

Health education and promotion are crucial in improving public health outcomes by empowering individuals and communities to make informed decisions about their well-being. Health education provides knowledge and skills to promote healthy behaviors and prevent diseases. On the other hand, health promotion focuses on creating supportive environments and advocating for policies that enable healthy choices.

This book delves into the transformative impact of health education and promotion initiatives in promoting healthy behaviors, preventing diseases, and enhancing overall health outcomes.



Abdirahman Moalim

Health Education and Health Promotion

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Dr. Abdirahman Moalim - Bachelor Science of General Nursing, Master of health service Mgt. & PhD of Nursing science. He has been a university senior lecturer for the last 10 years.

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DEDICATION

This work is dedicated to my parents, sisters, brothers, friends, students and everyone who helped me during my work.

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ACKNOWLEDGEMENT

First and foremost, I thank to **ALLAH** for keeping me strong and healthy throughout my work and for surrounding me with wonderful people. My profound thanks go to everyone I know; I would like to say this book is gift for you. Each member of the working group for their time and expertise in bringing together such a useful guidance document. Especial thanks for cater center, African medical and research foundation (AMRAF), MedlinePlus, Centers for Disease Control and Prevention (CDC), Mayo Clinic websites WHO guidelines for their useful information I would like to say thank you.

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ABOUT THE AUTHOR

I am Dr. Abdirahman Moalim bachelor science of general Nursing, Master of health service Mgt. & PhD of Nursing science I have been a university senior lecturer for the last 10 years and I have seen many lectures who have not given a textbook at the student level, students and lectures do not have reference books I decided to put together a simple book with all the information necessary to the subject. It was a dream I had been thinking about for a long time to produce a book and collect it in several different sources, so that this book is intended for health science undergraduate students, lectures of the universities, health care workers and everyone who interest studying communicable disease control., I am not the creator of this textbook but I have compiled it and put a lot of time into it for students to refer to. I picked up most of the book from the carter center, Myoclonic, MedlinePlus websites. This booklet is a summary that can be completed throughout the semester if planned, it was not really easy work but many thanks to Allah I finally succeeded.

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Signature

A handwritten signature in black ink, appearing to read 'Abdirahman', written on a light blue rectangular background. Below the signature is a horizontal dotted line.

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LIST OF ABBREVIATION

AIDS	Acquired Immuno-Deficiency Syndrome
HE	Health Education
HEWs	Health Extension Workers
BCC	Behavioral Change Communication
FGM	Female Genital Mutilation
FP	Family Planning
HIV	Human Immunodeficiency Virus
HSDP	Health Sector Development Program
IEC	Information Education Communication
MOH	Ministry of Health
PHC	Primary Health Care
WHO	World Health Organization
UNICEF	United Nation Children's Fund

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PREFACE

Health is a highly subjective concept. Good health means different things to different people, and its meaning varies according to individual and community expectations and context. Many people consider themselves healthy if they are free of disease or disability. However, people who have a disease or disability may also see themselves as being in good health if they are able to manage their condition so that it does not impact greatly on their quality of life.

Health promotion is concerned with **promoting a healthy lifestyle and preventing illness** and it includes social, psychological, political, and educational factors. Health education is concerned with informing people about health issues.

Health is an important aspect of human life. It encompasses all activities aimed at ensuring the protection of the body from diseases and promoting good habit. According to World Health Organization. (WHO, 1947), *Health is defined as a state of complete physical, mental and social wellbeing of individual and not the mere absence of diseases or infirmities.*

To achieve all these variables to make individuals health, health education has an important role to play.

Health education is defined as any combination of learning experiences designed to help individuals and communities improve their health, by increasing their knowledge or influencing their attitudes (WHO,2008; Johnson, 2010).

The goal of the National Health Policy (1987) is to bring a comprehensive health care system based on primary health care that is *Promotive, protective, preventive, restorative and rehabilitative* to all citizens within the available resources so that individuals and communities are assured of productivity, social well-being and enjoyment of living.

Health Education is the profession of educating people so as to make an informed decision about their health. Health education can serve as a tool to mobilize people and educate people on simple ways to prevent themselves against the invasion of micro-organism which cause infection.

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CHAPTER ONE: INTRODUCTION TO HEALTH EDUCATION & HEALTH PROMOTION

LEARNING OBJECTIVES

AT THE END OF THIS CHAPTER, THE STUDENT WILL BE ABLE TO:

- ✓ Explain the concept of Health
- ✓ Define Health Education
- ✓ Define Health Promotion
- ✓ Definition of terms
- ✓ Describe objectives of Health Education
- ✓ State basic principles of Health Education

1.0 INTRODUCTION

Before discussing about health education, it is imperative to conceptualize what health itself means. Health is a highly subjective concept. Good health means different things to different people, and its meaning varies according to individual and community expectations and context. Many people consider themselves healthy if they are free of disease or disability. However, people who have a disease or disability may also see themselves as being in good health if they are able to manage their condition so that it does not impact greatly on their quality of life.

Health promotion is generally defined as the process by which individuals increase control over their health and enables achieving an optimal level of health. The foundations of health promotion are based on health education, and the declaration of Alma-Ata (Almaty) addressed the education of society about common health problems, their prevention, and control in a society as an indispensable element of basic health services. *The “Health for All”* targets of the World Health Organization aim to provide individuals with education that enables them to take responsibility for the protection and development of their health during their lifetime.

Good health means different things
to different people

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Health education, which offers structured opportunities for learning, includes, in part, communication approaches designed to promote health literacy practices, such as the increase of knowledge levels and the development of life skills to help improve individual and community health.

Health care education is not strictly provided through information sharing, but rather is also related to motivation, the encouragement of certain skills and trust, all of which are instrumental for bringing improvement to people's health.

It is of paramount importance that health care professionals who work in primary health care institutions have the requisite knowledge, experience, and skills to promote health and to inform society through counselling about proper health-promoting lifestyle behaviours. Considering that the key function of health promotion efforts is to strengthen individuals, and in turn, society, it is important that an examination be made of the implementation of health education skills and the role of the health service providers in family health centers, the first point of contact individuals have in the health care system.

Health is an important aspect of human life. It encompasses all activities aimed at ensuring the protection of the body from diseases and promoting good habit. According to World Health Organization. (WHO, 1947), *Health is defined as a state of complete physical, mental and social wellbeing of individual and not the mere absence of diseases or infirmities.*

To achieve all these variables to make individuals health, health education has an important role to play.

Health education is defined as any combination of learning experiences designed to help individuals and communities improve their health, by increasing their knowledge or influencing their attitudes (WHO,2008; Johnson, 2010).

“Time and health are two precious assets that we don’t recognize and appreciate until they have been depleted.” – Denis Waitley.

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The goal of primary health care (PHC) was to provide accessible health for all by the year 2000 and beyond, unfortunately, this is yet to be achieved in Nigeria and seems to be unrealistic in the next decade (Abdulraheem, Oladipo & Amodu,2011).

PHC is a new approach to health care which helps in improving the health status of the community.

According to WHO (2008), primary health care is described as an essential health care system based on practical, scientifically sound and socially acceptable method and technology, made universally accessible to individuals and families in the community, through their full participation and at a cost that the community can afford at every stage of their development in the spirit of self-reliance and self-determination.

The goal of the National Health Policy (1987) is to bring a comprehensive health care system based on primary health care that is *Promotive, protective, preventive, restorative and rehabilitative* to all citizens within the available resources so that individuals and communities are assured of productivity, social well-being and enjoyment of living.

The health services, based on PHC among other things are; education concerning prevailing health problems and the methods of preventing and controlling them, promotion of food supply and proper nutrition, maternal and child care, including family planning, immunization against the major infectious diseases, prevention and control of locally endemic and epidemic diseases and provision of essential drugs and supplies (Adeyemo, 2005).

Health Education is the profession of educating people so as to make an informed decision about their health. Health education can serve as a tool to mobilize people and educate people on simple ways to prevent themselves against the invasion of micro-organism which cause infection.

“A fit body, a calm mind, a house full of love. These things cannot be bought – they must be earned.” –

Naval Ravikant.

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1.1 DEFINITION OF TERMS

- **Health**, according to WHO, is defined as a state of complete physical, mental and social well-being and not the mere absence of disease or infirmity.
- **Public Health**- is a science & art of promoting health, preventing diseases and protecting the health of the public through organized community effort
- **Health Promotion**-, according to Green & Kreuter, is defined as any combination of educational, political, regulatory and organizational supports for action and condition of living conducive to health of individuals, groups & communities
- **Education**, according to Socrates, is defined as dispelling error and discovering truth
- **Health Education**, according to Green, is defined as any combination of learning opportunities and teaching activities designed to facilitate voluntary adaptation of behavior that is conducive to health.
- **Advocacy**- is, simply, defined as an act or process of supporting a cause or an issue to influence decision makers for program or policy change
- **Social Mobilization**-*Social mobilization is the process of bringing together all feasible inter-sectoral partners and social allies to raise people's awareness and demand for particular development program to assist in the delivery of resources & services and to strengthen community participation for sustainability and self-reliance*
- **Social Marketing**- Social marketing is a process concerned with introducing and disseminating new or re branded marketable ideas and services; *i.e. product (Material or idea), transaction (Mutual relationship where two parties benefit by exchange of product or service), and consumer (Client or partner which uses a product by buying it but based on his/her free will).*
- **I.E.C**- is a process which involves the provision of information, conduct of educational activities, and effective communication of health messages to enable individuals, families or communities to promote their health as well as to preserve their health.
- **B.C.C**- is a process of changing social and individual attitudes and behaviors by providing relevant information, education and motivation through appropriate communication strategies.

“Let food be your medicine and
medicine be your food.” – Hippocrates

Health Education and Health Promotion

- **Disease:** is the existence of some pathology or abnormality of the body, which is capable of detection using, accepted investigation methods.
- **Illness:** is the subjective state of a person who feels aware of not being well.
- **Sickness:** is a state of social dysfunction: a role that an individual assumes when ill.
- **Health education** has been defined in many ways by different authors and experts. Lawrence Green defined it as “a combination of learning experiences designed to facilitate voluntary actions conducive to health.”

1.2 HISTORICAL DEVELOPMENT OF HEALTH EDUCATION

The development of health education is related to the initiation of health promotion activities for school children and their environment including nutrition education.

At the beginning of the 20th century, official formulation of education policies has been started in Europe and USA. The growth and development of health education has been accelerated with the initiation of Primary Health Care (PHC) concepts. At the global level, many countries endorsed and showed their commitment at the time of declaration of PHC at Alma Ata- Russia in 1978.

At this point in time, health education was recognized as a fundamental to the attainment of ‘Health for all’, and was put as one of the eight (8) components of PHC.

“Physical fitness is the first requisite of happiness.” – Joseph Pilates

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1.3 Aims of Health Education

In 1954, the WHO expert committee stated the following three objectives of health education:

- 1) To ensure that the community accepted health as a valued asset.
- 2) To equip individuals with knowledge and skills to influence their attitudes in such a way as to help them to solve their own health problems.
- 3) To promote development of health services
- 4) Motivating people to adopt health-promoting behaviors by providing appropriate knowledge and helping to develop positive attitude.
- 5) Helping people to make decisions about their health and acquire the necessary confidence and skills to put their decisions into practice.

1.4 PURPOSE OF HEALTH EDUCATION

The following are three broad educational objectives of health education that gear interventions and approaches:

1. To provide appropriate knowledge
2. To help develop positive attitudes
3. To help exercise healthy practice (behavior)

1.5 Principles of Health Education

Principle of definite aim

In order to be successful, the health educator should have a well-defined objective. The health education program will be effective if educators exactly know what they want to accomplish-plan their health education program. The program should also target specific audiences- audience segmentation and message tailoring should be made.

“Physical fitness is the first requisite of happiness.” – Joseph

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Principle of credibility

Good health education is based on facts- it must be consistent and compatible with the scientific knowledge and also with the local culture and educational system.

Principle of interest

It is known that people are unlikely to listen to things that are not of their interest or concern. Therefore, health educators must find out the real health needs of people.

Principle of participation

Participation is a key principle in health education program, and it is based on the principle of active learning. A high degree of participation tends to create a sense of involvement, personal acceptance, and decision making

Principle of motivation

In every person, there is a fundamental desire to learn. Awakening this desire, hence, is called motivating. Motivation is said to be contagious; one motivated person can spread motivation throughout a group, if not throughout a given community.

Principle of comprehension

Health educators should know the level of understanding, educational status, and literally of the people to whom the teaching is directed so that they can easily tailor their message to their audiences.

“Good health is not something we can buy. However, it can be an extremely valuable savings account.” – Anne Wilson Schaefer

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Principle of Re-enforcement

Because only few people can learn all things that are new in a single exposure, repetition of the health education program is necessary. If a program is not re-enforced, the understanding of people possibly returns to its pre-awareness stage.

Principle of learning by doing

Learning will be best when supported by practical sessions such as demonstrations and field attachments instead of mere explanation of facts.

Principle of known to unknown

This refers to importance of starting the health education session from what people know (simple) Proceeding to what people don't know (complex) to ensure their participation and confidence.

Principle of role model (setting examples)

Health education should be supported by actual situations and practical examples, and health educators, themselves, should be model to what they educate.

Principle of good human relations

Good relationship (rapport) with audience should be established by sharing information, ideas, and feelings transparently so that there could be a process of establishing and maintaining trust. This can further be done by introducing the aim of the education, name, status and role of the educator.

“Health is not valued until sickness comes.” – Thomas Fuller

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Principle of leadership

Psychologists established that people learn best from individuals whom they respect and appreciate, and hence it is good to penetrate through leaders (gate keepers) to the community in health education intervention.

Principle of feed back

For effective communication process, response of the audience is very important element so that the health educator can confirm that the learning objective is already achieved or not.

Principle of successive Experience

People tend to adopt those practices that give them satisfaction and reject that end with unhappy experiences and hence it is necessary to provide satisfying experience in order to establish a new practice.

Principle of group support

Any new idea or practice will be feared at first; it is only when many people support the new idea that the individual members come out for adoption.

Principles of Health Education in relation on Health Care Behaviors (clinical set ups)

Principle of educational diagnosis

The first task in changing behavior is to determine its cause(s), and this is referred as the diagnostic principle of changing behavior- predispose enabling and re-enforcing factors.

“Good health and good sense are two of life’s greatest blessings.”

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The hierarchical principle

This principle states that there is a natural precedence in the sequence of factors influencing behavior. The first order of concern is to ensure that predisposing factors have been addressed before enabling factors and enabling factors before reinforcing factors.

Principle of cumulative learning

This principle is related to hierarchical principle, and to affect behavior of professionals or patients, a series of learning experiences must be planned in a sequence that takes into account the prior learning experience, and concurrent incidental experiences to which the learners are exposed.; Learning doesn't occur in a vacuum!!!

The principle of participation

No principle of behavioral change has greater generalizability than the principle of participation. This principle refers to involving a patient in the health education program or sessions at clinical settings.

Principle of multiple methods

This principle follows the diagnostic principle, for each of the multiple predisposing, enabling, and re-enforcing factors identified, different method or component of comprehensive behavioral change program must be provided.

The principle of individualization

The tailoring of message or individualization of learning essentially applies the principle of cumulative learning, participation and specificity tailoring refers to the adaptation of learning, experiences to each individual- because each individual has his/her own unique peculiar feature/Perception-It should be noticed that learning is individual.

“The way you think, the way you behave, the way you eat, can influence your life by 30 to 50 years.” –
Deepak Chopra

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Principle of feedback

This principle is critical, and it ensures that the individual whose behavior is expected to be changed obtains direct and immediate feedback on the progress and effects of his/her behavior.

1.5.1 OTHER BASIC PRINCIPLES OF HEALTH EDUCATION

- All health education should be need based. Therefore, before involving any individual, group or the community in health education with a particular purpose or for a program the need should be ascertained. It has to be also specific and relevant to the problems and available solutions.
- Health education aims at change of behavior. Therefore, multidisciplinary approach is necessary for understanding of human behavior as well as for effective teaching process.
- It is necessary to have a free flow of communication. The two-way communication is particularly of importance in health education to help in getting proper feedback and get doubt cleared.
- The health educator has to adjust his talk and action to suit the group for whom he has to give health education. E.g. when the health educator has to deal with illiterates and poor people, he has to get down to their level of conversation and human relationships so as to reduce any social distance.
- Health Education is based on scientific findings and current knowledge. Therefore a health educator should have recent scientific knowledge to provide health education.
- The health educators have to make themselves acceptable. They should realize that they are enablers and not teachers. They have to win the confidence of clients.
- The health educator should use terms that can be immediately understood. Highly scientific jargon should be avoided.

**“A good laugh and a long sleep are the best cures
in the doctor’s book.” – Irish proverb**

Health Education and Health Promotion

1.6 Role of Health Education in PHC

Primary Health Care (PHC) is, shortly, defined as an essential health care based on practical, scientifically sound and socially acceptable methods & technology.

Principles of PHC include: inter sectoral collaboration, community involvement, appropriate technology, universal accessibility (equity), Promotive, preventive, curative & rehabilitative health services, and effective, culturally acceptable, affordable, and manageable services.

The major problems in implementing PHC, in Ethiopia, are: lack of infrastructure at district level, lack of intersectoral collaboration, inadequate and maldistributed health service coverage, inadequate resource allocation, problems of clear guidelines, cultural problems, lack of sound legal rules and weak involvement in health.

Factors that contribute for sustainable PHC include: appropriate planning & management, problem identification & priority setting by the community, development of SMART action plan, close monitoring & follow-up, and preparation for gradual pleasing out.

The components PHC in Ethiopia, currently, are: Health education, MCH/FP, Environmental Sanitation & water supply, EPI, essential drug use, appropriate nutrition, first aid for minor illnesses & injuries, treatment of common communicable diseases, STD/HIV/AIDS, Control of ARI, Control of diarrheal Diseases, mental health, oral health, promotion of traditional medicine.

Health education is one the components of Primary Health Care (PHC) and further more; almost all other components have a health education sub- component. The following seven points demonstrate the role of health education in the application of PHC principles.

“Healthy citizens are the greatest asset any country can have.” – Winston Churchill

Health Education and Health Promotion

Promoting community involvement and self-reliance

Health education has been shown to be the most important tool to Promoting community involvement in PHC. The first step that facilitates community involvement is provision of information on health to the people. Changes in individual and community behaviors are the results of persistent and effective health education activities.

Enhancing decision-making skill at local levels

Health education is particularly effective approach for encouraging and enabling communities. Decision making skills are important for taking action at a community level. Health education should help people to develop such skills through discussions, communications and through creation of mutual understandings.

Allowing diversity of objectives in formulating policy

The need for broad diversity of objectives come from the comprehensive definition of health. Most community health problems are related to each other and intertwined. Problems in health are related to water supply, level of education, income, health care services, etc. In order to solve major problems that constitute to the overall condition, plan for intervention need to be multifaceted.

Harmonizing national and local plans

Community involvement can ultimately provide continuous guidance to the national policy to grass roots. Usually, government bodies at higher level produce plans that are practiced by lower levels. However, these plans may not reflect the needs of the local community. Health education improves the participation of people in health plans and activities. Hence, plans will reflect local needs and local situations under the umbrella of the national plans.

“The wish for healing has always been half of health.” –
Lucius Annaeus Seneca

Health Education and Health Promotion

Facilitating inter-sectoral action

Many actions concerning health need cooperation with other sectors. Inter-sectoral collaboration needs communication between two or more sectors. Communication helps identify common needs and possible collaboration areas. The health sector has the responsibility of maintaining the health of the people, prevention of disease, and promotion of health but in collaboration with other sectors such as education and agriculture, etc sectors.

Using appropriate technology

Policies are required to ensure the use of appropriate technology in health education. Appropriate technology is one of the pre-requisites of PHC. We can buy any technology as long as it is in the market and we have the money and also the need. However, not all technologies are acceptable to all communities readily, and in most instances, the technology cannot be affordable. Therefore, we need a technology that is scientific, at a reasonable cost, and within the taste of the community.

Measuring the community involvement and impact of health education

More sensitive and specific measures of health education outcomes are required for monitoring and evaluation. Health education provides models and frameworks to diagnose a problem, to draw a plan, to implement an action, and to evaluate a program. Involving communities in assessing impacts of health education will help strengthen and re-direct health programs.

**“The more you understand yourself, the more silence there is,
the healthier you are.” – Maxime Lagacé**

Health Education and Health Promotion

1.7 Health Education in Health Extension

Health extension package is generally a service that emphasizes on prevention and control of Communicable diseases such as malaria, HIV/AIDS & personal and Environmental sanitation, MCH/FP, and Health Education. The health Education component is a tool for the package implementation and sub-set of each and every component of the package. The major components of the package can be summarized as hygiene and sanitation, disease control and prevention, family health services and health education and Communication.

Strategies of health extension package include: preventive and, promotive services, intersectorial collaboration, appropriate technology, community participation, political commitment and decentralization.

The expected challenges of health extension package in general are high demand for health extension workers, poor health service coverage, low district management capacity, more emphasis on curative services, perception of the community towards the package, too busy health extension workers (engaged in other duties), and weak intersectoral collaboration.

“To ensure good health: eat lightly, breathe deeply, live moderately, cultivate cheerfulness, and maintain an interest in life.” – William

Londen

Health Education and Health Promotion

1.8 Targets for health education

- **Individuals** such as clients of services, patients, healthy individuals
- **Groups** E.g. groups of students in a class, youth club
- **Community** E.g. people living in a village

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“I have chosen to be happy
because it is good for my
health.” – *Voltaire*

Health Education and Health Promotion

1.9 REVIEW QUESTIONS & ANSWERS OF CHAPTER 1

PART ONE: TRUE AND FALSE

1. Many people consider themselves healthy if they are free of disease or disability.
 - A. True
 - B. False
2. Health Education is the profession of educating people so as to make an informed decision about their health.
 - A. True
 - B. False
3. Illness is the subjective state of a person who feels aware of not being well.
 - A. True
 - B. False
4. Participation is a key principle in health education program, and it is based on the principle of active learning.
 - A. True
 - B. False
5. Learning will be best when supported by practical sessions such as demonstrations and field attachments instead of mere explanation of facts.
 - A. True
 - B. False

PART TWO: CIRCLE THE CORRECT ANSWER

1. is a science & art of promoting health, preventing diseases and protecting the health of the public through organized community effort.
 - A. Public Health
 - B. Health promotion
 - C. Health education

Health Education and Health Promotion

2. is, simply, defined as an act or process of supporting a cause or an issue to influence decision makers for program or policy change
 - A. Advocacy
 - B. Social marketing
 - C. Social mobilization
3. is the existence of some pathology or abnormality of the body, which is capable of detection using, accepted investigation methods?
 - A. Disease
 - B. Illness
 - C. Sickness
4. combination of learning opportunities and teaching activities designed to facilitate voluntary adaptation of behavior that is conducive to health.
 - A. Health education
 - B. Public health
 - C. Health promotion
5. Which of the following Factors contribute for susceustainable PHC and may include?
 - A. Appropriate planning & management.
 - B. Problem identification & priority setting by the community.
 - C. Development of SMART action plan.
 - D. Close monitoring & follow-up.
 - E. Preparation for gradual pleasing out.
 - F. All the above.

Part One: T/F

1. A
2. A
3. A
4. A
5. A

Part Two: Circle

1. A
2. A
3. A
4. A
5. F

Health Education and Health Promotion

PART THREE: DIRECT QUESTIONS

1. Define health and health education?
2. Explain why voluntary actions are so important in health education programs?
3. Mention five basic principles of health education?
4. Define Health Promotion
5. Describe objectives of Health Education

PART THREE: ANSWERS OF DIRECT QUESTIONS

1. **Health Education**, according to Green, is defined as any combination of learning opportunities and teaching activities designed to facilitate voluntary adaptation of behavior that is conducive to health.
2. **Volunteering provides many benefits** to both mental and physical health. Volunteering **helps counteract the effects of stress, anger, and anxiety**. The social contact aspect of helping and working with others can have a profound effect on your overall psychological well-being.
3. **Principles of health education**
 - A. All health education should be need based.
 - B. Health education aims at change of behavior
 - C. The health educator has to adjust his talk and
 - D. action to suit the group for whom he has to give health education.
 - E. Health Education is based on scientific findings and current knowledge.
 - F. The health educator should use terms that can be immediately understood
4. **Health promotion is generally defined as** the process by which individuals increase control over their health and enables achieving an optimal level of health.
5. **Aims of health education**
 - A. To ensure that the community accepted health as a valued asset.
 - B. To equip individuals with knowledge and skills to influence their attitudes in such a way as to help them to solve their own health problems.
 - C. To promote development of health services

Health Education and Health Promotion

CHAPTER TWO: APPROACHES TO HEALTH EDUCATION

Learning objectives

- ✓ Targets of health education
- ✓ Educational objectives of health education
- ✓ Goals of health education
- ✓ Approaches in health promotion

2.0 INTRODUCTION

Health education and health promotion builds on a social and cultural understanding of health and illness within your community.

The approach to health education aims to improve access to health related information, knowledge and services that will give people more control over their own health and wellbeing. Health education is aimed at reducing morbidity and mortality due to preventable health problems. **Persuasion and informed decision-making** are important types of health education approaches. The scope of health education at community level includes raising awareness about primary prevention, this study session deals not only with the dissemination of simple health facts, but also with more detailed health messages. These messages include specific information and skills, such as negotiation and coping strategies, which can help prevent illness and promote health. It is important to use more detailed messages and promote specific skills in your work because this will help to positively influence peoples' behaviour and bring about desired healthy behaviours and practices.

What are the 5 approaches to health education?

These approaches are: **medical, behavioural change, educational, client-centred, and societal change**

Health education and health promotion builds on a social and cultural understanding of health and illness within your community.

Health Education and Health Promotion

2.1 Targets of health education

As a Health Extension Practitioner We will use health education activities to promote healthy behaviour and practices in the community. Each individual and every community needs to think about what will bring them a healthy life. There are different risk factors in each locality that expose people to unhealthy conditions and lead to sickness and disease. Health education activities are expected to reduce these risk factors and maintain the health of the community.

Every stage of life, each and every individual or social group in the community and all occupations are appropriate targets of health education programmes. The following sections cover the main target groups for health education programmes.

2.1.1 Individuals

All Health Extension Practitioners are expected to use health education to communicate with individuals within their community. Individuals include all health service users such as *women receiving antenatal care, school children, adolescents and young children*. will be able to deliver health education messages at both household and at a community level. For example, it is likely there will be TB patients in your community who are receiving anti-TB drugs. Health education for these individuals will include giving advice to cover their mouth while coughing, adhere to the full course of their treatment as well as a variety of other educational issues that will help them get better themselves — and protect the rest of the community from infection.

“He who has health has hope, and he who has hope has everything.” – Thomas Carlyle

Health Education and Health Promotion

2.1.2 Groups

Groups are gatherings of two or more people with a common interest; they are a good target for the health education.

Working with groups is a major activity in health education. When people get together to identify, define, and solve a problem, they have many more resources than when they work individually. Groups can often do things that several individuals could not do by themselves. Groups support their members in the practice of health behavior. They also enable people to learn from each other.

To understand the concept of group health education, imagine that there is a gathering of an HIV/AIDS peer educator group at the local secondary school. You may well be invited by the school administrator to deliver health messages on HIV/AIDS to help train groups such as these.

2.1.3 Community

Health education is among the tasks that all Health Extension Practitioners will also be expected to implement at community level. *A community can be described* as a collection of people who have a feeling of belonging and share a common culture, beliefs, values and norms. In this context a community will also have a common interest regarding the possible health problems within your area. Community is a specific group of people, often living in a defined geographical area and arranged in a social structure according to relationships that the community has developed over a period of time. Members of a community gain their personal and social identity through shared culture, beliefs, values and norms. All health education work relies on good relationships with people in the community. Community members will also exhibit some awareness of their identity as a group, their common needs and will have a commitment to meeting these needs.

**"Success is getting what you want,
happiness is wanting what you get." – W.P.
Kinsella**

Health Education and Health Promotion

In all health education work it is important to develop a good relationship with the people you are trying to influence.

Malaria is a health issue that affects many different people in the village. A message about its prevention is part of community-level health education so the target audience will be the whole community.

2.2 Educational objectives of health education

One of the most important objectives is to provide appropriate knowledge. *Knowledge is the collection and storage of information and experience.* Good quality health education relies on the provision of correct, credible, simple and understandable facts and information. Providing knowledge is about helping someone who has a problem, in the case of the job a health problem, so you will have to be aware of the possible health problems, their consequences and ways of preventing them.

TB health education messages. People with persistent coughing should visit the nearby health center for sputum tests because a cough lasting two weeks or more is a symptom that could be a sign of TB. Those people confirmed as TB patients and put on anti-TB drugs should adhere to their medication to prevent possible drug resistance and to help cure their disease.

Another important objective of health education is to help people to develop a positive attitude. Attitude has a lot to do with changing people's opinions, feelings and beliefs. Health education aims to encourage an attitude that helps people maintain healthy practices and behaviours.

“It is health which is real wealth and not pieces of gold and silver.”– Mahatma Gandhi

Health Education and Health Promotion

A positive attitude can also help with decision-making so that they are able to choose healthy practices for themselves and their families.

What Are the 7 Areas of Responsibility for Health Educators?

- 1) Assess Needs, Resources, and Capacity for Health Education/Promotion
- 2) Plan Health Education/Promotion
- 3) Implement Health Education/Promotion
- 4) Conduct Evaluation and Research Related to Health Education/Promotion
- 5) Administer and Manage Health Education/Promotion
- 6) Serve as a Health Education/Promotion Resource Person
- 7) Communicate, Promote, and Advocate for Health, Health Education/Promotion, and the Profession

Components of Health education:

- 1) Increasing knowledge.
- 2) Developing skills.
- 3) Changing behavior.

Case Study 2.1

Mama Halima Was TTBA with 10 years of experience, when working as a Health Extension Practitioner, Mama Halima found that the community she was working in commonly practiced female genital mutilation (FGM).

Mama Halima wanted to change the community's attitude towards practicing FGM and would regularly carry out health education activities with different individuals and groups within the community. For example, she organized a group meeting for the women living in the community and gave an audiovisual presentation on the health risks associated with FGM. **Mama Halima** followed this with a discussion where the women could talk about the practice and ask questions about her presentation. She put up posters like the one in.

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The belief that FGM is a harmful traditional practice became the most commonly held view amongst community members.

Decision-making

Decision-making based on awareness or knowledge about a health issue is about people's ability to choose healthy behaviours and practices from a range of alternatives. To do this people need to understand their health needs and the different options available for meeting them. Health education is a very important way that people in the community can develop decision-making skills for themselves.

Case Study

Farah is 18 years old and attends high school. Due to influence from his friend **Sharmake**, he smokes cigarettes. As a health educator role you frequently go to his home and tell him that he is damaging his lungs due to smoking and he is at risk of lung cancer, even his classmate, family and some friends will probably think it is dirty. At first he refused to listen to you, however one day he told you that he believes that smoking is harming his health. After a few days he completely stopped smoking cigarettes.

“Happiness lies first of all in health.” –
George William Curtis

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Why do you think Farah stopped smoking?

Farah changed his attitude and now he believes that smoking is harmful because he was given *enough knowledge and information to help him in his decision-making*. For example, smoking causes cancer and heart disease he also probably changed his mind because of the effect it might be having on his classmate family and friend.

2.3 Goals of health education

For a Health Extension Practitioner, the main goal of health education is to enable each individual and family within the community to exercise their right to develop and achieve their physical, mental and social potential. Through health education you should aim to help prevent illness and disease, maintain and improve the health of the community members, reduce exposure to risk factors and help people adjust so they are able to live with disabilities.

Activity

Look at the paragraph above again and think about health education messages that have been focused on:

- A. Prevention.
- B. Maintenance and improvement of health.
- C. Reduced exposure to risk.
- D. Adjustment to disability

It's clear that these aims are all linked. For example, reducing risk can improve health and prevent disease, and adjusting to disability can prevent mental health problems and reduce self-harming behaviours. health education messages can be anything from very straightforward to very subtle messages which affect whole lives. Understanding health education approaches will help health workers to influence the community and encourage the desired healthy behaviour and practices.

**“Looking after my health today gives me a better hope for tomorrow.” – Anne
Wilson Schaefer**

Health Education and Health Promotion

Persuasion is often used by Health Extension Practitioners to influence the behaviour of their community. **For example**, imagine you have analyzed the latrine usage within your area and found that many people are not using the latrines that have been constructed. You could try to persuade the community to increase latrine usage by explaining the health risks of not using a latrine and stressing the benefits of using one, after using the persuasion approach you should follow up by making frequent visits to the households you surveyed and checking that they are still using the latrines.

2.3.1 Informed decision-making

Informed decision-making focuses on *providing the necessary health information needed* to create awareness of a health problem in the community. This approach leaves the actual decision-making about action to the individuals. using several different methods in this approach including giving people information about the issues and teaching decision making skills. It is important to allow people in the community to make the choice themselves as this will build their decision-making skills. *For example, imagine that you have gathered Hashish smokers in your community together.*

You conduct a health education session aimed at creating awareness about the health risks of smoking cigarettes. During the session you include a role play activity where different members of the group take it in turns to play a smoker and a doctor discussing the health risks associated with smoking. This type of activity encourages decision-making and will help people to make their own decision about whether to stop smoking.

“The first wealth is health.” – Ralph Waldo Emerson

Health Education and Health Promotion

2.4 Approaches in health promotion

Health promotion will be an important part of your work as a Health Extension Practitioner.

2.4.1 Behaviour change

The behaviour change approach is used to bring about changes in an individual's thinking or perception. Using this method to change the behaviour of individuals within the community and help them to make their own health-related decisions.

This approach can be applied using locally available methods and media such as leaflets and posters. The behaviour change approach is very broad; you will be expected to consider wider issues of health education such as individual perceptions of exposure to health risks and risky behaviour. This approach also covers the benefits an individual can gain through health practices.

Think about smoking for a moment. You'll be aware that smokers deciding whether or not to give up smoking should consider: To what extent they think they are susceptible to high blood pressure (hypertension), lung cancer, social and financial consequences, and other smoking-related health problems. Their perception of how serious continuing to smoke may be in terms of their possible future morbidity (illness) and mortality. Their perception of the extent and value of the benefits of giving up smoking. The potential negative consequences of giving up smoking.

Sadia is a Health Extension Practitioner. She wants to help young adolescents who are exposed to smoking in her area. How do you think she could use the behaviour change approach to health promotion outlined above to do this? What ways do you think **Sadia** might use to help the young adolescents to decide whether to give up smoking or not? **Sadia** could invite adolescents and young men who smoke to a group meeting, where several things can happen.

Keep your vitality. A life without health is like a river without water. Maxime Lagacé

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She could hold an activity such as an audiovisual presentation about the health risks associated with smoking. This would help the young adolescents to consider all these factors and then decide for themselves whether to stop smoking.

She could also use a discussion group after the presentation to help them explore the social aspects of smoking, why people do it and what good things they can find in giving up both now and in the future. Importantly she could also give hints and tips for actually giving up.

Sadia does not smoke herself so she is also acting as a role model for the young adolescents. So she uses a number of behaviour change methods: *giving information, opinion-forming, and modeling healthy behaviour.*

2.4.2 Self-empowerment

Your role as a Health Extension Practitioner will be to help individuals in your community make healthy choices. It's important to remember that self-empowerment is rooted in awareness and understanding that people can act to change their own lives on their own behalf. Using the self-empowerment approach you can provide the tools they will need to make their own choices about their health and increase their control over their physical, social and psychological environment. Self-empowerment techniques include, but are not limited to, group work, problem solving, client-centered counselling, assertiveness training, social skills training and educational drama.

“Three things in life – your health, your mission, and the people you love.” That’s it.
Naval Ravikant

Health Education and Health Promotion

Case study

Suppose that you as Health Extension Practitioner planned to create awareness amongst your community members on the problems of tuberculosis.

Write down some of the ways you can create awareness about tuberculosis and so help people to begin to act positively for themselves.

You may have thought of some of the following ways:

- A. Health education sessions are important for the community to reduce transmission of tuberculosis by helping people to understand how to break the route of transmission.
- B. A health education session would help you to identify those people with signs and symptoms of tuberculosis and encourage them to take action and visit a larger health facility for diagnosis.
- C. Your health education session could encourage patients who are already on anti-TB medication to adhere to their treatment, which is a form of personal action which will help prevent drug-resistant TB.

2.4.3 Community development

This approach requires the participation of community members at every stage of the programme. *Community development is a collective action where members of the community participate in assessing the needs of the community and help in the planning of actions, targets and goals to meet those needs.* This approach includes the interpersonal skills component of the self-empowerment approach.

