Spring 2003

Health Education: An Eclectic Profession

Beverly S. Mahoney
Liberty University, bmahoney@liberty.edu

Health Education: An Eclectic Profession

Beverly S. Mahoney

Introduction

In 2001, the Coalition of National Health Education Organizations (CNHEO) published an assessment/planning document for the health education profession entitled *The Health Education Profession in the Twenty-First Century*. This document was generated by representatives from the ten national organizations whose focus is health education.

The common vision shared by these ten national organizations in 1995 had been that of "promoting and improving the public's health through education, advocacy, and research" (p. 113).The 2001 document provided a comprehensive overview of professional accomplishments and growth from 1995 to 2001, as well as a thorough assessment of what had been accomplished and what might still be priority goals. Authors acknowledged that the report, by virtue of the constituents who created it, did not "represent the progress made by individual practitioners or researchers or of groups of health educators working at the institutional, local, state, or regional levels" and that it was a "work in progress" (Brown, et al., 2001, p. 2)

Six focal points were established in 1995, to provide a framework and direction for the national organizations, including:

1. Professional preparation,
2. Quality assurance,
3. Research,
4. Advocacy,
5. Promoting the profession, and
6. Dynamic/Contemporary Practice.

The 2001 document was designed to include a definition, introduction, internal actions/goals, external actions/goals, and further actions needed for these six foci. These priorities, and related current trends and concerns, as well as related questions for practitioners to consider, are the focus for this article. Uniting the profession, vision, mission, goals, and objectives must be recognized as pivotal to the future success of the profession as well as its practitioners.

Trends

Serving our varied clients, health educators need an equally varied supply of resources, materials, and approaches. Perhaps the most universally accepted concept for those of us who are health educators is that we need always to be focused on primary prevention, to minimize risk and prevent disease and injury. It is easy, however, to get lost in the pessimism of thinking about how far we have to go. Since most of the remainder of this article will deal with where we are going, with our goals and plans for the future, allow me a moment to congratulate those who have been working in this profession over the years, and to share one example of how far we have come in prevention efforts.

Health In Your Daily Living (Rathbone, Bacon, & Keene, 1958) was a "cutting edge" text for high school students during the late 1950s. Many sections of this book do highlight prevention, including exercise, nutrition, stress management, and environmental health issues to name a few. Health educators were working diligently toward primary prevention nearly a half-century ago. The world has changed since then, as illustrated by Rathbone et al. (1958) in a chapter titled Your Part in the Nation's Health Program, that included tips for self-responsibility–what we would consider health literacy today. A sub-section of that chapter titled *"How can you cooperate in case of family illness?"* advises students as follows.

> *The next sign or symptom of many infectious diseases, such as colds, diptheria, scarlet fever, and measles, is a sore and inflamed throat. Since many disease germs enter the body through the throat, it is not strange that the mucous membrane in this area becomes inflamed. Unless a sore throat clears up quickly, you should call a doctor. Before he arrives, you can have the patient gargle with very warm salt water....If you have a clinical thermometer—and every home should have one—you can tell the doctor exactly what the temperature is. If he is delayed in arriving, he will be glad to know ....(p. 433)*

Another section regarding costs of good health advises:

> *The financial budget for your home should include in it an item for "sickness insurance," or medical care. If the family is not large enough to take care of medical costs, in addition to housing, clothing, and food, your family may have to use the public-health services for medical aid. But medical care should come before any luxuries...telephone, radio, movies, or automobile. The average health needs of a family ought to be met before money is spent for extras...Health protection is a necessity. (p.436-437)*

Future trends develop from perspectives and approaches of the past. Health educators still are trying to prevent illness and injury. The medical system has changed radically (at least I haven't heard of any physicians making house calls recently, and I think there are very few of us who would consider telephone, radio, or automobiles to be luxury items). The United States spends more on our health care than any nation in the world. According to the Centers for Disease Control and Prevention (2003) our total health care costs for 2001 totaled $1.4 trillion ($5,035 for every American). This represents 14.1% of our national budget, yet we ranked 25th among all nations in life expectancy. Perhaps most frightening, only one percent of health dollars are spent on public health efforts to improve overall health (APHA, 2003).

