McKENZIE NEIGER THACKERAY

PLANNING, IMPLEMENTING & EVALUATING
Health Promotion Programs

A PRIMER

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Planning, Implementing, and Evaluating Health Promotion Programs

A Primer

SEVENTH EDITION

James F. McKenzie, Ph.D., M.P.H., M.C.H.E.S.
Ball State University

Brad L. Neiger, Ph.D., M.C.H.E.S.
Brigham Young University

Rosemary Thackeray, Ph.D., M.P.H.
Brigham Young University

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CONTENTS

Preface xiii

Acknowledgments xvii

Chapter 1 Health Education, Health Promotion, Health Education Specialists, and Program Planning 1

Health Education and Health Promotion 4
Health Education Specialists 4
Assumptions of Health Promotion 9
Program Planning 10
Summary 13
Review Questions 13
Activities 13
Weblinks 14

PART I **PLANNING A HEALTH PROMOTION PROGRAM** 15

Chapter 2 Starting the Planning Process 17

The Need for Creating a Rationale to Gain the Support of Decision Makers 18
Steps in Creating a Program Rationale 20
Step 1: Identify Appropriate Background Information 20
Step 2: Title the Rationale 26
Step 3: Writing the Content of the Rationale 26
Step 4: Listing the References Used to Create the Rationale 30
Planning Committee 33
Parameters for Planning 36
Summary 37
Review Questions 37
Activities 37
Weblinks 38

Chapter 3 Program Planning Models in Health Promotion 41

Evidence-Based Planning Framework for Public Health 43
Mobilizing for Action Through Planning and Partnerships (MAPP) 45

MAP-IT 46
PRECEDE-PROCEED 48
The Eight Phases of PRECEDE-PROCEED 48
Intervention Mapping 50
Healthy Communities 51
SMART 53
The Phases of SMART 55
Other Planning Models 57
An Application of the Generalized Model 58
Final Thoughts on Choosing a Planning Model 62
Summary 63
Review Questions 63
Activities 64
Weblinks 64

Chapter 4 Assessing Needs 67
What to Expect from a Needs Assessment 70
Acquiring Needs Assessment Data 71
Sources of Primary Data 71
Sources of Secondary Data 82
Steps for Conducting a Literature Search 87
Using Technology to Map Needs Assessment Data 88
Conducting a Needs Assessment 90
Step 1: Determining the Purpose and Scope of the Needs Assessment 91
Step 2: Gathering Data 91
Step 3: Analyzing the Data 93
Step 4: Identifying the Risk Factors Linked to the Health Problem 96
Step 5: Identifying the Program Focus 97
Step 6: Validating the Prioritized Needs 98
Application of the Six-Step Needs Assessment Process 98
Special Types of Health Assessments 100
Health Impact Assessment 100
Organizational Health Assessment 101
Summary 102
Review Questions 102
Activities 103
Weblinks 103

Chapter 5 Measurement, Measures, Measurement Instruments, and Sampling 105
Measurement 106
The Importance of Measurement in Program Planning and Evaluation 107
Levels of Measurement 108
Types of Measures 111

Desirable Characteristics of Data 111
Reliability 112
Validity 114
Bias Free 117
Measurement Instruments 117
Using an Existing Measurement Instrument 117
Creating a Measurement Instrument 118
Sampling 121
Probability Sample 123
Nonprobability Sample 126
Sample Size 127
Pilot Testing 127
Ethical Issues Associated with Measurement 129
Summary 130
Review Questions 130
Activities 131
Weblinks 131

Chapter 6 Mission Statement, Goals, and Objectives 133
Mission Statement 134
Program Goals 135
Objectives 136
Different Levels of Objectives 136
Consideration of the Time Needed to Reach the Outcome of an Objective 138
Developing Objectives 139
Questions to be Answered When Developing Objectives 139
Elements of an Objective 139
Goals and Objectives for the Nation 142
Summary 148
Review Questions 149
Activities 149
Weblinks 150

