Chapter 1

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 concepts
- concepts related to antecedents of behavior
- counselor
- dietitian
- evidence-based health promotion
- health
- health behavior
- health coach
- health education
- health literacy
- health promotion
- knowledge-based health education interventions
- Master Certified Health Education Specialist (MCHES®)
- nursing educator
- precision health education interventions
- skill-based health education interventions
- theory
- theory-based health education interventions

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 concepts related to antecedents of behavior.
- Delineate community-related concepts.
- List the responsibilities of the Certified Health Education Specialist (CHES®).
- Explain the role of theory in health education and health promotion.
- Identify different types of theories and provide examples.
- List at least five national health education organizations.
- Describe the evolution of theories in health education and health promotion.

HEALTH

Health is an age-old concept. In Old English it was referred to as *haelen*, meaning "to heal," and in Middle English as *helthe*, "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). In ancient India, medicine was called *Ayurveda*, "the science of life or health." In the 17th century, most medical textbooks commonly used the word *restoration* to refer to healing. 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).

Following World War II, the word *health* came back to the forefront with the formation of the World Health Organization (WHO), an international organization devoted to global health. Around the same time, in the United States, the U.S. Hygienic Laboratory was renamed as the National Institutes of Health. In 1948, the 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" (World Health Organization [WHO], 1974, p. 29).

The WHO definition of health has been the focus of much criticism over the years for a number of reasons. First, the use of the word *state* in the definition is misleading. Health is dynamic and changes over 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 various aspects of health. For example, one dimension missing from the WHO definition is the spiritual dimension (Perrin & McDermott, 1997). Bensley (1991) 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. However, none of these concepts are included in the WHO definition.

Another dimension that is not mentioned in the WHO definition is the political dimension. The WHO definition does not address how wealth and power affect health. Do the rich get sick more often, or do the poor? What groups have greater access to health resources? Who has a greater burden of mortality, the rich or the poor? These and many other questions pertaining to the politics of health must be explicitly mentioned in the definition for it to be complete.

Third, the word *well-being* is subjective. Definitions should be objective, with the goal of minimizing subjectivity.

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)

Fourth, the way in which health is defined by the WHO makes it very difficult to measure. As McDowell and Newell (1987) point out, "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, the WHO definition of health presents an idealistic or utopian view. In fact, it would be impossible to find anyone who embodies all the attributes presented in the definition. Thus, the WHO definition of health lacks practical applications.

Sixth, the WHO definition presents health as an end product. Most people perceive health as a means of achieving something that they value more highly; for example, people want to be healthy so that they can raise their families.

Table 1-1 Limitations of the World Health Organization's Definition of Health

Health is dynamic; it is not a state.
The dimensions are inadequate.
The definition is subjective.
Measurement of health is difficult.
The definition is idealistic.
Health is not an end but a means.
The definition lacks a community orientation.

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 international discussions. 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)

A more contemporary definition is that health as 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 This definition is more inclusive.

BEHAVIOR

Another important basic concept is behavior. The *Merriam-Webster Dictionary* (n.d.) defines *behavior* as "anything that an organism does involving action and response to stimulation." The key word in this definition is *action*. A **behavior** is any overt action, conscious or unconscious, with a measurable frequency, intensity, and duration. *Frequency* refers to how many times a particular behavior occurs in a given time period. For example, we may classify someone who participates in some sort of physical activity 5 days a week as being active. *Intensity* refers to how intensely or with how much effort 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 a person's heart rate or the number of calories burned. *Duration* refers to the amount of time spent performing an activity. For example, a person may perform 20 minutes of physical activity on any given day.

Any behavior is influenced by five levels of factors. 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, the individual may work at a workplace that has a policy that requires every employee to engage in physical activity for an hour. 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.

HEALTH BEHAVIOR

Now let us focus our attention on defining *health behavior*. The WHO (1998) 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" (p. 8). David Gochman 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" (1982, p. 167; 1997, p. 3). 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: primary, secondary, and tertiary (Modeste & Tamayose, 2004). **Primary prevention** refers to preventive actions taken prior to the onset of a disease or injury with the intention of removing the possibility of its 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 injury with the intention of assisting the individual with the disease or disability. The actions for primary, secondary, and tertiary levels of care are taken at the individual, interpersonal, organizational, community, and public policy levels. Hence, **health behavior** can be defined as all actions with a potentially 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 regularly engaging in physical activity or eating five or more servings of fruits and vegetables each day. Other health behaviors focus on extinguishing negative attributes, such as smoking or binge drinking. Thus, behaviors can be categorized as risk behaviors or protective behaviors. The WHO (1998) defines *risk behaviors* as "specific forms of behavior which are proven to be associated with increased susceptibility to a specific disease or ill-health" (p. 18). For example, indiscriminate sexual behavior is a risk behavior for sexually transmitted diseases (STDs), 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, thus preventing the disease. Green and Kreuter (2005) divide protective behaviors into two categories: health-directed behaviors 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, such as an individual who is trying to lose weight in order to improve his or her appearance.

