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SPECIALIOSIOS PEDAGOGIKOS FAKULTETAS

UŽSIENIO KALBŲ KATEDRA
MEDICINOS PAGRINDŲ KATEDRA

HEALTH EDUCATION

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UDK.....

Sveikatos edukologija (anglų kalba)

Mokomoji knyga

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Mokomoji specialybės (dalyko) anglų kalbos knyga skirta Specialiosios pedagogikos fakulteto studentams, būsimiems sveikatos edukologams, ir anglų kalbos dėstytojams. Mokymo priemonėje pateikiamos ištraukos iš šiuolaikinių užsienio autorių publikacijų, nagrinėjančių aktualias sveikatos edukologijos problemas. Užduočių tikslas – ne tik lavinti mokslinių tekstų anglų kalba supratimą, įsisavinti terminiją, diskutuoti, bet ir papildyti sveikatos edukologijos žinias. Knygą sudaro: įžanga, terminijos skyrius, ištraukos iš užsienio leidinių, klausimai ir užduotys studentams, anglišku santrumpų skyrelis, anglų-lietuvių kalbų žodynelis, priedai ir rekomenduotinos literatūros sąrašas lietuvių ir anglų kalbomis.

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Preface

“Health Education” is a teaching / learning aid meant both for students of the Special Education Faculty and teachers presenting English for specific purposes (ESP). The book contains current materials (texts of different complexity) on health education. Its aim is to teach students to analyze and comprehend scientific texts, master the basic terminology, discuss the urgent issues of the field and enrich their knowledge in health education.

The teaching / learning aid includes a terminology section (definitions and interpretations), extracts from contemporary sources on health education, questions and tasks for the students, abbreviations, English-Lithuanian vocabulary, supplements and suggestions for further reading.

J. Petruševičius
J. V. Vaitkevičius

HEALTH EDUCATION

Terminology

Definitions and Interpretations

Addiction. An acquired motivation based on a physiological need that develops as a consequence of an individual's continued experience with specific substances such as alcohol, opiates and nicotine.

/ Grusec, J. E., Lockhart, R. S., Walters, G. C. (1990). *Foundations of Psychology*. Toronto: Copp Clark Pitman Ltd., p. 781 /

Addiction. A physiological dependence on a drug developed through continual use in increasing dosage.

/ Hewstone, M., Stroebe, W., Stephenson, G. M. (Eds). (1997). *Introduction to social psychology: a European perspective*. Oxford: Blackwell Publishers Ltd, p. 605 /

Adrenaline. A hormone and neurotransmitter particularly associated with emotional states.

/ Hayes, N. (1998). *Foundations of psychology*. Walton-on-Thames: Thomas Nelson & Sons Ltd., 631 /

Affective disorders. Disorders of mood (depression, mania, or some combination of the two) that affect all spheres of one's life.

/ Grusec, J. E., Lockhart, R. S., Walters, G. C. (1990). *Foundations of Psychology*. Toronto: Copp Clark Pitman Ltd., p. 781 /

Aggression. A term used in several ways, but generally to describe negative or hostile behavior or feelings towards others.

/ Hayes, N. (1998). *Foundations of psychology*. Walton-on-Thames: Thomas Nelson & Sons Ltd., 632 /

Alcoholic. A person addicted to the drug alcohol.

/ Hayes, N. (1998). *Foundations of psychology*. Walton-on-Thames: Thomas Nelson & Sons Ltd., 632 /

Alcoholism. Alcohol abuse, characterized by psychological dependence, physical dependence, and impaired social functioning.

/ Crider, A. B., Kavanaugh, R. D., Goethals, G. R., Solomon, P. R. (1993). *Psychology*. New York: Harper Collins College, p. G-1 /

Amphetamines. Drugs commonly used for losing weight, or to provide additional short-term energy in demanding situations.

/ Hayes, N. (1998). Foundations of psychology. Walton-on-Thames: Thomas Nelson & Sons Ltd., 632 /

Antianxiety drugs (minor tranquilizers or neuroleptics). Drugs used to reduce tension and anxiety. They are used by normal people during times of stress, by neurotics, by people with stress-related physical disorders, and by people withdrawing from alcohol and other drugs.

/ Hewstone, M., Stroebe, W., Stephenson, G. M. (Eds). (1997). Introduction to social psychology: a European perspective. Oxford: Blackwell Publishers Ltd, p. 605 /

Aversion therapy. A behavior modification technique in which the patient's maladaptive response is paired with an aversive stimulus such as an electric shock or a nausea-producing drug; often used in the behavioral treatment of homosexuality, sexual deviations, and alcoholism.

/ Bootzin, R. R., Acocella, J. R. (1988). Abnormal Psychology: Current Perspectives. New York: McGraw-Hill, Inc., p. 606 /

Behavioral medicine. Research and application that focus on the relationship between mental and physical health.

/ ibid, p. 606 /

Behavior therapy. A general term for a variety of therapeutic techniques derived originally from learning principles but now including methods derived from other psychological research areas.

/ Crider, A. B., Kavanaugh, R. D., Goethals, G. R., Solomon, P. R. (1993). Psychology. New York: Harper Collins College, p. G-2 /

Clinical psychology. The psychological specialty involving the assessment and treatment of persons with psychological difficulties.

/ Crider, A. B., Kavanaugh, R. D., Goethals, G. R., Solomon, P. R. (1993). Psychology. New York: Harper Collins College, p. G-3 /

Dissociative reactions. Disorders that affect a patient's consciousness, memory, and self-identity. They may take the form of amnesia (partial or total forgetting), fugue (leaving home and adopting a different personality), somnambulism (sleep walking), and multiple personality.

/ Grusec, J. E., Lockhart, R. S., Walters, G. C. (1990). Foundations of Psychology. Toronto: Copp Clark Pitman Ltd., 784 /

Family therapy. The therapeutic technique in which an entire family is seen together so that destructive roles and attitudes can be exposed and treated.

/ Bootzin, R. R., Acocella, J. R. (1988). Abnormal Psychology: Current Perspectives. New York: McGraw-Hill, Inc., p. 611 /

Family therapy. Treatment of more than one member of a family simultaneously on the assumption that a disturbance in one family member reflects a more general difficulty in the family's interactions.

/Crider, A. B., Kavanaugh, R. D., Goethals, G. R., Solomon, P. R. (1993). Psychology. New York: Harper Collins College, p. G-6 /

Health. A positive state of being which has physical, cultural, psychosocial, economic and spiritual dimensions, not simply the absence of illness.

/ Marks, D. F., Murray, M., Evans, B., Willig, C. (2002). Health Psychology. *Theory, Research and Practice*. London: SAGE Publications, p. 352 /

Health education is defined as the process by which individuals and groups of people learn to behave in a manner conducive to the promotion, maintenance or restoration of health.

/ "http://en.wikipedia.org/wiki/Health_education" /

/ From Wikipedia, the free encyclopedia /

Health education. The process by which individuals' knowledge about the causes of health and illness is increased.

/ Marks, D. F., Murray, M., Evans, B., Willig, C. (2002). Health Psychology. *Theory, Research and Practice*. London: SAGE Publications, p. 353 /

Health educator. Health educators are professionals who design, conduct and evaluate activities that help improve the health of all people. These activities can take place in a variety of settings that include schools, communities, healthcare facilities, businesses, colleges and government agencies.

Health educators are employed under a range of job titles such as *patient educators, health education teachers, trainers, community organizers* and *health program managers*. Certified Health Education Specialists (CHES) are those who have met the standards of competence established by The National Commission for Health Education Credentialing Inc. and have successfully passed the CHES examination. The responsibilities: 1. Assess individual and community needs for health education. 2. Plan effective health education programs. 3. Implement health education programs. 4. Evaluate effectiveness of health education programs. 5. Coordinate provision of health education services. 6. Act as a resource person in health education. 7. Communicate health and health education needs, concerns, and resources.

/ <http://www.nchec.org/competencies.htm> /

Health promotion. Any event, process or activity which facilitates the protection or improvement of the health of individuals, groups, communities or populations. Its objective is to prolong life and to improve quality of life, that is to prevent or reduce the effects of impaired physical and / or mental health on those individuals who are directly (e.g. patients) or indirectly (e.g. carers) affected. Health promotion includes both *environmental and behavioral interventions*.

Three Approaches to Health Promotion

Behavior change approach

Objective: to bring about changes in individual behavior through changes in individuals' cognitions.

Process: provision of information about health risks and hazards.

Aim: to increase individuals' knowledge about the causes of health and illness.

Assumption: humans are rational decision-makers whose cognitions inform their actions.

Self-empowerment approach

Objective: to empower individuals to make healthy choices.

Process: participatory learning techniques.

Aim: to increase control over one's physical, social and internal environments.

Assumption: power is a universal resource which can be mobilized by every individual.

Collective action approach

Objective: to improve health by addressing socio-economic and environmental causes of ill health.

Process: individuals organize and act collectively in order to change their physical and social environments.

Aim: to modify social, economic and physical structures which generate ill health.

Assumption: communities of individuals share interests which allows them to act collectively.

These three approaches pursue different goals, utilize different means to achieve their goals and propose different criteria for their evaluation. However, they all aim to promote good health and to prevent or reduce the effects of ill health (French and Adams, 1986).

/ Marks, D. F., Murray, M., Evans, B., Willig, C. (2002). *Health Psychology. Theory, Research and Practice*. London: SAGE Publications, p. 325-326 /

Health psychology. Field of psychology concerned with the role of psychological factors in health and illness.

/ Crider, A. B., Kavanaugh, R. D., Goethals, G. R., Solomon, P. R. (1993). *Psychology*. New York: Harper Collins College, p. G-7 /

Heroin. An addictive narcotic drug derived from morphine.

/ Bootzin, R. R., Acocella, J. R. (1988). *Abnormal Psychology: Current Perspectives*. New York: McGraw-Hill, Inc., p. 612 /

Hot line. Round-the-clock telephone service where people in trouble can call and receive immediate comfort and advice from trained volunteers.

/ Bootzin, R. R., Acocella, J. R. (1988). *Abnormal Psychology: Current Perspectives*. New York: McGraw-Hill, Inc., p. 612 /

Humanistic therapy. A form of psychotherapy which regards the person as a continuously unfolding set of potentials. The goals of humanistic therapy are to remove

blocks to self-development, to put the person in touch with his or her self, and to promote continued growth.

/Crider, A. B., Kavanaugh, R. D., Goethals, G. R., Solomon, P. R. (1993). *Psychology*. New York: Harper Collins College, p. G-8 /

Marasmus. A behavioral state of lethargy and general illness as a consequence of severe malnutrition.

/ Meyer, W. J., Dusek, J. B. (1979). *Child Psychology*. Lexington: D. C. Heath and Company, p. 573 /

Marital therapy. A therapeutic procedure that aims at pinpointing the role expectations and patterns of communication between the couple, encouraging each member to examine his or her role and the role he or she imposes on the other.

/ Bootzin, R. R., Acocella, J. R. (1988). *Abnormal Psychology: Current Perspectives*. New York: McGraw-Hill, Inc., p. 614 /

Mental health. It is generally used to designate one who is functioning at a high level of behavioral and emotional adjustment and adaptiveness and not for one who is, simply, not mentally ill.

/ Reber, A. S., and Reber, E. (2001). *The Penguin Dictionary of Psychology*. 3rd ed. London: Penguin Books Ltd., p. 428 /

Mental hygiene. Originally, the art of developing and maintaining mental health.

/ *ibid* /

Morphine. An addictive narcotic derived from opium.

/ Bootzin, R. R., Acocella, J. R. (1988). *Abnormal Psychology: Current Perspectives*. New York: McGraw-Hill, Inc., p. 614 /

Narcotics. A class of drugs that induces relaxation and reverie and provides relief from anxiety and physical pain.

/ Bootzin, R. R., Acocella, J. R. (1988). *Abnormal Psychology: Current Perspectives*. New York: McGraw-Hill, Inc., p. 615 /

Obesity. An excessive amount of fat on the body. Each culture sets its own standard for ideal body weight, so what is considered obese in one culture may be desirable in another.

/ Bootzin, R. R., Acocella, J. R. (1988). *Abnormal Psychology: Current Perspectives*. New York: McGraw-Hill, Inc., p. 615 /

Opium. A chemically active substance derived from the opium poppy; one of narcotics.

/ Bootzin, R. R., Acocella, J. R. (1988). *Abnormal Psychology: Current Perspectives*. New York: McGraw-Hill, Inc., p. 615 /

Peer self-help groups. Groups of people who share a special problem and meet to discuss that problem without the help or guidance of a mental health professional.

/ Bootzin, R. R., Acocella, J. R. (1988). *Abnormal Psychology: Current Perspectives*. New York: McGraw-Hill, Inc., p. 615 /

Phobia. An intense and debilitating fear of some object or situation that actually presents no real threat.

/ Bootzin, R. R., Acocella, J. R. (1988). *Abnormal Psychology: Current Perspectives*. New York: McGraw-Hill, Inc., p. 616 /

Preventive health behaviors. Behaviors people choose to engage in with the aim of protecting and / or improving their health status.

/ Marks, D. F., Murray, M., Evans, B., Willig, C. (2002). *Health Psychology. Theory, Research and Practice*. London: SAGE Publications, p. 358 /

Psychological dependence. The psychological need for a drug that is not physiologically addictive.

/ Bootzin, R. R., Acocella, J. R. (1988). *Abnormal Psychology: Current Perspectives*. New York: McGraw-Hill, Inc., p. 617 /

Public health. The science and art of preventing disease, prolonging life, and promoting health and human efficiency through organized community efforts is known as *public health*. Public health-health efforts are directed towards the health of a community, whereas private-health efforts are directed towards the health of individuals. Modern public-health practice involves many different health services, including disease prevention, health promotion, treatment of illness, and rehabilitation. It also involves the collection , analysis, and use of vital health records to establish or influence public policy.

/ <http://phs.os.dhhs.gov/progorg/prpgorg.htm> /

/ Compton's Interactive Encyclopedia. (1997). The Learning Company, Inc. /

Public health (definition of the UK Public Health Association). At the UKPHA we believe that public health:

- is an approach that focuses on the health and well being of a society and the most effective means of protecting and improving it.
- encompasses the science, art and politics of preventing illness and disease and promoting health and well being. It addresses the root causes of illness and disease, including the interacting social, environmental, biological and psychological dimensions, as well as the provision of effective health services.
- addresses inequalities, injustices and denials of human rights, which frequently explain large variations in health locally, nationally and globally.
- works effectively through partnerships that cut across professional and organizational boundaries and seeks to eliminate avoidable distinctions.
- relies upon evidence, judgment and skills and promotes the participation of the populations who are themselves the subject of policy and action.

Public health reflects a broad variety of activities, with the ultimate goal of reducing disease mortality and morbidity and promoting health of the population as a whole. In the past, population health was measured by relative absence of diseases, and the focus of public health research and practice was on the control of such diseases (especially communicable and infectious ones). However, more recently, a broader definition of health has been recognized. The World Health Organization views health as not just an absence of something, namely disease, but as a resource for realizing higher aspirations, satisfying needs, and coping with changes in the environment (Young, 1998). With this conceptualization being more widely adopted, the focus of population health has broadened to include social, environmental, and behavioral factors that may jeopardize health, placing individuals at risk for disease. Consequently, there is increased interest in including behavioral science and theory in the dialogue of public health research (Muehrer et al., 2002). Public health efforts aimed at pediatric populations have focused on either preventing problematic health outcomes in children (e.g., injury, childhood obesity, social / emotional problems) or preventing health risk behaviors associated with adult-onset chronic diseases (e.g., smoking prevention to reduce cancer or heart disease).

Public health and population-based research and practice have not traditionally been the focus of pediatric psychology. Few articles submitted or published in the Journal have taken a public health focus (Kazak, 2002; La Greca, 1997; Roberts, 1992). However, recent surveys of pediatric psychologists and commentaries on the state of the field of pediatric psychology suggest the field is evolving and expanding. For instance, pediatric psychologists view primary prevention of poor health outcomes and the promotion of optimal physical and mental health in children to be of high priority (Brown & Roberts, 2000; Roberts, 1992). These sentiments are not germane solely to the pediatric psychology community; they are echoed by national health organization priorities and leaders in prevention science research calling for primary prevention and health promotion efforts to begin early in life and to include children, their families, schools, and communities (Perry, 2000; Stokols, 1996). [...]

/ Fuemmeler, B. Bridging Disciplines: An Introduction to the Special Issue on Public Health and Pediatric Psychology. *Journal of Pediatric Psychology*. Vol. 29. No. 6, p. 405 /

Questions and Tasks

1. How was population health measured in the past?
2. How does the WHO view health?
3. What do pediatric psychologists view to be of high priority?
4. Point out two interrelated disciplines referred to in the extract.

School phobia. Of all the “internalized” disorders among youth, the one most subject to controversy is school phobia (Kearney et al., 1995). The reason for this controversy is, in part, due to some confusion about the descriptive terms and definitions used by various researchers. In 1941 “school phobia” was developed as a phrase to describe an “over-dependent mother-child” relationship (Murray, 1998). Over time “school phobia” evolved into an umbrella term that covered virtually everything dealing with school absenteeism. School phobia, school refusal, school avoidance, and separation anxiety are terms used interchangeably to report on this phenomenon. Yet the literature suggests that each separate term possesses inherent characteristics that demand differentiation.

School phobia further evokes controversy because not all students who refuse to attend school are phobics; some may just not want to attend and should more properly be labeled as truant. More confusion over the terms results because the fourth edition *Diagnostic and Statistical Manual of Mental Disorders (DSM-IV)* does not differentiate among these events. The terms are referenced under the headings of social phobia, separation anxiety, and conduct disorder (Murray, 1998). Thus, each counselor / psychologist has his or her own way of defining the problems and a consensus has not been about the nature of the problems. The issue has been labeled “anxiety-based school refusal” as well as “anxiety-based” and “nonanxiety based school refusal” (Murray, 1998). Other counselors / psychologists refute both of these definitions, instead designating school refusal as symptomatic of more complex issues, such as social phobias. For the purposes of this review, focusing on relevant information for school health educators, school phobia is defined as “anxiety and fear related to being in school” (Murray, 1998).

Several studies distinguish between the meaning of separation anxiety and school phobia. Separation anxiety is the term of choice whenever a disproportionate amount of anxiety is associated with a child separated from his or her care giver (i.e., mother) (Lee & Miltenberger, 1996). Often the child fears harm coming to his or her guardian while they are separated. In contrast, school phobia is not tied exclusively to such separation. The key factors that differentiate school phobia and separation anxiety are the “significance of the attachment figure (i.e., mother), and the “specificity of the anxiety / phobia” (e.g., fearing embarrassment) (Lee & Miltenberger, 1996). School phobia, which can strike at any time during a child’s matriculation through school, can result from varying causes, such as an extended illness, geographic relocation or new school, death in the family, trauma at school, or a threat to the child’s security (APA Experts, 1997; Jenni, 1997).

/ Salemi, A. T. and Brown, K. McC. School Phobia: Implications for School Health Educators. *American Journal of Health Education*; Jul / Aug 2003; 34, 4, p.200 /

Self-acceptance. Quite literally, an acceptance of oneself. The term is used with the specific connotation that this acceptance is based on a relatively objective appraisal of one’s unique talents, capabilities and general worth, a realistic recognition of their limits and a rich feeling of satisfaction with both these talents and their boundaries.

/ Reber, A. S., and Reber, E. (2001). *The Penguin Dictionary of Psychology*. 3rd ed. London: Penguin Books Ltd., p. 659 /

Stress. A pattern of disruptive psychological and physiological functioning that occurs when an environmental event is appraised as a threat to important goals and one's ability to cope.

/Crider, A. B., Kavanaugh, R. D., Goethals, G. R., Solomon, P. R. (1993). *Psychology*. New York: Harper Collins College, p. G-16 /

Stress management workshops. Training programs in stress management usually delivered to groups, frequently lasting for a whole day or a weekend, and focusing on changing the way in which participants appraise situations as stressful and cope with stressful events.

/ Marks, D. F., Murray, M., Evans, B., Willig, C. (2002). *Health Psychology. Theory, Research and Practice*. London: SAGE Publications, p. 360 /

Therapeutic environment. The arrangement of an institutional environment in such a way that all the patient's interactions with that environment will serve some therapeutic purpose.

/ Bootzin, R. R., Acocella, J. R. (1988). *Abnormal Psychology: Current Perspectives*. New York: McGraw-Hill, Inc., p. 620–621 /

Welfare model. A welfare model aims to provide comprehensive health care to all members of a population regardless of age, socio-economic status, gender, sexual preference, race or religion.

/ Marks, D. F., Murray, M., Evans, B., Willig, C. (2002). *Health Psychology. Theory, Research and Practice*. London: SAGE Publications, p. 361 /

Well-being. The state of 'wellness'; the general state of health of an individual.

/ Marks, D. F., Murray, M., Evans, B., Willig, C. (2002). *Health Psychology. Theory, Research and Practice*. London: SAGE Publications, p. 361 /

Questions and Tasks

1. Define the concept *health education* in your own words.
2. What terms are used interchangeably to report on "school phobia"?
3. What students should more properly be labeled as truant.?

HEALTH EDUCATORS. TRAINING AND CAREER

Career: Health Educators (Abridged)

Did you know that one child in five is overweight in the United States? Why? The reason has a lot to do with overeating and lack of exercise. If you become a health educator, you may help unhealthy children grow into healthy adults.

As a health educator, you'll promote and improve the health of your community. Whether you work in schools, senior centers, or public health institutions, you'll find creative ways to educate people about healthy life styles.

Health educators study the latest health information and design programs to encourage healthier behavior and practices in their communities.

Health educators are often behind the cautionary ads you see on TV about heart disease, diabetes, and addiction.

Are you ready to...?

- Spread the word, in person and in writing, about disease prevention, proper nutrition, and other health information;
- Create and conduct community health surveys;
- Work on projects with health professionals, as well as community leaders;
- Promote health discussions and training in schools, industry, and community agencies?

It helps to Be...

Interested in health and helping people from all walks of life. You should have a genuine desire to help the average person make sense of complicated and often-conflicting information.

Make High School Count

- Take as many math, health, and science courses as you can.
- Sign up for statistics.
- Pay attention to your teachers' strategies and teaching styles. Which seem most effective in reaching out to students?
- Volunteer to tutor other students and learn what it feels like to teach.
- Participate in any student health awareness programs at your school.
- Volunteer after school or during the summer at a local hospital or clinic.

Did You Know?