Issues/Concerns

The scope of this article does not permit an in-depth review of all six priority areas, but I have identified two concerns that I would like to review from the second area, quality assurance, and one that has been expressed over the Health Education listserve (go to http://www.HEDIR.org to subscribe). In each of the three instances, I have posed questions for thought and discussion. I do not have specific answers to these questions, but offer them as a springboard for discussion among colleagues. The authors of the 21st Century Report were correct when they indicated that not only national efforts need to be made in a coordinated, planned fashion, but also individual practitioners need to be aware of the results they can create through their efforts. We need to be working at all levels toward reaching our collective goals.

Ethics

As Health Education began to make its transition from being considered a discipline to a profession, it became evident that a guiding Code of Ethics for practice was an important document to develop. To the credit of hundreds of Health Educators from across the country, this process began to occur. In the late 1990s, both the American Association for Health Education (AAHE) and the Society for Public Health Education (SOPHE) had developed such documents.Under the

Continued on next page

Continued from previous page

leadership of the Coalition for National Health Education Organizations (CNHEO) a single, unified document was created. This draft document was then presented to all of the member organizations for review. By November of 1999, it was ratified by all nine members of the CNHEO and it officially became our profession-wide Code. The document is available on-line, as well as through the Coalition and several of the organizations. It contains seven articles, each one describing a specific responsibility of Health Educators. The abridged version describes each responsibility, while the unabridged version also delineates separate sections under each responsibility, providing detailed areas of practice.

The Code of Ethics for the Health Education Profession is a well thought out, thorough document. Two of the future actions noted in the 21st Century Report are directly related to the Code of Ethics.

1. Widely disseminate the Code of Ethics throughout the profession as well as to employers and other audiences
2. The CNHEO must commit to a system for revising and updating the code in the coming years. (Brown, et al., 2001, p. 18-19)

Over the past 18 months, the code has been disseminated widely. The hope is that it is also being taught in preservice programs across the nation. At this writing, it is too early to need plans for updating, but the structure is in place through the CNHEO to accomplish that task on a regular basis.

The dilemma, and the question posed for readers here, is now that we have this document, what can, or should, we do with it? Unlike licensed professions such as nursing, medicine, or dentistry, health educators are not required to have a license in order to work. Although states require initial clearances, and demonstration of competency via certification or licensure tests for those who work in public schools, not all health educators are required to possess a license to perform their professional duties as a health educator. State Boards of Education do not use our Code of Ethics as a guide. Therefore, there is no existing mechanism to enforce any of the components of the Code of Ethics as they would relate to a practitioner's unethical behavior. The logistics involved in monitoring complaints regarding an action of a health educator would be complex at best, and carrying that to the level of enforcement would be even more challenging.

Consider these questions.

1. Is the Code of Ethics for the Health Education Profession primarily a guiding document, a document that should carry the force of law, or a document that lies somewhere on a continuum between the two?
2. If you believe it should provide a means for enforcement of punishment for unethical behavior, how would that be carried out?
3. Would enforcement for the Code of Ethics be the responsibility of each state, or would a national review board be needed to hear cases?

Competency Update Project

Since 1998, a group known as the Competency Update Project (CUP) has been working to review and update the entry-level health education competencies and to verify the advanced-level competencies. All of the ten health education organizations, as well as the National Commission for Health Education Credentialing, Inc., were asked to send representatives to the first meeting in 1998, and these representatives have been working diligently since that time to accomplish this goal. The original Role Delineation Project was carried out decades ago, and provided the original *Framework for the Development of Competency-based Curricula for Entry Level Health Educators (NCHEC, 1985)*. This guide provided the first overarching outline of the scope of practice for health educators, since it focused on the competencies and skills required. It has served the profession well, but there was a desire to examine the scope of practice for health educators today; to determine exactly what it is they do "on the job."

