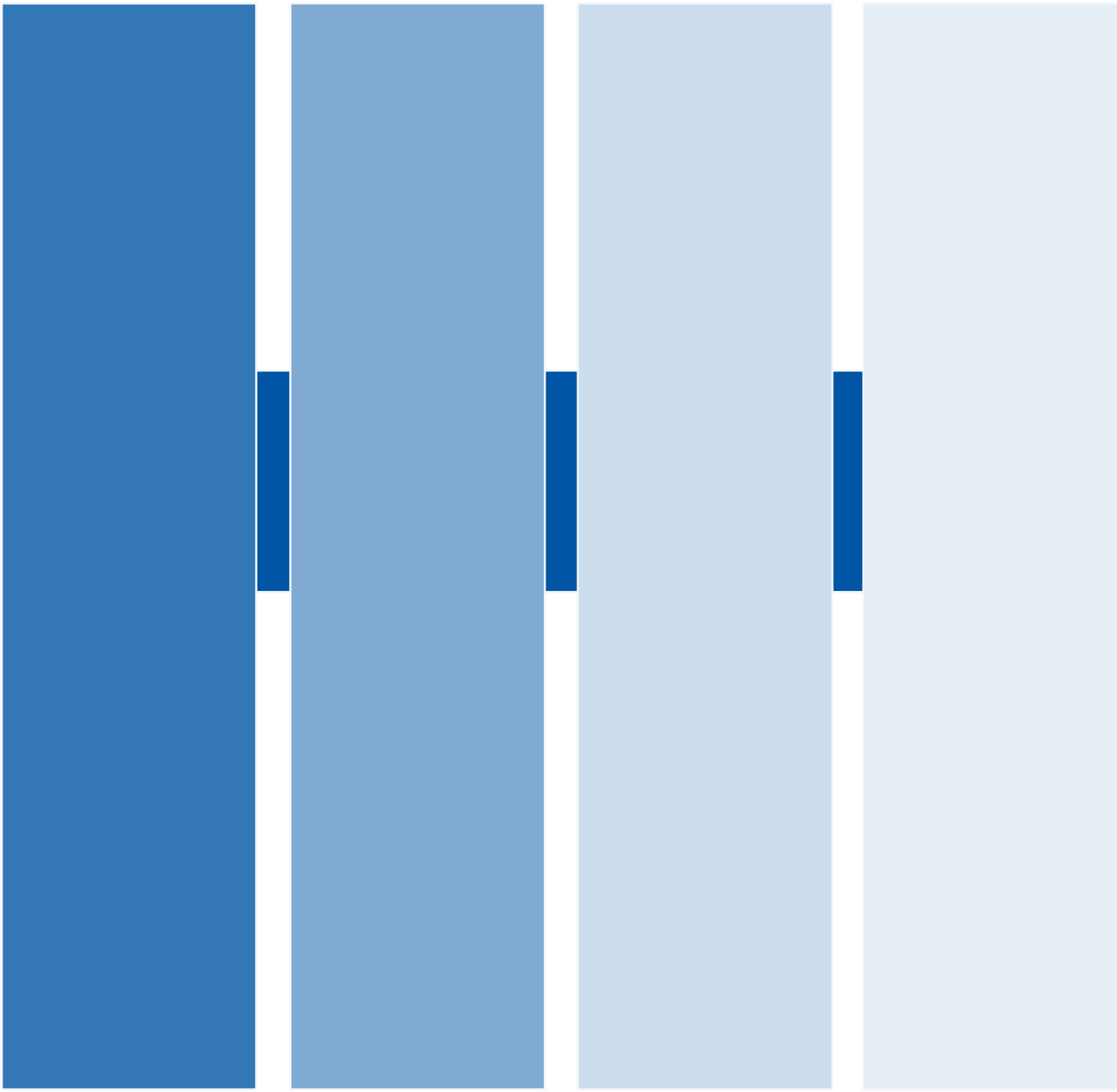
Report of the 2011 Joint Committee on Health Education and Promotion Terminology



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Report of the 2011 Joint Committee on Health Education and Promotion Terminology

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FOREWORD

Recognizing that the health education and promotion fields are constantly evolving, representatives of the professional health education associations have convened every ten years to define terms key to the work of the profession. Well defined and widely accepted essential terms help health education and promotion professionals communicate accurately with one another and with those outside the profession.

