Health Promotion Theory, Praxis, and Needs in Transylvania, Romania

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Abstract

English:

Working with Romanian colleagues from the Institute of Public Health, Cluj-Napoca, Romania, researchers set out to discover what health promotion strategies and interventions were being used by Romanian health professionals, to find out who Romanian citizens learn healthy behaviors from, and to discover the perceived needs regarding health promotion which include; strengths, weaknesses, barriers, and enablers of healthy behavior. A quantitative survey examining health promotion activities, needs, and theoretical constructs was developed, translated and administered to thirty-eight health professionals recruited from five different counties in Transylvania. Following this survey, five focus sessions were conducted with small groups of health care professionals to elicit descriptive information concerning the health promotion activities, needs, and theoretical approaches currently in use.

Health professional responses were analyzed using JMP statistical discovery software, version 4.0.2. Contingency analysis utilizing the Chi square statistic (Likelihood ratios and Pearson's coefficient) were ran for all variables. These are reported and include such items as types of health education/promotion professionals, contact hours with clients by type of professional, enablers of health promotion, barriers to health promotion, and health educators experience with western theories of health education and promotion. Our findings indicate that Romanian health promotion practices represent approaches and strategies that focus on the individual level and the intrapersonal dynamic. Based on this field research, current approaches put the responsibility for health behavior squarely on the individual. Consideration of other variables such as the environment, cultural differences, and the need for community action must be developed to continue improving the health education/promotion infrastructure in Romania, particularly in rural village settings.

Spanish:

Funcionamiento con los colegas rumanos del instituto de la salud pública, Cluj-Napoca, Rumania, investigadores precisó para descubrir qué estrategias de la promoción de la salud y los interventions eran utilizados por los profesionales de salud romanian, para descubrir quién Los ciudadanos rumanos aprenden comportamientos sanos de, y descubrir las necesidades percibidas en relac'ion con a la promoción de la salud que incluyen; fuerzas, debilidades, barreras, y enablers del comportamiento sano.Una promoción de la salud del examen que examina cuantitativo las actividades, las necesidades, y las construcciones teóricas fueron desarrolladas, traducido y administrado a los profesionales de salud del thirty-eight reclutados a partir del cinco diferente condados en Transylvania.Después de este examen, cinco sesiones del foco estaban conducido con los grupos pequeños de profesionales del cuidado médico para sacar descriptivo información referente las actividades, las necesidades, y al teórico de la promoción de la salud acercamientos actualmente en uso.

Las respuestas del profesional de salud eran analizadas usando JMP software estadístico del descubrimiento, versión 4.0.2.El utilizar del análisis de la contingencia la estadística del cuadrado del chi (los cocientes de la probabilidad y el coeficiente de Pearson) era funcionó para todas las variables.Éstos se divulgan e incluyen los artículos tales como tipos de profesionales de la salud education/promotion, horas del contacto con los clientes por tipo profesional, enablers de la promoción de la salud, barreras a la promoción de la salud, y experiencia de los educadores de la salud con teorías occidentales de la educación de salud y promoción.Nuestros resultados indican que la promoción rumana de la salud practica represente los acercamientos y las estrategias que se centran en el nivel individual y intrapersonal dinámico.De acuerdo con esta investigación de campo, acercamientos de la corriente puestos la responsabilidad del comportamiento de la salud en ángulo recto en el individuo. Consideración de otras variables tales como el ambiente, diferencias culturales, y la necesidad de la acción comunitaria se debe

desarrollar para continuar mejorar infraestructura de la salud education/promotion en Rumania, particularmente en rural ajustes de la aldea.

Romanian:

În colaborare cu colegii români de la Institutul de Sănătate Publică din Cluj-Napoca, România, cercetătorii au încercat să stabilească ce strategii şi acţiuni de promovare a sănătăţii sunt utilizate de specialiştii români din domeniul sănătăţii, de la cine învaţă cetăţenii români comportamentele igienice şi care sunt necesităţile sesizate în legătură cu promovarea sănătăţii, necesităţi care se referă la punctele de sprijin, punctele slabe, obstacolele şi factorii favorizanţi ai comportamentului sănătos. S-a elaborat un instrument de evaluare cantitativă a activităţilor de promovare a sănătăţii şi a necesităţilor şi constructelor teoretice, care a fost apoi tradus în limba română şi aplicat la 38 de specialişti din domeniul sănătăţii provenind din cinci judeţe ale Transilvaniei. După încheierea anchetei, s-au organizat cinci discuţii tematice în grupuri mici de specialişti din domeniul medicinei preventive, pentru a se obţine informaţii privind activităţile de promovare a sănătăţii, a necesităţilor şi a concepţiilor teoretice curente. Răspunsurile specialiştilor din domeniul medicinei preventive au fost analizate folosindu-se pachetul de programe de calcul statistic JMP, versiunea 4.0.2. Pentru toate variabilele în cauză s-au desfăşurat analize de contingenţă utilizând coeficienţi Chi-pătrat (rapoarte de probabilitate şi coeficienţi Pearson). Ele sunt prezentate în lucrare şi se referă, de exemplu, la tipurile de specialişti în domeniul educaţiei şi al promovării sănătăţii, orarul desfăşurării activităţii pe categorii de specialişti, factorii de sprijin şi obstacolele în promovarea sănătăţii, familiarizarea instructorilor cu teoriile occidentale privind educaţia pentru sănătate şi promovarea sănătăţii etc. Rezultatele obţinute arată că practica promovării sănătăţii în România se bazează pe abordări şi strategii la nivel individual şi la cel al dinamicii intrapersonale. Conform acestor cercetări de teren, abordările curente plasează răspunderea comportamentului legat de sănătate numai asupra individului. Se impune luarea în considerare şi a altor variabile cum ar fi mediul înconjurător, diferenţele culturale şi nevoia de acţiune la nivel comunitar, pentru a îmbunătăţi în continuare baza organizatorică şi materială a educaţiei pentru sănătate şi a promovării sănătăţii în România, mai ales în zonele rurale.