- According to the National Institutes of Health, teenagers whose parents smoke are more than twice as likely to smoke as teenagers whose parents don't?

Questions and Tasks

1. Why are many children in the United States overweight?
2. What are the main responsibilities of a health educator in the United States?
3. Comment on the activities a future health educator should engage while still being a pupil at school.

Public Health Educator

General description of class

The public health educator uses a variety of skills derived from theories and principles of education, public health, and social psychology to assess, plan, organize, and implement health education services and programs at the state and local level.

Distinguishing features

This is the first level of a two-level series. It is distinguished from the higher level in that activities performed are usually focused on a specific program area such as maternal and child health, immunizations, dental health, communicable disease, or family planning. Supervision is more direct, although the employee is expected to develop his / her work plan based on recognized and established public health program methods and models.

Duties and responsibilities

1. Health Education Program Planning. Typical tasks: using public health principles, researches health problems in communities and determines educational approaches needed to address them; plans appropriate educational strategies, and either provides direct service or coordinates activities with others to implement plan; evaluates program activities using appropriate evaluation methods and tools.
2. Technical Assistance. Typical tasks: prepares and edits publications and reports; develops or arranges to have educational material produced; edits material produced by others for purposes of health education program responsibilities, for content and readability; develops or arranges to have produced public service announcements, news releases, promotional materials, or media coverage, as needed; participates in grant writing; answers questions and acts a resource to other health and community programs.
3. Training. Typical tasks: plans, develops , and conducts conferences, workshops, in-service, or seminars relating to specific public health programs; does presentations at major conferences upon request; trains staff at State and local health departments as needed; may provide training opportunities for health education students through special assignments; may train and supervise volunteers in specific health education program assignments.

Liaison Activities. Typical tasks: attends and occasionally chairs committees, task forces, and work groups; takes leadership role in assigned special projects; gives input and direction in the development of health policy; provides health education representation at national meetings, and at key decision making / administrative levels.

Relationships with others

Employees in this class have periodic contact (in person or by phone) with health departments throughout the State. Employees also have formal meetings with all public health educators in the State. Employees in this class may have periodic phone or in-person contact with other community agencies, volunteers, schools, and churches, depending upon nature of work. All contact is to obtain or provide information or to provide technical assistance.

Supervision received

Employees in this class receive general supervision from an administrative superior, who reviews work on a periodic basis through meetings with the employee. Work is reviewed for compliance with Federal and State laws, rules, and regulations and agency policies and procedures.

General information

Positions in this class require the willingness to travel, including overnight stays.

Knowledge, skills, and abilities (KSA)

General knowledge of public health education theories and principles.

General knowledge of Oregon Administrative Rules (OAR's) and related laws.

General knowledge of disease processes and medical / behavioral interventions.

General knowledge of current scientific literature and study findings in the field.

General knowledge of educational behavioral approaches to change behavior.

General knowledge of current risks to health and prevention strategies.

General knowledge of epidemiology.

Basic knowledge of community organization theory.

Skill in written and verbal communication sufficient to perform the functions of the position.

Skill in health related program planning and evaluation.

Skill in speaking on health related issues to audiences of diverse backgrounds.

Skill in preparing lesson plans, training programs, and materials.

Skill in group process techniques.

Skill in working with a variety of health professionals.

Ability to plan and organize own work schedule.

Ability to use word processing equipment.

Ability to instruct proper health and personal hygiene procedures.

Ability to gain cooperation of local school district administrators.

Ability to motivate others to provide health education services.

Ability to monitor long-term projects and theory impact on learning.
Ability to develop long-range program plans. [...]

[/ www.hr.das.state.or.us/hrsd/class/2327.HTM /](http://www.hr.das.state.or.us/hrsd/class/2327.HTM)

Questions and Tasks

1. Translate the paragraph under the heading “General description of class”.
2. What are distinguishing features of the public health educator?
3. What are the duties and responsibilities of the public health educator?
4. Which KSA do you consider as most important? Why?

Health Care Public Relations

Individuals that specialize in health care public relations are in charge of handling the internal and external communications for a health facility. They interact with physicians, nurses, managers, administrators, and patients, and therefore must have excellent communication skills. Some of their responsibilities include writing for internal publications such as newsletters, handling calls from the media, as well as writing and creating various material that promote the services offered at the facility. Public relations specialists may also be called upon to prepare marketing plans that highlight various aspects of an organization. The most important function of this position is handling all communications with the public. They may organize events between the organization and the public, or they might prefer to correspond by publishing press releases. Public relations specialists must be highly organized and be prepared to deal with a variety of situations. They usually work 40-hours a week, but this can vary due to deadlines or an unforeseen crisis involving the health care organization. Individuals interested in health care public relations should be detailed oriented, be able to cope with high levels of stress, and be able to handle a heavy workload.

Work Environment

These public relations specialists work in a variety of settings such as hospitals, nursing homes, rehabilitation facilities, health maintenance organizations (HMOs), psychiatric facilities, and community health centers. They may supervise several public relations assistants that help with daily operations.

High School Preparation

Students interested in a career as a health care public relations specialist should take high school courses in algebra, biology, computer skills, data processing, psychology, English, health, government, history, literature, foreign language, anatomy, sociology, and health occupations / medical professions education.

College Requirements

Individuals interested in public relations must have a high school diploma or the equivalent. The majority of health care public relations positions require a bachelor's degree combined with experience in public relations as an intern. Employers usually prefer a degree in communications, journalism, English, public relations, advertising, or a related field. Individuals can become accredited through the Public Relations Society of America or the International Association of Business Communications.

Students interested in public relations should contact school for information on admission and course of study.

Career Outlook

Employment opportunities for health care public relations specialists should grow faster than the average for all occupations through 2012. There is an expected increase of 21%-35% in the number of jobs that will become available over this period of time. The demand for good public relations personnel will increase because of the need to keep the public informed about a variety of issues that could affect their daily lives. Competition will be the greatest for entry-level public relations jobs because the number of qualified applicants is expected to exceed the number of job openings.

<http://www.natfh/>

Questions and Tasks

1. Why must health care public relations specialists have excellent communication skills?
2. What do some of their responsibilities include?
3. Where do health care public relations specialists work?
4. What courses should students interested in a career as a health care public relations take?
5. What are the college requirements for individuals interested in health care public relations?
6. Why will the competition be the greatest for entry-level public relations jobs?

The Institute of Health Promotion and Education

(Abridged)

The Institute of Health Promotion and Education was established 40 years ago to bring together professional workers on the basis of their common interest in Health Education and Health Promotion with a view to their sharing experience, ideas and information. The Institute is a recognized professional association offering Full or Associate membership to those engaged in the practice of Health Education and Health Promotion. It offers Affiliate membership for individuals of good standing

with an interest in health education and promotion. The Institute concerns itself solely with professional interests and activities related to the practice of Health Education and Health Promotion and does not undertake any trade union activities. [...]

Our members' interests are varied including: nursing, midwifery, health visiting, medicine, dentistry, public health, stress management, psychology and teaching.

The Institute of Health Promotion and Education has achieved a recognized role in the field of prevention and management of illness and promotion of health. Its activities have been mainly concerned with Health Education and following the Alma Ata Declaration they also include Health Promotion. The accepted differentiation between the two activities defines Health Education as the intervention on a personal level, whereas Health Promotion is considered to be concerned with interventions on a population level. This differentiation has in recent years contributed to a dynamic development in both areas including different disciplines in addition to medicine and public health, such as educational and social sciences. The Institute of Health Promotion and Education has been in the forefront of these developments with special contributions to the development of a settings approach within an organizational model. This has been reflected in recent publications which have dealt with health promoting settings, models of management and quality assessment as a part of evaluation. [...] The International Journal of Health Promotion and Education is free to members and available to non-members on subscription. [...]

/ <http://www.ihpe.org.uk/memb/institute.htm/>

Questions and Tasks

1. What does the Institute offer?
2. What does the Institute concern itself with?
3. What are the members' interests?
4. How is the difference between Health Education and Health Promotion explained?
5. Compare the interpretations of these two concepts with those presented in the Terminology section of this book.

Public health training in Europe

Development of European masters degrees in public health (Abridged)

The first attempts to develop a European master's program in public health were in 1988. At that time, the World Health Organization (WHO) gave the mandate to set up a new European training program following Health for All principles to the Association of Schools of Public Health in the European Region (ASPHER). However, within a few years it became clear that circumstances were not right for a common European program or degree. National training programs were so different and the training was organized on

a national basis for a national needs. Mechanisms for credit transfer and recognition were poorly developed and bodies concerned with certification of training would not normally accept training in other institutions. Furthermore, the approach was top-down and did not respect the diversity and traditions in each country. Although the original vision was not implemented, the attempts by ASPHER led to a European Training Consortium which is still organizing courses in health promotion each year and has provided useful experiences for the present development.

The developing integration in Europe in the 1990s, with new EU member states, was the reason in 1995 for renewed attempts by the European Community to establish European public health programs. The individuals and organizations to whom this opportunity was offered had been part of, or were at least aware of, the previous failure and, therefore, understood the need to be cautious. It was important to start the process slowly, discuss widely and listen to the opinions of the schools through the forum of the now regular meetings of ASPHER's deans and directors. The diversity of European public health schools and their programs is now better understood. It also became clear that there is no advantage in a single model of training and the relevant European content and perspectives can be fitted into the style and traditions of existing programs.

The first stage of the EU-funded project was a feasibility study which aimed to ensure that past problems were avoided. Increased understanding and cooperation between schools and the changing circumstances of public health practice have made conditions more suitable for the development of a common master's program.

A Developmental Approach

The basic idea of the new approach is to develop existing programs, putting in place procedures to guarantee high quality and including within them the 'European dimension' of public health. The aim is not to design a brand new course or program that is separate from existing undergraduate or postgraduate courses. It will not compete with existing programs, but will give an opportunity for schools to offer training of particular value to public health specialists working within the European context. A similar approach has been used by the group of European schools offering specialized training in tropical medicine (<http://www.liv.ac.uk/lstm/ecte.html>). In TropEdEurope the hope is that a process of 'harmonization' of training across Europe might lead to full recognition of titles across nations. This issue is crucial in public health as it is one of the few health domains where harmonization of curricula and mutual recognition of titles and degrees across Europe is still far off.

The European Degrees in Public Health project group was established by ASPHER in 1995 supported by the EU. It started by agreeing on three basic principles. The curriculum to be designed had to i) create a competence in European public health for a European specialist, that is a person able to move easily across countries and who is familiar with public health problems at European level, ii) be built on the existing experience of the European schools of public health from the point of view of contents,

structure and didactic innovations and iii) be based on a set of well-identified 'European values'.

In addition, it was realized from the beginning that high quality in the programs would be the key to their success.

In summary, it was decided to design a European Master Program in Public Health (EMPH). The detailed structure of the planned curriculum as well as the process of work are presented in the final report written for the Commission and published in the webpages of ASPHER (<http://www.ensp.fr/aspher/>; then click on EMPH).

The Principles and Structures and Structures of the EMPH Program

The principle of the program is that a network of schools will run it. Each school wishing to be involved has to decide how this program and their ordinary programs fit together. The EMPH can use the existing modules or modules with some modifications. Some new ones will have to be developed, particularly those containing the European dimension. For the EMPH program, the main principles are as follows.

/ Cavallo, F., Rimpela, A., Normand, C., Bury J. Public health training in Europe. Development of European Masters degree I public health. *European Journal of Public Health* 2001; 11, p. 171-172 /

PREVENTING INJURIES

Injury Prevention

Of concern in pediatric populations are the alarmingly high rates of injury. Among pediatric populations, injury (accidental injury and injury due to violence) is the number-one reason for emergency department visits and the leading cause of death (Centers for Disease Control and Prevention, 2002). The circumstances leading to these injuries include motor vehicle accidents, drowning, poisoning, firearm use, sports, and falls. Failure to use common safety devices (e.g., seat belts, bicycle helmets) has been identified as one reason for unintentional injury. Other factors are psychological and behavioral, such as parental stress and parental monitoring, which have been associated with these high rates of injury, especially among young children. Further, children's individual perceptions regarding their risk of injury or their skill ability may also be an important factor in injury causation, especially during adolescent years, when risk perception and physical abilities are changing rapidly.

Morongiello and her colleagues describe results from a two-part study designed to move beyond epidemiological association to more closely examine what is occurring in the home between parents and children that leads to increased or reduced risk of childhood injury. The first study assesses child-related factors that are associated with minor injury, and the second study examines naturally occurring strategies used by parents to prevent

their child from being injured. These studies address questions about what exactly is occurring among young boys that places them at greater risk compared with young girls and, if parental monitoring decreases risk of injury, what kind of parenting / monitoring strategies are most effective and for what age groups. These studies by Morrongiello et al., as well as others, provide important useful evidence that could dovetail into community- and population-based injury prevention interventions.

The study by Kontos examines the association between cognitive and behavior factors in sports-related injury among a sample of young adolescents. Specifically, the study was designed to examine the relationship in soccer-related injury among risk taking, perceived risk of injury, estimation of ability to play soccer, and previous injury in both boys and girls. This study has important implications for injury prevention in adolescents and demonstrates that the importance of risk perception and an accurate estimation of one's ability in sports may be important factors relevant to the development of effective prevention programs to reduce sports injury.

These studies help to bridge the gap between pediatric psychology and public health, as they exemplify how epidemiological evidence can be used to guide the development of research programs to gather more detailed data about the underlying processes that may be occurring. In general, greater attention is needed that addresses more precisely the biological, developmental, cognitive, behavioral, and social factors that set the occasion for injury occurrence in order for more effective prevention strategies to take place (Damashek & Peterson, 2002; Schwebel et al., 2000).

/ Fuemmeler, B. Bridging Disciplines: An Introduction to the Special Issue on Public Health and Pediatric Psychology. *Journal of Pediatric Psychology*. Vol. 29. No. 6, p. 410 /

Questions and Tasks

1. What are the circumstances leading to injuries among pediatric populations?
2. What do Morrongiello and her colleagues describe?
3. What does the first study assess?
4. What does the second study examine?
5. Describe the study by Kontos.

Preventing Unintentional Injuries in Schools

Introduction

Health educators who work in schools know that academic achievement and high test scores are not the only measures of a successful school. A good school is a safe school. Unfortunately, each year approximately 3.7 million students ages five to 19 years are injured at school severely enough to require medical attention or limit activity (Miller & Spicer, 1998). That is about one in every 14 students. The vast majority of these injuries are unintentional (Posner, 2000) and not due to violence-related behavior.

Injuries are preventable, and guidance exists to help health educators and schools implement effective injury prevention practice. In this issue of the *American Journal of Health Education*, Barrios, Sleet and Mercy (2003), summarize the *School Health Guidelines* published by the Centers for Disease Control and Prevention (2001). In addition, a complementary set of school health guidelines is due to be released later this year by the Health Resources and Services Administration's Maternal and Child Health Bureau. These guidelines provide valuable information for health educators working in a school system. However, no single health educator can implement guidelines alone. Creating safe schools is a team effort, and to maximize the probability of success, health educators need to enlist partners and collect information that will justify prevention efforts and facilitate design of prevention programs.

Advantages of Using Injury Data in Prevention Activities

Comprehensive data collection is a critical tool for injury prevention. Injury is the most common health problem treated by school health personnel (Nader, 1981), and yet many schools fail to maintain injury records. Lack of data conceals the extent of the injury problem and contributes to a false impression that school injuries are isolated and unpredictable events. In fact, data collection can document the overall pattern of injuries in a school, including where, when, how, and to whom the injuries occurred (Posner, 2000). Data collection also can demonstrate strengths or weaknesses in a school's response to injuries. In addition, data can demonstrate the cost advantages of adopting injury prevention programs and policies, rather than simply responding to injuries after they occur (Miller & Levy, 1997). Once injury prevention programs and policies are designed and implemented, continued data collection can be used to evaluate these initiatives.

Data can be convincing, and when collected well, they provide compelling evidence of a problem as well as indicate potential solutions. At a minimum, information collected should include the age, grade, and sex of each injured student as well as the activity, place of occurrence, intent, nature, and cause of each injury event. However, additional information may be useful depending on the objectives of the system, the school's acceptance of the surveillance system and willingness to report data, and simplicity and flexibility of the system.

/ Spicer, R. S., Young, X. J., Sheppard, M. A. et al. Preventing Unintentional Injuries in Schools: How to Use Data to Build Partnerships and Develop Programs. *American Journal of Health Education*. Sep / Oct 2003; 34, 5, p. S 13-14 /

Questions and Tasks

1. Paraphrase the concept *unintentional injuries*.
2. Explain the statement that creating safe schools is a team effort.
3. What should the information collected include?
4. What is the use of data concerning school injuries?

SUBSTANCE ABUSE PREVENTION

How to Talk to Your Kids about Drugs

First and foremost it is important to be educated about drugs yourself. This site and others can provide you with information as well as the books and materials the Narconon International offers. There are many other resources available, including several government websites that provide basic drug information, current news, and study results.

Also important is *how* you talk to your kids. What has never worked in any drug education is to tell a person something from an authoritative viewpoint. As soon as one starts in with that approach, the child will immediately tune the person out. A better approach is to ask them questions and then provide basic, true information.

One can just ask “What have you heard about drugs that is good?” At this point it is very important for the parent to simply listen to the child’s response without interrupting them. Give them your full attention, no matter what they say, be patient and listen carefully.

When they have finished telling you the good things they have heard about drugs, we have found it is best to just say “thank you” or “I understand” to the communication they just gave you. This helps give your child confidence that they can talk to you and that you are interested in what they have to say. It’s like having communication with your best friend, only this one happens to be your child.

Now that they have told you what they heard that was positive about drugs, it is time to get them the correct information. The objective is to give the child correct information so they can make sound decisions on their own. We have found that when young people are given the accurate information about drugs their attitude about them changes and they make their own decisions not to use them. Their own solid decision will carry them a long way.

When providing them with information, ensure that they fully understand it. Consult their understanding and ask for an example of what they have just learned. If they ask a question that you can’t answer, it is important that you are honest with them and don’t try and make something up. Use the opportunity to work with them to find the answer.

Honestly, patience and good communication is the key to talking to your kids about drugs. Getting their questions answered will help ensure they make the right decision not to use drugs.

/ 2004 Narconon International; http://www.narconon.org/narconon_kids.htm /

Questions and Tasks

1. What has never worked in any drug education? Do you agree with the position expressed in the article?
2. What, according to the author, helps to give children confidence?
3. What is the objective of talking to children about drugs?
4. What is most important in talking to children about drugs? Give your reasons.

What are the core elements of effective research-based prevention programs?

In recent years, research-based prevention programs have been proven effective. These programs were tested in diverse communities, in a wide variety of settings, and with a range of populations (for example, family-based programs in schools and churches).

As community planners review prevention programs to determine which best fit their needs, they should consider the following core elements of effective research-based programs.

- *Structure* – how each program is organized and constructed;
- *Content* – how the information, skills, and strategies are presented; and
- *Delivery* – how the program is selected or adapted and implemented, as well as how it is evaluated in a specific community.

When adapting programs to match community needs, it is important to retain these core elements to ensure that the most effective parts of the program stay intact. [...]

Structure. Structure addresses program type, audience, and setting. Several program types have been shown to be effective in preventing drug abuse. School based programs, the first to be fully developed and tested, have become the primary approach for reaching all children. Family-based programs have proven effective in reaching both children and their parents in a variety of settings. Media and computer technology programs are beginning to demonstrate effectiveness in reaching people at both community and individual levels.

Research also shows that combining two or more effective programs, such as family and school programs, can be even more effective than a single program alone. These are called multi-component programs.

Content. Content is composed of information, skills development, methods, and services. Information can include facts about drugs and their effects, as well as drug laws and policies. For instance, in a family intervention, parents can receive drug education and information that reinforces what their children are learning about the harmful effects of drugs in their school prevention program. This opens opportunities for family discussions about the abuse of legal and illegal drugs.

Drug information alone, however, has not been found to be effective in deterring drug abuse. Combining information with skills, methods and services produces more effective results. Methods are geared toward change, such as establishing and enforcing rules on drug abuse in the schools, at home, and within the community. Services could include school counseling and assistance, peer counseling, family therapy, and health care. Parental monitoring and supervision can be enhanced with training on rule-setting; methods for monitoring child activities; praise for appropriate behavior; and moderate, consistent discipline that enforces family rules.

Delivery. Delivery includes program *selection* or *adaptation* and *implementation*. During the selection process, communities try to match effective research-based programs to their community needs. Conducting a structured review of existing programs can help determine what gaps remain. This information can then be incorporated into the community plan, which guides the selection of new research-based programs. [...]

Adaptation involves shaping a program to fit the needs of a specific population in various settings. For programs that have not yet been adapted in a research study, it is best to run the program as designed or include the core elements to ensure the most effective outcomes.

Implementation refers to how a program is delivered, which includes the number of sessions, methods used, and program follow-up. Research has found that how a program is implemented can determine its effectiveness in preventing drug abuse.

Use of interactive methods and appropriate booster sessions helps to reinforce earlier program content and skills to maintain program benefits.

http://www.narconon.org/narconon_drug_prevention.htm/

Questions and Tasks

1. What are the core elements of effective research-based prevention programs?
2. What are multi-component programs?
3. What is *Content* composed of?
4. What does *Delivery* include?
5. Point out the services aimed at deterring drug abuse.

Developing Successful Drug Abuse Prevention Programs

NIDA's research over the past 25 years has identified many factors that put young people at risk for drug abuse, and has also identified factors that decrease the likelihood that young people will use or abuse drugs. NIDA's drug abuse prevention research has shown how to develop, test, and implement programs that families, schools, and communities can use to successfully prevent drug use among young people.

Risk Factors

Research has shown that although there are many risk factors for drug abuse, the most crucial ones are those that influence a child's early development within the family. These risk factors include parents who abuse drugs or suffer from mental illness; lack of strong parent-child attachments in a nurturing environment; poor parental monitoring; and ineffective parenting, particularly with children who suffer from conduct disorders or have difficult temperaments. Other risk factors involve a child's interaction in environments outside the family – in school, among peers, or in the community at large. These risk factors include inappropriate classroom behavior or failing school performance, poor social skills or affiliation with deviant peers, and a perception that drug use is acceptable within peer, school, or community environments.

Protective Factors

The most important protective factors, like risks, come from within the family, but include factors that influence a child in other environments. Among protective factors identified by NIDA research are strong bonds and clear rules of conduct within a family, involvement of parents in a child's life, successful school performance, strong bonds with positive institutions such as school and religious organizations, and a child's agreement with the social norm that drug use is not acceptable.