HEALTH EDUCATION AND HEALTH PROMOTION

Health education professionals engage in **health education** to facilitate modification of health behaviors. Health education has been defined in several ways. Downie, Fyfe, and Tannahill (1990) defined it as "communication 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 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" (Gold & Miner, 2002, p. 3). The WHO (1998) defined it 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" (p. 4). Green and Kreuter (2005) defined health education as "any planned combination of learning experiences designed to predispose, enable, and reinforce voluntary behavior conducive to health in individuals, groups or communities" (p. G-4).

These definitions share some commonalities with regards to how health education is defined. 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—awareness, information, knowledge, skills, beliefs, attitudes, and values—so that healthy behaviors develop in a voluntary fashion (i.e., without coercion). Health education can be performed one on one, such as in a counseling session; with a group of people, such as through a group discussion; at an organizational level, such as through an employee wellness fair; or at the community level, such as through a multiple-channel, multiple-approach campaign.

Healthy People 2030 sets data-driven national objectives to improve health and well-being over the next decade. Healthy People 2030 includes 355 core—or measurable—objectives as well as developmental and research objectives.

—U.S. Department of Health and Human Services (2020)

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 grow in importance. Health promotion has been an area of focus in the *Objectives for the Nation* (USDHHS, 1980), *Healthy People 2000* (USDHHS, 1990), *Healthy People 2010* (USDHHS, 2000), *Healthy People 2020* (USDHHS, 2009), and *Healthy People 2030* (USDHHS, 2019, 2020). **Table 1-2** summarizes the vision, mission, foundational principles, and overarching goals of *Healthy People 2030*.

Green and Kreuter (2005) 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" (p. G-4). The 2000 Joint Committee on Health Education and Promotion Terminology defined it as "any planned combination of educational, political, environmental, regulatory, or organizational mechanisms that support actions and

Table 1-2 Vision, Mission, Foundational Principles, and Overarching Goals of *Healthy People 2030*

Vision	A society in which all people can achieve their full potential for health and well-being across the lifespan.
Mission	To promote, strengthen and evaluate the Nation's efforts to improve the health and well-being of all people.
Foundational principles	• Health and well-being of all people and communities are essential to a thriving, equitable society. • Promoting health and well-being and preventing disease are linked efforts that encompass physical, mental, and social health dimensions. • Investing to achieve the full potential for health and well-being for all provides valuable benefits to society. • Achieving health and well-being requires eliminating health disparities, achieving health equity, and attaining health literacy. • Healthy physical, social, and economic environments strengthen the potential to achieve health and well-being. • Promoting and achieving the Nation's health and well-being is a shared responsibility that is distributed across the national, state, tribal, and community levels, including the public, private, and not-for-profit sectors. • Working to attain the full potential for health and well-being of the population is a component of decision-making and policy formulation across all sectors.
Overarching goals	• Attain healthy, thriving lives and well-being, free of preventable disease, disability, injury and premature death. • Eliminate health disparities, achieve health equity, and attain health literacy to improve the health and well-being of all. • Create social, physical, and economic environments that promote attaining full potential for health and well-being for all. • Promote healthy development, healthy behaviors and well-being across all life stages. • Engage leadership, key constituents, and the public across multiple sectors to take action and design policies that improve the health and well-being of all.

Source: U.S. Department of Health & Human Services. Healthy People 2030 Framework. What is the Healthy People 2030 framework? Retrieved from https://www.healthypeople.gov/2020/About-Healthy-People/Development-Healthy-People-2030/Framework

conditions of living conducive to the health of individuals, groups, and communities" (Gold & Miner, 2002, p. 4). The *Ottawa Charter for Health Promotion* defined health promotion as "the process of enabling people to increase control over, and to improve, their health" (WHO, 1986, p. 1). Specifically, the Ottawa Charter identified five key action strategies for health promotion:

1. Build healthy public policy.
2. Create physical and social environments supportive of individual change.
3. Strengthen community action.
4. Develop personal skills such as increased self-efficacy and feelings of empowerment.
5. Reorient health services to the population and partnership with patients.

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

1. Promote social responsibility for health.
2. Increase investments for health development.
3. Expand partnerships for health promotion.
4. Increase community capacity and empower the individual.
5. Secure an infrastructure for health promotion.

Note that all of these definitions of health promotion have some things in common. First, just as with 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 to change his or her behavior. 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 [AAEH], 2003). As of 2019, the National Commission for Health Education Credentialing (NCHEC) online *Health Education and Promotion Program Directory* (HEPPD) listed 87 programs and was adding more.

