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Theories and Models as Vehicles for Health Communication and Promotion in Contemporary Nigeria

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Abstract
Human communication is about producing and exchanging information and meaning using signs and symbols. Health communication is the study and practice of communicating promotional health information such as in public health campaigns, health education, between doctor and patient. The purpose of spreading the health information is to influence personal health choices by improving health literacy. Communication category includes intrapersonal, interpersonal, organizational community and public/mass media. Communication for health promotion composes of complex processes including information encoding, transmitting and receiving (decoding) as well as synthesizing meaning. Key dimensions of communication include the sender, the message, the channel and the receiver. Three theories were used to illustrate the importance of the use of theories in communication for health promotion which include; Bandura Social Learning Theory, the Trans-theoretical Model and health belief model. Conclusion was made that for any change in behaviour, there is a high need for proper health communication for health promotion either through mass media or public service announcement but most importantly researchers need to use theories for better communication in health promotion. It was recommended that theories and models should be frequently used in the area of health education.

Introduction

Health of the people is the greatest natural resource of a nation, upon which all their happiness and all the powers as a state depend. Health was also defined by World Health Organization (WHO) as the complete state of physical, mental, spiritual, emotional, and social wellbeing of an individual. Health education was also defined by World Health Organization (2018) as the combination of learning experiences designed to help individuals and communities improve their health, by increasing their knowledge or influencing their attitudes. It is also the process of providing teaching – learning experiences and activities for the purpose of favourably influencing knowledge, attitudes, practices and conducts with regard to individual, family and community health.

Health communication is the study and practice of communicating promotional health information such as, in public health campaigns, health education, and between doctor and patients. Human communication is about producing and exchanging information and meaning using sign and symbols. The purpose of disseminating health information is to influence personal health choices by improving health literacy. Health communication may seek to, increase audience knowledge and awareness of a health issue, demonstrate health practices, demonstrate the benefits of behaviour changes to public health outcomes, advocate a position on a health issue or policy, increase demand or support for health services, argue against misconceptions about health. (Freimuth, Vicki & Sandra, 2004). Communication has an essential role in any action that aims to improve health. It is difficult to imagine how a message could be delivered to promote healthy choices if we could not communicate. The communication process is a multi-dimensional transaction influenced by a variety of factors. In health promotion work, the successful exchange of information between the practitioner and target audience is an area that has received mixed attention.

According to World Health Organization (WHO) (2009) the United States Department of Health and Human services, health communication is seen to have relevance for virtually every aspect of health and well-being, including disease prevention, health promotion and quality of life.

How are health promotion communication categorized?

1. **Intrapersonal:** communicated within a personal i.e. what we think.
2. **Interpersonal:** one to one, small groups, emails, phone calls and other activities.

3. **Organizational:** newsletters, workshops, seminars, meetings, memos and lectures.
4. **Community**: local radio, talks, seminars, health fairs, bill board, and local newspapers.
5. **Public or mass media**: newspapers, television, digital television, national radio, internet, phone etc (Nova, 2007).

Key dimensions of health communication include:

1. **The sender**: the person that encodes and transmits, the person giving out the information i.e. health information for health promotion.
2. **The message:** the health promotion information for behavioural change.
3. The channel of communication: the channel of communication could be face to face, phone calls, lecture, seminar, workshop, television, newspaper, internet, etc.
4. **The receiver or audience**: The populations in which the health promotion programmes are meant for. E.g. pregnant women, a particular occupation group, school children, etc.

Communication for health promotion also comprises of complex processes including information encoding, as well as synthesizing meaning (Nova, 2007).

Why use theoretical models?

Models are derived from a simplified version of theory and can be used to guide the development of health promotion programmes. Theories and models are useful in planning, implementing and evaluating interventions: models in health promotion usually seek to include key elements important to behaviour and decision-making process. In health promotion and health education, models are often borrowed from areas of social psychology or health communication and applied to health contexts. Theories are valued in the field of health promotion because of their use in explaining influences on health alongside the ability to suggest ways where individual change could be achieved. Effective communication strategies should be achieved in a sound theory. Theories could be used to design and plan health promotion programmes and to generate decisions and solution, ensuring that all variables are taken into consideration. There is nothing more practical than a good theory. (Nova, 2007). If communication is based on a theoretical model, some of the pitfalls associated with poor communication can be eliminated.

Theories

There are a multitude of theories that can be used in communication of health. Three of such theories are chosen here for illustration.

Bandura-Social Learning Theory

This theory was propounded by Albert Bandura (1977). This idea includes:

1. Mediating processes occur between stimuli and responses.
2. Behaviour is learned from the environment through the process of observational learning.

