

# A REVIEW ON SELF HEALTH EDUCATION

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## ABSTRACT

An expanded role for educated consumers interacting with responsive healthcare teams is a central thrust of the health reform. However, the benefit of health education also requires a high degree of commitment for individuals. Population studies have documented the gap between expectations and actual behaviour performance related to healthcare participation and prevention. Self-care interventions have demonstrated improvements in efficiency, patient satisfaction, coping skills, and social assistance perceptions. Trials of self-management or lifestyle interventions under conditions such as diabetes, coronary heart disease, heart failure and rheo-arthritis have seen significant clinical benefits. However, many studies focus on short-term results rather than long-term effects. It is also clear that participation in patient education programmes is not evenly distributed among socio-economic groups. This review examines three other issues that may be important for enhancing the impact of patient education on public health. The first is health literacy, capable of seeking, understanding and acting on health information. While health literacy involves the skills of an individual, health care has a major responsibility in establishing the health interaction parameters and the style, content and information mode.

**Keywords:** Health, Education, Review

## INTRODUCTION

Chronic disease self-management and preventive health programmes, focusing mainly on promoting informed choices of lifestyles, modifying the risk factor and actively handling chronic diseases for patients. This process is largely based on improved information and communication practises. The logic of health reform, which underlines preventive and improved primary care models, is an expanded role for informed and active consumers interacting with responsive health care equipment. [1-5] Many observers agree that this key role requires better education and understanding of the behaviour of health and the management of chronic diseases. For people to achieve the benefits of health education, however, a high level of participation and commitment, i.e. action or behaviour related to health, is also required. It has been shown that these deaths could be delayed with only 10 changes in behaviours, such as tobacco consumption, diet, physical activity, alcohol use and other, including microbial exposures, exposure to toxicants, use of firearms, sexual behaviour, engine crashes, and illicit drug use. Almost 80% of premature deaths were attributed to just three of the lists – tobacco use, dietary patterns and physical activity. More recent evidence of an 8-year cohort study of more than 23,000 German adults shows that four behaviours represent a 78% variance in the apparent risk of serious chronic disease. 3 Again, it involves smoking, diet and physical activity. As one of the four (the maintenance of BMI, 30) is a by-

product of two other behaviours already included in the List (eating well and being active), the "difference between life, death, health and illness is dictated substantially by only three behaviours." For all "healthy behaviours" compared to none, 0.22 [95 percent Confidence Interval (CI): 0.17–0.28] was the hazard ratio of diabetes, myocardial infarction, stroke, or cancer. The presence of a single healthy behaviour compared to none reduced the risk of chronic disease by half (adjusted HR, 0.51; 95% IC: 0.43–0.60). [6-9]

## **FACTORS INFLUENCING BEHAVIOR**

Many factors influence behaviour, and the scope of this review is not included in a review of the social determinants of health. To give an example of the power of social factors, such as inadequate access to healthcare, education inequalities and poverty, however, take Woolf et al's analysis of death rates for adults with insufficient education in the US into consideration. For this web of sociological, economic and biological variables, authors used education-related surplus mortality as a proxy. They used indirect standardisation methods to estimate the maximum number of deaths prevented from 1996 to 2002 due to medical progress and the number of mortalities that would have been prevented if death rates among adults with lower education were the same as those among adults with college education. The authors concluded that "compared with the gain from medical progress, the number of deaths is 8 times higher if mortality rates are the same for adults who are inadequately educated as those in higher education." With this overwhelming statistics in mind, this review focuses on the limited and specific issues of patient or health education, generally within the healthcare system.

The literature documents the gap between expectations and the actual performance of behaviours related to health care participation and prevention. The Cochrane library review shows that most interventions to increase consumer involvement include the promotion of patient drug compliance, self-management of chronic disease, and traditional drug, diet and exercise health promotion behaviour. Efforts to improve clinical meetings have been largely aimed at encouraging patients to ask questions in writing or coaching. Another focus was on people improving self-care, better health literacy and helping them make clinical decisions. [10-14] Coulter and Ellins found little or no studies or systemic reviews in a recent review describing procedures to navigate the health care system or to promote easy access to care.

## **SOLUTIONS**

This article reviews some evidence regarding the effective treatment improvement strategies, especially chronic conditions, before looking at some of the issues related to patient education and consumer engagement and participation that can affect those strategies,. A systematic review concluded that "the evidence is over-written that the risk of many diseases including coronary artery disease, hypertension, diabetes and metabolism is reduced by physical activity and diet. Few studies examined the isolated

effect of training on diabetes prevention in patients with impaired glucose tolerance, but there is good evidence that combined physical and dietary training have a beneficial effect. [15-19] examined dietary evidence and lifestyle changes in diabetes prevention. A number of studies have shown that lifestyle changes can decrease the incidence of type 2 diabetes by 28 percent to 59 percent. These effects have been observed long after the procedure. Regular exercise was needed to maintain weight control and reduction of risk. A comprehensive systematic review has demonstrated that strong evidence exists for the benefits of exercise in improving clinical results of metabolism, for example diabetes and hypertension; Coronary Heart and Heart Insufficiency (CHD); depression; fibromyalgia and knee arthritis. [20-21] There is less evidence that asthma, COPD or other types of arthritis are clinically significantly improved. Exercise training improves the exercise capacity of patients receiving hemodialysis for chronic renal failure. The advantages of life quality are often most remarkable in the lowest standards.

## CONSLUSION

A number of interventions have been studied to improve adherence to medication regimes. Few succeeded in increasing the use of medicines in the long term. Nearly all the interventions effective for long-term care with multiple combinations were complex. These included more convenient treatment, information, reminders, self-monitoring, strengthening, advice, family therapy, psychological therapy, crisis intervention, manual telephone monitoring and supportive care. In general, however, improvements in compliance and treatment outcomes were modest. Others have seen modest improvements in ER and pulmonary obstruction, but not other self-management clinical findings. Similarly, self-management epilepsy programmes can improve epilepsy knowledge and reduce seizure frequency. However, the evidence is limited and has tended to include more persons with partial seizures than would be expected in a community sample so that conclusions are difficult to reach.

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