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Health Promotion and Health Education: Theory and Practice

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Background. *Since health promotion and health education are developing concepts around the world, the purpose of this paper was to compare theory and practice, at certain point in time in various countries.* ***Methods.*** *Data were collected using the structured direct interview. We approached 16 participants at the XVI World Conference on Health Promotion and Education. The responses of 11 participants were analyzed.* ***Results.*** *Health promotion is a separate profession in 4 out of 11 countries. Physicians are responsible for health promotion and education in all 11 countries. School was identified as a health promotion setting in all 11 countries, while community and hospital in 10. The Ottawa Charter (1986) guided the definition of health promotion for all participants, while 7 participants defined health promotion and health education differently.* ***Conclusion.*** *Unified definition of terms may allow similar practice at the international level; comprehensive approach to health includes all aspects of health, determinants, settings and practitioners; there occurs the need for health education as a separate profession globally.*

Key words: **health promotion; health education; congresses; questionnaires; geographic locations.**

Introduction

The World Health Organization (WHO) defined in 1984 health promotion as "a process of enabling people to increase control over and to improve their health . . . as a mediating strategy between people and their environments, synthesizing personal choice and social responsibility in health" (1).

Two definitions of health promotion that are most widely used throughout the world are that of the Ottawa Charter and the one by Green & Kreuter (1, 2). The Ottawa Charter, created at the first International Conference on Health Promotion in Ottawa, Canada in November of 1986, defined health promotion as the "the process of enabling people to increase their control over, and to improve, their health. To reach a state of complete physical, mental and social well-being, an individual or group must be able to identify and to realize aspirations, to satisfy needs, and to change or cope with the environment. Health is, therefore, seen as a resource for everyday life, not the objective for living. Health is a positive concept emphasizing social and personal resources, as well as physical capacities. Therefore, health promotion is not just the responsibility of the health sector, but goes beyond healthy life-styles to well-being" (2).

Green and Kreuter defined health promotion as "any planned combination of educational, political, regulatory, and organizational supports for actions and conditions of living conducive to the health of individuals, groups, or communities" (3).

In the Report of the 2000 Joint Committee on Health Education and Promotion Terminology, we find that health promotion is defined as "Any planned combination of educational, political, environmental, regulatory, or organizational mechanisms that support actions and conditions of living conducive to the health of individuals, groups, and communities" (4).

Health education is a primary profession devoted to health promotion in the United States. The health education field is "that multidisciplinary practice . . . concerned with designing, implementing, and evaluating educational programs that enable individuals, families, groups, organizations, and communities to play active roles in achieving,

protecting, and sustaining health," according to the 1990 Report of the Joint Committee on Health Education Terminology (JCHET). Further, health education is "that continuum of learning which enables people, as individuals and as members of social structures, to voluntary make decisions, modify behaviors, and change social conditions in ways which are health enhancing" (5).

Health education is "combination of planned social actions and learning experiences designed to enable people to gain control over the determinants of health and health behaviors, and the conditions that affect their health status and the health status of others", according to the Position Paper on Health Education prepared jointly by the International Union for Health Education and the Division of the Health Education, WHO, Geneva, with the support from the Centers for Disease Control, USA (6).

According to Green and Kreuter, health education is "any combination of learning experiences designed to facilitate voluntary actions conducive to health. *Combination* emphasizes the importance of matching the multiple determinants of behavior with multiple learning experiences or education interventions. *Designed* distinguishes health education from incidental learning experiences as a systematically planned activity. *Facilitate* means predispose, enable, and reinforce. *Voluntary* means without coercion and with full understanding and acceptance of the purposes of the action. *Actions* means behavioral steps taken by an individual, group, or community to achieve an intended health effect or to build their capacity for health" (7).

In the 2000 Report of the Joint Committee on Health Education and Promotion Terminology, health education is "any combination of planned experiences based on sound theories that provide individuals, groups, and communities the opportunity to acquire information and the skills needed to make quality health decisions" (4).

The purpose of this study was to find out similarities and differences in health promotion and health education, theoretical definitions and practical application in various countries. The main objective was the organization of health promotion and health education in those countries that had representatives at the XVI World Conference on Health Promotion and Education, June 1998, San Juan, Puerto Rico. The international meeting was a convenient setting for obtaining such information from health professionals gathered together around a common goal – health for all.