Keywords: Health Promotion Theory, Public Health Education, Transylvania, Romania

Introduction

Health promotion as a field of study has come of age in the past 20 years in Western Europe, Canada, and the United States. The same cannot be said for many other countries around the world where the field of health promotion, while present in one form or another, is not as highly developed. Eastern Europe, in particular, the country of Romania has faced considerable economic re-development hardships following the dissolution of the Soviet Union. Transition away from a centrally planned system began with the revolution of 1989, and Romania improved in many areas in regard to the country's health status. Since 1970, female life expectancy in Romania has increased 3.5 years (EOHCS, 2000, WHO, 1999). The standard death rate for suicide and self-inflicted injury in Romania has improved greatly and is the lowest among other Eastern European reference countries (WHO, 1999). Reference countries (all of which have gone through transition of governments) include Bulgaria, Czech Republic, Estonia, Hungary, Latvia, Lithuania, Poland, Slovakia and Slovenia (WHO, 1999).

In addition to some positive health effects, hardships have fallen on the Romanian citizens as well. Romania's overall life expectancy is the lowest among reference countries that provided life expectancy rates (WHO, 1999). Romania has the highest maternal mortality rate among reference countries providing maternal mortality rates. Infectious diseases, including tuberculosis are on the rise as well as newly emerging problems such as HIV/AIDS and drug abuse (McNeil, 2001, EOHCS, 2000, WHO, 2000, 1999). Besides direct health problems, there are also serious environmental problems, such as drinking water contamination, that indirectly contribute to poor health outcomes (WHO, 1999).

Working with Romanian colleagues from the Institute of Public Health, Cluj-Napoca, Romania, researchers set out three objectives. The first objective was to discover what health promotion strategies and interventions were being used by Romanian health professionals. The second objective was to find out who Romanian citizens learn healthy behaviors from. The third objective was to discover the perceived needs regarding health promotion which include; strengths, weaknesses, barriers, and enablers of healthy behavior. This was done by seeking the health professional's opinions and perceptions in regard to the current status of health promotion in Transylvania, via surveys and focus sessions.

The purpose of this paper is to delineate and describe the health promotion practices of health "education" providers in Transylvania, Romania

based on field research. This work provides a descriptive analysis of the health promotion activities and needs of Romanian health professionals based on survey and focus group results from 38 medical and health professionals in the Transylvania Region of Romania conducted in the spring of 2001. To lay the groundwork for a descriptive definition of health promotion in Transylvania, a brief review of literature pertinent to needs assessments and descriptive studies in Romania is included.

Literature Review

Romanian Studies

Few studies focusing exclusively on Romania have been published examining the link between environmental contamination and health, (Billig, 1998, Ault, Pepper, Pollard, & Rest, 1997,) and even fewer studies were designed to evaluate health promotion and education practices in the Country (Steiner et. Al., 1999, Skoufias, 1998, Enachescu, 1998, Makara, 1998).

A research partnership between the city of Constanta, Romania, the Humana Foundation, and the University of Louisville descriptively defined community health needs through the use of the Precede-Proceed model (Steiner et al., 1999). The community was mobilized via media messages designed to promote, educate, and facilitate all health promotion programs in Constanta (Steiner et al., 1999). This study illustrated the importance of utilizing a needs assessment and using the results to develop behavior change interventions.

A research team funded by The Environmental Health Project (EHP) conducted another relevant needs assessment in Zlatna, Romania, which is located in Alba County in west-central Transylvania (Billig, 1998). The information uncovered was used to guide interventions and public health education in regard to environmental health problems. The EHP also performed another needs assessment in the Transylvania region that is pertinent to this research involving 172 general practitioners (GPs), from Cluj-Napoca, Romania (Ault, Pepper, Pollard, & Rest, 1997). The work delineated what the GPs needed as far as continuing medical education in environmental and occupational health (Ault et al., 1997). Later environmental health interventions were guided by the needs assessment results. Categorization and identification of environmental and occupational health problems in the Cluj area was also completed (Ault et al., 1997). Priority lists of environmental/occupational health problems were created as a result of this research and objectives were developed to address these problems (Ault et al., 1997).

In another study, a cross-sectional design was used to explore child health status during transition in Romania. This study found the mother's education level directly affected the health status of boys and girls (Skoufias, 1998). This study provided valuable insight into how the Mother's background affected the health of her children, and it indicated the need for further research and programming in the area of health and health promotion interventions aimed at improving the Mother's educational level.

