level health educator. Although obviously in need of continual updating, the definition of the role was a significant step

in the evolution of health education as a discipline. An important finding suggested that the health educator's role was essentially the same regardless of the health education setting. The result was the definition of the generic health educator, a concept very important for the training of health educators. It states that all health educators should possess certain common skills. These skills were later more fully defined as *competencies for entry-level health educators* by a panel of experts meeting at Ball State University. In 1985, a survey of health educators was used to create a framework for the development of competency-based curricula for entry-level health educators (National Commission for Health Education Credentialing [NCHEC], 1985). Based on these competencies and the framework, work to clarify the expectations of professional health educators continued in the 1980s.

At the Second Bethesda Conference held in 1986, consensus for the certification process was found and the National Commission for Health Education Credentialing (NCHEC) body was created. NCHEC functions to certify individuals as Certified Health Education Specialists (CHES). A Masters Certified Health Education Specialist (MCHES) credential is also available for health educators with advanced training and experience. The competencies are also used by the National Council for the Accreditation of Teacher Education (NCATE) as part of the teacher-training accreditation review process.

Advancements in computers and telecommunications have significantly accelerated the evolution of the health education profession. Searching for health information is one of the most common reasons consumers use the Internet (Greenberg, D'Andrea, & Lorence, 2004). Not long ago, searching for information about any subject usually involved a trip to a local library and a walk through the dusty stacks of books, hoping the volume in question had not already been borrowed by another inquisitive patron. Although libraries still fulfill an important role as providers of the printed word, these institutions have altered their services to include direct access to data via the Internet. Most librarians are now thought of as Internet experts.

Today, health educators have immediate access to data. National databases such as the Youth Risk Behavior Surveillance System (YRBSS) and the *Morbidity and Mortality Weekly Report* (MMWR) are just a click away. Professionals, as well as laypersons, have instant access to the most current information available at the CDC or the National Institutes of Health (NIH). Additionally, the ability to collaborate and share information with others has been enhanced via the use of podcasting, video streaming, blogs, and bulletin boards. The information age has assisted in the evolution of the health education process.

Goals of the Text

After reading and synthesizing this text, the health educator will

- Plan properly for health education instruction.
- Develop quality lesson/presentation plans and unit plans.
- Plan for the special needs of target populations.

- Select appropriate methods through a systematic approach.
- Use methods of intervention properly.
- Use methods to promote health literacy.
- Identify appropriate strategies for the marketing of health promotion.

Format of the Text

Competencies

Each chapter begins with a listing of the generic entry-level and/or advanced-level competencies developed for the National Task Force on the Preparation and Practice of Health Educators, Inc. In some instances the entry-level and advanced level competencies are the same. A complete listing of the competencies can be found in the Appendix.

The entry-level health education competencies were first developed during the early 1980s and were published in 1985. Over the last few years, health education professionals have worked to reverify them through the Competencies Update Project (CUP), initiated in 1998 by the NCHEC. This project examined how other professions distinguished themselves among levels of practice and attempted to identify current specifications of entry-level competencies.

The CUP model outlined distinct sets of competencies and subcompetencies for each of the three levels of practice (National Commission for Health Education Credentialing, Society for Public Health Education, & the American Association for Health Education, 2006). Findings from the Health Educator Job Analysis 2010 (Health Educator Job Analysis, 2010) have resulted in further refinement of professional preparation, credentialing, and professional development for health education specialists.

The purpose of the Health Educator Job Analysis was to validate the contemporary practice of entry- and advanced-level health education specialists. The Health Educator Job Analysis reaffirmed the "seven major areas of responsibility for health education specialists; however, new and/or expanded competencies were identified related to ethics, partnerships, training, consultative relationships, influencing policy, promoting the health education profession, and other areas" (Rehrig, 2010, p. 2). A complete listing of the seven areas of responsibility and their competencies and subcompetencies can be found in the Appendix.