As the health education profession has grown, interest has increased in establishing standards and holding professionals accountable to those standards. 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 with the goal of examining the role of the entry-level health education specialist and identifying the desirable responsibilities, functions, skills, and knowledge for that level based on 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, a second Bethesda Conference provided consensus for the certification process, and in 1988 the National Commission for Health Education Credentialing (NCHEC) 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®)**. As of 2019, there were approximately 13,000 CHES®s and 1,500 professionals who had obtained the **Master Certified Health Education Specialist (MCHES®)**designation (L. Lysoby, personal communication, November 26, 2019). **Table 1-3** summarizes the eight areas of responsibility for health education specialists (NCHEC, 2019a).

In 1992, the Society for Public Health Education (SOPHE) and the American Association for Health Education (AAHE) came together to determine graduate-level competencies, and a Joint Committee for the Development of Graduate-Level Preparation Standards was formed. The resulting publication, *A Competency-Based Framework for Graduate Level Health Educators,* was published in 1999 (AAHE, NCHEC, & SOPHE, 1999; Rehrig, 2010).

Table 1-3 Eight Areas of Responsibilities for Health Education Specialists

I. Assessment of needs and capacity
II. Planning
III. Implementation
IV. Evaluation and research
V. Advocacy
VI. Communication
VII. Leadership and management
VIII. Ethics and professionalism

Source: National Commission for Health Education Credentialing. (2020). Responsibilities and competencies for health education specialists. Retrieved from https://www.nchec.org/responsibilities-and-competencies

In 1998, the profession launched the National Health Educator Competencies Update Project (CUP), a 6-year project to verify entry-level health education responsibilities, competencies, and subcompetencies and advanced-level competencies and subcompetencies (Airhihenbuwa et al., 2005; Gilmore, Olsen, Taub, & Connell, 2005). The CUP model identified 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 7 areas of responsibility, 35 competencies, and 163 subcompetencies, many of which are similar to previous models. The CUP model also identified six settings for health education, an expanded contemporary version of which is depicted in **Table 1-4**.

In 2010, the AAHE, NCHEC, and SOPHE undertook the Health Educator Job Analysis (HEJA) project, which was a multiphase national study (NCHEC, 2019a). The HEJA project verified the three levels of practice identified in the CUP model, namely entry, advanced 1, and advanced 2, and reaffirmed the seven major areas of responsibilities.

In 2015, the Health Education Specialist Practice Analysis (HESPA) study was completed (NCHEC, 2019a). The purpose of this study was to validate the practice of entry-level and advanced health education specialists to determine whether there were any changes in health education practice since HEJA 2010 so that the certification process, professional preparation, and continuing education of health education specialists could be improved. The study identified 36 competencies and 258 subcompetencies, of which 141 subcompetencies were for entry, 76 for advanced 1, and 41 for advanced 2.

Table 1-4 Settings for Health Education

Community including recreation centers, faith-based organizations, not-for-profit groups, etc.
Schools (K–12)
Pre-schools and day cares
Health care including clinics, nursing homes, hospitals, etc.
Businesses/industry including worksites, employee assistance programs, etc.
Colleges/universities including student wellness centers, university health services, faculty and staff wellness centers, etc.
Media including newspapers, TV channels, Internet-based media, etc.
Local government health departments
State government health departments
Federal government health agencies including Centers for Disease Control and Prevention, United States Department of Health & Human Services, etc.
International organizations including World Health Organization, UNICEF, etc.

In 2019, the Health Education Specialist Practice Analysis II 2020 (HESPA II 2020) project was completed (NCHEC, 2019a) to verify entry-level and advanced responsibilities, competencies, and subcompetencies. The project identified eight areas of responsibilities (see Table 1-3). In addition, the project delineated 35 competencies comprising 193 subcompetencies, of which 114 are entry level, 59 are advanced 1, and 20 are advanced 2.

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 (Schneider, 2017) identified 6 public health goals and 10 essential public health services. The six public health goals are as follows:

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.
6. Assure the quality and accessibility of health services.

The 10 essential public health services are:

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 healthcare workforce.
9. Evaluate the effectiveness, accessibility, and quality of personal and population-based health services.
10. Research new insights and innovative solutions to health problems.

Both of these lists reflect 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 an NCHEC, since 2005 the National Board of Public Health Examiners (NBPHE, 2015) 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 earn the credential **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) and seven cross-cutting areas (communication and informatics, diversity and culture, leadership, public health biology, professionalism, programs planning, and systems thinking). The foundational competencies in public health, as identified by Council on Education for Public Health (CEPH, 2019), for baccalaureate and master's programs in public health also explicate the linkage between health education and public health.

