-SQA- SCOTTISH QUALIFICATIONS AUTHORITY

NATIONAL CERTIFICATE MODULE: UNIT SPECIFICATION

GENERAL INFORMATION

-Module Number- **7141556** **-Session-1996-97**

-Superclass- **PA**

-Title- **HEALTH PROMOTION**

-DESCRIPTION-

GENERAL COMPETENCE FOR UNIT: This module aims to introduce the candidate to the concept of health promotion, and enables the candidate to combine personal choice with social responsibility for health to create a healthier awareness and understanding of the influencing factors and attitudes which may affect health promotion within the individual, family, environment, culture, religion and social class will be developed.

The module will enable candidates to develop the knowledge and skills necessary for the promotion of health. It is particularly aimed at those working or hoping to work within the statutory or voluntary agencies in health and caring.

However, this module could be offered to any candidate, as the content involves all people regardless of workplace or lifestyle.

OUTCOMES

1. explain the main factors which contribute and influence health choices;

2. describe positive and negative aspects of the theoretical models of health education;

3. demonstrate health and social well-being advice to others.

CREDIT VALUE: 1 NC Credit

ACCESS STATEMENT: There is no access statement for this unit.

For further information contact: Committee and Administration Unit, SQA, Hanover House, 24 Douglas Street, Glasgow G2 7NQ.

Additional copies of this unit may be purchased from SQA (Sales and Despatch section). At the time of publication, the cost is £1.50 (minimum order £5.00).

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STATEMENT OF STANDARDS

UNIT NUMBER: 7141556

UNIT TITLE: HEALTH PROMOTION

Acceptable performance in this unit will be the satisfactory achievement of the standards set out in this part of the specification. All sections of the statement of standards are mandatory and cannot be altered without reference to SQA.

OUTCOME

1. EXPLAIN THE MAIN FACTORS WHICH CONTRIBUTE AND INFLUENCE HEALTH CHOICES

PERFORMANCE CRITERIA

(a) The explanation of the concept of health is clear and consistent with current views.
(b) The explanation of behaviour likely to promote good health is comprehensive in terms of current knowledge.
(c) The explanation of behaviour likely to cause ill-health is comprehensive in terms of current knowledge.
(d) The explanation of the main influencing factors which might affect health choices is comprehensive in terms of current research.

RANGE STATEMENT

World Health Organisation (WHO) definition of health.

Behaviour likely to promote good health: health awareness; regular exercise; good dietary practice; moderate alcohol intake; avoidance of smoking and drug misuse; ability to form and keep relationships with others; self-satisfaction and contentment.

Behaviour likely to cause ill-health: smoking tobacco and other drugs; excessive alcohol usage; lack of exercise; poor dietary intake; health education and awareness; poor self-esteem.

Main influencing factors: discrimination; social class; environment; financial; culture; education; services available; media and advertising; likes and dislikes.

EVIDENCE REQUIREMENTS

Written and/or oral evidence to cover all performance criteria and meet the outcome.

OUTCOME

2. DESCRIBE POSITIVE AND NEGATIVE ASPECTS OF THE THEORETICAL MODELS OF HEALTH EDUCATION

PERFORMANCE CRITERIA

(a) The description of positive aspects of the range of models of health education is consistent with current trends.
(b) The description of negative aspects of the range of models of health education is consistent with current trends.

RANGE STATEMENT

Models of health education: medical; educational; community development; political.

EVIDENCE REQUIREMENTS

Written and/or oral evidence to cover all performance criteria and meet the outcome.

OUTCOME

3. DEMONSTRATE HEALTH AND SOCIAL WELL-BEING ADVICE TO OTHERS

PERFORMANCE CRITERIA

(a) The identification of various media for health promotion is appropriate to the selected target group.
(b) The investigation of a health promotion topic is comprehensive.
(c) The presentation of health and safety routines is appropriate in format and style to the subject matter and audience.

RANGE STATEMENT

Sources of advice: Health and care publications; media health promotion.

EVIDENCE REQUIREMENTS

Written and/or oral evidence to cover the performance criteria and meet the outcome.

ASSESSMENT

In order to achieve this unit, candidates are required to present sufficient evidence that they have met all the performance criteria for each outcome within the range specified. Details of these requirements are given for each outcome. The assessment instruments used should follow the general guidance offered by the SQA assessment model and an integrative approach to assessment is encouraged. (See references at the end of support notes).

Accurate records should be made of the assessment instruments used showing how evidence is generated for each outcome and giving marking schemes and/or checklists, etc. Records of candidates' achievements should be kept. These records will be available for external verification.

