Mobilizing Resources for Health Education

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If we are to meet the potential "national crisis in health care," health education must be an integral part of any Extension program designed to improve the quality of living. The author suggests that the expertise of Extension or community health educators in helping people identify their needs and organize for action can be used to mobilize resources — actual and potential patients, professionals, lay people, community groups and specific agencies — to launch and carry out such activity. Program innovations at the state and local levels in Maryland are reviewed.

Extension has rich resources to be a powerful trigger in the promotion of "health consumer citizenship" through health education. "Health consumer citizenship" is responsible citizenship for promotion and maintenance of health for the individual, family, and community.

Conquering communicable disease through medical advances and environmental sanitation has changed the form and substance of medical and community health practices in recent decades. One consequence is that the prevention of disease and health maintenance has become more a matter of changing habits and customs than of controlling environmental conditions and immunizations. Educating the consumer in self-help will become an increasingly important element in health care.

We're beginning to recognize that the greatest single untapped source of manpower for participation in health care resides within the patients (actual and potential) themselves and their families. Their awareness and initiative aren't only significant in preventing physical and mental illnesses, but are at the crux of disease prevention and health maintenance. Services will be of little

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benefit to people unless they know how and when to use the system appropriately. Furthermore, the abuse of tobacco, alcohol, narcotics, etc., is an individual matter, subject ultimately to the patient's control and his alone.

Since Extension is charged with the responsibility of helping people improve their economic and social well being and quality of living, one of the most important ways it can do this is to help them solve their health and medical problems. Health is an essence of the quality of life. It's also a by-product of the quality of living.

Today the influence of housing, recreation, industry, employment, etc., has as much to do with health maintenance as immunization and early diagnosis and treatment. New methods of health education are needed to produce behavior change in individuals and customary practices of groups. The Extension educator's expertise in working with people in self-help projects is a potential source of influence in innovative health education service delivery in the face of the "national crisis in health care."

What Is Health Education?

Health education is concerned with people and their health behavior. It's an educational process through which people increase their understanding, or change their thinking or actions as a result of being exposed to new experiences. It involves communication, motivation, and decision making.[1]

The desired outcome of the educational process is the development of appropriate health knowledge, desirable attitudes, and practices among "the well and the sick, the young and the old, the urban and rural dwellers, so that they are equipped to make wise decisions on behalf of their own and their community's health."[2] Health is the result of a series of individual decisions made over a long period of time.

Health education objectives contribute to the overall broader program by adopting appropriate health practices and procedures among the groups or individuals that the health problem specifies. The educational approach can be used effectively at the promotional level and primary prevention in averting the disease, or at any level of secondary prevention as in halting progression of disease from its early unrecognized state to a more severe one, thus preventing complications.

Certain processes are basic to health education programs. These include community organization, training professionals and lay persons in health education methods and skills, consultation with other professionals, coordination of activities, program planning, and evaluation. These processes may occur within an agency or with other agencies or community groups both in developing and carrying out programs. Supportive to all such processes are legislation, research, and the procurement and distribution of

funds and resources. Together they make it possible to plan and to carry out the program designed to launch an aggressive attack on disease and to promote the community's health.

Consumer health education especially concerns the aspects of education that increase the consumer's decision-making ability in preventive health behavior. The components include: (1) knowledge of access and entry into the health care system; (2) the use of available resources and services; (3) the importance of following a prescription or medical advice whether it's about a drug, chronic illness, or weight reduction; and (4) the maintenance of a healthy home and community environment.

But aside from personal preventive health behavior, health education creates an awareness of the consumer's role in influencing legislation through public hearings and elected officials.

Community Health Educator or Extension Educator

The educational process for health described above has a familiar tone to Extension educators. Note again the striking similarities between the functions of the community health educator and the Extension educator.

In a statement of Functions of Community Health Educators, the Society of Public Health Education reported:

> The community health educator is prepared to analyze situations in terms of educational needs; plan the educational aspects of a program so as to utilize the contributions of other health and related specialists; assist other specialists in applying educational principles and concepts; assume major responsibilities for seeing that the educational activities are carried out and coordinated and that a sound plan for evaluating the educational component of the program is incorporated.
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> The work of the community health educator requires an understanding notably of the facts and conditions that govern human behavior but also of how such understanding can be applied to modify health practices. The community health educator seeks to obtain the active participation of all individuals concerned with a health problem in order to explore all facets of the problem and to develop realistic solutions to it. A basic tenet of the community health educator is that final decisions about health practices should be made by the individuals involved. However, the community health educator recognizes a responsibility to provide access to all sources of information and experience needed by the individual in relating desirable health practices to his motives, goals, aspirations and values.[3]

If the term "Extension educator" is substituted for the term "community health educator" and "behavior outcome" substituted for "health practices," we clearly have a similarity between the Extension

educator and community health educator working with individuals and groups in the community.

