An Analysis of Health Education Programs in Public Health Centers

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The purpose of this study was to investigate and analyse health education programs in public health centers. Major research issues were the themes of health education programs, target population, budget, and the use of health education materials. Research methods included survey of health education programs and preparation of workforce in public health centers. Officers in the public health centers who are in charge of health education were asked to respond to the survey. Among 244 public health centers, 181 public health centers responded to the survey questionnaire. An average of 8.6 kinds of health education programs were implemented for each public health center in 2001. The number of the types of health education programs varied widely across public health centers (from 1 to 34). The themes of health promotion and education were anti-smoking (22.71%), hypertension and diabetes control (22.59%), nutrition and weight management (12.52%), sex education (5.55%), and maternal and child health (5.94%). Other relevant topics included prevention of infectious diseases, prevention of disability, and general health class. Target population included adults (51.9%), adolescents (21.50%), mothers (9.00%), infants and young children (8.60%). Other target population were disabled people, patients, health workers, and other health professionals. More than half of the health education materials produced by the public health centers were pamphlets and leaflets. They tend to buy videotapes developed by other institutes. Most prominent type of health education was one-time health lecture, and this showed that health education programs in public health centers were focused on publicity. Anti-smoking and hypertension & diabetes control were popular topics which rated 21% respectively. Staff members who are in charge of health education pointed out that major barriers to health education are shortage of manpower, facility and equipments, and professional training. Local health education programs should be made more diversified so as to meet the needs of various target groups. Realizing the current vision of healthy lifestyle would require governmental efforts to train and increase manpower, develop systematic education guidance, and conduct periodic program assessment.

Key Word: health education, public health centers

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Ⅰ. Introduction

Entering aging society and increased prevalence of chronic diseases are the factors that increase burden of socio-economic costs in south Korea. About 4 out of 10 people in south Korea are suffering from chronic diseases (MOHW, 2002). The proportion of annual loss of productivity is about 1.7% of GDP. To overcome the burden of chronic diseases, health policy has to focus on prevention rather than treatment of diseases. This is the major part of health promotion policy.

Since 1998, community health promotion and health education programs in Korea have been increased as the National health promotion Law was enacted in 1995. This is in part because the budget for health promotion programs has been increased (Suh, 2003). According to the National Health Promotion Law, the term ‘health education’ means education which leads an individual or group to practice voluntarily deeds beneficial to health. Health promotion programs mean the projects to improve health of the citizens through health education, prevention of diseases, improvement of nutrition, as well as practice of healthy life style (National Health Promotion Law, 1995). Individual and groups' deeds for health, healthy lifestyles, have been clearly spelled out in the National Health Plan 2010 established by the Ministry of Health and Welfare in 2002. They are non-smoking and moderate consumption of alcoholic beverages, nutrition, exercise, and weight management. The goal of the Health Plan 2010 is to increase healthy life expectancy of Koreans. To accomplish this goal, the

National Health Plan focuses on development and provision of health promotion programs.

Koreans' life expectancy was 75.9 years in 2000, and is projected to 78.8 years in 2010. Korean's health expectancy is 66.0 in 2000, and this means 13% of a person's life is spent with some sort of illness or unhealthy status (WHO, 2001). The proportion of life years with unhealthy status is relatively bigger than that in advanced countries such as Japan, Germany and France. Lifestyle factors such as smoking, drinking alcoholic beverages, lack of exercise are major causes of reducing healthy life expectancy. This is because chronic diseases are major public health threat during the last 10 years in Korea, and causes of chronic diseases are related to lifestyle factors.

Lalonde's report in 1974 became the milestone in the area of public health worldwide, and the major objects of health promotion by WHO have been services, environment, natural resources, lifestyle, labour, and leisure.[1)] The methods of health promotion for the nation have been public policies, environmental improvements, improved health services, reinforcing local activities and personal skill improvements. The personal skill improvement is one of the focal point in the are of health promotion as indicated in the Ottawa Charter for the first international health promotion conference. Positive lifestyle factors became a focal point in preventing chronic diseases, and this was proven by some controled studies (Berkman & Breslow, 1983).