True silence is the rest of the mind, and is to the spirit
what sleep is to the body, nourishment and refreshment.
William Penn

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At the community level there are many influences over health-related behaviours, some of these such as social and cultural norms, beliefs, and values have been covered in this Module, but influences can also include factors such as the local socio-economic situation of the community and prevailing environmental conditions such as drought or floods. Community participation is essential for the Health Extension Practitioner to understand and deal with those influences.

Communities often have detailed knowledge about their history, culture and surrounding environment so it is crucial to include them at all stages of your community development activities. If the community is involved in choosing healthcare priorities and making plans those people are much more likely to become involved in the implementation of the health education activities, and these are more likely to be successful. Encouraging participation is also important for developing the self-reliance, empowerment and problem-solving skills of the community members, it will also enable to use locally available resources and help to create better relationships with the people in the community are working in.

The Health Extension Programme is an innovative community-based programme. As a Health Extension Practitioner you will be expected to help address the health problems of the community. All efforts on health promotion and disease prevention activities should include the full participation and involvement of the community members.

Health education is an important tool that helps to implement all community-based packages of the Health Extension Programme. The Health Extension Programme focuses mainly on prevention and community-based health promotion activities. Preventive activities are usually considered in the levels: **Primary prevention** includes those measures that prevent the onset of illness before the disease process begins. Immunization against infectious disease is a good example.

Life is a question and how we live it is our answer.

Gary Keller

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Secondary prevention includes those measures that lead to early diagnosis and prompt treatment of a disease. Breast self-examination is a good example of secondary prevention.

Tertiary prevention involves the rehabilitation of people who have already been affected by a disease, or activities to prevent an established disease from becoming worse. These activities are less likely to be undertaken by Health Extension Practitioners.

At the primary prevention level your health education activities will focus on changing behaviour by raising awareness of the risk factors that predispose the community members to future health problems. *For example, imagine* that you distribute insecticide treated bed nets (ITN) to prevent the pregnant mothers in your area getting infected with malaria. This is primary prevention because you are preventing exposure to malaria. Your role as Health Extension Practitioner is to use health education to create awareness among the pregnant women on how and why to use ITN. Health education also includes secondary prevention methods such as early diagnosis and treatment and extends to tertiary prevention such as rehabilitation.

Before finishing this session, think about a health education issue that you are familiar within the community or area. Make a note of a primary prevention action and a secondary action that has been taken.

Make sure that you are comfortable with the difference between primary prevention activities and secondary prevention activities. Remember that primary prevention activities will actually stop the illness happening, while secondary activities stop the illnesses getting worse.

“Early to bed and early to rise makes a man healthy, wealthy, and wise.”— Benjamin Franklin

Health Education and Health Promotion

2.5 Review questions and answers of chapter 2

PART ONE: TRUE AND FALSE

1. Health education and health promotion builds on a social and cultural understanding of health and illness within your community.
 - A. True
 - B. False
2. Groups are gatherings of two or more people with a No interest; they are a good target for the health education.
 - A. True
 - B. False
3. A community can be described as a collection of people who have a feeling of belonging and share a common culture, beliefs, values and norms.
 - A. True
 - B. False
4. Members of a community gain their personal and social identity through shared culture, beliefs, values and norms.
 - A. True
 - B. False
5. Good quality health education relies on the provision of correct, credible, simple and understandable facts and information.
 - A. True
 - B. False

PART TWO: DIRECT QUESTIONS

1. What are the Goals of health education?
2. Approaches in health promotion
3. Targets of health education
4. What are the 5 approaches to health education?
5. Define Knowledge

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PART TWO: DIRECT QUESTION ANSWERS

1. **Goals of health education are:**
 - A. Prevention.
 - B. Maintenance and improvement of health.
 - C. Reduced exposure to risk.
 - D. Adjustment to disability
2. **Approaches in health promotion are:**
 - A. Behavioral change
 - B. Self-empowerment
 - C. Community development
3. **The approaches of health education are:** medical; behavioural change; educational; client-centred, and societal **change**
4. **Target of health education are:**
 - A. Individuals
 - B. Groups
 - C. Communities
5. **Knowledge is** the collection and storage of information and experience.

Part One: T & F

1. A
2. B
3. A
4. A
5. A

Health Education and Health Promotion

CHAPTER THREE: HEALTH AND HUMAN BEHAVIOR

Learning Objectives

At the end of this chapter, the student is expected to:

- Define behavior and related terms
- Describe the factors which affect human behavior
- Discuss on the role of human behavior in prevention of disease and promotion of health.

3.0 INTRODUCTION

In the previous section, we have tried to discuss the concept of health and health education. Human behavior is among the major determinants of the health of individuals, families or communities. Healthy behaviours contribute to the overall health of individuals and communities and unhealthy behaviours adversely affect the quality of life people at different levels. Most health issues cannot be dealt with by treatment alone. The promotion of health and prevention of diseases will usually involve some changes in life styles or human behaviours.

Definition of terms

- Behavior- is an action that has specific frequency, duration and purpose; whether conscious or unconscious.
- Health Behavior- refers to practices or activities undertaken by people to prevent or avoid the occurrence of health or health related problems.
- ❖ **Behaviour** is an action that has a specific frequency, duration and purpose whether conscious or unconscious. It is what we “do” and how we “act”. People stay healthy or become ill, often as a result of their own *action* or *behaviour*.

Human behavior flows from three main sources: desire, emotion, and knowledge. Plato

Health Education and Health Promotion

The following are examples of how people's actions can affect their health:

- ✓ Using mosquito nets and insect sprays helps to keep mosquito away.
- ✓ Feeding children with bottle put them at risk of diarrhoea.
- ✓ Defecating in an open field will lead to parasitic infection.
- ✓ Unsafe sex predisposes people to unwanted pregnancy, HIV/AIDS and other STDs In health education it is very important to be able to identify the practices that cause, cure, or prevent a problem.

3.2. Concepts of Health Determinants

Multiple variables affect (influence) a person's health status. Some of these are internal factors such as the person's genetic make-up, and others are external such as the person's culture and physical environment.

Generally, variables affecting health status can be genetic make-up, sex, race, age and developmental level, mind-body relation ship, life style (behavior), physical environment, standards of living, culture, family, etc

According to the Health field concept, all the above determinants of health can broadly be categorized as Environmental, Biological, behavioral and health care delivery system factors as illustrated in the figure below:

Certainly, if you look at human behavior around the world, you have to admit that we can be very aggressive. Jane Goodall

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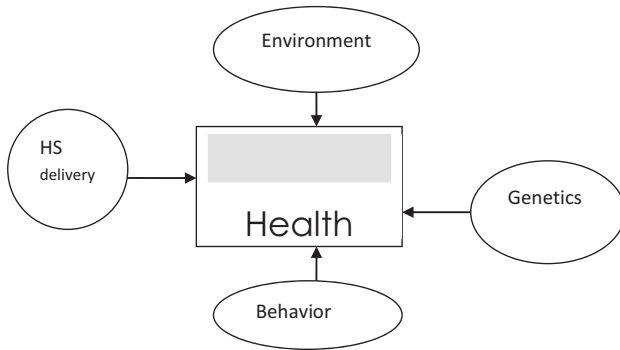


Figure 1

3.3. Role of Behavior in Health and disease

It is known that all diseases are related to people's life style or behavior, and hence leading healthy life entails understanding and dissemination between good (health) and bad (unhealthy) practices. Experiences show that health care delivery system is unproductive if not supported by health education program.

Hippocrates pointed out that human wellbeing is influenced by the totality of environmental factors: life style, climate, water, food, etc –social, physical, political environments.

The words **actions**, **practices** and **behaviours** are different words of the same thing.

- **Life style:** refers to the collection of behaviours that make up a person's way of life-including diet, clothing, family life, housing and work.
- **Traditions:** are behaviours that have been carried out for a long time and handed down from parents to children.

Strange are the ways of human behavior. Orson Bean

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- **Culture:** is the whole complex of knowledge, attitude, norms, beliefs, values, habits, customs, traditions and any other capabilities and skills acquired by man as a member of society.

Distinguishing characteristics of culture

- **Culture is shared.** People in the same society share common behavior patterns and ways of thinking through culture. For example people living in a society share the same language, dress in similar styles, eat much of the same food and celebrate many of the same holidays.
- **Culture is learned.** A person must learn culture from other people in a society. For instance, people must learn to speak and understand a language and to abide by the rules of a society.
- **Culture is adaptive.** People use culture to adjust flexibly and quickly to changes in the world around them. For instance a person can adjust his diet when he changes an area of residence.

Examples of behaviours promoting health and preventing diseases

- ❖ **Healthy behaviours:** - actions that healthy people undertake to keep themselves or others healthy and prevent disease. Good nutrition, breast feeding, reduction of health damaging behaviours like smoking are examples of healthy behaviours.
- ❖ **Utilization behaviour:** - utilization of health services such as antenatal care, child health, immunization, family planning...etc
- ❖ **Illness behaviour:** - recognition of early symptoms and prompt selfreferral for treatment.
- ❖ **Compliance behaviours:** - following a course of prescribed drugs such as for tuberculosis.
- ❖ **Rehabilitation behaviours:** - what people need to do after a serious illness to prevent further disability.

Human behavior is incredibly pliable, plastic. Philip Zimbardo

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- ❖ **Community action:** - actions by individuals and groups to change and improve their surroundings to meet special needs.

3.4 Factors Affecting Health Behavior

The health field concept classifies factors affecting behavior as biological, environmental, lifestyle and health care organization factors-which in turn classified, generally, as predisposing, enabling and re-enforcing factors, according to Green Classification.

- ☞ Predisposing factors- are factors which motivate the behavior to occur, and these include knowledge, belief, attitude, confidence and values.
- ☞ Enabling factors- are factors which enable a motivation to be realized, these include availability and accessibility of services, priority given and commitment to health (community, government policy, law), and presence of health related skills.
- ☞ Re-indorsing factors- are factors which facilitate the persistence or reputation of a behavior, and these include influences of family, peer, teachers, efforts of health service providers, and follow – up of community leaders and policy makers.

The other way of classifying factors which determine human behavior is as: intra individual factors (such as knowledge, belief) and extra individual factors (such as peer insurance, socio-economic factors, environmental factors, service factors).

**Fortunately, most human behavior is learned
observationally through modeling from others. Albert
Bandura**

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Factors affecting human behaviour

1. **Predisposing factors:** provide the rationale or motivation for the behavior to occur. Some of these are:

- ✓ Knowledge
- ✓ Belief
- ✓ Attitudes
- ✓ Values

E.g. For an individual to use condom, he has to have knowledge about condom and develop positive attitude towards utilization of condom.

❖ **Knowledge** is knowing things, objects, events, persons, situations and everything in the universe. It is the collection and storage of information or experience. It often comes from experience. We also gain knowledge through information provided by teachers, parents, friends, books, newspapers, etc...

E.g. knowledge about methods of prevention of HIV

❖ **Belief** is a conviction that a phenomenon or object is true or real. Beliefs deal with people's understanding of themselves and their environment. People usually do not know whether what they believe is true or false. They are usually derived from our parents, grandparents, and other people we respect.

Beliefs may be helpful, harmful or neutral. If it is not certain that a belief is harmful, it is better to leave it alone.

The most perfect expression of human behavior is a string quartet. Jeffrey Tate

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For example, a certain society may have the following beliefs:

- Holding materials made of iron by mothers during postpartum (Neutral)
- Diarrhea may end up with death (helpful)
- Measles cannot be prevented by immunization (harmful).

❖ **Attitudes** are relatively constant feelings, predispositions or set of beliefs directed towards an object, person or situation.

They are evaluative feelings and reflect our likes and dislikes.

They often come from our experiences or from those of people close to us. They either attract us to things, or make wary of them.

E.g. Maryama had fever and visited the nearby health center.

The staff on duty that day was very busy and shouted at her, “Do you want us to waste our time for a mild fever? Come back when we are less busy.” She did not like being shouted at.

This experience gave her bad attitude toward the health staff. This bad attitude could discourage her from attending the health center next time she is sick.

❖ **Values** are broad ideas and widely held assumptions regarding what are desirable, correct and good that most members of a society share. E.g. being married and having many children are highly valued in most Somali community.

❖ **Norms** are social rules that specify appropriate and inappropriate behavior in given situations. They tell us what we should and must do as well as what we should not and must not do.

Most of the images of reality on which we base our actions are really based on vicarious experience.
Albert Bandura

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3.4.1 Core Concepts of Somali values

- A. Generosity
- B. Honour (*Sharaf*)
- C. Kinship
- D. Clan structure
- E. Respect for elders
- F. Modesty (*Xishood*)
- G. Entrepreneurship

there are certain values that are characteristic to Somalis, these being generosity, hospitality, kinship, respect for the elderly and honour. Broadly, Somalis have also demonstrated a high level of adaptability and entrepreneurialism in the face of adversity.

For Example,

- We often regard greeting as a social norm to be conformed among members who know each other.
- Murder, theft and rape often bring strong disapproval.

2. Enabling factors: these are characteristics of the environment that facilitates healthy behavior and any skill or resource required to attain the behavior. Enabling factors are required for a motivation to be realized.

Examples of enabling factors include:

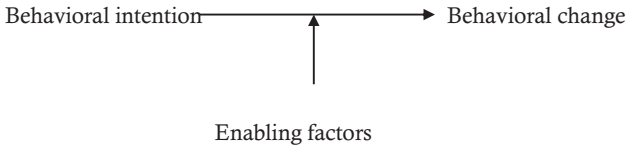
- Availability and or accessibility of health resources
- Government laws, priority and commitment to health
- Presence of health related skills

E.g. enabling factors for a mother to give oral rehydration solution to her child with diarrhea would be:

- Time, container, salt, sugar
- Knowledge on how to prepare and administer it.

In general, it is believed that enabling factors should be available for an individual or community to perform intended behavior.

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(Time, money and materials, skills, accessibility to health services).

3. Reinforcing factors: these factors come subsequent to the behavior.

They are important for persistence or repetition of the behavior. The most important reinforcing factors for a behavior to occur or avoid include:

- ✓ Family
- ✓ Friends, teachers
- ✓ Employers, health providers
- ✓ Community leaders
- ✓ Decision makers

We are all influenced by the various persons in social network.

Pressure from others can be a positive influence to adopt health promoting practices as well as an obstacle. Influential people significant influence to change others. In the case of a young child, it is usually the parents who have the most influence. As a child grows older, friends become important.

E.g. a young man starts smoking because his friends encouraged him to do so.

“Prevention is better than cure.” – **Desiderius Erasmus**

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3.5 Change in human Behavior

Change in behavior could be natural or planned in its nature based on natural events or based on plan respectively.

- ☞ **Natural change in behavior-** people's behavior changes all the time; some changes take place because of natural events or processes such as age and sex related behaviors.
- ☞ **Planned change in behavior** – people make plans to improve their life or to survive, for that matter, and they act accordingly. Planned change in behavior can be faster or slower depending on the response of the adapter or acceptor.
- ☞ **Readiness to change behavior-** is experienced after the stages of unawareness awareness, concern, acquisition of knowledge and skill, and motivation are attained one after the other or overlapping one over the other.

Readiness to behavior change, usually, is followed by stages known as trial and illustrated below.

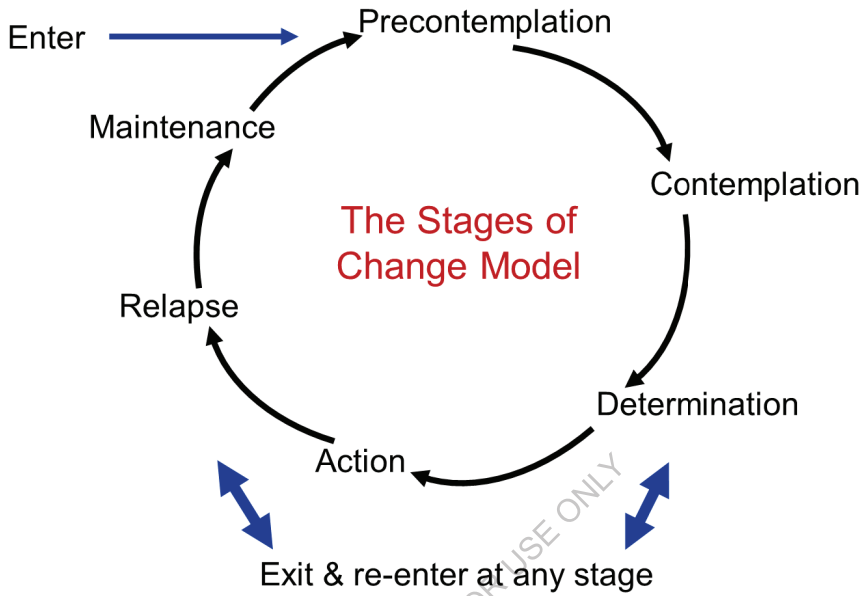
Helping people change their lifestyle will be effective and efficient when done in accordance with the behavior change stage processes attained by the individual or group of individuals.

Therefore, it is very important to identify the level of behavior stage processes attained by the individual or group of individuals.

Therefore, it is very important to identify the level of behavior stage attained by individual or group of individuals before a giving behavior change intonation is implemented for effectiveness and efficiency of the program.

The behavior change stage model is illustrated on the next page for better understanding:

“The groundwork for all happiness is good health.” – **Leigh Hunt**



3.6 Relevance of Behavioral sciences to Health Education

It is said that human being is a social animal because people live in social groups in need of security. Human being is also called a social animal that actually thinks and acts logically.

The issue of accessibility, affordability, and acceptability health service doesn't guarantee health care service utilization for the social aspects of human life is equally important factor in this regard. The community, itself, cares for its members in all cases where there is acceptable and proper social intercalation.

“Men worry over the great number of diseases, while doctors worry over the scarcity of effective remedies.” – **Pien Ch'iao**

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Behavioral sciences such as psychology, anthropology, sociology, etc are highly related to health education in one or another way; a group has a behavioral pattern which is called human behavior. Social sciences and medicine are concerned with their own ways with human behavior; social science is applied to disciplines like sociology, anthropology, psychology, economics, politics, etc, and these influence medical practices, and the influence can clearly be illustrated as follows:

The fact that health education is also concerned with behavior change communication and it is one of the tools of health promotion in addition to social marketing, social mobilization and advocacy, relevance of social sciences to health education is remarkably justifiable.

3.7 Diffusion of innovation

There are a number of theories on stages of adoption and diffusion of innovation and communication. Among these, diffusion theory is the important one and it is based on works in communication and extensive experience in agriculture, education, family planning and public health in general.

Behavior change is analyzed over time, and the stages through which behavior is adopted are observed at individual and societal level. Individuals pass through stages labeled as awareness, interest, persuasion, decision and adoption

Not: Diffusion is the process of borrowing culture traits, complexes or patterns from other individuals or/and societies directly or indirectly.

“He who takes medicine and neglects to diet wastes the skill of his doctors.” – **Chinese Proverb**

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3.8 Adoption of innovation

Decision to adopt an innovation is made after multiple contacts with a variety of communication channels (media mix) over along period.

Types of adopters (categories of adopters) include early adopters, early majority, late adopters and late majority.

Stages in the adoption of innovation

The process of adoption of innovation can be summarized in the following 5(five) stages which is supplementary to the stages of behavioral change illustrated in figure 1 of this material.

Stage -1- Stage of awareness- here, the individual learns the existence of an idea or practice, but has little knowledge about it.

Stage -2-Stage of interest -here, the individual develops interest in the idea, and seeks more information about it and considers its general merits.

Stage- 3- Stage of evaluation- here, the individual makes mental application of the idea and weighs its merit for his/her own situation.

Stage- 4- Stage of trial- here, actual application of idea, usually on a small scale.

Stage- 5- Stage of adoption- here, the acceptance of the idea leads to continual use.

Those who do not find time for exercise will have to find time for illness. **Edward Smith-Stanley**

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3.9 Behavior change in population

Not all people change their behavior; some people are apt to change and others are reluctant to change. Based on researchers' findings, in any given society, there are four types of people taking their response to change: some are quick while others are resistant to change.

- A very small percentage of people (2-3%) accept new ideas without any question and these include people who come up with new ideas and those who are early adopters of behavior

Example- community leaders who are also known as opinion leaders or gate keepers.

- Some people don't take the new ideas readily (15%). But they prefer to observe the behavior from other people who are accepted by the community (opinion) leaders.
- The great majority (about 65%) say -- ok-- but later on it is not usually easy to see them practicing the new behavior. This is the group that is difficult to change.
- No matter what one says or does, about 17% will not accept the new idea. This group includes grandparents (older people).

Note: Each of the above groups, fortunately, has group leaders. If health professionals identify and use them, they can change behavior of others.

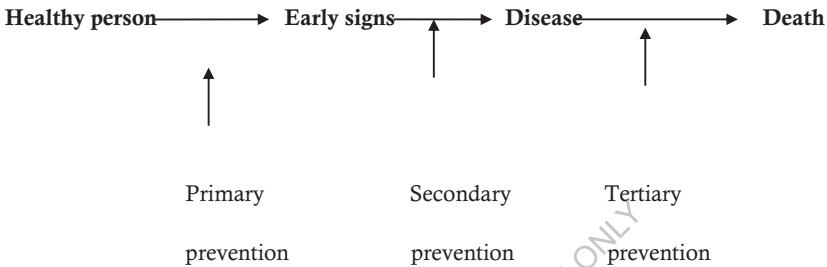
Without health, life is not life; it is only a state of languor and suffering- **Francois Rabelais**

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3.10 The role of human behavior in prevention of disease and promotion of health

What is prevention?

Prevention is defined as the planning for and the measures taken to forestall the onset of a disease or other health problem before the occurrence of undesirable health events. There are three distinct levels of prevention: primary, secondary, tertiary prevention.



Levels of prevention of disease

1. Primary prevention

Primary prevention is comprised of those activities carried out to keep people healthy and prevent them from getting disease. Examples of important behaviors for primary prevention includes using rubber gloves when there is a potential for the spread of disease, immunizing against specific diseases, exercise, and brushing teeth. And any health education or promotion program aimed specifically at prevention of the onset of illness or health problems is also an example of primary prevention.

“The best of all medicines is resting and fasting” ~
Benjamin Franklin

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Example: Health Education Program on Condom use to prevent HIV/AIDS

2. Secondary prevention

Secondary prevention includes preventive measures that lead to an early diagnosis and prompt treatment of a problem before it becomes serious. It is important to ensure that the community can recognize early signs of disease and go for treatment before the disease become serious.

Example: Health Education Program on Early Treatment of STI

Tertiary prevention

Tertiary prevention seeks to limit disability or complication arising from an irreversible condition. Even at this stage actions and behaviors of the patient are essential. The use of disability aids and rehabilitation services help people from further deterioration and loss of function. For example, a diabetic patient should take strictly his/her daily insulin injection to prevent complications.

Example: Health Education Program on positive living with HIV/AIDS

3.11 Behavior Change Models

Models: are generalized hypothetical concepts that directly or indirectly interact one another in an organized manner.

Models are important to propose a working set of determinants or factors in situations where there are too many determinants or factors, which differ by various characteristics, so that different scholars can have a certain workable guideline.

To keep the body in good health is a duty...
otherwise we shall not be able to keep our
mind strong and clear." ~ Buddha

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Theories: are explanations or accounts of some phenomenon, a way of making sense out of things

When trying to understand a given health behavior or design a certain program to change behavior (health behavior), the behavior change models such as Health Belief Model, help to organize thinking, prioritize

Issues, prevent planners from overlooking important factors, and guide the development and enforcement of health education.

3.12. Health Belief model (HBM)

Health Belief model is a behavior change model which has been developed by a group of psychologists in the 1950s to help explain “why people would or would not use health services”. It is one of the most frequently used and being used in health behavior applications of health. The theory has helped explain different behaviors related to health.

Components of Health Belief model

This model has four well formulated components known as perceived susceptibility or risk, perceived severity, perceived benefit and perceived barrier, and two being evaluated components known as cues to action and self-efficacy.

- a. **Perceived susceptibility (risk)** refers to the individual's perception of the risk of contracting a health problem, which may, finally, lead the individual to examine his own behavior.
- b. **Perceived severity** refers to an individual's perception on the potential seriousness of the condition (a health or health related problem) in terms of pain or discomfort, disability, economic difficulties, death, etc which help the individual seriously consider his behavior and its consequences.

"Before thirty, men seek disease; after thirty, disease seeks men."

Chinese Proverb

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- c. *Perceived benefit* includes the perceived benefits of taking health action and its helpfulness which lead the individual to maintain the act and raise his/her confidence.
- d. *Perceived Barriers* are events which may act as obstacle in adopting the recommended behavior leading the individual not attaining the behavior. For a health action to take place, therefore, barriers should be either removed or reduced to the minimum. Some of the barriers could be cost, side effects, cultural influences, inconvenience, etc.

Modifying Factors

- A. Age
- B. Gender
- C. Ethnicity
- D. Personality
- E. Socioeconomics
- F. Knowledge

Individual Beliefs

- A. Perceived susceptibility to & severity of disease - Perceived Threat
- B. Perceived Benefits
- C. Perceived Barriers
- D. Perceived Self-efficacy

Action

- A. Individual Behavior
- B. Cues to Action

"He who cures a disease may be the skillfullest,
but he that prevents it is the safest physician."

Thomas Fuller

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3.13. Theory of Reasoned Action

This theory is also called behavioral intention, and assumes that behavioral intention is a basis for a behavior to be adapted. Reasons or intentions behind an action determine the practice. The intention comes from the values attached to the behavior.

Behavior performance is a function of attitude towards behavior and perception of social or subjective norms favorable to the behavior.

Note: *It would be very important to note that for a behavior change to be sustainable, the change in behavior should necessarily come after change in attitude; a behavior change without change in attitude is less likely to be SUSCTAINABLE. Look at the figure below:*



3.14.3. Social learning (Cognitive) Theory

Unlike the two theories explained above, the Social learning (Cognitive) theory examines behavior in relation to the environment. Social learning theory (SLT) believes in that behavior is dynamic. It emphasizes that people self-regulate their environments and actions. The interaction of people with their environment is multilateral (environment, people, and behavior) interaction.

Free education and health care are essential for the welfare of the population.

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Self-efficacy is the core concept in Social learning theory (SLT). Self-efficacy is a perception of one's own capacity for success in organizing and implementing a pattern of behavior that is new, based largely on experience with similar action or circumstances encountered or observed in the past.

According to this theory, learning takes place through the following ways:

- a. Direct experience; learning through doing
- b. Indirect experience; learning through observing others doing the job
- c. Cognitive learning; storing and processing of complex information (evidence based).

Trans theoretical model

This model critically assumes that behavior change is Complex and a process that involves sequences of change. The stages are both stable and open to change. The stages are both stable & open.

The model has two dimensions: stage of change and process of change. The constructs of the model are stage of change, process of change, decisional balance and self-efficacy.

The stage of change includes:

- *Pre contemplation stage: Force able, resistance to change*
- *Contemplation stage: Willing but poor commitment*
- *Preparation stage: Intending change (in one month)*
- *Action Stage: Overt modification of behavior (For greater than six months)*
- *Maintenance stage: Sustainable behavior change*

Life is not merely being alive, but being well.

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The Process of change includes:

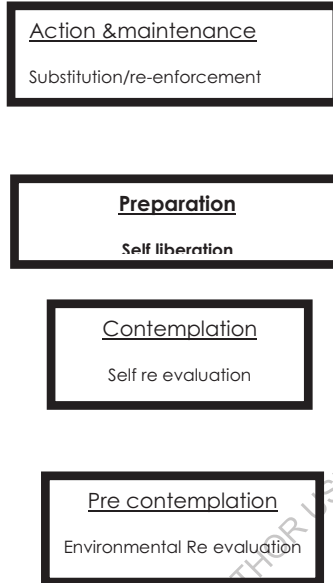


Figure- Constructs of trans theoretical Model

Without health, life is not life; it is only a state of languor and suffering.

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Approaches to the diagnosis of health behavior

A starting point for understanding the factors that influence people's decisions about adopting a behavior is to define the behavior in as much detail as possible. This involves specifying not only what the behavior is but also who is to carry it out and why.

It is difficult to analyze vaguely stated behaviors such as "HIV prevention" but easier with more precise statements that specify the method of prevention (e.g.-condom Use) and the skill of condom use.

To be effective in diagnosing a given health behavior of individuals, group of individuals or community, **formative assessment** of desired behavior and target audience profile should be made, and this assessment provides:

- a. Insight into the knowledge, attitudes, preference, behavior of primary and secondary audience
- b. A description of community infrastructures, networks, potential partners, BCC agents (gate keepers)
- c. Knowledge about the available audience related channels

Specifically, insights about audiences such as risk behaviors, current and desired behaviors, psychological factors (both enhancing and inhibiting to behavior change), habits, and external factors should be assessed in advance **through research and community participation**.

Example:

Psychological factors include perception of risk, barriers to behavior change, perceived key benefits, motivation to make changes, future hopes and fears.

Habits include risk and other current behaviors, desired behavior, media habits, entertainment habits, health care seeking habits, and purchasing habit.

"Be careful about reading health
books. You may die of a misprint." ~
Mark Twain

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External factors include settings for risk, opinion leaders, and services for health, communication resources and infrastructures

Important questions that should be addressed during the analysis process of the target audience include the following general profiles (taking HIV/AIDS as a problem youth specifically)

- Where do they live?
- How do they make a living?
- How many partners do they have?
- Why do they have many partners? (if so)
- Do they feel at risk?
- Do they have personal power?
- Where do they want to be in the coming five years?
- What are their fears and hopes?

In assessing behavior, both the current (existing) and desired behaviors should be considered and investigated.

Example: HIV / AIDS prevention

<i>Existing Behaviors</i>	<i>Desired Behaviors</i>
Self-medication for STDs	Seeking proper treatment at clinics
Using condoms only with perceived “un clean” partners	Using condoms with all partners.
Having multiple partners	Reducing number of partners.

"Neurotic behavior is quite predictable.
Healthy behavior is unpredictable."

Carl Ransom Rogers

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Note:

A check list for describing a behavior should include how often a practice should be performed, how complicated it is to carry out, how similar it is to the existing practices, how easily it fits to the existing practice, how much it costs, whether the behavior fits to the felt need of the community, how much impact will the behavior can have on health, and whether beneficial effects can be observed in the short or long term.

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care of your body. It's the only place you have to live."

Jim Rohn

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3.15 Review Questions and Answers of Chapter 3

PART ONE: CIRCLE THE CORRECT ANSWER

1. is an action that has specific frequency, duration and purpose; whether conscious or unconscious.
 - A. Behavior
 - B. Attitude
 - C. Practice
2. Multiple variables affect (influence) a person's health status as external factors except
 - A. The person's culture.
 - B. Physical environment.
 - C. the person's genetic make-up
3. According to the Health field concept, determinants of health can broadly be categorized as the following, which one is true
 - A. Environmental
 - B. Biological
 - C. behavioral and health care delivery system factors
 - D. All the Above
4. are factors which motivate the behavior to occur, and these include knowledge, belief, attitude, confidence and values.
 - A. Predisposing factors
 - B. Enabling factors
 - C. Re-indorsing factors
5. are broad ideas and widely held assumptions regarding what are desirable, correct and good that most members of a society share.
 - A. Values
 - B. Attitudes
 - C. Norms

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PART TWO: DIRECT QUESTIONS

1. Mention Factors affecting human behaviour
2. Explain Type Change in human Behavior
3. What is Health Belief model (HBM)?
4. Differentiate between behaviour and attitude?
5. List Characteristics of culture?

ANSWERS OF DIRECT QUESTIONS

1. Factors affecting human behaviour are

- A. Predisposing factors
- B. Enabling factors
- C. Re-indorsing factors

2. Type Change in human Behavior

- A. Natural change in behavior
- B. Planned change in behavior
- C. Readiness to change behavior

3. **Health Belief model (HBM)** is Health Belief model is a behavior change model which has been developed by a group of psychologists in the 1950s to help explain “why people would or would not use health services”.

4. **Attitudes** are relatively constant feelings, predispositions or set of beliefs directed towards an object, person or situation **while Behavior** is an action that has specific frequency, duration and purpose; whether conscious or unconscious.

5. Characteristics of culture are

- A. Culture is shared.
- B. Culture is learned.
- C. Culture is adaptive.

Part One:
T&F

1. A
2. C
3. D
4. A
5. A

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CHAPTER FOUR: WORKING WITH COMMUNITIES

Learning Objectives

At the end of this chapter, the student will be able to:

- Explain the concept of community and community participation
- Describe the benefits of community participation in the achievement of health education programs.
- Explore the mechanisms of achieving community mobilization for common goal and the role of community leaders towards this issue.

4.0 Introduction

In the past, health education follows approach to force behavior change among individuals. However, health education program underscores an informed decision-making approach emphasizing community participation and empowerment.

When the idea of primary health care was launched, community participation was one of the important principles identified for its implementation. Although everyone talks about it, real community participation is rarely practiced.

4.1 What is community?

Community could be defined as organized groups of people who share a sense of belonging, beliefs, norms, and leadership and who usually interact within a defined geographical area.

E.g. People living in a “Kismayo” or Baydhabo”. People organized under one religion etc

4.2 The concept of community participation

The health of the community will improve only if the people themselves become involved in planning, implementing, and having a say about their own health and health care. Nevertheless, involvement will not just happen.

"Some remedies are worse than the disease."

Publius Syrus

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We may say communities are participating when they are actively involved in:

- ✓ The assessment of the situation/needs
- ✓ Problem identification
- ✓ Priority setting and making decisions
- ✓ Sharing responsibility in the planning, implementing, monitoring and evaluation.

Checklist for identifying the degree of participation in a program:

- Is the community involved in planning, management, control and evaluation of the health program at community level?
- Are community representatives nominated in decision-making at higher levels?
- Are deprived groups, such as poor, landless, unemployed, and women, adequately represented in the decision making process?
- Are local resources such as labour, buildings, money etc... exhaustively used?

4.3 Benefits of community participation

- It leads development endeavors to success.
- Shifts the emphasis from the individual to the community e.g. If all members of a community are convinced of the benefits of cleanliness, they will help each other to find pure water sources and keep such sources clean. They will build and use latrines everywhere in the community and keep them clean as well.
- Ensures community motivation and support. If the community is involved in choosing priorities and deciding on plans it is much more likely to become involved in program implementation and take up of the services because they are seen to be meeting their needs.

“The only way to keep your health is to eat what you don't want, drink what you don't like and do what you'd druther not.”

Mark Twain

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- Promotes self-help and self-reliance. If community members do their own development work, they learn and become more conscious of their needs and potentials for solving their own problems, they make use of local skills, they learn to be responsible for projects and their maintenance, and they gain the necessary self-confidence to tackle further and perhaps more complicated development projects.
- Improves trust and partnership between the community and health workers.

4.4 The Role of Health Extension Workers

Success in community participation involves a series of overlapping stages.

They include:

- Knowing the community
- Learning about the community (its structure and pattern)
- Contacting with families, leaders and community groups.
- Discussing on concerns and felt needs.
- Taking some actions:
 - Further activities and organization building
 - Build up-on existing community organization or associations.
 - Formation of committee e.g. Health committee
 - Educational in-puts
 - Select and train volunteers
 - Decision making on priorities

In the process of promotion of community participation, community leaders are very essential.

Trust and partnership between the community and health workers is important.

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Who are the leaders?

A leader is a person whose ideas or actions influence others to get things done that the people want done.

- Could be a person of wisdom and sound judgment
- Might be one whose advice has been valuable in the past.
- Might be wealthy and powerful
- Is known to be religious

Why are leaders important?

- Usually make decisions that result in success or failure of a project
- They are trusted and the community members are ready to work with them.
- Help people in the community know you and gain confidence in you.
- Serve as an officer in an organization or chairperson of a committee.

In summary, the most important resources for the promotion of health are the people themselves. Through community participation, you can use that resource to improve the health of the people. However, successful community participation is not as simple as people may think. It requires a demanding task of working with the local communities, holding dialogue, initial teaching and awareness-raising activities, supporting community organization, and being able to convince and work with community leaders. However, overcoming all the challenges and achieving community participation require systematic and careful planning. Obviously, this is the usual challenge for the community health educators

A leader is a person whose ideas or actions influence others to get things done that the people want done.