When one observes the people around them behaving in various ways, the individuals that are observed are called models which can be their parents within the family, characters on the television, attending seminars, workshops, etc. and also peers, this model provide examples of behaviour to observe, listen and imitated. People pay attention to some of those people or information and encode them to their own behaviour.

First, the individual is more likely to attend to and encode the health information which is rewarding for example, when one watches his or her neighbour exercising probably an overweight person and observed that such a person loses weight with time such a person might decide to also exercise because from observation, the exercise was rewarding.

Bandura (1977) believes that humans are active information processors and think about the relationship between their behaviour and its consequences. He also stated that individuals do not automatically observe the behaviour or act on any given information, there is some thought prior to imitation or action which is called the mediational processes which can be seen in intra-personal communication method which means the communication going on within a person's mind.

The mediational processes include:

1. **Attention:** attention to the health information both from peer, television and other source is therefore extremely important on whether there will be change in behaviour. Example, listening to a health talk on the television on prevention of cancer through nutrition education.

2. **Retention**: the health information communicated should be retented for change in behaviour to take place. If such an individual listens and forgets, there won't be a change in behaviour. It is important therefore that a memory of the information is formed to be performed later by the listener.
3. **Reproduction:** the effort the individual puts to demonstrate the information gathered during a watch of a particular television programme on health issues is very important to show that the information is mastered.
4. **Motivation**: the rewards and punishment that follow behaviour will be considered by the observer. If the perceived rewards outweigh the perceived costs, then the health information will likely be imitated as seen in an exercise programme or cancer prevention

The Trans Theoretical Model (TTM)

TTM of behavioural change is used to identify a number of stages that individual experiences as they progress through life style modifications. The TTM is made up of five stages of change;

1. **Pre-contemplation stage**: this is the stage in which the individual is not even considering nutrition education, drug use and abuse, personal health education etc. even if they are being talked about on the television, radio by their peer into his or her daily routine. When working with an individual in the pre-contemplation stage, one should encourage one to start thinking about change and the benefits that come with it. This is the time to educate the individual of the risk associated with some unhealthy behaviours.
2. **Contemplation stage**: this is the stage where the individual begins to consider the health information and trying to adopt them. An individual in this stage is still sedentary. But has commences thinking about the effects of an unhealthy life style. At this stage, the individual is still not ready. But at this stage the information on health matters still has to go on until there is change in behaviour.
3. **Preparation stage**: at this stage the individual is both mentally and physically preparing to adopt a healthy life style from the information provided. But there is no consistency or commitment in this stage. Health education is needed to overcome challenges. The preparation stage is all about establishing a plan for adopting healthy behaviour changes that are specific to an individual.
4. **Action stage:** in this stage such individual has started to engage in healthy behaviour for less than six months. It is important to offer continuous support, education and encouragement, while helping such individual focus on the long-term advantages of making positive behaviour changes. At this stage, it is important to teach the individual how to anticipate and overcome obstacles that might reduce or take away the individual motivation or adherence.
5. **Maintenance stage**: this stage takes place for more than 6 months. It is important to offer continued health education to the individual so he or she maintains the changed behaviour and to identify things that might tempt or undermine the positive changes he or she made. Such individual may oscillate back and forth. Between stages throughout their life time.

Health Belief Model.

The Health Belief Model (HBM) is a psychological health behaviour change model which was developed to predict health behaviours. In the area of accepting a health services it was developed in 1950's by social psychologists and remains one of the best theories in health behaviour research. The Health Belief Model was developed by social psychologists, Irwin M. Kosenstock, Godfrey M., Hockbaum S. Stephen Kegeles and Howard Leventhal at the U.S public health services to better understand the widespread failure of screening programs for tuberculosis, detection of a symptomatic diseases and receiving immunizations. The model was amended in late 1988 to include emerging evidence within the field of psychology about the role of self-efficacy in decision-making and behaviours.

Theoretical constructs of health belief model:

1. **Perceived severity:** This includes an individual assessment of the severity of a health problem and its consequences. When they do, they are more likely to engage in healthy behaviours to prevent or reduce the severity or occurrence. Example, during cancer screening, one might be interested to go for the screening exercise but by the time such a person is told that cancer is a terminal illness and possibly has no cure the person will definitely want to go for the cancer screening in an attempt to prevent the occurrence.
2. **Perceived susceptibility**: It includes the assessment of the risk of developing a health problem. When an individual knows, he or she is susceptible to a particular health problem, the individual engages in behaviours to reduce the risk of developing the health problem. One may also belief that he or she is not likely to acquire any disease condition and therefore, engage in an unhealthy behaviour. Perceived

severity and perceived susceptibility to a given health condition depend on knowledge about the condition (Rosen Stock & Irwin, 1974).