Romania's whole health care system was evaluated from a management perspective by Enachescu (1998). Enachescu described the Romanian health care system as being in need of managerial overhauling. Enachescu noted that one of the main reasons the system was experiencing difficulties in delivering even basic patient care was the quick transition to new political leadership and a new, market based economy which was unfamiliar to health care managers use to functioning under a Soviet program (Enachescu, 1998). External assistance was needed as health educators and clinical educators were using cultural models that were outdated (Enachescu, 1998). Enachescu, concluded that administrative change at the highest levels coupled with a desire for reform were necessary if the system were to improve (Enachescu, 1998).

International Cross-Sectional Studies and Needs Assessments

With very little data and few studies focusing on health education theory and practice in Romania, other international studies, needs assessments and cross-sectional studies carried out in situations of political or economic struggle or renewal may help to inform current research.

In the country of Thailand, Khon Kaen, the biggest and poorest location within the country was the focus of a project to promote the behavior of hand washing, and dish washing in order to decrease infectious disease rates (Pinfold & Horan, 1996). The behaviors of feeding a baby, cooking, eating, defecating, and infant bathing were analyzed and observed. A needs assessment which measured the beliefs, attitudes, and practices of villagers in regard to these cleanliness behaviors and the avoidance of infectious material containing microorganisms was used to collect data (Pinfold & Horan, 1996). The assessment led to the construction of a social marketing based intervention program that strived to change hygiene practice through an emphasis on strong, healthy children. This study illustrated how valuable needs assessments were to planning community health interventions.

Another developing country whose rural villages have benefited from preliminary health needs assessment is the country of Ecuador. Research in the Province of Cotopaxi was conducted in 26 indigenous communities in order to identify priority health and health education needs (Puertas & Schlesser, 2001). Six areas covered by the assessment included: access to health services, family composition, frequent illnesses, family health, reproductive health, and the health of children under five (Puertas & Schlesser, 2001). Clear differences in health status between the rural and urban populations were discovered (Puertas & Schlesser, 2001). Researchers concluded that a description of culture, lifestyle, socio-economic status, importance of traditional medicine, and the general health status of the population must be taken into consideration when developing health service plans for Ecuador's rural and urban populations (Puertas & Schlesser, 2001).

Needs assessments have been used not only to develop but also to evaluate health promotion programs. In South Africa, researchers used a qualitative needs assessment to assess the health education programs offered through sexually transmitted diseases, STD clinics (Reddy, Meyer-Weitz, Van Den Borne, Kok, & Weijts, 1998). Their purpose was to create better functioning STD clinics via improved health education programs in the clinics (Reddy et al., 1998). The health care workers were interviewed and asked questions that explored their educational background, knowledge of STD related information, specific health education training, attitudes towards health education and their clientele, and attitudes toward the organization as a whole in regard to health education. The research revealed that health educator's had positive attitudes towards health education. Barriers of time, space, and financial resources were found to have hindered the practice of health education (Reddy et al., 1998). Researchers found that the health workers wanted to positively influence their clients' health but did not have the structural capacity to do so.

The control of malaria has been a major concern for public health authorities in Zimbabwe. Researchers evaluated the health behaviors related to Malaria control in rural communities of Zimbabwe (Vundule & Mharakurwa, 1996). Knowledge, practices, and perceptions concerning malaria control in rural Zimbabwe were obtained using a survey (Vundule & Mharakurwa, 1996). Researcher's discovered that villagers were in great need of preventative, environmental health education (Vundule & Mharakurwa, 1996).

In summary, needs assessments and cross-sectional studies have been used to delineate the health concerns and describe health status in Romania and throughout other countries who are struggling to develop their health education and promotion infrastructure. In particular, the studies mentioned have been used to develop and guide health interventions. This work this work builds on past work by describing the health education concerns and health promotion practices of health educators throughout the Transylvania region of Romania (Zeman, 2000, Depken and Zeman, 2000). Interviews, surveys, and focus sessions were used to gather data and develop insights into the theoretical orientation, current health promotion practices, and health promotion and education needs of this region.

Methodology

A quantitative survey was developed, translated and administered with the goal of describing the health promotion activities and needs reported by Romanian health care professionals (Fowler, 1984). Careful translations of both the survey and focus group scripts were developed by American and Romanian colleagues (Depken and Zeman, 2000). Romanian colleagues were fluent in English and were well versed in medical and public health terminology. The translators were actively involved in data acquisition and focus session meetings.

Thirty-eight health professionals were recruited from five different counties in Transylvania through the Institute of Public Health, Cluj-Napoca. Researcher's sought to generate a broad cross-section of occupations and opinions in the Transylvania region of Romania. These individuals all had job related responsibilities in the areas of health education and promotion. Occupations included Primary Physicians (n=8), Specialist Physicians (n=8), General Practitioners (n=5), Family Practitioner (n=4), Epidemiologists (n=5), Administrators within the Sanitary Police Inspectorate, and the regional Health Departments (n=4), Psychologists (n=2), and Nurses (n=2). These individuals completed a survey questionnaire prior to participating in a script guided focus session lasting up to two hours.