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4.5 Review questions and answers of chapter 4

PART ONE: CIRCLE THE CORRECT ANSWER

1. The health of the community will improve only if the people themselves become involved in
 - A. Planning
 - B. Implementing
 - C. Having a say about their own health and health care.
 - D. All the above
2. We may say communities are participating when they are actively involved in:
 - A. The assessment of the situation/needs
 - B. Problem identification
 - C. Priority setting and making decisions
 - D. All the above
3. is a person whose ideas or actions influence others to get things done that the people want done?
 - A. A leader
 - B. Manager
 - C. Chief
4. Which one of the following are Benefits of community participation?
 - A. It leads development endeavors to success.
 - B. Shifts the emphasis from the individual to the community
 - C. Ensures community motivation and support.
 - D. All the above
5. Success in community participation involves a series of overlapping stages.
 - A. Knowing the community
 - B. Learning about the community (its structure and pattern)
 - C. Contacting with families, leaders and community groups.
 - D. Discussing on concerns and felt needs.
 - E. Taking some actions
 - F. All the above

PART TWO: DIRECT QUESTIONS

1. Who are the leaders?
2. Why are leaders important?
3. List Benefits of community participation?
4. What is community?
5. What are The concept of community participation?

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ANSWERS OF DIRECT QUESTIONS

- 1- **Leader** is a person whose ideas or actions influence others to get things done that the people want done
- 2- leaders important because of the
 - A. Usually make decisions that result in success or failure of a project
 - B. They are trusted and the community members are ready to work with them.
 - C. Help people in the community know you and gain confidence in you.
 - D. Serve as an officer in an organization or chairperson of a committee.
- 3- Benefits of community participation are
 - A. It leads development endeavors to success.
 - B. Shifts the emphasis from the individual to the community
 - C. Ensures community motivation and support.
- 4- **Community** could be defined as organized groups of people who share a sense of belonging, beliefs, norms, and leadership and who usually interact within a defined geographical area.
- 5- **The concept of community participation**

The health of the community will improve only if the people themselves become involved in planning, implementing, and having a say about their own health and health care. Nevertheless, involvement will not just happen.

Part one: T&F

1. D
2. D
3. A
4. D
5. D

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CHAPTER FIVE: HEALTH COMMUNICATION

Learning Objectives

At the end of this chapter, the student will be able to:

- Define communication
- Discuss the components of communication
- Explore methods of communication
- Explain stages of communication
- Identify barriers to effective communication and how to overcome them

5.0 INTRODUCTION

Communication is the core of health education and promotion programs. In human society communication can play an important part in daily life. We have the advantage of language, spoken words, songs, and written scripts and so on. It is by communication that an individual makes himself/herself to understood by others. This act requires an appropriate design so as transmit an effective message.

5.1 What is communication?

Communication is the process of sharing of ideas, information, knowledge, and experience among people to take action.

Communication may take place between one person and another, between an individual and a group or between two groups.

Communication facilitates creation of awareness, acceptance and action at individual, group and inter-group level. The process always involves a sender and a receiver regardless of the number of people concerned.

Communication- is a process by which an idea is transferred from a source to a receiver with the intent of establishing commonness or to change behavior.

"Attention to health is life greatest hindrance."

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Health Communication-is an art and a technique of informing, influencing, and motivating individuals, institutions, and public audiences about important health issues. It applies the principles and methods of the general communication to convey health messages to improve health status of the community.

Health communication, together with the program components, can change behavior sustainably and adopts procedures or acts quickly, whereas when it is done alone, (without other program components), health communication can result in the following:

- Increases awareness and knowledge
- Influences perception, beliefs and attitudes, etc
- Promotes action
- Demonstrates or illustrates skill
- Shows benefit of behavioral change
- Increases demands for health services
- Re-enforces knowledge, attitude, or behavior
- Strengthens organizational relation ship
- Refuels misconception
- Advocates health issues or messages

Organizational Communication- is also called serial communication, and occurs in our day-to-day (routine) organizational activities such as report writing, verbal preparation, official letters, recommendations and other documents which, usually, take a long period of time(from hours to years) to be communicated.

*te: If health communication is integrated with other program
ponents, it can change behavior sustainably and adopt acts or
cedures quickly.*

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Organizational communication, like any other communication types, applies the methods and principles of the general communication process, and it mainly refers to a communication process which occurs in organizations such as universities, hospitals, factories, etc where there is verbal official relationship.

Organizational communication is called serial because it passes through a series of bureaucracies to be communicated.

5.2. Communication process

Communication is an essential part of human life. It is attached to almost anything that people do; individuals carry out most of their daily activities through communication.

Communication creates dynamism and interaction with the environment where people live; through communication people learn, create mutual understanding, establish relationships, change or maintain behavior and lead life. Communication process, generally, has six (6) components or elements and these are: **Source** (is originator of message), **Message** (an idea that is communicated-something that is considered important for people in the community to know or do which shouldn't be seen as single wave of communication but a series of transmission), **Channel** (is a physical means by which message travels from a source to a receiver which includes verbal, visual, printed or combined audio-visual and printed materials), **Receiver** (is a person or group for whom the communication is intended), and **Effect and feedback** (response) (Effect is the change in receivers knowledge, attitude, and practice or behavior while feedback (response) is the mechanism of assessing what has happened on the receiver after communication has occurred- the effect of communication could be either positive in which case the desired change in KAP occurs or negative in which case the desired change in KAP does not occur).

1) Source (sender)

Originator of message can be from an individual or groups, an institution or organization. People are exposed to communication from different source but Mostlikely to accept a communication from a person or organization that they trust i.e. has high source credibility. Depending on the community, trust and source credibility may come from:

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- ✓ Personal qualities or actions e.g. a health worker who always comes out to help people at night.
- ✓ Qualification and training
- ✓ A person's natural position in the family or community, e.g. village chief or elder.

2) Message

It consists of what is actually communicated including the actual appeals, words, and pictures and sounds that you use to get the ideas across.

A message will only be effective if the advice presented is relevant, appropriate, and acceptable and put across in an understandable way.

A message is said to be good if it:

- Is Epidemiologically correct (evidence based)
- Is affordable (feasible)
- Requires minimum time/effort
- Is realistic
- Is culturally acceptable
- Meets a felt need
- Is easy to understand

3) Channel

A Channel is a physical means by which message travels from a source to a receiver. The commonest types of channels are verbal, visual, printed materials or combined audio visual and printed materials. Your choice of channel will depend on what you are trying to achieve, the nature of your audience and what resources are at your disposal.

4) Receiver (Audience)

The person or a group for whom the communication is intended

The first step in planning any communication is to consider the intended audience.

Before communication, the following characteristics of audiences should be analyzed.

- Educational factors: can they read? What type of appeals might convince them?
- Sociocultural factors: What do they already believe and feel about the topic of communication?

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- Patterns of communication: how people show respect when talking to another person? What time of the day and which programs do they listen? Which places do they pass that might be good places to put up posters?

5) Effect and feedback

Effect is the change in receiver's knowledge, attitude and practice or behavior.

Feedback is the mechanism of assessing what has happened on the receiver after communication has occurred.

Note: Encoding involves the selection of specific signs or symbols (codes) to transmit the message (eg. Tone of voice), whereas decoding means relating the message perceived to the receiver's store house of knowledge and experience to sort out the meaning of the message.

5.3. Types of communication

There are different ways of classifying communication. The classification can be made on the basis of mode (channel) of communication (as verbal and non-verbal communication), feedback of communication (as mass media and form of interpersonal communication) and number of communicators involved (as intrapersonal, interpersonal, group and mass communication).

1. *Intra-personal communication*

This type of communication occurs within an individual and is limited at that level. This part shows how people process and understand a message within. The understanding of people could be affected by a number of factors including previous experience, language, culture, personal need, etc.

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Example: the way people communicate the moment they see a lady with completely shaved head hair and totally dressed in black, who previously had long hair and a habit of using different fashion styles.

2. *Interpersonal communication*

This type of communication occurs between individuals or within groups, and it includes interactions that happen often together or are made together at the same time and place.

Example: Communication between health care provider and patient, teacher with students, health educator with client, etc. In most instances, the decisive criterion for personal communication is that the communication, in this case, happens at the same time and place.

Counseling and individual health education can be categorized under this type of communication

Advantages of interpersonal communication

a) Dynamic or bidirectional communication

Here, the communication takes place in both directions; from the source to the receiver and vice versa.

b) Questions can be asked and answered

Here, there is a chance to raise questions and discuss so that the idea is understood at the same time & place.

c) Multi-sensory (channel) approach

Since the communication is active where both the source and the receiver are interacting, the communication could utilize more than two senses such as seeing, hearing and touching, and tasting.

Communication is one of the most important skills you require for a successful life. Catherine Pulsifer

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d) Useful in all stages of adoption of innovations

Adoption of behavior passes through different stages. A person may become aware of a given behavior; however, he/she may not practice the behavior.

Example: knowledge about HIV/AIDS is not adequate to prevent the acquisition of HIV/AIDS! Use of condom for any sexual exposure effectively needs further development in behavior adoption such as change of attitude, readiness, trial, etc. these types of behaviors, therefore, require continuous efforts, professional support and counseling.

Limitations of inter personal communication

In spite of all the above advantages of interpersonal communication, it is limited in that it requires language ability of the source (often needs multi-lingual), it needs personal status, and needs professional knowledge and preparation.

Making interpersonal communication effective

To make interpersonal communication effective, health educators and health education professionals should pay attention to the following 5 (five) general points:

- a. Exchanging ideas with clients (participating clients)
- b. Realizing the importance of first impression when meeting a person
- c. Learning to observe the person and deriving useful information
- d. Keeping in mind that the same words mean different things to different persons.
- e. Paying attention to the body language: non-verbal behaviors tell often more about people's feelings than the words spoken.

Get to the point quickly to prove that what you're saying is worth reading or listening to, otherwise people will lose interest. Corrina Thurston

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3. *Group communication*

Group Process- is a psychological interaction and change that take place within the group and the different roles played by the individual members in the group. *Group health education can be categorized under this type of communication.*

Group- is a collection of people who share some characteristics and interact; it is not a mere collection of people as in the case of aggregate. The ideal size of a group is 4 up to 24 people

Characteristics of formal groups

- They are powerful (common goal oriented)
- There is specifically stated or understood membership always
- They have already recognized leader (elected by members or appointed by officials)
- They have organized activities and meetings
- They have governing rules and regulation

Note: *Unlike formal groups, informal groups are not easily manageable for to attain educational objective as they have no common goal and interest. Therefore, to make these groups manageable, the following four important points should be considered:*

- I. Finding out common goals and interest
- II. Developing relationship and encouraging participation
- III. Making people in the group feel welcome
- IV. Pointing out uncommon interests

Emotional awareness is necessary so you can properly convey your thoughts and feelings to the other person. Jason Goldberg

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Formation of groups

When we form a group, it would be inevitable to go through the following four consecutive stages:

Stage-1- Forming Stage (individual oriented stage)

Stage-2- Conflict stage (storming stage)

Stage-3- Norming stage (normalization stage)

Stage-4-Cohesive stage (performing stage)

Group dynamics- is an aspect of a group that tells us what is happening among group members or in the group itself. It is a force in the group situation that determines the behavior of the group and its members (Jenkins, 1974).

Group dynamics is a way of looking at groups. Every group has its own unique dynamics and constantly changing pattern of force from within and that shapes the person's behavior.

To study the dynamics of a group, several factors, in addition to the group's structure and organization, may be analyzed and these include:

Commitment, leadership style, diffused leadership function, decision making methods, members' behavior, interaction patterns, group cohesiveness, and group power.

We usually concentrate on the task or the work to be done and not on how things are proceeding. Group dynamics keeps the group together. It is very important for maintaining the group, it tells about the group members' feelings, roles and contributions. Here, one can read the feelings of the individual members like anger, nervousness, tiredness, or boredom, etc

Emotional awareness is necessary so you can properly convey your thoughts and feelings to the other person. Jason Goldberg

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In group dynamics, one should find out the following:

- Who is participating and who is not? When and how?
- Who have the influence? How?
- How are decisions made?
- Who is helping in task achievement, and who is helping in the maintenance of the group (gate keeping function)?
- How is one accepted as a member of the group?
- What feelings are observed and felt?
- What is the norm of the group? (what is permissible and what is not permissible)?

Note: In a group where there is coherence, we expect success, where as if disagreement prevails, there will be a failure.

Leadership is a highly interlinked concept with communication and it hence requires good communication skill in group process, and generally the leadership styles have been described as: **Autocratic** (where leaders make decision for the group), **Democratic** (where the leaders participate as facilitators encouraging group discussion and decision), **Laissez-Faire** (where the leaders participate minimally and often only on the request of members) and **Diffused** (where group functions are distributed among members)

"Communication sometimes is not what you first hear, listen not just to the words, but listen for the reason." Catherine Pulsifer

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Listed below are some descriptive statements about effective leadership:

- Effective leaders use a style that is natural to them and appropriate style to the task and the members
- Effective leaders assess the effect of their behavior on others and on themselves
- Effective leaders are sensitive to the force acting for and against change
- Effective leaders express an optimistic view about human nature
- Effective leaders are energetic
- Effective leaders are open and encourage openness
- Effective leaders facilitate personal relationships
- Effective leaders plan and recognize activities of the group
- Effective leaders are consistent in behavior
- Effective leaders delegate tasks and responsibilities
- Effective leaders value and use group members' contribution
- Effective leaders encourage creativity
- Effective leaders encourage feedback about their leadership style

4. Mass media communication

Mass media communication is a type of mass Communication and the aim of mass media communication is to create awareness on a given problem, to transmit knowledge, to set and change norms, and to offer alternatives of behavior.

"Verbal communication is essential in order to understand what is going on inside other people. If they do not tell us their thoughts, their feelings, and their experiences, we are left to guess." Dr. Gary Chapman,

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The word media is used, currently, to refer not only to print media, radio and television but also covers traditional means of communication such as art, town cries, songs, role play, puppet shows and dance. Combining these with interpersonal approaches is very useful and may be critical to the success of communication. Mass media messages must be very carefully designed so that the right message gets to the target audience in a form appropriate to their needs and life styles. It should be realized that there is poor, if not none, feed back when utilizing a mass media.

It is one way of giving health education. The communication that is aimed to reach the masses or the people at large is called mass communication. The media that are generally used for mass communication go by the name of mass media. The commonly used mass media are microphones or public address system, radio, television, cinema, newsprints and posters.

Mass media are the best methods for rapid spread of simple information and facts to a large population at low cost. However, the major concerns with this method of communication are availability, accessibility and popularity in a given community.

Note: Mass media have greatest impact at creating awareness for a larger number of people, communicating new ideas to early adopters (opinion leaders), increasing self- awareness and knowledge, which is the first stage to influence feelings of people and then their decision making.

"Children should be provided with activities that encourage them to talk a lot. This will help them to increase their use of words and improve their communication skills." C. F. Crist,

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Advantages of mass media

Mass media have the following 3(three) general Advantages:

- a. They reach (can reach) many people quickly
- b. They are (usually) believable especially when the media use or broadcast “Voice” of a highly respected person of different profession and background.
- c. They can provide continuing reminders and reinforcement

Limitations of mass media

In spite of the above advantages of mass media, they are limited in that they are one sided, don't differentiate the target audience, and the stimuli emanating from these types of communication oblige the individual to develop a filtering mechanism in order to perfect him/her.

Traditional means of communication

These are also called popular art forms and they are usually put under mass media communication and yet they differ to some extent.

These forms of communication are useful for the following 10 general reasons:

- They are realistic and are based on the daily lives of the average citizens.
- They can communicate attitudes, beliefs, values, and feelings in powerful ways.
- They can motivate people to change behavior
- They communicate problems of community life
- They can show ways to solve problems
- They may not require modern education or literary in the majority of instances
- They can improve participation and self- esteem development
- They are, usually, very interesting; they can be funny, sad, serious or happy.
- They are easily understood and captured
- They usually cost very little or no money; only imagination and practice are required.

Eye contact is one of the primal ways of communicating. Clive Harman

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5.4- Communication in Health Education

Communication in health education is a vital process, and the process consists of six (6) consecutive stages:

Stage-1- Reaching the intended audience

Stage-2- Attracting the audience's attention

Stage-3- Understanding the message (perception)

Stage-4- Promoting change (acceptance)

Stage-5- producing a change in behavior

Stage-6- Improvement in health

5.5- Communication model

In order to show clearly what communication looks like and the parts that make up communication, schematic presentations are used. There are two types of simple models of communication known as *linear (one-way) and systems (two-way) models*.

A. *Linear (one-way) model*

In this type of communication, information flows from the source to the receiver and the communication is unidirectional (in one direction).

"The best speakers in the world are the best storytellers. Larry Hagner

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This model doesn't consider feedback and interaction of the receiver with the source. The communication is dominated by the sender's knowledge- the information is poured out.

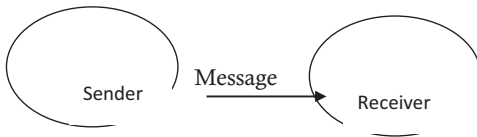


Figure- Linear communication model

In this type of model, messages from “experts”, “educators”, or people who know more about a specific content are included. It should be noticed that messages from many of the mass media flow in one direction unless mechanisms are set to get feedback from the audience.

This is a linear type of communication in which information flows from the source to the receiver. There is no input (feedback) from the receiver. It is commonly used in advertising; the message is designed to persuade the receiver to take action prescribed by the sender. The model is best used by organizations when the message is simple and needs to be communicated quickly, for example, the date and time of a public meeting.

There is no opportunity to clear up Misunderstanding and meaning is controlled by the receiver.

Sender→Message→Channel→Reciever

B. Systems (two-way) model

In recent times, people considered communication as a process. The process is dynamic and the flow is in both directions; information flows from the source to a receiver and back from the receiver to the source. In reality, most communications required to create understanding or change behavior are interactive.

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2. Two-way communication

As the message is more complex, two-way communication becomes essential. In this type of communication, information flows from the source to the receiver and back from the receiver to the source. The addition of feedback allows the sender to find out how the message is being received and so it can be monitored and adapted to better suit the receiver's needs.

Sender→Message→Channel→Receiver - Feedback

For example, a health professional counseling a mother for accepting family planning methods, needs to know what the mother feels about the new behavior and about her problems.

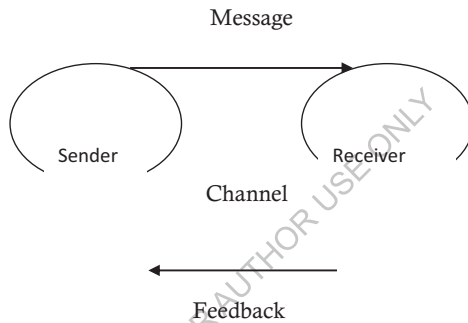


Figure- Systems communication model

By nature, we tend to speak our own language.
Gary Chapman

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5.6- Qualities of effective communication

For effective communication, the following five general points should be considered; we should communicate when we have to communicate; communication is purposeful; it is not important to communicate unless there is a need and a purpose behind it.

Ideas must be clear to one self before communicating to others; if we are communicating ideas in which we are not clear, it will be very difficult to create understanding. Thinking of the behavior, its calluses and effects will be helpful. We have to also try to find out the most important reason (s) for the behavior to happen.

Get prepared first.

Preparation is one quality of effective communication, and this should include knowing the purpose or objective or relevance of the ideas, identifying the targets, assessing the extent and scope of the idea to be communicated, the place where the communication takes place, and how best the idea could be communicated, making it clear and brief, and making presentation short and clear as this facilitates easy and more capturing of ideas than long and complex presentation-[The issue of **KISS!**]

Develop natural style

Although we can learn how to present, each person has his/her own natural way of presenting ideas. Some communities commonly understand most reactions in similar way. Therefore, expression of emotions should be natural and understandable.

Check whether you are understood or not.

The communicator (sender) should develop a mechanism of checking that he/she is being understood by the audience for effectiveness, and this is usually done by getting feedback! Posing questions and listening to the audience.

"Every man needs to express great love as every women needs to feel great love." Tito Tinajero,

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Use simple straight forward language

Remember that your audience could be of different background. Even with the same background, people understand things not the same way; simple language helps communicate the ideas in understandable way.

Listen to ideas of people

Careful listening to the problems and talking to people is important as it helps to identify their feelings and establish good rapport.

Mode and Method of Communication

Modes and methods of communication can be grouped as spoken words or verbal (which is the most natural and common method), written words (includes any printed material), pictures (pictorial presentations), music/sounds (artistic presentation of message), non-verbal communication or body languages (facial expressions, posture, movement or gestures, body position, tone of voice) and any combination of the above methods.

Approaches to Communication

The common communication approaches include **Informing** (introducing and making a “new idea” familiar), **Educating** (explaining about the strength or weakness of a “new idea”), **Persuading** (the receiver is persuaded to accept “new idea”), and **Entertainment** (attracting the attention of the audience to a “new idea”)

Note: *The 5Cs of effective communication are Clear, Concise (Brief), Complete, Convincing and Capable of being duplicated.*

The single biggest problem in communication is the illusion that it has taken place.

George Bernard

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5.7 Barriers to communication

Barriers to communication can be categorized as physical barriers, intellectual barriers, language barriers, inconsistencies in verbal and non verbal communications, emotional barriers, and status of the source of information (occasionally).

Physical barriers

- unable to see and hear properly
- unclear speech and visual presentations
- reasonably inappropriate physical facilities

Intellectual barriers

- the way something is perceived and understood
- Unable to understand what one sees and hears depending on natural ability, home back ground, schooling (eg. Students vs. elders in a rural village)
- In ability of the facilitator or educator or instructor.

Language barrier

- Difference in language, vocabulary and use.
- Different meanings of the same word or sentence

Inconsistent verbal and non-verbal messages

Sometimes, verbal and non-verbal communications will be inconsistent due to deliberate acts or perception differences.

Example: facial expression and verbal explanation of an individual to his opponent on his happiness

"We take communication for granted because we do it so frequently, but it's actually a complex process." Joseph Sommerville

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Emotional barriers

- Lack of readiness and willingness or eagerness to receive the message being disseminated
- Distractive emotional status of the educator

Status of source of information

This may affect communication when the status of the source person is either too high or too low in his/her position as compared to the audience.

Socio-economic barriers

- Difference in social status, income and place of residence.

Example: Uncommonness that occurs when rich and poor persons communicate on a hotel food menu.

Note: Generally, barriers could arise from the source, receiver, message and / or channel of communication.

Say a little and say it well.
Irish Proverbs

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Therefore, barriers of communication can be overcome by reducing or avoiding the challenges/obstacles stated under each and every barrier. Educators/facilitators/instructors can make the communication process not fail by considering the following important points:

- They should say what they wanted to say
- They should hear what they were supposed to hear
- They should avoid any form of message distortion
- They shouldn't attempt to communicate without sufficient knowledge, skill, and when their attitude is negative
- They should overcome semantics difficulties

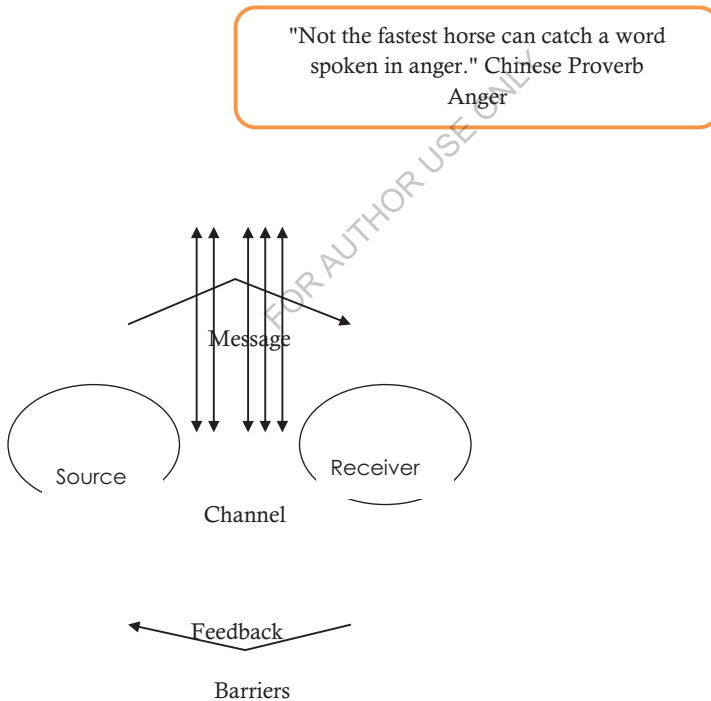


Figure- Illustration for Barriers of communication

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The above schematic presentation of communication pattern is just to illustrate how barriers appear on the two-way communication model; acting as obstacles between the source and the receiver impairing commonness.

Why communication is important?

- ✓ To have dialogue with communities.
- ✓ Influence decision makers to adopt health promoting policies and laws.
- ✓ Raise awareness among decision makers on issues regarding poverty, human rights, equity, environmental issues, etc...
- ✓ Communicate new laws and policies to the public
- ✓ Raise public awareness in order to mobilize community participation.
- ✓ Develop community action on health issues.

Communication stages

In health education and health promotion we communicate for a special purpose – to promote improvements in health through the modification of the human, social and political factors that influence behaviors.

"But good healthy communication is impossible without openness, honesty, and vulnerability." Paul Kendall,

"A lot of problems in the world would be solved if we talked to each other instead of about each other." Nickey Gumbel

"Our presence in front of diverse people and large crowds hinges on our ability to communicate properly." John Shea

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To achieve these objectives, a successful communication must past through several stages:

SENDER

RECEIVER

↓

Reaches senses

↓

Gain attention

↓

Message understood

↓

Acceptance /change

↓

Behavior change

↓

Change in health

"Talking about kindness motivates us to be kind. David R. Hamilton

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5.8 Review questions and answers of chapter 5

Part One: True and False

1. Communication is the process of sharing of ideas, information, knowledge, and experience among people to take action.
 - A. True
 - B. False
2. Sometimes, verbal and non-verbal communications will be inconsistent due to deliberate acts or perception differences.
 - A. True
 - B. False
3. A Channel is a physical means by which message travels from a source to a receiver.
 - A. True
 - B. False
4. Feedback is the mechanism of assessing what has happened on the receiver after communication has occurred.
 - A. True
 - B. False
5. Health education provides opportunity for people to learn, practice and experience health and health related behaviors.
 - A. True
 - B. False

Part Two: Direct Questions

1. Mention Types of communication?
2. List Process of communication?
3. Why communication is important?
4. What is barrier of communications?
5. Define Communication?

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1- Types of communication

- A. Intra- personal communication
- B. Interpersonal communication
- C. Group communication
- D. Mass media communication

2- Process of communication

- A. Sender
- B. Receiver
- C. Channel
- D. Message
- E. Feedback

3- Communication is important because of

- A. To have dialogue with communities.
- B. Influence decision makers to adopt health promoting policies and laws.
- C. Raise awareness among decision makers on issues regarding poverty, human rights, equity, environmental issues, etc...
- D. Communicate new laws and policies to the public
- E. Raise public awareness in order to mobilize community participation.
- F. Develop community action on health issues.

4- Barriers of communication are:

Barriers to communication can be categorized as physical barriers, intellectual barriers, language barriers, inconsistencies in verbal and nonverbal communications, emotional barriers, and status of the source of information (occasionally).

- 5- **Communication** is the process of sharing of ideas, information, knowledge, and experience among people to take action.

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CHAPTER SIX: EDUCATIONAL METHODS AND MATERIALS

Objectives

At the end of this chapter, the students are able to:

- Explain the common methods of transmitting health information
- Describe the advantages and disadvantages of interpersonal and mass media communication means
- Explores the role of counseling at the grass root level
- List major traditional as well as modern methods for group communications
- Explain common teaching aids used for effective communication

6.0 Introduction

Basically health education helps people to make wise choices about their health and the quality of life of their community. To do this, accurate information must be presented in an understandable way using different methods.

Teaching methods range from what is heard to what is seen and done. They include modern methods and materials (teaching methods) and different combination of tools. In this context, methods refer to ways messages are conveyed. Teaching materials include all materials that are used as teaching aids to support the communication process and bring desired effects on the audience. The methods and the materials could be classified broadly as audio, written words, visuals, audio-visuals, direct experience, and multi-sensory modalities. These classifications, in turn, are categorized into three (3) general domains taking the desired and expected educational objectives into consideration, and these are discussed in the method part.

"Use different messaging for different groups to ensure your communications are relevant." Andrea Plos,

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6.1 Methods of Health Education

Methods of Health Education are simply strategies or approaches used by a health educator to deliver the health education program or session.

Health education provides opportunity for people to learn, practice and experience health and health related behaviors. It has a large element of education of individuals and groups to acquire information, to identify problems, and to adapt new behavior and to realize better ways of living and so on. It should be noted that for any change of behavior to be sustained and purposeful, there a need for proper internalization of ideas and formation of favorable attitude.

Learning is, therefore, a totality of change of behavior through acquisition of knowledge; a subtle difference between education and learning is that learning can be passive or incidental while education is a deliberate effort. A properly motivated person may learn by his/her own effort.

Learning, in general, is a process by which individuals acquire information and idea which may latter result in change in attitude and behavior. Education can be, simply, taken as a process by which learning is facilitated.

Domains of learning

Domain of learning is one of the important factors that affect health education method choice. *Bloom (1956)* has identified three domains of or areas of learning: Cognitive, affective and psychomotor domains. Each of these domains has a well developed hierarchical classification systems and health educators should include each of these domains in their audience/client teaching plan.

Note: The three most important factors that affect learning in general are: teaching-Learning methods employed motivation of the learner and differences in individual learner's background, intelligence quotient (IQ) and sex.

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6.1.1. Cognitive domain

This is an educational objective which is concerned with all knowledge (cognition, mental) creation processes, and teaching method; appropriate for this domain includes lecture (talks), discussion, etc. The hierarchical classifications are: knowledge, comprehension, application, analysis, synthesis and evaluation:

- **Knowledge:** refers to remembering previously learnt materials; for example, recalling name of a person, defining a certain term, listing a sort of learnt materials, etc
- **Comprehension:** refers to the ability to grasp the meaning of some learnt materials. For example, translation of graphs, providing examples after definition of terms, etc
- **Application:** refers to the ability to use learnt materials in a new or unfamiliar situation; for example, calculating area of a plot of land, developing a tailored bill board which influence attitude of the public after a certain lesson, etc
- **Analysis:** refers to the ability to break down learnt materials into its component parts so that its organizational structure may be understood. It is a bit complicated level ; for example, analyzing the relationship that exists, identifying what may be relevant and irrelevant, stating the difference between components ,etc
- **Synthesis:** refers to the ability to put parts together to form a new whole(summarizing) ; for example, Producing a new idea, formulating a procedure or principle, summarizing learnt material in few words as possible ,etc
- **Evaluation:** refers to the ability to judge the value of something ; for example, presentation of some material, statement making such as poems, research, preposition, novels, decoding the precise standard , evaluating materials ,etc

“The Best way to predict your Future is to create it.”
— abraham lincoln

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Lecture method

The most natural way of communicating with people is to talk with them. A spoken word is a symbol standing for an object or covering an idea, when talks are on health agenda, we call them health talks. Health talks are the most common ways of sharing health information and knowledge. The word “Lecture” is driven from a Greek word called “lecare” which means “speaking louder”

When preparing a talk (lecture), you should consider the following important points:

- Make sure whether you speak the local language or find a good interpreter.
- Words may not mean the same for all people
- Know about the listeners
- Build on what the listeners know.
- Encourage listeners to challenge, raise questions and comments
- Choose the appropriate time
- Pay attention to both verbal and non-verbal communication
- Know that some error is inevitable and admit
- Lack of understanding is not because of stupidity of audience

Note: Talks (lecture) become effective when combined or supported by teaching aids.

Children have to be educated, but they have also to be left to educate themselves. **Ernest Dimnet**

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In addition to the above considerations, health educators should also pay attention for the following issues:

- Know the group: find out their needs and interests
- Select an appropriate topic, should be single, simple topic
- Have correct and up-to- date information: look for sources of facts and recent information
- List the points you make: prepare only few main points
- Write down what you will say: If you don't like writing, think carefully about what to include in your talk. Think of examples and proverbs and stories to emphasize your points.
- Think of visual aids; well chosen posters, photos, etc will help people learn
- Practice your whole talk; this should include telling of stories and showing of posters and pictures.
- Determine the amount of time you need; the talk, including visual aids, should take about 15-20 minutes. Allow 15 minutes or more for question and discussion. It shouldn't be a long talk.

Group Discussion method

Discussion is exchange of ideas among many individuals (group members) to reach at agreement or consensus, where as meetings is conducted to discuss and solve problems. In meeting, the purpose is to gather information, share ideas, make decision and plans.

Education is what survives when what has been learned has been forgotten. **B. F. Skinner**

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In discussion, learning takes place among learners partly as receptive and partly as productive the educator leads the process through questions, impulses and answers. The process has three functions:

1. The educator asks and the learner answers and this form is used to check learners' memory of the previously learnt materials /matters/ points.
2. The educator asks and learner's answer but finally the educator summarizes, and this form is used to make learners get new idea/knowledge.
3. The educator asks and the learners answer. Then the educator asks opinion on the answers given, finally the learners themselves summarize, and this form is used to make learners gain new knowledge and form attitude and argument skill.

6.1.2- Affective Domain

This is the second category of educational objective which is related to attitude, feeling, appreciation, interest and other emotional acts. Methods appropriate for this domain include drama, experience sharing, etc. *The hierarchical classifications are: Receiving, responding, valuing, organization of value & characterization by a value:*

- **Receiving:** refers to the willingness to attend a certain session or information or phenomena; for example, Giving attention to a given session, etc
- **Responding:** refers to the willingness to actively participate or interact in a certain session or information or phenomena; for example, participating or involving a given session, etc
- **Valuing:** refers to displaying a behavior that is consistent with a particular issue or value that a person or a community holds; for example, value of helping or supporting poor people, etc

Learning never exhausts the mind. **Leonardo Da Vinci**

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- **Organization:** refers to the state of bringing together different extreme values resolving the conflict between them (harmonizing conflicting values) ; for example, Value of helping or supporting poor people even at times of shortage of money to oneself(at times of difficulty) ,etc

Drama and role plays

Drama

In drama, ideas, feelings, beliefs and values are communicated by participants to spectators. They are very valuable in subjects when personal and social relationships are often more important than detailed appearance. Basic ideas like health can be communicated to people of different ages, education, and experience. They are suitable teaching methods specially for people who can't read because they often present ideas dramatically.

The duration of the drama can be short or long, and drama could be used during training of CHWs, special meetings, festivals, teachings of school children, for people in a village, etc.

The guide line for drama include: choosing an appropriate theme, identifying an appropriate place, preparing for the drama and practicing, using health team as a main character, making sure that every body hears, presentation should be based on local culture, language, dressing style, etc, mixing the serious with the funny, including songs and teaching the song to the audience (if possible), conducting discussion after the drama and planning to repeat the drama in other community.

You learn something every day if you pay attention.

Ray LeBlond:

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Role play

Role play is a type of drama but in a simplified manner. It portrays behavior of people and, it is unrehearsed acting out of real- life situation; a script is not necessary. Here, an individual takes the part of some other character; and also can explore ones own emotions and reactions in specific situation.

Experience sharing method

This method focuses on sharing experiences of a behavior change or experience which leads to a behavior change; usually, inviting known and respected people to explain their previous hardships and ups and downs and successes to share to people of the same back ground or exposure helps a lot in the attitude and behavior change process.

6.1.3- Psychomotor Domain

This an educational objective which is concerned with skill or practice development, performance ability of the learner, and methods appropriate for this domain are demonstration and re-demonstration. *The hierarchical classifications are: Perception, set, Imitation, manipulation, precision, articulation and naturalization:*

- **Perception:** refers to the use of sense organs to obtain cues that guides to motor activity (here there is no activity but simply observation) ; for example, closely observing at a computer key board ,etc
- **Set:** refers to readiness to take a particular action. This could be mental or physical or emotional set; for example, properly positioning fingers on a computer key board ,etc
- **Guide Response/Imitation:** refers to earlier stage of learning complex skills ; for example, initiation, trial and error of typing on a computer key board ,etc
- **Manipulation/Mechanism:** refers to acting when learning responses become habitual and movements can be performed with some sort of confidence and proficiency ; for example, exhibition of a given skill to mass of people ,etc

Learning is finding out what we already know. Doing is demonstrating that you know it. **Richard Bach**

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- **Precision/Complex Overt:** refers to skill full performance of motor function or acts that involve complex movements. It is higher in degree of performance than mechanism level ; for example, very proficient & synchronized motor activity in performance, etc
- **Articulation/Adaptation:** refers to well developed skill level where the learner can modify movement patterns to fit special requirements or problem situations ; for example, developing one's own style of doing things ,etc
- **Naturalization/Organization:** refers to creating entirely new pattern of movement to fit a particular situation or a specific problem ; for example, performing the activity even with sub-conscious mental status ,etc

Demonstration Method

A demonstration is a pleasant way of sharing skills and knowledge .Although it basically focuses on practice, it additionally involves both theoretical and practical teaching (showing how!!)