A health education program is composed of several factors such as health information, media, behavior change methods, providers and recipients. Any health education program in a community sector should reflect health problems and special health needs of the local

1) http://www.hc-sc.gc.ca/hppb/phdd/pdf/perspective.pdf

population. Provision of health education program in public health sectors pretty much depends on availability of budget, materials, and workforce (Bensley & Brookins-Fisher, 2001). These components of health education has been reviewed through the survey in this study.

Roles of public health centers are becoming more and more important because health promotion is a public health policy. In the United States, health education programs including anti-smoking, moderate consumption of alcoholic beverages, nutrition, exercise and stress management are conducted at local level and there are health education departments or units at local level. In addition, the federal government provides information on health education resources which can be obtained free or at a low cost (Lum, C., 2002). In Japan, nutrition, exercise and rest are the major nationwide health promotion themes and relevant educational activities are spread at local level (Korean Society for Health Education and Promotion, 2001).

Korean Public health Centers' health promotion roles are defined in the National Health Promotion Law and Regional Public Health Law. In the article 19 of the National health promotion law, local government should make a health promotion plan for the local population. The contents of the health promotion for the public include health education and health counseling on healthy lifestyles such as non-smoking, moderate consumption of alcoholic beverages, nutrition and diet, oral health, public sanitation, prevention of chronic diseases, exercise, and so on. The article 9 of the Regional Public Health Law spells out that local public health centers have to provide health promotion, health education, oral health and nutrition improvement. Suh et al (1999) pointed out that health education budgets for local public health centers were too little to provide health education to those who are in need of health education services. Choi (1998) found that many public health

centers' health education were focusing on sexuality education and reproductive health. There has been few studies done to investigate the status of health education in community settings in Korea.

The purpose of this study was to identify characteristics of health education programs in community settings and to investigate health education programs in public health centers. There are a couple of assumptions as follows; first, there must be limited themes, health education recipients, budgets, and workforce, second, utilization of health education resources must be limited.

Ⅱ. Methods of the study

To investigate major components of health education programs, the study design was based on a set of research questions, as follows.

1. How much funding available for health education programs in public health centers from the national health promotion fund?
2. What are the major resources of the health education programs?
3. What are the needs of workforce in public health centers?

Subjects of this study were staff members who are in charge of health education programs in public health centers. Overview of items in the survey questionnaire is described in Table 1. The health education program, by the National Health Promotion Law, is one of the activities of health promotion in Public health centers. Statistical analyses included descriptive statistics, Chi-square analysis, and ANOVA tests. In addition, Researchers conducted literature reviews on health education programs in community settings.

Table 1. Items of Survey Questionnaire

Items	Summary of Questions
structure	- organizational and administrative structure
Budgets of health promotion programs	- Financial resources for health promotion and education - Proportion of funding sources
Workforce information	- Duration of health education duty - Education - Major duties - Number of staff members responsible for health education
Training	- experience of continuing education for health education - area of training (current and future)
Healthy lifestyle practice council	- Role and contribution of the council - comments for improvement of its role
Health education programs	- themes of programs - frequencies, subjects, methods, places of education - budget for each program - Health education materials - comments from experience of health education programs

Ⅲ. Result of the Study

A mailing survey of 244 public health centers resulted in 74.2% response rate. According to the responses of the 181 public health centers in 2002. The low response rate (74%) may be due to lack of incentives or low understanding of health education activities. The health education program investigated for this study included smoking prevention, drinking alcoholic beverages, nutrition education, exercise education, oral health education, mental health education, sexuality education, and education for chronic diseases.

1. Budget for Health Education Program

Funding from the national health promotion fund is divided into

several categories. These including building health promotion infrastructure, health promotion programs, disease prevention programs, and health promotion research projects. The program funding was available for provincial health offices, public health centers, and NGOs. Large proportion of the health promotion fund has been used for management of the national health insurance. About 4.4% of budget was used for health promotion projects and programs in 2002. Because health education is a part of many health promotion programs, we can say that only small amount of money is allocated for health education.