Methods

The data collecting method was a survey, i.e. face-to-face interview. A short questionnaire was developed to guide the interview and data collection process.

Participants in the Study

The participants in the study were the participants at the XVI World Conference on Health Promotion and Health Education. There were three criteria to be satisfied for the selection of participants: a) the participant was to be a health promotion practitioner, b) participation in the study was on the voluntary basis, and 3) each participant was to be from a different country.

In the process of selecting the sample, 16 people were approached. Eleven of them provided valuable interviews. Three agreed to give an interview, but never returned, one person was not a health promotion practitioner, and one was from the same country of origin as another participant.

Data Collecting Instrument

The questionnaire consisted of two parts. The first part of the questionnaire included general information about participants in the study, such as city and country of origin, place of work, job title, level of education (degrees), number of years in health promotion, and membership in the International Union for Health Promotion and Education (IUHPE).

The second part of the questionnaire was composed of eight questions. The first three questions related to organization and delivery of health promotion and health education services. The fourth question asking the definition of health promotion and health education was followed by a question about the current highest priority in health promotion and health education in the particular country. Following were the two questions about the organization of primary health care and immunization practices in different countries. The questionnaire ended with an open-ended question that seeked for an opinion about the factors that contributed to the compliance with immunization as a recommended preventive measure.

Results

Participant Characteristics

The participants were from 11 different countries, Australia, Canada, Cuba, Finland, France, Haiti, India, Puerto Rico, the United Arab Emirates, the United States of America, and Yugoslavia. Three participants were male and eight were female. The work places of the participants were: hospital setting (2), university setting (4), community setting (2), correctional services (1), government organization (1), and retired (1). The participants listed a variety of job titles: professor-lecturer (4), physician's assistant (1), director of public health services (3), investigator (1), health educator (1), and unemployed (1). The number of years in health promotion ranged from 2 to 28 years. Out of 11 participants, five have been the members of IUHPE from two to ten years. All eleven participants voluntarily agreed to participate in the study after a brief explanation of the purpose of the study. Although anonymity was assured, all the participants made their name known to the interviewer. The interviews were held in the breaks between the sessions and at the convenience of the participants. Each interview lasted from 10 to 30 minutes. All participants were cooperative

and provided the information with great interest and seriousness.

Responses

For the purpose of this paper, the data obtained through the first four questions in the second part of the questionnaire were analyzed. The following data were collected and represented in Tables 1 and 2.

Cuba, physicians were recognized to be responsible for the delivery of health promotion/education in all 11 surveyed countries. Nurses delivered health promotion/education in all countries except in Haiti. Dentists were not recognized as professionals who delivered health promotion/education in India, Haiti, Australia, Finland, and Canada, while they were recognized in USA, France, Yugoslavia, Cuba, Puerto Rico, and the United Arab Emirates.

Table 1

Who is responsible for delivery of health promotion/education in your country?

Country	Teachers	Priests	Physicians	Nurses	Dentists	Health educators	Others
USA	+	+	+	+	+	+	
France	+		+	+	+	+	+
India			+	+		+	+
Yugoslavia	+		+	+	+		
Haiti	+		+				
Cuba	+	+	+	+	+	+	
Australia	+		+	+		+	+
Puerto Rico	+		+	+	+	+	
Finland	+		+	+			
United Arab Emirates	+		+	+	+	+	+
Canada	+		+	+		+	+++
Total	10	2	11	10	6	8	7

Table 2

In what settings is health promotion/education delivered in your country?

Country	School	Church	Hospital	Community	Organization	Other
USA	+		+	+	+	
France	+		+	+	+	
India	+		+	+		
Yugoslavia	+			+	+	+
Haiti	+	+	+	+	+	
Cuba	+		+	+		
Australia	+		+	+	+	+
Puerto Rico	+	+	+	+	+	+
Finland	+		+		+	+
United Arab Emirates	+		+	+	+	+
Canada	+		+	+	+	
Total	11	2	10	10	8	5

In four surveyed countries – Australia, France, the United Arab Emirates, and USA, health promotion is a separate profession, while in Cuba, Finland, Haiti, India, Puerto Rico, and in Yugoslavia it is not. The response was not declared for Canada.

