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Chapter 3

Promotion and Health Education for Healthy Sexuality

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Additional information is available at the end of the chapter

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1. Introduction

Health promotion is a broad concept that can be interpreted differently by different disciplines since numerous health-oriented activities, which are based on different philosophies, can be found under this term [1]. The history and development of the health promotion movement can be traced back to seven conferences for health promotion held in Ottawa (1986), Adelaide (1988), Sundsvall (1991), Jakarta (1997), Mexico (2000), Bangkok (2005) and Helsinki (2013) [2]. The most important historical milestone for health promotion was the first international conference in Ottawa, where the Ottawa Charter introduced the concept of citizen empowerment, the need for multi-sectoral and multi-agency operations, the media as one of the key promoters of health and the decentralization of health promotion in a manner that involves more active involvement of people in the implementation of strategies for health promotion at the local and community levels [3]. Within the context of health promotion, we are attempting to have an impact on individuals and the community so that they care for, maintain and strengthen their health. Health should be seen in conjunction with the natural and social environments in which people live and work, so the "Ottawa Charter for Health Promotion" defined the creation of environments that depict health as a priority area and an important value and is striving to create conditions for healthy choices (supportive environments) [4].

Health promotion in practice utilizes seven key strategic approaches: health communication, health education, self-help and mutual assistance, community development and mobilization, advocacy and policy development [1]. Health education is a component of health promotion and not a synonym for it. Health professionals often equated the concept of health education with health promotion [5, 6, 7]. Health promotion is a versatile social and political process, involving not only activities aimed at strengthening the skills and abilities of people but also activities aimed at changing social, environmental and economic circumstances so as to mitigate their impact on the health of both individuals and communities [1]. The purpose of health education is to help people assume a healthy lifestyle, motivate them to this end and

enable them to become actively involved in the care of their health [8]. Through health education, we improve both individual and community knowledge as well as values and skills to ensure effective action in the direction of health [9].

In the context of health promotion and health education, midwives act as promoters of healthy sexuality, being the ones that help people adopt and maintain healthy sexual behaviour. Healthy sexuality is a topic to which sufficient time must be devoted already in early childhood which should continue and be supplemented all the way up to late old age. Sexuality is an important part of a person's life throughout the entire life cycle and, thus, may promote or inhibit the development of personal identity, well-being and health [10, 11]. People experience sex very subjectively because it is associated with love and anger, with tenderness and aggression, with intimacy and adventure, and with pleasure and pain [12]. In society, the subject of sex has always been taboo which is spoken of "quietly" [13]. It is a topic that is strongly linked to the individual's intimacy; therefore, the manner in which the midwife explains healthy sexuality is very important. Numerous definitions exist regarding what healthy sexuality is. "The definition of sexuality includes many components including (but not limited to): sexual attitudes, sexual desires, sexual behaviours engaged in, sexual preferences, sexual identification, and sexual function" [14]. The World Health Organization (WHO) defines healthy sexuality as "a state of physical, emotional, mental and social well-being in relation to sexuality; it is not merely the absence of disease, dysfunction or infirmity. Sexual health requires a positive and respectful approach to sexuality and sexual relationships, as well as the possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination and violence. For sexual health to be attained and maintained, the sexual rights of all persons must be respected, protected and fulfilled" [15].

If the midwife finds that a person's life does not include healthy sexuality, she can assist the individual in changing risky sexual behaviour. Theories and models of individual health behaviour can prove helpful, such as the health belief model (HBM), theory of reasoned action (TRA), theory of planned behaviour (TPB), integrated behavioural model, transtheoretical model and stages of change (TTM), and precaution adoption process model.

This chapter will present the health education for the individual or couple in a more comprehensive manner using the transtheoretical model and stages of change and prior determination of his/her health literacy.

2. Methodology

A literature review was performed. Literature found with the aid of the information service EBSCOhost using the databases CINAHL (Cumulative Index to Nursing and Allied Health Literature) and MEDLINE was used. The following keywords using Boolean operators (AND, OR) in various combinations were used: healthy sexuality, health education, health promotion communication, midwifery, motivational interviewing, motivation, patient, health behaviour change, theory change, a model of change. To narrow down the search for literature, we chose: the English language, scientific journals, available extracts, available full-length articles and

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the past ten-year period (2004– 2014). We also utilized earlier literature for explaining the terms, definitions and results of some studies. The search for literature was conducted from June 2014 to November 2014.

3. Literature review

Gynaecological examination is a common intervention in reproductive health care and may present an opportunity for midwives with the help of a conversation (dialogue) to promote the healthy sexuality of women [11, 16]. The midwife can carry out a conversation either before or after a gynaecological examination/intervention. The midwife should reserve time for a conversation, be well prepared for it and conduct it in a location where nothing will disturb them (without people entering the room). Over the course of the conversation, the midwife will be able to determine the sexual behaviour of the individual – whether that individual has any problems they would like to discuss. If the midwife determines deviations in the sexual behaviour of the individual [17], she should, together with the individual, create a plan to change the individual's behaviour using the transtheoretical model of behaviour change. It is important to establish a good dialogue that gives the individual an opportunity to tell and receive answers from the midwife and allows them to reflect on their sexual health and life situations [18]. In doing so, the midwife should let the individual know that they can confide in her without feeling guilty, afraid or ashamed [19].