Table 2. Budget of National Health Promotion Fund in 2002 and 2003

(unit: million won, %)

Programs of Funding	Budget					
	2002		2003		Amount Changed	
Total	585,742	100.0	736,277	100.0	150,485	25.7
- management	287	0.1	426	0.1	139	48.4
management	26	0.0	27	0.0	1	3.8
evaluation	261	0.1	399	0.1	138	52.9
- projects and programs	25,652	4.4	30,481	4.1	4,829	18.8
infrastructure of health promotion	120	0.1	140	0.1	20	16.7
health promotion education and publicity	2,691	0.4	6,749	0.9	4,058	150.8
health promotion and disease prevention	20,266	3.5	21,527	2.9	1,261	6.2
research projects	2,575	0.4	2,065	0.2	△510	△19.8
- health insurance	545,600	93.1	644,588	87.6	98,988	18.1
- spare budget	14,203	2.4	60,732	8.2	46,528	327.6

Source: Suh, Mi-Kyung, "An Analysis of Health Promotion Budget in 2003", *Health and Welfare forum*, No.75, 2003, p.17.

2. Charateristics of Health Education Programs

Each public health center offered an average of 8.6 health programs during 2001--ranging from a minimum of 1 to a maximum

of 34 different programs. There are the Healthy Lifestyle Practice Councils at local areas; only 55.6% of them are actually operating. 75.4% of people who participated in the survey expressed the organizations were not useful. The topics of health improvement and health education projects were varied: 22.71% were on anti-smoking campaigns; 22.59% on prevention projects of degenerative diseases such as hypertension & diabetes; 12.52% on nutrition programs including obesity management; 5.55% and 5.94% on sex education and Parenting health education, respectively (see Table 3). Other project topics were prevention of communicable disease, prevention of disabilities, and general health education. For the educational target groups, other group included disabled people, community health workers, and general public.

The projects mainly focused on adults (51.9%) and teenagers (21.50%), which showed the highest proportions. The next highest target groups were mothers (9.00%) and infants (8.60%). Other groups included the physically challenged, patients, health education teachers, and specialists.

The annual average frequencies of health education classes or events on smoking or drinking provided by the public health centers were 35.7 times. The annual frequencies by project topics were 23.9 times for anti-smoking projects, 23.4 for hypertension & diabetes projects, and about 44.6 for other chronic disease management projects. Other topics included prevention of communicable diseases, training of community health workers. In the case of dental health projects, many public health centers responded to the survey in terms of the frequencies of individual counseling sessions, so this led to a relatively high annual frequencies for dental health projects. The annual average number of people, who has received health education, was 1,600 by projects.

Table 3. Themes of Health Education Projects by Target Groups

(Unit: Project Rate, %)

	Teens	Infants	Women	Elderly	Adults	Others[2)]	Total
Anti-smoking	177 53.15	11 8.27	1 0.71	2 2.30	157 19.53	4 7.55	352 22.71
Drinking Problems	1 0.30	1 0.75	-	-	8 1.00	-	10 0.65
Exercise	1 0.30	-	8 5.71	11 12.64	18 2.24	-	38 2.45
Obesity	22 6.61	32 24.06	43 30.71	3 3.45	94 11.69	-	194 12.52
Mental Health	9 2.70	1 0.75	-	12 13.79	66 8.21	20 37.74	108 6.97
Dental Health	60 18.02	54 40.60	1 0.71	3 3.45	53 6.59	3 5.66	174 11.23
Chronic Disease	-	-	27 19.29	43 49.43	85 10.57	10 18.87	165 10.65
Hypertension & Diabetes	2 0.60	-	1 0.71	5 5.75	174 21.64	3 5.66	185 11.94
Sex Education	45 13.51	16 12.03	4 2.86	-	20 2.49	1 1.89	86 5.55
Parenting Education	1 0.30	15 11.28	52 37.14	-	22 2.74	2 3.77	92 5.94
Others[1)]	15 4.50	3 2.26	3 2.14	8 9.20	107 13.31	10 18.87	146 9.42
Total	333 100.00	133 100.00	140 100.00	87 100.00	804 100.00	53 100.00	1,550 100.00

Notes: 1) Other project topics were about prevention of communicable disease, prevention of disabilities, and general health education.
2) Other target group included disabled people, community health workers, and general public.