Other professionals besides health education specialists and public health professionals also practice health education. Among these are **nursing educators**, who provide patient education and sometimes community health education as community health nurses, and **dietitians** (registered dietitians, licensed dietitians, nutrition educators), who provide nutrition education in both patient care and community settings. Professional **counselors** also sometimes provide health education. A new field that is emerging is that of **health coaches** who work one-on-one with individuals to help them achieve their health goals through lifestyle and behavior adjustments. All six of these professionals—namely, health education specialists, public health professionals, nursing educators, dietitians, counselors, and health coaches—will find this book extremely helpful in practicing evidence-based behavior change approaches in their respective fields.

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 SOPHE (Taub, Kreuter, Parcel, & Vitello, 1987). In 2019, a coalition of national health education organizations comprising the American Academy of Health Behavior (AAHB); the AAHE; the American College Health Association (ACHA); the APHA's Public Health Education and Health Promotion (PHEHP) and School Health Education and Services (SHES) sections; the American School Health Association (ASHA);

Table 1-5 Sections of the Code of Ethics for the Health Education Profession

Section I. Responsibility to the public. Supports principles of self-determination and freedom of choice for the individual.
Section II. Responsibility to the profession. Exhibits professional behavior.
Section III. Responsibility to employers. Accountable for professional activities and actions.
Section IV. Responsibility to the delivery of health education/health promotion. Respects the rights, dignity, confidentiality, and worth of all people.
Section V. Responsibility in research and evaluation. Conducts oneself in accordance with federal and state laws, organizational and institutional policies, and professional standards.
Section VI. Responsibility in professional preparation and continuing education. Provides quality education that benefits the profession and the public.

Source: Code of Ethics for the Health Education Profession®. (2020). Coalition for National Health Education Organizations (CNHEO). Retrieved from https://www.nchec.org/code-of-ethics

the Directors of Health Promotion and Education (DHPE); Eta Sigma Gamma; the SOPHE; and the Society of State Directors of Health, Physical Education, and Recreation (SSDHPER; now known as the Society of State Leaders of Health and Physical Education) developed a unified **code of ethics for health educators** (NCHEC, 2019b). The code has six sections with regards to ethical practice expectations, which are summarized in **Table 1-5**.

HEALTH EDUCATION ORGANIZATIONS

Twelve health education organizations exist at the national level in the United States. The following subsections provide a brief description of each of these organizations.

AMERICAN ACADEMY OF HEALTH BEHAVIOR (AAHB) (HTTPS://WWW.AAHB.ORG/)

The American Academy of Health Behavior (AAHB) 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.) and by developing and disseminating a cohesive body of knowledge in the area of health behavior research.

American College Health Association (ACHA) (https://www.acha.org/)

The American College Health Association (ACHA) 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.
- Be the primary source of information, education, and consultation on health and health promotion issues affecting college and university students within the campus community.
- Be the leading source of evidence-based knowledge about the field of college health.
- Be the principal advocate for national public policy affecting the health of all college students and campus communities.
- Develop and maximize the use of human, financial, and technological resources to ensure and sustain growth.

APHA Public Health Education and Health Promotion (PHEHP) Section (https://apha.org/apha-communities/member-sections/public-health-education-and-health-promotion)

The APHA established the Public Health Education and Health Promotion (PHEHP) section in 1920. The parent organization, the APHA, was formed in 1872. The section has more than 3,000 members. Its specific objectives are 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.
- Encourage the inclusion of health education, disease prevention, and health promotion activities in all of the nation's health programs.
- Stimulate thought, discussion, research, and programmatic applications aimed at improving the public's health.
- Improve the quality of research and practice in all public health programs of health education, disease prevention, and health promotion.
- 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.
- Provide section members with opportunities to become informed and engaged in all of the activities and matters of concern to the association.
- Facilitate collaboration with all of the association's boards, committees, special primary interest groups, caucuses, sections, and affiliates.
- Provide section members with such benefits as the annual meeting program, continuing education opportunities, newsletters, and a structure for exercising association leadership.
- Identify and recognize individuals who make outstanding and substantial contributions to health education, disease prevention, and health promotion.

APHA School Health Education and Services (SHES) Section (https://apha.org/apha-communities/member-sections/school-health-education-and-services)

The APHA established the School Health Education and Services (SHES) section in 1942. Today, the SHES 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.
- Interpret the functions and responsibilities of health agencies to day care, preschool, school, and college personnel.
- 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.
- Provide a forum for discussion of practices and research in early childhood, school, and college health.
- Encourage the provision of health promotion programs within the school and college settings that address the needs of children and school personnel.
- 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

American School Health Association (ASHA) (https://www.ashaweb.org/)

The American School Health Association (ASHA) was established in 1927 and has a membership of more than 3,000. ASHA's mission 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.
- Provide professional development opportunities for all those associated with school health programs.
- Provide advocacy for building and strengthening effective school health programs.
- Advance a research agenda that promotes quality school health programs.
- Fulfill these initiatives by acquiring human, fiscal, and material resources.