The rate of the change in the field between 2000 and 2011 has increased due to the electronic and digital revolution as well as to national and international recognition of the importance of disease prevention and health promotion through health education/promotion and the skyrocketing of health care costs. The practice of health education and promotion will continue to evolve quickly during the next decade.

Seven major terminology reports have been developed for health education over the past 80 years. The Public Health Education Section of the American Public Health Association (APHA) developed the first statement of terminology around 1927 (1). The first Joint Terminology Committee was established in the 1930s by the Health Education Section of the American Physical Education Association (APEA) and released the first terminology report in 1934 (2). Since then, a new report has been generated each decade producing a total of seven major terminology reports (2-7). In 1950, the American Public Health Association (APHA) took the lead and involved the American Alliance for Health, Physical Education, and Recreation (AAHPER). By 1990, the Association for the Advancement of Health Education (currently the American Association for Health Education) had taken the lead and included delegates from the Coalition of National Health Education Organizations (CNHEO) and the American Academy of Pediatrics. In 2000, the National Commission for Health Education Credentialing (NCHEC) and key Federal agencies also participated.

In 2011, the American Association for Health Education (AAHE) of the American Alliance for Health, Physical Education, Recreation, and Dance (AAHPERD) convened the task force that created this report. The 2011 Joint Committee on Health Education and Promotion Terminology (herein referred to as the Joint Committee) is comprised of representatives from the member organizations in the Coalition of National Health Education Organizations (CNHEO), the National Commission for Health Education Credentialing, Inc. (NCHEC), and governmental agencies. The names and affiliations of the representatives are published elsewhere in the report.

To create this report, the American Association for Health Education of AAHPERD (AAHE/AAHPERD) identified committee co-chairpersons, sent invitations to each organization inviting it to send a representative, created a survey to get feedback from the profession and disseminated it through various channels to health education and promotion profession-

als broadly, collated the responses, identified background information, and disseminated it to the selected organizational representatives. Each invited organization submitted the name and contact information for its representative to AAHE/AAHPERD and supported the participation of its representative financially. The co-chairs reviewed the survey results, prepared a presentation for the convened representatives, chaired a two-day meeting of organizational representatives, and drafted the initial report. See the Survey of the Profession section for a detailed review of the survey process.

In keeping with past Joint Committee efforts, a list of criteria were reviewed and agreed upon by Committee members to guide Committee decisions (Table 1). There are some terms that require more than one definition; such terms are health, holistic health, wellness, and quality of life (Tables 2 and 3). Given the ever increasing role certification, accreditation, and accountability play in our lives today, the 2011 Joint Committee decided to include a separate table of health education certification terms (Table 4).

As the lead for the 2011 Committee, AAHE will publish the Committee's report in the *American Journal of Health Education* in 2012 and also make it available online. Because it is the work of all the participating professional associations and because the Committee's expectation is that the report will receive wide dissemination to encourage use by researchers, leaders, practitioners, authors, and students in the profession, AAHE will grant complimentary permission to each participating organization to reprint the report.

The report of the 2011 Joint Committee on Health Education and Promotion Terminology reflects the committee members' respect for the evolutionary history of our profession and their futuristic view. Some terms in the report are unchanged from 2000, others modified, and a few were eliminated. In addition a number of new terms were added based on suggestions from the survey. The terms in the report are in alphabetical order and not within a contextual framework. The 2011 report includes citations or references for the terms, whenever possible, and when appropriate links to electronic reports and websites.