Chapter 7 Theories and Models Commonly Used for Health Promotion Interventions 151
Types of Theories and Models 154
Behavior Change Theories 154
Intrapersonal Level Theories 157
Interpersonal Level Theories 176
Community Level Theories 182
Cognitive-Behavioral Model of the Relapse Process 186
Limitations of Theory 187
Summary 188

Review Questions 188
Activities 189
Weblinks 190

Chapter 8 Interventions 191
Types of Intervention Strategies 193
Health Communication Strategies 194
Health Education Strategies 203
Health Policy/Enforcement Strategies 206
Environmental Change Strategies 210
Health-Related Community Service Strategies 211
Community Mobilization Strategies 212
Other Strategies 215
Creating Health Promotion Interventions 225
Intervention Planning 225
Adopting a Health Promotion Intervention 226
Adapting a Health Promotion Intervention 226
Designing a New Health Promotion Intervention 228
Limtations of Interventions 233
Summary 234
Review Questions 234
Activities 235
Weblinks 236

Chapter 9 Community Organizing and Community Building 237
Community Organizing Background and Assumptions 238
The Processes of Community Organizing and Community Building 241
Recognizing the Issue 244
Gaining Entry into the Community 244
Organizing the People 245
Assessing the Community 248
Determining Priorities and Setting Goals 252
Arriving at a Solution and Selecting Intervention Strategies 254
Final Steps in the Community Organizing and Building Processes 254
Summary 255
Review Questions 255
Activities 255
Weblinks 256

PART II IMPLEMENTING A HEALTH PROMOTION PROGRAM 259

Chapter 10 Identification and Allocation of Resources 261
Personnel 264
Internal Personnel 264

External Personnel 265
Combination of Internal and External Personnel 266
Items Related to Personnel 267
Curricula and Other Instructional Resources 272
Space 275
Equipment and Supplies 276
Financial Resources 276
Participant Fee 277
Third-Party Support 277
Cost Sharing 278
Cooperative Agreements 278
Organization/Agency Sponsorship 278
Grants and Gifts 279
Combining Sources 282
Preparing and Monitoring a Budget 282
Summary 287
Review Questions 287
Activities 287
Weblinks 288

Chapter 11 Marketing: Developing Programs That Respond to the Wants and Needs of the Priority Population 291
Marketing and Social Marketing 291
The Marketing Process and Health Promotion Programs 293
Exchange 293
Consumer Orientation 294
Segmentation 296
Marketing Mix 301
Pretesting 310
Continuous Monitoring 312
Summary 314
Review Questions 314
Activities 315
Weblinks 316

Chapter 12 Implementation: Strategies and Associated Concerns 319
Logic Models 321
Defining Implementation 322
Phases of Program Implementation 322
Phase 1: Adoption of the Program 323
Phase 2: Identifying and Prioritizing the Tasks to Be Completed 323
Phase 3: Establishing a System of Management 326
Phase 4: Putting the Plans into Action 331
Phase 5: Ending or Sustaining a Program 335
Implementation of Evidence-Based Interventions 335

Concerns Associated with Implementation 336
Safety and Medical Concerns 336
Ethical Issues 338
Legal Concerns 340
Program Registration and Fee Collection 341
Procedures for Record Keeping 341
Procedural Manual and/or Participants' Manual 341
Program Participants with Disabilities 342
Training for Facilitators 342
Dealing with Problems 345
Documenting and Reporting 345
Summary 346
Review Questions 346
Activities 347
Weblinks 348

PART III EVALUATING A HEALTH PROMOTION PROGRAM 349

Chapter 13 Evaluation: An Overview 351
Basic Terminology 352
Purpose of Evaluation 354
Framework for Program Evaluation 356
Practical Problems or Barriers in Conducting an Evaluation 358
Evaluation in the Program Planning Stages 360
Ethical Considerations 360
Who Will Conduct the Evaluation? 361
Evaluation Results 362
Summary 362
Review Questions 363
Activities 363
Weblinks 363