SPECIAL NEEDS

In certain cases, modified outcomes and range statements can be proposed for certification. See references at end of support notes.

NATIONAL CERTIFICATE MODULE: UNIT SPECIFICATION

SUPPORT NOTES

UNIT NUMBER: 7141556

UNIT TITLE: HEALTH PROMOTION

SUPPORT NOTES: This part of the unit specification is offered as guidance. None of the sections of the support notes is mandatory.

NOTIONAL DESIGN LENGTH: SQA allocates a notional design length to a unit on the basis of time estimated for achievement of the stated standards by a candidate whose starting point is as described in the access statement. The notional design length for this unit is 40 hours. The use of notional design length for programme design and timetabling is advisory only.

PURPOSE SQA publishes summaries of NC units for easy reference, publicity purposes, centre handbooks, etc. The summary statement for this unit is as follows:

The purpose of this unit is to enable candidates to develop an awareness of health choices and the practice of health promotion. In the light of the awareness and knowledge they have gained the candidate should be able to consider how to plan and implement effective health promotion. It is particularly aimed at those working or hoping to work within the statutory or voluntary agencies in health and care. However, the unit could be offered to any candidate as the content involves all people regardless of workplace or lifestyle.

CONTENT/CONTEXT Corresponding to Outcomes 1-3:

1. Definition of terms such as health, health promotion, epidemiology, self-empowerment, peer pressure, peer education. Consideration could be given to the Black Report, Inequalities in Health.

   WHO Definition of health (1958). 'Health is a state of complete physical, mental and social well-being, and not merely the absence of disease or infirmity'.

   Health Education:

   Hochbaum (1970) 'To equip people intellectually and emotionally to make sound decisions in matters affecting their health, safety and welfare.... health education has not only to equip people with the means for making sound decisions but also tries to influence the outcome of such decisions'.

Attention could be drawn to Maslow's hierarchy of human needs ie physiological, sensual/sexual needs, affectional-emotional needs, ego-development needs etc.

Factors which might influence health choices might be: nutrition, adequate, safe and well-distributed food supplies as well as appropriate levels of personal nutrition. Mental health, importance of equanimity in the face of the natural and inevitable frustrations of living, an acceptance of self and limitations. Adequate housing, proper safeguards against accidents for persons of all ages. Moderate and well-balanced personal habits - restraints in use of alcohol and other drugs. Sufficient rest and appropriate amounts of exercise, health management, sleep and rest, activity and exercise. Access to recreational opportunities and facilities. An individual's beliefs and culture can influence choices as can values and basic likes and dislikes.

2. The concept of Health Promotion should be developed by looking at four key models of health education.

The H.E.B.S./S/H.E.G. models are probably the most comprehensive and should be used if possible.

They include:

(i) The Medical Model: based on the assumption that medicine is a scientific discipline, based on facts and experimentation. It is further assumed that people are persuaded by facts and will change their behaviour accordingly. It relies heavily on information giving the best use of mass media advertising, the use of pamphlets, posters, lecturers, factually based films and other health education materials. Has been known to emphasis negative messages - presentation of facts and warnings about the health hazards.

This approach is inherently conservative and tends to rely on the assumption that knowledge leads to action. It involves a simplistic view of the way mass media advertising influences people's behaviour. It tends to avoid the controversial issues of how people's attitudes, values and life styles are to be changed. It also creates and nurtures dependency of patients on professionals, instead of encouraging them to take responsibility for their own health.

(ii) The Educational Model: attempts to achieve effective as well as cognitive change, on the assumption that changes in attitudes/values/knowledge are all necessary to achieve changes in behaviour. The teacher attempts to work with individual, instead of working on him/her. The teacher seeks to motivate and inform, present a range of health choices available, promote self-esteem and ability to make autonomous choices, encourage responsibility for own health and stimulate fitness and positive health.

Though it may achieve change in individuals, it does not affect the socio-economic structures which contribute to patterns of ill-health. It does not guarantee sufficient motivation to resist the pressures of mass-media advertising nor provide the means to resist peer-group pressures. There is a risk that the educational approach contributes to 'blaming the victim' because of the emphasis given to individual responsibility without adequate regard to the limiting forces of the environment. It can be sociologically naive if pursued as the only means to affect change in health behaviour.