The basis for effective and quality implementation of health education is to determine the health literacy of the individual. This can be determined on the basis of a conversation with the individual and with the aid of various questionnaires to assess health and specific literacy, for example the Test of Functional Health Literacy in Adults (TOFHLA) [20], the Rapid Estimate of Adult Literacy in Medicine (REALM) [21], the Nutritional Literacy Scale (NLS) [22] and the Literacy Assessment for Diabetes (LAD) scale [23].

3.1. Health literacy

Health literacy, a priority in health promotion initiatives, is a pillar of modern life and one of the bases of individual health. A growing belief is that healthcare professionals should take into account the level of health literacy of individuals in order to adapt interventions and to optimize their impact [24]. Health literacy is a stronger predictor of the health status of an individual than income, employment status, education level, or racial and ethnic group [15]. Individual health literacy may vary depending on the health problems of the individual, the healthcare provider and the system that provides health care [25, 26]. Health literacy is the ability to access, understand, evaluate and communicate information as a way of promoting, maintaining and improving health in a variety of environments based on life stages [27]. This definition of health literacy shows what influences the medical decisions of individuals regarding themselves and others in everyday life [28].

Health literacy need to address in a broader sense than simply becoming informed and reading pamphlets and brochures, and the proper selection of health services [29]. Health literacy

comprises the skills and knowledge necessary for understanding diseases and treatment, as well as the capability for efficient orientation and functioning within the health system [30]. Health literacy is a cognitive and social skill which determines the individual's motivation and ability to obtain access to information and to understand them and use them to improve and maintain their health [29].

Health literacy for the individual includes the search for timely and proper medical care, proper taking of medication and understanding of given instructions. It is the capability of the individual to understand instructions and properly introduce the information received into everyday life [31].

In the health care system, health literacy refers to the following: 1) the expression of an individual's needs, signs and symptoms ; 2) the identification of health services and when to seek them; 3) the use of resources in a complex health care system; 4) how to act when cooperating with health professionals; 5) the ability to understand the recommendations of health professionals and the rights and responsibilities of the individual; and 6) the ability to adopt measures to improve their own health and safety, including that which is necessary for individual treatment and optimum use of equipment or medication [24, 32, 33].

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3.1.1. Studies on the impact of health literacy

Researchers have established limited health literacy to be quite common. Compared to general literacy, health literacy can be measured at the individual, organizational, community and population levels. Research by the European Health Literacy Survey showed that 12% of all respondents were generally inadequately health literate, while 35% possessed problems regarding health literacy, so this is not just a problem of minority populations [15].

The low level of health literacy is associated with more frequent visits to emergency medical care, as well as more frequent and prolonged hospitalization [26]. Low health literacy not only affects the individual's health and development but also has great economical, social and cultural consequences. The research also stated that personal limiting factors, such as advanced age (over 65 years), low education, another native language or culture (recent immigrant), unemployment, low income, lack of daily reading and learning disorders, also affect health literacy [24]. The high level of health literacy is associated with improved ability of self-sufficiency of the population, results in more adequate supervision and control of chronic diseases and increased accessibility to and appropriate use of health services at a lower cost of operation of the health care system, and is also due to decreased use of other services and results in improved health outcomes [34, 35, 36].

Low health literacy is a widespread problem in the USA and affects approximately 40% of adults [37]. Studies in the USA have shown low health literacy to be associated with low self-initiative [25, 38] and fewer visits to the doctor [38, 39]. The use of complex medical terminology

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can lead to poor communication between doctors and patients [38, 40]. Patients with low health literacy find it harder to understand medical prescriptions [40]; patients possess limited skills in self-managing disease [41], leading to a higher incidence of hospitalization [25, 38] and higher mortality [31, 42].

In the Czech Republic, based on a sample of pregnant women (n = 360), the key determinants that affect their health literacy were found. Health literacy and healthier lifestyle of pregnant women are associated with a higher level of education and long-term contact with a midwife in prenatal courses. These participants reported that they were better prepared overall for labour and birth and felt less stressed at the end of pregnancy, with a number of them opting for breastfeeding. Professional intervention and advice on primary prevention topics are necessary to achieve goals such as decreased smoking, alcohol consumption and bad nutritional habits, and improved support and skills for coping with stress. These enlightened and well-educated women clearly stated that the information provided to them by midwives helped them manage the postnatal period and that they plan to be in contact with midwives during future pregnancies [43].

In some countries in Africa, health literacy, especially among women, is especially low because they do not know how to read and write. Thus, the level of health literacy in South Africa and Zimbabwe is close to 80%, while in the poorest countries, such as Nigeria and Burkina Faso, only 10% of the women know how to read and write. Health literacy among women in these countries can be raised only through a greater involvement of young girls in education [44].

3.2. Health promotion and health education

Health promotion represents a comprehensive social and political process; it not only embraces actions directed at strengthening the skills and capabilities of individuals but also actions directed towards changing social, environmental and economic conditions so as to alleviate their impact on public and individual health. Health promotion is the process of enabling people to increase control over the determinants of their health and there by improve their health [45]. It focuses primarily on those determinants of the natural (air, water, soil, food and immediate living conditions) and social environments (social networking, social exclusion and health inequality) which one has the power to influence. At the forefront on the one hand are the health- risk behaviours of individuals, such as smoking, an unbalanced diet, lack of physical activity, alcohol abuse and illicit drugs, elevated blood lipid and blood sugar levels, obesity and stress [46, 47].