The co-chairs and the Joint Committee members extend a heartfelt thanks to all of the organizations and professionals who contributed to the survey and assisted in the development of this report. We also thank Becky Smith, Linda Moore and Meaghan Walsh for their valuable assistance. We sincerely hope this report will contribute to both advancing the practice of health education and promotion and unifying the profession.

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ACKNOWLEDGMENT

Each of the organizations and agencies represented on the committee demonstrated their recognition of the importance of this project through the selection and support of their representative and their commitment to widely circulate this report. Additional support for publication and distribution of the report was received from the Foundation for the Advancement of Health Education. We also thank the American Association for Health Education/American Alliance for Health, Physical Education, Recreation and Dance for hosting the committee activities and providing staff.

SURVEY OF THE PROFESSION

SURVEY PURPOSE AND PROCESS

An essential component of the Joint Committee's work in both 2000 and 2011 was to obtain input from members of the profession. However, in 2011 the process was changed in a way that made a significant difference. In 2000, the survey was completed mid-way in the process of the Joint Committee's work, thus members of the profession were responding only to the proposed terminology changes. In 2011, the survey was completed prior to the Joint Committee convening for discussion and thus all of the input from those in the profession was used as developmental material. The purposes of the survey were to ask members of the profession to review and respond to the terminology from the 2000 report and to solicit their suggestions for additional terms that should be addressed by the Joint Committee.

The process used to review the terms from the 2000 report was to post an online survey for open review by members of the profession, related national organizations, and federal agency staff. The survey was sent electronically by the invited organizations to their members or constituents and through the Health Education Directory (HEDIR) and Comprehensive Health Education Network (CHEN) list serves. The survey asked participants to rank each term in the 2000 report using the following criteria: 1) keep the term as is; 2) modify the term definition; or 3) remove the term from consideration. For recommendations to modify, participants suggested language and references for the changes. In addition, and most importantly for the developmental process, survey respondents were asked to submit suggestions for any additional terms they believed should be in the new Joint Committee on Health Education and Promotion Terminology report.

Response to the survey was very good with over 1,500 respondents. Becky Smith who served as a consultant to the Joint Committee and the AAHE staff compiled the survey results for the Joint Committee to review. Using electronic means, conference calls, and a two-day meeting in the AAHPERD's headquarters, the Joint Committee members sorted through the responses using the criteria noted in Table 1.

SURVEY RESULTS

One thousand seven hundred and forty members of the profession responded to the survey and 1,190 (68.4%) responded to all survey questions. Following a preliminary review of the survey results the Joint Committee members determined they would not discuss a term if 90% or more of the survey respondents agreed that no changes were needed, unless an organizational representative brought forward a specific reason to revise the definition.

In addition to debating the potential revision or deletion of terms from the 2000 Report, the Joint Committee considered the recommendations for new terms to be added to the 2011 Report. Survey respondents suggested 243 new terms to be considered for the report. After a preliminary review of the suggestions by the Committee Co-chairs and AAHE staff, the Joint Committee carefully examined 59 new terms for possible inclusion.

CONCLUSION

Surveying the members of the profession at the beginning of the Joint Committee's work resulted in a robust process. The level of response and the detail of input from health education and promotion professionals clearly demonstrate the significance professionals place on the terminology used within the profession. The 2011 Report is significantly revised. The 2000 Report featured 36 terms; whereas, the 2011 Report provides 41 terms. They include new terms as well as revised terms and definitions reflecting changes in practice during the past ten years. The new terminology report will give guidance for health education and promotion professionals, researchers, authors, publishers, and students throughout the decade ahead.

Table 1. Criteria Used as the Basis of the 2011 Terminology Review

Essentialness—is basic to the field of health education and necessary for communication.

Authoritativeness—is recognized or accepted by the profession as official language.

Significance—is so important in communication within and among groups that its use requires common interpretation.

Encompassment—is sufficiently broad and inclusive to eliminate unnecessary additional definitions but is restrictive enough to have clear meaning.

Usage—occurs frequently enough to affect and effect communications.