Chapter 14 Evaluation Approaches and Designs 365
Formative Evaluation 366
Pretesting 373
Pilot Testing 373
Summative Evaluation 374
Selecting an Evaluation Design 375
Experimental, Control, and Comparison Groups 376
Evaluation Designs 378
Internal Validity 381
External Validity 382

Summary 383
Review Questions 383
Activities 384
Weblinks 384

Chapter 15 Data Analysis and Reporting 387
Data Management 388
Data Analysis 389
Univariate Data Analyses 390
Bivariate Data Analyses 391
Multivariate Data Analyses 392
Applications of Data Analyses 393
Interpreting the Data 394
Evaluation Reporting 396
Designing the Written Report 397
Presenting Data 397
How and When to Present the Report 398
Increasing Utilization of the Results 399
Summary 400
Review Questions 400
Activities 400
Weblinks 401

Appendix A Code of Ethics for the Health Education Profession 403
Appendix B Health Education Specialist Practice Analysis (HESPA 2015)–Responsibilities, Competencies and Sub-competencies 409
Glossary 419
References 433
Name Index 459
Subject Index 465
Text Credits 477

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PREFACE

This book is written for students who are enrolled in a professional course in health promotion program planning. It is designed to help them understand and develop the skills necessary to carry out program planning regardless of the setting. The book is unique among the health promotion planning textbooks on the market in that it provides readers with both theoretical and practical information. A straightforward, step-by-step format is used to make concepts clear and the full process of health promotion planning understandable. This book provides, under a single cover, material on all three areas of program development: planning, implementing, and evaluating.

Learning Aids

Each chapter includes chapter objectives, a list of key terms, presentation of content, chapter summary, review questions, activities, and Weblinks. In addition, many of the key concepts are further explained with information presented in boxes, figures, and tables. There are also two appendixes: *Code of Ethics for the Health Education Profession* and *Health Education Specialist Practice Analysis 2015—Responsibilities, Competencies, and Sub-competencies;* an extensive list of references; and a Glossary.

Chapter Objectives

The chapter objectives identify the content and skills that should be mastered after reading the chapter, answering the review questions, completing the activities, and using the Weblinks. Most of the objectives are written using the cognitive and psychomotor (behavior) educational domains. For most effective use of the objectives, we suggest that they be reviewed before reading the chapter. This will help readers focus on the major points in each chapter and facilitate answering the questions and completing the activities at the end.

Key Terms

Key terms are introduced in each chapter and are important to the understanding of the content. The terms are presented in a list at the beginning of each chapter and are printed in boldface at the appropriate points within the chapter. In addition, all the key terms are presented in the Glossary. Again, as with the chapter objectives, we suggest that readers skim

the key terms list before reading the chapter. Then, as the chapter is read, particular attention should be paid to the definition of each term.

Presentation of Content

Although each chapter could be expanded—in some cases, entire books have been written on topics we have covered in a chapter or less—we believe that each chapter contains the necessary information to help students understand and develop many of the skills required to be successful health promotion planners, implementers, and evaluators.

Responsibilities and Competencies Boxes

Within the first few pages of all except the first chapter, readers will find a box that contains the responsibilities and competencies for health education specialists that are applicable to the content of the chapter. The responsibilities and competencies presented in each chapter are the result of the most recent practice analysis—the *Health Education Specialist Practice Analysis 2015* (HESPA 2015), which is published in *A Competency-Based Framework for Health Education Specialists—2015* (NCHEC & SOPHE, 2015). These boxes will help readers understand how the chapter content applies to the responsibilities and competencies required of health education specialists. In addition, these boxes should help guide candidates as they prepare to take either the Certified Health Education Specialist (CHES) or Master Certified Health Education Specialist (MCHES) exam. A complete listing of the Responsibilities, Competencies, and Sub-competencies are presented in Appendix B.