Recall the Chinese proverb for better explanation:

“When I hear, I forget; when I see, I remember, and when I do, I know!!

Note: For effective demonstration, demonstration should fit in the local culture must be realistic, use materials and objects that are familiar to the people, have enough materials for everyone to use during the practice, and finally make the learners re-demonstrate. Learners should get enough time and adequate place to demonstrate and re-demonstrate.

**Time is a great teacher, but unfortunately, it kills
all its pupils (Louis) Hector Berlioz**

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Re- demonstration Method

This is, simply, to make some audiences demonstrate in front of the educator and/or other audiences following the educator's demonstration session.

6.1.4- Other Methods of Health Education

Other methods of health education are Symposium, panel discussion, forum, workshop, conference, brain storming, buzz session, and colloquy. The major similarities and differences these methods are briefly described here under:

- **Symposium:** is a formal presentation method of health education, and it is a type of lecture in which different speakers are asked to give lecture on the same subject. The speakers, here, prepare the talk in such a manner that each of them presents a particular aspect of a subject which ultimately makes the audience get the benefit of understanding the subject with its different aspects dealt by different speakers separately. In symposium, we don't expect the audience to be allowed to participate and give feedback.
- **Panel discussion:** is a formal presentation method of health education, where a small group of people get around a table in the presence of audience and discuss among themselves on the subject or subject which is relevant to the audience and in which the panel members (panelists) have specialized knowledge. Like symposium, panel discussion also doesn't allow audiences to participate and give feedback normally.
- **Forum:** is a formal presentation method of health education where opportunity is given to audience to participate by raising questions and doubts at the end of a lecture, panel discussion or symposium.

Experience is a hard teacher because she gives the test first, the lesson afterward-**Vernon Law**

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- **Workshop:** is a group discussion method of health education where a large number of people belonging to a particular discipline or allied discipline are collected together to take up specific issues and problems for making recommendation for future action. It usually lasts for 3 days to 3 weeks.
- **Seminar:** is a group discussion method of health education where large groups are convened amongst persons with common discipline and interest, with reference to learning or academic institution to come together to exchange views on current problem or to share experience from one another; pooling experiences.
- **Conference:** is a type of seminar which can be held around a big table with reference to other institutions including religious institutions that are still used to exchange views and pool experience.
- **Brain storming:** is a modern method of eliciting from the participants their ideas and solution on debatable issues or current problems.
- **Buzz session:** is group discussion method of health education where a large group is divided into smaller groups of not more than 10-12 people in each small group that will be given time to discuss a problem. Finally, the whole large is reconvened and the reporters of the large group will report their findings & recommendation.
- **Colloquy:** is a formal presentation method of health education where a few members from the audience made to stimulate discussion by presenting problems or raising questions to group of experts on the stage and the experts give their comments and answers on the various aspects. If the problems raised are controversial in nature, the experts would be able to pinpoint solution within the available time for discussion.

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6.2- Selection of methods and materials

For any teaching learning process, methods and supporting materials should be selected, and the selection depends on:

- The type of the message
- The purpose of the teaching
- The people addressed
- The circumstance
- Availability of resources
- Availability of skills

Teachers open the door, but you must enter by yourself." Chinese Proverb

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A case study on METHODS & MATERIALS of Health Education

Suppose that you are working in one rural health center where a given Non-Governmental Organization (NGO) is running a project on CONDOM PROMOTION at a High school where students are found practicing unsafe sex. The project was initiated after a long period of social mobilization process at the high school & community levels on importance of Condom use, and the NGO ultimately made students have a good access to condom in the school compound with secured privacy in isolated container free of charge.

However, on evaluation of the project activities, after six months, it was found that only few condom packets were used by the students and some packets were found torn out and thrown on the floor deliberately.

If the operating NGO, after observing the issue, seeks your professional advice or invited you as a consultant to narrow the gap observed, WHICH METHOD & MATERIALS OF HEALTH EDUCATION do you recommend? WHAT POSSIBLE FACTORS ARE INFLUENCING THE OBSERVED BEHAVIOR OF STUDENTS?

The teacher who is indeed wise does not bid you to enter the house of wisdom but rather leads you to the threshold of your mind. **Kahlil Gibran**

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Qualities of a good Health Educator

1. Good Appearance
2. Appropriate voice
3. Good knowledge of the subject
4. Relevant gesture
5. Good word selection
6. Providing practical examples
7. Using Appropriate method
8. Good class control (eye contact)
9. Good time management
10. Good motivation
11. Good feedback

6.3- Materials for Health Education

Materials of Health Education are simply aids or devices that are used to supplement the health education program or session.

Teaching materials include all materials that are used as teaching aids to support the communication process and bring desired effect on the audience. The following are some selected teaching aids that are commonly used in health education programs.

Audio-visual aids

Communications are supported with different teaching aids or tools depending on the purpose of the communications. If the purpose is to transfer skill and knowledge, combinations of these materials are used. The availability of the technology and materials limit the usage.

“It is the supreme art of the teacher to awaken joy in creative expression and knowledge.”
— albert einstein

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Audiovisuals are multi-sensory materials they combine both seeing and listening as in the case of a television set. When they are used appropriately, more effective communication takes place. When teaching aids are effectively used, people can receive experience through all five senses: seeing, hearing, smelling, tasting, and touching.

- **Audios**

Audios include anything heard such as spoken-word (talk), music or any other sounds. Talks are the most commonly used audio teaching methods.

Characteristics of audios:

- ✓ Effective when based on similar or known experience
- ✓ Could be distorted or misunderstood when translated
- ✓ Easily forgotten

- **Health talks**

The most natural way of communicating with people is to talk with them. In health education, this could be done with one person, a family, or with groups (small or large). Health talks have been, and remain, the most common way to share health knowledge and facts.

The most natural way of communicating with people is to talk with them.

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In preparing a talk, consider the following points:

- ✓ Know the group: their interests and needs
- ✓ Select single and simple topic: e.g. Nutrition is too big as a topic. Thus, select subtopic such as breast-feeding, weaning diet etc.
- ✓ Have corrected and up-to- date information.
- ✓ Limit the points to only main once.
- ✓ Write down what you will say, use examples, proverbs and stories to help emphasize points.
- ✓ Make use of visual aids.
- ✓ Practice your whole talk
- ✓ Make the talk as short as possible - usually 15-20 minutes talk and 15 minutes discussion.

- **Visual aids**

Visuals are objects that are seen. They are one of the strongest methods of communicating messages; particularly when accompanied with interactive methods.

Advantages

- ✓ They can easily arouse interest
- ✓ Provide a clear mental picture of the message
- ✓ Speed up and enhance understanding
- ✓ Can stimulate active thinking
- ✓ Create opportunities for active learning
- ✓ Help memory and provide shared experience.

Visuals are more effective than words alone, and it will be rather more effective when extended to practice (action).

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The Chinese proverb goes for this:

- ✓ If I hear, I forget
- ✓ If I see, I remember
- ✓ If I do, I know

Poster and chart

A poster is a large sheet of paper with words and pictures or symbols that includes message on it. Posters are widely used visuals by commercial firms for advertising products. However, in recent years, the use of posters for communicating health messages has increased dramatically.

The use of posters in teaching requires the following considerations: don't hold up a poster and start explaining it right away instead;

- Ask every one to look at the poster carefully
- Ask people what they see; let them think for themselves.
- If there are words on the poster, let some one read it for the group
- Add your own ideas as the discussion continues
- Turn to the poster again at the end of your discussion
- Ask once more about the message.

Posters

A poster is a large sheet of paper, often about 60 cm wide by 90cm high with words and pictures or symbols that put across a message. It is widely used by commercial firms for advertising products, but can also be used for preventive purposes.

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Advantages

- Give information and advice, e.g. beware of HIV/AIDS!
- Give directions and instructions, e.g. how to prevent HIV / AIDS
- Announce important events and programmes, e.g. World AIDS day

Standard rules in making posters:

- ✓ All words should be in the local language
- ✓ Words should be limited and simple
- ✓ Symbols that illiterate people will also understand should be used
- ✓ Mix of colors should be used to attract attention
- ✓ Only put one idea on a poster.

Note: Charts are used to present facts in a visual form, and classified as wall charts (eg-child growth monitoring chart), teaching chart (eg-Diarrhea treatment chart), and flipcharts (eg-female reproductive organs)

Television and video

Some health centers and hospitals in Ethiopia are equipped with television and video. These teaching aids could be used in health education sessions on a day-to-day basis or during special presentations- depending on the availability of equipment, and the size of the group, they can be used for different purposes.

"Education's purpose is to replace an empty mind with an open one." - Malcolm Forbes

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In spite of their importance, the use of these materials at a health center level is limited; the equipments are costly, maintenance and operations are not easier. They are breakable, difficult to transport and need electric power supply. In addition, preparation of the message (audio-visual materials) is often difficult and done at central level.

Radio

Radio is an audio aid which is used by mass media agencies usually, and it can be arranged at a community level using a community radio programs.

Principles of audio-visual aids

The most important principles in development and production of audio- visual materials include:

- Some music should be inserted briefly at the beginning of the program
- Make the whole recording short, not more than 20 minutes for audio-visual and 10 minutes for audio programs.
- Use simple language and simple sentence structure.
- Avoid jargon words. If you have to use, you should explain
- Assume that you are communicating with a single person and write the script for a single person.
- Spend time getting to know and understand the chosen audience.
- Avoid a word that has two or more meanings.
- Use illustrations as much as possible especially audio as it is an aural medium.

Life is a series of lessons that have to be understood. Thomas Carlyle

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Generally, teaching aids of any type should be developed in such a way that they convey effective communication (idea), and this is best achieved by considering the **7 Cs** of effective communication:

- ☞ Commands Attention
- ☞ Caters to the head and heart
- ☞ Clarifies the message
- ☞ Communicates a benefit
- ☞ Creates trust
- ☞ Conveys a consistent message
- ☞ Calls for action

Note: Audio- visual materials are, generally, good for realistic illustration (eg- photographic shows with slides/projectors), they can convey strong messages with high emotional appeal, they are good for showing examples and studies, they can show movements, and information can reach to the vast area with in short period of time.

Teaching is the ability to inspire learning.
Nick Saban

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Ways to put across health messages:

- Direct – Interpersonal (Individual and groups)
- Indirect – Mass media and visual aids.

To transmit information effectively, you have to choose appropriate educational tools and intensive interpersonal educational efforts may be necessary. Where the benefits of a recommended change are so great mass media can be used.

The important thing to remember is that effective health communication is seldom achieved through the use of one method alone. Nearly always, a combination of techniques is needed to achieve behavior changes. Both effectiveness and costs must be considered in choosing a combination of techniques. Besides, selection of local media is appreciably useful.

6.4 Educational methods

Individual educational methods - Counseling

Counseling is one of the approaches most frequently used in health education to help individuals and families. It is a person-to-person communication in which one person is helped by another to increase in understanding, ability and confidence to find solutions to own problems.

This service could be given to patients at the health center, to pupils at school, to families during a home visit or during casual visits to community (e.g. Market place, at water well etc).

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- **Home Visits**

Advantages

- ✓ When people are in their home, they usually feel happier and more secure. You may find that people are more willing to talk in their own homes than when they are at the clinic.
- ✓ It also gives an opportunity to see how the environment and the family situation might affect a person's behavior; thus, making observations and any necessary suggestions for change right there.
- ✓ Keeps a good relationship with people and families
- ✓ Encourages the prevention of common diseases.
- ✓ Enables detecting and improving troublesome situations early, before they become big problems.
- ✓ Enhances checking on the progress of a sick person, or on progress towards solving other problems.
- ✓ Motivate the family on how to help a sick person in which their participation is needed.

Therefore, health extension workers should visit all homes in their communities regularly. Home visits become convenient if we design our own family health education folder for use.

Teaching by precept, without example, is mighty poor teaching.

Heber J. Grant

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What information should be in the folder and kept up to date?

- The family name.
- The address and location of the house
- The date of the visit.
- The name and ages of all members of the house hold. (Be sensitive to local customs about collecting such information)
- Health problems
- Information discussed
- Ideas offered
- Agreements reached
- What you agreed to do
- Date of next visit

Purposes of counseling

- ✓ To help individuals increase knowledge of self
- ✓ To encourage individuals or families to think about their problems and understand the causes.
- ✓ Help people commit themselves to take action on their own will to solve the problems.
- ✓ Help individuals to choose, but not forcing them to do so.

Teaching is mostly listening, and
learning is mostly telling.

Deborah Meier

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Principles in counseling

- ✓ Counseling requires establishing good relationship between the counselor and the client
- ✓ Counselors should assist people identify their own problems.
- ✓ Counselors develop empathy (understanding and acceptance) for person's feelings. It is thinking by putting self on the shoe of the others.
- ✓ Counselors should never try to persuade people to accept their advice. Rather help people to think about all the factors involved in their problems and encourage them to choose the solutions that are best in their particular situation.
- ✓ Counselors should always respect the privacy of the people they are helping. They never reveal information without specific permission.
- ✓ Counselors should share information and ideas on resources, which the client needs in order to make a sound decision. For example, many people do not realize the connection between their behavior and their health.

Below is an example of the problems that arise when a person is advised and forced:

"During a home visit one health extension worker (HEW) saw a mother with a marasmic child. The child was so thin and very small for age.

The HEW worried the child would die in a near future. She scolded the mother for not taking to the clinic. The HEW persuaded the mother to take the child to a hospital where nutrition rehabilitation is given and stay there until the child would regain weight.

The mother nodded her head in agreement. While she was packing her things she began to cry.

"Communication is your ticket to success, if you pay attention and learn to do it effectively." Theo Gold,

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A brother of the women's husband came to see what she was crying about. The HEW explained, but the man became angry. He said there were many good reasons why the woman was crying. She was worried because, if she stayed in hospital, there would be no one to care for her other two older children. She had

recently moved to another village with her husband. She felt that there would be no one whom her children knew and trusted enough to stay with. Also the mother was crying for fear that the HEW might refuse to help her in the future, if she did not agree to go to hospital now. This health worker had obviously not learned the techniques of counseling; otherwise, she would have followed the simple rules listed above”

2. Group Educational Methods

It is needless to mention that much of the problem solving in the community has to be done by group work and cannot be attempted at individual level alone. Specifically, working with groups is a major activity in health education. When people get together to identify, define, and solve a problem, they have many more resources than when they work individually.

What is a Group?

A group could be defined as a gathering of two or more people who have a common interest.

To achieve good communication, you should have the ability to “see” beyond what is being said. Liam Jackson

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Example of groups often found in a community:

- A family
- A health committee
- People working at the same factory, business, or agency
- A class of school children
- A farmers' cooperative
- A youth club
- People attending a religious ceremony together
- Some friends getting together to relax
- A gathering of patients at a clinic
- People riding together on a bus

Types of Groups - There are two main kinds of group

1. Formal groups

Groups that are well organized with some rules and regulations E.g. Farmer's – cooperative, Women's Associations

2. Informal groups

Groups that are not well organized E.g. People attending market on a particular day and People attending funereal place.

Characteristics of formal group

- ✓ Has a purpose or goal that everyone strives to achieve together.
- ✓ There is a set membership, so people know who is a member and who is not.
- ✓ There are recognized leaders who have the responsibility of guiding the group towards achievement of its goals.
- ✓ There are organized activities such as regular meetings and project.
- ✓ The group has rules that members agree to follow and works towards the welfare of the members.

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Characteristics of informal gatherings

- ✓ May have some features in common, but no special goal that they are trying to achieve together E.g. People riding together on a bus
- ✓ No special membership or feeling of belonging People come and go at will
- ✓ No special leader selected, no special rules apply
- ✓ Usually no special activity is planned by the people themselves E.g. People coming to watch a football match
- ✓ There is usually more concern for self, and less for the welfare of the other people.

"Use assertive communication. Assertive communication is about being nonreactive and still respectful." Ryan Cooper

The Value of Group Education

- ✓ In a group, one can find the support and encouragement needed to promote and maintain healthy practices.
- ✓ It permits sharing of experience and skills.
- ✓ Working in groups makes it possible to pool the resources of all members.
E.g. to dig a well, group of families can contribute enough money

6.4.1 Common Methods Used for Group Education

A. Group discussions

Health education has been quick to recognize that groups provide an ideal set-up for learning in a way that leads to change and action. Discussion in a group allows people to say what is in their minds. They can talk about their problems, share ideas, support and encourage each other to solve problems and change their behavior.

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- **Size of a group**

For sharing of ideas an ideal group is the one with 5-10 members. If the members are large every one may not have a chance to speak.

- **Planning a discussion**

Planning a discussion involves:

- ✓ Identification of the discussants that do have a common interest e.g. mothers whose child suffers from diarrhea.
- ✓ Getting a group together
- ✓ Identification of a comfortable place and time

"Our presence in front of diverse people and large crowd's hinges on our ability to communicate properly." John Shea

- **Conducting the discussion**

- ✓ Introduction of group members to each other
- ✓ Allow group discussion to begin with general knowledge E.g. any health problems they have ever faced
- ✓ Encourage everyone to participate.
- ✓ Limit those who talk repeatedly and encourage the quiet to contribute.
- ✓ Limit the duration of discussion to the shortest possible, usually 1- 2 hrs.
- ✓ Check for satisfaction before concluding the session.

E.g. do they think that they are learning? And do they think the group should continue?

B. Meetings

Meetings are good for teaching something of importance to a large group of people. They are held to gather information, share ideas, take decisions, and make plans to solve problems. Meetings are different from group discussions. A group discussion is free and informal, while meetings are more organized. Meetings are an important part of successful self-help projects.

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- **Planning a meeting**
 - ✓ It should be need based
 - ✓ Determine the time and place
 - ✓ Announce the meeting through village criers or word of mouth.
 - ✓ Prepare relevant and limited number of agendas.
- **Conducting the meeting**
 - ✓ Should be led by a leader
 - ✓ Encourage participation as much as possible
 - ✓ Try to reach at consensus based decisions
 - ✓ Use some visual aids to clarify things
 - ✓ Finally, get ready to take actions to solve problems.

Meetings are good for teaching something of importance to a large group of people.

C. Clubs

There are many kinds of organizations to which women, men and young people belong. Clubs are becoming popular in many areas.

They provide an opportunity for a systematic way of teaching over an extended period of time. E.g. a group of citizens could form an association to deal with problems related to a major local disease or to protect the environment.

D. 'Village' criers

They spread information in the community in the past eras & even today in remote areas where modern mass media are scarce. When they have some thing to say, ordered by village leaders, they may use a bell or drum to attract attention. Drum beats and other sounds can be a special code or signal that people understand.

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The following messages could be passed on:

- ✓ A reminder to mothers to immunize their children
- ✓ A request that people participate in a village sanitation campaign
- ✓ A call for people to work in a community project such as digging a well
- ✓ A warning about dirty water during cholera outbreak

E. Songs

People sing to express ideas and feelings, such as love and sadness, to tell story of a famous person, commemorate religious days etc. Particularly village people like to sing and dance and almost every village have someone who can sing and put works to music. In addition to expression of feelings, songs can also be used to give ideas about health. You can give topics that you want to make popular to those persons for synthesis and dissemination.

People sing to express ideas and feelings, such as love and sadness, to tell story of a famous person, commemorate religious days etc.

For instance, the following issues could be entertained:

- ✓ The village with out safe water
- ✓ The malnourished child who got well with the proper food to eat
- ✓ The village girl who went to school to become a health extension worker
- ✓ The house where no flies and mosquitoebreed

F. Proverbs

They are short common-sense sayings that are handed down from generation to generation. They are like advice on how best to behave. Some proverbs are straight forward- others are more complicated.

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Examples

- ✓ One does not go in search of a cure for ringworm while leaving leprosy unattended.
This is to mean: try to solve the most serious problem first.
- ✓ A young man may have as many new clothes, but not as many worn-out clothes, as an old man. This is to mean: □ An old man has more experience than a young one
- ✓ Prevention is better than cure.

The first proverb could be useful during a talk to mothers that emphasizes the importance of bringing their children to the clinic when they are sick, instead of going about some other business. The second proverb could encourage young people to respect and care for their elderly parents.

Teaching materials include all materials that are used as teaching aids to support the communication process and bring desired effect on the audience.

6.5 Non-projected materials (aids) or graphics

They are shown or displayed and do not necessarily depend on any projected equipment.

- **Leaflets**

Leaflets are unfolded sheet of printed material. Leaflets can be very appealing if their message is simple and clear, and if the language is understood by the reader. In preparing them, short sentences and paragraphs should be used, illustrated with simple drawings or pictures that are easily understood. They need to be pre-tested before distributed to the villagers.

Visuals are more effective than words alone, and it will be rather more effective when extended to practice (action).

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- **Newspapers/Newsletters**

Newspapers might be of some help in reaching the villagers. Very often, though, the national or regional newspapers do not reach smaller communities, or the people are unable to read them. In this case, newsletters, written by the villagers themselves, teachers and extension workers can become the communities' newspaper. Place copies on a bulletin board or wall in a public meeting places (market and wells are the best places).

Selection of Teaching Methods and Materials

The selection of the teaching methods and aids depends on

- The type of the message
- The purpose
- The people addressed
- Availability of resources
- Availability of skills

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6.6 Review questions and answers of chapter six

Part one: circle the correct answer

1. Talks (lecture) become effective when combined or supported by
 - A. Teaching aids
 - B. Good style of lecturer
 - C. Good climate
2. The most natural way of communicating with people is to
 - A. talk with them.
 - B. Gesture with them
 - C. Demonstration
3. Qualities of a good Health Educator are the following except
 - A. Good Appearance
 - B. Appropriate voice
 - C. Good knowledge of the subject
 - D. Relevant gesture
 - E. Over qualified person
4. is a large sheet of paper with words and pictures or symbols that includes message on it.
 - A. A poster
 - B. Talks
 - C. Meeting
5. The selection of the teaching methods and aids depends on
 - A. The type of the message
 - B. The purpose
 - C. The people addressed
 - D. All the above

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Part Two: Direct Questions

1. Mention Advantages of poster?
2. List Principles of audio-visual aids?
3. Highlight The Value of Group Education?
4. List Non-projected materials (aids) or graphics?
5. What is a Group?
6. List Qualities of a good Health Educator
7. Mention 7 Cs of effective communication
8. List Principles in counseling
9. The selection of the teaching methods and aids depending on many factors mention?
10. Define Counseling?

Answers of review questions

1- Advantages of posters

- A. Give information and advice, e.g. beware of HIV/AIDS!
- B. Give directions and instructions, e.g. how to prevent HIV / AIDS
- C. Announce important events and programmers, e.g. World AIDS day

2- Principles of audio-visual aids

- A. Some music should be inserted briefly at the beginning of the program
- B. Make the whole recording short,
- C. Use simple language and simple sentence structure.
- D. Avoid jargon words. If you have to use, you should explain
- E. Assume that you are communicating with a single person
- F. Spend time getting to know and understand the chosen audience.
- G. Avoid a word that has two or more meanings.
- H. Use illustrations as much as possible especially audio as it is an aural medium.

3- The Value of Group Education?

- A. In a group, one can find the support and encouragement needed to promote and maintain healthy practices.
- B. It permits sharing of experience and skills.

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C. Working in groups makes it possible to pool the resources of all members.

4- Non-projected materials (aids) or graphics are

- A. Leaflets
- B. Newspapers/Newsletters

5- Group is defined as

A group could be defined as a gathering of two or more people who have a common interest.

PART TWO: DIRECT QUESTIONS

ANSWERS OF DIRECT QUESTIONS

6- Qualities of a good Health Educator

- 6. Good Appearance
- 7. Appropriate voice
- 8. Good knowledge of the subject
- 9. Relevant gesture
- 10. Good word selection

7- Seven Cs of effective communication

- A. Commands Attention
- B. Caters to the head and heart
- C. Clarifies the message
- D. Communicates a benefit
- E. Creates trust
- F. Conveys a consistent message
- G. Calls for action

Part one: circle

- 1. A
- 2. A
- 3. E
- 4. A
- 5. D

8- Principles in counseling

- A. Counseling requires establishing good relationship between the counselor and the client
- B. Counselors should assist people identify their own problems.
- C. Counselors develop empathy (understanding and acceptance) for person's feelings.

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9- Selection of Teaching Methods and Materials

- A. The type of the message
- B. The purpose
- C. The people addressed
- D. Availability of resources
- E. Availability of skills

10- Counseling is one of the approaches most frequently used in health education to help individuals and families.

Mass media are the best methods for rapid spread of simple information and facts to a large population at low cost.

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CHAPTER SEVEN: HEALTH EDUCATION SETTINGS

7.0 Introduction

The most commonly used settings of health education can be broadly categorized as three major settings: *Health Care settings*, *School settings*, and *Community settings*.

"Health is created and lived by people within the settings of their everyday life; where they learn, work, play, and love." *The Ottawa Charter, 1986*

Healthy Settings, the settings-based approaches to health promotion, involve a holistic and multi-disciplinary method which integrates action across risk factors. The goal is to maximize disease prevention via a "whole system" approach. The settings approach has roots in the WHO Health for All strategy and, more specifically, the Ottawa Charter for Health Promotion. Healthy Settings key principles include community participation, partnership, empowerment and equity.

The communication that is aimed to reach the masses or the people at large is called mass communication.

"The place or social context in which people engage in daily activities in which environmental, organizational, and personal factors interact to affect health and wellbeing."

A setting is where people actively use and shape the environment; thus it is also where people create or solve problems relating to health. Settings can normally be identified as having physical boundaries, a range of people with defined roles, and an organizational structure. Examples of settings include schools, work sites, hospitals, villages and cities.

The most commonly used settings of health education can be broadly categorized as three major settings: *Health Care settings*, *School settings*, and *Community settings*.

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Action to promote health through different settings can take many forms. Actions often involve some level of organizational development, including changes to the physical environment or to the organizational structure, administration and management. Settings can also be used to promote health as they are vehicles to reach individuals, to gain access to services, and to synergistically bring together the interactions throughout the wider community.

7.1. The Health care setting

Patient education is a type of Health Education given at health care settings.

Objective of patient education and rationale

Health provider-patient interaction should express support, provide information and feedback, correct distortions and provide hope in modern era. There are reasons why provider-patient interaction should be given due considerations and these include:

- Chronic diseases are increasing
- The contribution of health related problems and the environmental factors has been recognized
- The role of patient in self-care is required
- The need for involvement in disease prevention/control
- Home based care is advocated against institution based care
- Patient education and participation in doctor-patient interaction is well recognized.

"Health is created and lived by people within the settings of their everyday life; where they learn, work, play, and love." *The Ottawa Charter, 1986*

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From the sociologists' point of view, one can closely look into the status of the patient and the health practitioner (the doctor) in the lights of their respective environment in the following ways:

- ***The patient***

- Not feeling well (sick, abnormal obvious physical symptom)
- “Ignorant” – does not know why
- Thinks or believes that the solution is in the hands of others
- Often goes to unfamiliar place, process, procedures, people or facilities.
- May not know the norms
- Needs help and reassurance, information, advice, treatment
- The desired outcome is cure, normal functioning of the body and the psyche (healthy life).
- Not recognized, difficult to express feelings (real).

- ***The doctor***

- Equipped with medical knowledge, skill and has power
- Systematic, organized thinking, diagnosis, treatment
- Aware of his/her professional value
- Works in familiar place, procedure, facility, people or work mates.
- Often busy, time conscious
- Interested in disease progress outcome and also in chronic health problems
- Less interested in other aspects social, economic, psychological aspects, etc.
- Good reputation in acute diseases, self-limiting or reversible
- In chronic diseases, the reputation is not high as in acute conditions; many of them are irreversible.
- Patient may know more about his/her problem through time and this leads to conflict.

Healthy Settings key principles include community participation, partnership, empowerment and equity.

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7.2 Theories of patient education

These theories state the current perspectives on patient- provider interaction, and they integrate social and psychological perspectives on interpersonal influence (attitude, feelings and behavior). The theories are based on health practitioner-patient relationship and sometimes called as patient-provider interaction.

The relationship needs the following qualities:

- Clarity, openness, and effectiveness of communication
- Good interpersonal relationship
- Mutual understanding
- Awareness of external social factors

In practice, conflict arises between providers and patients (clients) in the areas of nature of the health problem (disease), treatment, expected outcome and lack of providers' awareness about patient's feelings, concerns and perspectives. These discrepancies will lead to poor patient satisfaction, poor compliance suggested by social psychological perspectives:

Cognition and information processing

- Provision of information about diagnosis, treatment, etiology and outcome.
- Provision of written information
- Use of shorter words and sentences
- Presentation of important information
- Categorization, memorization and check-ups

Interpersonal interaction

- Convey concern, warmth, sincerely, respect, genuineness
- Use exploratory and open ended questions
- Listen, clarify, paraphrase and check
- Beware of your personal reactions.

Compliance is willingness to follow doctors' recommendations or orders

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Conflict resolution and negotiation

- provide information, accept, respect
- Elicit patient's view about problem, treatment and outcome
- Prioritize and negotiate requests
- Develop a mutually acceptable plan

Social influences

- Inference patients' attitude, motivation and behavior
- use techniques to enhance persuasiveness, cognition and information processing
- Emphasize patients wellbeing as a mutual goal
- Give positive feedback and accept feed back

Compliance

Compliance is willingness to follow doctors' recommendations or orders, and hence non-compliance refers to failure or refusal to do so. Non-compliance can occur into different forms: *error of omission* (on clients who are not currently seeking or receiving medical care for their illness or condition- the undiagnosed), and *error of commission* (on clients who have symptoms or risk factors that could warrant examination and health counseling – the unscreened).

Both errors (types of errors) can be attributed to: failure of health care professionals or failure of patients or failure of both professionals and patients.

Community setting includes home, public gatherings, social organizations, campuses, work

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7.3 Methods of improving compliance

Compliance, generally, can be improved by identifying causes of non-compliance and by acting up on them accordingly. The common causes of non-compliance that should be prevented include:

- Language barriers
- Un convinced needs
- Too costly procedures and equipments
- Problems in understanding (due to literacy, ability to concentrate, memory lapse, etc)
- Undesirable side effects of treatments/medications
- Conflicts with health providers
- Philosophical, cultural, and religious beliefs
- Inconvenience
- Criticism form friends, employers, etc.

7.4 The School Setting

School health education is a type of health education program which is undertaken in school settings starting from kindergarten (3-5 years old children) up to secondary school students (14-18 years old youths).

Rationale of school health education

- School children are groups of young people with similar background and environment.
- There is potential for occurrence of epidemics and spread of communicable diseases.
- School communities have special health problems
- It also an opportunity to the health care delivery system to include this large community in health matters. They can also serve as a bridge between families, community of teachers and the health system.

School children are groups of young people with similar background and environment.

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4 Scope of school health education

Schools are unique settings for health education and promotion activities, and are effective to improve the health of pupils, staff, families and members of the community. It can produce significant outcome because schools contain many young people. Through these young people, families and communities could be traced and communicated with. It has been shown in many places that even three years of education for girls improve their children survival by 50%- influence of schooling on the health of the community.

Instructional methods in schools

The selection of instructional methods in schools, like any other settings, solely depends on the learning outcome intended, the nature of the audiences, and the already available resource and skill.

Therefore, assessment should be done first and the methods to be used will be decided based on the findings of the assessment.

Diagnosis of problems in schools

Diagnosis of problems in schools involves 4 (four) steps, and these include 1st – Determining (interpreting) the state of health of the school students, 2nd – Determining (interpreting) the pattern of health care (service) delivery in schools, 3rd- Investigating the relation ship between the health status of school students and the health care delivery, and 4th – summarizing the evidences and establishing determinants of the problems identified.

Note: The predisposing factors for the problems, the enabling factors to take action, and the re-enforcing factors to maintain the action should also be studied- Educational Diagnosis!!

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7.5 The Community Setting

This setting includes home, public gatherings, social organizations, campuses, work sites, etc. The type of Health Education that is given at community settings is called Community Health Education.

Schools are unique settings for health education and promotion activities, and are effective to improve the health of pupils, staff, families and members of the community.

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7.6 Review questions and answers of chapter 7

Circle the correct answer

1. The most commonly used settings of health education can be broadly categorized as three major settings except
 - A. Health Care settings
 - B. School settings
 - C. Community settings.
 - D. Individual setting
2. is willingness to follow doctors' recommendations or orders.
 - A. Compliance
 - B. Health education
 - C. Health promotion
3. The common causes of non- compliance that should be prevented include the following except
 - A. Language barriers
 - B. Un convinced needs
 - C. Too costly procedures and equipment
 - D. Problems in understanding
 - E. Preference

PART TWO: TRUE AND FALSE

4. School children are groups of young people with similar background and environment.
 - A. True
 - B. False
5. Community setting includes home, public gatherings, social organizations, campuses, work.
 - A. True
 - B. False

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6. "Health is created and lived by people within the settings of their everyday life; where they learn, work, play, and love."
 - A. True
 - B. False

7. Healthy Settings key principles include community participation, partnership, empowerment and equity.
 - A. True
 - B. False

PART THREE: DIRECT QUESTIONS

1. What is the Diagnosis of problems in schools?
2. The common causes of non-compliance that should be prevented?
3. There are reasons why provider-patient interaction should be given due considerations?

Answers of review questions

Diagnosis of problems in schools involves 4

- 1- **Four steps, and these include** 1st – Determining (interpreting) the state of health of the school students, 2nd – Determining (interpreting) the pattern of health care (service) delivery in schools, 3rd- Investigating the relationship between the health status of school students and the health care delivery, and 4th – summarizing the evidences and establishing determinants of the problems identified.
- 2- **Common causes of non-compliance that should be prevented the following**
 - A. Language barriers
 - B. Un convinced needs
 - C. Too costly procedures and equipment
 - D. Problems in understanding (due to literacy, ability to concentrate, memory lapse, etc)

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- E. Undesirable side effects of treatments/medications
- F. Conflicts with health providers

3- Reasons why provider-patient interaction should be given due considerations

- A. Chronic diseases are increasing
- B. The contribution of health related problems and the environmental factors has been recognized
- C. The role of patient in self-care is required
- D. The need for involvement in disease prevention/control

Part one: Circle

- 1. D
- 2. A
- 3. E

Part two: T&F

- 4. A
- 5. A
- 6. A

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CHAPTER EIGHT: TRAINING

Learning Objectives:

- Describe what training is
- Discuss types and phases of training
- Explore the methods of training
- Discuss evaluation of training process

8.0 Introduction

In the previous chapters, we have tried to see some basic principles and components of communication and teaching methods and materials. In this chapter, we will see training approaches that are relevant to health educator roles and activities. In the context of the professional role of health educator, training is of vital importance.

The health educator has to play the role of trainer for training various categories of health personnel and other development workers.

8.1 What is Training?

Training is the process of education in which both the mind and body are brought under exercise and discipline. It is the act of acquiring

Necessary qualification or occupation or feat of physical skill or endurance.

8.2 Types of training

- **Pre-service:** involves the preparation in general of any trainee for qualifying for a certain set of professional or specific job oriented roles.
- **Orientation training:** refers to a preparation for the specific job to be performed in a particular position.
- **In service training:** It is a refresher course given with a view of updating knowledge and skills of the workers in any department or organization.

Training is the process of education in which both the mind and body

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8.3 Phases of Training

- Preparation (pre-training) phase
- Training phase
- Post-training (follow-up component)

8.4 Choosing Training Methods

Some of the important questions to ask ourselves to determine the type of methods to use are:

- What are the learning objectives? Is it to influence or change thinking, believing, feeling or doing? Also the role and experience status
- Who are the learners? Educational, cultural, motivational future
- How much time do we have?
- What other resources are available?
- How can active involvement by the participants be made certain?

Based on these queries, the following methods or combinations of them can be used.

- Lecturing- the most common and easiest method but the least efficient especially in addressing how to do a job.
- Lecture and discussion-asking questions encourage participation. It gives more opportunity to learn.
- Provision of textbooks /handouts.
- Learner presentations
- Demonstrations-essential tools of training in task learning
- Audiovisual support- flipcharts, posters, slides, models.
- Popular art forms-they are one of the most effective training methods for many resources. These include dramas, role-plays, poems, sings and games

Evaluation is a process of determining the degree or amount of success with pre-determined objective.