When asked who was responsible for the delivery of health promotion/education in their country, the participants responded with a variety of answers: the teachers were responsible in 10 countries – USA, France, Yugoslavia, Haiti, Cuba, Australia, Puerto Rico, Finland, the United Arab Emirates, and Canada, the priests were delivering health education/promotion in the USA and

Health educators were responsible for health promotion/education in 8 countries (USA, France, India, Cuba, Australia, Puerto Rico, the United Arab Emirates, and Canada), while not in Yugoslavia, Haiti and Finland. Other professionals, such as social workers, sociologists, and psychologists (Canada), specialists in communications (France), community health workers (India), and employees in governmental departments (Australia), were identified as those who were responsible for the delivery of health promotion/education. The professionals responsible for the delivery of health promotion/education are presented in Table 1.

A variety of settings were identified where health promotion/education was delivered. School was identified as a health promotion/education setting in all 11 countries. Church was a setting in Haiti and Puerto Rico, hospital in 10 countries (except Yugoslavia), community in 10 countries (except Finland), organization/work place in 8 countries (except India, Cuba, and Canada). Other settings that delivered health promotion/education were recognized as family in Australia, voluntary organizations in Finland and Yugoslavia, health fairs, festivals and media in the United Arab Emirates, or correctional institutions in Puerto Rico. The settings for the delivery of health promotion/education are presented in Table 2.

The next question was whether the terms health promotion and health education were defined similarly or differently. In 3 countries – Haiti, India and Puerto Rico, they were defined similarly, while in Australia, Canada, Finland, France, UAE, USA, and Yugoslavia, they were defined differently.

Discussion

Defining and outlining the profession has many advantages and purposes. Based on the traditionally established professions, such as medicine, law, and higher education, the sociologists outline the characteristics of a profession in general. The essential characteristics of a profession would be: 1) a service mission, 2) a unique body of knowledge, and 3) a period of prolonged training (10). The characteristics such as continuing education, code of ethics, control of standards of education, shaping legislation related to the profession, peer review and control of licensure board, and strength of identity with the profession are identified as related to the profession. Accordingly, occupations can be classified along a continuum from nonprofessional to professional.

Based on the essential characteristics of a profession occupational field that is specific in mission, with a specific body of knowledge and acredited programs that prepare professionals for the mission of health, education was established in the United States of America, France, Australia, and the United Arab Emirates. According to Livingood (8), a profession is „the sociological construct for an occupation that has a special status." Health education may be called an emerging profession with that special status (9). In the US there are undergraduate as well as graduate levels of preparation in the health education. The degrees Master of Arts (MA), of education (MEd) and science/research (MS), Doctor of Philosophy (PhD), and Doctor of Education (EdD) in health education are offered at the accredited schools of Public Health, or through the Schools of Education. There is a specific curriculum identified for preparation of qualified professionals based on the competencies needed in the health promotion/education field (9). The field draws content from social and behavioral sciences, epidemiology, medicine and other areas (10).

Similarly in Canada, as reported in our survey, there are programs that prepare health promotion/education professionals. There has been an international initiative supported by IUHPE (International Union for Health Promotion and Education) to define health promotion clearly with the objective to prepare professionals properly and adequately (11).

In some other countries in the world, such as India, Yugoslavia, Haiti, Cuba, Puerto Rico, and Finland, health promotion and health education are not separate professions. In those countries, there is no specific professional preparation; there is no defined unique body of knowledge, yet there is a need and an intention toward defining a mission of the field. Even though health educator position exists within the organization of health in India, there is no formal preparation, or the identified specific and unique mission. Similarly, in Yugoslavia, teachers and physicians may receive isolated courses in health education and promotion, also without formal training or a degree in health promotion/education. The mission is vaguely defined and nonspecific, and there is no clear delineation of the occupation/profession yet.