Chapter Summary

At the end of each chapter, readers will find a one- or two-paragraph review of the major concepts covered in the chapter.

Review Questions

The questions at the end of each chapter provide readers with some feedback regarding their mastery of the content. These questions also reinforce the objectives and key terms presented in each chapter.

Activities

Each chapter includes several activities that allow students to use their new knowledge and skills. The activities are presented in several different formats for the sake of variety and to appeal to the different learning styles of students. It should be noted that, depending on the ones selected for completion, the activities in one chapter can build on those in a previous chapter and lead to the final product of a completely developed health promotion program plan.

Weblinks

The final portion of each chapter consists of a list of updated links on the World Wide Web. These links encourage students to explore a number of different Websites that are available to support planning, implementing, and evaluating programs.

New to This Edition

In revising this textbook, we incorporated as many suggestions from reviewers, colleagues, and former students as possible. In addition to updating material throughout the text, the following points reflect the major changes in this new edition:

- Chapter 1 has been updated to include information about the revised areas of responsibility, competencies, and subcompetencies based on the *Health Education Specialist Practice Analysis* (HESPA 2015) (NCHEC & SOPHE, 2015), and the implications of HESPA 2015 for the Health Education Profession.
- Chapter 2 has been expanded to include additional information on sources of evidence to support a program rationale, additional information on determining the financial burden of ill health, a new example of a written program rationale, and information on the importance of partnering with others when creating a program.
- Chapter 3 has been restructured to place more emphasis on the prominent planning models used in health promotion. The chapter also now includes the Evidence-Based Planning Framework in Public Health, the CHANGE tool used to plan healthy community initiatives, and more evidence-based examples of how planning models are used in practice.
- Chapter 4 has new information on the importance of needs assessment in the accreditation of health departments and the IRS requirement for not-for-profit hospitals, new information on using technology while conducting a needs assessment, and a new section on organizational health assessments.
- Chapter 5 includes new information on wording questions for different levels of measurement, how to present data in charts and graphs, how to write questions and response items for data collection instruments, and guidelines for the layout and visual presentation of data collection instruments.
- Chapter 6 now includes a new section on short-term, intermediate, and long-term objectives, and a new SMART objective checklist.
- Chapter 7 includes additional information on the expansion of the socio-ecological approach, additional information on the constructs of the social cognitive theory, the inclusion of the diffusion of innovations theory which was previously found in Chapter 11, and a new section on the limitations of theory.
- Chapter 8 features new information on motivational interviewing, new content on the built environment, new content on behavioral economics, information on the Affordable Care Act and its impact on incentives, and new content on the limitations of interventions.
- Chapter 9 includes new information on the renaming of community organizing strategies and updated figures on community organizing and community building typology and on mapping community capacity.
- Chapter 10 now includes expanded information on using volunteers as a program resource, and program funding by governmental agencies.
- Chapter 11 has been reworked and now has several new boxes and tables that include a social marketing planning sheet, factors to consider when selecting pre-testing methods, a 4Ps marketing mix example, types of questions to ask for formative research, and examples of segmentation.