Adaptability—can be used effectively by various health professions and other individuals and groups.

Clarity—definition is necessary to maintain consistency of use among disciplines.

Table 2. Definitions of Health and Wellness

HEALTH

A state of complete physical, social and mental well-being, and not merely the absence of disease or infirmity.

Source: Preamble to the Constitution of the World Health Organization as adopted by the International Health Conference, New York, 19 June - 22 July 1946; signed on 22 July 1946 by the representatives of 61 States (Official Records of the World Health Organization, no. 2, p. 100) and entered into force on 7 April 1948.
Link: http://www.who.int/suggestions/faq/en/

Within the context of health promotion, health has been considered less as an abstract state and more as a means to an end which can be expressed in functional terms as a resource which permits people to lead an individually, socially and economically productive life. Health is a resource for everyday life, not the object of living. It is a positive concept emphasizing social and personal resources as well as physical capabilities. (Ottawa Charter for Health Promotion. WHO, Geneva, 1986)

Source: World Health Organization (1998). Health Promotion Glossary. *Geneva, Switzerland: Author.*
Link: http://www.who.int/healthpromotion/about/HPG/en/

Health is a dynamic state or condition that is multidimensional, a resource for living, and results from a person's interactions with and adaptation to the environment and therefore exists in varying degrees unique to the individual.

Adapted from: McKenzie, J.F., Pinger, R.R., & Kotecki, J.E. (2012). An introduction to community health (7th ed.). Sudbury, MA: Jones & Bartlett Learning.

HOLISTIC HEALTH

A concept that concern for health requires a perception of the individual as an integrated system rather than one or more separate parts including physical, mental, spiritual, and emotional.

Source: Mosby's Medical Dictionary (2009), 8th edition. Elsevier.

WELLNESS

An approach to health that focuses on balancing the many aspects, or dimensions, of a person's life through increasing the adoption of health enhancing conditions and behaviors rather than attempting to minimize conditions of illness

Adapted from: Dunn, H.L. (1961). High-level wellness: A collection of twenty-nine short talks of different aspects of the theme "high-level wellness for man and society." Arlington, VA: R.W. Beatty.

Table 3. Multiple Definitions for Quality of Life

Quality of life reflects a general sense of happiness and satisfaction with our lives and environment. General quality of life encompasses all aspects of life, including health, recreation, culture, rights, values, beliefs, aspirations, and the conditions that support a life containing these elements. *Health-related quality of life* reflects a personal sense of physical and mental health and the ability to react to factors in the physical and social environments. Health-related quality of life is more subjective than life expectancy and therefore can be more difficult to measure. Some tools have been developed to measure health-related quality of life.

Source: USDHHS Health People 2000: Understanding and Improving Health. p. 10.

Quality of life is defined as individuals' perceptions of their position in life in the context of the culture and value system where they live, and in relation to their goals, expectations, standards and concerns. It is a broad ranging concept, incorporating as complex way a person's physical health, psychological state, level of independence, social relationships, personal beliefs and relationship to salient features of the environment.

Source: Quality of Life Assessment. The WHOQOL Group, 1994. What Quality of Life? The WHOQOL Group. In: World Health Forum. WHO, Geneva, 1996.

Table 4. Health Education Certification Terminology

CERTIFIED HEALTH EDUCATION SPECIALIST (CHES)

An individual who has met required academic preparation qualifications, successfully passed a competency-based examination administered by the National Commission for Health Education Credentialing, Inc., and who satisfies the continuing education requirement to maintain the national credential.

National Commission on Health Education Credentialing, Inc.
Link: http://www.nchec.org/

HEALTH EDUCATION TEACHER

A teacher who is certified, licensed, or endorsed in health education by a state's education agency.

CDC's School Health Policy and Practices Study (SHHPS)/Health Education
Link: http://www.cdc.gov/healthyyouth/shpps/index.htm

MASTER CERTIFIED HEALTH EDUCATION SPECIALIST (MCHES)

An advanced-level practitioner who has met required academic qualifications, worked in the field for a minimum of five years, has successfully passed a competency-based assessment administered by the National Commission for Health Education Credentialing, Inc., and who satisfies the continuing education requirement to maintain the national credential.