(iii) The Community Development Model: based on the assumption that social and economic structures severely limit the capacity of people either to take responsibility for their own health or to change their lifestyle and forms of unhealthy behaviour. On this model people are largely passive to the forces of their environment, such as the forces of commercial advertising, the provisions of the state for health, education and welfare. The assumption is too that the higher up the social scale the greater the freedom and mobility of people and the better their health and educational opportunities. Conversely, the poorer and more socially deprived, the more passive people tend to be to their environment, and the more unhealthy. Individual change is seen as ineffective and Community Development strategies seek to promote collective and corporate action to improve the total well-being of the community. As a strategy for health education it involves an attempt to assist the community to identify its own needs and objectives, to facilitate local community self-help by promoting local self-esteem, encouraging local political action, mobilising the resources of the community to deal with the issues to housing, lack of health facilities, economic hardship etc., which affect the social, physical and mental health of the community.

Community Development strategies cannot work without some reliance on the other two types of strategies as well. Locally based community development programmes will be ineffective in the long run without more comprehensive changes in the socio-economic structures.

(iv) The Political Model: is both very old and very new. The public health measures of the Victorians - which ranged from legislation enforcing the notification of contagious diseases, improvements in housing sanitation and water supplies to movements for social reform and reform of health service provisions of the physically and mentally ill - were in a fundamental sense political health education measures. Today this model encompasses a similar range of legislative, fiscal and political strategies, including compulsory seat belt legislation, motor-cycle helmet laws, taxes on tobacco and alcohol and the creation of local health councils.

Interpretations of this model range from conservative to revolutionary, from attempts to encourage individual responsibility, through incentives and sanctions to attempts to transform the structures of society itself and the health services themselves.

The political model assumes that in order to achieve improvement in the nation's health it is necessary and justifiable to use a greater or lesser degree of compulsion.

This model has been criticised on the grounds that it may achieve change by compulsion but fail to provide the motivation to internalise the values it promotes. Without components of the other models it can become unduly authoritarian and paternalistic, reducing people to passive compliance rather than promoting autonomous individual and community self-care.

3. Current media campaigns eg. HIV, drug use and harm reduction methods. Previous campaigns can be used in comparison.

APPROACHES TO GENERATING EVIDENCE Candidates should be expected to build up a portfolio of evidence corresponding to the outcomes and the performance criteria.

Evidence for all outcomes could be generated by classwork, group discussion, case studies, talks by visiting speakers, videos, magazine and newspaper articles, advertising and television programmes.

This unit is candidate-centred with candidates working on their own individual project and practical demonstration. Candidates should select the topic he/she wishes to investigate in consultation with the lecturer. Every opportunity should be taken to provide and use topical examples and illustrations of health promotion and health issues. Full use should be made of the local and national press and other media, visiting speakers particularly the local Health Promotion Officer, Health Visitor and visits wherever relevant and feasible.

Possible approaches to delivery of the module

1. The lecturer might generally open the discussion on "health" and perhaps use a brainstorming exercise to help ascertain class knowledge and experience. The class could divide into small groups and be asked to produce a definition of health on Flipchart paper. General discussion could follow depending on results. Introduce class to WHO definition and others.

2. The class could be given case studies, divided into small groups and asked to identify good and poor health practices. This information will help when completing Outcome 3 and candidates should start their portfolio as soon as possible.

   The candidate should be introduced to models of health promotion as the underpinning theoretical knowledge required when looking at 'the big picture'. Perhaps the teacher and candidates could gather posters, media campaigns, magazine advertising etc and identify which model is most appropriate and why. Some anti-drug campaigns are extremely useful to identify models, target groups and health messages.

3. It is understood that a practical demonstration may cause some candidates concern; they may find the task of “public speaking” daunting and may require additional support and guidance. Time should be allowed for candidates to collate as much material and knowledge as possible, the lecturer should be available throughout for guidance. Candidates should be made aware of different methods used within health promotion and should be allowed to use their imagination when planning and carrying out their demonstration. There should be no added stressors such as video-taping or timing unless so wished by the candidate.

PROGRESSION This National Certificate unit forms part of the GSVQ In Care at level III.

RECOGNITION Many SQA NC units are recognised for entry/recruitment purposes. For up-to-date information see the SQA guide ‘Recognised Groupings of National Certificate Modules’.

REFERENCES

1. Guide to unit writing. (A018).
2. For a fuller discussion on assessment issues, please refer to SQA’s Guide to Assessment. (B005).
3. Procedures for special needs statements are set out in SQA’s guide ‘Candidates with Special Needs’. (B006).
4. Information for centres on SQA’s operating procedures is contained in SQA’s Guide to Procedures. (F009).
5. For details of other SQA publications, please consult SQA’s publications list. (X037).