Use of Competencies in the Text

In order to assure quality in the professional preparation of health educators standards and guidelines, or competencies, have been established. These competencies serve as the foundation for the health education credentialing system known as the Certified Health Education Specialist (CHES) or Master Certified Health Education Specialist (MCHES) credential. Many health professionals are required to obtain and maintain certification, licensure, or other credentials to be qualified to practice in a specific field. Readers of the text will find it valuable to evaluate the competencies addressed in this text as they evaluate their own preparedness for the credentialing process.

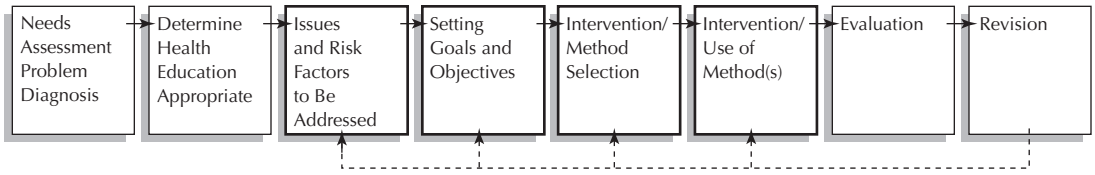

Figure 1-6 Method Selection in Health Education

Methodologies Each chapter also begins with a graphic (**Figure 1-6**) that illustrates the components of proper method selection addressed in the chapter. As the caption explains, the heavy-bordered boxes identify the components addressed in this text. One or more of these boxes are shaded to indicate the subject or subjects of a chapter.

Method Selection Components

Many public health and health education texts deal with program planning and evaluation. This text focuses on the conducting of health education—the pedagogy. **Pedagogy** is the art or profession of teaching. Pedagogy is what health education practice is about and is best accomplished by ensuring the seven following components are applied:

1. **Needs assessment and problem diagnosis.** This text begins with the assumption that some type of needs assessment has been done, and it has been determined that health education is a viable alternative.
2. **Determination of whether health education is the appropriate intervention.** This text also begins with the assumption that it has been determined health education is the appropriate intervention. Health education can be very complicated, expensive, and difficult, so this is an important assumption. Often other methods of health promotion may be more appropriate. Altering the environment, for example, might make better use of resources. If students are eating unhealthy lunches, it may be easier to ensure that they eat lunch at school where they will be offered only healthy choices. Such tactics can lead to much better behavior at relatively low cost. However, the long-term behavior may not be altered with only a change in the physical environment.
3. **Issues and risk factors to be addressed.** This text considers some of the issues and risk factors to be taken into account when making decisions. See Chapters 2, 3, 9, and 10.
4. **Setting goals and objectives.** Goals and objectives are an important component of pedagogy and are addressed in Chapters 2 and 3.
5. **Intervention/method selection.** Selection of the appropriate intervention or method for health education is the major issue addressed in this text. See Chapters 4 through 10 and the Appendix.
6. **Evaluation.** *The issue of evaluation is so major that it cannot be sufficiently addressed in this text.* The importance of this area cannot be overestimated. Entire books and courses are dedicated to evaluation, as

is fitting for such important and lengthy material. Therefore, although there are many references to evaluation here, no chapter is dedicated to the issue. Instead, the reader is referred to books that can treat the subject in detail.

7. **Revision.** Good, practical evaluation leads to revision of any intervention. Revision is an important tool that should be part of any program. However, because it should be based on evaluation, revision is not addressed in this text.

Objectives

Each chapter states the objectives to be achieved by the reader. The behavioral objectives are also are useful in providing the reader measurable targets to self-assess his/her learning.

Case Studies

Case studies are used throughout the text and are revisited at the end of each chapter. Case studies provide opportunities to apply the principles found in each chapter to specific situations. Each scenario is designed to provide an authentic example of how the content described in the text can be applied in practice. The case studies are useful for class discussions or independent practice. A discussion of each case study can be found at the end of each chapter (under "Case Studies Revisited"). Following is an example of such a case study and its evaluation.