Since that first meeting in 1998, CUP representatives developed an instrument that included a wide variety of competencies and skills; those already included from the original document, and many new ones that are reflective of changes in business, technology, education, and health. After the instrument was piloted in four states, and validated, it was sent to health educators all across the country, first to 16 randomly selected states, and then to all other states and the District of Columbia. All efforts were exhausted to obtain the names of health educators who are actively working in all the settings, and lists were obtained from multiple state, regional, and national organizations as well. Those data were collected during 2002. In all, over 4000 health educators, representing a 70% return rate, completed the nineteen page instrument (Competency Update Project, 2003, press release). Data analysis is ongoing in early 2003, and expected to be completed by the end of 2003. The data set is understandably enormous (more than 1.6 million data points), and CUP members will be working over the next months to examine the shape of health education practice, as it exists today.

From the inception of this project five years ago, to now, the major challenge has been to secure adequate funding to accomplish the goals of the project. The CUP project's member organizations have been asked to contribute financially, and some grant funding has been obtained to launch the project, but costs have been a constant challenge. In order to have appropriate and valid quality assurance for our profession, it seems critical that we update our entry level competencies and that we validate those established for the advanced levels of practice.

Consider these questions

1. What are the unifying competencies that all health educators should master?
2. How often should competencies be reviewed and updated?
3. What sources of funding could be used now to support any review and/or update of competencies?
4. What sources of funding might be used in the future to support any review and/or update of competencies?
5. What responsibilities, if any, do our professional organizations have to support this effort to update and maintain the competencies that define our scope of practice?

Professional Organizations

Most of the work that has been accomplished over the decades to advance the Health Education profession has been made possible through the efforts, and financial support, of one or more of our professional organizations. Certainly the efforts of the ten organizations mentioned earlier, along with the National Coalition for Health Education Credentialing, Inc., have provided direction, coordination, and financial resources for health educators to achieve multiple goals for the profession. At the individual level, however, confusion sometimes is evident. No one would argue the fact that health education is an eclectic profession. Health educators come into the field from a variety of backgrounds including health and allied health fields, education, physical education, and others. We represent a multiplicity of practice settings with further division of practice among those settings. Our challenges are not unique, but we are still in, if not infancy, then perhaps in early childhood, as to our professional representation.

As an analogy, consider the profession of nursing. Probably the most widely known professional organization for registered nurses (a licensed profession) is the American Nurses Association (ANA). Nursing has evolved into a highly specialized field, however, and there are multiple professional organizations that represent nurses, contingent upon their specialization, such as The Emergency Nurses Association, the American School Nurses Association, and The American Association

of Nurse Anesthetists. In fact, a quick visit to the website http://www.nursingworld.org/affil/ will provide a list of 94 different national associations whose membership consists of nurses in various specialties, in addition to the fact that the ANA has 53 constituent state members.

Some professionals within Health Education have indicated a concern that we do not stand as united as we might in light of our practice, and of advancing the profession, because we have several organizations, as opposed to one, stronger organization (archives, HEDIR.org). In addition to the organizations mentioned earlier, most states have affiliated organizations, such as the Pennsylvania State Association for Health, Physical Education, Recreation, and Dance. Many have state-wide affiliates of the American School Health Association, the Society for Public Health Education, and the American Public Health Association. Furthermore, there are regional affiliates of national organizations. Lastly, there are a variety of national or state level organizations whose purpose is to focus on one or more content areas with which Health Educators work. For example, Health Educators might wish to join organizations such as The Society for the Scientific Study of Sexuality *(http://www.sexscience.org/)*, the Association for Death Education and Counseling *(http://www.adec.org/)*, or any of a variety of state, national, and international organizations that focus on prevention/treatment of addictions (http://www.asam.org/webprof_org.htm)

The economic reality of professional practice is that most practitioners have limited resources available to invest in professional memberships. Therefore, we feel we must choose wisely, and select organizations that will provide us with the best services and resources. At the same time, the organizations that represent us have economic realities of accomplishing the most they can for their members while using their funds wisely The existing organizations have accomplished much as a group of independent associations whose memberships have similar characteristics (those who work in health education and health promotion). Still, some practitioners have indicated a desire for consolidation of professional organizations.