- Chapter 12 content includes expanded information on logic models, new content on professional development including a template for a professional development plan, new content on monitoring implementation, and new content on the implementation of an evidence-based intervention.
- Chapter 13 now includes updated information on CDC's Framework for Program Evaluation and new information on CDC's characteristics of a good evaluator. In addition, new information has been added to support the importance of evaluation and the use of evaluation standards.
- Chapter 14 includes updated terminology and context for internal and external validity, and updated context for experimental, quasi-experimental, and non-experimental evaluation designs.
- Chapter 15 includes updated information for data management, data cleaning, and the transition to data analysis. In addition, new information is presented to show the relationship between levels of measurement and the selection of statistical tests including parametric and non-parametric tests.
- All chapters include more practical planning examples and, where appropriate, new application boxes have been added to chapters.
- A new appendix has been added that contains all of the Responsibilities, Competencies, and Sub-competencies that resulted from the Health Education Specialist Practice Analysis 2015.
- To assist students, the Companion Website (https://media.pearsoncmg.com/bc/bc_mckenzie_health_7) has been updated and includes chapter objectives, practice quizzes, Responsibilities and Competencies boxes, Weblinks, a new example program plan, the Glossary, and flashcards.
- To assist instructors, all of the teaching resources have been updated by Michelle LaClair, Pennsylvania State College of Medicine. These resources are available for download on the Pearson Instructor Resource Center. Go to http://www.pearsonhighered.com and search for the title to access and download the PowerPoint® presentations, electronic *Instructor Manual* and Test Bank, and TestGen Computerized Test Bank.

Students will find this book easy to understand and use. We are confident that if the chapters are carefully read and an honest effort is put into completing the activities and visiting the Weblinks, students will gain the essential knowledge and skills for program planning, implementation, and evaluation.

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J. F. M.
B. L. N.
R. T.

Chapter 1

Health Education, Health Promotion, Health Education Specialists, and Program Planning

Chapter Objectives

After reading this chapter and answering the questions at the end, you should be able to:

- Explain the relationship among good health behavior, health education, and health promotion.
- Explain the difference between health education and health promotion.
- Write your own definition of health education.
- Explain the role of the health educator as defined by the Role Delineation Project.
- Explain how a person becomes a Certified Health Education Specialist or a Master Certified Health Education Specialist.
- Explain what the Competencies Update Project (CUP), Health Educators Job Analysis (HEJA-2010), and Health Education Specialists Practice Analysis (HESPA-2015) have in common.
- Explain how the Competency-Based Framework for Health Education Specialist is used by colleges and universities, the National Commission for Health Education Credentialing, Inc. (NCHEC), Council for the Accreditation of Educator Preparation (CAEP), and the Council on Education for Public Health (CEPH)
- Identify the assumptions upon which health education is based.
- Define the term *pre-planning*.

Key Terms

Advanced level 1-health education specialist
Advanced level-2 health education specialist
community
decision makers
entry-level health education specialist
Framework
health behavior
health education
health education specialist
health promotion
Healthy People
pre-planning
primary prevention
priority population
Role Delineation Project
secondary prevention
stakeholders
tertiary prevention

History has shown that much progress was made in the health and life expectancy of Americans since 1900. During these 116+ years, we have seen a sharp drop in infant mortality (NCHS, 2015); the eradication of smallpox; the elimination of poliomyelitis in the Americas; the control of measles, rubella, tetanus, diphtheria, Haemophilus influenzae type b, and other infectious diseases; better family planning (CDC, 2001); and an increase of 31.5 years in the average life span of a person in the United States (CDC, 2015e). Over this same time, we have witnessed disease prevention change "from focusing on reducing environmental exposures over which the individual had little control, such as providing potable water, to emphasizing behaviors such as avoiding use of tobacco, fatty foods, and a sedentary lifestyle" (Breslow, 1999, p. 1030). Yet, even with this change in focus we, as a society, have done little to encourage health community design, and as individuals, most Americans have not changed their lifestyle enough to reduce their risk of illness, disability, and premature death. As a result, unhealthy lifestyle characteristics have lead to the United States ranking 94th (out of 225 countries) in crude death rate; 42nd (out of 224 countries) in life expectancy at birth; and 1st in health care spending (CIA, 2015).