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A. Training Phase

In the actual training phase, training curriculum is to be followed and the necessary arrangements have to be made for concurrent monitoring and evaluation. The training curriculum should be modified now and then by making mid-course correction and change to suit the objectives and needs. The training phase must insure the opportunities for learning by doing and also creating necessary climate or environment in which learning can take place effectively.

B. Evaluation of Training

Evaluation is a process of determining the degree or amount of success with pre-determined objective.

Steps for evaluation

- **Input evaluation-** examines what resources were used based on which we can calculate the cost per graduate-efficiency.
- **Process evaluation-** looks at what methods are used; see how trainees are progressing, training run as per the schedule.
- **Output evaluation-** reviews the quality and numbers of people trained to see if they meet standards and the targets or objectives set during the planning process. This includes the knowledge and skill tests.
- **Outcome/Impact evaluation-** examines what the results or effects the graduates have achieved in the work they are trained for. This is performed using field assessment through observations and surveys.

The training phase must insure the opportunities for learning by doing and also creating necessary climate or environment in which learning can take place effectively.

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8.5 Review questions and answers of chapter 8

PART ONE: TRUE AND FALSE

1. Evaluation is a process of determining the degree or amount of success with pre-determined objective.
 - A. True
 - B. False
2. The training phase must insure the opportunities for learning by doing and also creating necessary climate or environment in which learning can take place effectively.
 - A. True
 - B. False
3. The training phase must insure the opportunities for learning by doing and also creating necessary climate or environment in which learning can take place effectively.
 - A. True
 - B. False
4. Lecturing- the most common and easiest method but the least efficient especially in addressing how to do a job.
 - A. True
 - B. False
5. Demonstrations-essential tools of training in task learning
 - A. True
 - B. False

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PART ONE: DIRECT QUESTIONS

1. What is Training?
2. Types of training
3. Phases of Training
4. Steps for evaluation
5. Evaluation

Answers to review questions

1. **Training** is the process of education in which both the mind and body are brought under exercise and discipline.
2. **Types of training**
 - A. Pre-service
 - B. Orientation training
 - C. In service training
3. **Phases of Training**
 - A. Preparation (pre-training) phase
 - B. Training phase
 - C. Post-training (follow-up component)
4. **Steps for evaluation**
 - A. Input evaluation
 - B. Process evaluation
 - C. Output evaluation
 - D. Outcome/Impact evaluation
5. **Evaluation** is a process of determining the degree or amount of success with pre-determined objective.

Part one: T&F

1. A
2. A
3. A
4. A
5. A

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CHAPTER NINE: HEALTH EDUCATION PROGRAMS

9.0 Introduction

The Health Education Program mission is to provide basic information about the Health Service committee of any country that leads the responsibility of the people, and also Believing that many of the health problems found in most African country particularly Somalia are the result of behavior and lifestyle choices, the Health Education program is committed to an emphasis on wellness through health promotion and disease prevention.

There are a huge number of health education programs that has an important role in promotion of health and prevention of disease and some of them are the following:

9.1 The importance of breast feeding

Virtually all mothers can breastfeed, provided they have accurate information, and the support of their family, the health care system and society at large.

Colostrum, the yellowish, sticky breast milk produced at the end of pregnancy, is recommended by WHO as the perfect food for the newborn, and feeding should be initiated within the first hour after birth.

Breast milk is the milk produced by a lactating female. Breastfeeding should commence as soon as possible after giving birth (8-12 times per 24 hours). Babies should be breastfed exclusively for the first 6 months and continued with weaning until 12 months and further on, depending on the situation of the mother and child. Breast milk creates a special bonding experience between the mother and child that suggest lovely, parenthood and strong relations between the child and his/her parents. Breast milk is a complete food for the infant. The nutritional profile of breast milk in terms of calories, vitamins, and minerals is the BEST for the infant as it has the perfect proportion of them all. From antibodies which protect an infant at birth, to the exclusive nutrients in mothers' milk which prevent a number of childhood diseases, the benefits of breastfeeding are incalculable.

Breast milk is a complete food for the infant.

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Exclusive breastfeeding is recommended up to 6 months of age, with continued breastfeeding along with appropriate complementary foods up to two years of age or beyond.

Numerous studies from around the world have shown that stomach viruses, lower respiratory illnesses, ear infections, and meningitis occur less often in breastfed babies and are less severe when they do happen. Exclusive breastfeeding (meaning no solid food, formula, or water) for at least six months seems to offer the most protection.

One large study by the National Institute of Environmental Health Sciences showed that children who are breastfed have a 20 percent lower risk of dying between the ages of 28 days and 1 year than children who weren't breastfed, with longer breastfeeding associated with lower risk.

The main immune factor at work here is a substance called secretory immunoglobulin A (IgA) that's present in large amounts in colostrum, the first milk your body produces for your baby. (Secretory IgA is present in lower concentrations in mature breast milk.) The substance guards against invading germs by forming a protective layer on the mucous membranes in your baby's intestines, nose, and throat.

9.2 Hygiene and sanitation

Hygiene refers to conditions and practices that help to maintain health and prevent the spread of diseases. Medical hygiene therefore includes a specific set of practices associated with this preservation of health, for example environmental cleaning, sterilization of equipment, hand hygiene, water and sanitation and safe disposal of medical waste, Also including body hygiene, personal hygiene, sleep hygiene, mental hygiene, dental hygiene, and occupational hygiene.

Hygiene refers to conditions and practices that help to maintain health and prevent the spread of diseases.

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Sanitation is the hygienic means of promoting health through prevention of human contact with the hazards of wastes as well as the treatment and proper disposal of wastewater. Hazards can be physical, microbiological, biological or chemical agents of disease. Wastes that can cause health problems include human and animal excreta, solid wastes, domestic wastewater, industrial wastes and agricultural wastes.

The importance of hygiene and sanitation included:

- provide barriers between excreta and humans in such a way as to break the disease transmission cycle
- Promotion a healthy living environment for everyone, to protect the natural resources (such as surface water, groundwater, soil), and to provide safety, security and dignity for people when they defecate or urinate.
- Limitation and controlling of Diarrhea, malaria, chest infections, skin diseases and other serious infections caused by poor hygiene and sanitation
- Body hygiene eliminates bad breath, unpleasant sensation, body secretions and smell or bad Oder
- Personal hygiene also keeps your mouth healthy by protecting your oral cavity from germs and also helps your skin to be clean
- Proper hygiene and good sanitation makes our economic progress because of the most infectious diseases that we treat high expensive cost can be prevented by proper sanitation and personal hygiene

Proper hygiene and good sanitation makes our economic progress because of the most infectious diseases can be prevented by proper sanitation and personal hygiene

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9.3 Balanced Diet

A balanced diet is one that gives your body the nutrition it needs to function properly. In order to get truly balanced nutrition, you should obtain the majority of your daily calories from fresh fruits and vegetables, whole grains, and lean proteins. The number of calories in a meal is a measure of the amount of energy stored in that food. Your body uses calories from food for walking, thinking, breathing, and everything else it does. The average person needs to eat about 2,000 calories every day to maintain his or her weight. A person's daily calorie intake should be based on age, gender, and physical activity level. Men generally need more calories than women, and active people need more calories than sedentary people.

9.4 The importance of Antenatal Care

Antenatal care is the care provided by a health professional or midwife to a woman during her pregnancy. Antenatal care is essential for every woman either trying to conceive or for those that have just discovered they are pregnant., Labor and birth of a child are important milestones in a couple's life.

A woman's health and behavior in pregnancy affect her baby. A poor diet, smoking, intake of alcohol, certain drugs, and severe illnesses can hold back the baby's development. Hence during pregnancy, you should not only take good care of your own health but also go for regular checkups with your doctor. This is antenatal care and it is absolutely necessary because it makes sure that you and the baby are fit and well. Antenatal checkups prevent most medical problems. Even if there is a problem, early detection helps to control the problem better. For example, there is a condition called pre- eclampsia in which there is weight gain, high blood pressure and stress on the kidney.

A person's daily calorie intake should be based on age, gender, and physical activity level.

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9.5 Family planning system

More than 200 million women in developing countries who want to use contraceptives don't have access to it according to the United Nations Population Fund and Guttmacher Institute. Family planning contraception reduces the amount of maternal and child deaths. every year, 100,000 women who don't want to be pregnant die in childbirth and pregnancy complications that can be limited by proper use of family planning system. Family planning is the planning of when to have children and the use of birth control and other techniques to implement such plans. Other techniques commonly used include sexuality education, prevention and management of sexually transmitted infections, pre-conception counseling and management, and infertility management.

The key facts of importance in family planning include:

- An estimated 225 million women in developing countries would like to delay or stop childbearing but are not using any method of contraception.
- Some family planning methods, such as condoms, help prevent the transmission of HIV and other sexually transmitted infections.
- Family planning / contraception reduce the need for abortion, especially unsafe abortion.
- Family planning reinforces people's rights to determine the number and spacing of their children.
- By preventing unintended pregnancy, family planning /contraception prevents deaths of mothers and children.
- Family planning allows people to attain their desired number of children and determine the spacing of pregnancies. It is achieved through use of contraceptive methods and the treatment of infertility

Family planning contraception reduces the amount of maternal and child deaths.

Health Education and Health Promotion

- Promotion of family planning – and ensuring access to preferred contraceptive methods for women and couples – is essential to securing the well-being and autonomy of women, while supporting the health and development of communities.
- Family planning can prevent closely spaced and ill-timed pregnancies and births, which contribute to some of the world's highest infant mortality rates. Infants of mothers who die as a result of giving birth also have a greater risk of death and poor health.
- Family planning reduces the risk of unintended pregnancies among women living with HIV, resulting in fewer infected babies. In addition, male and female condoms provide dual protection against unintended pregnancies and against STIs including HIV.
- Family planning is key to slowing unsustainable population growth and the resulting negative impacts on the economy, environment, and national and regional development efforts.

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Family planning reduces the risk of unintended pregnancies among women living with HIV, resulting in fewer infected babies.

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9.6 Review questions and answers of chapter 9

PART ONE: TRUE AND FALSE

1. Breast milk creates a special bonding experience between the mother and child that suggest lovely, parenthood and strong relations between the child and his/her parents.
 - A. True
 - B. False
2. Exclusive breastfeeding is recommended up to 6 months of age, with continued breastfeeding along with appropriate complementary foods up to two years of age or beyond.
 - A. True
 - B. False
3. Hygiene refers to conditions and practices that help to maintain health and prevent the spread of diseases.
 - A. True
 - B. False
4. A person's daily calorie intake should be based on age, gender, and physical activity level.
 - A. True
 - B. False
5. Breastfeeding should commence as soon as possible after giving birth 8-12 times per 24 hours.
 - A. True
 - B. False
6. Family planning reduces the risk of unintended pregnancies among women living with HIV, resulting in fewer infected babies.
 - A. True
 - B. False

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7. The nutritional profile of breast milk in terms of calories, vitamins, and minerals is the BEST for the infant as it has the perfect proportion of them all.
 - A. True
 - B. False

Part two: Direct Questions

1. Define Hygiene
2. Define Sanitation
3. Mention The importance of Antenatal Care
4. List importance in family planning
5. Highlight The importance of breast feeding.

Answers of review questions

1. **Hygiene** refers to conditions and practices that help to maintain health and prevent the spread of diseases.
2. **Sanitation** is the hygienic means of promoting health through prevention of human contact with the hazards of wastes as well as the treatment and proper disposal of wastewater.
3. **The importance of Antenatal Care**
 - A. provide barriers between excreta and humans in such a way as to break the disease transmission cycle
 - B. Promotion a healthy living environment for everyone, to protect the natural resources
 - C. Limitation and controlling of Diarrhea, malaria, chest infections, skin diseases and other serious infections caused by poor hygiene and sanitation
 - D. Body hygiene eliminates bad breath, unpleasant sensation, body secretions and smell or bad Oder
 - E. Antenatal care is the care provided by a health professional or midwife to a woman during her pregnancy. Antenatal care is essential for every woman either trying to conceive or for those that have just discovered they are pregnant., Labor and birth of a child are important milestones in a couple's life.

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4. importance in family planning

- A. Some family planning methods, such as condoms, help prevent the transmission of HIV and other sexually transmitted infections.
- B. Family planning / contraception reduce the need for abortion, especially unsafe abortion.
- C. Family planning reinforces people's rights to determine the number and spacing of their children.
- D. By preventing unintended pregnancy, family planning /contraception prevents deaths of mothers and children.

5. The importance of breast feeding

Babies should be breastfed exclusively for the first 6 months and continued with weaning until 12 months and further on, depending on the situation of the mother and child. Breast milk creates a special bonding experience between the mother and child that suggest lovely, parenthood and strong relations between the child and his/her parents. Breast milk is a complete food for the infant. The nutritional profile of breast milk in terms of calories, vitamins, and minerals is the BEST for the infant as it has the perfect proportion of them all.

Part one: T &F

- 1. A
- 2. A
- 3. A
- 4. A
- 5. A

SECTION TWO: HEALTH PROMOTION

CHAPTER ONE: OVERVIEW

1.1 Overview

Health promotion is the process of improving and protecting the health of the public, including individuals, populations, and communities. Health promotion and disease prevention can be achieved through planned activities and programs that are designed to improve population health outcomes. Health promotion and disease prevention programs can empower individuals to make healthier choices and reduce their risk of disease and disability. At the population level, they can eliminate health disparities, improve quality of life, and improve the availability of healthcare and related services.

Health promotion programs can be implemented in varied settings, including rural communities. Rural residents can benefit from health promotion and disease prevention programs scaled for use in rural communities, which have unique implementation considerations.

Health promotion and disease prevention programs focus on keeping people healthy. Health promotion programs aim to engage and empower individuals and communities to choose healthy behaviors, and make changes that reduce the risk of developing chronic diseases and other morbidities.

It is more than preventing illness and focuses on changing patterns of behaviors. Health promotion and disease prevention are the challenge of the 21st century.

Health promotion is the process of improving and protecting the health of the public, including individuals, populations, and communities.

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Defined by the World Health Organization, health promotion:

“enables people to increase control over their own health. It covers a wide range of social and environmental interventions that are designed to benefit and protect individual people’s health and quality of life by addressing and preventing the root causes of ill health, not just focusing on treatment and cure.”

Disease prevention differs from health promotion because it focuses on specific efforts aimed at reducing the development and severity of chronic diseases and other morbidities.

Wellness is related to health promotion and disease prevention. *Wellness* is described as the attitudes and active decisions made by an individual that contribute to positive health behaviors and outcomes. Health promotion and disease prevention programs often address **social determinants of health**, which influence modifiable risk behaviors. Social determinants of health are *the economic, social, cultural, and political conditions* in which people are born, grow, and live that affect health status. Modifiable risk behaviors include, for example, tobacco use, poor eating habits, and lack of physical activity, which contribute to the development of chronic disease.

Social determinants of health are the economic, social, cultural, and political conditions in which people are born,

Health Education and Health Promotion

Typical activities for health promotion, disease prevention, and wellness programs include:

- **Communication:** Raising awareness about healthy behaviors for the general public. Examples of communication strategies include public service announcements, health fairs, mass media campaigns, and newsletters.
- **Education:** Empowering behavior change and actions through increased knowledge. Examples of health education strategies include courses, trainings, and support groups.
- **Policy, Systems, and Environment:** Making systematic changes – through improved laws, rules, and regulations (policy), functional organizational components (systems), and economic, social, or physical environment – to encourage, make available, and enable healthy choices.

Since the early nineteenth century, the health of the public has improved dramatically, though the extent of such changes has varied between countries and within populations. In high income countries, such improvements have resulted from three main approaches: *health care; health promotion, including prevention services; and public policies covering a wide variety of social and environmental conditions*. Recently, attempts to quantify the contributions of these different approaches have demonstrated the difficulties of arriving at rigorous conclusions. Despite this, it would appear that the three main approaches have probably contributed equally to the staggering declines in mortality and improvements in people's health that have taken place.

Health Education and Health Promotion

Health promotion is probably the most ethical, effective, efficient and sustainable approach to achieving good health. It was defined initially by the World Health Organization in 1986, but the definition has since been refined to take account of new health challenges and a better understanding of the economic, environmental and social determinants of health and disease. The most widely accepted and utilized definition of health promotion is: *'The process of enabling people to increase control over the determinants of health and thereby improve their health'* (WHO, 1986). Before considering where health promotion is located in relation to other public health activities, you first need to think about what is meant by the term 'health'.

Health promotion is probably the most ethical, effective, efficient and sustainable approach to achieving good health.

The emergence of public health

Terms in public health are used differently in different countries and are interpreted differently by politicians, depending upon their ideological perspectives. There is a multitude of terms, including health education, health improvement, health protection, disease prevention and health development. It is important to reflect upon the historical context and the professional and political interests and ideologies that underpin these different concepts.

Learning objectives

After working through this chapter, you will be able to:

- A. distinguish between public health, health education and health promotion
- B. understand the origins and development of health promotion
- C. understand what is meant by a health promotion need
- D. distinguish health-related behaviours from health-related needs
- E. describe the way in which health promotion attempts to influence people to change their behaviour
- F. identify a range of intervention targets and needs that may be addressed to improve the health of a population
- G. understand what are meant by a health promotion intervention and health promotion programme
- H. plan health promotion programmes that address multiple needs

Health Education and Health Promotion

Health promotion is: 'The process of enabling people to increase control over the determinants of health and thereby improve their health' (WHO, 1986).

Key terms

Aim an expanded and refined version of a goal that sets out the means by which the end point, in general terms, is to be attained.

Health-related behaviour Things people do that affect their health (e.g. sexual activity that involves exposure to infections).

Health-related needs Attributes people need to have to be able to control their health-related behaviour: knowledge and awareness; access to resources; interpersonal skills and physical motor skills; and bodily autonomy.

Intervention A purposeful activity using finite resources that occurs in a specific place with the aim of changing something specific for a specific person or group of people.

Objective Concrete and specific elaboration of an aim.

Programme A collection of interventions that share an overall health-related goal.

Setting (site) The place or location in which intervention activities.

Aim is an expanded and refined version of a goal that sets out the means by which the end point, in general terms, is to be attained.

Health Education and Health Promotion

1.2 INTRODUCTION

The process of enabling people to increase control over the determinants of health and thereby improve their health. *Health is the state of complete physical, mental and social well-being and not merely the absence of disease or infirmity.* Model Simplified versions of something complex used to analyses and solve problems or make predictions. *Public health is the science and art of promoting health, preventing disease and prolonging life through the organized effects of society.* *Theory A set of interrelated propositions or arguments that help to clarify complicated problems or help to understand complex reality more easily.*

Health promotion is probably the most ethical, effective, efficient and sustainable approach to achieving good health. It was defined initially by the World Health Organization in 1986, but the definition has since been refined to take account of new health challenges and a better understanding of the economic, environmental and social determinants of health and disease.

The most widely accepted and utilized definition of health promotion is: *'The process of enabling people to control over the determinants of health and thereby improve their health' (WHO, 1986).*

States of health and disease are influenced by various behaviours. For example, eating a balanced diet or taking antibiotics reduce the risk of some diseases and engaging in unprotected sex or breathing asbestos increase the risk of others.

In turn, whether individuals engage in such behaviours is influenced by whether people possess various things required to have maximum control over their behaviours – i.e. whether various 'needs' are met or not. For example, whether someone eats a balanced diet or not may be influenced by whether their need for accurate information about nutrition has been met or not; whether someone engages in unprotected sex or not may be in part influenced by whether their need for developing interpersonal sexual negotiation skills has been met or not.

Self-love is the greatest medicine.

Health Education and Health Promotion

We can identify needs by asking the individuals themselves (i.e. 'expressed' need) or by 'experts' identifying on the basis of logic or research what someone might need (i.e. 'normative' need). Most complex behaviours are associated with a number of different needs (e.g. knowledge, interpersonal skills, access to resources). In addition, different people may require different interventions to meet the same need. For example, knowledge may be gained by some through a leaflet while others may require a face-to-face conversation.

The extent to which individuals' identified health needs are met is dictated by the actions of policy-makers, education, health and social services and communities.

Policy-makers include central and local governments and strategic decision-makers in organizations, and it is policy-makers – rather than the people delivering the services – who usually determine which and how services are delivered. Further, everyone is a member of one or more 'community' and people get many of their health-related needs met by the people they live with and are around on a daily basis, making them important vectors for health too. Each of the three constituencies (policy-makers, services and communities) influences the health of others as a result either of their planned or unplanned intervention or as a result of their not intervening.

These constituencies' activities are themselves dictated by the extent to which their own 'needs for action' are met. 'Need for action' here refers to the things that these people need to have, such as information, institutional capacity and favorable attitudes, in order to intervene in a useful manner.

"To insure good health: Eat lightly, breathe deeply, live moderately, cultivate cheerfulness, and maintain an interest in life." **William Londen**

Health Education and Health Promotion

An overall goal to improve the health of a population may involve interventions targeted at the needs of these three constituencies to act in the interests of the population, as well as (or even instead of) interventions targeted at the population itself. It follows that no one type of intervention will be able to meet all needs associated with a health issue for all people. Consequently, a collection of interventions is usually needed to address any health issue. A collection of interventions is called a program.

The relationships between health outcomes, behaviours and needs are complex and often poorly understood. Most interventions are able to impact on a number of needs, most needs are associated with a number of behaviours and most behaviours have impacts on more than one health outcome. Conversely, how frequently a disease occurs in a population (its incidence) is related to many biological, psychological and social factors. Not all of these are amenable to change through medicine or health promotion and therefore not all can be thought of in terms of 'need'. Many diseases have multiple risk behaviours associated with them and the incidence of each risk behaviours in a population influences the incidence of several health outcomes. *For example*, the frequency of unprotected sexual intercourse between people with and without HIV infection will influence how frequently HIV is transmitted (only a proportion of these events will result in transmission).

How frequently this occurs will be influenced by rate of partner change in the population and the overall frequency of unprotected intercourse. These two factors will also influence the incidence of other sexually transmitted infections, as well as pregnancies. So the same population behaviours have multiple health impacts. It follows then that any unmet health need is likely to impact on several health related behaviours. *For example*, lack of assertiveness makes safer sexual negotiation more difficult and reduces ability to resist peer pressure around smoking and drinking, as well as disadvantaging people in the health market-place. This is part of the explanation for *why different types of ill health cluster in the same people*.

“Eat Good Feel Good.”

Health Education and Health Promotion

What one views as acceptable means of influence will determine how one evaluates the success of health promotion interventions. If the approach to behaviour change is solely in terms of empowering people to make their own choices, one would evaluate health promotion mostly in terms of the extent to which it meets identified needs as well as the behaviour it is intended to influence.

If one views health promotion as aiming to influence behaviours by any means necessary, including empowering and in some cases directive ones, one would primarily focus on changes in behaviour or health status, although one might also want to examine other factors such as whether needs have been met in order to understand how interventions may have worked.

“The best investment you’ve ever make is your own Health.”

1.3 BRIEF HISTORY OF HEALTH PROMOTION

The first International Conference on Health Promotion was held in Ottawa in 1986, and was primarily a response to growing expectations for a new public health movement around the world. It launched a series of actions among international organizations, national governments and local communities to achieve the goal of "Health For All" by the year 2000 and beyond. The basic strategies for health promotion identified in the Ottawa Charter were: **advocate** (to boost the factors which encourage health), **enable** (allowing all people to achieve health equity) and **mediate** (through collaboration across all sectors).

Health promotion is the process of enabling people to increase control over and improve their health. Health is seen as a resource for everyday life, not the objective of living. Health promotion is not just the responsibility of the health sector, but goes beyond healthy lifestyles to wellbeing.

“Health is the greatest gift.”

Health Education and Health Promotion

The fundamental conditions and resources needed for good health are:

- ✓ Peace
- ✓ Shelter
- ✓ Education
- ✓ Food
- ✓ Income
- ✓ A stable ecosystem
- ✓ Sustainable resources
- ✓ Social justice and equity.

Three basic strategies for health promotion

The Ottawa Charter identifies three basic strategies for health promotion:

1. **Advocate** – good health is a major resource for social, economic and personal development, and an important dimension of quality of life. Political, economic, social, cultural, environmental, behavioural and biological factors can all favour or harm health. Health promotion aims to make these conditions favourable, through advocacy for health.
2. **Enable** – health promotion focuses on achieving equity in health. Health promotion action aims to reduce differences in current health status and to ensure the availability of equal opportunities and resources to enable all people to achieve their full health potential. This includes a secure foundation in a supportive environment, access to information, life skills and opportunities to make healthy choices. People cannot achieve their fullest health potential unless they are able to control those things that determine their health. This must apply equally to women and men.

“Health requires healthy food.” – Roger Williams

Health Education and Health Promotion

3. **Mediate** – the prerequisites and prospects for health cannot be ensured by the health sector alone. Health promotion demands coordinated action by all concerned, including governments, health and other social and economic sectors, non-government and voluntary organisations, local authorities, industry and the media.

Health promotion priority action areas identified in the Ottawa Charter are:

- **Build healthy public policy** – health promotion policy combines diverse but complementary approaches, including legislation, fiscal measures, taxation and organisation change. Health promotion policy requires the identification of obstacles to the adoption of healthy public policies in non-health sectors and the development of ways to remove them.
- **Create supportive environments** – the protection of the natural and built environments, and the conservation of natural resources must be addressed in any health promotion strategy.
- **Strengthen community actions** – community development draws on existing human and material resources to enhance self-help and social support, and to develop flexible systems for strengthening public participation in, and direction of, health matters. This requires full and continuous access to information and learning opportunities for health, as well as funding support.
- **Develop personal skills** – enabling people to learn (throughout life) to prepare themselves for all of its stages and to cope with chronic illness and injuries is essential. This has to be facilitated in school, home, work and community settings.
- **Reorient health services** – the role of the health sector must move increasingly in a health promotion direction, beyond its responsibility for providing clinical and curative services. Reorienting health services also requires stronger attention to health research, as well as changes in professional education and training.

Health promotion is the process of enabling people to increase control over and improve their health.

Health Education and Health Promotion

- **Moving into the future** – caring, holism and ecology are essential issues in developing strategies for health promotion. A guiding principle should be that women and men should become equal partners in each phase of planning, implementation and evaluation of health promotion activities.

Commitment to health promotion

The participants at the conference pledged to:

- Move into the arena of healthy public policy and advocate a clear political commitment to health and equity in all sectors
- Counteract the pressures towards harmful products, resource depletion, unhealthy living conditions and environments, and bad nutrition, and focus attention on public health issues such as pollution, occupational hazards, housing and settlements
- Respond to the health gap within and between societies, and tackle the inequities in health produced by the rules and practices of these societies
- Acknowledge people as the main health resource – to support and enable them to keep themselves, their families and friends healthy through financial and other means – and accept the community as the essential voice in matters of its health, living conditions and wellbeing
- Reorient health services and their resources towards the promotion of health, and share power with other sectors, disciplines and with people.
- Recognize health and its maintenance as a major social investment and challenge, and address the overall ecological issues of our ways of living.

Health is seen as a resource for everyday life, not the objective of living.

Health Education and Health Promotion

1.4 What constitutes an intervention description?

Interventions are purposeful and planned actions intended to contribute to a reduction in unmet health-related need (and hence a reduction in illness-related behaviour or an increase in health-related behaviours). They include actions directed towards, for example, government ministers, newspaper editors and service commissioners as well as actions directed at the population of concern. Without a purpose and a plan, an activity should not be considered an intervention.

The purpose for a health-related intervention is to address the requirements for action, or needs, in a specific person or group of people. The needs are defined by the health- or illness-related behaviour they are attached to.

The plan consists of a number of activities that take place in a specific location, the site of the intervention. In order to complete an intervention description, we should say something about the resources required to do the intervention. So there are five essential elements to all intervention descriptions: *aim, setting, target, objectives and resource*.

Intervention aims

As discussed above, different people approach influencing behaviours in different ways. Some approach behaviour change through reducing the needs of the target of the intervention. Others may seek to influence behaviour via empowering people to make their own decisions (e.g. educating people about a healthy diet) and sometimes by using more directive means (e.g. taxing foods with high fat content). Which, if either, approach is effective will vary depending on the behaviour under consideration. If we take the view that empowered populations act in their own.

Interventions are purposeful and planned actions intended to contribute to a reduction in unmet health-related need.

Health Education and Health Promotion

interests and make healthier decisions than disempowered populations, interventions should aim to influence needs. In other words, the success of a specified intervention is defined by its impact on needs. The remainder of this chapter argues for evaluation to focus primarily on outcomes concerned with reductions in need. Needs in this case are defined as the requirements for control over health-related behaviours. For example, in the case of HIV risk behaviours, HIV prevention needs may include physical autonomy (freedom from assault and rape), assertiveness skills, ability to negotiate safer sex (interpersonal skills), ability to establish one's own HIV status (i.e. access to HIV testing), access to condoms and the knowledge and ability to use them properly, knowledge and awareness of HIV and its prevention etc. What we judge the needs related to a behaviour to be are related to our theories about why people do what they do, our judgements about what can be changed by interventions and our ethical position about what interventions should do.

One way to elucidate the aims of an intervention is to answer the question In what way is the target group different after the intervention objectives have occurred? It is important not to fall back on the behaviours of the target group here. Since different people may do the same thing for different reasons, and since the same people may do different things for the same reason, any behaviour may be associated with a wide range of needs. Interventions do not change people's behaviours. Interventions (sometimes) change people, and people change their behaviours.

Intervention settings and sites Settings specify how the people the intervention is intended to change encounter the intervention activities. All intervention objectives must take place somewhere and the place they occur in is a key determinant of both their feasibility and the profile of the people who encounter them. Although no specific activities can be done everywhere, there are few places in which no health promotion activities can be done.

Challenging yourself every day is one of the most exciting ways to live.

Health Education and Health Promotion

This means the potential range of settings for health promotion interventions is enormous. Interventions intended to reduce health-related needs can be carried out in: the media (press, radio, television); the street; socializing business (pubs, clubs, restaurants); schools; community and religious centres (including churches, mosques, synagogues); service centres (clinics, organizational bases); care-homes; prisons; personal homes. In addition, interventions targeted at the needs for action of, for example, policy makers and service providers can occur through professional networks.

In these cases, the potential targets may hear about the intervention through being contacted directly. Many of these settings are places where people are present for some reason other than health promotion activities. Activities in these settings do not usually require a front-end (the people are already there). Interventions occurring in places where people have to attend (i.e. where the intervened on come to the intervenor) usually require an additional intervention (recruitment) in a place where people are already (including, e.g., reading press magazines and newspapers). Where these front-end interventions occur will dictate who attends.

Intervention Targets

target groups are defined to maximize the impact of the intervention through trying to ensure the people who encounter the intervention are those in most need of it. Descriptions of target groups are therefore in some ways surrogate markers for a combination of the health concern at issue or the specific unmet needs the intervention addresses. However, interventions are not always targeted at those most likely to suffer from an illness or most likely to have a need unmet. Very few interventions can aspire to serve people equally irrespective of where they live in a country (there are, e.g., few 'national' interventions). The interests of the funder of the intervention and the values of the intervenor both mediate between need and target group.

Never give up on a dream just because of the time it will take to accomplish it. The time will pass anyway. -
Earl Nightingale.

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The specified target should be as comprehensive as possible and aspects of the target group not mentioned should be assumed to be equally served by the intervention. So, for example, 'young people' does not mean 'young heterosexual people' unless it explicitly says so. An intervention whose target is simply 'young people' should be expected to be of equal benefit to gay/lesbian and heterosexual young people, young people from ethnic minorities as well as the ethnic majority, disabled young people as well as able-bodied young people, and so on. It should also be expected equally to benefit young men as well as young women, unless specified otherwise. The profile of people whose needs are intended to change as a result of intervention activities can include consideration of gender, age, ethnicity, sexuality, disability, class/occupation/education, area of residence, as well as other characteristics. If the intervention is targeted at service providers or policy-makers, the intervention description should be as precise as possible about who these people are. In this case, the potential target audience is usually much smaller than the potential target audience among the general public.

Intervention objectives

Generally, aims are where you want to be and objectives are what you do to get there. What constitutes an objective depends on where an aim is pitched. For example, if our aim is reducing new sexually-acquired HIV infections, our objectives could be to reduce sexual HIV exposures and the biological factors that facilitate transmission (e.g. concurrent STIs, body fluid transfer, increasing post exposure prophylaxis etc.). Subsequently, if our aim is reducing sexual HIV exposure, our objectives could be to increase knowledge, awareness, skills, access to condoms, etc. Then if our aim is to increase knowledge, our objectives could be to write, design, produce and distribute an information leaflet. At the most immediate and basic level then, objectives are the things that you do that constitute the intervention. This is the first level at which objectives can be specified and it is what is meant when we refer to intervention objectives. Objectives include the sequence of events that occur as well as the methods and approaches being used.

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The different methods and approaches commonly used in health promotion to address individual, there is not a simple divide between 'effective' and 'ineffective' methods; rather, different methods are more or less effective at achieving different aims with different groups in different settings.

Note that the objectives include what the people being intervened on do as well as what the intervention does. An intervention cannot be said to have occurred if a leaflet is put in a rack but no one ever takes it and reads it. It is the act of reading the leaflet that completes the objectives of the intervention.

Small media such as leaflets and postcards require a distribution mechanism to get them into people's hands. So, for example, 'a leaflet' is not in itself an intervention. Similarly, some objectives are incomplete without a 'front-end'. Recruitment is often half of an intervention and should be included in the description of the activities.

Intervention resources

A description of an intervention should say something about the resources required to carry it out. While this can be expressed as money, there may also be some resources required to do the intervention that cannot be purchased by the health promoter.

Three basic strategies for health promotion Political, economic, social, cultural, environmental, behavioural and biological factors can all favour or harm **health**. **Health promotion** aims to make these conditions favourable, through advocacy for **health**.

What are the 5 principles of health promotion?

The **five principles** are: (1) A broad and positive **health** concept; (2) Participation and involvement; (3) Action and action competence; (4) A settings perspective and (5) Equity in **health**.

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Pillars of health promotions according to the WHO:

1. Build **healthy** public policy
2. Create supportive environments
3. Strengthen community actions
4. Develop personal skills
5. Reorient **health** services.

Others Pillars of health promotions

1. Good Governance.
2. Healthy Cities.
3. Health Literacy.

Why is health promotion important?

Why is health promotion important? Health promotion reduces premature deaths. By focusing on prevention, health promotion reduces the costs (both financial and human) that individuals, employers, families, insurance companies, medical facilities, communities, the state and the nation would spend on medical treatment.

Examples of effective health promotion activities for child and family health

1. Promoting breastfeeding.
2. Promoting child and family nutrition.
3. SIDS prevention and education
4. Injury prevention
5. Promoting physical activity.
6. Smoking cessation programs such as 'quit' activities and 'brief interventions'

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Initiatives and benefits to promote physical wellbeing include:

1. Exercise programmes such as outdoor activities, team sports, exercise groups or gym memberships.
2. Improving workplace safety through training, safe equipment and safe practices.
3. Healthier working environments, such as ergonomic work areas.

How do you implement health promotion?

1. Step 1: manage the planning process.
2. Step 2: conduct a situational assessment.
3. Step 3: identify goals, populations of interest, outcomes.
4. Step 4: identify strategies, activities, outputs, process.
5. Step 5: develop indicators.
6. Step 6: review the program plan.

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Motivation is what gets you started. Habit is what keeps you going. - Jim Ryn

Health Education and Health Promotion

1.5 Review questions and answers of chapter 1 health promotion

Part one: circle the correct answer

1. The first International Conference on Health Promotion was held in
 - A. Ottawa in 1986
 - B. France 1987
 - C. Qahira 1977
2. The process of enabling people to control over the determinants of health and thereby improve their health' (WHO, 1986)
 - A. Health promotion
 - B. Health education
 - C. Health process
3. The fundamental conditions and resources needed for good health are the following except
 - A. Peace
 - B. Shelter
 - C. Education
 - D. Food
 - E. Money

PART TWO: TRUE AND FALSE

1. Health promotion are purposeful and planned actions intended to contribute to a reduction in unmet health-related need.
 - A. True
 - B. False
2. Health promotion strategies and programs should be adapted to the local needs and possibilities of individual countries and regions to take into account differing social, cultural and economic systems.
 - A. True

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- B. False
3. Good health is a major resource for social, economic and personal development, and an important dimension of quality of life.
- A. True
B. False
4. The relationships between health outcomes, behaviors and needs are complex and often poorly understood.
- A. True
B. False
5. Health education is probably the most ethical, effective, efficient and sustainable approach to achieving good health.
- A. True
B. False

PART THREE: DIRECT QUESTIONS

1. Define health promotion?
2. When was the first International Conference on Health Promotion?
3. What are The fundamental conditions and resources needed for good health?
4. List Principles of health promotion?
5. What constitutes an intervention description?