Prevention Principles

Prevention programs include a wide variety of techniques depending on the target population, but NIDA research has identified several fundamental principles, such as:

- Prevention programs should enhance protective factors and reverse or reduce risk factors;
- Prevention programs should target all forms of drug abuse, including use of tobacco, alcohol, marijuana, and inhalants;
- Prevention programs aimed at young people should be age-specific, developmentally appropriate, and culturally sensitive; and they should be long-term with repeat interventions to reinforce prevention goals originally presented early in a school career;
- Prevention programs should include a component that equips parents or caregivers to reinforce family antidrug norms;
- Family-focused prevention programs have a greater impact than those that target parents only or children only;
- Prevention programs should be adapted to address specific drug abuse problems in the local community. [...]

[/ http://www.nida.gov/NIDA_Notes/NNVol14N6/tearoff.html /](http://www.nida.gov/NIDA_Notes/NNVol14N6/tearoff.html)

Questions and Tasks

1. What are the most crucial factors for drug abuse?
2. Where do the most protective factors come from?
3. Point out the fundamental principles that NIDA research has identified.

Substance Use and Risky Sexual Behavior

Teens and young adults face many pressures and decisions involving alcohol, drugs, and sexual activity – decisions that often occur simultaneously. Research has shown that many health risk behaviors occur in combination with one another, yet it is often unclear which behavior comes first (Eisen et al., 2000). Substance use increases the probability that an adolescent will initiate sexual activity, and relatedly, sexually experienced adolescents are more likely to initiate substance use (Mott & Haurin, 1988). Alcohol and drug use may lead to earlier sexual initiation, unprotected sexual intercourse, and multiple partners as well as putting young people at risk for sexually transmitted diseases (STDs), unintended pregnancy, and sexual violence. There is still much to learn about the attitudes and knowledge of youth toward the intersection of substance use and sexual activity, including how conscious they are of the connection between the two.

Following is a detailed summary of findings based on the Kaiser Family Foundation’s Youth Knowledge and Attitudes on Sexual Health: A National Survey of Adolescents and Young Adults that includes interviews with 998 teens (ages 15 to 17) and young adults (ages 18 to 24). [...]

Perceptions of Risk and Personal Concern

Young people say that alcohol and drugs often go hand-in-hand with sexual activity among their peers. Almost 9 of 10 (88%) of those 15 to 24 years old say that people their age drink or use drugs before having sex at least “sometimes,” including 50% who say this happens “a lot.”

Seven of 10 (73%) young people 15 to 24 also agree that condoms often do not get used when people are drinking or using drugs. Girls and young women are more likely than boys and young men to report that their peers are having unprotected sex under the influence (79 vs. 65, respectively).

In spite of the risks, one in five (21%) young people 15 to 24 say it is not a big deal if their peers make decisions about sex while drinking or using drugs.

When it comes to their own decision making, many young people are worried about the influence of substance use. Forty-three percent of young people 15 to 24 say they are personally concerned that they “might do more sexually than [they] had planned because of alcohol or drugs.” Teens are more likely than young adults to express personal

concern; almost half (49%) of teens 15 to 17 compared with 40% of young adults 18 to 24.

Sexual Activity While Drinking or Using Drugs

Significant numbers of young people – including underage teens who cannot legally drink alcohol – report engaging in risky sexual behaviors because of alcohol or drugs. More than a third (36%) of sexually active young people 15 to 24 say that drinking or drug use have influenced their decisions about sex, including more than a quarter (29%) of teens 15 to 17 and 37% of young adults 18 to 24. Twenty-nine percent of sexually active young people 15 to 24 say they have “done more” sexually than they had planned while drinking or using drugs.

Many teens and young adults admit that they have put themselves at risk because of alcohol or drugs. Almost one quarter (23%) of sexually active young people 15 to 24 report having had unprotected sex because they were drinking or using drugs, including 12% of teens 15 to 17 and 25% of young adults 18 to 24. Because of something they did while drinking or using drugs, 26% of sexually active teens 15 to 17 have worried about STDs or pregnancy, as have 28% of sexually young adults 18 to 24.

Information Needs

Almost 4 of 10 (37%) young people 15 to 24 want more information about the effects of alcohol and drugs use on their sexual decision making. Teens are more likely to say they would like to learn more than young adults, with 48% of teens 15 to 17 expressing interest compared with 32% of those 18 to 24. [...]

Discussion

For many teens and young adults alcohol and drug use are closely linked to sexual decision making and risk taking. Nearly 9 of 10 say that their peers use alcohol or drugs before having sex at least some of the time, and many young people report that condoms are often not used when people are drinking or using drugs. In spite of the risks, a fifth of teens and young adults are unconcerned that their peers often make decisions about sex while they are under the influence. Many young people report that they themselves have engaged in risky behaviors because of substance use. More than a third of sexually young people report that alcohol or drugs have influenced their decisions about sex. Almost as many have “done more” sexually than they had planned while under the influence. Because of decisions they made while drinking or using drugs, young people also report having unprotected sex and worrying about STDs and pregnancy.

/ The Henry Kaiser Family Foundation. Substance Use and Risky Sexual Behavior: Attitudes and Practices Among Young Adolescents and Young Adults. *American Journal of Health Education*. Sept / Oct 2002; 33, 5, p. 278-281 /

Questions and Tasks

1. What is the topic of the article?
2. What has research shown?
3. How was the information gathered for the National Survey of Adolescents and Young Adults?
4. Prepare a short summary disclosing perception of risk, personal concern and sexual activity while drinking or using drugs by adolescents and young adults.

Drug Prevention and Youth Justice

There is evidence that drug use among young people is on the increase. Moreover, although relatively little rigorous data on young offenders' drug use is available, all the indications are that prevalence rates are high among this group and that significant numbers of young offenders may be at risk of becoming problematic drug users (and that a small but important minority already are). The need to target this and other vulnerable groups has been recognized officially and now forms a central plank of UK anti-drugs policy. The program of action in support of the strategy specifically aims to 'ensure that the groups of young people most at risk of developing serious drugs problems receive specific and appropriate interventions' (President of the Council 1998: 15).

The research examined the experience of attempting to establish youth justice-based drugs prevention projects in two sites. Although the numbers of referrals made to the individual projects were relatively modest they nonetheless supported the proposition that this is indeed a 'high risk' group. Among the young offenders interviewed the key risk factors associated with problematic drug use were especially visible. Thus, rates of family disruption were high, educational achievement was minimal, association with delinquent peers was very common and, perhaps most importantly of all, age of onset was extremely young and frequency of drug use was particularly high.

Predictably, attempting to integrate drugs prevention activity within youth justice was less straightforward than had been anticipated. Innovative work inevitably gives rise to challenges to accepted philosophies, practices and policies. The focus of this paper has been on the identification of these challenges and the tensions that result. Three main sources of tension were highlighted: diversion versus drugs prevention; holism versus compartmentalization; and the problems of 'joined-up' working.

The first issue concerned the tension between the ongoing commitment within youth justice to the principles and practice of diversion and the more 'intrusive' and extensive practices associated with certain drugs interventions. The challenge in the successful establishment of drugs work within youth justice lies in convincing social workers and others of its 'benign' effects (and, of course, attempting to ensure that its effects are 'benign'). This requires, at least, two things. First and obviously, convincing colleagues that interventions may have beneficial intended consequences in terms of reducing drug use or drug-related harms. Secondly, countering concerns among youth justice colleagues that such interventions may have negative unintended consequences. More particularly,

this means working to ensure that the practice of drugs prevention does not come to replicate the worst aspects of the 'welfarist' approach to juvenile crime in which the social control net is 'widened' in the guise of treating the needs of the young (Harwin, 1982). Current changes to youth justice may also smooth this path for drugs prevention. In the aftermath of the Audit Commission's (1996) critique of the youth justice system, the Labour Party set out a radical programme of reform, first in opposition and then later in government (Newburn, 1998). One of the central thrusts of the reforms introduced by the Crime and Disorder Act 1998 is to reorient youth justice away from diversion and towards intensive and constructive youth justice-based programmes. In short, youth justice is set to become significantly more interventionist. There are clear risks of 'net widening' associated with increased criminal justice-based intervention. On the other hand, one of the potential outcomes of the current process of philosophical reorientation taking place within youth justice may be increased opportunities for the successful integration of drugs prevention within newly established Youth Offending Teams (YOTs).

As more is learned about the risk factors associated with delinquency and drug use, so it becomes clearer how extensively such factors are interconnected (Farrington, 1996; Graham, 1998; Loyd, 1998). As Graham (1998) notes, 'Existing knowledge ... suggests that effective interventions need to target more than one risk factor [and] involve the delivery of more than one service'. This leads to two conclusions. First, that drug-focused work needs to be embedded within other work with young offenders. Secondly, that successful drugs work needs to be inter-agency or 'joined up'. Clearly, at the core of the projects discussed here was an attempt to 'embed' drugs prevention within youth justice. Whilst successful in many respects, a further tension appeared: that between 'holism' and 'compartmentalization'. The key lesson from the projects was that 'embeddedness' doesn't simply happen, it has to be continually negotiated. Where the boundaries are to be set between different forms of working within multi-agency youth justice teams (as all will be once YOTs are fully established) and how these boundaries are to be agreed, are undoubtedly key to successful interventions. In these pilot projects, there were attractions for youth justice workers both in keeping cases themselves and 'failing' to refer and in 'handing over' cases completely to drugs workers. For the drugs workers it was often necessary to become at least partly immersed in issues wider than simply drug use, particularly given the tendency for clients 'to be suffering from a wide range of serious problems, compared to with current-or future-drug-related problems may appear trivial' (Lloyd 1998: 228) but which may be inextricably linked to their drug use. Such work, however, is often intensive and time-consuming and in a world of fiscal restraint workers can often find themselves pulled in two directions at once.

/ Newburn, T. (1999) . Drug Prevention and Youth Justice. *Brit. J. Criminol.* Vol. 39. NO. 4. Autumn, p. 619-621 /

Questions and Tasks

1. Explain the title of the article in your own words.
2. Is there any evidence that drug use among young people is on the increase?
3. What forms a central plank of UK anti-drugs policy?
4. What did the research examine?
5. Why are questions raised by the need to too-ordinate the activities of different agencies?
6. What five issues did this paper raise?

HEALTH PROMOTION IN SCHOOLS

Health Literacy and Schools

(Abridged)

Nutbeam has proposed a three-level hierarchy in health literacy: basic / functional literacy, through communication / interactive literacy to critical literacy (Nutbeam, 2000). He argues that achieving the level of critical literacy ‘allows for greater autonomy and personal empowerment’. This is also an important goal of a school education.

Schools are about maximizing the educational outcomes for students. We need to remind ourselves that their core business is education and their level of expertise in health issues is minimal. Yet research clearly shows there are strong links between poor health and educational achievement (Lavin et al., 1992; Devaney et al., 1993).

Schools and the education sector in general, have begun to recognize these links and embrace the concept of a whole school approach in addressing health and social issues, which assist them in maximizing learning outcomes (Allensworth, 1993; Cameron and McBride, 1995; WHO, 1996). The approach is often called ‘health promoting school’, or in the USA, ‘co-ordinated school health’. It is not a vehicle for legitimizing topic-based and school-located health promotion interventions in areas such as drug reduction, weight management and injury prevention. When mapped in educational terms, it demonstrates that its prime purpose is achieving education goals through addressing health issues within an educational framework. St Leger and Nutbeam have proposed that the health promoting school contributes to four main school-related outcomes: (i) lifelong learning skills; (ii) competencies and behaviors; (iii) specific cognate knowledge and skills; and (iv) self-attributes (St Leger and Nutbeam, 2000). It is asserted that these building blocks are necessary to achieve both health and educational outcomes, and are fundamental to health literacy. [...]

All of these four school-related health / education outcomes are dependent on students achieving each of Nutbeam’s three levels of health literacy. It is possible that a person can manage some level of survival on level one, i.e. basic / functional health literacy, but being able to read a food product label and not being able to analyze the information for one’s own needs or that of one’s family severely limits a person’s autonomy.

It is argued that when the purposes of the health curriculum are examined in most schools in most countries, a number of common factors emerge.

These are characterized by:

- a focus of building certain knowledge, e.g. knowledge about one's body;
- an attention to developing certain competencies, e.g. analyzing contemporary health issues (these are nearly always written in education terminology; and
- developing certain attitudes, e.g. attitudes to one's own health, interpersonal relationships or social responsibilities.

/ Leger, L. St (2001). Schools, health literacy and public health: possibilities and challenges. *Health Promotion International*. Vol. 16, No 2, p.198-199 /

Questions and Tasks

1. What has Nutbeam proposed?
2. What does, according to Nutbeam, achieving the level of critical literacy allow?
3. What does research show?
4. What does, according to St Leger and Nutbeam, the health promoting school contribute to?
5. How does basic / functional health literacy limit a person's autonomy?
6. Name the common factors that emerge when the purposes of the health curriculum are examined in most schools.

The Potential of the Health Promoting School in Enabling the Achievement of Health Literacy Outcomes

The health promoting school shows great potential in enabling high levels of health literacy to be achieved. The health promoting school concept emerged simultaneously in Europe and North America in the mid-1980s, where its beginnings can be traced to the Ottawa Charter for Health Promotion (WHO, 1986). It challenged those involved in traditional school health education to rethink the problem-based focus of the health curriculum. This focus, which had framed the direction of school health education in many countries, was characterized by giving students substantial amounts of knowledge in the classroom about diet, physical activity, drugs, safety, oral health, sexuality and relationships, in the belief that such information would develop certain attitudes on which health behaviors would be based. It was also believed this would impact on morbidity and mortality rates. This traditional top-down approach to health education resulted in few sustainable behavior changes and did not address the gap in health status between those in the higher and lower socio-economic groups. [...]

Termed the 'health promoting school' in Europe and 'comprehensive school health' in the USA (now called 'co-ordinated school health'), a new framework for school health was in place in many countries by the beginning of the 1990s. Basically, it looked beyond the curriculum in identifying those components of schooling that impacted on health opportunities for young people. Attention was given to the school environment, both social and physical, school-based health policies, links with health services, and school partnerships with the local community (Allensworth and Kolbe, 1987; WHO, 1996). This new approach to school health endeavored to increase student knowledge and skills by shifting health into a more dynamic and political domain, and to provide young people with opportunities to develop skills in advocacy and to achieve a sense of empowerment. It provided a framework that facilitated the attainment of all three levels of Nutbeam's hierarchy of health literacy (Nutbeam, 2000). It more clearly reflected the core business of schools – educational outcomes- and provided a strategic approach for schools to address health issues (Lister-Sharp et al., 1999).

Whilst the health promoting school framework should make the attainment of health literacy more achievable, the comprehensiveness of health literacy (i.e. all three levels present in a reasonable amount) is largely dependent on the type of school (autocratic or democratic), and the cultural and political practices of the region or country in which the school exists. Schools that demonstrate breadth and depth in how they are led and managed, the ways they seek to maximize educational outcomes for their students, and how they foster relationships between both students and staff provide excellent environments for the growth of empowerment and the achievement of level 3 – critical literacy (Edmonds, 1979; Sammons et al., 1994). Such schools also have a very close affiliation with the building blocks of the health promoting school framework (Parsons et al., 1996; WHO, 1996). [...]

Conclusion

There is now sufficient prima facie evidence to suggest that it is possible to attain the changes needed in school structures and practices to achieve better education and health outcomes, and that they do in fact work under many different conditions. But increasing the number of schools capable of making such changes will require governments to invest more in three core areas: professional development for teachers, research into school health frameworks and their effects, and dissemination of the evidence of effective school health initiatives to a wider school-based audience.

A great deal has been achieved in school health in the last 20 years. The evidence base of what is effective has increased considerably. Producing changes in schools to reflect 'best practice' in school health is still a major challenge. Health literacy is a very important concept, which shows us how education and health can collaborate to achieve both public health outcomes and high levels of skills and knowledge in students. Schools can achieve all three levels of health literacy, and the attainment of level three – critical health literacy – will be easier if schools adopt the health promoting school approach. Increased and widespread empowerment of students through health literary concepts is possible, but only if there is a will to support schools in their efforts.

/ Leger, L. St (2001). Schools, health literacy and public health: possibilities and challenges. *Health Promotion International*. Vol. 16, No 2, p.199-204 /

Questions and Tasks

1. What does the health promoting school show?
2. What synonymous (similar) concepts do you know for the *health promoting school*? Comment on what they have in common.
3. What did the new approach to school health Endeavour?
4. What does the concept *comprehensiveness of health literacy* imply?
5. What are the three core areas requiring governments to invest more?
6. What does the concept *health literacy* show?

The Coordinated School Health Program: Panacea or Potential?

The Coordinated School Health Program (CSHP) offers a solution to schools' responsibilities for both the health and academic success of children and adolescents (Allensworth & Kolbe, 1987; Marx & Wooley, 1998; Kolbe, 2002). The 2000 Joint Committee on Health Education and Promotion Terminology defined the CSHP as "an organized set of policies, procedures, and activities designed to protect, promote, and improve the health and well-being of student and staff, thus improving the student's ability to learn." The CSHP includes, but is not limited to (1) family and community involvement in school health; (2) comprehensive school health education; (3) physical education; (4) school health services; (5) school nutrition services; (6) school counseling, psychological, and social services; (7) healthy school environment; and (8) school-site health promotion for staff (Joint Committee on Health Education and Promotion Terminology, 2000). The CSHP model recognizes that the focus of the school should be on the whole child, with academic achievement as its *raison d'être*. Schools with such a program provide basic health programs and services to meet the routine physical and mental health needs for children and adolescents, as a support, essential so that students can learn, which is central to the educational mission of the institution. [...]

Family and Community Involvement in School Health. Students whose parents are actively involved in their education have demonstrated significantly greater achievement gains in math and reading (achievement and comprehension), improved attendance, and consistency of complete homework compared with students with uninvolved parents. Nettles (1991) and Allen et al. (1997) found that community activities that connect to the classroom reduced school suspension rates, improved school-related behaviors, and positively impacted academic achievement.

Comprehensive School Health Education. From the School Health Education Evaluation study, students who participated in health education classes using proven effective curricular increased their health knowledge and attitudes and improved their health

promoting skills and behaviors (Connell, Turner, & Mason, 1985). Constancy of these effects is established for all three learning domains with 40-50 classroom hours of instruction. Dent and colleagues (1995) found that through a social influences model curriculum (Project Towards No Tobacco), smokeless tobacco and cigarette use increases can be attenuated by various approaches, and these effects were stable for junior high adolescents at 2 years postprogram and with the transition to high school. Botvin et al. (2001) found similar results for the reduction of binge drinking in early adolescents. Protective effects from a school-based program were present at the 1-year (8th grade) and 2-year (9th grade) follow-up assessments. Elias et al. (1991) found that students who had received an intensive 2-year social decision-making and problem-solving program in elementary school showed more prosocial behavior and less antisocial and self-destructive behavior when followed up in high school 4 to 6 years postprogram.

Physical Education. Physical activity among adolescents is consistently associated with higher levels of self-esteem, lower levels of anxiety and stress (Calfas & Taylor, 1994), and higher levels of perceived life satisfaction. Physical activity is positively associated with academic performance for children and adolescents (Dwyer, Blizzard, & Dean, 1996).

School Health Services. Early childhood and school-aged, school-based intervention programs that provide parental support and health services are associated with improved school performance and academic achievement (Reynolds et al., 2001). The Chicago Child-Parent Center Program also found that early intervention improved high school completion rates and lowered juvenile crime (Reynolds et al., 2001) for students up to 20 years of age. McCord et al. (1993) found that schools with school-based health centers increased school attendance, decreased school drop-outs and suspensions, and had higher graduation rates.

School Counseling, Psychological, and Social Services. Hawkins et al., (1999) through use of the social development model found that a comprehensive intervention combining teacher training, parent education, and social competency training for children had long-term effects including greater commitment and attachment to school, reductions in violent behavior, heavy drinking and sexual intercourse by age 18 (6-year follow-up), less school misbehavior, and better academic performance for multiethnic urban children. Eggert et al. (1994), through the use of an intensive school-based social network development program targeted at high-risk youth in grades 9–12, found increases in grade point averages (all grades), school bonding, and self esteem and modest success in stemming the progression of substance use. Bowen (1999), using school social workers and school-family partnerships, found improved academic performance for children who participated in a social service intervention focused on improving parent-child and parent-teacher communication. Resnick and colleagues (1997) found from the National Longitudinal Study on Adolescent Health that parent-family connectedness and perceived school connectedness were protective against every health risk behavior (with the exception of history of pregnancy), and parental expectations for school achievement were associated with lower levels of health risk behaviors.

School Nutrition Services. Alaimo et al. (2001) found that teenagers who were “food-insufficient” were more likely to have repeated a grade, visited a psychologist, been suspended from school, and difficulty getting along with other children. From a study of public school students in Philadelphia and Baltimore, Murphy et al. (1998) found that school breakfast programs increased learning (especially math) and academic achievement, improved student attention to academic tasks, decreased visits to the school nurse, and decreased psychosocial problems (days absent and days tardy). Meyers et al. (1989) in their Massachusetts study found that school breakfast programs positively impacted academic performance and reduced absenteeism and tardiness among low-income elementary school students.

Healthy School Environment: Physical. From a study in the District of Columbia, Berner (1993) found that the size of a school’s PTA budget is positively related to the school building’s condition. In turn, the physical condition of a school is statistically related to student achievement. This study found an improvement in the school’s physical condition by one category, poor to fair, was associated with a 5.5 improvement in average achievement scores. Allan Cross (2002) suggests taking a closer look at pesticide use around and in a school. Safe levels are determined by extrapolating from adult and rat studies, and currently we do not know the harm these toxins may cause in children. Asthma is the leading cause of school absenteeism due to chronic illness, and indoor air quality (IAQ) is a key factor in asthma exacerbations. Half the schools in the United States have poor IAQ. [...]