Health promotion enables individuals or groups to increase control over their own health by maintaining and improving it [48]. Health thus becomes a condition for everyday life, not just the result of life since the individual or community can identify and fulfil expectations, satisfy needs and to adapt to and manage the environment [49]. Some, due to such classifications, actually see the essence of health promotion in the empowerment of individuals to resist the industry which is selling them bad products; for example, they stop buying overly sweet or fatty foods that have adverse effects on their health. Nevertheless, individuals though well informed and even those for whom health represents a fundamental value do not always act in accordance [3].

Health promotion is not the exclusive responsibility of health professionals. Many agencies or entities are involved: education, employment, housing, transport and social services, as well as the individuals themselves [50]. It includes primary, secondary and tertiary prevention. Primary prevention consists of action that prevents disease or disability before it occurs. Secondary prevention comprises action related to early detection and treatment of disease. Tertiary prevention consists of action to avoid needless progression or complications of disease [50, 51].

Research shows that people find it very difficult to abandon unhealthy lifestyles (risky behaviours). Health professionals can achieve a great deal in this area within the scope of health education by implementing activities to change individual behaviour in schools, workplaces, hospitals and local communities. These activities include topics such as healthy diets, physical activity, prevention of smoking, mental health, prevention of infectious diseases, etc. [52]. Health education focuses on building the capacity of individuals through education, motivation, and the enhancement of skills and techniques to raise individual awareness for a healthy life. The health literacy of individuals is the result of effective health education which increases the capacity of individuals to access and use health information in adopting appropriate decisions on health and maintaining basic health [47, 52].

The major factors relating to health education are the voluntary cooperation of individuals and determination of their own health practices [53]. The individual should not have the feeling that health professionals want to push them into anything at any price. The process of learning and obtaining experience must be designed together with the individual using a variety of methods, such as individual learning, counselling, and encouragement to change their behaviour and habits [54, 55]. The aim of health education actions is primarily to change already- established behaviour and often to introduce new lifestyle habits and behaviours that will contribute to improving the health status of an individual [56]. Health education also plays a role in the prevention of disease, in health promotion, in the recognition and treatment of a disease, and in rehabilitation [57]. Health education is a constituent part of nursing and midwifery. It is important to take into account that we, healthcare professionals, are not the ones making the decisions in the process of health education and counselling and transmitting information to the individual. More effective are strategies where the individual decides what to do regarding behavioural changes [58].

Implementers of health education are also known as health educators. Health educators apply theories and models of health education in a targeted manner; they incorporate concepts of cooperation, encourage voluntary changes in the individual, incorporate health literacy and strengthen the capacity of individuals within health programmes and services, and they are important and indispensable members of the health promotion team [52]. It is important that health educators begin with health education early enough. Health education should already be introduced in the schooling period because children form their positions, values and attitudes at a very early age. People's habits and behaviours change considerably during the course of their lives. Even adults will often decide to change an unhealthy lifestyle [59], so health education is an important part of lifelong learning and accompanies people throughout their lives. Within the context of health education, children particularly acquire new patterns of healthy behaviour, while in adults, it most often regards the cessation of risky behaviours and habits that negatively affect the individual's health.

It is important that the midwife together with the individual plans the course of health education: when, where, how and in what way health education will take place [50]. The implementation of health education itself can be carried out based on the learning process, which is divided into four stages: assessment of learning needs (goals), preparation for achieving them (planning), implementation of teaching plans and evaluation of health teaching. Throughout all the stages of the health education process, it is important that the midwife monitors the mode of communication with individuals to enable her to obtain all necessary information concerning the individual's sexual behaviour. Based on the information obtained, the midwife, together with the individual, in the event of deviations in sexual behaviour will be able to develop a plan of health education to eliminate the risky behaviour.

3.2.1. The importance of communication in working with individuals

Communication is something we do all the time, whether we want to or not. We can avoid meeting others when we are not in the mood; nevertheless, we are still communicating. We cannot keep ourselves from communicating, even if we attempt not to talk to others [60]. Health professionals cannot perform their duties within the context of health promotion, such as providing physical and emotional support and information, without communicating with their patients [61, 62, 63]. Communication is a dynamic process and is influenced by social, cultural, ethical, economic, legal and technological factors [64].

Communication is the most important component of our work, for everything we do depends on communication [65, 66]. It is the foundation of our interaction with people. Communication enables a good and efficient exchange of information between people [65]. Good communication allows for the establishment of a genuine, relaxed relationship between health professionals and patients [66]. Everything we do with others comprises communication [67]. The ability to communicate is of vital importance for people, and through effective and open communication, the midwife can acquire the individual's trust and respect [68].