All 11 participants in the study identified a variety of professionals who deliver health promotion/education in their country. The diversity of professional backgrounds of those who deliver health education and the variety of settings in which it is delivered may confirm the mission and goal of health promotion and health education – complete health for all. In our study, in all 11 countries surveyed physicians were identified as those who were involved in health promotion/education, teachers and nurses in 10, health educators in 8, dentists in 6. Other professions such as communication, community health workers, employees in governmental departments, interested community leaders, sociologists, psychologists, and social workers have also been also involved in health promotion/education.

A variety of settings were identified as places where health education and health promotion took place: school in 11 countries, hospital in 10, community in 10, organization in 8, church in 2, and health centers, voluntary organizations, families, correctional institutions, festivals, health fairs, the media in 5 countries. Media initiatives may be a temporary solution in public health education (12).

Almost every aspect of human existence either affects upon or is affected by health. The determinants of health may allow for an area of specialization within the profession. According to Simons-Morton, Greene, and Gottlieb the extensive study of health determinants resulted in their organization in four broad categories: 1) genetics, 2) environment, 3) health care, and 4) personal behavior (lifestyle) (10). Again, Dželetović, et al. reported that health determinants discussed through media in Yugoslavia provided some information, but did not comply with the established and recognized theoretical frameworks utilized in health promotion/education internationally, such as socio-ecological model and others (13).

For a seemingly difficult open-ended question searching for definitions of health promotion and health education, the finding was interestingly simple. With the three exceptions (one – no answer, and two without a statement), all countries surveyed had the same confidence in and guidance with the resolution of the Ottawa Charter from 1986 in defining the terms. From the data collected in written answers, it may be appropriate to summarize and conclude that health promotion is a complex social framework, while health education is a method or a vehicle of delivery of information and strategies for the improvement of health. The majority of responses (seven) were that those two concepts were different, while only three responses indicated that they were similar. The three responses (similar) corresponded with the nonexistence of a health promotion/education as a separate profession in the country (India, Puerto Rico, and Haiti). It may be appropriate to contemplate that the establishment of a profession and clear delineation of the field helps in understanding similarities and differences of concepts related to health.

Considering all the responses to the above questions, there is no misunderstanding of the mission of health promotion and health education, internationally. The collected data showed that countries were at a different level of development of the occupation from non-professional to professional, although all started from the same understanding of complexity and multiplicity of human health. Therefore, the international meetings are convenient communities of learning which allow for the exchange of experience and results collected at national levels.

Conclusion

A unified definition of health promotion and education may help in uniting efforts in practicing of it internationally. A comprehensive approach to health needs to encompass all aspects of health, such as the determinants of health, settings, and professionals. There is a clear need for delineation and establishment of health promotion/education as a separate profession.

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Apstrakt

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PROMOCIJA ZDRAVLJA I ZDRAVSTVENO VASPITANJE: TEORIJA I PRAKSA

Uvod. Polazeći od konstatacije da su promocija zdravlja i zdravstveno vaspitanje koncepti u razvoju širom sveta, cilj ovog rada je poređenje teorije i prakse u jednom vremenskom periodu u različitim zemljama sveta. **Metode**. Za prikupljanje podataka sprovedeno je istraživanje putem strukturisanog direktnog intervjua, pri čemu je zamoljeno 16, a analizovani su odgovori 11 učesnika na XVI svetskoj konferenciji o promociji zdravlja i zdravstvenog vaspitanja. **Rezultati**. Pokazalo se da je od 11 zemalja u 4 promocija zdravlja zasebna profesija. Lekari su odgovorni za sprovodjenje promocije zdravlja i zdravstvenog vaspitanja u svih 11 zemalja. Škola je mesto realizacije u svih 11 zemalja, a zajednica i bolnica u 10. Otavska Povelja (1986) je za sve bila osnov definicije promocije zdravlja, dok je 7 ispitanika različito definisalo promociju zdravlja i zdravstveno vaspitanje. **Zaključak**. Jedinstvena definicija pojmova bi omogućila sličniju praksu na internacionalnom nivou; sveobuhvatan pristup zdravlju podrazumeva sve aspekte zdravlja, determinante, sredinu i osoblje; globalno postoji potreba za zdravstvenim vaspitanjem kao novom profesijom.

Ključne reči: **zdravstveno unapređenje; zdravstveno prosvećivanje; kongresi; upitnici; geografske lokacije.**

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