Healthy School Environment: Psychosocial. The feeling of belonging to and being cared for at school has been referred to as school connectedness (McNeeley, 2002). Intervention research suggests that the relationship between feeling connected to school and good health may be causal. For example, a classroom management program that gave middle school students responsibility for setting classroom rules and managing the classroom increased school connectedness and promoted self-discipline. After 1 year, between 30 and 100% fewer students were sent to the principal’s office for acting out in class and fighting, or assault (Freiberg, 1989). Although school connectedness in and of itself improve student learning, it is one important ingredient (Lehr & Christenson, 2000). When students feel they are part of their school and are cared for, they are more receptive to the high expectations of academically rigorous programs. In turn, school administrators do not have to choose between competing social and academic agendas. Efforts to promote connectedness can reinforce efforts to increase academic achievement (Bosworth, 2000) and reduce misconduct at school (Simons-Morton et al., 1999). School connectedness can be modified via intervention. Evaluation of the Yale Child Study Center School Development Program found that if a program is well-implemented, sensitivity, caring, respect, and trust increase in the school, and this change is responsible, in part, for improved student academic performance (Comer et al., 1989). Improving school connectedness requires a focus on positive development rather than simply preventing bad outcomes. Two key developmental needs are caring support from adults and acceptance by peers. When these needs are met, young people learn to self-regulate and avoid risky behaviors and develop competences necessary for adulthood. [...]

School-Site Health Promotion for Staff. Blair and colleagues (1984) found that teachers who in Texas who participated in a 10-week health promotion program emphasizing exercise, stress management, and nutrition reported increased participation in exercise, improved physical fitness, lost weight, lowered blood pressure, higher levels of general well-being, and better ability to handle job stress. A study in Michigan found a staff wellness program responsible for a significant drop in teacher absences and a subsequent savings of approximately \$8,000 related to substitute teachers (Falck & Kilcoyne, 1984). [...]

In summary, the CSHP model has potential for improving students' academic performance and increasing healthy behaviors as well as preparing school-aged children and adolescents for their future of "making a living, and leading a healthy life" (Valois, Ory, & Stone, 1989).

/ Valois, R. F. Promoting Adolescent and School Health: Perspectives and Future Directions. *American Journal of Health Education*. Nov / Dec 2003; 34, 6, p. 320 - 322 /

Questions and Tasks

1. What does the Coordinated School Health Program offer?
2. What does the CSHP include?
3. Comment on the effectiveness of CSHP components. What advantages and disadvantages do you see in this model?

Future Directions: Micro Level

To sustain our current and previous efforts in child, adolescent, and school health, professionally we need to pursue a number of imperatives at the micro level. These include the following.

- There should be adequate time for staff development in health promoting procedures as compared to reading and mathematics.
- School health promotion needs to receive a fair share of staff development dollars and justify this funding via training for systemwide procedures such as school discipline and warning signs for health risk and problem behaviors.
- School health coordinators need to perceive themselves and behave as important and valuable „players“ in planning and implementation for health and academic success at school district level – not operating out of a scarcity mentality, but positioning health as a requisite.

- Reward school and community people for working in a CSHP. This is a process (not a n event) that takes time and perseverance. In turn, people need to be rewarded appropriately for sustained efforts.
- It is necessary to utilize research-documented, proven effective interventions aligned with objectives for improved health and academic performance.
- Eliminate disorganized, “one-shot“ and “vampire-type“ programs that give health education and health promotion a bad reputation.
- It is necessary to do a better job of finding the niche for school health in the context of school reform, treating school healthand CSHPs as systems change, rather than a program “add on.“
- Our training for school health personnel needs to parallel systems change over time by building the capacity to move the system to higher levels over time. [...]
- We need ongoing training, consultation, and technical assistance in CSHP at the local level.
- It is imperatyve that we focus on the “whole child / adolescent“ and begin convincing policy and decision makers to begin a movement away from high-stakes testing.
- We need to build coalitions of support, comprised of people who adequately represent “community“ and the components of the CSHP model.
- To be successful in the future, we will need to build bridges to the educational leadership community with a clear understanding that superintendents and principles are the gatekeepers of the local education system. [...]
- Interdisciplinary state teams that represent the components of CSHP need to be developed, sustained, and connected with local efforts for support and technical assistance.
- Relationships need to be established and sustained with the business community with the shared understanding that a healthy and academicallysuccessful child / adolescent has more value to a community than those who are not.
- We need to pursue funding from various sources in the community, stagger ourfunding to eliminate gaps in financial support, and avoid brokered situations.
- We should solicit support from civic organizations regarding our common missionof connectedness among schooland community organizations, for healthy kids becomong responsible and engaged citizens.

- Health educators need to get involved in the political arena. [...]
- The media should be challenged at the state, national, and local levels for more positive coverage on health-related topics associated with children and adolescents and successful school / community health education programs.
- Health educators need to get off the “treadmill of life“ at appropriate intervals, celebrate our successes, and socialize away from the workplace. It is imperative that we recharge our batteries, nourish our souls, and foster Professional and personal connectedness and “esprit de corps“.

/ Valois, R. F. Promoting Adolescent and School Health: Perspectives and Future Directions. *American Journal of Health Education*. Nov / Dec 2003; 34, 6, p. 324 - 325 /

Questions and Tasks

1. Which imperatives at the micro level do you consider most important? Why?
2. Translate the paragraph beginning with *It is necessary to utilize research-documented...*
3. Where can school health promotion receive support from?

HYGIENE

Personal Hygiene

The persons with Alzheimer’s Disease will be able to care for themselves in the early stages of the disease but may gradually begin to neglect themselves and may eventually need total help. Problems may arise in getting person to change clothes, bathe, brush teeth and groom self.

1. Dressing. Inappropriate Choice of Clothing or Lack of Interest in Dressing:

Possible Underlying Causes:

Confusion resulting from multiple choices; reduced ability to distinguish colors; depression / apathy; embarrassment, loss of independence.

Possible Modifications:

- Reduce choices in color and style and in matching tops and bottoms.
- Remove clothing that is seldom used.
- Arrange clothing by color and in a **sequence** to make decision-making easier.
- Provide a mirror in room for person to view self. If the person’s reflection is disturbing him / her, the mirror should be removed.

4. Dressing. Difficulty with the Mechanics of Dressing:

Possible Underlying Causes:

Memory loss; lack of coordination; difficulty remembering the steps; arthritis.

Possible Modifications:

- Provide clothing with elcro closings, front closings, large zippers and with few buttons. The use of pull-on, two-piece exercise suits or loose clothing are easy to handle.

5. Bathing. Resistance to Bathing:

Problems often arise in getting a person to take a bath because of decreased interest in personal hygiene or increased fears or phobia about water and bathing activity.

Possible Underlying Causes:

Resistance to bathing may come from embarrassment; fear of water; fear of getting in and out of bathtub; lack of interest; inability to remember how long it has been since last bathed; apathy; depression or loss of desire.

Possible Modifications:

- Arrange implements in order they are to be used: soap, washcloth and towel can be laid out in sequence.
- Check water temperature and depth of water in the tub. (Keep lower than normal levels).
- Try bathing products like bubble bath, gels.
- Remove lock on the bathroom door or deactivate.
- Post bathing schedule on calendar of daily events.

6. Bathing. Difficulty with Mechanics of Bathing:

Possible Underlying Causes:

Reduced strength and balance; fear of falling.

Possible Modifications:

- Provide grab bars and skid proof strips on bottom of bathtub or shower.
- Provide bath bench if difficulty in sitting or standing.
- Provide hand-held shower for ease in washing or long handled bath brush.
- Place towel on edge of bathtub for slippery hands.
- Use “soap on a rope” for ease in handling soap.
- If bathtub has a glass enclosure, consider removing it for easier access into tub.
- Make sure the floor is non-slippery. If a throw rug is being used, it should be firmly secured to the floor.
- Consider the use of wall-to-wall carpeting.

7. Grooming. Difficulty or Resistance:

Many personal care activities are complex and require a number of steps and therefore should be simplified to support the person's functioning level. Reduced coordination and / or chronic limitations (e.g., arthritis) may also affect the person's ability or interest in grooming. Personal care related to putting on makeup, brushing hair, oral hygiene, nail care and shaving may require the assistance of the care giver as the person may not have the motor skills or memory to carry out these activities.

Possible Underlying Causes:

Lack of motor skills, confusion as to sequence of task; depression; embarrassment.

Possible Modifications:

- Keep bathroom area uncluttered and simple with only necessary items left out.
- Lay out all implements in sequence (e.g., brush, comb, mirror).
- Place simple instructions next to bathroom mirror outlining steps. You might also put a picture of procedure next to direction (e.g., for brushing hair, a picture of person brushing hair).
- Install telescoping magnifying mirror to make viewing easier.
- If person has problem gripping or using grooming products because of arthritis or limited strength, there are many aids available that provide a better grip or reduce the need to twist or bend (e.g., comb that bends).

/ <http://www.homemods.org/library/carhom/part8d.htm> /

Questions and Tasks

1. Find the interpretation of *Alzheimer's Disease* in the *English-Lithuanian Dictionary of Special Education*.
2. What do you think might be the most difficult in caring for themselves for the persons with *Alzheimer's Disease*?
3. In what cases is the caregiver's assistance indispensable? Why?

A Point of School Hygiene (Abridged)

The subject of postures in schools is one of such grave moment that it is advisable to draw the attention of parents to the question, which for several years now has engaged the powers of medical experts and teachers. So many of our children, more particularly the weakly and delicate ones, emerged from school life with spines permanently or otherwise deformed, and with the eyesight seriously injured, that both parents and teachers, but more especially surgeons and oculists, were roused, and not only roused but alarmed, so that investigations were at once instituted, which investigations have finally culminated in the latest pronouncement by the recent International Congress of Hygiene, held last August in London. [...] The question of postures has naturally an almost exclusive

reference to the positions assumed and taught in the writing class. So much work in school is done with the pen and pencil (sometimes half as much or three-fifths) that the attitude which is maintained during these exercises becomes a potent force in the physical development of the children. [...]

The ever-increasing employment and importance of hand-writing is a cause of continual surprise. There is no occupation of life above the merely manual tasks of day-labourers into which writing does not enter. We cannot exaggerate its importance, notably in the departments of law, commerce, civil service, science, and individual as well as international correspondence. [...] Calligraphy has not been studied with reference to the writer, but on absolutely independent grounds. To give a typical example, all writing was originally, and down to comparatively modern date, vertical; but the fashion of a sloping and semi-illegible hand was introduced for reasons actually absurd in themselves; a mere sentimental and vitiated taste suggested the change, since the sloping writing favoured the style of ornamental flourishing which was the rage at that time, whilst the upright, by its very nature, discountenanced and deprecated any attempts at useless and ornate embellishments. Indeed it is only within the past few years that any physiological requirements have been recognized, and even now hardly one teacher in fifty would admit any connection between hygiene and handwriting, so defective is education on this matter. That physiological and hygienic principles should be an integral part of any system of penmanship goes without saying; but it is still more remarkable that when the subject of school postures first occupied the attention of the medical faculty, the real root of the malady was never, for one moment, suspected. Investigators informed us that it was the instruction which was inferior – want of proper supervision and correct teaching. This explanation proving unsatisfactory, the “light” was attacked, and a canon law was established both for sufficient and properly directed light. Still no signs of improvement so far as the maladies concerned. A further flood of light then seemed to burst upon the experimentalists, and the evil was unearthed. Ill-constructed desks and seats were of course the sole origin of all the mischief, and we had a furore of hygienic and adjustable desks and forms. The old, cumbrous, and killing instruments of torture have disappeared and made way for excellently constructed desks of a truly scientific and hygienic kind. The teachers received a stimulus from the reflections cast upon them; school buildings have been modified and built upon sound principles with regard to the disposal of light and the arrangements of windows; and, school furniture for the accommodation of writers has been brought to a point of excellence bordering on absolute perfection. Still the children sat upon the new benches approved by the faculty just as badly as upon the old.

Last of all the position of the book was assailed. Medical experts were at a loss to account for the crooked postures, and thought possibly an oblique position of the book might avert the twisting position of the writer. Alas! No! [...]

The slant or slope of the writing itself necessitated all this twist, contortion and pain. Experiments on a large scale have been made, evidence of a most voluminous and unmistakable character given, and the concurrent testimony of medical and educational specialists states that sloping writing demands the side or twisted position (as one

authority on handwriting prescribes it, a position of 45° to the desk) of the body, a corresponding twist of the neck, distortion of the spine, displacement of the chest, and a very unequal action of the eyes. No wonder writing of the age is so miserably illegible when it has to be practiced under such cruel conditions and disqualifying abnormalities.

Notwithstanding that men of the highest eminence in their profession declare and repeat in the most emphatic and dogmatic language that "no postures of young people assumed in the sloping writing are one of the chief factors in the production of spinal curvature;" that these postures of sloping writers are "without doubt recognizable as one of the most frequent causes of crooked growth;" that the sloping writing is "a prolific cause of short sight;" the great mass of teachers remain entirely oblivious, and continue their suicidal and pernicious practice with the oblique penmanship, apparently indifferent to the irreparable damage they are inflicting upon the juveniles committed to their care. [...]

Vertical writing must resume its ancient sway. ... the absolute superiority of this method of writing over all other methods must be recognized; that it is much to be preferred to oblique writing, and it strictly fulfils all hygienic requirements. Vertical (or as our continental brethren call it, steep) writing demands only one position, and that "the normal". Instead of the side posture we have the square or strait posture, securing an identity or parallelism of the facial and chest planes, no twist of the neck or the wrist, no compression of the chest, and no unequal strain upon the eyes. The writer sits evenly and strait before his desk, with both arms leaning equally thereon, the eye looks directly down upon its task, the hand, wrist and arm are in the best and easiest position for a running handwriting, the body is not in the least distressed by any artificial posing, the spine is normal, the chest is unrestrained by undue leaning forward, and the work of writing is proceeded with under conditions of hygiene and ease, the most favourable and perfect possible. But the hygienic superiority is also seen in the educational advantages which vertical writing possesses. [...]

If we contemplate the ease in both teaching, acquiring, and writing the vertical style, its hygienic advantages and immense superiority are clearly apparent. In these respects it has, in every possible way, relation and test, justified its claims to the highest hygienic principles. Parents should investigate the interesting question for themselves. A couple of evenings of quiet reading will supply all the arguments and facts necessary for a complete apprehension of the whole matter. So far as the evidence from teachers has been collected and collated, there is but one issue undisturbed by a single dissentient. Briefly summarized, it shows that whatever introduced, vertical writing (A) enkindles a greater interest in the art both with teachers and pupils; (B) entails much less labour in teaching; (C) greatly increases the rate of progress; (D) develops a much greater command of the pen; (E) secures a much higher standard of excellence; (E) increases materially the speed of the writer; (G) avoids every undesirable and injurious posture; and (H) entirely averts all and any of the unhealthy and deplorable consequences resulting from the practice of sloping or oblique penmanship. Surely the eyes of our teachers will speedily be opened to their true position and interests in this controversy. If medical evidence, if theoretical demonstration, if practical proof, separately and collectively, fail to convince the

skeptical and indifferent amongst the ranks of our teaching profession, I would appeal to parents and say, let your voices be heard. You are deeply affected for good or evil in this question. Claim to have a vote in the movement, demand for your children that they be given safe and sound and healthy instruction; not that of style or system as contrary to, as it is inimical to health, and, on the other, to a prejudice or unconcern as dishonourable in the teacher as it is dishonest to his charge. It may encourage our parents to learn that the movement is progressing on the Continent with wonderful rapidity.

The Supreme Council of Health in Vienna has declared emphatically in favour of upright penmanship. At Lubeck, a resolution in its favour has been passed by the large association of teachers there.

The Bavarian Government introduced the style into some of its schools in 1888, and the system is being widely adopted in the schools of Berlin, Leipzig, Hamburg, Frankfurt, Hanover, Karlsruhe and other cities. In Flensburg the steep writing was adopted (1888) and now about three-fourths of the pupils in that city write vertically (Dr. Scharff, 1891). [...]

So that whilst the leading Educational Governments and bodies on the Continent are agitating the question, we at home, both teachers and Government (saving an enterprise by the writer, started about 1886) are utterly oblivious to the danger and to our duty alike.

When the highest, when the supreme and only authorities have finally, explicitly and categorically declared by unanimous resolution, "That the hygienic advantages of vertical writing have been clearly demonstrated, and established both by medical investigation and practical experiment," and that "it is hereby recommended that upright penmanship be introduced and generally taught in our elementary and secondary schools," surely it is time for us all to join the crusade and enlist our powers in the promotion of that system of handwriting which is at once easiest to read, write, learn and teach, and which in every aspect possesses a monopoly of merit and advantages, hygienic, educational and practical. [...]

/ Page updated 7/10/2004.
<http://www.amblesideonline.org/PR/PR03p031SchoolHygiene.shtml> /

Questions and Tasks

1. Why is the problem of postures in the writing class so important?
2. What styles (?) of handwriting are discussed in the article?
3. What measures have been used to improve pupils' postures while writing?
4. Point out and comment on the advantages of vertical writing emphasized by the author.
5. What do you think: is it worth trying to introduce vertical (steep) writing in our schools? Give your reasons.

MENTAL HEALTH PROMOTION

Physical Activity and Mental Health

Self-acceptance ‘I feel totally at one, totally alive and totally happy’

Respondents understood mental health as self-acceptance within the scheme.

Self-acceptance focused on respondents’ acceptance of themselves, their health and social status, and life situation and provided respondents with self assurance or confidence:

Out on the bike I feel at one with the whole of life and the whole of creation [self-acceptance]... I feel that that is the extreme of what a human being can feel in pleasure and in being alive. I just love life and when you use everything, your body and your mind, to achieve the best then you get the best feeling. [Mary]

Properties of this theme included the act of participating in physical activity and the realization that participation was achievable. These provided both self-acceptance and inner contentment:

When I go out on a bike some moments... I sweat and physical things like that but the greatest moments are those moments when I feel totally at one, totally alive and totally happy. [Mary]

Other properties include the challenge of mentally persuading the body to undertake a physical task, the dimensions of which included a number of stimuli and experiences, both cognitive and visual, and provided self-assurance:

Paula: We were walking up cliff faces which was really enjoyable... when we got onto the height bit well the wind just blew you off, and you had to hold on to one another because it were blowing you and there was a big drop.

D. C.: How did that make you feel?

Paula: Ahh, Brilliant.

The remaining property was their perception, which improved over time, that physical activity was ‘age appropriate’ behavior: ‘... and finding other women my sort of age and shape and size and things; that it wasn’t all you know leotard slim fits’ [Alison]. The degree of self-acceptance (i.e. the dimension of the theme) was dependent on time in the facility, the inclusive nature of the scheme, self-efficacy, body image perceptions and feeling comfortable. [...]

Discussion

The conceptual framework explains the experiences and understandings of the social world of respondents on exercise referral schemes with respect to the physical activity and mental health relationship. Respondents report mental health benefits which are conceptualized into the core category, self-acceptance. Self-acceptance focused on respondents' acceptance of themselves, their health and social status, and life situation, and provided respondents with self-assurance or confidence. Whilst self-acceptance has not been reported elsewhere in the physical activity and mental health literature, other themes and properties, such as social support, social norm and social interaction, are supported by qualitative work (Faulkner and Sparkes, 1999; Hardcastle and Taylor, 2001; Stathi et. al., 2004). The framework reinforces these and other findings [...] that show the importance of social constructs to mental health. By providing a framework, however, it develops previous research by providing a model of the psycho-social aspects of the phenomenon and their interrelationships that exist for positive mental health experiences to occur for participants on exercise referral schemes.

Fontaine (2000), Biddle and Mutrie (2001) and others have suggested that the mechanism responsible for the physical activity and mental health relationship lies in a combination of biological, psychological and social factors. Self-acceptance is affected by a number of factors, not solely the exercise *per se*, but the contexts in which people's experiences are embedded. This study has empirically demonstrated that the context related factors of social network, environment, culture and social support aspects of such schemes are influential and interrelated. [...]

Exercise is often seen as a means of changing people either to meet an aesthetic ideal (i.e. before and after) or to achieve a physical fitness or health goal (e.g. losing fat). The findings from this research emphasize the importance of the experience of exercising itself, irrespective of the outcomes it may lead to. It also demonstrates how exercise referral schemes can make people comfortable with who they are now, not with who, or what, they may become in the future. [...]

/ Crone, D., Smith, A. and Gough, B. 'I feel totally at one, totally alive and totally happy': a psycho-social explanation of the physical activity and mental health relationship. *Health Education Research*. Vol. 20, no. 5, 2005, p. 604; 608-609 /

Questions and Tasks

1. Explain the concepts *mental health* and *self-acceptance*.
2. What was the degree of self-acceptance dependent on?
3. What did self-acceptance focus on?
4. What have Fontaine, Biddle, Mutrie and others suggested?
5. How is exercise often seen?

Social Ties and Mental Health

Modifiers of the relationship between social ties and mental health

The costs and benefits of social ties are not randomly distributed in the population, but vary systematically with gender, socioeconomic position, and stage in life. Certain stages in the life course are clearly critical in terms of social relationships. Thus, emotional support during childhood from parents or caregivers has been shown to influence the risk of subsequent depression. Attachment in early life is critical to psychological development. At the opposite end of the life course, social isolation and loss of social ties are among the most potent predictors of depressive symptoms among the elderly. On the other hand, social support received from children can paradoxically reinforce a sense of dependence in the elderly, thereby undermining self-esteem and leading to feelings of helplessness. We suspect that social support can either promote a sense of self-efficacy and self-esteem or become “dis-abling” by reinforcing dependence; therefore, social support can have “mixed” affects.

An important new area of research relates the impact of social networks and support to cognitive function among the elderly. Over the last 5 years, three studies have shown that social participation, social engagement, or social networks have predicted dementia or cognitive decline in men and women over the age of 65 years. All of these studies were longitudinal and controlled for baseline cognitive function. While this does not preclude that social withdrawal is in some way a prodromal symptom or marker of early decline, the strength of the study designs and the magnitude of effect size are intriguing.

The effects of social ties on mental health differ also by gender. It has been widely documented that women report significantly higher rates of psychological distress than men, a finding that may be partly explained by gender differences in social network involvement. Summarizing these gender differences, Belle (1987) observed that women tend to (1) maintain more emotionally intimate relationships than men, (2) mobilize more social supports during periods of stress than men, and (3) provide more frequent and more effective social support to others than do men.

With regard to the first observation, women’s propensity for intimate social involvements may predispose them to the “contagion of stress” when stressful life events afflict those to whom they feel emotionally close. In other words, women suffer more from other people’s problems. [...]

With regard to the second observation that women tend to mobilize more support than men during periods of stress, research has established that widowhood is consistently more damaging to the mental and physical health of men than of women. This finding has been attributed to the fact that men’s mobilization of support is heavily focused on their spouses, whereas women are more likely to rely on a child, close relative, or a friend as their confidant. Interestingly, among couples, supportive aspects of the marital relationship (e.g., satisfaction with spouse, spouse as confidant) appear to be much more strongly linked to the mental health of women than of men. This may reflect the fact that

gender inequalities in domestic relationships – for example, household authority and bargaining power with respect to access to financial resources – result in women being more exposed to the vagaries of their partners' support.