We are familiar with verbal and non-verbal communication [66, 69]. Verbal communication is used to transfer messages and also to establish relationships and empathy. Non-verbal communication includes behaviours that convey a message without the use of verbal language (touch, eye contact, gestures, posture, etc.) [66]. It is important that we establish a relationship of trust with individuals. Health professionals need to obtain the individual's trust and should in no way "buy" or demand it. In order to acquire a trusting relationship, health professionals must first establish a relationship based on respect with the other party. In addition, it is very important that health professionals transfer their expertise to patients in a manner that they will understand while not forgetting that they themselves are just people. When individuals ask us things, we should attempt to answer every question and, if necessary, turn to other professionals for advice. Each answer must be honest and never fake. In the process of communicating with patients, we should act in the way we want others to treat us [65].

When transferring a message, the words themselves hold little meaning, only 7%. A total of 55% of messages regard social significance and are the result of body language and facial expression, while the remainder 38% are derived from paralanguage, which includes tone, strength and colour of the voice [70]. Non-verbal communication comprises kinaesthetics

(body movement), gestures, facial expressions, external appearance (clothing, jewellery and other accessories), paralanguage (communicative value of the voice) and time (duration of the event, intervals between events or sequence of events) [71]. For a proper understanding of non-verbal communication, one should consider the following: an error in reading body language is made if we interpret each gesture separately from each other or from the circumstances. Like spoken language, body language also comprises words, phrases and punctuation. For a proper understanding, body language needs to be seen as a series or group of gestures. Gestures should be studied in relation to the circumstances in which they occur [72].

The entire purpose of communication is to be express and exchange information, be comprehensible and to reach a mutual understanding [73]. One should be familiar with the four elements of open communication to ensure good communication: openness, timeliness, accuracy and comprehension. All these elements have a significant impact on the effectiveness of communication [74]. Effective communication is possible only if the recipient understands the information provided by the person transmitting it [17]. When communicating, we collaborate with others by listening, considering and hearing [67]. Listening can be defined as the art of capturing the true essence of the sender's message. In this case, the art means skill and ability [73]. When listening, one must observe the four main components of listening, as stages: the focus of attention, passive listening, paraphrasing and active listening [67]. It is important to mentally prepare ourselves so that we focus all our attention on our conversation partner. With passive listening, we further encourage our conversation partner to open up and express their concerns and ideas and describe the problem. Silence is very appropriate in doing so [67], because we do not always need to speak and silence always has priority over words [65]. More efficient than asking questions is encouraging the other person to clarify and provide more details while paraphrasing and actively listening. Particularly challenging is the skill of active listening, where we repeat the key points of the message by summarizing the statements of the other person, as is typical for paraphrasing, while also capturing what was not said. Active listening is mirroring contents and emotions [67, 73] and a reflection of feelings, including those that are concealed [73].

We should never judge interlocutors (patients) or caution them of the things that they have done. During the conversation, we should avoid medical terms, because all patients will not understand them and they may only confuse them. It is a good practice to put ourselves in the shoes of the patient so as to see the world through their eyes, making it easier to understand how the patient is experiencing and feeling the disease, treatment and rehabilitation. We should always ask the patient for their opinion. Never force the patient into the decision that seems most correct to us [65].

Communication between health professionals and patients should be assertive, and we define as firm, honest and respectful communication that which at the same time comprises responsible and mature behaviour where we assume full responsibility for our actions and behaviour [75]. Assertive communication is a self-expression for the defence of human personal rights, without violating the rights of others, and self-expression which allows for the different opinions and desires of others. In addition, health care professionals must ensure that they supply information which is supported by evidence through a number of sources such as

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various professional and scientific articles, books and videos and must support individuals by providing advice over telephone [76].

It is important that in their work, doctors, nurses, midwives, psychologists, social workers and physiotherapists master the skills of good communication and not only skills from their area of expertise [65]. As good communicators, they should respect the individuals. They should understand that in front of them is a person who has opinions, views and feelings; the individual may also be a person who comes from a different cultural environment, which should not adversely affect their communication [65, 77].

Good and effective communication is essential in the process of changing behaviours related to health. Models of individual health behaviour and models of interpersonal health behaviour can be used to change risky behaviours within the health education process. The transtheoretical model, a model involving individual health behaviour, will be presented in more detail later in the chapter.

3.3. Behavioural theories of change connected to health

To help in the development, management and evaluation of health education interventions, midwives and other health care professionals use a variety of design models based on health behavioural theories, such as the health belief model, theory of reasoned action, theory of planned behaviour, the transtheoretical model and stages of change, and the precaution adoption process model.

The health belief model (HBM) was developed in the 1950s by three social psychologists working in the public health field in the U SA (US Public Health Services) [1, 78]. The model focuses on the individual's attitude to health and their beliefs regarding health [57]. According to this model, the health behaviour of an individual depends on the degree of perceived health threats and judgements that a certain behaviour will be effective in reducing those threats [1, 78]. The application of HBM in practice has a positive impact on improving the health of the individual (e.g. regular condom use, regular physical activity). It is used at the individual level (one on one) and at the social level (legislation, changes in the physical environment) [57]. The theory of reasoned action (TRA) was developed by Icek Ajzen and Martin Fishbein. TRA says that health behaviours are the direct result of behavioural intentions (obligation to one's self and others), which are dependent on the actions and subjective norms regarding their adequacy. Subjective norms are derived from individual beliefs about what others think they should have done and the motivation to comply with them [1, 79, 80]. Later, Ajzen and his colleagues transformed the theory into the theory of planned behaviour (TPB), which in addition to the previously mentioned factors emphasizes that perceived behavioural control over a given action is required for the prediction of behaviour [1, 79]. TPB also includes motivational factors that indicate the extent a person is willing to take the new behaviour into account and how much effort they must invest to arrive at the desired result. TRA and TPB have been used to predict behaviour in a number of settings [81, 82]. The precaution adoption process model is a preventive behaviour model. It comprises the stages of cognitive processes that an individual must go through to be able to change their behaviour. The model seeks to

identify all the stages involved when people commence health-protective behaviours and to determine the factors that lead people to move from one stage to the next [83, 84].