Part one: T&F

1. B
2. A
3. A
4. A
5. B

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Answers of review questions

1. **Health promotion** is the process of enabling people to increase control over and improve their health.

2. **The first International** Conference on Health Promotion was held in Ottawa in 1986

3. **The fundamental conditions** and resources needed for good health?

- A. Peace
- B. Shelter
- C. Education
- D. Food

4. **Principles of health promotion?**

- A. A broad and positive health concept
- B. Participation and involvement
- C. Action and action competence
- D. A settings perspective and
- E. Equity in health.

5. **Interventions** are purposeful and planned actions intended to contribute to a reduction in unmet health-related need.

Health Education and Health Promotion

CHAPTER TWO: AN OVERVIEW OF HEALTH & HEALTH PROMOTION

2.0 Introduction

The "first and best known" definition of health promotion by the American Journal of Health Promotion (AJHP) since at least 1986 is: " The science and art of helping people change their lifestyle to move toward a state of optimal health " .

The goal of health promotion: Enable people to exercise control over their well – being and ultimately improve their health.

Health promotion combination:

1. Education
2. Organizational involvement
3. Economics
4. Political influences

Fundamentals areas of health promotion

- 1) Nutrition
- 2) Physical fitness
- 3) Weight control
- 4) Cultural sensitivity
- 5) Avoidance of harmful substance

Factors affecting health:

- 1) Genetics and human biology
- 2) Environmental influences
- 3) Personal behavior
- 4) Health care

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- A. **Genetics** (genetic makeup may include inherited disorders such as sickle-cell anemia)
- B. **Female & male** hormones (produce biological effects)

Environmental influences (Natural or man-made):

- A. Exposure to chemicals (asbestos in older buildings, lead paint in older houses, mercury in polluted water sources)
- B. Radiation from the sun, exposure to solar radiation
- C. Natural disasters; hurricanes, floods, volcanic eruptions, heat waves
- D. Man – made environmental crises; wars, bombings, pollution

Personal behavior:

- A. Diet (healthy eating habits)
- B. Exercise (improves muscle strength, circulation, emotional wellness, increases endurance, lowers BP, reduces the chances of heart attacks, osteoporosis) Health club are wonderful places for regular exercise
- C. Personal care: skin hygiene, proper body mechanics, adequate sleep, dental hygiene
- D. Sexual relationships: use values, ethics, morals
- E. Level of stress: not all stress is harmful, limited stress raises one's energy level & makes more alert
- F. Tobacco & drug use
- G. Alcohol use 8 – Safety

Health protecting behaviors: Those that protect people from problems that jeopardize (expose to hazard) their health and well-being ,e.g ;

- 1 – Immunization against infectious diseases
- 2 – Reducing exposure to environmental health hazards

Health Education and Health Promotion

Health promoting behaviors: Those that improve health by fostering personal development or self-actualization. e.g ;

- A. Managing dietary intake
- B. Exercise
- C. Stress management

Health promotion & health Protecting programs:

- A. Programs for individual (depend on accurate assessment of individual needs & risk to health)
- B. Programs for families (community health nurse works with family)
- C. Programs for communities (the major types include; school, workplace, faith community, hospital, senior center, community wide programs)

2.1 Community health role as health promoter

- A. Assist people & groups in taking actions that promote & maintain health and wellness
- B. Use the nursing process to promote health and prevent disease in the community 3 – An advocate for health
- C. Assisting individuals & groups in assessing their level of wellness
- D. Provide health education & options for health care.
- E. Helps clients establish goals for lifestyle changes

2.2 Levels of prevention:

1 – Primary Prevention, includes: - - Childhood immunization - Calcium rich foods to prevent osteoporosis - No smoking to prevent lung. cancer

Criteria of primary prevention: 1 - Primary prevention usually the least expensive intervention 2 - provides the greatest benefits.

2 – **Secondary Prevention:** It refers to the early detection, screening, diagnosis, and intervention to reduce the consequences of a health problem.

Health Education and Health Promotion

3 – **Tertiary Prevention:** Caring for a person who already has a health problem, which is treated after symptoms appeared to prevent farther prognosis, such as :

- A. Taking antibiotics for any infectious disease.
- B. Rehabilitation to prevent deterioration of person's condition & minimizing the lose of function.

Prevention health care team:

- A. **Individual:** Is the center of the prevention health care team, he / she must combine the knowledge & behavioral changes to live a healthier life (self-care).
- B. **Nurses:** They are great teachers of preventive health habits & health promotion activities.
- C. **Primary physicians (Family doctors) :** They refer clients to specialists for specific problems when necessary .

Health promotion: The primary means of health promotion occur through developing healthy public policy that addresses the prerequisites of health such as :-

- A. income
- B. housing
- C. food
- D. security
- E. employment
- F. quality working conditions

Worksite health promotion programs: (also called "workplace health promotion programs," "worksite wellness programs," or "workplace wellness programs") include:

- ✓ Exercise
- ✓ Nutrition
- ✓ Smoking cessation
- ✓ Stress management

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Conclusion: Health is affected by biological, psychological, chemical, physical, social, cultural and economic factors in people's normal living environments and people's lifestyles.

Sites for health promotion activities

- 1) Home
- 2) Community setting
- 3) Schools
- 4) Hospitals
- 5) Workplace

2.3 Approaches to health promotion:

- A. Medical approach: It focuses on disease & the biological, medical explanations of health ignoring the impact of social and environmental dimensions on health.
- B. Behavioral change approach: It encourages individuals to adopt healthy behaviors such exercise
- C. Educational approach: It is the provision of information and education to allow the individual to make informed decisions.
- D. Empowering approach: It helps individuals to identify their own health concerns and needs.
- E. Social change approach: It involves lobbying and policy planning. This approach focuses on the socioeconomic environment in determining health such as law income.

Poor households have limited resources for preventing and treating illnesses and injuries.

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Health As defined by the World Health Organization (WHO): state of complete physical, mental and social well-being, not merely the absence of disease or infirmity.

Characteristics

- A. A concern for the individual as a total system
- B. A view of health that identifies internal and external environment
- C. An acknowledgment of the importance of an individual's role in life

(A dynamic state in which the individual adapts to changes in internal and external environment to maintain a state of well-being.)

Illness State in which a person's physical, emotional, intellectual, social developmental or spiritual functioning is diminished or impaired. It is a condition characterized by a deviation from a normal, healthy state.

2.4 Stages of Illness

1. **Stage of Denial:** Refusal to acknowledge illness; anxiety, fear, irritability and aggressiveness.
2. **Stage of Acceptance:** Turns to professional help for assistance
3. **Stage of Recovery** (Rehabilitation or Convalescence) : The patient goes through of resolving loss or impairment of function.

Degrees of illness

- A. A person with terminal cancer or end stage of renal failure is classified as "very ill"
- B. Person recovering from a surgery" thyroidectomy" is classified as "less ill"
- C. Person with infections like bronchitis is classified as " mildly ill"

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Wellness

is generally used to mean a healthy balance of the mind, body and spirit that results in an overall feeling of well-being.

- **Wellness** is an active process of becoming aware of and making choices toward a more successful existence. This is consistent with a shift in focus away from illness in viewing human health, typical of contexts where the term wellness is used.
- In other words, wellness is a view of health that emphasizes the state of the entire being and its ongoing development.

2.5 Dimensions of wellness

- Physical dimension** The ability to carry out daily tasks achieve fitness by maintaining adequate nutrition, avoid using drugs and alcohol or using tobacco.
- Emotional dimension:** The ability to manage stress and express emotions appropriately. The ability to recognize, accept, and express feelings and to accept one's limitation.
- Social dimension:** The ability to interact successfully with people as a whole and within the environment of each person as part.
- Intellectual dimension:** The ability to learn and use information effectively for personal, family, and career development.
- Spiritual dimension:** Person's own morals, values and ethics.

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Measurement of Health Leading Health Indicators include:

1. Physical Activity.
2. Overweight and Obesity.
3. Tobacco Use.
4. Substance Abuse.
5. Responsible Sexual Behavior.
6. Injury, Violence and Safety.
7. Immunization.
8. Access to Health Care.

Disease prevention

Disease Prevention is to maximize public health and safety through the elimination, prevention, and control of disease, disability, and death.

The Three Levels of Prevention

✓ **Primary Prevention** primary prevention methods before the person gets the disease. Primary prevention aims to prevent the disease from occurring. So primary prevention reduces both the incidence and prevalence of a disease. Encouraging people to protect themselves from the sun's ultraviolet rays is an example of primary prevention of skin cancer.

✓ **Secondary Prevention** Secondary prevention is used after the disease has occurred, but before the person notices that anything is wrong. A doctor checking for suspicious skin growths is an example of secondary prevention of skin cancer. The goal of secondary prevention is to find and treat disease early. In many cases, the disease can be cured

✓ **Tertiary Prevention** Tertiary prevention targets the person who already has symptoms of the disease The goals of tertiary prevention are:

Health Education and Health Promotion

- A. prevent damage and pain from the disease
 - B. slow down the disease
 - C. prevent the disease from causing other problems (These are called "complications.")
 - D. give better care to people with the disease
 - E. make people with the disease healthy again and able to do what they used to do.
- Developing better treatments for melanoma is an example of tertiary prevention.

Examples include better surgeries, new medicines, etc.

Application of preventive measures

1. Primary prevention include:

a. Health Promotion

- ✓ Health education
- ✓ Environmental modifications
- ✓ Nutritional interventions
- ✓ Lifestyle and Behavioral Changes.

b. Specific Protection.

- ✓ Immunization
- ✓ Use of specific Nutrients
- ✓ Chemoprophylaxis
- ✓ Protection against hazards and accidents

2. Secondary Prevention Include:

- a. Early diagnosis
- b. Prompt treatment e.g. early detection of alteration of health/ Homeostasis and Treatment to reverse the condition.

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3. Tertiary Prevention Include:

a. Disability Limitation

To prevent or halt the transition of the disease process from impairment to handicap.

b. Rehabilitation

- **Medical Rehabilitation:** restoration of function.
- **Vocational Rehabilitation:** restoration of the capacity to earn a livelihood.
- **Social Rehabilitation:** restoration of family and social relationship.
- **Psychological Rehabilitation:** restoration of personal dignity and confidence.
- **Provision of community facilities for retraining and education.**

Health education is a process that informs, motivates, and help to adopt and maintain healthy practice and lifestyles, advocates environmental changes as needed to facilitate this goal.

- Health education is an approach for teaching patients and families to deal with past, present and future health problems. This knowledge enables them to make informed decisions, to cope more effectively with temporary or long-term alterations in health and lifestyle, and to assume greater responsibility for health.
- It can be defined as the principle by which individuals and groups of people learn to behave in a manner conducive to the promotion, maintenance, or restoration of health.

Health education is any combination of learning experiences designed to help individuals and communities improve their health, by increasing their knowledge or influencing their attitudes.

- The goal of all teaching is learning. Learning is defined as " a process resulting in some modification of relatively permanent of the behavior, i.e. way of thinking, feelings, doing of the learner". One way of understanding the nature of learning is to examine the three domains of learning.

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2.6 Domains of learning

1. Cognitive Domain The cognitive domain deals with the "recall" or recognition of knowledge and the development of intellectual abilities and skills.

2. Affective Domain This domain describes changes in attitudes, values, and appreciation. In affective domain nurses influence what clients, families and student think, value, and feel. It is difficult to change deep seated values, attitude, beliefs, and interests. To make such changes, people need support and encouragement from those around them. Praise is helpful. Group support also reinforce learning new behavior.

3. Psychomotor Domain This domain includes the performance of skills that require integration of mental and muscular ability. Three conditions must be met before psychomotor learning occurs:

- a) The learner must have necessary ability.
- b) The learner must have sensory image of how-to carryout the skill.
- c) The learner must have the opportunities to practice the learning Health education ultimately aims at adoption of new ideas and practice. People pass through a series of changes before they adopt a new practice.

2.7 Stage of Awareness

At this stage the person come to know about new idea or practice. He has only a general information about it and knows little about its usefulness and applicability to him.

1. Stage of Interest In this stage the person seeks more information, he is willing to listen or read or learn more about it.

2. Stage of Evaluation During this stage the person weights the pros and cones of the practice and evaluates its usefulness to him and his family. It is a mental exercise results in decision to try or reject the practice.

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3. Trial Stage In this stage education is put in to practice, he may experience the need for more information to solve the problems.

4. Adoption Stage At this stage, person decides that new practice is good and adopts it. In a community, people may be in different stages of the adoption process.

Health Promotion Health promotion is the process of enabling people to exert control over the determinants of health and thereby improve their health.

Strategies of Health Promotion:

1. Educational: To change values, beliefs, attitudes, opinions and behaviors

2. Policy: To encourage adherence to healthy behavior and discourage unhealthy behavior

3. Environmental: To make the environment safe to encourage healthy behaviors

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2.8 Review questions and answer of chapter 2 health promotion

PART ONE: CIRCLE THE CORRECT ANSWER

1. **Domain deals with the " recall" or recognition of knowledge and the development of intellectual abilities and skills.**
 - A. Cognitive Domain
 - B. Affective Domain
 - C. Psychomotor Domain
 2. **Strategies of Health Promotion are the followings except**
 - A. Educational
 - B. Policy
 - C. Environmental
 - D. Spiritual
 3. **Primary prevention aims**
 - A. To prevent the disease from occurring.
 - B. To prevent damage and pain from the disease
 - C. To prevent and treat disease early
 4. **It focuses on disease & the biological, medical explanations of health ignoring the impact of social and environmental dimensions on health.**
 - A. Medical approach
 - B. Behavioral change approach
 - C. Educational approach
 5. **A person with terminal cancer or end stage of renal failure is classified as**
 - A. very ill
 - B. less ill
 - C. mildly ill
1. List Fundamentals areas of health promotion
 2. Highlight Factors affecting health:
 3. Mention Levels of prevention:
 4. List Stages of Illness?
 5. Define Wellness?

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ANSWERS OF REVIEW QUESTIONS

Fundamentals areas of health promotion

1. Nutrition
2. Physical fitness
3. Weight control
4. Cultural sensitivity
5. Avoidance of harmful substance

Factors affecting health:

- A. Genetics and human biology
- B. Environmental influences
- C. Personal behavior
- D. Health care

Levels of prevention

- A. Primary prevention
- B. Secondary Prevention
- C. Tertiary Prevention

Stages of Illness

1. Stage of Denial
2. Stage of Acceptance
3. Stage of Recovery

Wellness

is generally used to mean a healthy balance of the mind, body and spirit that results in an overall feeling of well-being.

Part one: Circle

1. A
2. D
3. A
4. A
5. A

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CHAPTER THREE: DEVELOPING A HEALTH PROMOTION- PREVENTION PLAN

Learning Objectives

At the end of this chapter, the student should be able to:

- A. Discuss the assessment phase of health planning process.
- B. Identify the methods of data collection.
- C. Describe the components of community diagnosis.
- D. List the factors affecting the implementation of health planning process.

3.0 Introduction

Assessment of Community Health

Assessing community health requires gathering relevant existing data, generating missing data, and interpreting the data base.

The systematic collection of data includes:

- a. Gathering or compiling existing data
- b. Generating missing data
- c. Analysis and interpretation of data
- d. Identification of health needs/problems and capabilities.

Data gathering It is a process of obtaining readily available data, which describe the demography of the community

- a. Age, sex, socioeconomic and racial distribution.
- b. Vital statistics, including morbidity and mortality data.
- c. Community institution
- d. Health manpower characteristics.

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Data gathering Is the process of developing data, that don't already exist, through interaction with the community members or groups, these data include:

- a. Knowledge and beliefs.
- b. Values and sentiments.
- c. Goals, perceived needs, norms, problem solving process.
- d. Power and leadership and influence structure.

Composite data base A composite data base is created by combining the gathered and generated data. Data Interpretation Data interpretation seeks to attribute meaning to the data.

Data are analyzed and synthesized and the following themes are identified:

- a. Community health needs.
- b. Community health capabilities.
- c. Resources available to meet the needs.

3.1 Data collection methods

Methods of data collection could be classified as collection of direct data and reported data.

Following are methods of data collection:

- a. Informant Interviews
- b. Participant observation
- c. Wind shield Surveys
- d. Secondary analysis of existing data
- e. Surveys

Collection of direct collection Informant interviews, participant observation, and windshield surveys are the three methods of directly collecting data.

These methods require sensitivity, openness, curiosity, and ability in the nurse to listen, taste, touch, smell, and see life as it is lived in a community. Informant interviews It consists of directed conversation with selected members of a community about members or groups and events.

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Participant observation The deliberate sharing in the life of a community. The above two methods are suitable techniques for generating information about community norms, beliefs, values, power and influence structures and problem solving process.

Wind shield surveys Are the motorized equivalent of simple observation. The nurse driving a car or riding public transportation can observe many dimensions of community's life and environment. (e.g. common characteristic of people on the street, neighborhood, gathering places, housing quality, geographic boundaries, etc..)

Collection of reported data Secondary analysis and surveys are two methods of collecting reported data. Secondary analysis means use the previously collecting data. e.g. minutes of health meeting. Public documents.

Statistical data

Health records

Surveys Report data from a sample population/group. They are useful but time consuming and costly. Surveys are for identifying certain community characteristics and problems.

In public health nursing practice, nurses use several methods to collect data to reduce bias in data collection. Using such multiple complementary methods for collecting data is called triangulation. **Community Diagnosis** Community Diagnosis refers to the identification and quantification of health problems in a community.

Community Diagnosis Community Diagnosis refers to the identification and quantification of health problems in a community. The statement of a community diagnosis must consists of the following three components:

- The problem faced by the recipient.
- The recipient of the care.

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The factors contributing to the problem. While stating a diagnosis, the three components must be stated as follows:

- A. The risk of
- B. Among
- C. Related to

Examples

Risk of infant malnutrition, among families in X community related to lack of breast feeding and weaning.

Risk of diarrhea in children under five, **among families** in town dwellings, **related to** unhygienic environmental condition/unsafe water supply.

3.2 Planning phase Steps of planning phase are:

1. Analyze the community diagnosis in terms of the importance, magnitude and intensity of risk involved.
2. Establish priorities among them.
3. Establish goals and objectives
4. Identify intervention activities that will accomplished the objective.
5. Rational allocation of limited resources

Implementation phase Factors influencing implementation

1. People readiness to participate in the problem resolution.
2. Characteristics of social change process.
3. Nurse's choosing role: a facilitator/ expert role in helping community to select and perform appropriate tasks to achieve objectives.

Evaluation Appraisal of the effects of the organized program:

- Documenting the progress.
- Comparing achievements against a performance standard.
- Preparing for needed modification.

Health Education and Health Promotion

Review questions and answers of chapter 3 health promotion

PART ONE: CIRCLE THE CORRECT ANSWER

1. Assessing community health requires
 - A. gathering relevant existing data
 - B. generating missing data
 - C. interpreting the data base.
2. The Following are methods of data collection except
 - A. Informant Interviews
 - B. Participant observation
 - C. Wind shield Surveys
 - D. Secondary analysis of existing data
 - E. Assessment and evaluation
3. Refers to the identification and quantification of health problems in a community.
 - D. Community Diagnosis
 - E. Community health
 - F. Community health Assessment
4. Collection of direct collection Informant interviews, participant observation, and windshield surveys are the three methods of
 - A. Directly collecting data.
 - B. Indirectly collecting data.
 - C. None of the abve
5. It is a process of obtaining readily available data, which describe the demography of the community
 - A. Data gathering
 - B. Interview
 - C. Questionnaire

1. A
2. E
3. A
4. A
5. A

CHAPTER FOUR: RISK FACTORS AND HEALTH PROMOTION

4.0 Introduction

Risk factors to health and wellbeing are affected by many factors, and those that are associated with ill health, disability, disease or death are known as risk factors. Risk factors are presented here individually, however in practice they do not operate in isolation. They often coexist and interact with one another.

4.1 Behavioral risk factors

Risk factors that can be eliminated or reduced through lifestyle or **behavioral changes** include:

- tobacco smoking
- excessive alcohol consumption
- poor diet and nutrition
- physical inactivity
- excessive sun exposure
- insufficient vaccination
- unprotected sexual activity.

4.2 Biomedical risk factors

Biomedical risk factors may be influenced by a combination of genetic, lifestyle and other broad factors. Biomedical risk factors include:

- a. overweight and obesity
- b. high blood pressure
- c. high blood cholesterol
- d. impaired glucose tolerance

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4.3 Environmental risk factors

The environment often predisposes a person to disease processes. Living conditions may promote illness. For instance,

- a. **bacterial.**
- b. **viral infections.**
- c. **tuberculosis is more prevalent in crowded living conditions.**
- d. **Persons in areas of contaminated water are at an increased risk for intestinal infections if sanitation measures are neglected.**
- e. • Environmental determinants of health cover a wide array of topics, and can be split into two broad categories. a. Social, economic, cultural and political b. Physical, chemical and biological

4.4 Genetic risk factors

Some diseases, such as cystic fibrosis and muscular dystrophy, result entirely from an individual's genetic make-up whereas many others reflect the interaction between that makeup and environmental factors. There are three broad groups of genetic diseases / disorders:

- single gene (monogenic) disorders, for example hemophilia;
- chromosomal abnormalities, for example Down syndrome; and
- multifactorial diseases, such as asthma.

4.4 Demographic risk factors

Demographic factors include age, sex, and population subgroups. Examples of risk associated with demographic factors include:

- Stroke death rates increase dramatically with age, with 81: of all deaths from stroke occurring among those aged 75 and over.

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- A woman's risk of developing breast cancer before age 75 is 1 in 11, whereas for men the chance is only 1 in 12426.

4.5 Work

Work influences health and wellness. Many employers-such as

a. Hospitals. b. Factories. c. large institutions.

- today provide health screenings and health prevention programs for employees.
- Work safety is imperative for optimum health and wellness
- The number of dependents living in the home and the head of the household play a large part in the status of the family and of the individuals within the household.

4.6 Socioeconomic Level.

- The socioeconomic level of an individual influences the affordability of health care and health-promotion activities.
- Often funds are limited and the resources are unavailable to access the care required for optimum health.
- Persons may delay seeking treatment or information due to a lack of money.
- Nutrition and living conditions may affect the health risk of the individual as well .

4.7 Education

- Education may influence the level of understanding among the public.
- Laypersons often do not have the knowledge base to know what causes a disease, much less how to prevent its development.
- Public education announcements and offerings of health information provide a beginning knowledge level and promote further learning.

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- Education must be simple, clear, and understandable.
- Intellectual differences may influence the type and length of educational offerings.
- Nurses should speak at the educational level of their patients, communicating the message in simple terms.
- The caregiver may also require explicit information regarding patient needs.
- This information should be given at the educational level of the caregiver
- Health-seeking behavior is critical to implementing health promotion.

Assumption essential to integrating health promotion into nursing practice

1. people have the capacity for self-direction, abstraction, and critical thinking.
2. the environment can affect a person's ability to live a long and prosperous life.
3. people are capable of learning and adapting and can be made aware of the things that promote well-being.
4. as open systems, people are capable of change.
5. people are biological, psychological, social, and cultural beings who form families and/or networks.
6. communication, both verbal and nonverbal, is essential to the achievement of health throughout the life span

4.8 Cultural and spiritual Influence

Cultural context of different countries are their social standards and value system. Culture is the sum of learned ways of doing, feeling and thinking and present of a social group within a given period of time. Culture is complex integrated system which includes knowledge , beliefs, skills, arts, morals, laws, customs habits, roles, attitudes. Lifestyle, community life and acquired capabilities of human beings. All these provide a pattern for living together.

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Values

• Value system determines the attitude and pattern of behavior in a group. • Cultural value system decides how people should behave in various situations. • Values tend to change or disappear over the years, e.g. possession of happy family life, clean environment, close friends, religion, good income, health preservation,...etc.

b. Beliefs, customs, norms and taboos • Middle-eastern people believe in fatalism, they don't plan for future rather leave them to the will of God. • Traditional women tend to breast feed the baby for extended period of time. • Children are believed to be a blessings to the family. • They believe their success of their parenthood is on Wight gain, healthy and normality of their children but not on cognitive skills.

• Religion and magical ideas and practices exist in the form of various beliefs, taboos, ethical code, rituals, mythology, which may positively or negatively influence health. • They believe in evil eye. Therefore , in health care setting avoid suspicious of the evil eye.

c. Religion • All religion allow certain kinds of such enjoyment that are known in religious language "permissible". , and sensor others that are designated as " forbidden". • In middle eastern countries, Islam is a dominant religion. In the Glorious Qurans, it is primary source of law. • Islam pays particular attention to marriage, showering it with such distinctive veneration that makes it unique among all human contracts.

d. Roles • In Islam , men tend to have earning position. • women on the other hand tend to be in control of household affairs. • Men have a great control over all situations. Therefore in health care setting, it is best to ask the man's permission or opinion

Severe shortages of trained health personnel and lack of access to reproductive health are holding back progress in many countries.

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4.8.1 The concept of Cultural and Lifestyle

Cultural assessment

- Data obtained from a cultural assessment will help the patient and nurse to formulate a mutually acceptable, culturally responsive treatment plan.
- The basic premise of the cultural assessment is that patients have a right to their cultural beliefs, values, and practices, and that these factors should be understood, respected, and considered when giving culturally competent care.
- The first step in cultural assessment is to learn about the meaning of the illness of the patient in terms of the patient's unique culture.

Questions to Ask During a Cultural Assessment

1. **What do you think has caused your problem?**
2. Why do you think it started when it did?
3. How severe is your illness? Will it have a long or short course?
4. What kind of treatment do you think you should receive?
5. What are the most important results you hope to get from this treatment?
6. What are the chief problems your illness has caused for you?
7. What do you fear most about your illness? By asking the patient and family these questions you can obtain valuable information needed for a teaching plan.

It is important to remember that the patient's personal interpretation of the illness experience is more significant than your view of the disease

The Health Belief Model is appropriate to be used alone or in combination with other theories or models.

Health Education and Health Promotion

Lifestyle Assessment Guideline for assessing lifestyle factors that affect the health and well-being.

- 1. Sleep habits:** sleeping from 6 – 8 hours a night; waking feeling rested, alert and able to function during the day.
- 2. Eating habits:** eating a variety of foods each day; including foods from each of the 4 food groups each day; feeling satisfied after eating; no adverse physical reactions to food.
- 3. Physical activity:** engaging in 30-60 minutes of moderate physical activity 5-7 times per week; a combination of cardiovascular activity, strength training, and flexibility exercises.
- 4. Low to moderate alcohol consumption:** limiting alcohol consumption to 2 or fewer standard drinks per day, with a maximum of 14 servings per week for males, and 9 servings per week for females.
- 5. Stress management:** being aware of factors affecting your stress level; practicing activities that reduce negative effects of stress.
- 6. Effective time management:** identifying a structure or system that helps you keep on track; recognizing time wasters; learning to prioritize; setting realistic goals; balancing your time between work and leisure activities

4.9 Review questions and answers

PART ONE: TRUE AND FALSE

1. The socioeconomic level of an individual not influences the affordability of health care and health-promotion activities.
 - A. True
 - B. False
2. Education may influence the level of understanding among the public.
 - A. True
 - B. False
3. Culture is the sum of learned ways of doing, feeling and thinking and present of a social group within a given period of time.
 - A. True
 - B. False

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4. Biomedical risk factors may be influenced by a combination of genetic, lifestyle and other broad factors.
 - A. True
 - B. False
5. Intellectual differences may influence the type and length of educational offerings.
 - A. True
 - B. False

Part two: Direct questions

1. Behavioral risk factors behavioral changes
2. List what are Biomedical risk factors include:
3. Culture is complex integrated system
4. What are three broad groups of genetic diseases / disorders?

Answer of review questions

1. Behavioral risk factors behavioral changes

- A. tobacco smoking
- B. excessive alcohol consumption
- C. poor diet and nutrition
- D. physical inactivity
- E. excessive sun exposure

2. Biomedical risk factors include:

- A. overweight and obesity
- B. high blood pressure
- C. high blood cholesterol
- D. impaired glucose tolerance

3. Culture is complex integrated system which includes

knowledge, beliefs, skills, arts, morals, laws, customs, habits, roles, attitudes.

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Three broad groups of genetic diseases / disorders?

- A. single gene (monogenic) disorders, for example hemophilia;
- B. chromosomal abnormalities, for example Down syndrome; and
- C. multifactorial diseases, such as asthma.

Part one: T& F

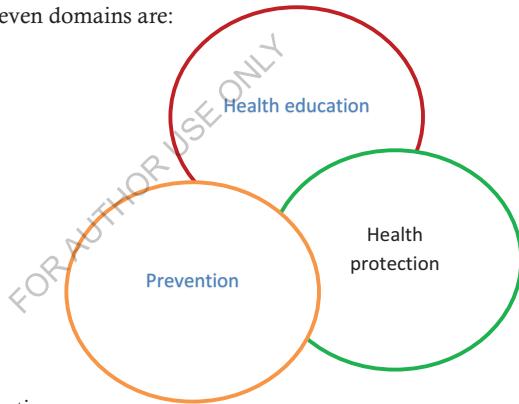
1. B
2. A
3. A
4. A
5. A

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CHAPTER FIVE: WHO AND INTERNATIONAL INITIATIVES

5.0 Introduction

Health promotion is a radical movement, which gathered momentum in the 1980s and which challenges the medicalization of health and stresses the social and economic aspects of health (Downie et al., 1990). Tannahill's model of health promotion sees it as comprising 'efforts to enhance positive health and prevent ill health, through the overlapping spheres of health education, prevention and health protection' (from Downie et al., 1990). Tannahill neatly places health promotion within the framework of the broad range of traditional public health domains. The model can be depicted as a set of overlapping circles with seven domains (Figure 2.1), which are united by the principles of health promotion, the nature of which is eclectic and multidisciplinary. The seven domains are:



The seven domains are:

1. preventive services
2. preventive health education
3. preventive health protection
4. health education for preventive health protection
5. positive health education
6. positive health protection
7. health education aimed at positive health protection

Feed your goals, starve your doubts. Find your motivation.

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There are three basic approaches (models) to improving health based on medical/ behavioural change, educational change or social change. In practice, these models overlap but can be described separately to show their differences. First, the medical model focuses on the prevention of disease (illness or negative health) and is combined with a philosophy of compliance with professionals' (usually the doctor's) diagnosis and prognosis. Second, the educational model is based on the view that the world consists of rational human beings and that to prevent disease and improve health you merely have to inform or educate people about remedies and healthy lifestyles because, as rational human beings, they will respond accordingly. And third, the social model is based on the view that health is determined by the social, cultural and physical environment. In this model, solutions are political and require protecting people from health-disabling environments. Like all models, these are simplifications of reality and as such are all incomplete. In practice, health promotion is a combination of these approaches

5.1 The role of the World Health Organization

Health for All (1978) While the World Health Organization (WHO) has fostered and supported health education and disease prevention programmes around the world throughout its fifty-year history, these efforts were largely uncoordinated and lacked a strategic reference point until the Health for All strategy adopted by WHO in 1978 declared: The main social target of governments, international organisations and the world community in the coming decades should be the attainment by all peoples of the world by the year 2000 of a level of health that will permit them to lead a socially and economically productive life. This prompted a significant re-orientation of the work of WHO and, for the first time, provided a comprehensive and coherent strategy for the organization and member states (WHO, 1981). Health for All has been important in making equity and social justice major social goals.

Exercise not only changes your body, but it also changes your mind, your attitude and your mood.

Health Education and Health Promotion

It has also been credited with fostering a resurgence of interest in public health internationally, particularly by re-focusing attention on social and economic determinants of health and their unequal impact on the health of populations.

5.2 Primary health care (1978)

The adoption of the Health for All strategy by WHO was followed by what has become recognized as a landmark meeting, jointly organized by the WHO and UNICEF, at Alma Ata, in Kazakhstan. This meeting resulted in the Declaration of Alma Ata on primary health care (WHO, 1978), which, like the Ottawa Charter that followed, has proved to be an inspirational statement, highlighting the need to reorient health systems in many countries towards the provision of primary health care. Primary health care was defined as: 'Essential health care based on practical, scientifically sound and socially acceptable methods and technology made uni-versally accessible to individuals and families'.

The Declaration emphasized that such essential health care: includes, at least education concerning prevailing health problems and the methods of preventing them and controlling them . . . involves all related sectors . . . demands the coordinated efforts of all those sectors . . . and requires and promotes maximum community and individual self-reliance and participation in the planning, organisation, operation and control of primary health care. This focus on primary health care, prevention, recognition of the role of other sectors in creating health and causing ill health, and of community participation and ownership of health programmes has been important to the work of WHO.

It has been particularly influential in the evolution of health systems in many lowincome countries but, disappointingly, national health policies that reflect the aspirations of Health for All and the Declaration of Alma Ata have been slow to materialize in high- and middle-income countries with established, medically oriented health care systems.

Stay healthy wealthy happy wise.

Health Education and Health Promotion

5.3 Targets for Health for All 2000 (1986)

The European Region of WHO has sought to interpret the Health for All concept into one more meaningful for the countries of Europe. WHO has promoted a common approach to health policy in Europe by developing a series of targets for improved health status that reflect the Health for All strategy – Targets for Health for All 2000 (WHO, 1986a). This report provided a clear statement of the scope for improving health status within member countries and called for a fundamental reorientation of the health systems in individual countries towards the achievement of the targets.

The report grouped targets into four major themes:

- a. lifestyles and health
- b. risk factors affecting health and the environment
- c. reorientation of the health care system
- d. the infrastructure supports necessary to bring about the desired changes in these three areas

The Ottawa Charter defines health promotion as 'The process of enabling people to increase control over the determinants of health and thereby improve their health'. This salutogenic view implies strengthening people's health potential and that good health is a means to a productive and enjoyable life. Human rights are fundamental to health promotion and a concern for equity, empowerment and engagement. In addition, it has the following characteristics:

1. health promotion is a process – a means to an end
2. health promotion is enabling – done by, with and for people, not imposed upon them
3. health promotion is directed towards improving control over the determinants of health

Human rights are fundamental to health promotion and a concern for equity, empowerment and engagement.

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The Ottawa Charter identified a set of five mechanisms:

1. building healthy public policy
2. creating a supportive environment
3. strengthening community action
4. developing personal skills
5. reorientating health services These were updated in the Jakarta Declaration (WHO, 1997), which focused on creating partnerships between sectors, including private–public partnerships

The priorities for the twenty-first century were to:

1. promote social responsibility for health
2. increase investment in health development
3. consolidate and expand partnerships for health
4. increase community capacity and empower the individual
5. secure an infrastructure for health promotion More recently WHO, through the Bangkok Charter (2005) has reviewed the strategies for health promotion in a globalised world as the context for health promotion has changed markedly since the Ottawa Charter. In particular, increasing health inequalities, environmental degradation, new patterns of consumption and communication, and increasing urbanisation.

Setting goals is the first step in turning the invisible into the visible. Tony Robbins

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5.4 Priorities for health promotion in the 21st century

1. Promote social responsibility for health Decision-makers must be firmly committed to social responsibility. Both the public and private sectors should promote health by pursuing policies and practices that: avoid harming the health of individuals; protect the environment and ensure sustainable use of resources; restrict production of and trade in inherently harmful goods and substances such as tobacco and armaments, as well as discourage unhealthy marketing practices; safeguard both the citizen in the marketplace and the individual in the workplace; include equity-focused health impact assessments as an integral part of policy development.

2. Increase investment for health development In many countries, current investment in health is inadequate and often ineffective. Increasing investment for health development requires a truly multi-sectoral approach including, for example, additional resources for education and housing as well as for the health sector. Greater investment for health and reorientation of existing investments, both within and among countries, has the potential to achieve significant advances in human development, health and quality of life. Investments for health should reflect the needs of particular groups such as women, children, older people, and indigenous, poor and marginalized populations.

3. Consolidate and expand partnerships for health

Health promotion requires partnerships for health and social development between the different sectors at all levels of governance and society. Existing partnerships need to be strengthened and the potential for new partnerships must be explored. Partnerships offer mutual benefit for health through the sharing of expertise, skills and resources. Each partnership must be transparent and accountable and be based on agreed ethical principles, mutual understanding and respect. WHO guidelines should be adhered to.

4. Increase community capacity and empower the individual Health promotion is carried out by and with people, not on or to people. It improves both the ability of individuals to take action, and the capacity of groups, organizations or communities to influence the determinants of health. Improving the capacity of communities for health promotion requires practical education, leadership training, and access to resources. Empowering individuals

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demands more consistent, reliable access to the decision-making process and the skills and knowledge essential to effect change. Both traditional communication and the new information media support this process. Social, cultural and spiritual resources need to be harnessed in innovative ways.