Delta Omega Honorary Society in Public Health (https://deltaomega.org/)

The Delta Omega Honorary Society in Public Health was established in 1924 at Johns Hopkins University within the School of Hygiene and Public Health (now known as the Bloomberg

School of Public Health). Delta Omega has about 17,000 members. Its mission is to promote excellence in practice, research, education, and academic achievement in the field of public health.

Eta Sigma Gamma (ESG) (https://etasigmagamma.org/)

Eta Sigma Gamma (ESG) 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.
- Stimulate and disseminate scientific research.
- Motivate and provide health education services.
- Recognize academic achievement.
- Support health education advocacy initiatives.
- Promote professional standards and ethics.
- Promote networking activities among health educators and related professionals.

SHAPE America (Society of Health and Physical Educators) (https://www.shapeamerica.org//)

SHAPE America was previously known as the American Alliance for Health, Physical Education, Recreation, and Dance (AAHPERD). The organization was formed in 1885 and has undergone seven name changes, the most recent, SHAPE America, occurring in 2014. SHAPE America is the country's largest organization of physical educators. Its vision is "Healthy People—Physically Educated and Physically Active!" The mission of SHAPE America is to enhance professional practice and augment research related to health and physical education, physical activity, dance, and sport.

Society for Public Health Education (SOPHE) (https://www.sophe.org/)

The Society for Public Health Education (SOPHE) was established in 1950 and has more than 4,000 members. The primary mission of SOPHE is to provide leadership to the profession of health education, 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.
- Promote the use of health education to eliminate health disparities.
- Review, expand, and promote a dynamic research agenda for health education and behavioral sciences.
- Support and enhance the professional preparation and training of health educators and public health professionals.
- Proactively market health education.
- Continually elevate SOPHE's performance in operations, governance, and resource development to achieve the strategic plan.

SOCIETY OF BEHAVIORAL MEDICINE (SBM) (HTTPS://WWW.SBM.ORG/)

The Society of Behavioral Medicine (SBM) was established in 1978 and has about 2,500 behavioral and biomedical researchers and clinicians as its members. Some health education professionals are also part of the membership of this organization. The purpose of this organization is to bring together different disciplines related to medicine and health behavior to provide fresh perspectives and progress on human behavior, health, and disease conditions.

SOCIETY OF STATE LEADERS OF HEALTH AND PHYSICAL EDUCATION (SSLHP) (HTTPS://THESOCIETY.ORG/)

The Society of State Leaders of Health and Physical Education (SSLHP) is the new name of the organization formerly known as the Society of State Directors of Health, Physical Education, and Recreation (SSDHPER). The SSLHP was established in 1926. Its mission is to provide leadership in facilitating and promoting initiatives to achieve national health and education goals and objectives. Members of SSLHP 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.
- Link state health, physical education, and recreation leaders with their counterparts in other states.
- Forge school–family–community linkages in support of school health, physical education, and recreation programs.
- Foster professional growth and the development of leadership and advocacy skills.
- Help resolve complex issues in education and health reform.
- Provide leadership in the effort to link postsecondary institutions to school districts for improvement in curriculum, instruction, and assessment.
- Provide a supportive network of professional and social relationships among members.
- Provide training and workshops for members to help them increase capacity to improve comprehensive school health education and programs within their states.

ROLE OF THEORY IN HEALTH EDUCATION AND HEALTH PROMOTION

Several disciplines influence the fields of health education and health promotion. Health education is influenced primarily by the behavioral sciences, whereas health promotion is deeply embedded in the social sciences. It is from these behavioral and social sciences that the fields of health education and health promotion, respectively, borrow their methods.

The core concepts in behavioral and social sciences are organized into theories that are developed as a result of research. Kerlinger and Lee (2000) 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" (p. 8). In health education and health promotion, we are primarily interested in predicting or explaining changes in behaviors or environments. Thus, a **theory** in the context of health education and health promotion is a systematic proposition of empirically (experimentally) tested constructs that explain or predict health behavior change.

A theoretical foundation is becoming almost mandatory for practitioners of health education and health promotion. Today, even entry-level health educators must demonstrate competency in developing a logical scope and sequence plan for health education (NCHEC, SOPHE, & AAHE, 2006). Graduate-level health educators also must base their practice on accepted theory. Theories help those in the health education and health promotion fields to articulate assumptions and hypotheses about the strategies and targets of interventions (National Cancer Institute, 2005).

Polit and Beck (2008) have classified theories into three types: macro, middle range, and descriptive. 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 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 middle-range theory. Finally, descriptive theories describe or explain a single discrete phenomenon, such as Hans Selye's (1974) general adaptation syndrome that describes the body's physiological response to stress.