Third, the finding that women tend to provide more frequent social support than men can result in what Belle (1987) termed the “support gap”. In dyadic relationships, when the flow of support is highly unequal between women and men, the result may be demoralization and depression. [...]

/ Kawachi, I. and Berkman, L. F. Social Ties and Mental Health. *Journal of Urban Health: Bulletin of the New York Academy of Medicine*. Vol. 78, No. 3, September 2001, p. 460-462 /

Questions and Tasks

1. What is the influence of emotional support and attachment during childhood?
2. How can social support received from children influence the elderly?
3. Explain why social support can have “mixed” effects.
4. What did Belle summarizing gender differences observe?
5. Do women suffer more from other people's problems?
6. What has research established about (?) widowhood?
7. What can the finding that women tend to provide more frequent social support than men result in?

Social Support Interventions to Improve Mental Health

[...] Some successes have been described in the intervention literature. These interventions have taken the form of support group interventions, one-to-one support interventions, or interventions to enhance natural networks. Mittleman and colleagues (1995) applied a multifaceted intervention to reduce depressive symptoms among 206 spouse caregivers of patients with Alzheimer's disease. The intervention included six sessions of individual and family counseling, followed by attendance at a support group that met for an indefinite period of time. The counseling sessions targeted communication between family members and taught techniques of problem solving for the caregiver. Caregivers in the intervention group were less depressed than those in the control group 8 months after the study began. Due to the multifaceted nature of the intervention, however, it was difficult to determine which component of the intervention was beneficial.

In an example of a one-to-one support intervention, Harris et al. (1999) randomly placed women in inner London with chronic depression to volunteer befriending. A statistically significant effect on remission of symptoms was found after 1 year for the intervention group compared to wait-listed controls.

In some cases, investigators have sought to train individuals to elicit more frequent or higher-quality support from their existing networks. For example, Brand et al. (1995) recruited 51 adults with low perceived social support from organizations for singles and from divorce and bereavement support groups. Individuals were randomly assigned to a cognitive-behavioral intervention to address cognitive and behavioral barriers to forming rewarding interpersonal relationships. Participants in the intervention experienced significant increases in perceived family support, although not perceived support from friends. Symptoms of anxiety and depression were also unaffected by the intervention.

From the foregoing examples, it is evident that there are significant variations in the design, duration, timing, and types of social support intervention, such that few generalizable lessons can be gleaned from the existing literature. [...]

/ Kawachi, I. and Berkman, L. F. Social Ties and Mental Health. *Journal of Urban Health: Bulletin of the New York Academy of Medicine*. Vol. 78, No. 3, September 2001, p. 460-462; 464 /

Questions and Tasks

1. What forms have social support interventions taken?
2. Which of the described social interventions do you consider the most effective? Why?
3. Explain the phrase *rewarding interpersonal relationships* in your own words.

Meaningful Activities Help Keep Older Adults Healthier and Happier

Depression does not go hand-in-hand with aging. In fact, older people who are able to stay engaged in day to day living and find simple joys to fill their days can go a long way avoiding the debilitating effects of depression.

According to Dr. Kathie Bates, associate professor of psychology at Argosy University / Tampa, "Positive activities and experiences for older adults should be part of each day, and they can be as meaningful as enjoying bird watching outside the window, to more fulfilling pastimes such as finishing a craft or household project." The key, says Bates, is to accomplish small tasks successfully and put aside more difficult ones until they no longer seem so challenging.

The best way to find out what makes an older adult happy is to be a good listener. "Listening to the person's concerns and providing support rather than advice or ultimatums generally has a more positive influence," she emphasizes.

Dr. Bates believes that listening includes identifying what an older adult is concerned about as well as what he or she would like to be doing to feel better, rather than imposing a family member's ideas and values on the person. For example, an individual who has

led a rather solitary life is more likely to respond to an offer to pick up a book on tape for him or her rather than take them to a senior center for bingo.

As adults age, they experience a loss of roles (for example, being the mother or father), loved ones, and sometimes physical capabilities. Where there are these losses, there is often understandable sadness. However, says Dr. Lynn Horne-Moyer, director of clinical training and associate professor at Argosy University / Atlanta, “Most older adults adjust to these difficulties relatively quickly.”

When older adults do become depressed, they often express it differently than younger adults. They may complain of fatigue or lack of interest in usual activities rather than displaying tearfulness or crying. For these reasons, depression is often under-diagnosed because its symptoms can overlap those of other illnesses that become more common in late life.

The most common signs of serious depression, points out Dr. Horne-Moyer, are sadness, irritability, hopelessness and worthlessness, dropping favorite activities or a preoccupation with death. All of these, she explains, should be treated very seriously and aggressively, with a mental health professional contacted immediately.

Unfortunately, many older adults feel that there is a stigma attached to seeking health – even through support groups. According to Dr. Bates, mental health services designed solely for older adults are rare, which may further discourage them from seeking help.

For mild levels of depression, psychotherapy or support groups, or both together, can help in avoiding the need for medication. Once the depression symptoms reach a severe level, medication is often needed.

There is some research to suggest, she adds, that the way in which older adults cope with the challenges of aging may be the best predictor of how susceptible they will be to depression. Individuals who stay flexible and adapt to their changing needs will fare better. In fact, positive planning for retirement, which includes activities and interests to focus on, as well as staying an active and involved member of the community, can be very beneficial to healthy aging.

With the right support systems in place, most older adults can find considerable joy and satisfaction in this new stage of life. Following are several recommendations for helping older adults live happier and healthier lives:

- Family connections are critical for most adults, including a spouse, children and siblings. Extended family plays a more vital role in minority families, with more help provided by elders and for elders within the family.
- Physical activity / exercise has been shown to be helpful in combating depression for those who were able to do so. A medical doctor should always be consulted before beginning any exercise program.
- Avoid excessive television viewing.

- Local agencies on aging are a good source of information for older adults and their families. They can provide lists of resources available for at-home care, food delivery and companionship. In addition, there are local senior centers, hospitals and wellness centers.

/ The Lion. December 2005 / January 2006, p. 16-17. Courtesy of ARA Content /

Questions and Tasks

1. What can help make older adults healthier and happier?
2. What roles do older adults lose?
3. Find the interpretation of *depression* in the English-Lithuanian Dictionary of Special Education and compare it with the most common signs of the illness pointed out by Dr. Horne-Moyer in the article.
4. How do often older adults express depression?
5. What can be very beneficial to healthy aging?
6. Which recommendations offered in the article do you find most effective? Why?

Make Friends with Good Health

Who you know can have a big effect on how you feel

People with strong social networks tend to be in better health, many studies show. In fact, social ties may be just as important for decreasing the risk of heart disease, cancer, and premature death as eating nutritious foods and getting to the gym.

There are a number of possible reasons for this. It may be that people who inherit a social disposition also have other health-positive genes. But mounting evidence suggests that social ties and the support they provide may have a direct influence on health. On the most obvious level, people who care may encourage loved ones and friends to avoid tobacco, alcohol, illegal drugs, and other risky behaviors – and to get to the doctor promptly when a symptom crops up. Having a sympathetic ear to tell your troubles and triumphs to may also increase your ability to handle stress – a contributing factor to many types of disorders. Among other things, stress can dampen the immune system’s ability to fight off disease.

Feeling part of a *community* may also help to combat the negative pressures of modern life. A recent survey of more than 21,000 American adults found that weekly church attendance was associated with seven years of longer life expectancy for white Americans, and 14 years for African-Americans, even when other differences in social, economic, health, and lifestyle indicators were taken into account.

What exactly is social support? The MacArthur Foundation study of successful aging defines it as a person's belief that he or she is cared for, loved, esteemed, and a member of a network of mutual obligations. "Like many truths about human life, this one has been discovered and rediscovered many times," notes the MacArthur study authors. While there are undoubtedly a few long-lived hermits, for most people positive human contact is a crucial factor in a healthy, lengthy life.

Social contact and longevity

Social isolation has been shown to contribute to a higher risk of alcoholism, arthritis, depression, heart disease, suicide, and other physical and emotional problems. At any age the risk of death is two to four times greater for the isolated than for socially connected people, even when such factors as race, socioeconomic status, physical health, smoking, use of alcohol, physical activity, obesity, and use of health services are accounted for.

For example, a study of 7,000 Alameda County, Calif., residents measured social interaction by marital status, friendship, religion, and volunteerism. The results: people who lacked those types of relationships were two or three times more likely to die during the nine-year study period. "We found that people could meet their social needs by making all kinds of relationship substitutions – friends, relatives, participating in volunteer groups – and still see a protective effect," explained lead researcher Lisa Berkman, Ph.D., a Harvard School of Public Health epidemiologist. "The key was to be socially integrated ... embedded in society."

What then, comprises a healthy network of social contacts? The average person reports a network of 8 to 11 members. The number varies somewhat by age: those from 35 to 50 tend to have slightly larger social circles than those younger or older. While the number of people stays fairly stable over a lifetime, there are losses and replacements, forming what the MacArthur Foundation study of successful aging calls a "convoy of social support" over a lifetime. [...]

/ *Consumer Reports on Health*. December 1999. Vol. 11. No. 12, p. 8 /

Questions and Tasks

1. Disclose the meaning of the concept *social networks*.
2. Why social ties may be so important?
3. What factors may increase one's ability to handle stress?
4. What did a survey of more than 21,000 American adults find?
5. What is *social support*?
6. What can *social isolation* contribute to?
7. What were the results of the study in Alameda County?
8. What comprises a healthy network of social contacts?

HEALTHY EATING AND HEALTHY WEIGHT

Healthy Eating Project

Between 1997 and 2001, four schools (two secondary and two primary) participated in healthy eating project as part of the European Network of Health Promoting Schools (ENHPS). The aim of the project was to develop innovative ways of promoting healthy eating in the school setting, using the health promoting school model as a framework for implementation. Thus, as well as having a behavioral focus, the project emphasized the importance of addressing broader organizational and environmental factors to ensure a consistent approach across the school and facilitate healthier choices. The project was evaluated by researchers at Edinburgh University.

Development Process

As baseline needs assessment was undertaken in each school to identify key issues in relation to food provision in school, eating behavior, attitudes towards healthy eating, psychosocial health, body image, physical activity, ethos and the school environment. Findings from the needs assessment were used to inform planning and development of school-based healthy eating initiatives. Schools were encouraged to adopt a collaborative partnership approach involving a range of individuals and agencies with an interest in school nutrition, such as school management, staff, pupils, parents, caterers, and local health and education professionals.

A range of initiatives was undertaken to promote healthy eating, physical activity and self-esteem and to improve the physical environment of the school. Examples included: installing healthy vending machines, promoting healthy snacks, providing drinking water, establishing a School Nutrition Action Group and pupil councils, promoting playground games, setting up “buddying / mentoring schemes, installing music systems in the dining halls, and redecorating staff and pupil toilets.

Conclusions

- School staff reported that they had enjoyed participating in the project and felt that it had led to a greater understanding of the health promoting school. They also reported that the project had resulted in many positive changes within their schools.
- No measurable changes in overall eating patterns were observed but this was not surprising given the broad and diverse nature of the initiatives undertaken. However, within individual schools, some positive changes were reported such as increased awareness of healthy eating, high usage of healthy vending machines, and increases in healthy snacks and fruit consumption.
- Working in partnerships between schools and catering providers enhanced the opportunities to promote healthy eating and ensure that the food provided in the canteen or dining hall was consistent with nutrition education in the classroom.

- The success of the project often relied on the commitment and enthusiasm of a key member of staff. However, it was recognized that over-reliance on one member of staff could stretch the personal resources of that individual and affect the sustainability of the project in the long term. A broader resource base and good communication among staff are therefore essential to a whole-school approach, but lack of time and teacher workloads are barriers to achieving this.
- The support of the head teacher or another member of school management was essential.
- The sustainability of initiatives was improved where the project build on existing good practice and where it was linked to ongoing developments and priority areas within the school.
- In response to identified needs, a training manual, *Confidence to teach*, is being prepared to support teachers in the upper primary and early secondary stages in addressing the complex issues around healthy eating and related psychosocial issues.

/ Inchley, J. Healthy eating project. *Network News. The European Network of Health Promoting Schools*. 2002. 7th Issue, p.4 /

Questions and Tasks

1. What project did four schools participate in?
2. What was the aim of the project?
3. Describe the baseline needs assessment undertaken.
4. What initiatives were undertaken to promote healthy eating?
5. What did school staff report?
6. What did the success of the project often rely on?

Healthy weight for adults

The UK population is getting fatter, with levels of obesity tripling since 1980. Over half of women, and around two-thirds of men are now either overweight or obese.

The main explanation for this is a change in our diet and life styles. High calorie food is cheap, well advertised and constantly available. Meanwhile, heavy work in industry and agriculture has mostly been replaced by sedentary activities in service industries. And increased use of cars, computers and labour-saving devices have cut the amount of physical activity in the daily routine.

The risks of being overweight

Being overweight increases the risk of health problems including heart attack and stroke, diabetes, bowel cancer and high blood pressure. Excess weight also makes arthritis more likely and can make breathing and sleeping difficult.

The risk of health problems increases the more overweight you are.

Causes of obesity

A calorie is a unit of energy. We take in calories when we eat and drink, and burn them up in daily activity. When the amount of calories taken in from food and drink equals the amount burnt off through physical activity, body weight remains roughly stable. The cause of obesity is consistently eating more calories than are burnt off.

Obesity does run in families, and the tendency to put on weight is greater in some people than in others eating a similar diet. However, it is likely that family eating and activity habits are a more important cause of obesity.

Guidelines for a healthy weight

The most common benchmark of healthy weight for adults is based on height and weight, and is called body mass index (BMI).

BMI acts as a good indicator of the total amount of body fat and a reliable predictor of the likelihood of disease associated with being too heavy (or too light).

BMI is calculated with the formula:

$BMI = \text{weight (in kg)} \div \text{height (in m)}^2$???

To work out your BMI, divide your weight in kilograms by your height in metres, and then divide the figure you get by your height again.

Understanding your BMI

Underweight – BMI less than 18.5

Some people in the underweight category (BMI under 18.5) are naturally lean and healthy. But being underweight can also be bad for your health. If you are in the underweight category and have been restricting your diet, you should aim to gain weight and get back into the normal weight range for your height. If you are finding it difficult to put on weight, or you lose a lot of weight rapidly, you should see your doctor.

Healthy weight – BMI 18.5-25

If you are in the normal category (BMI 18.5-25) for your weight and height, you should aim to maintain your weight through a combination of healthy diet and physical activity. Don't be tempted to try to get into the underweight category.

Overweight BMI – 25.0-30

If you are in the overweight (BMI 25-30) category you should concentrate on not gaining any more weight. Try to cut down on sugary and fatty foods and on the amount

you eat to get back into the normal weight range for your height. Increasing your levels of physical activity will help.

Obese – BMI 30.0-40

If your body mass index is obese (BMI 30-40) or morbidly obese BMI over 40) then your risk of health problems is high. It is important that you try to lose some weight and should consider asking for help from your doctor.

Limitations of BMI

BMI doesn't apply to everybody. If you have a lot of muscle, you may have a BMI over 25 but very little body fat. Similarly, if you have very little muscle, you may still have too much body fat, even though you are in the correct weight range for your height.

If you suspect this is true for you, then looking at your body shape and body composition can be useful.

Body shape

Where the fat is stored on the body relates to the risk to health. Carrying fat around the middle of the body, giving the body an apple shape, is a greater risk to your health than carrying it around the bottom and thighs, which gives a pear shape.

Measuring your waist gives a rough guide to whether you need to lose some weight. The at-risk waist measurement is 102 cm for men and 88 cm for women. If you are under 150 cm tall, a smaller measurement will apply. Ask your GP or practice nurse for advice if you are worried about your weight.

Body composition

Measuring how much of your body weight is made up of fat can be a useful way of monitoring your weight. Your local gym or leisure centre may be able to arrange a body composition test. The usual methods of measurement are using skin fold calipers or an electronic monitor, which passes a painless electric current through the body.

Experts don't agree on what percentage of body fat is healthy and it varies depending on your age and sex. The maximum should be 35% fat for men and 40% for women.

How to be a healthy weight

In order to lose weight, you need to burn more calories through physical activity than you take in from food and drink. This means tipping the "energy balance" by eating fewer calories, burning more of them off or, preferably, combination of both of these.

If you have a lot of weight to lose, it is better to set a realistic medium-term goal, rather to lose 50 kg. Doctors often suggest a 10 percent weight loss to begin with, achieved over about six months. You should do this by tipping the energy balance. Then, once you've managed this, look again at setting a new goal. At this level, you may already have reduced many of the risks to your health and your blood pressure, blood sugar and cholesterol is likely to be lower. You may feel and look better too.

Choosing a diet

Some diet programs and adverts promise a “quick fix” of rapid weight loss. These are often unscientific, and may be harmful. The challenge is not just getting to, but maintaining a healthy weight in the long term. Avoid crash diets and fad diets if you want to follow an organized diet program, look for one that:

- only promotes weight loss of 0.5-1 kg a week – any more than this and you'll be losing water and muscle, not fat
- encourages you to follow the guidelines for healthy eating – a balanced, varied diet that incorporates all major food groups
- is realistic and flexible enough so that you can stick to it – no extreme and no blanket bans on certain foods
- encourages your everyday life to be more physically active
- helps you to learn new lifestyle habits and ways of thinking about food, so you can maintain your target weight once you have reached it.

Making your own changes

You can also lose weight by making your own adjustments to your daily diet and exercise patterns. The best way for most people to lose weight is to combine more physical activity with a diet that is lower in calories. In general you should aim to reduce the “energy balance” by 500-1000 calories per day. If you are unsure about the different calories content of foods and meals, a number of dieter's recipe books are available.

Tips for controlling calories

Keep a food diary for a week, writing down everything that you eat and drink. People who are overweight often don't realize how much they are eating.

Use your food diary to find ways of cutting down calories. For instance, you could cut 500 calories per day by changing the balance of foods on your plate, e.g. less cheese and more salad with your dinner. Or you could cut out a regular snack food and replace it with a piece of fruit.

Don't forget that drinks count towards your daily calorie intake. Alcohol is high in calories – three pints of beer could add up to 600 calories. Sugary drinks should also be limited. A can of cola contains 135 calories, but apart from the energy it has virtually no nutritional value.

Aim to 30 minutes of moderate physical activity on most days of the week. Moderate activity is where you feel slightly warm and out of breath – brisk walking is ideal and burns approximately 150 calories. Try to make this part of your routine. For example, take the stairs at work instead of the lift, and walk to the shops instead of taking the car. A longer session of lower-intensity activity is also good for burning fat. Could you walk at least part of the way to work every day?

Medical help

There are currently two medicines that your doctor can prescribe to aid weight loss in combination with a low calorie diet. These are generally only prescribed for people with BMI 30+, or BMI 28+ if there are other health risk factors such as diabetes. For severe obesity, surgery to bypass the stomach or to make it smaller, may be an option as a last resort.

/ Published by BUPA's Health Information Team, September 2003 /

Questions and Tasks

1. What are the causes of the British population getting fatter?
2. What are the risks of being overweight?
3. What is the main cause of obesity?
4. How is BMI calculated?
5. What is the BMI of a healthy weight?
6. What is a greater risk to your health: giving the body an apple shape or a pear shape?
7. Explain how you understand the concept *body composition*.
8. Why should one avoid crash and fad diets?

SUPPLEMENTS

Promoting staff health and wellbeing – a case study (Abridged)

Aim

In Sefton, a partnership between health education and LEA officers encouraged a two-pronged approach to the promotion of staff wellbeing in schools. The strategy centered on the need to support the development of whole-school approaches to issues such as stress management, assertiveness and team building, and to address concerns over staff absences and employer's liability. In addition, information from the occupational health service suggested that staff were seeking counseling help too late, which impeded the chance of success.

Action taken

Health professionals, school nurses, local authority and education staff and representatives from the independent sector formed an alliance to build a climate of change. The group encourages school staff to take up mind and body activities, such as tai chi, Alexander technique and relaxation. Leisure clubs are being promoted where staff can exercise and swim, and counselors are linked to this training to provide individual support for staff.

A series of training events, consultations and analyses of best practice resulted in the production of policy guidance and indicators, which are promoted on the Sefton LEA Web site www.pshe.org.uk. Schools are advised to include staff personal development in their School Improvement Plans. Staff appraisal is supported and assessed by the Healthy School Scheme. The LEA personnel department is working with external consultants to examine life-balance approaches and specific projects are now being developed. A further alliance between the Merseyside Health Action Zone, The local health authority and the council (local government) is providing support for staff around health concerns such as smoking. Counseling courses are offered and a pilot program to check staff has been started in several schools. There are also plans to promote the work in presentations to school governors.

Examples from practice

At the Holy Rosary Catholic Primary School, a staff health and wellbeing policy is being developed through team-building days, tai chi and supportive relationships. Several staff are trained in counseling skills and a deputy has taken responsibility for monitoring policy and practice.

At St John Bosco Catholic Primary School, similar activities take place at regular evening sessions where parents also join in. The school has trained its staff in counseling skills and also refurbished its staff room. This has been promoted as part of a healthy school video.

Both schools are monitoring staff absence rates and the staff report their appreciation of the opportunities they are being given.

Findings from the Sefton experience

- The development of this work needs to take place in a supportive climate.
- Alliances are crucial, particularly with LEA personnel departments.
- Plenty of practical opportunities should be available for schools and staff to access and use.
- The sharing of practice is valuable for normalizing expectations.
- Integrating practice into school planning and into implementation and review systems will help sustain good practice.

- School leaders who are models of good practice are also significant.

There is growing evidence to suggest that schools are now proactive in responding to staff health and wellbeing. Indeed there are expectations that an effective school will clearly demonstrate how it values staff. The challenge now is to sustain and build on these initial efforts.

/ Network News. *The European Network of Health Promoting Schools*. 7th Issue. 2002, p. 32-33. [www.wiredforhealth.gov.uk /](http://www.wiredforhealth.gov.uk/)

The UKPHA Mission

Our mission states that through our members, activities and co-operation with others, we aim to be a unifying and powerful voice for the public's health and well being in the UK, focusing on the need to eliminate inequalities in health, promote sustainable development and combat anti-health forces.