Today in the United States, much of the death and disability of Americans is associated with chronic diseases. Seven out of every 10 deaths among Americans each year are from chronic diseases, while heart disease, cancer, and stroke account for approximately 50% of deaths each year (CDC, 2015b). In addition, more than 86% of all health care spending in the United States is on people with chronic conditions (CDC, 2015b). Chronic diseases are not only the most common, deadly, and costly, they are also the most preventable of all health problems in the United States (CDC, 2105b). They are the most preventable because four modifiable risk behaviors—lack of exercise or physical activity, poor nutrition, tobacco use, and excessive alcohol use—are responsible for much of the illness, suffering, and early death related to chronic diseases (CDC, 2015b) (see **Table 1.1**). In fact, one study estimates that all causes of mortality could be cut by 55% by never smoking, engaging in regular physical activity, eating a healthy diet, and avoiding being overweight (van Dam, Li, Spiegelman, Franco, & Hu, 2008).

TABLE 1.1 **Comparison of Most Common Causes of Death and Actual Causes of Death**

Most Common Causes of Death, United States, 2013*	Actual Causes of Death, United States, 2000**
1. Heart disease	1. Tobacco
2. Cancer	2. Poor diet and physical inactivity
3. Chronic lower respiratory diseases	3. Alcohol consumption
4. Unintentional injuries	4. Microbial agents
5. Stroke	5. Toxic agents
6. Alzheimer's disease	6. Motor vehicles
7. Diabetes	7. Firearms
8. Influenza and pneumonia	8. Sexual behavior
9. Kidney disease	9. Illicit drug use
10. Suicide	

*Kochanek, Murphy, Xu, & Arias (2014).

**Mokdad, Marks, Stroup, & Greberding (2004, 2005).

But modifying risk behaviors does not come easy to Americans. One study (Reeves & Rafferty, 2005) has shown that only 3% of U.S. adults adhere to four healthy lifestyle characteristics (not smoking, engaging in regular physical activity, maintaining a healthy weight, and eating five fruits and vegetables a day). If moderate alcohol use were included in the healthy lifestyle characteristics the percentage would be even lower (King, Mainous, Carnemolla, & Everett, 2009). Now in the second decade of the twenty-first century, behavior patterns continue to "represent the single most prominent domain of influence over health prospects in the United States" (McGinnis, Williams-Russo, & Knickman, 2002, p. 82).

Though the focus on good health, wellness, and **health behavior** (those behaviors that impact a person's health) seem commonplace in our lives today, it was not until the last fourth of the twentieth century that health promotion was recognized for its potential to help control injury and disease and to promote health.

> Most scholars, policymakers, and practitioners in health promotion would pick 1974 as the turning point that marks the beginning of health promotion as a significant component of national health policy in the twentieth century. That year Canada published its landmark policy statement, *A New Perspective on the Health of Canadians* (Lalonde, 1974). In the United States, Congress passed PL 94-317, the Health Information and Health Promotion Act, which created the Office of Health Information and Health Promotion, later renamed the Office of Disease Prevention and Health Promotion (Green 1999, p. 69).

This paved the way for the U.S. government's *Healthy People: The Surgeon General's Report on Health Promotion and Disease Prevention* (USDHEW, 1979), which brought together much of what was known about the relationship of personal behavior and health status. The document also presented a "personal responsibility" model that provided Americans with a prescription for reducing their health risks and increasing their chances for good health.

It may not have been the content of ***Healthy People*** that made the publication so significant, because several publications written before it provided a similar message. Rather, *Healthy People* was important because it summarized the research available up to that point, presented it in a very readable format, and made the information available to the general public. *Healthy People* was followed by the release of the first set of health goals and objectives for the nation, titled *Promoting Health/Preventing Disease: Objectives for the Nation* (USDHHS, 1980).

These goals and objectives, now in their fourth generation (USDHHS, 2015c), have defined the nation's health agenda and guided its health policy since their inception. And, in part, they have kept the importance of good health visible to all Americans.

This focus on good health has given many people in the United States a desire to do something about their health. This desire, in turn, has increased the need for good health information that can be easily understood by the average person. One need only look at the Internet, current best-seller list, read the daily newspaper, observe the health advertisements delivered via electronic mass media, or consider the increase in the number of health-promoting facilities (not illness or sickness facilities) to verify the interest that American consumers have in health. Because of the increased interest in health and changing health behavior, health professionals are now faced with providing the public with information. However, obtaining good information does not mean that those who receive it will make healthy decisions and then act on those decisions. Good health education and health promotion programs are needed to assist people in reducing their health risks in order to obtain and maintain good health.