Integrating Health Education into Extension Programs

The goal of Extension education is to improve the quality of living. Health is part of that, for without health, there is no quality of living. Consumer health education is a part of housing, home management, family life, youth development, nutrition, and agriculture. The problem is how to build on and expand already existing Extension responsibilities. It's the channeling of health education efforts through existing Extension functions so that people will become knowledgeable and motivated to take action on health and health-related matters.

Since 1968, the Cooperative Extension Service of the University of Maryland has employed a full-time health specialist to give direction to an expanding program base. Program innovations have occurred at both the state and local levels.

Through a short-term training grant from the Rehabilitation Services Administration to the Extension Home Economics Department, the Institute for Home Teachers of the Blind was held in August, 1968. In developing the curriculum content, a sighted home economist and a blind rehabilitation teacher, who is both the consumer and provider of services, were teamed in planning. The former provided subject matter in foods and nutrition, home management, clothing and personal grooming, and the latter skills in working with the blind. Emphasis was primarily in the area of homemaking. This involved the management of human and material resources within the framework of the home of the handicapped person in keeping the family fed, sheltered, and clothed.

As a result of the interest this institute generated, the Workshop for Rehabilitation Teachers of the Blind and Extension Home Economists was held the following year. A psychologist joined the teaching team for child development and human relations. Working with vocational rehabilitation, several counties have since initiated programs for the blind homemakers.

A modification of the work with the blind is rehabilitation work with the deaf. The Extension home economist in Anne Arundel County developed techniques in teaching the adult deaf and organized special interest classes for deaf homemakers. She involved other Extension agents in neighboring counties in Maryland and northern Virginia, and helped them in program planning for this special audience.

The Conference on Consumer Health, sponsored by the Cooperative Extension Service and the Maryland State Department of Health and Mental Hygiene, was a new effort in cooperative activities. More than 150 professionals representing the state's 24 local jurisdictions attended the three-day, live-in conference.

During the general plenary sessions, qualified speakers and panelists gave an overview of crucial health problems with implications for: (1) consumer education and action, (2) the role of comprehensive health planning, (3) the contributions of the medical and social service organizations, (4) the role of the official health agency, (5) the components of quality health services, (6) examples of Maryland's different health care systems, (7) developments in insurance programs, (8) recourses for consumer action, (9) the promotion of healthful living, and (10) meeting the needs of special groups: youth and the aged. With the stimulus provided by these general sessions, the participants met in groups according to geographical base of operation to determine the implications for their areas.

These sessions were an exciting aspect of the conference. For the first time, many agency leaders identified resources available through their colleagues in other organizations, recognized that a number of agencies share responsibilities for various facets of community health, and felt the need to coordinate efforts. Some groups continued to meet after the conference, and some have carried out or initiated projects in their local areas. They were challenged to activate multidisciplinary, interagency teamwork approaches to solving the important personal and environmental health problems in Maryland communities.

In the Maryland Expanded Food and Nutrition Education Program, the supervising agents were encouraged to work closely with community agencies, especially the health and social service departments, in program planning and through referrals.

Initiated at the local level, 10 of the 16 program units have conducted family planning workshops for aide training. As the aide becomes acquainted with the homemaker, the homemaker will share with her many personal problems including family planning. The aide isn't in a position to teach family planning or the use of contraceptives, but she's in the position to say, "Do you know about the resources in the health department (or some other agency)? Would you like me to make an appointment for you to talk with someone about your concerns?" She can do the same with Medicaid and Medicare, prenatal and postnatal care, and other community resources.

Certainly the nutrition aide can become involved in health education without lessening her role in teaching food and nutrition.

Funded by Health Services and Mental Health Administration, the Consumer Health Education Demonstration project is a major attempt to transfer and adapt Extension education technology to the urban health center. The setting of the demonstration project is the Community Pediatric Center, a free clinic which is an ambulatory service of the University of Maryland Medical School, Baltimore City. This setting was selected because there were certain gaps between the health center and the

community served, and because the solutions to health problems in the inner city of Baltimore will have broad implications for other urban centers.