UKPHA Definition of Public Health

Different organizations have different definitions of public health. At the UKPHA we believe that public health:

- is an approach that focuses on the health and well being of a society and the most effective means of protecting and improving it.
- encompasses the science, art and policies of preventing illness and disease and promoting health and well being. It addresses the root causes of illness and disease, including the interacting social, environmental, biological and psychological dimensions, as well as the provision of effective health services.
- addresses inequalities, injustices and denials of human rights, which frequently explain large variations in health locally, nationally and globally.
- works effectively through partnerships that cut across professional and organizational boundaries and seeks to eliminate avoidable distinctions.
- relies upon evidence, judgment and skills and promotes the participation of the populations who are themselves the subject of policy and action.

UKPHA Priorities

Our three key priorities concerning public health are:

- working for a fairer, more equitable and healthier society
- ensuring healthy environments for future generations
- promoting health-sustaining production, consumption and employment. Collaborating with businesses to promote socially responsible and healthy products and services.

The UKPHA aims to become the voice of the public health movement in the UK, with strong European and world-wide links. It has evolved three priorities:

- combating health inequalities
- promoting sustainable health policy
- challenging anti-health forces

Health Inequalities

Health inequalities are the UK's most visible public health challenge. The health of people in the more affluent areas of the country is among the best in the developed world, but the health of the most disadvantaged groups rivals the worst. Health inequalities in the UK are the worst in areas where deprivation is keenest. People living in poorer communities die younger and experience poorer physical and mental health throughout life than those living in more affluent communities. Since the publication of the Black Report "Inequalities in Health" in 1979, which linked poor health to social class, a considerable body of evidence has developed which clearly demonstrates:

- a growing health gap between rich and poor
- poverty causes poor health and poor health causes poverty
- poorer people's expectations of health are below the better off
- poverty and inequality exist on many dimensions, ranging from experience of crime to a decaying environment
- a widening health gap, like the widening wealth gap, is bad for everyone, promoting insecurity, inefficiency and waste.

The tackling of health inequalities is embedded throughout all the UKPHA's work.

Sustainable Development

Sustainable development is intimately linked to public health. The best managed societies promote equitable environmental principles, apply these principles across industry, transport and other sectors, and regularly appraise the impact. Compared to the best practices of some European nations, the UK invests less in sustainable transport, housing, and waste management. We drive too much and walk or cycle too little. We throw too much away and pollute or litter too readily.

The UKPHA argues that public health and sustainable development must be complementary national priorities.

Anti-Health Forces

The UK is a world leader in health-degrading production and consumption. Our arms and tobacco industries produce measurable harm here and particularly overseas; our food and drink industries promote unhealthy consumption, frequently aimed at children or the most

vulnerable. Our society produces harmful attitudes and beliefs towards people with disabilities or mental health problems.

Challenging harmful production or consumption poses difficult choices. Such industries provide employment, sponsor the arts, and influence public opinion. Efforts to control them are portrayed as an attack on freedom of choice.

The UKPHA will promote health-sustaining production, consumption and employment. It will collaborate with business to promote socially responsible and healthy products.

[/http://www.ukpha.org.uk/default.asp?action=category&ID=23&order=categoryname&sort=asc&limit=0](http://www.ukpha.org.uk/default.asp?action=category&ID=23&order=categoryname&sort=asc&limit=0) /

Questions and Tasks

1. Decode the abbreviation UKPHA.
2. Compare the UKPHA definition of *public health* with that presented in the Terminology Section of this book.
3. What are the UKPHA priorities?
4. What is meant by the phrase *health inequalities*?
5. What does the UKPHA argue concerning public health and sustainable development?
6. What does the phrase *anti-health forces* imply?

Healthy Environment

The environment should be understood in its broadest sense, including not only physical living conditions but also the sociopolitical and sociocultural environment.. Sustainable development, economic and social equality, and justice and political freedom are the basics for a healthy lifestyle of boys and girls. Environmental factors have an obvious influence on the health and illness of populations. Such influences are very apparent in the eastern European countries. In order to improve the health of boys and girls in these countries, environmental living conditions in particular need to be improved. Access to safe drinking water, improved air quality, and reduced soil pollution could increase the health status of boys and girls. It is essential to develop programs that make living conditions in all areas (e.g. the home, school or community) healthier. Cooperation with all relevant sectors, such as labor or industry, makes it possible to formulate and implement effective environment-related strategies for health.

Improvements in societal factors (unemployment, isolation, poverty, social networks, etc.) would have an extremely positive influence on the health development of boys and girls. Health issues are nearly always social issues, too. Poverty, for example, is apparently an important risk factor for health risky behavior. This becomes very obvious when one looks at mortality and morbidity in the Eastern European countries. A fair

social policy which prevents poverty and isolation leads not only to sufficient food and safe living spaces for human beings but also to improved health-promoting behavior. Increases in budgets for social, educational or employment policies can thus also help to reduce gender difference concerning health and illness. Cutting military expenditure yields substantial savings which can be used to improve health promotion and health care for girls and boys.

Guidelines should be developed with the aim of eliminating health-damaging cultural attitudes and practices. Visible health risk behavior (such as excessive drinking or dangerous sports) is in most cultures linked to masculinity and is seen as an appropriate and necessary way in which boys can demonstrate their masculinity. Invisible health risk behavior (such as medication use or excessive dieting) is typical of girls and widespread. Social measures must be taken to decrease the social acceptance of health-damaging behavior for both sexes. This includes placing violence on the political agenda. Not only girls but also men suffer from male inflicted violence. Whereas girls and women are especially affected by sexual violence, boys and men are mainly subject to individual physical violence. Violence, sexual abuse and rape have a dramatic influence on physical and psychological health, and their perpetrators must be totally ostracized.

Entering into employment is very important for girls and may have implications for their health. Girls are especially affected by the conflict of deciding between job and family, since these roles are hardly compatible within a female biography. The stress this conflict causes for girls can lead to physical and psychological complaints. The jobs which are performed by girls generally impose a strain on their psychological health. Unpaid and "invisible" domestic labor, the generally low status of such work and the overrepresentation of girls and women in jobs with a low salary have an important influence on health and wellbeing of girls. Government services concerned with labor and the family must try hard to reduce the burdens for girls resulting from this. Sound training, access to male-dominated employment, the participation of women in management positions and in all decision-making processes, the participation of men in providing for the family, the provision of kindergarten places and more flexible organization of the workplace can all make it easier for girls to balance job and family and improve their work situation.

All settings of social life, such as cities, schools and workplaces, should provide greater opportunities for promoting gender-specific health. Concentrating health promotion in settings of daily living involves various disciplines in health promotion. The employees in all settings must be made sensitive to gender-related features, and sexual discrimination in settings must come to an end. It is not enough to offer special health programs which impart gender-sensitive knowledge: health-relevant gender issues must be considered in all areas of life. This implies, for instance, that local leisure programs must not involuntarily aim at boy-specific interests such as football or skateboard without offering corresponding programs for girls.

The long-term steady improvement of boys' and girls' health can only be achieved through networks involving all health-relevant actors. It is useful to consolidate

partnerships for health between different sectors at all levels of governance and society, with the aims of fostering communication, cooperation, networking, support and solidarity. Local, national and international networks allow synergetic effects to be achieved through the transfer of knowledge and exchange of views. Joint actions by ministries, administrations, nongovernmental organizations (NGOs) and private institutions in the sectors of health, education, environment, women, youth, law, finance, labor, transport, and industry are valuable ways of promoting the health of girls and boys.

/ Kolip, P. and Schmit, B. 1999. *Gender and health in adolescence*. Copenhagen, WHO Regional Office for Europe, p. 34-35 /

Questions and Tasks

1. Define the concept *healthy environment*.
2. What is meant by the phrases “visible and invisible health risk behavior”?
3. Why is entering into employment very important for girls?
4. How can the long-term steady improvement of boys’ and girls’ health be achieved?

The Importance of Holistic Health

We are currently living in an epidemic of chronic and degenerative diseases, with society too often depending on modern medicine for a “pill for every ill”. In the quest for a holistic vision toward wellness, complementary and alternative medicine (CAM) is assuming greater importance in many people’s lives. Interest in holistic approaches has been growing at a phenomenal rate over recent years, with the number of visits to CAM practitioners exceeding those to all United States primary care physicians, with 629 and 386 million visits respectively in 1997 (Eisenburg & Davis, 1998). This growing appeal has motivated the establishment of the National Center for Complementary and Alternative Medicine at the National Institutes of Health (National Center for Complementary and Alternative Medicine, 2000), Which is dedicated to exploring holistic treatments in the context of rigorous science and disseminating authoritative information to public an professionals. In all of its many forms, holistic modalities focus on the individual as a unique individual and empower one to take from it whatever one personally needs, with prevention as the focus.

/ Vamos, S. A Holistic Stress Management Health Education Lesson. *American Journal of Health Education*. May/Jun 2004; 35, 3, p. 179 /

Questions and Tasks

1. Decode and explain the abbreviation *CAM*.
2. What has motivated the establishment of the National Center for Complementary and Alternative Medicine at the National Institutes of Health?
3. What do holistic modalities focus on?

High-pressure Times

The poster shows a close-up of a strained-faced firefighter and police officer, over the words “Even heroes need to talk.” This sign has been ubiquitous on the New York City subway in recent months. In the aftermath of the September 11 attacks, the American image of the taciturn loner who can handle everything by himself seems to be yielding to a kinder concept of the real needs of people suffering tremendous stress and grief.

To those of us who experienced the attacks from the sidelines, not the front lines, it may seem self-dramatizing to admit that we, too, have lingering and unmet emotional needs. Yet with every new warning and threat, I find myself at least momentarily snapped back into the sheer horror of the traumatic events of a year ago.

Many Americans have fallen into a kind of chronic stress since the attacks. And meanwhile, of course, our lives have not been on hold. The more usual life stresses – health, economic, and relationship problems – have added to the pile of worries. So it’s not always easy to separate the stress we feel from national and world events from our personal collection of cares.

While it’s still not clear exactly how stress affects our physical health, or what we can do about it, it’s a good idea to pay attention to the relationship. Our blood pressure, for example, does tend to go up when stress chemicals, such as cortisol, stream through our blood. Scientists have not yet determined whether chronic stress is actually a cause of continuous high blood pressure, known as hypertension, which is a serious risk factor for heart attack and stroke. But it makes sense for all of us to try to keep our blood pressure at optimal levels.

Regular exercise, relaxation techniques such as yoga and meditation, and get-togethers with community groups and loving friends and relatives can all help keep stress under control. But if stress symptoms get out of hand, and anxiety, depression, or sleeplessness begin to interfere with your daily functioning, do get some help. Your family doctor may be a good place to start, but keep in mind that when antidepressant or anti-anxiety drugs are recommended, they often work best in combination with counseling.

Perhaps the most important thing is to have the courage to reach out for help or comfort when you are feeling tense or down. If even heroes need to talk, perhaps you do, too. It’s not a good idea to try to go it alone.

/ Sandroff, R. High-pressure times. *Consumer Reports on Health*. Sept. 2002. Vol. 14. No. 9, p. 2 /

Questions and Tasks

1. What is the main idea of the article? Which citation (phrase) expresses it best?
2. What are the usual life stresses?
3. What is it still not exactly clear?
4. Find the interpretation of the concept *stress* in the English-Lithuanian Dictionary of Special Education (meaning 2). What might be the causes of stress?

Is Grief Ever “Normal?”

Experts and popular media tend to view grief as a uniform experience that should come to an end within a given time. Use of words such as “acceptance” and “closure” gives the false impression that grief can be quickly banished, notes psychologist Robert Bauger in a recent issue of the *Columbia Journalism Review*. In our culture, the mourning period is expected to last no longer than a few weeks. “Normal” grief with dampened emotions, anger, anxiety, impaired concentration, mood swings, and restless sleep is supposed to last a year or less. When grief lasts longer than a year, or suddenly gets worse after that time, we classify it as complicated. This category includes post-traumatic reactions, with intrusive thoughts about the dead person, feelings of numbness, crying spells, and clinical depression, with feelings of worthlessness and thoughts of suicide.

Grief Is Personal

To me, the time distinctions between “normal” and “complicated” grief seem arbitrary. I have seen extreme grief reactions, including suicide, take place within three weeks of a loss. I’ve also seen anger and anxiety persist for years after a loved one’s death. Some people initially seem reserved or numb, only to fall apart months later. The most many people can expect is that they will eventually adapt to their loss.

The circumstances of death greatly influence the course of bereavement. Studies have shown that a sudden, unexpected death, as in an automobile accident, makes grieving more severe and difficult to manage. Grief may be less intense after a prolonged illness, because there is time for all concerned to reconcile themselves to the impending death and to say their farewells.

The death of a very old person after a long productive life is rarely mourned as intensely as the death of a child. Studies show this causes more emotional trauma than even the loss of a spouse.

Friends and relatives should encourage a bereaved person to talk about the departed loved one if such conversation is desired. That’s especially true for bereaved parents, who often fear their child’s too-brief life will be forgotten.

Most physicians I know, myself included, are greatly saddened by the loss of patients, especially long-time ones. Attending funerals and writing condolence notes gives us a chance to express our grief concretely. A call or visit to the physicians who cared for the loved one can help resolve doubts about their medical care.

When to Seek Help?

Grief needs professional attention when it interferes with a survivor's day-to-day functioning, such as going to school or work, making decisions, and sleeping and eating regularly. Not feeling up to resuming an active social life doesn't fall in that category and may often persist considerably longer.

If you need help coping with a loss, ask your doctor to recommend a mental-health professional with experience in grief counseling.

/ Lipman, M. M. The dimensions of grief. *Consumer Reports on Health*. July 2001. Vol. 13. No. 7, p. 11 /

Questions and Tasks

1. How do experts and media tend to view grief?
2. How long "normal" grief is supposed to last?
3. When is grief classified as complicated?
4. What have studies shown?
5. In what cases may grief be less intense?
6. How can friends and relatives help a bereaved person?
7. When does grief need professional attention? Give examples.

THE UNREACHABLE GOAL OF HEALTH EDUCATION

It is the general goal of health education to improve the health knowledge and attitudes of individuals and thereby inspire personal behaviors that lead to optimal health and wellness, or high levels of functioning in all of the various dimensions of health (Butler, 2001). Underlying this goal are several assumptions or beliefs about the nature of health. First *health* is typically defined in our literature as being multidimensional, the realization of which requires a degree of depth and balance among such diverse elements as physical health, emotional health, intellectual health, social health, and spiritual health (Cottrell, Girvan, & McKenzie, 2002). Further, these dimensions are considered to be dynamic inasmuch as the status of one dimension often influences the condition of another (Butler, 2001). Finally, it is argued that health is functional because most people value it primarily for its usefulness in the pursuit of higher aims, rather than merely as an end in itself (Read, 1977).

And yet the profession of health education seems philosophically inconsistent in its methodology, in that efforts at health promotion often ignore all three of the concepts presented in the preceding definition. First, the multidimensional nature of health is effectively discounted; most published health education objectives include only physical health variables as primary outcome measures (e.g., *Healthy People 2010*).[...]

If the multidimensional nature of health is disregarded, then its dynamic nature can hardly be appreciated or capitalized on. Although it is well documented, for example, that emotional well-being exerts a profound influence on cardiovascular health, we do not often consider emotional health variables as outcome goals for cardiovascular prevention programs. Similarly, social support is a significant factor in understanding a multitude of health outcomes, including various types of cancer, cardiovascular disease, immune function, women's health, and positive health practices. And spiritual well-being influences such diverse outcomes as recovery from addiction, teen sexual activity, depression, eating disorders, breast cancer, long survival with AIDS, and a number of health behaviors. Yet, with few exceptions, health educators seldom attempt to measure or influence social health or spirituality in health education interventions. Without an appreciation of multidimensionality, we are unable to investigate the dynamic nature of these health dimensions in terms of how they interrelate with and impact one another.

Instead physical health is generally promoted by health educators as a sufficient end in itself, with no considerations for some larger purpose that might justify its need in the first place. The functional nature of health, its basic role of serving higher human interests, is thus lost in a fervor of physical health promotion, which implies that good physical health is apparently the greatest achievement possible. In contrast, it seems likely that most individuals become interested in improving health behaviors only when they see a vital connection between enhanced health status and the realization of a self-defined, higher purpose in life.

Consider the overweight, middle-aged, divorced gentleman, hopelessly entangled in dead-end career, who spends inordinate amounts of time on the couch in front of the TV – eating chips, smoking cigarettes, drinking beer, and feeling sorry about his lonely and meaningless existence. In fact, he believes that his TV, stimulants, and snacks are the only things that make his otherwise unbearable life somewhat tolerable. How will this good man respond to the modern health educator who – without stopping to consider the various dimensions of health involved (e.g., social, emotional, intellectual), and without contemplating the general lack of purpose in this person's life – enthusiastically promotes dietary restrains, nicotine patches, and treadmills as the path to good physical health? Our client will likely roll his eyes with boredom, dismiss the notion of "health" altogether, and reach for another smoke.

And thus by failing to equitably consider and promote all dimensions of health, and without appreciating the true motivation that must underlie successful health behavior change – active engagement in a self-defined higher purpose – the realization of health education goals is substantially hindered. Indeed, as currently promoted, the primary goal

of health education (substantial health behavior change at the population level) may be largely unreachable.

/ Hawks, S. Spiritual Wellness, Holistic Health, and the Practice of Health Education. *American Journal of Health Education*. Jan / Feb 2004; 35, 1, p. 11-12 /

Questions and Tasks

1. What is the general goal of health education?
2. What does S. Hawks mean by the concept *multidimensional nature of health*.
3. What does spiritual well-being influence?
4. Why, according to the writer, may the primary goal of health education be largely unreachable? Give your own reasons.

ABBREVIATIONS

AIDS	acquired immune deficiency syndrome – įgytas imunodeficitu sindromas (AIDS)
ASPHER	Association of Schools of Public Health in the European Region – Visuomenės sveikatos mokyklų Europos regione Asociacija
BMI	body mass index – kūno masės indeksas
BUPA	British United Provident Association – sveikatos draudimo kompanija (<i>D. Britanijoje</i>)
CAM	complementary and alternative medicine – papildoma ir alternatyvioji medicina ?
CSHP	Coordinated School Health Program – koordinuota sveikatos ugdymo programa mokykloje
EMPH	European Master Program in Public Health – Europos visuomenės sveikatos magistro programa
ENHPS	European Network of Health Promoting Schools – Skatinančių sveikatingumą mokyklų tinklas Europoje
et al.	et alii – ir kiti
GP	general practitioner – apylinkės / rajono gydytojas (<i>vidaus ligų ir chirurgas</i>)
HMO	health maintenance organization – sveikatą palaikanti organizacija
IAQ	indoor air quality – oro kokybė patalpose
ibid	ibidem – ten pat, toje pat vietoje
KSA	knowledge, skills, and abilities – žinios, įgūdžiai ir gebėjimai
LEA	Local Education Authority – vietinės švietimo įstaigos (<i>D. Britanijoje</i>)
NGO	nongovernmental organization – nevyriausybinė organizacija
NHS	National Health Service – Nacionalinė sveikatos apsaugos tarnyba (<i>D. Britanijoje</i>)
STDs	sexually transmitted diseases – lytiniu būdu plintančios ligos
UKPHA	UK Public Health Association – Jungtinės Karalystės visuomenės sveikatos asociacija
vs	versus – prieš
WHO	World Health Organization – Pasaulio sveikatos organizacija

VOCABULARY

Abbreviations

<i>adj</i> (adjective)	- būdvardis
<i>adv</i> (adverb)	-rieveiksmis
<i>med.</i>	- medicina
<i>n</i> (noun)	- daiktavardis
<i>pl</i> (plural)	- daugiskaita
<i>prep</i> (preposition)	- prielinksnis
<i>v</i> (verb)	- veiksmazodis

English Alphabet

Aa Bb Cc Dd Ee Ff Gg Hh Ii Jj Kk Ll Mm Nn Oo Pp Qq Rr Ss Tt Uu
Vv Ww Xx Yy Zz

A

abdominal [QbÈd•mi n«l] *adj* abdominalinis, pilvo, pilvinis

absenteeism [Qbs«nÈti :i zm] *n* praleidinėjimas, pravaikšta

acceptance [«kÈsept«ns] *n* **1** priėmimas **2** pritarimas, sutikimas;
akceptacija

access [ÈQkses] *n* **1** priėjimas **2** įėjimas

accident and injury prevention [ÈQksi d«nt «nd Èi ndZ«ri

pri ÈvenSn] nelaimingų atsitikimų ir su(si)žalojimų prevencija

accomplish [«ÈkÃmpl i S] *v* įvykdyti, atlikti; nuveikti

address [«Èdres] *v* **1** kreiptis **2** (at)kreipti dėmesį

admission [«dÈmi Sn] *n* **1** priėmimas **2** (į)leidimas; įėjimas

admit [«dÈmi t] *v* **1** priimti, prileisti **2** sutikti; pri(si)pažinti

affiliate [«Èfi l i ei t] *v* **1** priimti nariu **2** pri(si)jungti, prijungti
kaip filialą

affluent [ÈQfl u«nt] *adj* turtingas; gausus

aftermath [ˈɛɑːftɚmɑːt] *n* padarinys, rezultatas
aging [ˈeɪdʒɪŋ] *n* senėjimas
alarming [ˈælɑːmɪŋ] *adj* keliantis nerimą, jaudinantis
amount [ˈæmaʊnt] *n* **1** kiekis, mastas **2** suma **3** reikšmingumas
anticipate [ˌæntɪˈsɪpeɪt] *v* numatyti, nujausti; laukti, tikėtis
anxiety [ˌæŋzaiˈæti] *n* **1** nerimas **2** susirūpinimas, rūpestis **3** troškimas
apparent [ˈæpɔːrənt] *adj* matomas, aiškus, akivaizdus
appeal [ˈæpiːl] *n* **1** kreipimasis **2** prašymas **3** apeliacija *v* kreiptis, apeliuoti
appraise [ˈæpreɪz] *v* įvertinti
appreciate [ˈæpriːʃiːt] *v* **1** (i)vertinti **2** pripažinti
approximately [ˌæprɒksɪmətli] *adv* apytiksliai, apytikriai, maždaug
arbitrary [ˈæbɪtrəri] *adj* arbitriškas, sutartinis; pasirenkamas
arms [ɑːmz] *n pl* ginklai
assail [ˈæsɛɪl] *v* (už)pulti, atakuoti
assault [ˈæsɔːlt] *n* **1** (už)puolimas; ataka **2** grasinimas smurtu / prievarta
assignment [ˈæsəɪnmənt] *n* **1** užduotis, pavedimas **2** paskyrimas
assumption [ˈæsʌmpʃn] *n* **1** prielaida, manymas **2** pri(si)ėmimas **3** apsimetimas
at one [ˈæt wʌn] visi kaip vienas, išvien, sutartinai
attachment [ˈætʃmənt] *n* prieraišumas, prisirišimas
attainment [ˈæteɪnmənt] *n* pasiekimas, įgijimas
attenuate [ˈætenjueɪt] *adj* liesas, plonas [ˈætenjueɪt] *v* **1** išsekinti, suliesinti **2** sumažinti, susilpninti
authorise [ˈɔːtəraɪz] *v* **1** įgalinti **2** leisti, sankcionuoti **3** pateisinti
avert [ˈævɛ:t] *v* **1** nukreipti, atitraukti **2** išvengti
avoidable [ˈævɔɪdəbl] *adj* išvengiamas
avoidance [ˈævɔɪdəns] *n* (iš)vengimas; šalinimasis
awareness [ˈɛvɛəni:s] *n* supratimas; įsisąmoninimas