Health Education and Health Promotion

There is more to health education than simply disseminating health information (Auld et al., 2011). Health education is a much more involved process. Two formal definitions of health education have been frequently cited in the literature. The first comes from the *Report of the 2011 Joint Committee on Health Education and Promotion Terminology* (Joint Committee on Health Education and Promotion Terminology [known hereafter as the Joint Committee on Terminology], 2012). The committee defined **health education** as "[a]ny combination of planned learning experiences using evidence-based practices and/or sound theories that provide the opportunity to acquire knowledge, attitudes, and skills needed to adopt and maintain healthy behaviors" (Joint Committee on Terminology, 2012, p. S17). The second definition was presented by Green and Kreuter (2005), who defined health education as "any planned combination of learning experiences designed to predispose, enable, and reinforce voluntary behavior conducive to health in individuals, groups, or communities" (p. G-4).

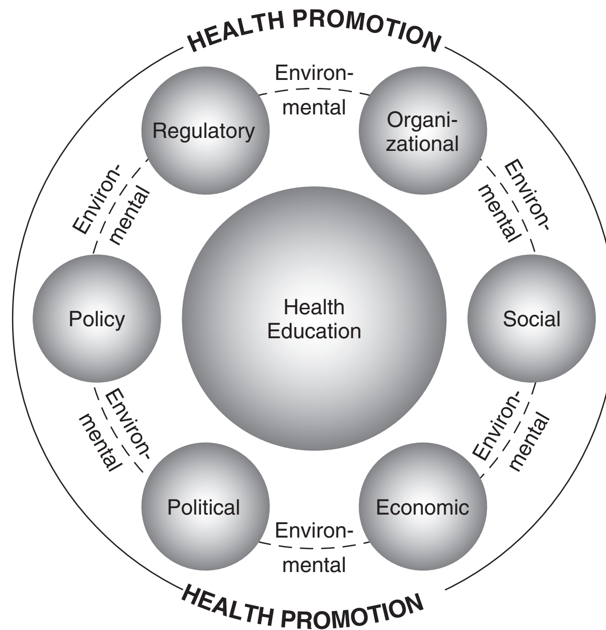
Another term that is closely related to health education, and sometimes incorrectly used in its place, is health promotion. *Health promotion* is a broader term than *health education*. In the *Report of the 2011 Joint Committee on Health Education and Promotion Terminology* (Joint Committee on Terminology, 2012, p. S19) **health promotion** is defined as "[a]ny 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." Green and Kreuter (2005) offered a slightly different definition of *health promotion*, calling it "any planned combination of educational, political, regulatory and organizational supports for actions and conditions of living conducive to the health of individuals, groups, and communities" (p. G-4).

To help us further understand and operationalize the term *health promotion,* Breslow (1999) has stated, "Each person has a certain degree of health that may be expressed as a place in a spectrum. From that perspective, promoting health must focus on enhancing people's capacities for living. That means moving them toward the health end of the spectrum, just as prevention is aimed at avoiding disease that can move people toward the opposite end of the spectrum" (p. 1031). According to these definitions of health promotion, health education is an important component of health promotion and firmly implanted in it (see **Figure 1.1**). "Health promotion takes into account that human behavior is not only governed by personal factors (e.g., knowledge, expectancies, competencies, and well-being), but also by structural aspects of the environment" (Vogele, 2005, p. 272). However, "without health education, health promotion would be a manipulative social engineering enterprise" (Green & Kreuter, 1999, p. 19).