National Commission on Health Education Credentialing, Inc.
Link: http://www.nchec.org/

NATIONAL BOARD CERTFICATION FOR HEALTH EDUCATION

An advanced teaching credential for accomplished teachers that complements, but does not replace, a state's teacher license for Health/Early Adolescence through Young Adulthood.

Link: http://www.nbpts.org/become_a_candidate/what_is_national_board_c

SCHOOL HEALTH COORDINATOR

A trained professional at the state, district, or school level who is responsible for managing, coordinating, planning, implementing, and evaluating school health policies, programs, and resources.

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TERMINOLOGY

Given today's technology the Joint Committee decided to provide links to online resources when we believed it appropriate.

CAPACITY BUILDING

Activities that enhance the resources of individuals, organizations, and communities to improve their effectiveness to take action.

COLLEGE HEALTH

A coordinated and planned set of policies, procedures, activities, programs, and services designed to enhance, protect, promote, and improve the health and well-being of students, faculty, and staff in institutions of post-secondary education.

COMMUNITY

A collective body of individuals identified by common characteristics such as: geography, interests, experiences, concerns, or values.

COMMUNITY CAPACITY

Characteristics of communities that affect their ability to identify, mobilize, and address social and public health problems.

COMMUNITY HEALTH

The health status of a defined group of people and the actions and conditions to promote, protect, and preserve their health.

COMMUNITY ORGANIZING

A process through which communities are helped to identify common problems or goals, mobilize resources, and in other ways, develop and implement strategies for reaching the goals they have collectively set.

COMPREHENSIVE SCHOOL HEALTH EDUCATION

The development, delivery, and evaluation of planned, sequential, and developmentally appropriate pre-kindergarten through grade 12 instruction and learning experiences designed to promote the health literacy, knowledge, attitudes, skills, and well-being of students. The content taught is standards-based, includes multiple health topics, and addresses the physical, intellectual, emotional, and social dimensions of health.

Link: http://www.cdc.gov/healthyyouth/sher/standards/index.htm

COORDINATED SCHOOL HEALTH

An organized set of policies, procedures, and activities, designed to protect, promote, and improve the health and well-being of pre-K students and staff, thus improving a student's ability to learn. It includes but is not limited to health education; school health services; a healthy school environment; school counseling, psychological and social services; physical education; school nutrition services; family and community involvement in school health; and school-site health promotion for staff.

CULTURAL COMPETENCE

A developmental process defined as a set of values, principles, behaviors, attitudes, and policies that enable health professionals to work effectively across racial, ethnic and linguistically diverse populations.

CULTURAL CONFIDENCE

A lifelong process based upon individuals' self-reflection about their personal biases and prejudices as evidenced by being flexible and humble enough to admit ignorance and willing to be uncomfortable addressing complex racialized issues.

DETERMINANTS OF HEALTH

The range of personal, social, economic, and environmental factors that influence health status.

Link: http://www.healthypeople.gov/2020/about/DOHAbout.aspx

EVIDENCE-BASED HEALTH EDUCATION AND HEALTH PROMOTION PRACTICE

The process of systematically identifying, appraising, and using scientific evidence as the basis for decision-making related to health education and health promotion.

GLOBAL HEALTH

Health problems, issues and concerns that transcend national boundaries and are beyond the control of individual nations, and are best addressed by cooperative actions and solutions.

HEALTH ADVOVACY

The processes by which the actions of individuals or groups attempt to bring about social, environmental and/or organizational change on behalf of a particular health goal, program, interest, or population.

HEALTH COMMUNICATION

The art and science of using theory-based communication strategies and technologies to inform and influence individual and community decisions that advance health

HEALTH DISPARITY

A particular type of health difference that is closely linked with a social, economic, and/or environmental disadvantage.