The survey consisted of three sections. The first section of the survey addressed the demographics of the participants including information regarding occupation, patient contact load, and time spent preventing vs. treating disease. In the second section of the survey, the participants were asked to provide their opinions on how influential certain components of society (schools, businesses, hospitals, churches, etc.), were in regard to health promotion. The last component of the survey consisted of some focused examples requiring the respondent to describe their specific use of health promotion activities in these

situations and it further explored their familiarity with theoretical models of health education and promotion.

Following this survey, five focus sessions were conducted with small groups of health care professionals to elicit descriptive information concerning the health promotion activities, needs, and theoretical approaches in the Transylvanian region. The script questions for the focus sessions covered four areas: short term health planning, long term health planning, barriers to health promotion and facilitators of health promotion. These four areas each had a main question that was asked, along with several follow-up questions, designed to stimulate and encourage discussion.

Depending on the pace of the focus session one to three questions were asked, or all the questions were asked. Immediately following the survey and focus sessions, meetings with translators occurred to first translate the surveys and then to transcribe the focus group audiotapes into English. The UNI researchers and Romanian translators then reviewed the transcripts to clear up any confusion that may have occurred after translation had been completed.

Data Analysis

Health professional survey responses were entered into an Excel database and statistically analyzed using JMP statistical discovery software, version 4.0.2. Contingency analysis utilizing the Chi square statistic (Likelihood ratios and Pearson's coefficient) were ran for variables measuring knowledge of health promotion theories and models, identification of barriers to and promoters of health education and such characteristics as professional field of practice and number of clients served yearly. For all comparisons, $P< 0.05$ was considered significant. Transcribed focus sessions were carefully reviewed and discussion questions were categorized according to the western health promotion and health education theoretical perspectives they engendered. This qualitative information was used to reflect on and support quantitative findings.

Results and Discussions

As seen in Table 1, fourteen of the health professionals surveyed serve between 100 and 800 patients a year while 11 of the professionals see less than a 100 patients per year (of 24 responding). It was found that the majority of health professionals who participated in the survey reported direct involvement in health education or promotion activities since seventy-three percent of the health professionals surveyed answered that they found it "routine to inform citizens of important health problems." Regardless of their specific responsibilities, all participants identified themselves as health educators.

Participants were asked to estimate the time spent on various work activities with this question; "If you had to divide up your time on a percentage basis, what percentage of your time is used in diagnosing and treating sickness and disease and what percentage of your time is used to educate people about preventing sickness and disease?" As seen in Figure 1, of the 8 categories of health professionals surveyed 6 of these categories contained respondents that believed they spent more time transmitting knowledge designed to better health, than they do diagnosing sickness or prescribing treatment.

Table 1. Demographics of Health

Participants by Occupation	Number by Occupation	0-100 Patients Seen a Year	100-800 Patients Seen a Year
Specialist			
Physician	8	2	1
Psychologist	2	1	1
Primary			
Physician	8	5	3
Nurses	2	0	0
General Practitioner	5	0	4
Practitioner Family	4	0	4
Epidemiologist	5	1	0
Management	4	2	1
Total	38	11	14

The GPs and family physicians reported spending more time treating sickness, and they also reported the greatest number of patient contacts during a year's time.

The 36 health professionals were asked the following open-ended questions in the written survey; "Are you using any health promotion or state sanctioned organizational strategies to educate Romanian citizens on health issues?" All respondents indicated that they believed they did use health promotion or state sanctioned organizational strategies. The follow-up question asked,All rea "What current, specific strategies they were using to educate people about healthy behavior?" Their responses were categorized as illustrated in Figure 2. The majority reported relying on National Health Laws which address specific diseases (60%). When this is considered along with other forms of state

organized health promotion strategies such as TB programs and National Campaigns, 68% were found to use some state sanctioned form of health promotion/education (Figure 2.).

The sixty percent of health promotion strategies described as guiding the health professional's health education practices under the category of "National Health Laws" are embodied in 34 National Health Laws covering specific diseases. While a detailed summary of these laws is beyond the scope of this paper, they are process oriented directives designed