The transtheoretical model and stages of change (TTM) is described in the following text, the use of which allows health professionals to establish why people fail to change unhealthy lifestyles, helps them identify what information is necessary for people to develop effective strategies to deal with a change in behaviour and provides an insight into how to design prevention programmes that are successful [85, 86, 87]. TTM developed from a comparative analysis of the leading theories of psychotherapy and behaviour modification in an effort to agglomerate an area which is fragmented in more than 300 theories of psychotherapy [87, 88]. The impetus for the model arose when Prochaska and his colleagues conducted a comparative analysis among smokers who undertook change of their own initiative and those undertaking professional treatment. They identified ten processes of change that are predictive of successful smoking cessation in these sample populations. They estimated how often the groups used any of the ten processes [87, 89]. The participants used different processes during different time periods in their fight against smoking. The authors found that behaviour change takes place over several stages [85, 87, 90, 91]. The individuals pass through the stages during the change process, from precontemplation to maintaining the changes [87, 89, 92]. During each stage, the individual experiences different feelings and thoughts and establishes that various activities help to achieve the change. This change model is almost always presented in the form of a circle or a spiral [87, 93].

3.3.1. Core construct theories

The core construct theories of TTM are presented in Table 1.

Constructs	**Description**
Stages of change	
Precontemplation	No intention to take action with in the next 6 months.
Contemplation	Intends to take action within the next 6 months.
Preparation	Intends to take action within the next 30 days and has taken some behavioural steps in this direction.
Action	Changed overt behaviour for less than 6 months.
Maintenance	Changed overt behaviour for more than 6 months.
Termination	No temptation to relapse and 100 % confidence.
Processes of change	
Consciousness raising	Finding and learning new facts, ideas and tips that support the healthy behaviour change.
Dramatic relief	Experiencing the negative emotions (fear, anxiety, worry) that go along with unhealthy behavioural risks.

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Constructs	Description
Self-reevaluation	Realizing that the behaviour change is an important part of one's identity as a person.
Environmental reevaluation	Realizing the negative impact of the unhealthy behaviour or the positive impact of the healthy behaviour one one's proximal social and/or physical environment.
Self-liberation	Making a firm commitment to change.
Helping relationship	Seeking and using support for the healthy behaviour change.
Counterconditioning	Substitution of healthier alternative behaviours and cognitions for the unhealthy behaviour.
Reinforcement management	Increasing the rewards for the positive behaviour change and decreasing the rewards for the unhealthy behaviour.
Stimulus control	Removing reminders or cues to engage in the unhealthy behaviour and adding cues or reminders to engage in the healthy behaviour.
Social liberation	Realizing that the social norms and changing in the direction of supporting the behaviour change.eh
Decisional balance	
Pros	Benefits of changing.
Cons	Costs of changing.
Self-efficacy	
Confidence	Confidence that one can engage in the healthy behaviour across different challenging situations.
Temptation	Temptation to engage in the unhealthy behaviour across different challenging situations.

Table 1. Transtheoretical Model Constructs [87].

3.3.2. Stages of change

In the past, a change in behaviour, such as quitting smoking, drinking or eating, was often constructed as an event. In TTM, researches identify three classes of variables: the stages of change, dependent variables (decisional balance and self-efficacy) and independent variables (the processes of change) [93, 94]. TTM represents change as a process that takes place over time, with progression through a sequence of six stages, although often not implemented in a straight line [87]. The individual goes through a series of stages with regard to their readiness to change: *precontemplation* where the individual does not intend to take action in the near future, *contemplation* where the individual has the intention of taking action in the next six months, *preparation* where the individual has the intention of taking action in the next 30 days, *action* where there is a permanent change in behaviour for six months or less and *maintenance* where the change lasts for more than six months. During the stages of change, individuals often return to a previous stage before achieving a lasting change in behaviour [89, 95]. People

in the *termination* stage are no longer tempted and are confident that they will not return to the old unhealthy behaviour, even if they are depressed, anxious, bored, lonely, angry or stressed out [87].

Precontemplation, where there is no interest to change, is the stage when people do not intend to take action in the near future, which is usually measured in the subsequent six months. People can find themselves in this state because they are uninformed or under-informed about the consequences of their behaviour. Another reason is that they have tried many times to change the behaviour and have begun to doubt their ability to change. Both groups usually avoid reading, conversation or thoughts regarding their high-risk behaviour [87]. The person sees only the advantages of their current state and has no interest in changing their behaviour [88, 96]. These people are often labelled as rebellious or unmotivated or unprepared for health promotion programmes. The question is whether traditional health promotion programmes are ready for such individuals and whether they are motivated enough to adapt to the needs of the programmes [87].