Glanz, Rimer, and Viswanath (2015) classify theories as explanatory theories, or theories of the problem, and change theories, or theories of action. Explanatory theories help identify why a problem exists and aid in the search for modifiable constructs. Change theories guide the development of interventions and form the basis of evaluation.

Theories start from discussions of concepts or ideas that are abstract entities that are unable to be directly measured or observed. The concepts are reframed and incorporated into theories as constructs. For example, in social cognitive theory (Bandura, 1986, 2004), self-efficacy is a construct that reflects a person's belief in his or her ability to execute an action in response to a situation. When specific properties are assigned to the construct, it becomes an indicator. For example, a questionnaire examining self-efficacy may contain 10 items that researchers think constitute the construct. A variable or quantitative score can be derived from each indicator, and scores will vary across individuals. For example, in a 10-item questionnaire, each item may have a possible score of 1 to 5, and the summation of the scores for the items may yield a score for the entire questionnaire of 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 cause significant changes in 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 generalizable across the population. The constructs of the theory must be able to explain phenomena, which in the context of health education and health promotion are behaviors or environmental conditions. **Figure 1-1** shows a generic depiction of a behavioral theory.

There is nothing so practical as a good theory.

—Kurt Lewin

Theories derived from the behavioral and social sciences are used in the practice of health education and health promotion in several ways. First, the use of a theory aids in developing program objectives that are measurable. For example, if a health education program uses social

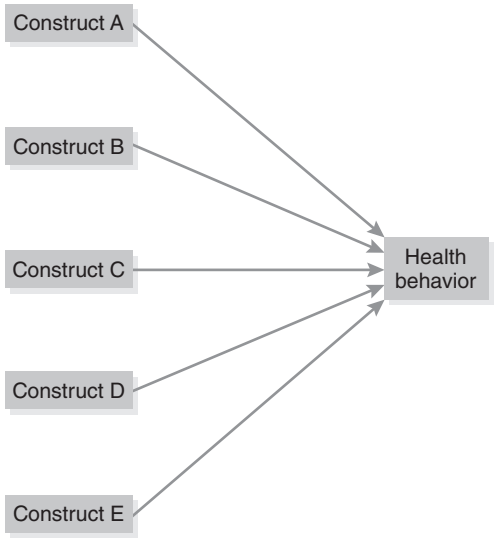


FIGURE 1-1 Generic depiction of a behavioral theory.

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

Second, a theory can be used to select an appropriate method 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, a theory can aid in determining 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 most likely to begin.

Fourth, a theory can aid a researcher in choosing the right mix of strategies and methods. In our earlier example, we were able to choose three constructs of the social cognitive theory because the theory suggests that these three constructs are important for early stage adolescents.

Fifth, a theory facilitates communication among professionals. The constructs of each theory remain the same in different applications, so readers can understand what was done across a number of different studies that are based on the same theory.

Sixth, the use of a 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 educators to design programs that are more effective (i.e., have greater impact) and more efficient (i.e., take less time). The benefits of the use of theory in health education and promotion are summarized in **Table 1–6**.

Table 1-6	**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.	
Enables replication.	
Improves program efficiency and effectiveness.	

EVOLUTION OF THEORY IN HEALTH EDUCATION AND HEALTH PROMOTION

The use of theory in health education and health promotion has evolved over the years (Sharma, 2017). The work on theory development in health education and health promotion began in the 1950s with the development of the health belief model (Rosenstock, 1974). In the 1960s, 1970s, and 1980s, health education (primarily family planning–related research) was based largely on Knowledge, Attitudes, Practices (KAP) surveys (Naylor, 1975; Taneja, 1972), and as a result **knowledge-based health education interventions** predominated (Maccoby, Farquhar, Wood, & Alexander, 1977; Perry, Killen, Telch, Slinkard, & Danaher 1980). These first-generation interventions were characterized by organizing awareness fairs, giving lectures or talks, distributing flyers or brochures, and other such activities. These types of interventions are still being implemented in some parts of the United States and in developing countries. However, it is now generally well recognized that although knowledge is necessary, it is not sufficient for behavior change, which is the desired outcome of health education and health promotion efforts.

In the 1990s, these first-generation interventions were replaced by second-generation approaches, in particular **skill-based health education interventions**. Several such approaches were developed and tested as interventions to combat the HIV/AIDS epidemic (Belcher et al., 1998; Gillmore et al., 1997), to promote refusal skills in adolescents (Charlton, Minagawa, & While, 1999; Elder, Sallis, Woodruff, & Wildey, 1993; Warzak & Page, 1990), to enhance problem-solving skills (Sharma, Petosa, & Heaney, 1999; Toseland, Blanchard, & McCallion, 1995), and others. Interventions such as first-aid training, cardiopulmonary resuscitation (CPR) training, and other such programs continue to utilize this approach. The second-generation approach was a good trend, but behavior change remained elusive.