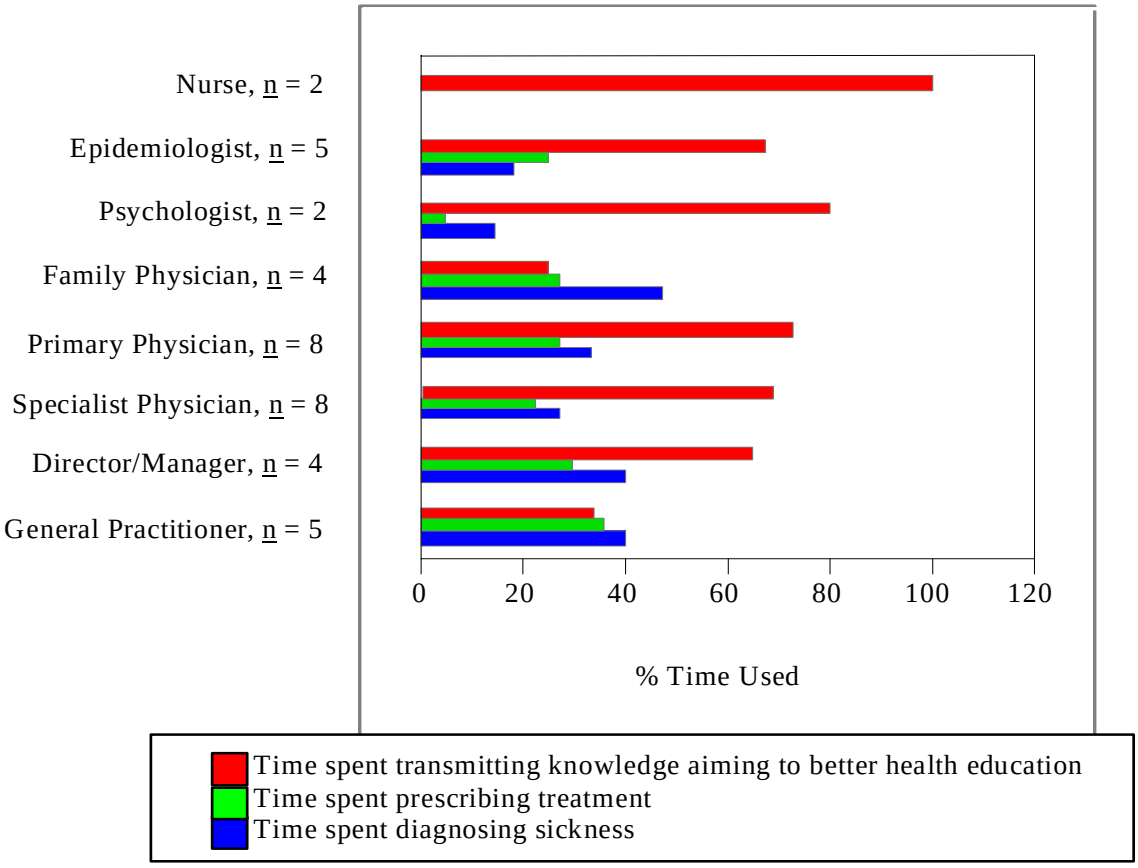

Figure 1: Health professionals perceived use of time

to address health issues at a national level ranging from cardiovascular diseases to various infectious diseases such as tuberculosis. These laws are process oriented directives designed to address health issues at a national level.

Participants were asked to rank various institutions and organizations as to the degree of facilitation they currently offer to Romanian health promotion on a ten-point rating scale, with one being a strong facilitator and ten being less expeditious of health promotion activities in the Transylvania region as perceived by the respondents (Table 2).

Responses tended to cluster under the mid-point (5) indicating that all respondent's felt that these institutions played roles in health education and promotion. However, for the sake of discussion the scale was divided in half based on the highest score (3.40) with 1.70 being the cut-off point between highly-rated and lower-rated facilitators of health promotion. Open-ended questions followed this rating scale which asked the professionals about their use of various health promotion strategies as well as their perceptions of the organizational barriers and constraints to improved health promotion in their country. Individual practitioners viewed themselves as the main promoters of health (avg. rank 1.30) followed by radio, television, schools, and newspapers. Churches (avg. rank 2.50), while recognized as having the potential to positively influence health promotion and education, have a score which is close to government agencies (avg. rank 2.70) both being considered lower ranking facilitators. The lowest rating went to both small and large business entities (3.30-3.40) indicating a potential for developing awareness of worksite health

promotion potential and modalities for accomplishing health education in the workplace setting.

The qualitative analysis tended to support this quantitative ranking. When transcripts of the focus sessions were analyzed the most prevalent constraining factors noted by the health professionals in open-ended questions were lack of funding and the lack of a properly trained work force to effectively carry out health promotion and education activities. In every survey and focus session, insufficient funding was mentioned numerous times. It was inferred by the health professionals that money was directly correlated with the lack of labor to carry out health promotion. Statements were made during focus sessions and on surveys indicating that a shortage of general practitioners and family physicians not only leads to elevated patient loads, but also to an overemphasis on treatment rather than prevention. Health professionals suggested that the labor shortage contributes to the mountainous regions and rural areas not being sufficiently covered in regard to health promotion and health care. They also suggested that the lack of communication infrastructure to reach the rural areas affects the health education system as well.

Table 2: High Facilitators and Low Facilitators of Health Promotion

Highly Ranked Facilitators	Top 50% of half-scale*
Workforce	1.30
Radio	1.70
Television	1.70
Low Ranked Facilitators	Bottom 50% of half-scale*
Schools	1.80
Newspapers	1.90
Magazines	2.00
Churches	2.50
Govt. Agencies	2.70
Govt. Funding	3.20
Small Employers	3.30
Big Corporations	3.40

The lower the number the better facilitator of health promotion; n=38
*Original responses on a 10 point scale with high of 3.40; divided into a half scale for purposes of discussion with 1.70 being break-off for top ½ of scale.

Health professionals suggested cooperation between organizations in regard to health promotion as a way to overcome deficient funding. Several of the focus session discussions led participants to the conclusion that if Romanian health promotion is to be successful, cooperative activities between different organizations need to take place. Health professionals suggested cooperation between government, academic institutions, and other organizations to work together and be involved in health promotion as well.