3. **Perceived benefits:** an individual change in behaviour can be influenced by the perceived benefit of taking action. It is referred to as an individual's assessment of the value of efficiency of engaging in a health promoting behaviour to decrease risk of disease. If an individual believes that a particular action will reduce susceptibility to a health problem or decrease its seriousness, then the individual is more likely to engage in the behaviour regardless of objective facts regarding the effectiveness of actions. Example, in screening for cancer when an individual determines or understands the health benefits of getting screened for cancer earlier, the individual would quickly get his or herself screened for cancer prevention. (Gianz, Kareen, Babara, Kimer & Viswanath, 2008).
4. **Perceived barriers:** this is referred to an individual assessment of the obstacles to healthy behavioural change. When such individual perceives a health condition as threatening and believes that a particular action will effectively reduce the threat, barriers may prevent engagement in the health promoting behaviour. It is important to take note that perceived benefits should outweigh perceived barrier for change in behaviour to be seen. For example, with screening for cancer, one may not have the finance, inconvenience, pain and discomfort, may be a barrier to getting screened for cancer. (Janz, Nancy, Marshall & Bector, 1984).
5. **Modifying variables:** the characteristics of an individual which include demography, psychosocial and structural variable, can affect perception e.g. age, race, ethnicity and education, personality social class, peer group and also knowledge about a given disease are all modifying variable to health promotion behaviours. Modifying variable affect the health behaviour indirectly by affecting perceived seriousness, susceptibility, benefits and barriers (Jane, Nancy, Marshall & Becker 1984).
6. **Cue to action:** a cue or trigger is very important for immediate engagement in health promoting behaviours. This cue could be internal or external. Physiological cues e.g. pain, symptoms are known as internal cues. External cue includes information from friends, media, health care providers, could lead to health promoting behaviours, example, individuals who believe they are at a high risk for a serious illness and who have an established relationship with a doctor maybe easily persuaded to get screened for illness such as cancer after seeing a public service announcement, whereas individuals who believe they are at low risk for the same illness and also do not have reliable access to health care may require more intense external cues in order to get screened.
7. **Self-efficacy:** this was added to the other components of health belief model. It is an individual's perception of their competence to successfully perform a behaviour. It explains individual difference. The model was originally developed in order to explain engagement in one-time health-related behaviours such as being screened for cancer or receiving an immunization. The developers of the model recognized that confidence in one's ability to effect change in health behaviour i.e. self-efficacy was an important component of health behavioural change. (Rosen Stock, Irwin, Strecher, Victor, Becker & Marshall (1988)).

Conclusion

Communication is an important tool for any change to occur both in health sector and other areas of life where there is lack of good communication network, Problems are not solved and where change is needed it becomes impossible. Communication is necessary and an important key in health promotion because when people are better informed about their health and possibility of acquiring some health problem, they seem to take precaution to either reduce or prevent the health problem from occurring and Communication could be within one selves Interpersonal, organizational community and mass media. Encouragement through communication is also a vital tool in health Promotion. Finally, theories should be used to communicate, explain and predict change in behaviour of any individual or group.

Recommendation

Since theories and models are effective tools in communicating for health promotion it is recommended that they are frequently used especially in the area of health education.

References

Guanz, Karen, Barbarak, Rimer and Kviswinath (2008). *Health behaviour and health education theory, research and practice.* (4th Ed.). San Francisco, C.A: Jossey-Bass pp 45-51. ISBN 978-0787996147.

Janz, Nancy K, Marshall H. and Becker (1984). “The health belief model: a decade later” *health education and behaviour. 11(1):*1-47.doi:10.1177/109019818401100101.

Mcleod S.A (2016). *Bandura-social learning theory*. retrieved from www.simplypsychology.org/bandura.html.

Nova Corcoran (2007). Communicating Health: Strategies for Health Promotion. London: Sage publications.

Rosen Stock and Irwin (1974) "Historical origin of the health belief model" *health education and behaviour: 2(4):*328-335.doi:10.177/109019817400200403

Rosen Stock, Irwin M, Stretcher, Victors, Becker, and Marshall H. (1988) *"social learning theory and the health belief model" health education and behaviour. 15(2).* 175-183:doi:101177/10901981880500203.

WHO (2009). Why health communication is important in public health. *Bulletin of the World Health Organization 2009*;87:247-247.doi:10.2471/BLT.08056713.

WHO (2018) Health Education. Retrieved from, http://www.who.int/topics/health_education/en/