Major annual budget for health education and promotion projects was spent on management of hypertension and diabetes, and sexuality education (see Table 4). According to the sources of budget for health education and promotion projects of public health centers, which has responded to the survey, an average rate of 69% was from local government fund and 64% from the national health promotion fund. The proportion of local government's financial support in health education projects is quite substantial.

Table 4. Health Education Programs' Frequency, Participants, and Annual Budget

(Unit: Frequency, Persons, 1,000won)

Topic		Annual frequency	Participants	Budget
Anti-Smoking	Mean	23.90	2,212.58	1,640.57
	Std. Deviation	151.17	7,198.72	2,120.96
	N[2)]	340	265	167
Drinking	Mean	4.78	976.50	2,065.50
	Std. Deviation	4.60	1,685.38	1,456.97
	N	9	8	4
Exercise	Mean	45.97	1,799.33	1,420.71
	Std. Deviation	67.99	2,827.21	1,513.44
	N	33	21	14
Nutrition & Obesity	Mean	11.46	571.18	2,704.30
	Std. Deviation	35.79	1,096.71	3,051.36
	N	188	132	84
Mental Health	Mean	12.84	621.51	759.11
	Std. Deviation	43.83	1,351.41	1,042.49
	N	101	77	54
Dental Health	Mean	135.13	3,825.60	3,224.67
	Std. Deviation	762.94	10,654.97	5,725.54
	N	163	141	58
Chronic Disease	Mean	44.56	1,393.12	2,437.28
	Std. Deviation	199.97	5,510.25	4,272.42
	N	158	147	78
Hypertension & Diabetes	Mean	23.43	705.44	3,781.62
	Std. Deviation	89.35	1,458.02	6,973.76
	N	180	154	125
Others[1)]	Mean	21.42	1,920.99	2,193.70
	Std. Deviation	86.36	6,284.58	3,006.95
	N	139	106	57
Sexuality Education	Mean	25.27	1,416.06	3,456.56
	Std. Deviation	48.80	1,737.18	10,523.74
	N	83	63	18
Parenting Education	Mean	16.22	733.42	1,275.00
	Std. Deviation	37.76	2,233.96	1,290.42
	N	91	73	25
Total	Mean	35.67	1,646.50	2,396.57
	Std. Deviation	276.71	5,858.99	4,518.16
	N	1485	1187	684

Notes: 1) This category included prevention of communicable diseases, and rehabilitation courses.

2) Frequencies by projects excluding missing cases due to non-responses

According to the methods and formats of health projects by public health centers, health classes showed the highest rate, 61.03% for all target groups (Refer to the Table 5). Unspecified target group are general public, community health workers, and disabled people. VTR was a popular method for school setting. In the case of broadcasting format, cable broadcasting method was commonly used. Practice format used a method of counseling, health examination and exercise classes. Event format included anti-smoking declaration ceremonies, road campaigns, and exhibitions. Projects for grade school children used one-time lectures and obesity camping, publication of gazettes, or health competition events.

Table 5. Methods of Health Education Projects by Target Groups

(Unit: # of projects, %)

	Lecture	Practice	Event	Dist. of Prints	Broad-casting	Others[2)]	Sum
Teens	227 68.17	17 5.11	44 13.21	4 1.20	14 4.20	27 8.11	333 100.00
Infants	69 51.88	19 14.29	20 15.04	2 1.50	5 3.76	18 13.53	133 100.00
Women	83 59.29	11 7.86	31 22.14	4 2.86	5 3.57	6 4.29	140 100.00
Elderly	62 71.26	14 16.09	4 4.60	-	1 1.15	6 6.90	87 100.00
Adults	462 57.46	43 5.35	159 19.78	45 5.60	32 3.98	63 7.84	804 100.00
Others[1)]	43 81.13	2 3.77	1 1.89	-	1 1.89	6 11.32	53 100.00
Total	946 61.03	106 6.84	259 16.71	55 3.55	58 3.74	126 8.13	1,550 100.00

Notes: 1) Other target groups are general public, community health workers, and disabled people.

2) Other methods included home visit services, other mobile services, and not specified services.