5. Secure an infrastructure for health promotion To secure an infrastructure for health promotion, new mechanisms for funding it locally, nationally and globally must be found. Incentives should be developed to influence the actions of governments, nongovernmental organizations, educational institutions and the private sector to make sure that resource mobilization for health promotion is maximized. 'Settings for health' represent the organizational base of the infrastructure required for health promotion. New health challenges mean that new and diverse networks need to be created to achieve inter-sectoral collaboration. Such networks should provide mutual assistance within and among countries and facilitate exchange of information on which strategies have proved effective and in which settings. Training in and practice of local leadership skills should be encouraged in order to support health promotion activities. Documentation of experiences in health promotion through research and project reporting should be enhanced to improve planning, implementation and evaluation.

All countries should develop the appropriate political, legal, educational, social and economic environments required to support health promotion

Female literacy has been shown to be important for family health.

Health Education and Health Promotion

5.5 Review questions and answers of chapter 5 of health promotion

1. There are three basic approaches (models) to improving health based on medical/behavioural change, educational change or social change.
 - C. True
 - D. False
2. Education may influence the level of understanding among the public.
 - A. True
 - B. False
3. The Ottawa Charter define health promotion as 'The process of enabling people to increase control over the determinants of health and thereby improve their health'.
 - A. True
 - B. False
4. Training in and practice of local leadership skills should be encouraged in order to support health promotion activities.
 - A. True
 - B. False
5. Intellectual differences may influence the type and length of educational offerings.
 - C. True
 - D. False
6. All countries should develop the appropriate political, legal, educational, social and economic environments required to support health promotion.
 - A. True
 - B. False
7. Health promotion not requires partnerships for health and social development between the different sectors at all levels of governance and society.
 - A. True
 - B. False

1. A
2. A
3. A
4. A
5. A
6. A
7. F

CHAPTER SIX: DETERMINANT OF HEALTH

DETERMINANT OF HEALTH BY (W H O)

DETERMINANTS OF HEALTH ARE A RANGE OF FACTORS THAT INFLUENCE THE HEALTH STATUS OF INDIVIDUALS OR POPULATIONS.

6.0 Introduction

At every stage of life, health is determined by complex interactions between social and economic factors, the physical environment and individual behaviours. Many factors combine together to affect the health of individuals and communities.

Whether people are healthy or not, is determined by their circumstances and environment. To a large extent, factors such as where we live, the state of our environment, genetics, our income and education level, and our relationships with friends and family all have considerable impacts on health, whereas the more commonly considered factors such as access and use of health care services often have less of an impact.

- 1) **Income and social status** - higher income and social status are linked to better health. The greater the gap between the richest and poorest people, the greater the differences in health.
- 2) **Education** – low education levels are linked with poor health, more stress and lower self-confidence.
- 3) **Physical environment** – safe water and clean air, healthy workplaces, safe houses, communities and roads all contribute to good health. Employment and working conditions – people in employment are healthier, particularly those who have more control over their working conditions
- 4) **Social support networks** – greater support from families, friends and communities is linked to better health. Culture - customs and traditions, and the beliefs of the family and community all affect health.

Low education levels are linked with poor health, more stress and lower self-confidence.

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- 5) **Genetics** - inheritance plays a part in determining lifespan, healthiness and the likelihood of developing certain illnesses. Personal behaviour and coping skills – balanced eating, keeping active, smoking, drinking, and how we deal with life's stresses and challenges all affect health.
- 6) **Health services** - access and use of services that prevent and treat disease influences health
- 7) **Gender** - Men and women suffer from different types of diseases at different ages.

Universal Declaration for Human Right Health as a Human Right (1948)

6.2 Millennium Development Goals

GOAL 1 Eradicate extreme poverty and hunger

GOAL 2 Achieve universal primary education

GOAL 3 PROMOTES GENDER EQUALITY AND EMPOWERS WOMEN

GOAL 4 REDUCE CHILD MORTALITY

GOAL 5 Improve Maternal Health

GOAL 6 HIV, TB, and Malaria

GOAL 7 Environmental Sustainability

GOAL 8 Global Partnerships

Men and women suffer from different types of diseases at different ages.

6.3 Poverty and Health

Definition

Poverty is a situation where an individual or household or a section of the population is in a condition that makes it difficult to command sufficient resources to meet basic needs of life such as food, shelter or clothing and is a situation where people live in severe deprivation of essential services such as health care, access to safe water, education, job opportunities among others.

Poverty Line Income (PLI) is a poverty threshold which marks the level of income below which one is not able to afford to make purchases of basic resources required for a minimum acceptable standard of living in society.

Poverty is accompanied by:

- ✚ Illiteracy and ignorance
- ✚ People mainly staying in rural settings
- ✚ Poor methods of farming
- ✚ Low technology
- ✚ Small land holdings hence subsistence production
- ✚ Low education
- ✚ Low incomes
- ✚ Early marriages
- ✚ Forced marriages
- ✚ High fertility level
- ✚ Large family sizes
- ✚ High dependency rate
- ✚ Poor shelter
- ✚ Poor nutrition
- ✚ Poor health
- ✚ Poor dressing
- ✚ Low status of women

People in developing countries are still chronically or acutely malnourished.

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- ✦ Lack of access to basic social services
- ✦ Lack of access to economic resources
- ✦ In cities- widening gap between rich and poor.
- ✦ High levels of unemployment
- ✦ High crime rate
- ✦ High corruption rate
- ✦ Low motivation to work harder
- ✦ Social inability
- ✦ Witchcraft practices

Whether people are healthy or not, is determined by their circumstances and environment

Two broadly defined forms of poverty can be distinguished as;

1. Case poverty
2. Community poverty.

Case poverty is found in more affluent societies where just an individual or a household suffers poverty that is visible compared to the living conditions of the individuals and families in the surrounding area.

Community poverty on the other hand manifests itself where almost everyone in the community is poor. Community poverty is found mostly but not exclusively in rural areas and in informal and squatter areas in cities.

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6.4 Types of poverty:

There are mainly **four major types of poverty** classified according to the level of disadvantage experienced i.e Absolute, Relative, Transient, and Chronic poverty.

Absolute poverty is a situation where deprivation is so severe that the basic needs of life can hardly be met. It is a condition under which ones income or consumption expenditure falls below (or is just on) the poverty line, and with a lack of means to satisfy BASIC material and social needs of life as well as a feeling of powerlessness to anything about the situation.

The World Bank (1975) describes **Absolute poverty** as a situation where incomes are so low that even a minimum standard of nutrition, shelter and personal necessities cannot be maintained. It also includes having low access to services like health care, education, credit, participation in political processes, and being given dignity.

The World Bank (2006) further defines extreme poverty as living on less than US\$1 a day and moderate poverty as living on less than US\$2 a day.

About 20% of the world's people live in absolute poverty and of these 85% live in rural settings of predominantly the Third World (Durning 1990).

Absolute poverty is a situation where deprivation is so severe that the basic needs of life can hardly be

Relative poverty is an expression of poverty levels of one entity in relation to another entity. It simply means some people are poorer than others, and is normally used in comparative terms, for example, in relation to an average American family, the Black American family is poor. While in relation to the Black American family, a Ugandan family is poor.

The concept of “Relative poverty” refers to people whose basic needs are met, but who in terms of their social environment are still experiencing some disadvantages. That is while trying to survive, some people are more materially disadvantaged as compared to others living in the same community.

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Hence, whereas absolute poverty refers to a desperate situation, relative poverty refers more to comparison of levels of poverty.

Transient poverty is where poverty situations vary overtime. In one period an individual or household may be poor and in other periods the average income is above the poverty line. It is a situation where the mean expenditures of an individual or household are over and above the poverty line but with time will usually experience episodes of poverty.

Chronic poverty is poverty that is both severe and multidimensional, and usually lasting for a long period of time. Due to its' identified long duration it becomes sufficient for it to be considered chronic.

The chronically poor have a history of deprivation, which may be transmitted across generations through economic, social, geographical, and cultural isolation and exclusion.

Chronic poverty could further be definition as inter-generationally transmitted poverty. Which is a kind of poverty that is perpetuated through the inherent socio-psychological, political, and economic traits of the poor themselves i.e due to parental traits and intentions, and as a result of the culture of poverty being perpetuated.

Chronic poverty is poverty that is both severe and multidimensional, and usually lasting for a long

6.5 CAUSES OF POVERTY IN DEVELOPING COUNTRIES

Poverty can be caused by many underlying factors that include;

- 1) Unemployment problem
- 2) Political factors in form of poor political systems
- 3) Political instabilities & poor governance
- 4) Occurrence of unfavorable natural factors like drought
- 5) High population size

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- 6) High population growth rates leading to higher expenditures with no savings.
- 7) Inadequate access to markets
- 8) Lack of access to credit facilities especially in rural areas
- 9) Inadequate access to infrastructure
- 10) Corruption & poor management of public resources
- 11) Economic instabilities in form of inflationary tendencies or Agricultural price fluctuations.
- 12) Cultural factors & poor land tenure system
- 13) Negative attitudes towards certain jobs & lack of skills
- 14) Lack of initiative to work due to laziness
- 15) Inadequate physical assets like land
- 16) Inadequate access to assistance for those living at the margin

High population growth rates leading to higher expenditures with no savings.

6.6 POVERTY INDICATORS

Poverty is not just about having a low income but experiences that people undergo along with their concerns have several inter-related causes of poverty. These include:

- 1) Insecurity
- 2) Low rates of investment and job creation
- 3) Low access to high public services and utilities
- 4) Land scarcity and insecure property rights
- 5) Environment change
- 6) High population growth
- 7) Poor education

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- 8) Toiling with little benefits
- 9) Lack of information.

Measure poverty:

- 1) **Income**= amount of take home pay earned by the household.
- 2) **Wealth**= the accumulated worth of household, livestock, and goods. Socioeconomic status is a strong predictor of health status.

Poor households have limited resources for preventing and treating illnesses and injuries.

Recent increases in the price of food have had a direct and adverse effect on the poor and are expected to push many more people – an estimated 100 million – into absolute poverty.

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Gender--based discrimination takes on many different forms, some aspects include: Human rights, Work, Assets

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6.7 Review questions and answers of chapter 6 health promotion

1. is an expression of poverty levels of one entity in relation to another entity.
 - A. Relative
 - B. Absolute
 - C. Transient
 - D. Chronic poverty.
2. The World Bank (2006) defines extreme poverty as living on less than
 - A. US\$1 a day
 - B. US\$2 a day.
 - C. US\$3 a day.
3. Moderate poverty as living on less than US\$2 a day.
 - A. US\$2 a day.
 - B. US\$1 a day
 - C. US\$3 a day.
4. Which one of the following is Causes of poverty in developing countries.
 - A. High population size
 - B. Political factors in form of poor political systems
 - C. Political instabilities & poor governance
 - D. All the above
5. amount of take home pay earned by the household.
 - A. Income
 - B. Wealth
 - C. Expense

Part one: circle

1. A
2. A
3. A
4. D
5. A

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CHAPTER SEVEN: TARGETS, STANDARDS AND INDICATOR

Learning objectives After working through this chapter, you will be better able to:

- A. understand key concepts associated with target setting in health promotion
- B. be familiar with the differences between goals, aims, objectives, targets and standards and how they interrelate
- C. appreciate why target setting and the targeting of health promotion interventions is key to the success of programmers.

Key terms

Aim An expanded and refined version of a goal that sets out the means by which the end point, in general terms, is to be attained.

Goal A general statement of intent, usually based on a set of principles or values.

Indicator An attribute or variable used in the measurement of change.

Objective Concrete and specific elaboration of an aim.

Standard The basis for comparison or a reference point against which other things can be evaluated. **Target** Similar to an objective in that it usually contains a quantifiable measure set to be achieved by a particular date.

Goal A general statement of intent, usually based on a set of principles or values.

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7.0 INTRODUCTION

Notwithstanding the real and persistent health inequalities that exist between and within communities, over the last hundred years the health of the populations of high-income countries have improved dramatically. To a lesser, but significant extent, the same is true for low- and middle-income countries. What led to this great advance was a host of interventions including improved housing, sanitation, food supply and safety, better working conditions and employment rights, immunization programmes and family planning services. These improvements were often made possible, and at the same time contributed to, the general economic development of communities and countries. The development of welfare provision and health services also made substantial contributions. One of the key factors that drove forward this improvement was the setting of often challenging but achievable targets for improvement. History teaches that the setting of well-informed health targets is one of the key mechanisms for not only raising expectations of better health but also delivering improvements.

The less healthy in many societies, however, are not just lagging behind the better off – they are not catching up, and in many cases, they are falling further behind. Figure 7.1 illustrates the growing mortality gap between social classes in England and Wales between 1930 and 1993. While the growing disparity between social classes is clear, it is also clear that it is possible to reduce such disparity as seen by the narrowing of the gap that took place in the early 1970s.

History teaches that the setting of well-informed health targets is one of the key mechanisms for not only raising expectations of better health but also delivering improvements.

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Many governments and organizations have made poor progress in health improvement for several reasons:

1. focusing too much on cure and too little on prevention
2. not developing a robust evidence-based approach to health promotion interventions
3. emphasizing short-term thinking and project-focused approaches as opposed to long-term strategic planning and programme approaches
4. failing to coordinate and make best use of all state and civic assets to tackle health challenges
5. failing to identify and share effective practice
6. adopting paternalistic attitudes to health issues dominated by professional prescriptions for action

Two additional reasons have been a failure to invest sufficiently in developing health and epidemiological surveillance systems and failing to invest in effective target setting that is integrated as part of a long-term commitment to developing a performance culture focused on continuous progressive improvement. Effective health target setting is one of the key elements of a sophisticated and effective health improvement strategy and is the subject of this chapter

7.1 Establishing a common language for target setting

The setting of health targets, while being a fairly universal feature of health improvement planning, is more an art than a science. There is a fair amount of agreement about the differences, applications and interplay between the terms 'goals', 'aims', 'objectives', 'targets', 'indicators' and 'standards'. The following should act as a guide rather than a set of absolute definitions. The difference in the meaning and application of these terms may seem unimportant but this is not the case.

Effective health target setting is one of the key elements of a sophisticated and effective health improvement strategy.

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Clarity in both selecting and applying these terms is vital if there is to be corresponding clarity about what is to be achieved, by when and by whom, and why this is important. In addition, a careful and consistent setting out of health promotion goals, aims, objectives, targets, indicators and standards will help to ensure that an intervention stands the best chance of being implemented successfully and evaluated fairly.

7.2 Goal

A goal is a general statement of intent usually based on a set of principles or values. Goals set out what should be achieved. A good example is the United Nations' (2000) Millennium Declaration: 1 eradicate extreme poverty and hunger 2 achieve universal primary education 3 promote gender equality and empower women 4 reduce child mortality 5 improve maternal health 6 combat HIV/AIDS, malaria and other diseases 7 ensure environmental sustainability 8 develop a global partnership for development

Aim an aim is an expanded and refined version of a goal that sets out the means by which the end point, in general terms, is to be attained (and which is believed to be attainable). An example of a health promotion aims derived from a health goal, such as the fourth Millennium Development Goal, would be: To reduce child mortality by instigating an international programme of infant nutritional supplementation in order to increase calorific intake and reduce Target A target usually contains concrete and quantifiable measures that are to be achieved by a particular date. For example, 'to reduce the numbers of smokers from workless households by 25% by 2007'.

Targets differ from objectives in that they often carry with them some implied or actual threat of penalty for failure to attain them, or incentive for fully meeting the target. Targets are discussed further in a moment.

Target is usually containing concrete and quantifiable measures that are to be achieved by a particular date.

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7.3 Objective

Objectives are concrete and specific elaboration of aims and they must be measurable. Indicator Bull and Hamer (2001) define indicators as follows: 'Indicators are selected to measure movement towards or away from a pre-defined target. They are attributes or variables used in the measurement of change, e.g. number of low income women attending smoking cessation clinics'. This definition makes it clear that indicators differ from targets in that they are more concerned with monitoring progress rather than setting out an achievement to be attained.

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Objectives are concrete and specific elaboration of aims and they must be measurable.

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7.4 Review questions and answers of chapter 7 health promotion

PART ONE: TRUE AND FALSE

1. A target usually contains concrete and quantifiable measures that are to be achieved by a particular date.
 - A. True
 - B. False
2. A goal is a general statement of intent usually based on a set of principles or values.
 - A. True
 - B. False
3. Effective health target setting is one of the key elements of a sophisticated and effective health improvement strategy.
 - A. True
 - B. False
4. Objectives are concrete and specific elaboration of aims and they must be measurable.
 - A. True
 - B. False
5. The setting of health targets, while being a fairly universal feature of health improvement planning, is more an science than a art.
 - A. True
 - B. False

Part one:

T&F

1. A
2. A
3. A
4. A
5. B

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CHAPTER EIGHT: RURAL HEALTH PROMOTION AND DISEASE PREVENTION PROGRAM APPROACHES

8.0 Introduction

There are several theories, strategies, and models that can be used to inform rural health promotion and disease prevention programs. Communities can use these theories, strategies, and models to develop and implement programs that empower and motivate people to improve and better manage their health. The theories and strategies can be implemented during program planning to ensure the integration of health promotion and disease prevention approaches to improve population health. The models can serve as frameworks for organizing health promotion and disease prevention activities.

Health promotion and disease prevention programs often integrate components of different theories and use more than one strategy to achieve their goals.

8.1 Health Promotion and Disease Prevention Theories and Models

There are *several theories and models* that support the practice of health promotion and disease prevention. Theories and models are used in program planning to understand and explain health behavior and to guide the identification, development, and implementation of interventions.

When identifying a theory or model to guide health promotion or disease prevention programs, it is important to consider a range of factors, such as the specific health problem being addressed, the population(s) being served, and the contexts within which the program is being implemented. Health promotion and disease prevention programs typically draw from one or more theories or models.

There are several theories and models that support the practice of health promotion and disease prevention.

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Selected theories and models that are used for health promotion and disease prevention programs include:

Ecological models

Are recognize multiple levels of influence on health behaviors, including:

- **Intrapersonal/individual factors**, which influence behavior such as knowledge, attitudes, beliefs, and personality.
- **Interpersonal factors**, such as interactions with other people, which can provide social support or create barriers to interpersonal growth that promotes healthy behavior.
- **Institutional and organizational factors**, including the rules, regulations, policies, and informal structures that constrain or promote healthy behaviors.
- **Community factors**, such as formal or informal social norms that exist among individuals, groups, or organizations, can limit or enhance healthy behaviors.
- **Public policy factors**, including local, state, and federal policies and laws that regulate or support health actions and practices for disease prevention including early detection, control, and management.

The Health Belief Model is a theoretical model that can be used to guide health promotion and disease prevention programs.

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The Health Belief Model

The Health Belief Model is a theoretical model that can be used to guide health promotion and disease prevention programs. It is used to explain and predict individual changes in health behaviors. It is one of the most widely used models for understanding health behaviors.

Key elements of the Health Belief Model focus on individual beliefs about health conditions, which predict individual health-related behaviors. The model defines the key factors that influence health behaviors as an individual's perceived threat to sickness or disease (perceived susceptibility), belief of consequence (perceived severity), potential positive benefits of action (perceived benefits), perceived barriers to action, exposure to factors that prompt action (cues to action), and confidence in ability to succeed (self-efficacy).

Key elements of the Health Belief Model focus on individual beliefs about health conditions, which predict individual health-related behaviors.

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Stages of Change Model

The Stages of Change Model, also called the Transtheoretical Model, explains an individual's readiness to change their behavior. It describes the process of behavior change as occurring in stages. These stages include:

- **Pre-contemplation:** There is no intention of taking action.
- **Contemplation:** There are intentions to take action and a plan to do so in the near future.
- **Preparation:** There is intention to take action and some steps have been taken.
- **Action:** Behavior has been changed for a short period of time.
- **Maintenance:** Behavior has been changed and continues to be maintained for the long-term.
- **Termination:** There is no desire to return to prior negative behaviors.

Termination means there is no desire to return to prior negative behaviors.

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Social Cognitive Theory

Social Cognitive Theory (SCT) describes the influence of individual experiences, the actions of others, and environmental factors on individual health behaviors. SCT provides opportunities for social support through instilling expectations, self-efficacy, and using observational learning and other reinforcements to achieve behavior change.

Social Cognitive Theory (SCT) describes the influence of individual experiences, the actions of others, and environmental factors on individual health behaviors.

Key components of the SCT related to individual behavior change include:

- **Self-efficacy:** The belief that an individual has control over and is able to execute a behavior.
- **Behavioral capability:** Understanding and having the skill to perform a behavior.
- **Expectations:** Determining the outcomes of behavior change.
- **Expectancies:** Assigning a value to the outcomes of behavior change.
- **Self-control:** Regulating and monitoring individual behavior.
- **Observational learning:** Watching and observing outcomes of others performing or modeling the desired behavior.
- **Reinforcements:** Promoting incentives and rewards that encourage behavior change.

Self-control Means Regulating and monitoring individual behavior.

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Theory of Reasoned Action/Planned Behavior

Two closely associated theories – The Theory of Reasoned Action and the Theory of Planned Behavior – suggest that a person's health behavior is determined by their intention to perform a behavior. A person's intention to perform a behavior (behavioral intention) is predicted by 1) a person's attitude toward the behavior, and 2) subjective norms regarding the behavior. Subjective norms are the result of social and environmental surroundings and a person's perceived control over the behavior. Generally, positive attitude and positive subjective norms result in greater perceived control and increase the likelihood of intentions governing changes in behavior.

Generally, positive attitude and positive subjective norms result in greater perceived control and increase the likelihood of intentions governing changes in behavior.

8.2 Health Promotion and Disease Prevention Strategies

Health promotion and disease prevention programs can improve health at every stage of life. To achieve this, there are several strategies for integrating health promotion and disease prevention perspectives into everyday practice.

The strategies are:

Health Communication

The study and use of communication strategies to inform and influence individual and community decisions that enhance health.”

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Health Education and Health Promotion

Health communication includes verbal and written strategies to influence and empower individuals, populations, and communities to make healthier choices. Health communication often integrates components of **multiple theories and models** to promote positive changes in attitudes and behaviors. Health communication is related to social marketing, which involves the development of activities and interventions designed to positively change behaviors.

Effective health communication and social marketing strategies include the following components:

- Use of research-based strategies to shape materials and products and to select the channels that deliver them to the intended audience.
- Understanding of conventional wisdom, concepts, language, and priorities for different cultures and settings.
- Consideration of health literacy, internet access, media exposure, and cultural competency of target populations.
- Development of materials such as brochures, billboards, newspaper articles, television broadcasts, radio commercials, public service announcements, newsletters, pamphlets, videos, digital tools, case studies, group discussions, health fairs, field trips, and workbooks among others media outlets.

Health communication strategies aim to change people's knowledge, attitudes, and/or behaviors

Health Education and Health Promotion

Using a variety of communication channels can allow health messages to shape mass media or interpersonal, small group, or community level campaigns. Health communication strategies aim to change people's knowledge, attitudes, and/or behaviors; for example:

- Increase risk perception
- Reinforce positive behaviors
- Influence social norms
- Increase availability of support and needed services
- Empower individuals to change or improve their health conditions

Examples of media strategies to convey health messages include the following components:

- Radio
- Television
- Newspaper
- Flyers
- Brochures
- Internet
- Social media tools (i.e., Twitter, Facebook, and YouTube)

Using a variety of communication channels can allow health messages to shape mass media or interpersonal, small group, or community level campaigns.

Health Education and Health Promotion

Health Education

Health education is one strategy for implementing health promotion and disease prevention programs. Health education provides learning experiences on health topics. Health education strategies are tailored for their target population. Health education presents information to target populations on particular health topics, including the health benefits/threats they face, and provides tools to build capacity and support behavior change in an appropriate setting.

Examples of health education activities include:

- Lectures
- Courses
- Seminars
- Webinars
- Workshops
- Classes

Health education provides learning experiences on health topics.

Characteristics of health education strategies include:

- Participation of the target population.
- Completion of a community needs assessment to identify community capacity, resources, priorities, and needs.
- Planned learning activities that increase participants' knowledge and skills.
- Implementation of programs with integrated, well-planned curricula and materials that take place in a setting convenient for participants.

Health Education and Health Promotion

- Presentation of information with audiovisual and computer based supports such as slides and projectors, videos, books, CDs, posters, pictures, websites, or software programs.
- Ensuring proficiency of program staff, through training, to maintain fidelity to the program model.

Community health workers (CHWs) may deliver health education to the target population.

- Health education is also used in care coordination to address barriers to care. A health educator is one type of care coordinator who deliver education to individuals, families, and communities.

8.3 Policy, Systems, and Environmental Change

For health promotion and disease prevention strategies to be successful, policies, systems, and environments (**PSE**) must be supportive of health. Policy, systems, and environmental change strategies are designed to promote healthy behaviors by making healthy choices readily available and easily accessible in the community. PSE change strategies are designed with sustainability in mind.

Health education activities should enhance the overall goal of the health promotion and disease prevention program.

Health Education and Health Promotion

Policy Change

Policy is a tool for achieving health promotion and disease prevention program goals. Policy decisions are made by organizations, agencies, and stakeholders. Policy approaches include legislative advocacy, fiscal measures, taxation, and regulatory oversight. Examples of health promotion and disease prevention policy approaches include:

- Establishing policies for smoke-free zones and public events
- Establishing healthy food options in vending machines in public places
- Adding a tax to unhealthy food options
- Requiring the use of safety equipment in a work setting to avoid injury

Systems Change

Systems change refers to a fundamental shift in the way problems are solved. Within an organization, systems change affects organizational purpose, function, and connections by addressing organizational culture, beliefs, relationships, policies, and goals. Examples of systems change in health promotion and disease prevention include:

- Developing plans for implementing new interventions and processes
- Adapting or replicating a proven health promotion model
- Implementing new technologies
- Creating training or certification systems that align with policies

Policy is a tool for achieving health promotion and disease prevention program goals.

Health Education and Health Promotion

Environmental Change

Environmental change strategies involve changing the economic, social, or physical surroundings or contexts that affect health outcomes. Environmental strategies address population health outcomes and are best used in combination with other strategies. Examples of environmental strategies for health promotion and disease prevention include:

- Increasing the number of parks, greenways, and trails in the community
- Installing signs that promote use of walking and biking paths
- Increasing the availability of fresh, healthy foods in schools, restaurants, and cafeterias

Environmental strategies address population health outcomes and are best used in combination with other strategies.

8.4 Program Models for Rural Health Promotion and Disease Prevention

Rural communities are implementing various models for health promotion and disease prevention programs. Common approaches used by communities include:

Community Organization Model

The Community Organization Model is a participatory decision-making process that empowers communities to improve health. It emphasizes active participation from the community in identifying key health issues and strategies to address them. Communities focus on their strengths and collectively mobilize to develop programs to achieve health goals.

Health Education and Health Promotion

Characteristics of the Community Organization Model include:

- Understanding the context and root causes of health issues
- Collaborative decision making and problem solving
- Focusing efforts on specific issues
- Actively engaging participation from various groups and organizations within the community
- Developing and maintaining capacity and power to produce lasting change
- Providing feedback to the community

Community Readiness Model

In the Community Readiness Model, communities are motivated by the difference between current health situations or behaviors and the desire to reach a goal. Community readiness refers to how prepared the community is to take action to address a particular health issue.

Community readiness refers to how prepared the community is to take action to address a particular health issue.

Health Education and Health Promotion

There are several stages in community readiness. These stages are:

- Absence of awareness – the community does not recognize the health issue.
- Denial or resistance – there is little recognition or concern among community members about the health issue.
- Vague awareness – the community may be concerned about the health issue, but the motivation to address it is low.
- Pre-planning – the community recognizes that action is needed, but there is a lack of focused activity around the health issue.
- Preparation – leaders in the community begin to plan and support approaches to addressing the health issue.
- Initiation – the community begins activities to address the health issue.
- Stabilization – the community activities are supported by administrators and other community leaders.
- Confirmation/expansion – activities have been implemented and the community is comfortable with addressing the health issue.
- High level of community ownership – data are being gathered that support the efforts, and the approach may be replicated in other communities.

PRECEDE-PROCEED

The PRECEDE-PROCEED model is a comprehensive structure for assessing health needs for designing, implementing, and evaluating health promotion and other public health programs to meet those needs. PRECEDE provides the structure for planning a targeted and focused public health program. PROCEED provides the structure for implementing and evaluating the public health program.

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- **PRECEDE** stands for Predisposing, Reinforcing, and Enabling Constructs in Educational Diagnosis and Evaluation.

It involves assessing the following community factors:

- **Social assessment:** Determine the social problems and needs of a given population and identify desired results.
- **Epidemiological assessment:** Identify the health determinants of the identified problems and set priorities and goals.
- **Ecological assessment:** Analyze behavioral and environmental determinants that predispose, reinforce, and enable the behaviors and lifestyles are identified.
- Identify administrative and policy factors that influence implementation and **match appropriate interventions** that encourage desired and expected changes.
- **Implementation** of interventions.

PRECEDE provides the structure for planning a targeted and focused public health program.

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PROCEED stands for Policy, Regulatory, and Organizational Constructs in Educational and Environmental Development.

It involves the identification of desired outcomes and program implementation:

- **Implementation:** Design intervention, assess availability of resources, and implement program.
- **Process Evaluation:** Determine if program is reaching the targeted population and achieving desired goals.
- **Impact Evaluation:** Evaluate the change in behavior.
- **Outcome Evaluation:** Identify if there is a decrease in the incidence or prevalence of the identified negative behavior or an increase in identified positive behavior.

Implementation Considerations

The PRECEDE-PROCEED model provides a structure that supports the planning and implementation of health promotion or disease prevention programs. This model has worked well for many health promotion topics, and can effectively support one-time interventions or long-running programs. Like the Community Readiness Model, PRECEDE-PROCEED invites participation from community members, and has the potential to increase community ownership of the program. When determining whether to use PRECEDE-PROCEED as a model for health promotion or disease prevention programs, it is important to consider whether all parts of the model are appropriate for the program and the resources available to support implementation. It is also important to remember that components of the plan may be adapted over time, as needed.

We cannot change anything until we accept it.

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Rural Clinical Models for Health Promotion and Disease Prevention

Healthcare providers and facilities play an instrumental role in improving the health of rural residents. Healthcare providers and hospital staff can use many of the strategies and theories included in this module to improve the health outcomes of their patients. Healthcare settings in rural areas have also adopted clinical models that support systems change and the way that care is delivered to patients managing and preventing chronic conditions and disease. These models include:

Chronic Disease Management: The Chronic Disease Self-Management Program is a workshop given for two and a half hours, once a week, for six weeks, in community settings such as senior centers, churches, libraries, and hospitals. People with different chronic health problems attend together. Workshops are facilitated by two trained leaders, one or both of whom are non-health professionals with chronic diseases themselves. Subjects covered include:

1. Techniques to deal with problems, such as frustration, fatigue, pain, and isolation
2. Appropriate exercise for maintaining and improving strength, flexibility, and endurance
3. Appropriate use of medications
4. Communicating effectively with family, friends, and health professionals
5. Nutrition
6. Decision making
7. How to evaluate new treatments

Our thoughts shape how we behave.

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Community Health Worker: This model uses community members with a shared cultural background to assist individuals with health issues and disease management. Community Health Workers (CHWs) assist people with information, provide care coordination services, and provide support to adopt healthy behaviors and lifestyles.

Patient-Centered Medical Home: A patient-centered medical home focuses on strengthening the clinician-patient relationship. This is achieved through improved access, managed and coordinated care, increased support, and is designed to help prevent, manage, and decrease the impact of various chronic diseases.

Workplace Model for Health Promotion and Disease Prevention

Rural workplaces can benefit from health promotion and disease prevention programs, often referred to as worksite wellness programs. Wellness is a process of actively making decisions that contribute to positive health behaviors and outcomes.

Research demonstrates that worksite wellness programs improve overall workforce through improved employee wellness, increased productivity, improved employee retention, and decreased absenteeism. They are also shown to reduce the costs associated with injury and illness. Workplace models are also used in rural communities to integrate health and human services. More information is available in the [Rural Services Integration Toolkit](#).

Implementation

Successful health promotion and disease prevention programs gather information on the target population by conducting a needs assessment. The needs assessment allows programs to identify opportunities for health promotion and disease prevention efforts, potential barriers, and appropriate strategies to address them. This knowledge is integrated into program planning, development, and implementation. This module presents important implementation considerations for health promotion and disease prevention programs.

To change any behavior we have to slow down and act intentionally rather than from habit and impulse.

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For a broad overview of rural program implementation, see **Implementing a Rural Community Health Program** in the Rural Community Health Toolkit.

Partnerships and Coalitions

Partnerships and coalitions are effective in rural communities for sharing scarce human and capital resources. Partnerships can improve and strengthen information exchanges; access to specific expertise; resource allocation; community outreach; trust among key stakeholder groups; and buy-in, commitment, and involvement.

Effective community partnerships are formed with organizations that share similar goals and are willing to designate responsibilities for achieving them. Common goals typically focus on broad environmental, policy, and social changes that affect the health and well-being of rural residents.

To identify appropriate partners, organizations should consider the following:

- **Engaging organizations with an established history.** Partner organizations should have a history of involvement in similar health activities and with the target population.
- **Involving partners from unique community sectors.** Partners should represent different sectors of the community such as local businesses in the private sector, trade organizations, and social clubs. This can improve the reach of the program.
- **Identify platforms for information sharing.** Information-sharing maintains transparency among coalition members. Simple platforms may be most effective for sharing data and information among partners.

“A+B=C
Action + Behaviour = Character”

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- **Identifying strengths and weaknesses.** Identify strengths and weaknesses in the coalition and seek technical expertise as needed.
- **Remaining flexible.** Remain flexible and creative when establishing meeting schedules, locations, and venues to accommodate member organizations.
- **Involving coalition partners early.** Include partners in program planning so that they are involved through-out the lifespan of the program, and afterwards.

Identify the target population and their key health needs. It is important to conduct a **needs assessment** to identify community factors that will affect program implementation. These include local health concerns, barriers, resources, complexity of local dynamics, and cultural acceptability.

Involve passionate people in all program aspects. Involve staff who are valued by the community and passionate about the program's goal and purpose. These staff are sometimes referred to as “program champions.” Motivated staff who are known by community members can positively influence program participation and acceptance.

Assess staff capacity. Involve staff who possess the knowledge, background, and skills necessary for the position. Additional **training** may be necessary.

Seek and maintain support from partners. Involve partners with similar missions and goals. See **Partnerships and Coalitions** for guidelines for identifying appropriate partners.

Facilitate administrative support for the program. Successful programs have **administrative supports** that encourage positive environments and reduce barriers to implementation. Organizations should be proactive in ensuring their resources, policies, procedures, and communication systems support program efforts.

“Your PhD do not make you a better person, your behavior does”

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Recruiting and Retaining Program Participants

Successful health promotion and disease prevention programs engage participants and maintain their participation over time. To achieve this, programs use a combination of strategies to develop a targeted implementation approach. To reach and involve participants in health promotion and disease prevention activities, consider the following strategies and approaches:

- **Identify the target population:** Consider the demographics, geography, existing behaviors, or desired behaviors within the community. Segmenting the population can result in greater receptiveness and benefit for participants.
- **Spread the word:** Develop recruitment materials such as flyers, newspaper articles, newsletters, radio advertisements, health fairs, presentations, and phone calls. Using more than one type of recruitment material often works well.
- **Develop culturally relevant materials:** Ensure messages are easy to read and culturally appropriate for the target population. Effective messages tell a story about how program participation will provide a tangible emotional and/or physical benefit.
- **Encourage participation:** Convey enthusiasm in recruitment strategies and materials. Have fun talking about the program!
- **Increase interest among the target population:** Ask “program champions” to help with recruitment.
- **Engage participants:** Plan a creative program structure based on the interest of the target population. Examples include cooking classes, exercise sessions, yoga classes, health screenings, and health fairs.

“A change in behavior begins with a change in the heart.”

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- **Motivate participants:** Provide incentives such as discounted memberships to athletic clubs, free items that encourage healthy eating (cutting boards and salad shakers), exercise equipment, and other items or services related to the goals of the health promotion or disease prevention program.
- **Retain participants:** Social support such as teams, coaching, and leadership opportunities can motivate and maintain participation.
- **Adjust the program as needed:** Assess the program's effectiveness, make any necessary adjustments, and redeploy the program to ensure it continues to be relevant and meaningful for the people involved.