In the *contemplation* stage, people intend to change their behaviour in the next six months [87, 93]. They are more aware of the benefits of change than those in the stage where they are not interested in change, but at the same time, they are also aware of the disadvantages arising from a change in behaviour [87]. This balance between the price of the change and its benefits can lead to a deep ambivalence with people remaining in the contemplation stage for a very long time, possibly for years, because they still have plenty of reasons to continue the current behaviour [88, 96]. Such persons are not prepared for traditionally oriented programmes which expect immediate action from individuals [87].

In the *preparation* stage, people intend to take action soon (within one month), knowing that the change is beneficial to them and is possible to achieve [88, 93, 96]. They have often already made some significant changes in the past year. They have a plan of action, such as visiting health education workshops, obtaining advice from an advisor and purchasing self-help books, or opt for the independent behaviour change approach [87].

People in the *action* stage have made specific, obvious changes in their lifestyles in the last six months [93]. The action can be observed; therefore, the change in behaviour is often equated with it. Action occurs when an individual abandons an unhealthy behaviour, for example ceases smoking, not merely by reducing the number of cigarettes smoked or replacing cigarettes with those having a lower tar and nicotine content [87].

Maintenance is the stage in which people have made certain obvious changes to their lifestyles and strive to avoid a relapse but without using the change processes as often as people in the action stage. The temptation to relapse is lower, and they are more confident that they can continue with their changing [88, 96]. They slowly begin to realize the advantages of behavioural changes [93]. Based on data on temptation and self-efficacy, it has been estimated that maintenance lasts from six months to about five years [87].

The behaviour of subjects in the *termination* stage becomes automatic. Examples are adults who put on their seat belt as soon as they get into the car or those that automatically take their medicines to lower blood pressure every day, at the same time and in the same place [87]. A

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study of ex-smokers and alcoholics found that less than 20% of people in each group reached the stage of no temptation and complete self-efficacy [87, 97]. The criterion may be too strict or perhaps this stage is the ideal goal for most people. In other areas, such as exercise, consistent use of condoms and weight control, maintained change could be a realistic goal for the temptation to relapse is dominant and powerful. Much less research has been performed regarding the termination stage than for the other stages [87].

3.3.3. Processes of change

The processes of change are covert and disclosed activities that individuals use to transition through the stages (levels) of change. Ten coping strategies that people use to transition through the stages of change [93, 98] are given below, which, based on research, have received the greatest empirical support [87]:

- *Consciousness raising (awareness)* includes increasing awareness of the causes, consequences and treatments of an individual's behavioural problem. Interventions that can increase awareness include response, confrontation, interpretation, therapy with the help of books and media campaigns.
- *Dramatic relief* initially produces a heightened emotional experience, followed by a reduced impact or envisioned relief by implementing an appropriate course of action. Role-playing, grief, personal stories, feedback regarding health risks and mass media campaigns are examples of techniques that can touch people emotionally.
- *Self-reevaluation* combines both cognitive and affective evaluation of the individual's self-esteem, with and without the unhealthy behaviour. It is an individual assessment of ourselves as a passive or active person. Interpretation of values, healthy role models and imagery are techniques which may result in individuals evaluating themselves.
- *Environmental reevaluation* combines both cognitive and affective assessment of how the presence or absence of an individual behaviour affects an individual's social environment. An example is the impact of the behaviour of the individual, for example smoking, on their surroundings. It can also include the awareness that one represents a positive or negative role model to others. Empathy training, documentaries, testimonials and family mediation can lead to such a reassessment.
- *Self-liberation* is the belief that one can change, and the individual is committed to striving in this direction. New Year's resolutions, public testimonials and mass selection can strengthen one's willpower.
- *Helping relationships* require one to increase social opportunities or alternatives, especially for people who are relatively disadvantaged or oppressed. Advocacy, authorization procedures and suitable policies can create greater opportunities for minority health promotion and health promotion among homosexuals and poor people. The same procedures can also be used as an aid in change for all people. Examples of these are non-smoking areas, salad bars in school canteens, and easy access to condoms and other contraceptives.

- *Counterconditioning* requires the individual to learn a healthier mode of behaviour, which can replace problematic behaviour. Strategies for healthier behaviour include release, various arguments, substitutes for nicotine and positive self-statements.
- *Reinforcement management* removes reminders of unhealthy habits and adds signs for healthier alternatives. Avoidance, a new choice of social environment and self-help groups may be incentives that support change and reduce the risk of a relapse.
- *Stimulus control* involves consequences for wrong decisions. Despite the fact that stimulus control involves the application of penalties on persons who are striving for self-change, it relies more on awards than on punishment. The philosophy of the stage model is that it takes place in harmony with the way people themselves naturally change, so here, fortification is primarily emphasized. Procedures for increasing fortification of and the probability that healthy responses will continue are unforeseeable contracts, visible and invisible reinforcement, encouragement and recognition given by groups.
- *Social liberation* combines caring, trust, openness and acceptance, as well as support for a healthy behavioural change. Sources of social support may include the establishment of contacts, therapeutic relationships, consultant calls and a peer system.