Consider these questions.

1. What are the advantages of having state and regional level affiliate organizations to national organizations, such as PSAHPERD and Eastern District AAHPERD?
2. What direction should health educators support regarding keeping our national organizations as separate entities, or encouraging mergers of some organizations?
3. What are the benefits of having a greater number of specialized organizations, such as The American Public Health Association, The American Association of Health Education, the American School Health Association, and others?
4. How can we best support our professional organizations?
5. How do our professional organizations assist us as we endeavor to serve our clients and students?

Final Thoughts

The past is just that, the past. The present changes with every passing moment, and the future is our chance to make a difference. My hope is that by considering where we have traveled as a profession over the past five decades, from taking the temperature and waiting at the door for a physician to arrive, to assisting people of all ages in gaining the knowledge for informed decisions, to critical thinking to promote healthful lifestyles, we can mold a better future. By uniting not only with others in the health education profession, but also by uniting with those in closely allied professions such as physical education, recreation, and dance, as represented through PSAHPERD, we can remain strong, determine where to become stronger, better qualified, and more effi in achieving our professional goals. I challenge you to not only foc your day-to-day responsibilities, but also to decide to give of your t and resources to enhance our profession. You won't regret it.

Organizations Involved in the 21st Century Report

American Association for Health Education
American College Health Association
American School Health Association
Association of State and Territorial Directors of Health Promotion and Public Health Education
Eta Sigma Gamma
National Commission for Health Education Credentialing, Inc.
Public Health Education & Health Promotion Section, APHA
School Health Education & Services Section, APHA
Society for Public Health Education, Inc.
Society of State Directors of Health, Physical Education, and Recreation

Source: Coalition of National Health Education Organizations, (2001)

Bibliography

American Association for Health Education, National Commission for Health Education Credentialing, Inc., & Society for Public Health Education. (1999) A competency-based framework for graduate-level health educators. USA: Au

American Public Health Association (2003). Retrieved April 15, 2003 at www.apha.org/news/press/2003/leading_causes.htm

Brown, K., Cissell, W, DuShaw, M., Goodhart, F, McDermott, R., Middleton, Tappe, M., & Welsh, V. (1996). The health education profession in the twenty-fi century: Setting the stage. Conference Proceedings. Journal of Health Educat 27(6), 357-364.

Centers for Disease Control and Prevention, (2003). Retrieved April 1, 2003, from http://www.cdc.gov/nccdphp.promiseofprevention/pop.spending.htm

Coalition of National Health Education Organizations (CNHEO) (2001). The health education profession in the 21st century. Progress Report 1995-2001. USA: Author.

Competency Update Project (2003). Press release available on HEDIR archive sent 4/16/03 at www.hedir.org More CUP information can be retrieved at thetr website http://www.nchec.org/aboutnchec/cup/cup.htm

Correll, R.R., Girvan, J.T., & McKenzie, J.F. (2002). Principles and foundation of health promotion and education (2nd ed.). San Francisco: Pearson Educatio Inc., as Benjamin Cummings.

Joint Committee on Health Education and Health Promotion Terminology. (2001). Report of the 2000 joint committee on health education and health promotion terminology. American Journal of Health Education, 32(2), 89-103.

National Commission for Health Education Credentialing (1996). A competenc based framework for professional development of certified health education specialists. Allentown, PA: Author.

National Task Force on the Preparation and Practice of Health Educators, Inc. (1985) A framework for the development of competency-based curricula for enh level health educators. New York: Author.

Rathbone, Bacon, & Keene (1958). Health in Your Daily Living. Boston: Houghton Mifflin Company

Dr. Mahoney is an Associate Professor of Health Education in the Department of Health and Physical Education at Edinboro University of Pennsylvania. Dr. Mahoney's research interests include tobacco prevention and cessation, faith groups and health, spiritual health, violence prevention, and eva uation research. She currently holds the office of Vice-president for Health in th Pennsylvania AAHPERD, has served as a board and executive committee memb for the American Association for Health. She is a past president of Eta Sigma Gamma, the National Health Education Honorary.