A third generation of interventions began appearing in the late 1990s that entailed use of behavioral theories more along the lines of evidence-based medicine in health care and the evidence-based practice movement in public health. Many of the interventions based on this approach included randomized controlled trials (RCTs) in their evaluation designs, which are considered the gold standard for evidence. This generation of interventions can be characterized as **theory-based health education interventions**. They include the health belief model, the transtheoretical model, the theory of reasoned action, the theory of planned behavior, theories of stress and coping, and social cognitive theory, as well as many others.

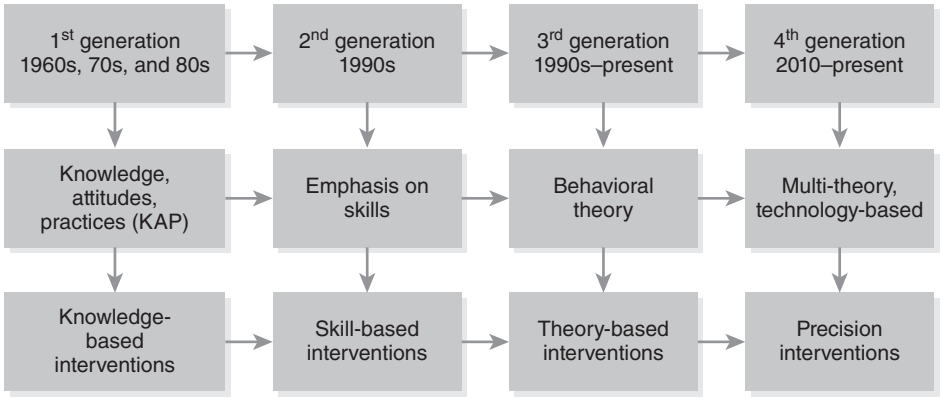


FIGURE 1-2 Evolution of theory in health education and health promotion interventions.

The theory-based trend has continued, but it is slowly being replaced by a fourth generation of interventions that entail the use of multiple theories and that rely on technology for behavior change. These types of interventions are known as **precision health education interventions**. Some notable developments in this regard include the integrative model of behavioral prediction, the multi-theory model (MTM) of health behavior change, and others. These interventions use technologies such as computers, tablets, smartphones, apps, etc. to facilitate behavior change (Brayboy et al., 2017; McKay et al., 2018). **Figure 1-2** depicts the evolution of theory in health education and health promotion interventions.

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* (n.d.) defines *aware* as "being mindful or heedful." The word *aware* implies knowledge gained through one's own perceptions or other means of information. Thus, **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, websites, 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 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 of skill, ranging from the simplest to the most complex skill, have been identified (Simpson, 1972):

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 CPR program, the instructor first shows the correct technique and then checks to see whether the participants have learned the technique correctly.

HEALTH LITERACY

The 2000 Joint Committee on Health Education and Promotion Terminology 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" (Gold & Miner, 2002, p. 5). Zarcadoolas, Pleasant, and Greer (2003) have suggested a four-part model of 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.

The Patient Protection and Affordable Care Act of 2010, Title V, defines health literacy as "the degree to which an individual has the capacity to obtain, communicate, process, and understand basic health information and services to make appropriate health decisions" (Centers for Disease Control and Prevention [CDC], 2019).

BELIEFS

Beliefs are convictions that a phenomenon is true or real (Rokeach, 1970). In other words, beliefs are statements of perceived facts or impressions about the world. Beliefs 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. Continuing with our example of the classroom, the student who found the classroom to be too small might qualify that belief by saying that it is "an ugly, small room." Because an evaluation has been made that the student dislikes the room, it becomes an attitude. Likewise, another student might find the same classroom 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 a topic and 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 makes up 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 return to the example of the student who likes cozy, small classrooms. He also likes the students and the instructor in the classroom, and he 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.

Evidence-Based Health Promotion

Evidence-based health promotion pertains to the utilization of data derived from empirical research and systematic investigations to identify determinants of health problems and design effective health promotion interventions (Smith, Tang, & Nutbeam, 2006). This term is also sometimes referred as *theory-based intervention planning* in health promotion.

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, 2012). 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) define 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" (p. G-2). 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 seven 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 have 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 WHO (1998) defines it as "a process through which people gain greater control over decisions and actions affecting their health" (p. 6). 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.