The health professionals' also emphasized the citizen's individual responsibility in regard to their health as both a guiding paradigmatic principle in regard to their beliefs about health promotion and as constraining factor to health promotion. In an effort to elicit open-ended responses which would illustrate the basic paradigmatic orientation of the health educators, the professionals were asked for reasons, "Why a patient of theirs would avoid seeing a doctor for an ailment." Upon coding of responses to indicate either intrapersonal or interpersonal reasons for avoiding seeing the doctor, 77% of the health educators said their patients gave intrapersonal reasons not to see them while 22% of the reasons were interpersonal as shown in Figure 3.

The majority of the health professionals (77% overall) indicated that intrapersonal or individual factors are totally responsible for their health; thus, the emphasis for health prevention is placed on the individual.

Other needs identified by health professionals in open-ended survey questions and focus sessions include a desire for increased use of mass media for health promotion purposes, acquisition of additional funding by the Romanian health professionals for health promotion programs, and improvements to the accessibility of health care and education for minority populations such as the Roma. These specific needs were found to be the most important to the health professionals in all focus sessions.

Specific Results from Focus Sessions

The focus group sessions covered four areas: short term health planning, long term health planning, barriers to health promotion and facilitators of health promotion. Focus Session statements were analyzed and placed into three identifiable, major areas with a count of statements supporting each area (Table 3). The statements are distributed according to their support for specific health promotion models (overwhelmingly the Health Belief Model), comments that were associated with needs (such as better laws or better financing for health promotion), and other miscellaneous issues that arose as a result

of the focus session discussions. In general, the focus group sessions served to expand on the survey findings as well as to further delineate issues, needs, and constraints regarding health promotion practices from the participant's perspective. Further discussion of relevant statements of interest follows.

Although participants' familiarity with Western health promotion theories were limited, the theoretical underpinnings of the Romanian health promotion practices were determined to most resemble the constructs of the early Health Belief Model (HBM), before the concept of self-efficacy was added by Bandura in 1977. Current practices of Romanian health promotion do not consistently include concepts of self-efficacy, thus the reference to the early HBM (Glanz et al., 1997, Bandura, 1986, Becker, 1974).

The premise behind the HBM is summarized by Glanz et al. (1997):

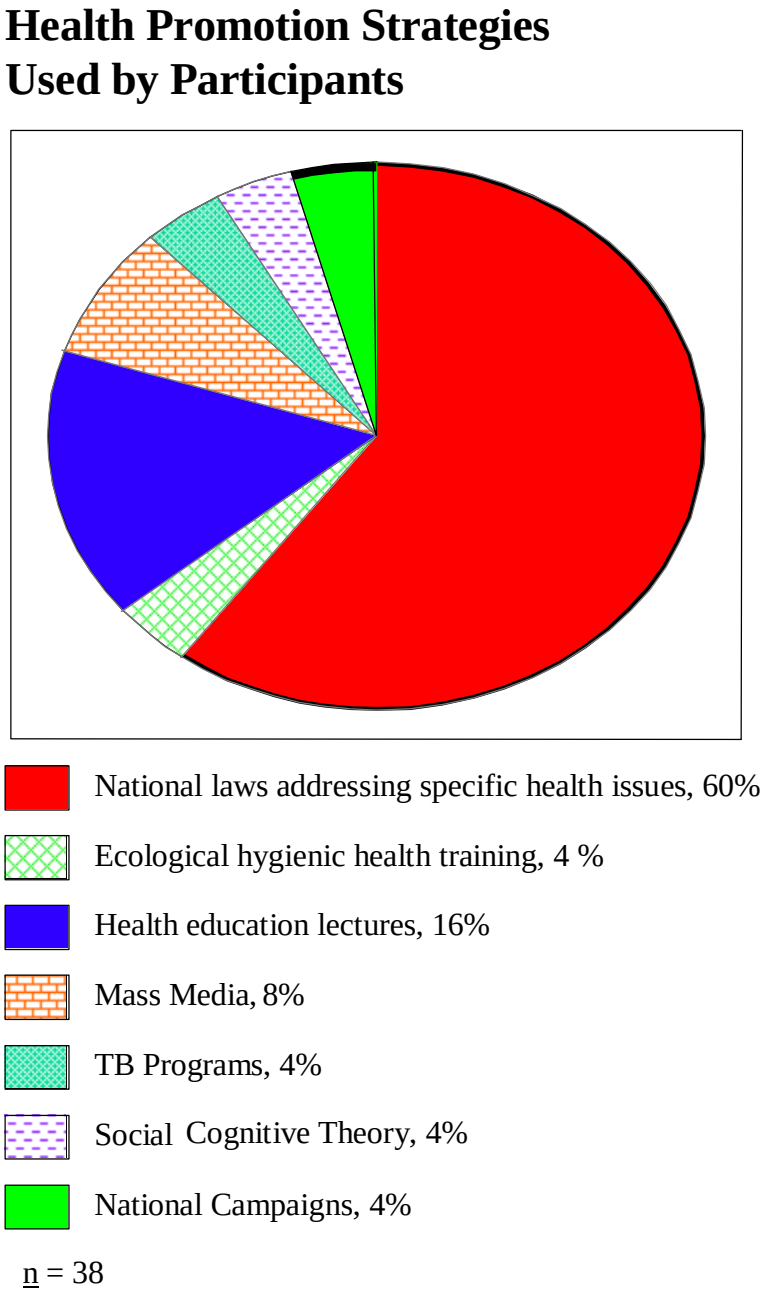

Figure 2: Health promotion strategies used by participants

> Individuals will take action to ward off, to screen for, or to control an ill-health condition if they regard themselves as susceptible to the condition, if they believe it to have potentially serious consequences, if they believe that a course of action available to them would be beneficial in reducing either their susceptibility to or the severity of the condition, and if they believe that the anticipated barriers to (or costs of) taking the action are outweighed by its benefits. (p. 356).