The program goal is directed toward helping the youth develop a life style and quality of life, of dignity and self-respect. It's hypothesized that a modified program in 4-H and youth work and home economics in urban Extension will have favorable effects on health knowledge, attitudes, and behavior in relation to the service provided by the free clinic.

This modified program in 4-H and youth work and home economics in urban Extension provides information, counseling, and leadership training through a broad educational program based on the needs of the people as identified by them.

While the program begins where people are, the focus is on learning experiences that will lead to greater individual and group effectiveness in decision making in health-related matters. The program begins with recreation and craft skill, but it leads to learning experiences in clinic use, use of prophylactics, nutrition, or personal hygiene.

The Extension home economist in Frederick County is cooperating with the local hospital director in launching a countywide educational program to orient the consumer to the health care system and patient education. A group of volunteers are trained by the hospital personnel on the educational message. These volunteers will in turn work with community groups to disseminate the information.

Mentally retarded children in Worcester County will soon have their own activity center. The Worcester County Extension home economist, serving on the Board of Directors of the local Association for the Mentally Retarded, was instrumental in obtaining a former elementary school building to serve as the center.

Although the building needs much repair, vocational education students and civic groups have already volunteered their services to renovate it. Equipment and money have also been received from concerned individuals and groups for preparation and use of the building. When the building is in operable condition, the first program will be a day care center for mentally retarded children between the ages 3-12.

Implications for Extension

For many years "family health" has been defined as an Extension focus. Extension's educational role in facilitating health service delivery, however, has been in the periphery. Health emphasis has been primarily on nutrition education and, secondarily, on health activities such as home safety and first aid, as related to family health. There has been little effort in the direction of family and community health planning.

Public affairs education has rarely included citizen discussions

on health issues such as partnership for health and the national health plan. Community resource development has given little emphasis to the development of health services and facilities and their incorporation into rural development. Yet, the shortage of physicians and service facilities are known to be both acute and chronic in rural communities.

The marginality of health education in Extension programs is reflected in the number of states that have a health specialist on their staff and the absence of a program leader at the national level. Tradition in programs coupled with the common-held belief that health belongs to the health professionals are among the barriers in developing the resources within Extension for health education purposes.

The need for consumer health education in the face of the "national crisis in health care" was highlighted in the recent 8 regional hearings held by the President's Committee on Health Education and in the 1972 National Health Forum.

Because of the changing nature of diseases from acute infections to chronic ailments, and the need for the citizen to participate in his own health care, there can be no doubt that health education is and will increasingly become an important element in illness prevention and health maintenance.

Extension is facing a tremendous challenge and an opportunity to make a major input in health education service delivery and help improve the nation's health.

Although Extension personnel don't have medical capabilities, they're experienced in helping people identify their needs and then organize for action. They can help people understand the existing opportunities and limitations, study alternatives and possible consequences, and seek means to solutions. To be effective in health education, the staff as well as the clientele must be made aware of the complexity of health issues and the health system organization. In-service training for staff would be the most effective and expedient method of accomplishing this.

The integration of health education into Extension programs could be greatly helped by placing a professionally qualified health education specialist at the state level.

As an educational arm of the university in outreach education, with personnel in every county and state, Extension is an ideal system through which to channel health education to consumers. Extension has a mandate in health education to enhance the quality of living.

An alliance with the state and county health departments, medical societies, and professional organizations is essential in this new thrust for health education service delivery. Extension should also act as a catalyst in mobilizing the resources of the university in health affairs, behavioral sciences, communication, and education, and seek input of others in the coalition for health education and for the promotion of a "health consumer citizenship."

Footnotes

1. Virginia Li Wang, *Planning for Community Health Services: Challenge to Extension*, MEP 285 (College Park, Maryland: University of Maryland, Cooperative Extension Service, 1969), p. 1.
2. Herman E. Hilleboe, "Public Health in the United States in the 1970's," *American Journal of Public Health*, LVIII (No. 9), 1606.
3. Ad Hoc Committee of S.O.P.H.E., "Statement of Functions of Community Health Educators and Minimum Requirements for Their Professional Preparation with Recommendations for Implementation" (New York, New York: Society of Public Health Educators, 1967), mimeographed.