Capacity Building

Capacity building of communities is an important function for health promotion professionals. According to Smith, Tang, and Nutbeam (2006), capacity building is

> the development of knowledge, skills, commitment, structures, systems and leadership to enable effective health promotion. It involves actions to improve health at three levels: the advancement of knowledge and skills among practitioners; the expansion of support and infrastructure for health promotion in organizations, and; the development of cohesiveness and partnerships for health in communities. (p. 341)

Networking

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

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) define advocacy as "working for political, regulatory, or organizational change on behalf of a particular interest group or population" (p. G-1). Advocacy in health involves 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 policymakers 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**.

Legislation

Legislation refers to 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.

Evaluation

Evaluation is an important responsibility for health educators and essential for providing credibility to health education and health promotion efforts. Sharma and Petosa (2014) define evaluation as judging "the strong points and weak points of programs/interventions, policies/procedures, personnel/staff, products/materials, and organizations/institutions to enhance their effectiveness" (p. 331).

SKILL-BUILDING ACTIVITY

Think of a positive or 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 1–7**, write at least three program objectives that would help bring about positive change in this behavior in your target population.

Table 1-7 The SMART Way to Write Objectives

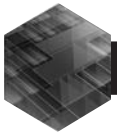
S	Specific (what exactly is being changed and in whom)
M	Measurable (percentage of participants who will change)
A	Action verb (list, describe, identify, explain)
R	Realistic (must be achievable)
T	Time frame (end of the session, end of 1 year)

CASE STUDY: JENNIFER'S DILEMMA IN CHOOSING THE BEST APPROACH FOR HEALTH EDUCATION

Jennifer has recently graduated from a prestigious health education program at a midwestern university. While she was pursuing her degree she was an active member of Eta Sigma Gamma (the honorary health education society) and organized and participated in several of its activities throughout her years as a student. Some of the salient activities she was instrumental in organizing were an annual health fair for students at her university, free condom distribution at the student wellness center, participation in American Heart Walk organized by American Heart Association, and many other such activities. She has recently been hired by a local health department in her state as a health education specialist under a block grant from the CDC for promoting heart health. Her supervisor has asked her to undertake some health education activities in her county. In her first quarter, she has organized health awareness fairs at different community centers in which she distributed flyers on smoking cessation, weight management, physical activity, the need for blood pressure and cholesterol screenings, and other such topics. She has submitted her report of the number of participants who attended these fairs to the CDC for the first quarter, but they were not pleased with her activities. She is wondering why that is the case although she worked so hard.

QUESTIONS FOR DISCUSSION

1. Why do you think CDC was not pleased with Jennifer's activities?
2. What is the primary purpose of health education with regard to promoting heart health in a community?
3. What are the advantages of organizing health fairs and distributing flyers?
4. What are the disadvantages of organizing health fairs and distributing flyers?
5. Can the distribution of flyers lead to health behavior change? Why or why not?
6. What would be the benefits of an evidence-based (theory-based) approach in augmenting Jennifer's efforts?
7. What evidence-based (theory-based) approach can Jennifer utilize to improve her efforts?



SUMMARY

Health is a means to achieve desirable life goals 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 needs and capacities; plan interventions; implement interventions; conduct evaluation and research; engage in advocacy; communicate; provide leadership and management; and display ethics and professionalism. 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 enhance program efficiency and effectiveness. Theories in health education and health promotion have evolved from designing knowledge-based interventions to skill-based interventions to single theory-based interventions to present-day fourth-generation multitheory precision interventions.

IMPORTANT TERMS

advocacy
attitudes
awareness
behavior
beliefs
capacity building
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
counselor
development of social norms
dietitian
evaluation
evidence-based health promotion
health
health behavior
health coach
health education
health literacy
health promotion
information
knowledge

knowledge-based health education interventions
legislation
lobbying
Master Certified Health Education Specialist (MCHES®)
networking
nursing educator
policy development
precision health education interventions
primary prevention
secondary prevention
skills
skill-based health education interventions
tertiary prevention
theory
theory-based health education interventions
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. How do the responsibilities for entry-level health educators and graduate-level health educators differ?
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 a theory in health education and health promotion?
12. Describe the evolution of theories in health education and health promotion.

WEBSITES TO EXPLORE

American Public Health Association (APHA)

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 for the conditions of 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)

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)

www.nbphe.org

The mission of the 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)

www.nchec.org

The mission of the 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.*

SHAPE America (Society of Health and Physical Educators)

www.shapeamerica.org

SHAPE America was founded in 1855 and has undergone several name changes since; its present name dates from 2014. SHAPE America is one of the largest organizations of physical educators. Its mission is to advance professional practice and promote research related to health and physical education, physical activity, dance, and sport. *Visit this website and find out the different types of membership. Locate your district and find out some of the activities that are occurring there.*

Society for Public Health Education (SOPHE)

www.sophe.org

The 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 and 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)

www.who.int/en/

The website has information about the formation and organization of the 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*.

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