The effectiveness of health promotion programs can vary greatly. However, the success of a program can usually be linked to the planning that takes place before implementation of the program. Programs that have undergone a thorough planning process are usually the most successful. As the old saying goes, "If you fail to plan, your plan will fail."

Health Education Specialists

The individuals best qualified to plan health promotion programs are health education specialists. A **health education specialist** has been defined as "[a]n individual who has met, at a minimum, baccalaureate-level required health education academic preparation qualifications,



▲ **Figure 1.1** Relationship of Health Education and Health Promotion

who serves in a variety of settings, and is able to use appropriate educational strategies and methods to facilitate the development of policies, procedures, interventions, and systems conducive to the health of individuals, groups, and communities" (Joint Committee on Terminology, 2012, p. S18). Today, health education specialists can be found working in a variety of settings, including schools (K–12, colleges, and universities), community health agencies (governmental and nongovernmental), worksites (business, industry, and other work settings), and health care settings (e.g., clinics, hospitals, and managed care organizations). (Note: Prior to the term *health education specialists* being used by the health education profession, health education specialists were referred to as *health educators*. Throughout the remainder of this book the term *health education specialist* will be used except when the term *health educator* is part of a title or when the term carries historical relevance.)

The role of the health education specialist in the United States as we know it today is one that has evolved over time based on the need to provide people with educational interventions to enhance their health. The earliest signs of the role of the health education specialist appeared in the mid-1800s with school hygiene education, which was closely associated with physical activity. By the early 1900s, the need for health education spread to the public health arena, but it was the writers, journalists, social workers, and visiting nurses who were doing the educating—not health education specialists as we know them today (Deeds, 1992). As we gained more knowledge about the relationship between health, disease, and health behavior, it was obvious that the writers, journalists, social workers, visiting nurses, and primary caregivers—mainly physicians, dentists, other independent practitioners, and nurses—were unable to provide the needed health

TABLE 1.2 **Levels of Prevention**

Level of Prevention	Health Status	Example Interventions
Primary prevention – measures that forestall the onset of a disease, illness, or injury	Healthy, without signs and symptoms of disease, illness or injury	Activities directed at improving well-being while preventing specific health problems, e.g., legislation to mandate safe practices, exercise programs, immunizations, fluoride treatments
Secondary prevention – measures that lead to early diagnosis and prompt treatment of a disease, illness, or injury to minimize progression of health problem	Presence of disease, illness, or injury	Activities directed at early diagnosis, referral, and prompt treatment, e.g., mammograms, self-testicular exam, laboratory tests to diagnosis diabetes, hypercholesterolemia, hypothyroidism, programs to prevent reinjury
Tertiary prevention – measures aimed at rehabilitation following significant disease, illness, or injury	Disability, impairment, or dependency	Activities directed at rehabilitation to return a person to maximum usefulness, e.g., disease management programs, support groups, cardiac rehabilitation programs

education. The combination of the heavy workload of the primary caregivers, the lack of formal training in the process of educating others, and the need for education at all levels of prevention—**primary**, **secondary**, and **tertiary**—(see **Table 1.2**) created a need for health education specialists.

As the role of the health educator grew over the years, there was a movement by those in the discipline to clearly define their role so that people inside and outside the profession would have a better understanding of what the health education specialist did. In January 1979, the **Role Delineation Project** began (National Task Force on the Preparation and Practice of Health Educators, 1985). Through a comprehensive process, this project yielded a generic role for the **entry-level health educator**—that is, responsibilities for health education specialists taking their first job regardless of their work setting. Once the role of the entry-level health educator was delineated, the task became to translate the role into a structure that professional preparation programs in health education could use to design competency-based curricula. The resulting document, *A Framework for the Development of Competency-Based Curricula for Entry Level Health Educators* (NCHEC, 1985), and its revised version, *A Competency-Based Framework for the Professional Development of Certified Health Education Specialists* (NCHEC, 1996), provided such a structure. These documents, simply referred to as the **Framework** were comprised of the seven major areas of responsibility,