Theoretically, placing all the responsibility for the individual's health on the individual and within the realm of individual choices is one of the primary resemblances between the HBM and professed Romanian health educator's beliefs. Perceived susceptibility, perceived severity, perceived benefits, perceived barriers, cues to actions, and other variables, are constructs within the HBM that closely resemble the paradigmatic statements made by Romanian health educators.

Perceived susceptibility as a construct of the HBM can be defined as an individual's belief that they are susceptible to disease and they will act out of self-interest to change it (Glanz et al., 1997). The idea of perceived susceptibility is expressed by the Romanian health professionals in both survey data and through comments made during focus sessions. For example, health professionals expressed the opinion, that young people rather than older people would be most likely to adopt new information pertaining to health. The young were perceived by these health professionals as having more concern for their health than did older people. Thus, they are more likely to act out of self-interest to prevent illness. Further, 77% of the health professionals surveyed were found to believe that intrapersonal reasons were the motives behind people going or not going to the doctor.

As an example of discussions that tended to focus on HBM constructs, discussions ensued with several of the groups of Romanian health professionals about the treatment and health education of Roma people who they noted sometimes did not adhere to suggested treatment regimes. These health educators noted that the Roma preferred to leave the hospital in the middle of TB treatment rather than persevering through the whole course of treatment. This is obviously a public health concern and the Roma were viewed as responsible for adhering to their program of treatment which they clearly did not. This was considered to be a unique failing of those individuals without large socio-cultural analysis. Poor health outcomes were placed within the intrapersonal context rather than the interpersonal. Ecological, interpersonal, or population health paradigmatic approaches would cast a lager web of determinants including the environment, socio-economic and/or cultural differences. This example also suggests that the Roma were responsible for recognizing their peril and the potential for reoccurring and possibly drug resistant forms of TB developing. Under the constructs of the HBM the responsibility for recognizing that their actions were not conducive to proper health reside with the individual Roma's themselves.

Table 3. Focus Session Statements of Groupings

Statements Grouped by Area of Concern	Number of Statements
Comments Supporting Health Promotion Models	
Health Belief Model	39
Other Health Promotion Models	10
Needs Based Comments	
Laws	5
Financing	7
Other	22
Miscellaneous	
Gypsy social and health problems	4
Burdens from Tuberculosis	12
Other	7

The HBM construct of perceived benefit wherein the individual's ability to understand and recognize the benefits of an action to reduce the risk of a health threat are considered key to engaging in healthy behaviors was also illustrated in focus session discussions (Glanz et al., 1997). The construct was embraced when health educator's portrayed individual Romanians as both responsible as individuals for their health and in being motivated by their perceived benefit to self. The following comment illustrates this point.

> Until the individual's are aware of the importance of there own welfare, he will not be able to change his behaviors. It is not only the information given but the individual should make out an awareness of what is beneficial to himself for his own health. (Focus Session 3, in Baia Mare, June 14, 2001)

Additionally, another reason that health educators gave for individuals not seeking out medical care was lack of understanding/recognition of disease processes (92% of respondents, =38). During discussions, health professionals noted that

in the local villages, better information of risks through mass media is needed. At least 5 minutes every single day on television. Not only is television important but the primary hours of television need to be utilized. (Focus Session 5, Salaj, June 7, 2001).

The last construct of the HBM that could be applied to Romanian health educators' views of what motivates individual health practices is the catch all of, "Other Variables". Comments reflecting the need for more staff to carry out health promotion work illustrate this point. "A serious problem is an understaffing of health promotion educators" (Focus Session 5, Salaj, June 7, 2001). "A major obstacle is the understaffing of health promotion educators" (Focus Session 2, Satu Mare, June 16, 2001). The availability of an adequately trained workforce to provide citizens with health information ranked as the highest facilitator of health in those surveyed. If there is a shortage of labor, then health education attainment is negatively affected. The identification of the need for adequately trained staff in the area of health promotion points out a barrier directly affecting an individual's ability to acquire health education information, impacting the citizen's ability to make choices that are conducive to good health.

Conclusions and Recommendations

Enhancement of health and the promotion of programs that prevent sickness are goals common to many countries. In the United States and Canada, theoretical foundations have expanded from early models that explain and predict behavior only on the intrapersonal (individual) level, to models that predict and explain health behavior on interpersonal levels as well (Glanz et al., 1997). These theories include constructs that examine the environment, significant personal relationships, social relationships, cultural differences, observational learning, and other determinates of health behavior that goes well beyond the intrapersonal dynamic.