B

- banish** [ÈbQni S] *v* **1** (iš)varyti, (išvyti) **2** atsikratyti; išmesti iš galvos
- baseline** [Èbei sl ai n] *n* pradinis / išeities taškas
- benchmark** [ÈbentSma:k] *n* **1** pažyma **2** etalonas; gairė
- beneficial** [Çbeni Èfi Sl] *adj* **1** palankus; naudingas **2** gydantis
- benign** [bi Ènai n] *adj* švelnus, mielas; malonus
- bereavement** [bi Èri :vm«nt] *n* (*artimuju*) netekimas, netektis
- binge** [bi ndZ] *n* išgertuvės, (per didelis) įsismaginimas *v* prisivalgyti, įsismaginti
- blanket ban** [Èbl QNki t ÈbQn] visiškas (už)draudimas
- body composition** [Èb•di Çk•mp«Èzi Sn] kūno sandara
- bonding** [Èb•ndi N] *n* ryšys, prisirišimas; prieraišumas
- boundary** [Èbaund«ri] *n* riba, siena
- bowel** [Èbau«l] *n* žarna, žarnos; viduriai
- brisk** [bri sk] *adj* smarkus, gyvas; greitas, judrus
- broad** [br•:d] *adj* platus
- buddy** [ÈbÃdi] *n* draugužis, bičiulis
- bypass surgery** [Èbai pa:s Ès«:dZ«ri] šuntavimas

C

- calipers** [ÈkQl i p«z] *n pl* skriestuvas
- calligraphy** [k«Èl i gr«fi] *n* **1** kaligrafija, dailyraštis **2** gražus braižas
- cancer** [ÈkQns«] *n* vėžys, piktybinis navikas
- capitalize** [ÈkQpi t«l ai z] *v* **1** paversti kapitalu **2** krauti(s) kapitalą
- cardiovascular** [ÇkA:di «uÈvQskj ul «] *adj* širdies ir kraujagyslių
- causal** [Èk•:zl] *adj* priežastinis; kauzalus
- causation** [k•:Èzei Sn] *n* sukėlimas, buvimas priežastimi
- cautious** [Èk•:S«s] *adj* atsargus, apdairus
- chair** [ÈtSE«] *v* **1** pirmininkauti **2** skirti pareigoms
- charge** [ÈtSa:dZ] *n* **1** kaltinimas **2** mokestis, kaina **3** atsakomybė,

pareiga; globa *v* **1** (ap)kaltinti **2** prašyti, nustatyti kainą **3** įpareigoti

chest [tʃɛst] *n* **1** krūtinės ląsta **2** skrynia, dėžė

circumstances [ˈɛsːkəmstənsɪz] *n pl* aplinkybės, sąlygos, padėtis

combat [kəmˈbɑt] *n* kova *v* kovoti, kautis

commitment [kəmɪtmənt] *n* **1** įsipareigojimas; pasižadėjimas **2** atsidavimas, pasišventimas **3** (nusikaltimo ir pan.) įvykdymas

compelling [kəmˈpɛlɪŋ] *adj* **1** įtikinamas **2** prikaustantis / patraukiantis dėmesį

complementary [kəmˈplɪmɛntəri] *adj* **1** papildantis vienas kitą **2** papildomas

compliance [kəmˈplaiəns] *n* **1** sutikimas **2** nuolaidumas, paklusnumas

compartmentalization [kəmˈpɑːtməntəlaɪzɪʃən] *n* dalijimas į skyrius / sekcijas

comprehensive [kəmˈprihɛnsɪv] *adj* visapusis, išsamus, platus *n* valstybinė bendrojo lavinimo mokykla

comprehensive school health [kəmˈprihɛnsɪv ɛsku:l ɛhelθ] sveikata vidurinėje mokykloje

conceal [kənˈsiːl] *v* **1** slėpti, maskuoti **2** laikyti paslapyje

concern [kənˈɛsən] *n* **1** susirūpinimas; rūpestis **2** reikalas, dalykas *v* **1** liesti, sietis **2** rūpėti, jaudinti

concurrent [kənˈkʌrənt] *adj* **1** sutampantis; vykstantis tuo pačiu metu **2** veikiantis kartu

condom [kəndəm] *n* prezervatyvas

confusion [kənˈfjuːʒn] *n* **1** (su)painiojimas **2** painiava **3** sąmyšis **4** sumišimas, sutrikimas

connectedness [kənektɪdnɪs] *n* **1** ryšys **2** nuoseklumas

canon law [kənən ɛlɔː] kanonų teisė

condolence [kənˈdɒləns] *n* užuojauta

conduct [kənˈdʌkt] *v* **1** vadovauti, vesti; tvarkyti **2** elgtis

conscious [kənˈsɪs] *n* sąmonė *adj* **1** suvokiantis, suprantantis **2** sąmoningas **3** mąstantis

considerable [k«nÈsi d«r«bl] *adj* žymus, didelis
consistently [k«nÈsi st«ntl i] *adv* nuosekliai, pastoviai
consumption [k«nÈsÅmpSn] *n* (su)naudojimas, (su)vartojimas
contemplate [Èk•ntempl ei t] *v* mąstyti, svarstyti
contribute [k«nÈtri bj u:t] *v* **1** aukoti, duoti (*pinigu*) **2** prisidėti, padėti
controversy [Èk•ntr«v«:si] *n* diskusija, ginčas, polemika
co-ordinated school health [k«uÈ•:di nei ti d Èsku:l Èhel T] koordinuota / suderinta sveikatos (ugdymo) sistema mokykloje
core [k•:] *n* **1** šerdis, pagrindas **2** centras, branduolys
cortisol, hydrocortisone [Èk•:ti z•l , Çhai dr«uk•:ti Èz«un] *n* hidrokortizonas, antinksčių hormonas
couch [kautS] *n* **1** sofa **2** kušetė (*gydytojo kabinete*)
counseling [Èkauns«l i N] *n* **1** patarimas; konsultacija **2** orientavimas
counter [Èkaunt«] *n* **1** kas nors priešinga / priešiška **2** kontrasmūgis
crash [krQS] *adj* **1** skubus **2** intensyvus
crooked [Èkruki d] *adj* **1** sulenktas, suriestas; susikūprinęs **2** išlenktas, kreivas
crucial [Èkru:SI] *adj* kritiškas, lemiamas
crusade [kru:Èsei d] *n* žygis, kampanija
culminate [ÈkÅl mi nei t] *v* pasiekti kulminacinį / aukščiausią tašką; baigtis
cumbrous [ÈkÅmbr«s] *adj* sunkus ir nepatogus, gremėzdiškas

D

dampen [ÈdQmp«n] *v* (ati)drėkinti, atidrėkti
data processing [Èdei t« Èpr«us«si N] duomenų apdorojimas
debilitating [di Èbi l i tei ti N] *adj* silpninantis
decay [di Èkei] *n* puvimas, irimas; dūlėjimas
deficiency [di Èfi Snsi] *n* stoka, trūkumas, deficitas; nepakankamumas
delicate [Èdel i k«t] *adj* **1** subtilus **2** delikatus, švelnus; trapus

deliverance [di Èl i v«r«ns] *n* **1** išvadavimas, išgelbėjimas **2** viešai paskelbta nuomonė

delivery [di Èl i v«ri] *n* **1** pristatymas; atgabenimas **2** įteikimas
3 kalbėsena **4** gimdymas

demand [di Èma:nd] *n* (pa)reikalavimas; paklausa *v* reikalauti; reikėti

denial [di Ènai «l] *n* **1** (pa)neigimas **2** atsisakymas

dental care [Èdentl ÈkE«] dantų priežiūra

deplorable [di Èpl •:r«bl] *adj* **1** apgailėtinas, apverktinas **2** bjaurus

deprecate [Èdepr«kei t] *v* griežtai smerkti; prieštarauti

deprivation [Çdepri Èvei Sn] *n* **1** netekimas, atėmimas **2** nepriteklus, skurdas

derive [di Èrai v] *v* **1** gauti; įgyti **2** kilti; kildinti

designate [Èdezi gnei t] *v* **1** pažymėti, nustatyti **2** pavadinti, nurodyti
3 skirti

deter [di Èt«:] *v* sulaikyti, atbaidyti, atgrasinti

deviant [Èdi :vi «nt] *n* nukrypėlis; iškrypėlis

dieter [Èdai «t«] *n* dietetikas, dietologas

disadvantaged [Çdi s«dÈva:nti dZd] *adj* (*socialiai*) nuskriaustas, neturintis palankių sąlygų

disaster [di ÈZA:st«] *n* **1** nelaimė, negandos; baisus atsitikimas; katastrofa **2** nesėkmė, nemalonumas

disaster preparedness [di ÈZA:st« pri ÈpE«dni s] pa(si)rengimas nelaimėms, katastrofoms

discouragement [di sÈkaunti n«ns] *v* **1** nepritari, nepalankiai žiūrėti
2 sugluminti, sutrikdyti

disease [di Èzi :z] *n* liga
chronic d. [Èkr•ni k] chroninė, lėtinė ~
communicable d. [k«Èmj u:ni k«bl] užkrečiamoji ~
degenerative d. [di ÈdZen«r«ti v] degeneracinė ~
frequency of a d. [Èfri :kw«nsi «v «] sergamumas
infectious d. [i nÈfekS«s] užkrečiamoji ~

spread of a d. [spred «v «] ~os (pa)plitimas
displacement [di sÈpl ei sm«nt] *n* **1** išstūmimas, pakeitimas
2 perkėlimas **3** (*neapykantos ir pan.*) perkėlimas nuo vieno objekto į kitą
disregard [Çdi sri Èga:d] *v* nekreipti dėmesio, nepaisyti, ignoruoti
dissemination [di Çsemi Ènei Sn] *n* skleidimas, platinimas
distinction [di Èsti NkSn] *n* **1** skirt(ing)umas **2** individualumas
3 pasižymėjimas, garsumas
distinguish [di Èsti Ngwi S] *v* **1** (at)skirti **2** įžiūrėti **3** išsiskirti
diverse [dai Èv«:s] *adj* įvairus, įvairiapusis; skirtingas
dovetail [ÈdÃvtei l] *v* (ati)tikti, su(si)derinti, pritikti
drug abuse [ÈdrÃg «Èbj u:z] piktnaudžiavimas vaistais, narkotinėmis medžiagomis
drug addiction [ÈdrÃg «Èdi kSn] narkomanija

E

eliminate [i Èl i mi nei t] *v* **1** (pa)šalinti **2** eliminuoti
embarrassment [i mÈbQr«sm«nt] *n* **1** varžymasis, sumišimas,
drovėjimasis **2** sunkumas, keblumas
embedded [i mÈbedi d] *adj* įstatytas, įtvirtintas
embellishment [i mÈbel i Sm«nt] *n* (pa)puošimas, (pa)gražinimas
embrace [i mÈbrei s] *n* ap(si)kabinimas, glėbys *v* **1** ap(si)kabinti
2 apimti
emerge [i Èm«:dZ] *n* **1** išeiti, pasirodyti **2** paaiškėti **3** kilti
emergency [i Èm«:dZ«nsi] *n* nenumatytas blogiausias atvejis;
kritiška padėtis; avarija
eminence [Èemi n«ns] *n* **1** žymumas, aukšta padėtis **2** eminencija,
šventenybė
empowerment [i mÈpau«m«nt] *n* įgaliojimas; įgalinimas
enable [i Ènei bl] *v* įgalinti, leisti; suteikti galimybę / teisę
encompass [i nÈkÃmp«s] *v* apimti; apsupti
endeavour [i nÈdev«] *n* stengimasis; siekimas *v* stengtis, siekti
enforce [i nÈf•:s] *v* **1** versti, spausti; primesti **2** (pri)versti vykdyti

engage [i nĖgei dZ] v 1 sudominti 2 užsiimti 3 įdarbinti 4 susižieduoti

enhancement [i nĖha:nsm«nt] n (pa)didinimas, (su)stiprinimas, (pa)kėlimas

enkindle [i nĖki ndl] v kurstyti (*aistras*)

enlist [i nĖl i st] v 1 pritraukti (*darbui*) 2 patraukti (*savo pusėn*)

entail [i nĖtei l] v sukelti, būti priežastimi

entangle [i nĖtQNgI] v įpainioti, įvelti

equip [i Ėkwi p] v 1 aprūpinti 2 apginkluoti

equitably [Ėekwi t«bl i] adv teisingai, nešališkai

estimation [Ėesti Ėmei Sn] 1 (į)vertinimas, nuomonė 2 pagarba

ethos [Ėi :T•s] n etosas – socialinės grupės priimtų normų, reguliuojančių jos narių elgesį, visuma; moralinis charakteris / veidas

exacerbation [i gĖZQs«Ėbei Sn] n pabloginimas, pasunkinimas; pablogėjimas

exaggerate [i gĖZQdZ«rei t] v perdėti, padidinti, išpūsti

exceed [i kĖsi :d] v 1 pralenkti, viršyti 2 (per)viršyti

excess [i kĖses] n 1 perteklius, perviršis 2 nesaikingumas

exemplify [i gĖzempl i fai] v 1 būti pavyzdžiu 2 duoti pavyzdį

exert [i gĖz«:t] v 1 įtempti (*jėgas*) 2 ištempti

expectation [ĖekspekĖtei Sn] n laukimas, tikėjimasis

expertise [Ėeksp«:Ėti :z] n 1 erudicija, kompetencija 2 ekspertizė; įvertinimas

explicitly [i kĖspl i si tli] adv 1 aiškiai, tiksliai 2 atvirai

extensive [i kĖstensi v] adj 1 platus, išplėstas; didelis 2 ekstensyvus

external [i kĖst«:nl] adj 1 išorinis, išviršinis 2 užsieninis

extrapolate [i kĖstrQp«l ei t] v išplėsti išvadas, gautas stebint vieną reiškinių dalį, kitai jo daliai

F

facilitate [f«Ėsi l i tei t] v palengvinti

facility [f«Ėsi l «ti] n 1 lengvumas 2 pl paslaugos

3 įranga; infrastruktūra
fad [fɒd] *n* 1 (*greitai praeinantis*) susižavėjimas **2** užgaida, kaprizas
fatigue [fætɪːg] *n* 1 nuovargis **2** varginantis darbas
feasibility [ˌfiːzəˈbiːləti] *n* 1 įvykdomumas
2 tinkamumas **3** galimumas
fervor [ˈfɜːvɔː] *n* užsidegimas, aistra; karštumas
firearm [ˈfaɪəːm] *n* šaunamasis ginklas
first aid [ˈfɜːst ˈeɪd] pirmoji pagalba
fiscal [ˈfɪskl] *adj* fiskalinis, išdo
fitness [ˈfɪtnəs] *n* 1 gera žmogaus fizinė būklė, pajėgumas, pasirengimas **2** pratybos, palaikančios žmogaus gerą fizinę būklę
flexibility [ˌfleksəˈbiːləti] *n* 1 lankstumas **2** žmogaus lankstumas, gebėjimas prisitaikyti
flexible [ˈfleksəbiːl] *adj* 1 lankstus **2** prisitaikantis
flourish [ˈflɔːrɪʃ] *v* 1 klestėti **2** gražinti
fold [fɒld] *n* 1 raukšlė, klostė **2** sulenkimas
frame [freɪm] *v* 1 įrėminti **2** (su)daryti **3** (su)formuluoti
funeral [ˈfjuːnərəl] *n* laidotuvės

G

gap [gæp] *n* 1 spraga **2** tarpas
gain [geɪn] *n* 1 įgijimas; laimėjimas **2** nauda, pelnas *v* 1 įgyti, gauti
2 uždirbti **3** laimėti **4** pasiekti
gear [gɪə] *n* 1 įrenginys; prietaisas **2** reikmenys *v* 1 paleisti **2** sukabinti
3 (pri)taikyti
gender [ˈdʒendə] *n* 1 giminė **2** lytis
germane [dʒəˈmeɪn] susijęs, tinkamas
grave [ɡreɪv] *n* kapas; mirtis *adj* 1 rimtas, svarus **2** liūdnas
grief [ɡriːf] *n* 1 širdgėla, sielvartas **2** bėda
guidelines [ˈɡaɪdlaɪnz] *n pl* nurodymai; gairės

guise [Ėgai z] *n* išorė; pavidalas; apgaulinga išorė

H

handle [ĖhQndl] *v* **1** liesti / imti rankomis **2** vartoti **3** elgtis

harmful [Ėha:mf«l] *adj* žalingas, kenksmingas

health [hel T] *n* **1** sveikata **2** tosta **3** klestėjimas, gerovė

h. abuse [«Ėbj u:s] kenkimas / žala sveikatai

h. behavior [bi Ėhei v«] sveika elgsena

h. care public relations [ĖkE« ĖpÅbl i k ri Ėl ei Snz] sveikatos apsaugos viešieji ryšiai

h. centre [Ėsent«] (vaikų) konsultacija; poliklinika

h. conditions [k«nĖdi Snz] sveikatos aplinka

h. education [Çedj uĖkei Sn] **1** sveikatos edukologija **2** sanitarinis švietimas

h. hazard [ĖhQz«d] pavojus ~ai

h. promoting school [pr«Ėm«uti N Ėsk:ul] sveikatingumą ugdanti mokykla

h. psychology [sai Ėk•l «dZi] ~os psichologija

h. resort [ri Ėz•:t] kurortas

h. service [Ės«:vi s] ~os apsauga; sanitarinis aptarnavimas

comprehensive h. [Çk•mpri Ėhensi v] visapusė ~

consumer h. [k«nĖsj u:m«] vartotojų ~

delicate h. [Ėdel i ki t] silpna ~

ecological h. [Çi :k«Ėl •dZi kl] ekologinė ~

emotional h. [i Ėm«uSnl] emocinė ~

environmental h. [i nÇvai «r«nmentl] aplinkos ~

holistic h. [h•Ėl i sti k] holistinė ~

intellectual h. [Çi nt«Ėl ektSu«l] intelekto / protinė ~

maintenance of h. [Ėmei nt«n«ns «v] ~os palaikymas

maternal and child h. [m«Ėt«:n«l «nd ĖtSai l d] motinos ir vaiko sveikata

mental h. [Èmentl] psichinë ~
oral h. [È•:r«l] burnos ~
overall h. [È«uv«r•:l] bendra ~
personal h. [Èp«:snl] asmens ~
physical h. [Èfi zi kl] fizinë ~
promotion of h. [pr«Èm«uSn «v] ~os stiprinimas
public h. [ÈpÃbl i k] ~os apsauga
restoration of h. [Çrest«Èrei Sn «v] ~os reabilitacija
social h. [Ès«uSl] socialinë ~
spiritual h. [spi Èri tSu«l] dvasinë / psichinë ~
state of h. [Èstei t «v] sveikatos būklė
healthful [Èhel Tf«l] *adj* 1 gydomasis, gydantis 2 sveikatingas
health-officer [Èhel T È•fi s«] sanitarijos gydytojas
healthy [Èhel Ti] *adj* 1 sveikas, sveikatingas 2 naudingas, palankus
healthy mode of living [Èhel Ti Èm«ud «v Èl i vi ng] sveika
gyvensena
heart attack [Èha:t «ÈtQk] širdies priepuolis
hinder [Èhi nd«] *v* 1 trukdyti; kliudyti 2 neleisti
hygiene [Èhai dZi :n] *n* higiena

I
illegal [i Èl i :gl] *adj* 1 neteisėtas; nelegalus
illegible [i Èl edZ«bl] *adj* neįskaitomas, neišskaitomas
impact [Èi mpQkt] *n* 1 poveikis, įtaka 2 smūgis
impending [i mÈpendi N] *adj* gresiantis, artėjantis
implement [Èi mpl i Çment] *v* 1 įgyvendinti, (i)vykdyti 2 aprūpinti
įrankiais
implication [Çi mpl i Èkei Sn] *n* 1 į(si)painiojimas 2 prasmė 3 išvada
imply [i mÈpl ai] *v* 1 reikšti; turėti mintyje 2 (nu)manyti; duoti suprasti
inappropriate [Çi n«Èpr«upri «t] *adj* netinkamas, nederamas

inconsistent [Çi nk«nÈsi st«nt] *adj* **1** nesuderinamas **2** nenuoseklus
inefficiency [Çi ni Èfi Snsi] *n* neveiksmingumas, neefektyvumas;
 nesugebėjimas
inequality [Çi ni Èkv•l «ti] *n* **1** nelygė **2** nevienodumas
inevitable [i nÈevi t«bl] *adj* neišvengiamas
inextricably [i nÈekstri k«bl i] *adv* neatskiriamai; painiai
inferior [i nÈfi «ri «] *n* pavaldinys *adj* **1** žemas, žemesnis **2** prastesnis,
 menkesnis
inflict [i nÈfl i kt] *v* **1** suduoti (*smūgi*) **2** sukelti (*skausmą*) **3** primesti
inhalant [i nÈhei l «nt] *n* įkvėpjamieji vaistai
inimical [i Èni mi kl] *adj* **1** priešiškas, nedraugiškas **2** nepalankus
injury [Èi ndZ«ri] *n* **1** sužalojimas, sužeidimas **2** žala, pakenkimas
injustice [i nÈdZÅsti s] *n* neteisingumas; neteisybė, skriauda
inordinate [i Èn•:di n«t] *adj* **1** besaikis, didžiulis **2** netvarkingas
input [Èi nput] *n* indėlis, įdėtos pastangos
insecurity [Çi nsi Èkj u«r«ti] *n* **1** nesaugumas **2** nepatikimumas
inspire [i nÈspai «] *v* **1** įkvėpti, uždegti **2** (su)kelti
intact [i nÈtQkt] *adj* nepalietas, nesugadintas, sveikas
intent [i nÈtent] *n* ketinimas, tikslas *adj* pilnas ryžto
interchangeable [Çi nt«ÈtSei ndZ«bl] *adj* sukeičiamas,
 apkeičiamas; sukeistinas
intern [Èi nt«:n] *n* studentas medikas *ar* jaunas gydytojas, atliekantis
 praktiką ligoninėje; internas
internal [i nÈt«:nl] *adj* vidinis, vidaus
internalize [i nÈt«:n«l ai z] *v* **1** priimti tikėjimą, vertybes, požiūrį,
 standartus kaip savus **2** įsigyti kultūros / elgesio elementų
interrelate [Çi nt«ri Èl ei t] *v* sieti(s); būti susijusiam
intersection [Çi nt«ÈsekSn] *n* perkirtimas; susikirtimas; sankirta
intrusive [i nÈtru:si v] *adj* **1** nepageidaujamas, neprašytas **2** įkyrus
invisible [i nÈvi z«bl] *adj* nematomas, nepastebimas
irresistible [Çi ri Èzi st«bl] *adj* **1** nenugalimas, neatremiamas