Example of Case Study

Objective: While reviewing the case study, the reader will identify multiple factors that contributed to the results of the intervention described.

The government authorizes $6 million to evaluate a large clinical trial aimed at influencing the health behaviors of Americans. A group of volunteers provides pamphlets and educational counseling at a large shopping mall, and each volunteer spends about an hour with over 5,000 people. The research design for evaluating the program is solid. Proper comparison groups are in place, and the instrumentation for assessing change is of high quality. We know what the behaviors, attitudes, and knowledge were before, during, and after the intervention (treatment), and we are certain threats to internal and external validity of the study have been controlled. The outcome measures are well matched with the objectives of the health education program. According to all measures, however, the intervention does not change anything.

Example of Case Study Revisited

There are, of course, many possibilities for the no-change results, but here are three questions that we want you to consider in particular:

1. Were the methods selected for the intervention appropriate and properly implemented?

2. Was adequate time provided for the intervention to achieve the objectives?
3. Were the people conducting the intervention properly trained? Were they in fact health educators?

Also note the following points:

- Although we do not have the objectives before us, it seems clear that few behavioral objectives could be reached by an intervention consisting solely of pamphlets and educational counseling by volunteers.
- An hour is not enough time to change most behaviors unless you have a very highly motivated clientele.
- Volunteers can play important and sometimes powerful roles but do not qualify as health educators.

This only moderately exaggerated example shows why health educators must work to improve the art and science of health education. Becoming a high-quality health educator requires hard work and dedication. A top-quality health educator is always working to develop communication skills, increase current knowledge of the subject matter, and remain a motivator. It is hoped that this text will provide some of the tools needed to accomplish the goals and objectives of health educators.

Summary, Practice Exercises, and References

Each chapter ends with a summary, a series of exercises, and a list of references and resources.

Glossary

A glossary can be found at the end of the text.

Proverbs

Scattered throughout the text are health education proverbs from "Mohan Singh," the pseudonym of Horace G. "Hod" Ogden. Before his death in 1998, Mohan Singh directed many programs for the institution now known as the CDC during his more than 20 years with the U.S. Public Health Service. He always believed it was important to keep life in perspective and that having a good laugh was one way to do that. We are certain he must be laughing about the continuing life of his sayings, often constructed on napkins in Atlanta and Washington, DC beverage houses. We are pleased to continue spreading these timeless messages for health educators willing to listen.

SUMMARY

1. A major goal of the text is a systematic approach to the selection of methods of intervention.
2. Education about health has been part of general education since antiquity. Health education as a formal discipline, however, is relatively new.
3. Successful health education interventions and presentations require the development of realistic and meaningful goals and objectives.
4. The basic skills required for effective health education, whether it occurs in the community, worksite, healthcare facility, governmental agency, or school, are essentially the same.

EXERCISES

1. Health educators perform an array of tasks in several diverse settings. Examine the following job descriptions. In which setting (community, worksite, healthcare facility, governmental agency, or school) do you believe these activities are most likely to be performed?
   - **a.** The health educator asks a high-risk patient about medical procedures, operations, services, and therapeutic regimens to create activities and incentives that will encourage him or her to take advantage of available services.
   - **b.** The health educator helps identify needs, mobilize resources, and build coalitions to improve the health status of a target area.
   - **c.** The health educator provides employee counseling, education services, risk appraisals, and health screenings to comply with occupational health and safety regulations.
   - **d.** The health educator teaches health as a subject while promoting and implementing the coordinated school health programs.
   - **e.** The health educator ensures that state and federal mandated programs are implemented while working closely with nonprofit organizations to secure resources, such as grants.
2. Prioritize the three key influences for behavior change (knowledge, attitude, and skills) according to your opinion of their impact and importance.
3. Justify why the term *generic health educator* is an appropriate descriptor of a professional health educator.

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