3. Development and Usage of Educational Materials

Educational materials purchased or developed by a public health center were 6～7 on average. Anti-smoking materials were the major health education materials produced by public health centers (see Table 6). Printed materials (50%) are the popular medium of health education among public health centers. The expense for the purchase or development of an educational material was an average

Table 6. Topics and the Types of Educational Materials

(Unit: Kind of materials, %)

	Prints	Video	CD	Panel	Poster	Others[2)]	total
Anti-Smoking	98 48.28	31 15.27	6 2.96	26 12.81	1 0.49	41 20.20	203 100.00
Drinking	9 81.82	1 9.09	-	-	-	1 9.09	11 100.00
Exercise	17 60.71	4 14.29	-	3 10.71	2 7.14	2 7.14	28 100.00
Nutrition & Obesity	65 51.59	12 9.52	1 0.79	8 6.35	3 2.38	37 29.37	126 100.00
Mental Health	42 54.55	23 29.87	-	-	2 2.60	10 12.99	77 100.00
Dental Health	40 62.50	6 9.38	2 3.13	2 3.13	3 4.69	11 17.19	64 100.00
Chronic Disease	90 52.94	46 27.06	1 0.59	10 5.88	5 2.94	18 10.59	170 100.00
Hyper-tension & Diabetes	107 71.33	4 2.67	2 1.33	10 6.67	3 2.00	24 16.00	150 100.00
Others[1)]	58 43.61	57 42.86	-	2 1.50	1 0.75	15 11.28	133 100.00
Sex Education	19 18.63	75 73.53	-	1 0.98	-	7 6.8	102 100.00
Parenting Education	25 34.72	31 43.06	-	1 1.39	1 1.39	14 19.44	72 100.00
Total	570 50.18	290 25.53	12 1.06	63 5.55	21 1.85	180 15.85	1,136 100.00

Notes: 1) Other topics included prevention of communicable diseases, and rehabilitation courses.
2) Other category of materials included demonstration models, educational kits, puzzle games, etc.

of 890,000 won. There were significant financial differences among types of materials. Materials developed by the public health centers were pamphlets or leaflets, which were half of the educational materials. Video materials were usually purchased rather than developed by the centers. Quantity and budget of material production were significantly different for the kind of materials (See Table 7).

Table 7. Average Quantity and Average Budget Developed or Purchased for Educational Materials

(Unit: # of Copies, 1,000won, %)

Material Types		Quantity	Budget	Self-Produce Rate
Pamphlet	Mean Std. Deviation N	2184 3,900.07 402	799 1,186.89 375	52.8
Video	Mean Std. Deviation N	4 30.98 280	217 1,640.76 270	1.8
CD	Mean Std. Deviation N	21 41.61 10	172 338.92 9	1.1
Panel	Mean Std. Deviation N	19 33.98 62	1,223 1,327.17 59	7.1
Poster	Mean Std. Deviation N	1821 6,192.2 16	1,054 1,346.8 16	2.9
Broadcasting	Mean Std. Deviation N		2,971 - 1	-
Others[2)]	Mean Std. Deviation N	969 2,463.87 171	1,221 1,670.10 163	16.6
Other Prints	Mean Std. Deviation N	1071 1,348.25 143	2,048 2,420.70 124	17.7
Total	Mean Std. Deviation N	1133 2,861.51 1084	890 1,683.40 1017	100.0
Anova test	sig. level	p<.05	p<.01	

Notes: 1) N is the number of kind of materials
2) Other category of materials included demonstration models, educational kits, puzzle games, etc.

According to the types of educational materials by target groups, as it is shown in Table 8, more visual materials were used for teens than any other age groups. This implies that audio-visual materials were more effective in motivating teenagers and increasing learning experience. Print materials were commonly used for adults. Because mothers are main guardians of infants' health management, print materials were often used in this case also. Materials for other target groups were those for the physically challenged, rare-diseased patients, or responsible educators. Printed materials were mainly used for this group of people.