2 neatsispiriamas, žavus
irritability [Çi ri t«Èbi l «ti] *n* irzlumas; dirglumas

J

jeopardize [ÈdZep«dai z] *v* statyti į pavojų, rizikuoti

justice [ÈdZÅsti s] *n* teisingumas; teisumas

K

keen [ki :n] *adj* **1** labai trokštantis / siekiantis **2** energingas
3 aštrus

L

label [Èl ei bl] *n* **1** etiketė, kortelė (*su užrašu*) **v** **1** pritvirtinti etiketę
2 priskirti

legal [Èl i :gl] *adj* **1** teisėtas; legalus

legitimize [l i ÈdZi ti mai z] *v* **1** įteisinti **2** įvaikinti

likelihood [Èl ai kl i hud] *n* tikėtinumas, tikimybė, galimumas

linger [Èl i Ng«] *v* **1** užtrukti, užsibūti **2** laikytis, tvyroti

link [l i Nk] *n* ryšys, sąsaja *v* (su)jungti, sukabinti

litter [Èl i t«] *n* šiukšlės *v* (pri)šiukšlinti

longitudinal [Çl •ndZi Ètj u:di nl] *adj* longitudinalinis, tęstinis, ilgalaikis

M

maintenance [Èmei nt«n«ns] *n* **1** palaikymas; parama **2** išlaikymas
3 tvirtinimas

malady [ÈmQl «di] *n* **1** negerovė, blogybė **2** liga

malnutrition [ÇmQl nj uÈtri Sn] *n* blogas maitinimas(is); prasta
mityba

manual [ÈmQnj u«l] *n* žinynas; vadovėlis *adj* fizinis; rankinis, rankų

meaningful [Èmi :ni Nf«l] *adj* reikšmingas; prasmingas

means [Èmi :nz] *n* **1** priemonė **2 pl** lėšos, ištekliai

measurable [ÈmeZ«r«bl] *adj* išmatuojamas

measure [ÈmeZ«] *n* **1** matas, matavimo priemonė **2** saikas **3** mastas,

laipsnis **4** priemonė *v* matuoti

medical examination [Èmedi kl i gÇzQmi Ènei Sn] medicininis
(*sveikatos*) patikrinimas

medicine [Èmedsn] *n* **1** medicina **2** vaistas, medikamentas

holistic m. [h•l i sti k] holistinė ~, kovojanti už visapusišką fizinę, dvasinę, socialinę žmogaus gerovę, o ne vien tik gydanti ligas ir šalinanti jų priežastis ?

social m. [Ès«uSI] socialinė ~

mental well-being [Èmentl Èwel bi :i N] gera psichinė savijauta

mentor [Èment•:] *n* vadovas, patarėjas, auklėtojas

minor [Èmai n«] *adj* **1** nedidelis, smulkus **2** mažesnis, mažasis

misbehavior [Çmi sbi Èhei vi «] *n* blogas / netinkamas / nepriimtinas elgesys

mischief [Èmi stSi f] *n* **1** žala; piktadarybė, bėda **2** išdykumas; išdaigos

misconduct [Çmi sÈk•ndÃkt] *n* **1** netinkamas / neetiškas pasielgimas
2 neištikimybė (*santuokoje*)

monitoring [Çm•ni Èt•:ri N] *n* kontrolė, tikrinimas; stebėseną

morbidity [m•:Èbi d«ti] *n* liguistumas; sergamumas

morbidity [Èm•:bi dl i] *adv* liguistai; patologiškai

mortality [m•:ÈtQl «ti] *n* **1** mirštamumas **2** mirtingumas

mourn [m•:n] *v* **1** (ap)raudoti, (ap)verkti **2** gedėti, liūdėti

multidimensional [ÇmÃl ti dai ÈmenSn«l] *adj* **1** daugiamatis **2** plačių interesų

N

negotiate [ni Èg«uSi ei t] *v* **1** vesti derybas; tartis **2** susitarti

nicotine patches [Èni k«ti :n ÈpQtSi z] pleistras nuo rūkymo

numb [nÃm] *adj* **1** nutirpęs; sustingęs **2** sustiręs, sugrubęs

nurturing [Èn«:tS«ri N] *n* **1** auklėjimas; ugdymas **2** maitinimas

nutrition [nj u:Ètri Sn] *n* **1** maistas **2** maitinimas(is), mityba

O

obesity [«uÈbi :s«ti] *n* nutukimas
oblique [«Èbl i :k] *adj* 1 įžambus, įstrižas 2 netiesioginis
oblivious [«Èbl i vi «s] *adj* užmirštantis; užsimiršęs, nesuvokiantis
obvious [È•bvi «s] *adj* akivaizdus, aiškus
occur [«Èk«:] *v* 1 atsitikti, įvykti 2 pasitaikyti 3 ateiti į galvą
ostracise [È•str«sai z] *v* išstremti, išvaryti; atstumti
outcome [Èautkãm] *n* rezultatas, pasekmė, išdava
overlap [Ç«uv«Èl Qp] *v* 1 iš dalies uždengti, užleisti 2 iš dalies sutapti
overweight [È«uv«wei t] *n* svorio perviršis, antsvoris

P

pattern [ÈpQt«n] *n* 1 modelis, šablonas 2 būdas; struktūra 3 pavyzdys
pedestrian and bicycle safety [pi Èdestri «n «nd Èbai si kl Èsei fti] pėsčiųjų ir dviratininkų saugumas
pediatric [Çpi :di ÈQtri k] *adj* pediatrijos; vaikų
penmanship [Èpenm«nSi p] *n* 1 kaligrafija, dailyraštis 2 rašysena
permanent [Èp«:m«n«nt] *adj* nuolatinis, pastovus, ilgalaikis
pernicious [p«Èni S«s] *adj* pražūtingas; kenksmingas, žalingas
perpetrator [Èp«:pi trei t«] *n* nusikaltėlis, kaltininkas
persist [p«Èsi st] *v* 1 užsispirti 2 išsilaikyti, išlikti; tęstis
personal care [Èp«:sni ÈkE«] asmens priežiūra / globa / slauga
physical condition [Èfi zi k«l k«nÈdi Sn] fizinė būklė / sveikata
physical fitness [Èfi zi k«l Èfi tni s] gera fizinė būklė
physical well-being [Èfi zi k«l Èwel bi :i N] gera fizinė savijauta
pint [pai nt] *n* pinta (*D. Britanijoje* – 0,57 litro)
plane [pl ei n] *n* 1 plokštuma 2 (*žinių, vystymosi ir pan.*) lygis
 3 lėktuvas
plank [pl Qnk] *n* pagrindinis bruožas; partijos programos punktas
pollute [p«Èl u:t] *v* (su)teršti, užteršti
poster [Èp«ust«] *n* skelbimas, plakatas *v* reklamuoti

posture [Ėp•stS«] *n* (*kūno*) laikysena, padėtis, poza *v* statyti į tam tikrą padėtį
potent [Ėp«ut«nt] *adj* **1** galingas; stiprus; veiksmingas **2** lytiškai pajėgus
poverty [Ėp•v«ti] *n* neturtas, skurdas
predictor [pri Ėdi kt«] *n* pranašautojas, numatytojas
prejudice [ĖpredZudi s] *n* **1** išankstinis nusistatymas **2** prietaras
preoccupation [pri :Ç•kj uĖpei Sn] *n* nuolatinis rūpestis, susirūpinimas
preventable [pri Ėvent«bl] *adj* išvengiamas
prevention [pri ĖvenSn] *n* prevencija, išankstinis kelio užkirtimas
dependency p. [di Ėpend«nsi] priklausomybių ~
drug abuse p. [ĖdrĀg «Ėbj u:z] narkomanijos ~
preventive care [pri Ėventi v ĖkE«] profilaktinė priežiūra
prima facie [Çprai m« Ėfei Si :] *adj, adv* **1** iš pirmo žvilgsnio **2** atrodantis patikimu, akivaizdus
priority [prai Ė•r«ti] *n* pirmumas; prioritetas, svarbiausias dalykas
prodrome [Ėpr«udr«um] *n* (*ligos*) pirmasis simptomas, pranašingas požymis
prolific [pr«Ėl i fi k] *adj* vaisingas, produktyvus
promotion [pr«Ėm«uSn] *n* **1** paaukštinimas, pakėlimas **2** mokinio perkėlimas į aukštesniąją klasę **3** rėmimas, parama; propagavimas
proof [pru:f] *n* **1** įrodymas **2** išmėginimas; patikrinimas
proven [Ėpru:v«n] *adj* įrodytas
psychotherapy [Çsai k«uĖTer«pi] *n* psichoterapija
pursuit [p«Ėsj u:t] *n* **1** siekimas, vaikymasis **2** persekiojimas

Q

quackery [ĖkwQk«ri] *n* šundaktariavimas, šundaktarystė; šarlataniškumas
quest [kwest] *n* **1** ieškojimas **2** ieškomas daiktas

R

- rage** [Èrei dZ] *n* **1** įniršimas, įniršis **2** siautėjimas, šėlimas
- raison d'être** [Çrei s•nÈdetr«] (*egzistavimo*) prasmė, pagrindas
- range**[Èrei ndZ] *n* **1** sritis, sfera **2** spindulys, ribos, nuotolis
3 diapazonas *v* svyruoti (*tam tikrose ribose*)
- rank** [rQNk] *n* **1** eilė, greta **2** laipsnis, rangas; kategorija
3 aukšta padėtis
- rapid** [ÈrQpi d] *adj* greitas, spartus
- rapidity** [r«Èpi d«ti] *n* greitumas, sparta
- rate** [Èrei t] *n* **1** tempas, greitis; dažnis **2** proporcija; procentas
3 kaina
- readability** [Çri :d«Èbi l «ti] *n* išskaitomumas, aiškumas
- receptive** [ri Èsepti v] *adj* imlus; juslus
- recipe** [Èresi pi] *n* receptas; būdas
- recognition** [Çrek«Ègni Sn] *n* **1** (at)pažinimas **2** pripažinimas
- recreation** [Çrekri Èei Sn] *n* rekreacija: **1** jėgų, sveikatos atgavimas
2 poilsis; pramoga
- reduce** [ri Èdj u:s] *v* **1** (su)mažinti; susilpninti **2** suvesti **3** pažeminti
4 sutrumpinti
- refute** [ri Èfj u:t] *v* atmesti, paneigti
- reinforce** [Çri :i nÈf•:s] *v* (su)stiprinti, pastiprinti
- relate** [ri Èl ei t] *v* **1** (su)sieti **2** būti susijusiam; giminiuotis
3 artimai bendrauti
- release** [ri Èl i :s] *n* **1** oficialus pareiškimas **2** paleidimas
- reliable** [ri Èl ai «bl] *adj* patikimas, tikėtinas, tikras
- rely** [ri Èl ai] *v* pasitikėti, pasikliauti
- remain** [ri Èmei n] *v* **1** (pasi)likti **2** išlikti
- remedy** [Èrem«di] *n* **1** vaistas **2** priemonė *v* **1** ištaisyti, pataisyti
2 išgydyti
- replicate** [Èrepl i kei t] *v* **1** kopijuoti **2** kartoti
- respond** [ri Èsp•nd] *v* **1** reaguoti, atsiliepti **2** atsakyti

restoration [ʧrest«Èrei Sn] *n* **1** restauravimas **2** atstatymas, atkūrimas
restraint [ri Èstreint] *n* **1** (ap)ribojimas, (su)varžymas
2 susilaikymas; santūrumas
restrict [ri Èstrikt] *v* (ap)riboti; (su)varžyti
retain [ri Ètein] *v* išlaikyti; (už)laikyti
rigorous [Èri g«r«s] *adj* **1** griežtas, rūstus **2** tikslus, kruopštus
rival [Èrai vl] *n* konkurentas, varžovas

S

safety education [Èsei fti ʧedj uÈkei Sn] (*darbo ir elgesio*) saugos taisyklių mokymas
schedule [ÈSedj u:l] *n* **1** tvarkaraštis, grafikas **2** katalogas, sąrašas
secure [si Èkj u«] *adj* **1** saugus; nepavojingas **2** patikimai saugojamas
3 tvirtas **4** ramus, be rūpesčių
seek [si :k] *v* **1** ieškoti **2** stengtis; siekti, reikalauti
self attributes [Èsel f ÈQtri bj u:ts] asmeninės savybės
sense [sens] *n* **1** jautimas; pojūtis **2** jausmas **3** išmintis; sveikas protas **4** prasmė; reikšmė
sensitive [Èsensi ti v] *adj* **1** jautrus, juslus **2** jausmingas; švelnus
severely [si Èvi «li] *adv* **1** sunkiai **2** griežtai **3** smarkiai; labai
sex education [Èseks ʧedj uÈkei Sn] lytinis švietimas
sexually transmitted [ÈsekSu«li trQnzÈmi ted] perduodamas lytiniu keliu; lytiškai plintanti (*liga*)
sexual relationships [ÈsekSu«l ri Èl ei SnSi ps] lytiniai santykiai
sheer [Si «] *adj* grynas; visiškas, absoliutus
sibling [Èsi bl i N] *n* (*vienų tėvų, tikras*) broils, sesuo
sick [si k] *adj* **1** sergantis, nesveikas **2** ligotas
sick condition [Èsi k k«nÈdi Sn] liguista būklė
sickness [Èsi kni s] *n* **1** liga **2** šleikštulys; vėmimas
s . prevention [pri ÈvenSn] ligų prevencija

s. rate [rei t] sergamumas
significant [si gĕni fi k«nt] *adj* 1 reikšmingas, prasmingas; svarbus
 2 žymus, pastebimas
simultaneous [Çsi m«l Ètei ni «s] *adj* vienalaikis, vykstantis /
 egzistuojantis tuo pat metu
single [Èsi NI] *adj* 1 vienas, vienintelis 2 skirtas vienam asmeniui
 3 nevedęs, netekėjusi *n* viengungis; neištekėjusi
skateboard [Èskei tb•d] *n* riedlentė
skin [ski n] *n* 1 oda 2 kailis 3 žievelė, odelė
slant [sl a:nt] *n* nuožulnumas; šlaitas, nuokalnė
sloping [Èsl «upi N] *adj* nuožulnus; pasviras
smooth [smu:D] *v* (su)lyginti, (su)glostyti; išlyginti
snack [snOk] *n* lengvas užkandis
social phobia [Ès«uSI Èf«ubi «] liguista visuomenės / viešumos
 baimė
soil [s•i l] *n* 1 dirva, žemė 2 žemė, kraštas, šalis
sole 1 [s«ul] *n* padas; puspadis
sole 2 *adj* vienintelis, vienas; išimtinis
solely [Ès«ul l i] *adv* išimtinai; tikrai
solution [s«Èl u:Sn] *n* 1 (iš)sprendimas; išaiškinimas 2 sprendinys
spell [spel] *n* 1 (*trumpas*) laiko tarpas 2 (*ligos*) priepuolis *v* pakeisti
spine [spai n] *n* stuburas, nugarkaulis
spiritual [Èspi ri tSu«l] *adj* 1 dvasinis 2 įkvėptas 3 religinis
spouse [spauz] *n* sutuoktinis
steep [Èsti :p] *adj* status, staigus
stem [stem] *v* kilti
stigma [Èsti gm«] *n* 1 gėda, dėmė 2 stigma, žymė
store [st•:] *v* 1 aprūpinti, tiekti 2 (su)kaupiti 3 sandėliuoti
strained [Èstreind] *adj* 1 įtemptas; nenatūralus 2 išvargęs
 3 iškreiptas
stretch [ÈstretS] *n* 1 nutįsimas 2 rąžymasis 3 įtempimas

stroke [str«uk] *n* **1** smūgis, kirtis **2** priepuolis; insultas
strong constitution [Èstrc•N Çk•nsti Ètj U:Sn] sveikas / stiprus organizmas
subsequent [ÈsÃbsi :kw«nt] *adj* einantis po, paskesnis, tolesnis
substance use [ÈsÃbst«ns Èj u:s] narkotikų vartojimas
suicidal [Çsj u:i Èsai dl] *adj* savižudiškas; linkęs į savižudybę
suicide [Èsj u:i sai d] *n* **1** savižudybė **2** savižudis
surgery [Ès«:dZ«ri] *n* **1** chirurgija **2** operavimas **3** (gydytojo) kabinetas
surveillance [s«Èvei l «ns] *n* sekimas, priežiūra
susceptible [s«Èsepti bl] *adj* linkęs; imlus
suspension [s«ÈspenSn] *n* **1** sustabdymas, sulaikymas **2** atleidimas, nušalinimas
sustainable [s«Èstei n«bl] *adj* palaikomas, išlaikomas
synergetic [Çsi n«ÈdZeti k] *adj* sąveikaujantis, sinergetinis

T

taciturn [ÈtQsi t«:n] *adj* tylus, nekalbus
tackle [ÈtQkl] *v* imtis, griebtis, užsiimti; (iš)spręsti
tardy [Èta:di] *adj* **1** pavėluotas, vėlus **2** lėtas, nerangus
target [Èta:gi t] *v* nukreipti (į taikinį); nutaikyti
tension [ÈtenSn] *n* įtempimas, įtampa
teen [ti :n] *adj* paauglių
thigh [Tai] *n* šlaunis
threat [Tret] *n* **1** grasinimas **2** grėsmė
three-level [ÈTri : Èl evl] *adj* trijų lygių
thrust [TrÃst] *n* **1** stūmimas, brukimas **2** dūris
tip 1 [ti p] *n* galas, galiukas
tip 2 *n* pasvirimas; pavertimas
tolerable [Èt•l «r«bl] *adj* **1** pakenčiamas **2** pakankamas, neblogas
torture [Èt•:tS«] *n* kankinimas *v* **1** kankinti **2** iškraipyti
traffic safety [ÈtrQfi k Èsei fti] eismo saugumas

transfer [ÈtrQnsf«:] *n* **1** per(si)kèlimas **2** perdavimas, perleidimas;
pervedimas

transmit [trQnzÈmi t] *v* **1** perduoti; transliuoti; siųsti **2** pernešti
(užkrata)

treadmill [Ètredmi l] *n* **1** bègtakis (*treniruoklis*) **2** rutina

truant [Ètru«nt] *n* **1** mokinys, praleidinèjantis pamokas
2 pravaikštininkas; dykinètojas *adj* (pra)dykinèjantis *v* praleidini

U

ubiquitous [j u:Èbi kwi t«s] *adj* visur esantis

ultimate [ÈÃl ti m«t] *adj* **1** paskutinis, galutinis **2** didžiausias;
kraštutinis

unanimous [j u:ÈnQni m«s] *adj* vieningas; vienbalsiškas

underlie [ÇÃnd«Èl ai] *v* **1** gulèti **2** sudaryti (*ko*) pagrindà; sukelti

underweight [ÈÃnd«wei t] *n* svorio trūkumas

unearthed [ÃnÈ«:Tt] *adj* iškastas; atskleistas

unify [Èj u:ni fai] *v* (su)vienyti, (su)jungti

unintentional [ÇÃni nÈtenSn«l] *adj* netyčinis; iš anksto neapgalvotas

unpredictable [ÇÃnpr«Èdi kt«bl] *adj* neišpranašaujamas,
nenuspèjamas, nenumatomas

unprotected [ÇÃnpr«Ètekti d] *adj* nesaugomas; neapsaugotas

upright [ÈÃprai t] *adj* status, stačias, tiesus

urban [È«:b«n] *adj* miesto, miestiškas

V

variable [ÈvE«ri «bl] *adj* kintamas, nepastovus *n* kintamasis (*dydis*)

variety [v«Èrai «ti] *n* **1** įvairumas, įvairovė **2** daugybė

vending-machine [Èvendi N m«ÈSi :n] *n* smulkių prekių automatas

versus [Èv«:s«s] *prep* prieš

violence-related [Èvai «l «ns ri Èl ei ti d] susijęs su smurtu;
smurtinis

virtual [ˈvɪ:ʃuəl] *adj* **1** beveik visiškas **2** faktinis, tikras **3** tariamasis, galimas

virtually [ˈvɪ:ʃuəli] *adv* faktiškai; iš esmės

visible [ˈvɪzəbl] *adj* **1** matomas, regimas **2** aiškus; akivaizdus

vital organs [ˈvaɪtəl ˈɪ:gənz] gyvybiškai svarbūs organai

vitiate [ˈvi:si:ti] *v* (su)gadinti, paversti niekais; iškraipyti

voluminous [vɒljuːmɪnəs] *adj* **1** laisvas, platus **2** didelės apimties

vulnerable [ˈvʌlnərəbl] *adj* **1** sužeidžiamas **2** pažeidžiamas, silpnas

W

waist [weɪst] *n* talija, juosmuo, liemu

waste [weɪst] *n* **1** eikvojimas, švaistymas **2** atliekos, likučiai

3 nuostoliai *v* eikvoti, švaistyti

weight control [ˈweɪt ˈkɒntrɒl] svorio kontrolė

workload [ˈwɜ:kləʊd] *n* darbo krūvis

Y

yield [jɪ:l d] *v* nusileisti; pasiduoti

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