Facilitators to Health Promotion and Disease Prevention Programming

The following factors can facilitate the success of rural health promotion and disease prevention programs:

- **Access to local leaders:** Local leaders, providers, and community organizations can support health promotion efforts. Local leaders who are recognized within the community can help to increase program buy-in and ownership among participants. “Program champions” can also serve as unofficial leaders and can help increase community buy-in.
- **Strong relationships:** Forming close partnerships can increase the potential for success. Organizations with similar missions can work together to achieve similar goals, organize local support and community buy-in, and maximize the use and efficient allocation of resources.
- **Common social centers:** Health promotion and disease prevention programs can use local gathering spots like parks, churches, schools, city centers, and social clubs to reach large numbers of people. Involving participants through these social avenues can build trust in and commitment to the program.
- **Flexibility:** It may be necessary to adapt programs as they are implemented to address challenges or accommodate local circumstances. Plan ahead,

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troubleshoot, and maintain flexibility to options while remaining true to the program's primary purpose.

- **Importance of word of mouth:** Word of mouth can help establish credibility and trust of rural programs. Use social networking strategies and understanding of community dynamics to spread positive program messages.

“There is nothing permanent except change.” – Heraclitus

8.5 Health Promotion and Disease Prevention Program Challenges

- **Appropriate communication methods:** Using multiple channels to communicate with local residents about the program can be highly effective for recruitment. To identify the best communication channels, and to understand the dynamics of the target population, conduct focus groups, surveys, or other assessments about how they receive information.
- **Keeping the community motivated:** It's important for program planners to understand that one component of success is **recruiting and retaining** participants. Conduct education and outreach to identify community awareness of health concerns, determine community members' expectations, and to motivate individuals to achieve better health outcomes.
- **Cultural and social issues:** Unique cultural and social norms can affect the program's likelihood of success. Many rural communities have deeply rooted traditions and cultures around food, lack of trust for medical professionals and outsiders, and/or social beliefs around certain behaviors. Make a conscious effort to recognize and understand these norms before implementing the program and develop strategies to address them. Involving members from the target population in this process can help achieve cultural competency and encourage participation.

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- **Resources and sustainability:** Rural communities have finite financial, technological, and workforce resources. Program staff may be involved in other activities and commitments. To create sustainable support for the program, focus on a shared vision and involve partner organizations and a larger body of community stakeholders.
- **Barriers to participation:** Local circumstances such as geography can influence program implementation and operations. The program design should accommodate lengthy travel times, availability of (or lack of) transportation, childcare needs, and site availability to minimize potential barriers to program participation.

*“Be the change that you wish to see in the world.”
– Mahatma Gandhi*

8.6 Evaluation Tools for Rural Health Promotion and Disease Prevention Programs

Evaluation in health promotion and disease prevention programs can be used to document a program’s effectiveness and impact by assessing quality, cost, and impact or to identify areas of improvement by gathering information throughout program implementation to determine if program objectives are being met. Evaluation can provide a level of transparency and accountability that encourages community support and informs policy decisions.

- **Engaging stakeholders:** Stakeholders can support data collection efforts by ensuring credible information is collected that logically corresponds with program expectations, reflects the practices and realities of the people served by the program, and can be organized to showcase the lessons learned.
- **Defining evaluation goals and objectives:** The goal of the evaluation may be to provide insight into program processes, effectiveness, outcomes, and/or impact. By defining evaluation goals and objectives, organizations can identify how program elements interact, the practices that maximize program effectiveness, the value of those effects, and how the program promotes health and prevents disease among participants.

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- **Connecting program goals and objectives to outcomes:** Organizations should define the goals and objectives of their health promotion/disease prevention program and connect them to measurable indicators and outcomes. Objectives should address program activities, the target population, the extent of the change, and the timeline (short-term and long-term).
- **Available resources:** Organizations should implement an evaluation strategy that reflects the program's budget, timeline, and other available resources.

“To change a habit, make a conscious decision, then act out the new behavior.”- Maxwell Maltz

Types of Evaluation in Health Promotion and Disease Prevention Programs

Several types of evaluation designs and frameworks can be used to assess health promotion and disease prevention programs. Each design and framework uses different approaches for assessment, data collection, and measurement. The types of frameworks that have been used for rural health promotion and disease prevention program evaluations include:

- **Formative evaluation:** Formative evaluation occurs during program development and implementation. It provides information on achieving program goals or improving your program.
- **Process evaluation:** Process evaluation is a type of formative evaluation that assesses the type, quantity, and quality of program activities or services.
- **Outcome evaluation:** Outcome evaluation can focus on short- and long-term program objectives. Appropriate measures demonstrate changes in health conditions, quality of life, and behaviors.
- **Impact evaluation:** Impact evaluation assesses a program's effect on participants. Appropriate measures include changes in awareness, knowledge, attitudes, behaviors, and/or skills.

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Data Collection Strategies

Prior to identifying data collection strategies, it is important to develop the specific questions that the evaluation will address. Evaluation questions should be reasonable, answerable, and appropriate given the program's process and outcomes. Well-defined evaluation questions consider the purpose of the evaluation, intended use of the results, the needs of stakeholders, and the real world circumstances that influence program success. Important contextual information for rural areas includes local beliefs and behaviors, system capabilities, and limitations regarding capacity, technology, and needed resources.

"We tend to judge others by their behavior, and ourselves by our intentions." – Albert F. Schlieder

Both quantitative and qualitative data should be collected to answer the research questions. Types of quantitative and qualitative data collection methods include surveys and questionnaires, focus groups, interviews, and observations and progress tracking.

Measures for Evaluating Health Promotion and Disease Prevention Programs

Rural health promotion and disease prevention programs collect data to document changes and evaluate effectiveness. An effective evaluation tracks changes over time by collecting data at the start of the program and after program implementation.

When identifying evaluation measures for health promotion and disease prevention programs, it is important to consider the program's focus, the needs of the audience or funders, and the time frame and training available for meeting program goals. Population health measures may also be used in evaluation. Common measures used in health promotion and disease prevention programs include:

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Participant data

- **Demographic data:** such as age, gender, race/ethnicity, educational attainment income, and primary language spoken.
- **Biological markers:** such as height, weight, body mass index (BMI), blood pressure, cholesterol, skin circumference, and A1Cs.
- **Health status:** such as disease, injury, stress, disability, risk factors, and perceived health status.
- **Medical history:** such as medication use, doctor's visits, and hospitalizations.
- **Knowledge:** such as health concerns, perceived risk, and feedback on program implementation.

“People don’t change their behavior unless it makes a difference for them to do so.” – Sharon Stone

Program process measures

- Number of participants who complete the program
- Number of participants participating in screenings or risk assessment
- Number of participants participating in health education or skill activities development
- Number of participants that receive and follow up with referrals
- Number of patients enrolled in health promotion or disease prevention programs
- Number and types of educational materials produced for the program
- Number of key stakeholders involved in the program

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- Number of people aware of program messaging and intend to take action
- Number of policies developed
- Types of program activities and settings
- Number and characteristics of staff offering the program
- Extent to which activities are implemented according to the program plan
- Types of resources and contributions provided by stakeholder groups
- Cost to complete program-related activities

Participant/community outcome measures can assess:

- Perceived health status
- Biometric markers
- Healthy behaviors
- Prevalence of risk factors or disease
- Healthcare costs
- Policies
- Environmental conditions
- Knowledge and skills

“We change our behavior when the pain of staying the same becomes greater than the pain of changing.” – Henry Cloud

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Using and Sharing Results

Sharing evaluation findings is a strategy for communicating the value of the rural health promotion or disease prevention program, marketing the program to other groups and individuals, securing more funding, and influencing policy decisions. Consider the following when developing a plan for sharing evaluation results:

- **Coordinate with stakeholders:** Ensure evaluation findings meet the needs of stakeholders by involving them in the review and discussion of results.
- **Create a communications plan:** Identify techniques for conveying results such as short videos, newsletters, audio segments, websites, or presentations to community partners or other groups.
- **Consider the audience:** Ensure the evaluation results are clear, concise, and appropriately formatted for different audiences.
- **Describe important features of the program and evaluation:** Share contextual information for the evaluation, including background and purpose, methods, findings, conclusions, recommendations, and lessons learned.
- **Present meaningful information effectively:** Use graphics, charts, and tables to present data. Include examples and meaningful anecdotal narratives. Avoid technical jargon and acronyms in writing.
- **Be upfront about strengths and limitations:** List the strengths and limitations of the evaluation. Discuss the advantages and disadvantages of the results and recommendations

Behavior is the mirror in which everyone
shows their image.

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8.7 Funding and Sustainability of Rural Health Promotion and Disease Prevention Programs

Careful planning can help to ensure the long-term success of health promotion and disease prevention programs and improved population health. Sustainability planning can help to address shifting health priorities, changes in local economies, and unpredictable availability of funding sources.

For an overview of the sustainability strategies that all types of programs might consider, see *Planning for Funding and Sustainability in the Rural Community Health Toolkit*.

This module describes the importance of sustainability, key considerations of sustainability planning, strategies for program sustainability, and a list of potential funders for rural health promotion and disease prevention programs.

Importance of Sustainability

The sustainability of health promotion and disease prevention programs often depends on the perceived value of the program and the support that individuals and organizations are willing to commit to ongoing operations. Sustainability can be achieved through continued commitment to achieving the program's goals and mission, increasing capacity in local systems, changing knowledge and attitudes, ongoing collaboration, improving services models, and implementing new policies that support program impact.

Knowing is not enough; we must apply. Willing is not enough; we must do. Johann Wolfgang von Goethe

Integral to achieving sustainability is the development of a sustainability plan. Sustainability planning can be facilitated by:

- Obtaining input and buy-in from community and stakeholder organizations.
- Determining appropriate indicators for evaluation.
- Documenting information on program progress.

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- Sharing results of program success that resonates with funders.
- Identifying long- and short-term sustainability strategies to achieve program goals.
- Organizing and prioritizing financial, human, and in-kind resources.
- Documenting and sharing information on program progress.
- Empowering employees and program partners to support sustainability strategies.
- Establishing mechanisms to identify and solve challenges.

Key Considerations for Sustainability Planning

When planning for sustainability, health promotion/disease prevention programs should focus on the following:

- Identifying potential barriers to sustainability and strategies to address them.
- Identifying potential opportunities to leverage and build upon existing priorities, strategies, and interventions.
- Identifying and pursuing diverse funding opportunities early in the development phase.

Let everyone sweep in front of his own door, and the whole world will be clean. Johann Wolfgang von Goethe

- Implementing data-driven decision-making processes.
- Emphasizing the intrinsic motivation that can exist in programs which maintain participant behavior change.
- Identifying ways to demonstrate cost savings and cost-effectiveness.
- Identify payment models that support and reward improvements in population health.

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- Considering which partner organizations are best positioned to run the program over the long-term and or that can assume certain programmatic responsibilities when necessary.
- Exploring opportunities for partnering with existing federal, state, county, or community initiatives.
- Considering how **services integration** and **care coordination** strategies can support health promotion and disease prevention programs and population health improvements.

Sustainability Strategies

Sustainable financing and funding models are especially important for rural health promotion and disease prevention programs. Because health promotion and disease prevention strategies support improvements in population health outcomes, one sustainability strategy is to create or identify funding models that support improvements in population health. These include value-based and/or alternative payment models. Alternative payment models change the care is paid for and delivered by focusing on improved quality, costs, and health outcomes. Rural communities should also consider developing a financial plan that identifies how to bill for services provided through the health promotion/disease prevention programs.

Thinking is easy, acting is difficult, and to put one's thoughts into action is the most difficult thing in the world. Johann Wolfgang von Goethe

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Other strategies for achieving sustainability include:

- Strengthening partnerships
- Building capacity
- Diversifying funding streams
- Implementing organizational or structural changes
- Developing effective messaging

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The attitude is very important. Because,
your behavior radiates how you feel.
Lou Ferrigno

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8.8 Review questions and answers of chapter 8 health promotion

1. Health promotion and disease prevention programs often integrate components of different theories and use more than one strategy to achieve their goals.
 - C. True
 - D. False
2. The Health Belief Model is a theoretical model that can be used to guide health promotion and disease prevention programs.
 - A. True
 - B. False
3. Social Cognitive Theory (SCT) describes the influence of individual experiences, the actions of others, and environmental factors on individual health behaviors.
 - A. True
 - B. False
4. Health communication includes verbal and written strategies to influence and empower individuals, populations, and communities to make healthier choices.
 - A. True
 - B. False
5. Health communication strategies aim to change people's knowledge, attitudes, and/or behaviors.
 - C. True
 - D. False

Part one:

T&F

1. A
2. A
3. A
4. A
5. A

CHAPTER NINE: DEVELOPMENT OF STANDARDS FOR DISEASE PREVENTION AND HEALTH PROMOTION

9.0 Introduction

The integrated activity of hospitals with regard to treatment, rehabilitation, disease prevention and health promotion forms a continuum and should be subject to the same requirements for quality development as other services of the hospital sector. In spite of the increasing evidence of the value of health promotion as part of hospital services few resources have been directed to the definition of quality goals for this area.

In environments where people don't practice good hygiene, they are not protected from feces and they are exposed to germs, which cause diarrhea and acute respiratory diseases.

These two illnesses are big killers of young children, and they are the primary illnesses facing school-aged children.

Safer water, combined with good hygiene practices, can reduce diarrhea infections by more than half. When safe water and good sanitation facilities are available, but there are poor hygiene practices, we get fewer of the benefits of improved water and sanitation.

What are “good hygiene practices?” There are three categories:

1. Personal hygiene. Personal hygiene includes washing hands with soap at key times, including: before eating, before preparing food, after defecating and after cleaning a baby's bottom or assisting an older or sick person to defecate. Hands should be washed with soap for 20 seconds and air-dried or dried with a clean cloth/paper.

Personal hygiene involves keeping the body clean (nails, fingers, toes, teeth, ears, face, hair, body), wearing shoes, wearing clean clothes, using a latrine for urination and defecation and cleaning the body well after defecation. Personal hygiene also includes menstrual hygiene and managing menstruation hygienically.

Psychology is the science of the intellects, characters and behavior of animals including man. Edward

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2. Household hygiene. Household hygiene includes: keeping clothes and bedding clean; the safe disposal of rubbish; sweeping floors; cleaning cooking pots and utensils after use and storing these items above the ground; ensuring children do not crawl near the latrine or other areas where they might be exposed to animal or human feces; separating animals from family living areas; and managing animal urine and feces and its disposal.

3. School and community hygiene. School and community hygiene includes: ensuring a safe water supply for drinking and washing hands; providing soap; providing and maintaining latrines; maintaining clean and tidy classrooms; keeping animals and their excrement away from school compounds; and dealing with difficult weather conditions. Ridding the community/school ground of stagnant water, and places where water might collect is also an important aspect of school and community hygiene, as is disposing of litter and rubbish in a central location.

Hygiene is fundamental to good health practices, and it needs to be taught in a fun, engaging way that connects it with the realities of children's lives.

Children can be powerful activists for change when they understand the deeper issues. If teachers simply *tell* children what to do and what not to do, little will change. Reflect on the fact that most adults know they should wash their hands with soap, but do not do it. Reflect on why this is: costs, services, culture? Before teaching important hygiene messages, we need to understand the challenges families and communities must overcome to practice good hygiene. For example, are there adequate supplies of water and soap?

Most children will have little control over how to use water, the purchasing and use of soap, the amount of water that can be used to wash with or to drink, how and when clothes are cleaned, or how water is made cleaner and safer (methods such as filtering, boiling or using sunshine). It is important that children are not stigmatized for their own poor hygiene. Often it is through no fault of their own and other children and teachers need to be aware of this, behave in a sensitive way and find ways to support them.

At school, children can work with teachers and other adults to make an important contribution to improving the conditions for practicing good hygiene, raising awareness in the community, and supporting families who have less access to water or who do not have a

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latrine. Once better conditions for families are in place, children can help by raising awareness and monitoring their own and others' hygiene practices.

We have to stop rewarding bad behavior.
Natalie Cole

Despite, all the effort of the Federal Government through the state Government to the local government to achieve the Millennium Development Goals (MDGs 2011), there are still enough cases of maternal mortality (Oyewole, 1999), high mortality rate due to malaria, typhoid, cholera and other infectious diseases (Abiodun, 2010) at the primary level as a result of ineffective primary health care system.

9.1 Underlying principles for work on HPH The Vienna Recommendations

The Vienna Recommendations on Health Promoting Hospitals (based on WHO's Health for All strategy, the Ottawa Charter for Health Promotion, the Ljubljana Charter for Reforming Health Care and the Budapest Declaration on Health Promoting Hospitals) establish that a health promoting hospital should:

1. Promote human dignity, equity and solidarity as well as professional ethics, acknowledging differences in the needs, values and cultures of different population groups.
2. Be oriented towards quality improvement, the well-being of patients, relatives and staff, protection of the environment and development of a learning organization.
3. Focus on health in a holistic perspective and not only on curative services.
4. Be centred on people and provide health services in the best way possible to patients and their relatives in order to facilitate the healing process and contribute to the empowerment of patients.
5. Use resources efficiently and cost-effectively and allocate resources on the basis of an assessment of contributions to health improvement.

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6. Form as close links as possible with other levels of the health care system and the community.

It always seems impossible until it's done. Nelson Mandela

9.2 Health promotion efforts should focus on:

developing a policy; - providing supportive environments; - strengthening initiatives at community level; - developing personal skills; - reorienting health services so that disease prevention and health promotion become an integrated part of curative efforts.

Health promotion initiatives are thus oriented towards increasing the competence and the capacity of individuals and towards providing a basis for change through influencing surrounding environments and local communities. Health promotion, including rehabilitation and disease prevention, is seen as an integrated part of health care services in the same way as examination, treatment, and care. Hospital services cannot provide the foundations for health promotion through their own efforts. This requires initiatives that cut across sectors.

The Ottawa Charter defines health promotion as the process of enabling people to exert control over the determinants of health and thereby improve their health. It is described as a 'process', the purpose of which is to strengthen the skills and capabilities of individuals to take action and the capacity of groups or communities to act collectively to exert control over the determinants of health.

With the new day comes new strength and new thoughts. Eleanor Roosevelt

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9.3 Determinants of health can be divided into:

1. determinants that can be influenced by the individual, such as lifestyle or the use of health care services;
2. determinants that cannot be influenced by the individual, such as economic and environmental conditions

According to the Vienna Recommendations, health promoting activities comprise the following four perspectives:

1. patients
2. health care staff
3. the organization
4. environments and communities

Prevention of disease

Usually a distinction is made between three different kinds of disease prevention:

1. primary prevention which prevents disease from occurring;
2. secondary prevention which identifies disease at an early stage and prevents it from developing
3. - tertiary prevention which prevents worsening or recurrence of symptoms and secures maintenance of functional level.

Programmes can also be defined as: - general programmes covering activities that should address all patients and should be part of any patient pathway;

- specific programmes addressing specified groups of patients and diseases.

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General programmes address general determinants of health and disease (including tobacco, alcohol, nutrition, exercise and psychosocial issues). One instance of this is lifestyle intervention, which includes activities aimed at influencing the behaviour of individuals (alcohol consumption, smoking etc). Lifestyle intervention includes advisory and support services for patients with a view to enhancing their competence as regards to preventing disease and changing behaviour. Specific programmes address determinants or risk factors of importance for defined groups of patients. Examples are the prevention of late complications in diabetes, education of patients with asthma, cardiac rehabilitation etc. An important element is the activation of the patient's individual resources and competencies in coping with disease.

It does not matter how slowly
you go as long as you do not
stop. Confucius

Thus, health promotion and disease prevention form a continuum. Traditionally, hospitals mainly take care of tasks that relate to secondary or tertiary prevention, whereas the primary health care sector takes care of primary prevention. But there is a growing recognition that also hospitals have an important role to play with regard to primary prevention. Existing knowledge on the importance of lifestyle factors for treatment and prognosis should have as a consequence that all hospitals establish advisory services and offer support for lifestyle changes as an integrated part of the individual patient pathway. One instance of this is intervention in connection with surgery.

There is evidence that smoking and excessive alcohol consumption increase the risk of complications in relation to surgery. Clinical testing of preoperative intervention confirms that the patients want and accept information and intervention and that such an initiative has an effect on the occurrence of complications in the form of, for instance, decreased rate of post-surgical infections, heart and lung complications. Similar evidence exists of the effect of, for instance, cardiac rehabilitation programmes following acute cardiac attack.

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Several investigations have proved that programmes containing advice and behavioural change strategies for exercise, diet, smoking cessation etc. reduce risk of a second cardiac attack, reduce readmission rate and improve life quality in patients. Evidence as described above has led to an increasing focus on integrating disease prevention and health promotion activities in all patient pathways, not as a supplement to, but as part of treatment.

9.4 Standards for Health Promotion

Perspectives A common set of standards developed by the Network of Health Promoting Hospitals involves both national and international perspectives. In a national perspective a common set of standards can:

1. provide a framework for the objectives and for concrete disease prevention and health promotion initiatives;
2. give hospitals a platform for the planning and establishing of activities and for documentation and evaluation of these; - support systematic implementation and recognition of activities carried out;
3. be part of the hospitals' quality management plans and be used for quality development;
4. support learning processes internally in the organization;
5. provide a platform for comparisons within the national networks and support mutual learning and exchange of experience;
6. uncover new needs for disease prevention and health promotion;
7. support cooperation between the primary and secondary health care sectors on prevention and health promotion; and
8. support the need for training of staff.

Don't watch the clock; do what it
does. Keep going. Sam
Levenson

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Patient-oriented strategies

1. Empowerment of patients for health promoting self-care/ self-maintenance/ self-reproduction in the hospital
2. Empowerment of patients for health promoting participation / coproduction in treatment and care
3. Development of the Hospital into a supportive, health promoting and empowering setting for patients

New health promotion services for hospital patients

1. Empowerment of patients for health promoting management of chronic illness
2. Empowerment of patients for health promoting lifestyle development
3. Participation in health promoting and empowering development of community infrastructures for specific patient needs

Promoting health of staff

1. Empowering staff for health promoting self-reproduction / self-care
2. Empowering staff for health promoting coproduction at work
3. Development of hospital into a supportive, health promoting and empowering setting for staff
4. Empowering staff for health promoting management of occupational illness
5. Participation in health promoting and empowering development of community infrastructures for specific needs of staff.

Only I can change my life. No one can do it for me. Carol Burnett

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9.5 Promoting the health of the population in the community

1. Empowerment of community for health promoting self-care by adequate access to hospital services in case of illness
2. Empowerment of health professionals and lay carers for health promoting coproduction in treatment and after-care for patients
3. Development of the hospital into a health promoting and empowering setting for the community
4. Empowerment of community population for health promoting management of chronic illness
5. Empowerment of community population for health promoting lifestyle development
6. Participation in health promoting community development for the general population

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A good plan violently executed now is better than a perfect plan executed next week. George S. Patton

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9.6 Review Questions and Answers of Chapter 9 Health Promotion

1. According to the Vienna Recommendations, health promoting activities comprise the following four perspectives except
 - A. Patients
 - B. Health care staff
 - C. The organization
 - D. Politician and leaders
2. Programm which covering activities that should address all patients and should be part of any patient pathway
 - A. General programme
 - B. Specific programme
 - C. None of the above
3. Programme addressing specified groups of patients and diseases.
 - A. Specific programme
 - B. General programme
 - C. None of the above
4. New health promotion services for hospital patients
 - A. Empowerment of patients for health promoting management of chronic illness
 - B. Empowerment of patients for health promoting lifestyle development
 - C. Participation in health promoting and empowering development of community infrastructures for specific patient needs
 - D. All the above
5. Which one of the following is Promoting the health of the population in the community?
 - A. Empowerment of community for health promoting self-care
 - B. Empowerment of health professionals and lay careers.
 - C. Development of the hospital into a health promoting and empowering setting for the community
 - D. All the above

Circle the correct answer

1. D
2. A
3. A
4. D
5. D

CHAPTER TEN: SOMALI CULTURE

10.0 Introduction

Somalia is located in the Horn of Africa, bordering Ethiopia, Djibouti and Kenya. The majority of the population are ethnically Somali and can trace their genealogy back to common forefathers. Somalis are distinguished by their traditional clan system, Somali language and Sunni Islamic beliefs. Daily life and culture can differ significantly across Somalia as many regions experience varying levels of poverty, governance and safety. Widespread and prolonged displacement has also contributed to diverse understandings of Somali culture. For example, many displaced people and refugees rely on abstract ideas of the Somali identity as they have few or no personal memories of their homeland. Nevertheless, there are certain values that are characteristic to Somalis, these being generosity, hospitality, kinship, respect for the elderly and honour. Broadly, Somalis have also demonstrated a high level of adaptability and entrepreneurialism in the face of adversity.

10.1 The Somali Identity

The entire Somali population and land area was separated between five countries during the colonial period – British Somaliland, Italian Somaliland, French Somaliland, Ethiopia and Kenya. The present-day Republic of Somalia was formed when British and Italian Somaliland were united as an independent state in 1960. However, significant numbers of ethnic Somalis continue to reside in the regions they have historically inhabited across the Horn of Africa which now belong to the countries of Djibouti (former French Somaliland), the Ogaden region of Ethiopia and northeastern Kenya.

Since independence, Somali nationalism has been largely based on the idea that Somalis across all these regions share a common language, religion, culture and ethnicity, and hence are united under a single identity. For example, Somalia's flag is an ethnic flag that has a star with five points to represent the unity of the Somali people inhabiting the five territories. Somalia fought a very damaging war against Ethiopia (1977-1978) in an effort to reclaim the territory of the predominantly Somali Ogaden region.

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The goal of uniting Somali territories has become a lower priority since the civil war. Nonetheless, Somalis from neighbouring countries are generally treated as citizens rather than foreigners when they visit.

10.2 Traditional Lifestyles, Displacement & Urbanisation

The Somali people are traditionally semi-nomadic, having lived subsistence lifestyles as agro-pastoralists or nomadic livestock herders. Somali nomads typically live in domed structures (*agal*) made of branches, mats and/or animal skins that can easily be taken down and moved to another area. However, many people's mode of living has been disrupted over recent decades. The cultural lives of many Somalis have been significantly impacted by the turmoil of the past 30 years.

It is estimated over 2 million Somalis are internally displaced within the country, and almost a million refugees are hosted in the region. In addition to conflict, many pastoralists and farmers have been displaced by famine and drought and have had to give up their livelihood and lifestyle, moving to refugee camps or urban areas. In 2014, the UN Population Fund estimated that 42% of the Somali population resided in urban areas, 26% were nomadic, 23% lived rurally and 9% were internally displaced.

Despite what mass displacement may suggest, many Somalis are very educated, urbanised, well-travelled and familiar with industrialised environments. The coastal cities have tended to absorb global influences from the colonial period and international trade. While those from the interior of the country are less likely to have experienced such international exposure, many displaced people are also introduced to infrastructure and modern industrial functions during their time in refugee camps or urban areas. People who are located in the more well-established and organized refugee camps sometimes have the ability to further their education and skill set.

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10.3 Social Structure and Clan System

One's genealogy is a defining factor in Somali culture. Society is characterised by a large extended family clan system. Membership to clans is determined by paternal lineage (through the father). People can trace their lineage back for generations and are generally able to determine how they are related to a person, how they should address them and pay respect to them, simply from learning their name and clan membership.

There are four major clans in Somalia and a number of medium-to-small groups. Each clan can be further divided into numerous sub-clans that can consist of tens of thousands of people alone. Within these sub-clans, there are even more group divisions based on kinship alliances of smaller extended families. The group divisions within the clan system are not necessarily based on geographic differences. It is common for a variety of sub-clans to live within the same area.

10.4 The Role of Elders

Elders play a very important role in Somali society and everyday life. They are negotiators, mediators and counsellors. They can also act as clan representatives. Somalis generally seek advice from a community elder about an issue before any further course of action. Being an elder is more closely linked to a person's status and authority rather than their actual age. For example, clan chiefs (*aqal*) and religious leaders are considered elders due to their authority, regardless of how old they are.

The power and authority elders hold has been immensely important in upholding law and order in areas of Somalia that do not have functioning governments. When an incident occurs, elders sit together and try to resolve the issue with a decision that de-escalates the situation non-violently. Indeed, in some regions where there is a strong respect for customary law, elders' decisions reached under a tree in a rural area can carry the strength of law.

The observance and enforcement of elder's' decision-making depends on respect for their traditional authority. Nevertheless, generally all Somalis continue to have a deep respect for age and experience. Elders continue to be the first point of contact for many living overseas to work through personal problems.

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10.5 Tribalism and Nationalism

Clan loyalty is traditionally very strong and deep-rooted in Somalia. Many Somalis derive their sense of belonging from their ancestry and being born into a particular clan group – a concept known as ‘*u dhashay*’. Some people may feel a stronger sense of belonging to their clan or sub-clan than with the broader Somali society and nation. For example, people are likely to side with members of their own kin-group in any dispute with other Somalis. However, such alliances and coalitions can change at short notice depending on the context. This is summed up in the Somali proverb: “*Me and my nation against the world. Me and my clan against my nation. Me and my family against the clan. Me and my brother against the family. Me against my brother.*”

The Somali people tend to unite whenever faced with the threat of foreign interference. This overarching national allegiance has been formed through repeated confrontations with outsiders and a history of colonial resistance. The population suffered under colonialism and many still have bitter feelings about the era. The involvement of some international powers in Somali internal politics is also a source of resentment, foreign assistance is often seen as having political motives. Today, social attitudes are often strongly opposed to outside interference. The Somali people generally reject hierarchical authority and seek independence from controlling bodies.

10.6 Somali Civil War

It is important to understand the political history of Somalia as the events and hardships of the past few decades have drastically changed Somali society and shaped the diaspora living overseas.

Many (if not most) Somalis currently living in other countries fled Somalia during or after the outbreak of the civil war. Over the years, the country’s political infrastructure completely collapsed and the political violence turned into clan-based violence perpetrated on and by ordinary citizens. This broke down mutual trust throughout society on a large scale.

Killings, lootings, sexual violence and the destruction of property led to large numbers of internally displaced people within the country, and to refugees fleeing to neighbouring

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countries. Famine and drought have also contributed to widespread poverty and displacement.

10.7 Political Sensitivities

Somalia's political history may be a sensitive issue for many, particularly for those who were displaced. Every Somali family is likely to have their own personal experiences of the civil war. The role of clan politics is particularly complicated and controversial. When the government collapsed, clans became the organising units of conflict with people splitting into factions. There are varying opinions and accounts of the truth. Therefore, be cautious forming opinions on clan dynamics as you may be perceived as taking sides without having a full understanding of the situation.

Many Somalis may consider the clan system to be divisive and problematic and prefer not to discuss it at all. Some argue that clan rivalries are exaggerated by politicians and the media to be a bigger issue than they are, and do not have as much social relevance outside of politics. People may prefer to emphasise the unity of all Somalis in an effort to promote stability. This is particularly common among Somali diaspora living overseas who generally view themselves as a single conglomerate. Many people have also intermarried between different clans. Ultimately, one should not allow clan politics to inform opinions of other people as generalized knowledge and information on clans are becoming less relevant to understanding the average Somali.

10.8 Contemporary Challenges

Somalia did not have an effective government for over 20 years after the outbreak of civil war in 1991. However, Somalia continues to face challenges.

Today, the strength of law and order in Somalia differs between regions. In 1991, the northern state of Somaliland (formerly British Somaliland) self-declared as an independent breakaway republic. This region has not been as directly affected by the war in southern Somalia. However, its current declaration of independence is not internationally recognised.

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Somalia also has five autonomous regions that have created their own political institutions in part to secure peace from clan rivalries – Puntland, Galmudug, Jubaland, South West Somalia and Hirshabelle. Unlike the secessionist region of Somaliland, these regions are not trying to gain international recognition as separate nations. Meanwhile, south-central Somalia continues to suffer the most from clan-based violence and Islamic insurgencies. The majority of internally displaced people reside in camps in south-central Somalia, including around one-third in the region surrounding the capital of Mogadishu.

10.9 Minorities

10.9.1 Occupational Castes

There are some occupational caste groups in Somalia who are minority groups within their tribes, such as the Gaboye, Tumul and Yibir people. These groups are known as ‘midgaan’ and are treated as social outcasts in Somalia. They are discriminated against in all levels of society, unable to marry other Somalis and face a higher risk of violence. For these people, settlement as refugees overseas can be a very empowering experience as they are able to gain equal rights that they were previously denied.

10.9.2 Minority Ethnicities

There are also some minority ethnic groups who are not part of the Somali genealogical clans, but have been living in Somalia for centuries. These include the Somali Bantu, Bajun, Barawani and Hamari people. Little statistical information is available on minority groups in Somalia. However, it is believed that there is a higher concentration of minorities in south-central Somalia. They are interspersed throughout society and do not have the political representation and military organization that the majority Somali clans have. The Somali Bantu are the largest ethnic minority, and tend to face more social barriers than other groups such as the Barawani and Hamari. Credible sources indicate that many internally displaced peoples in south-central Somalia are Bantu.

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10.10 Honour (Sharaf)

The notion of honour (*sharaf*) is central to Somali culture. Personal honour is deeply intertwined with family reputation in Somalia, regardless of wealth or power. Traditionally, one's behaviour would affect the honour or reputation of the entire clan or community. This is still the case for some tribes in rural areas, while in urban areas it has changed to be reflective of the family alone. People's awareness of their personal honour informs their sense of pride and integrity, and tends to guide behaviour and interactions in almost all circumstances.

One's honour is linked to an individual's personal demeanour, treatment of others, honesty and modesty (*xishood*) – specifically, the sexual modesty of one's female family members. These reflect many Islamic principles. If a woman is perceived to be promiscuous, her family name is put to shame. In some conservative communities, the unproven suspicion of a woman's infidelity can cause enough disgrace to ruin her family's reputation.

However, a person's honour is determined by more than their sexual modesty. Respectability and character are also reflected in the way people dress, the language they use, the hospitality they show their friends, the respect they give the elderly and their general demeanour. By remaining conservative, modest and respectable in all these aspects, one is thought to have proper decorum. It is important to note that the expectations and standards of behaviour are different for men and women. Generally, women are subject to higher expectations of social compliance than men. For example, it would be seen as uncivilised for girls to laugh or speak loudly in public whereas the same behaviour would be less inappropriate for men.

10.11 Community Interdependence

There is a very strong community focus embedded in Somali culture. People are mutually reliant on their family and community for support meeting essential needs. Dependence upon kin has become particularly crucial to survival since the civil war. The government's capacity to provide basic services or respond to humanitarian or conflict-related disasters is low. Therefore, Somalis rely on their kin to provide food, protection and conflict resolution. Everything is always redistributed and shared among the community, from engagement money to compensation money. One's community also takes responsibility for an individual's

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actions. For example, if a person commits an offence, traditionally it is their kin group that is held responsible and must pay compensation.

10.12 Generosity

Generosity is a core value of Somali culture that people extend towards the broader community and public rather than limit to their immediate community or family. Somalis find dignity in being helpful, hospitable and charitable to others with everything (money, food, time, personal connections, etc.). Hence, individuals may also receive social, emotional and financial support from the broader Somali community and public when going through particular hardship. Local mosques also often play a key role in mobilising community support.

Some Somalis report that they feel spontaneous generosity is more common in Somalia, such as a stranger paying for someone's food without telling them. Somalis tend not to think conservatively about the future, but rather give what they can to others at the present moment. Therefore, people can often rely on the hospitality of strangers. For instance, a person may be able to travel long distances across Somalia without comprehensive provisions as they will be taken care of by the strangers they come across on their journey.

10.13 Social Life

The community focus of Somalia gives the culture a strong social dimension. For example, Somali men may be able to maintain a healthy social life simply by sitting at tea shops on popular streets, watching locals and waiting to be spoken to by those passing. Meanwhile, women often make spontaneous visits to their neighbours and friends. It is common for people to meet friends without having to organise to do so. Generally, people tend to be very social, friendly and open.

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Rather than having ‘acquaintances’, Somalis generally see everyone as their friends. Once a Somali has met somebody, they are usually prepared to open up their homes and lives to that person, and help them in times of need. It is similarly expected that the person would be willing to do so in return. This quick development of personal relationships can be very different from Western notions of privacy. Sometimes their openness to conversation can come across as quite direct or bold to those from the English-speaking West. For example, it is normal for a Somali to approach a stranger for a chat. Many Somalis report that they miss this aspect of their culture whilst living overseas. They often describe how strangers in Somalia are met with a very welcoming and open attitude that they do not necessarily experience in Western countries.

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