Table 8. Types of Educational Materials by Target Groups

(Unit: Kind, %)

	Prints	Video	CD	Panel	Poster	Others[2)]	Sum
Teens	78 35.78	91 41.74	3 1.38	15 6.88	1 0.46	30 13.76	218 100.00
Infants	49 38.58	34 26.77	1 0.79	6 4.72	3 2.36	34 26.77	127 100.00
Women	68 48.23	39 27.66	3 2.12	5 3.55	3 2.13	23 16.31	141 100.00
Elderly	16 55.17	10 34.48	-	1 3.45	-	2 6.90	29 100.00
Adults	351 57.45	116 18.99	5 0.82	35 5.73	14 2.29	90 14.73	611 100.00
Others[1)]	8 80.00	-	-	1 10.00	-	1 10.00	10 100.00
Total	570 50.18	290 25.53	12 1.06	63 5.55	21 1.85	180 15.85	1,136 100.00

Notes: 1) Other target groups were those for the physically challenged, rare-diseased patients, or responsible educators.
2) Other category of materials included demonstration models, educational kits, calendars, etc.

4. Characteristics of Health Education Workforce

A. General Characteristics

In this study, a survey on responsible educators was included to investigate systematic problems in developing and using educational materials for health projects. The age range of the staff of health education projects who responded to the survey was mostly 30s or mid-40s, and the average age was 39, which was relatively high; 95% of the staff was women. 48.5% of the department of health education was independent of the department of health promotion and health guidance. The average number of staff for public health education was 1.8 persons. 63.1% were nurses, and 27.9% were public health staff members. 90% of the staff were 7th and 8th rank civil servants. According to the education level, 49.6% were community college graduates, and 31.9% were college graduates. About 47.4% of the staff were performing other tasks in addition to health education. The average duration of health education duty was 22.7 months, and 2-year duration was very common. The problem of health education workforce is that the rate of holding an additional duty was high, and the work experience was short. For these reasons, there can be some limitations in planning and executing health education projects within the department.

B. Experience of Educational Training

Out of the staff members who responded to this survey, 65.9% received an educational training within a year. Among the areas of training, anti-smoking was 51.7%, which was the highest, and chronic disease ares was 20.4%. The desired training areas were: 56.5% for physical exercise, 39.5% for nutrition, 48.3% for obesity

control program, and 40.1% for stress management. There were many staff members who wished to have training on chronic disease area, so there should be a training program for hypertension & diabetes. Some expressed the desire to have hospice, recreation, general health promotion projects, and health education program. Therefore, educational training areas should be based on the local residents' health needs, and lond-term plans should be established.

Table 9. Training Areas for the Last One Year & Topic of Desired Training Areas for the Future

	Training Experience Areas		Desired Training Areas	
	Frequency	%	Frequency	%
Anti-Smoking	76	51.7	50	34.0
Drinking	19	12.9	34	23.1
Exercise	16	10.9	83	56.5
Nutrition	8	5.4	58	39.5
Obesity	1	0.7	71	48.3
Stress	2	1.4	59	40.1
Dental Health	4	2.7	20	13.6
Physical Exam	7	4.8	12	8.2
Chronic Disease	30	20.4	47	32.0
Accident and Safety	3	2.0	16	10.9
Others[1)]	12	8.2	6	4.1

Notes: 1) Other topics experienced were sexuality education and counseling, and other topics the staff wants to receive were recreation, hospice, and general health promotion.
2) Respondents N=147

Ⅳ. Conclusion

Among the health education projects, anti-smoking, hypertension

& diabetes management projects were very popular, and the their popularity rates were 21% respectively. Projects with low popularity were the lectures on general health. To increase local residents' popularity, the health education themes need to be specified and tailored. Tailored messages are more likely attract people's attention and their intention of adopting healthy practice. Health education material alone, however, may not lead people to desired health behaviors (Kreuter, 1999; Holt, 2000).

Health education staff members indicated the lack of manpower, facilities & equipment, and professional training as the major causes of the problems of health education projects. Another problem was that there was no link between health promotion project itself and the existing health projects. In the aspect of budget, it was pointed out that there was no clear instructions on how to use the expenses and resources of a project. Some gave an opinion that there should be a health promotion department in every public health center, which can control all the disease management projects that are run by different departments. Some people also suggested that local government training offices should open training programs and provide training locally for health education staff members. Each local government should develop a program which can accommodate local needs. There might some difficulties in promoting educational programs if there are many elderly people. Because literacy among elderly is very low in rural area, it is not easy to communicate with them.