3.3.4. Studies that have shown the positive effects of using the transtheoretical model

There have been a number of studies carried out in which the distribution of stages for a precise determination of behaviours with increased risk such as smoking was first established [99, 100, 101, 102, 103, 104]. Researchers were also interested in determining the systematic relationships between the stage the individual was in and the processes of change which they were subjected to [86, 87]. Many intervention studies were also performed to identify their connection with the TTM for smoking cessation, dietary habits, physical activity, stress management, taking of medication, alcohol abuse and use of condoms. TTM has been used in various areas, including kindergartens, at home, in schools, churches, campuses, and in different communities and workplaces. Several studies showing the usefulness of TTM are presented next [87].

In a study conducted in Thailand among pregnant women and women with young children (n = 315), the progression of implementing preventative behaviour in stages for preventing passive smoking was established. They found that knowledge on the effects of exposure to passive smoking of health care professionals had a positive impact on women in the precontemplation stage. For those who are in the action or maintenance stages, practicing preventive behaviours in different situations and learning communication skills as well as effective and appropriate communication with smokers are important [105].

Haakstad et al. [106] used TTM to measure the readiness of pregnant women to become or stay physically active. Healthy pregnant women (n = 467), 32 – 36 weeks pregnant, who responded to the questionnaire on physical activity to assess what stage of TTM they were in participated. The results showed that the acquisition of advice from health professionals can increase the likelihood that pregnant women would fall under higher stages of the change process (stages 4–5), while older age, obesity, poor diet, pelvic pain and urinary incontinence increase the likelihood of poor readiness to change exercise habits (stages 1–3). Despite the fact

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that many pregnant women were categorized as inactive, these were the ones who displayed a high motivational willingness or intention to increase their level of physical activity. Thus, pregnancy can also be an opportunity to establish long-term habits of physical activity.

A study on adult volunteers (n = 1455) in the USA established a link between body satisfaction and the use of TTM for changing behaviour – physical activity. The results showed a characteristic statistical change in body satisfaction depending on the stage of change. The highest satisfaction that was found was in the final stage and the lowest in the precontemplation stage. Participants with higher body satisfaction are often tempted to leave out physical activity, which was contrary to the initial expectations. Those found to be already in the initial stages were more satisfied with their bodies and mostly remained in the stage in which they were at the beginning because they did not feel the need to change, since nothing regarding their bodies bothered them, and they therefore did not contemplate the benefits of exercise [107].

A research carried out on adult women in Pennsylvania (n = 27) studied whether the use of TTM in strength training programmes had an impact on the likelihood of behavioural change. The use of TTM has shown positive effects in progressing from a lower to a higher stage of change, facilitating decision-making in relation to the advantages and disadvantages of introducing changes and increasing general physical capacity [108].

3.4. Motivation for change

The term "motivation" is used to refer to our reasons for action (what our motives are) and our enthusiasm for doing them (how motivated we are) [109]. Motivation can be internal or external. The concept of internal motivation was developed to explain people's desire to carry out certain activities without external rewards – the motivation for such behaviour was the satisfaction of some internal needs and that the individual feels competent to make their own decisions [110]. Internal motivation is encouraged by three universal human needs, namely the need for autonomy, competence and affiliation. When an individual is free to choose their own activities (autonomy), when they master activities (competence) and when important people support the individual in these endeavours (affiliation), it is highly likely that the individual will carry out the activities with happiness and internal satisfaction. So in order to establish a certain behaviour, internal motivation and self-determination are needed which arise from satisfying the aforementioned needs [109, 110]. An individual who is internally motivated (*intrinsic motivation*; coming from within, like an aspiration to do something due to a desire to be a "better person") does not require a stimulus from the environment and expands their interests and develops and obtains new knowledge; for this individual, the path to the goal is more important than the goal itself [111, 112]. In the case of external motivation (*extrinsic motivation*), it is a fact that people are motivated to make a change if they are rewarded for doing so (e.g. praise, fear, coercion, material goods, beautiful appearance, recognition from the surroundings, fame, acknowledgement). These people are dependent on the opinions of people in their environment and on external stimuli [112, 113].

One of the most famous theories, namely the TTM theory, is strongly related to motivation. This defines the type of motivational stages through which people pass; however, they could also repeat (relapse) unhealthy behaviours [85]. The TTM theory is most commonly used for

health education and health promotion, such as for the cessation of smoking, use of condoms, weight loss, drug abuse and stress management [114]. Many psychological theories define motivation as an important behavioural factor. However, it is difficult to identify the various factors that influence motivation, including conscious and unconscious processes, internal and external influences, different beliefs regarding the consequences of one's current behaviour, expected results of the new behaviour and perceptions of social norms [109].

In order to implement a change, the individual must be motivated [31]. Dilts et al. [115] point out that when changing the lifestyle habits of an individual, one must take into account their environments and personality traits, which are defined as behaviour, strategies (skills and abilities), beliefs, values, identity, mission and spirituality.

Most core behavioural change theories include both the individual's motivation and also their confidence. This regards the confidence of the individual that they will be able to implement a change in behaviour, in other words, their confidence in their capabilities. The concept can also be called self-efficacy and represents the basis of models and theories such as the health-belief model and social cognitive theory and that of perceived behavioural control in the theory of planned behaviour [109].