HEALTH EDUCATION

Any 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.

HEALTH EDUCATION AND HEALTH PROMOTION OUTCOMES

Measurable changes in health knowledge, attitudes, behaviors, and/or skills of individuals or populations; changes in social norms; or changes in organizational practices and public policies that might result from health education and health promotion interventions.

HEALTH EDUCATION PROFESSION

A profession that uses evidence-based practice, and behavioral and organizational change principles to develop, plan, implement and evaluate interventions that enable individuals, groups, and communities to achieve personal, environmental, and societal health.

HEALTH EDUCATION SPECIALIST

An individual who has met, at a minimum, baccalaureate-level required health education academic preparation qualifications, 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.

HEALTHY EQUITY

Attainment of the highest level of health for all people by valuing everyone equally with focused and ongoing societal efforts that address avoidable inequalities, historical and contemporary injustices, and the elimination of health and health care disparities.

HEALTH INFORMATICS

The systematic application of information and technology to research, theory, practice, and learning applied to health education and health promotion.

HEALTH IMPACT ASSESSMENT

A combination of procedures, methods, and tools by which a policy, program, or project may be judged as to its potential effects on the health of a population, and the distribution of those effects within the population.

HEALTH LITERACY

The degree to which individuals have the capacity to obtain, process, and understand basic health information and services needed to make appropriate health decisions.

HEALTH NUMERACY

The degree to which individuals have the capacity to access, process, interpret, communicate, and act on numerical, quantitative, graphical, biostatistical, and probabilistic health information needed to make effective health decisions.

HEALTH OUTCOME

Measurable change in health status or quality of life.

HEALTH PROMOTION

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.

HEALTH PROMOTING SCHOOL

A school that constantly strengthens its capacity as a healthy setting for living, learning, and working

Link: http://www.who.int/school_youth_health/gshi/hps/en/index.html

HEALTHY LIFESTYLE

Patterns of behavior that maximize people's quality of life and decrease their susceptibility to negative health outcomes.

PREVENTION

Actions and interventions designed to identify risks and reduce susceptibility or exposure to health threats prior to disease onset (primary prevention), detect and treat disease in early stages to prevent progress or recurrence (secondary prevention) and alleviate the effects of the disease and injury (tertiary prevention).

PROFESSIONAL DEVELOPMENT

Education and training to maintain and enhance one's competence in health education and health promotion following a previously attained level of professional preparation.

PROFESSIONAL PREPARATION

An undergraduate or graduate course of study based on the areas of responsibilities, competencies and sub-competencies for health education offered through an accredited college or university, that is designed to prepare individuals to practice competently in health education.

PUBLIC HEALTH EMERGENCY PREPAREDNESS

The capability of the public health and health-care systems, communities, and individuals to prevent, protect against, quickly respond to, and recover from health emergencies,

particularly those whose scale, timing, or unpredictability threatens to overwhelm routine capabilities. Preparedness involves a coordinated and continuous process of planning and implementation that relies on measuring performance and taking corrective action.

RISK REDUCTION

Successfully decreasing the probability that individuals, groups, or communities will experience disease, injury, or debilitating health conditions.

SCHOOL HEALTH ADVISORY COUNCIL

An advisory group composed of school, health, and community representatives who act collectively to advise the school district or school on aspects of Coordinated School Health sometimes referred to as a school wellness council.

Link: http://www.fns.usda.gov/tn/healthy/wellnesspolicy_steps.html

SOCIAL MARKETING

A process that uses marketing principles and techniques to influence priority audience behaviors that will benefit society as well as the individual. The process relies on creating, communicating, delivering, and exchanging offerings that have positive value for individuals, clients, partners, and society at large.

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We, the Joint Committee, would like to acknowledge the following references used in preparation of the 2011 terminology document. In some cases these references served as sources for our collective thinking in devising a definition. Some definitions were revised through review and comment by the profession, and therefore they might appear similar to a definition located in the references.

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