Romanian health promotion practices represent approaches and strategies that focus on the individual level and the intrapersonal dynamic. Based on this field research, current approaches put the responsibility for health behavior squarely on the individual. Consideration of other variables such as the environment, cultural differences, and the need for community action must be developed to a greater extent both theoretically and in actual practice. While a discussion of the social, political and cultural roots of this individualistic approach is beyond the scope of this paper, this tendency is understandable given the traditional medical models for training health professionals embraced, even during the communist era while at the same time this community of scholars and practitioners was isolated from changes occurring in the western community of health behavior scholars for over 40 years. Further, it is only within the last 25-30 years that western medical training has expanded beyond the diagnosis/disease model and embraced more holistic, ecological and/or systems approaches to understanding, preventing and treating illness and disease.

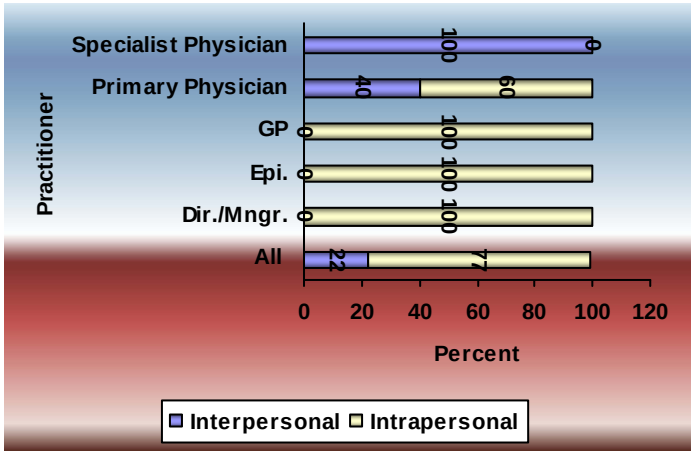

Figure 3 Interpersonal vs. Intrapersonal ideation of reasons why a patient would not go to a doctor for health care; All = combined, GP = general practitioner, Epi. = epidemiologist, Dir./Mngr. = director/manager

Romania could significantly improve its health promotion strategies, by expanding training opportunities for health professionals and including models and theoretical approaches which consider the interpersonal, ecological, and community influence on health behavior. For example, Romanian health professionals could develop their understanding of the Theory of Planned Behavior, TPB theory including such constructs as perceived behavioral control, in order to allow for peripheral factors such as available resources to be considered when health promotion programs are being developed.

Romanian health promotion practices may also from benefit using and developing interventions from models such as the Social Cognitive Theory (SCT), in which self-efficacy and consideration for the environment are key components to predicting health behavior. A greater understanding among health professionals of concepts such as self-efficacy and empowerment approaches to changing health behavior could aid in the development of Romanian health promotion infrastructure. The integration and application of these approaches by health professionals may have great potential benefits in

motivating citizens to become active participants in their own health care. According to this analysis, the Romanian system is not currently using methodological approaches that involve these constructs.

Although health professionals in this study were well aware of the many barriers that kept people from receiving the proper health promotion and education, (funding, labor, use of planned health strategies), they will remain limited in their ability to analyze these barriers in terms of the macro-determinants of health via the currently embraced theoretical constructs without additional opportunities for on-going professional training.

Discussions were limited to the responsibilities that Romanian citizens needed to take in regard to health problems. While these professionals were clear that the individual barriers to health stemmed from social, political and financial inequities, without specific training and support from the medical and health infrastructure larger level community/regional or national praxis is not possible.

Additionally, Romanian health promotion practices could benefit from the application of theoretical approaches that include the environment in an ecological context, as this approach would move the current individually focused approach to one that more effectively examines health behavior and the larger determinants of health within the social, cultural, and physical settings.

The health professional's recognition of schools, churches, and foreign organizations as potentially being very influential in regard to citizens receiving health related information showed the recognition of aspects of the environment as being influential to health promotion. This recognition is important, but ecological approaches alone may not be enough. True empowerment is needed within the communities of Romania. Data consistently showed that access to health education and promotion was limited, especially for the rural population. Problems in providing adequate infrastructure, lack of health promotion professionals in the rural setting, and insufficient overall funding all contributed to the difficulties and challenges of delivering health education services to the rural population.

For the Romanian health professionals to have an impact on their communities and to understand how to most effectively change health behaviors and empower both the communities they live in and remote, rural villages, it is suggested that community-level health theory, models and strategies be taught to health promotion/education professionals and funding be provided for pilot project planning, implementation and evaluation. Community level models are ideal for developing cooperation between different organizations, and for encouraging the convergences of social and public policy goals.

The overall suggestion of advancing Romanian Health Promotion from its current individualistic state to one that considers external, community, and environmental factors must have an ordered, accountable approach to succeed. Therefore the use of the Precede-Proceed Model is suggested as well. This would provide for an ordered guided approach to determining health education needs, planning and implementing health promotion programs and evaluating those programs. The Precede-Proceed Model, is characterized by a framework that provides a structure for applying theories, which would then be evaluated to ensure continued improvement of the health promotion theories imposed. The incorporation of ecological approaches, community change models, and the constructs such as empowerment could all be facilitated through a precede-proceed approach. When used correctly, theses components could guide and improve current health programs.

Although problems exist and improvements within the Romanian health promotion system are needed, the health professionals surveyed showed awareness of needs, the desire to learn about and implement new theoretical approaches, and willingness to succeed through praxis. Continued research, partnerships, perseverance, and pilot project work will be key elements for change, and modernization as the Transylvania region, and Romania as a whole, continue to transform and develop the health education and promotion infrastructure.

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