A problem that was indicated by the central government was that there was not enough health educational materials which reflect the characteristics of each target group. There should be different educational materials for each target group such as for people who want to start smoking, for heavy smokers, and for non-smokers.

The difficulties of training students were also indicated because of lack of educational materials specifically for students. The problem of general health educational materials was that it was difficult to get direct responses (educational effects) from target groups. Another problem that was indicated was that, to increase the effects of education, there were about a pause of 20 minutes in the tape, and in this case, too much general information could be included in the educational materials. They wanted some specific practical information.

In general, it is not easy for health education staff to develop an educational program and educational materials because of lack of budget and experience. To improve health education projects, there should be a collaborating center at the national level so that manufacturing educational materials and educational programs can be systematically managed. This may solve the financial restriction of developing quality health education materials at local level in Korea.

It is required that the government has to develop a guidelines for local health education because the themes and scope of activities vary greatly. Provision of public health education programs needs balance and appropriate evaluation system, too. Another important issue is to provide appropriate training for health education officers at local level. Since their duration of health education duty is very short, appropriate technical support from central government is very important. Finally, systematic provision of health education can save money, and the government monitor the health education activities and evaluate them periodically. Researching effectiveness of the health education activities is also major factor for successful health education policy.

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Summary

보건소 보건교육사업의 분석

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본 연구의 목적은 보건소의 보건교육사업을 조사분석하여 보건교육사업의 종류별 특성을 고찰하는 데 있다. 주요 연구문제로는 첫째, 보건교육사업의 주제, 교육대상, 예산 등의 제한점에 대한 것이고, 둘째 보건교육사업에 활용된 보건교육자료의 현황에 대한 것이다. 연구방법은 보건교육사업현황 설문조사, 보건교육담당자의 보건교육사업 및 교육훈련요구도 조사를 기초로 한 데이터 분석을 시도하였다. 조사대상은 전국의 시군구 보건소 보건교육담당자였다. 설문에 응답한 보건소(181개소) 중에서 2001년도에 수행된 보건교육사업의 건수는 한 보건소 당 평균 8.6개로 1개 사업을 수행한 보건소도 있었고, 많게는 34가지의 보건교육사업을 수행한 보건소도 있었다. 건강증진 또는 보건교육사업의 주제는 금연사업이 22.71%, 고혈압당뇨사업 등 만성퇴행성 질환예방관리사업이 22.59%, 비만관리를 포함한 영양사업이 12.52%, 성교육 5.55%, 모자보건사업 5.94% 등을 나타내었다. 기타 사업주제로는 전염성 질병예방, 장애예방, 일반건강교실 등이 있었다. 사업의 대상은 일반성인 51.9%, 청소년 21.50%, 모성 9.00%, 영유아 8.60% 등임. 기타 대상은 장애인, 환자, 교육담당자, 전문가 등으로 나타났다. 보건소에서 개발한 교육자료는 팜플렛 및 리플렛 종류가 반 이상을 나타내었으며, 비디오자료는 자체 개발보다는 구입한 경우가 대부분이었음. 보건소에서 실시하는 사업의 형태가 행사 및 1회성 강연이 많았다는 점을 비추어 볼 때 홍보사업이 중심이 되고 있음을 알 수 있었다. 보건교육 사업 중 호응도가 높았던 사업은 금연사업 및 고혈압당뇨관리사업이 각각 21%로 나타났다. 보건교

육담당자들은 보건교육사업의 문제점으로 인력부족, 시설 및 장비부족, 전문적 훈련부족 등을 지적하였다. 지역단위에서 보건교육이 다양한 계층을 상대로 하므로 이들의 특성과 보건문제에 맞는 다양한 교육자료들이 활용될 수 있어야 한다. 최근 보건교육사업의 주제들이 건강생활이 강화된 경향이 있는데 효과적 추진을 위해서는 정부에서 인력과 훈련프로그램을 뒷받침하여야 할 것이며, 체계적인 보건교육지침이 개발되어야 하고, 주기적인 프로그램평가가 뒷받침되어야 할 것이다.