The concepts of confidence and motivation differ from one another, but they are also linked. From the literature, it is evident that motivational factors and self-efficacy are important when designing intentions (i.e. the individual's obligation to carry out a certain behaviour). Intentions express the individual's motivation to achieve a certain objective [31, 109].

It is important that health professionals be familiar with the ways in which individuals who opt for a lifestyle change can be effectively motivated. One such way is motivational interviewing which is suitable for all areas of lifestyle change, especially when the individual already requires treatment [116].

3.4.1. Motivational interviewing

The concept of motivational interviewing was developed by Muller from his experience of treating alcoholism and was first described in 1983 [117]. Motivational interviewing is an advisory technique that increases the individual's motivation to change problematic behaviours [118, 119]. As an advisory technique, it involves strengthening the patient's motivation to change using the following four guiding principles: encouraging the patient's independence, understanding the patient's own motivation, empathic listening and encouraging the patient – giving the patient power [120].

With the aid of motivational interviewing, during the communication process, the health professional can assess the readiness of the patient (client) to change, assist them in entering the next stage of the change process, and direct and guide them through the change process [121, 122, 123]. This is a technique that highlights an individual's ambivalence regarding change and their arguments "for" and "against" change [121, 122, 124, 125]. The advisor in using motivational interviewing helps the individual adopt important life decisions. Ambivalent individuals are characterized by their difficulty to make decisions [121, 122]. Motivational

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interviewing is particularly useful in helping clients identify current and potential problems and do something about them [126].

The basic assumption in motivational interviewing is that the change will occur if the client is ready for it [127]. The main components of motivational interviewing comprise assessment of the individual's readiness to change, provision of feedback (e.g. in the form of praise, respect and understanding; encouraging the individual during the process of introducing changes), avoidance of resistance, negotiation of goals and strategies, coping with ambivalence, determination of the level of significance of the change and assessment of the individual's confidence in their own ability to change [128].

A major characteristic of motivation interviewing is the patient-oriented manner of counselling, which seeks to change the behaviour of the patient leading them to explore and resolve their ambivalence to changes. Telling individuals what they should do, using persuasion employing logic, arguments, lectures, or provision of advice or solutions are conceptually opposites of motivational interviewing [129]. Motivational interviewing is by no means a technique whereby we manipulate people into doing something they do not want to do! It is a clinical advisory skill that enables people to recognize their own health motives necessary for deciding to change their behaviour. This involves management of more so than prescribing [129, 130]. It is a support action of the advisor who seeks to enhance the inner motivation of the individual so that the change comes from within and not from outside [119].

The most important concepts describing the philosophy of motivational interviewing are participation, respect for the individual's autonomy and elicitation. A collaborative conversation is carried out between the individual and advisor, developed through a collective decision-making process. The basic skills of motivational interviewing comprise therapeutic tools that help build relationships, explore concerns and provide empathy. This includes "open" questions, affirmations, reflective listening and summarization [119, 129, 130]. Authors in the context of communication techniques recommend the use of open questions to aid in determining what the problem means to a person and how they will remedy it. This technique is particularly useful for people who health professionals have previously assessed as "resistant to change" [96]. A major characteristic of open questions is that the individual speaks the majority of the time while the health professional (advisor) poses targeted questions including: What are the disadvantages of your current situation, what are the benefits of change, how optimistic are you about change and what is the purpose of the change [131]? Reflective listening is a communication strategy involving two key steps: seeking to understand the speaker's idea a nd then offering the idea back to the speaker using the listener's own words (without paraphrasing), to confirm the idea has been understood correctly [132].

3.4.2. Studies that have shown the positive effects of using motivational interviewing

Motivational interviewing is a well-known scientific testing method to provide advice to clients and is regarded as a useful intervention strategy for treating problems regarding lifestyle and disease. A systematic review and meta-analysis of randomized controlled studies showed that motivational interviewing in the scientific environment outperforms traditional advice for behavioural problems and illnesses [126]. Motivational interviewing was used and

evaluated in relation to alcohol abuse, drug addiction, smoking cessation, weight loss, increase in fruit and vegetable intake [133, 134], adherence to treatments and follow-up, increase in physical activity, and treatment of asthma and diabetes [126, 127]. No research found any negative effects of using motivational interviewing. It has been used by various health care providers, including psychologists, doctors, nurses and midwives [126, 135, 136, 137]. The literature review found motivational interviewing to already be effective after only15 minutes of use and that more than one session increases the possibility of a positive effect on the individual [124, 135, 138, 139, 140, 141].

Over 200 randomized controlled studies showed that motivational interviewing can encourage changes in behaviour in different health care facilities, improve relationships between patients and doctors, and increase the effectiveness of counselling [142] and that it has positive effects on many aspects of health [143]. The impact of the use of motivational interviewing in health was established in a randomized controlled study conducted on patients (n = 146) with low motivation for a healthy lifestyle by the Cardiac Rehabilitation Centre in Hong Kong. They found that motivational interviewing had long-term positive effects because it primarily affects the psychological aspects of the quality of life (motivation, emotional stability, depression, stress management) and eventually also helps improve general well-being and reduce physical pain. It has no direct effect on specific factors such as blood pressure, cholesterol, etc. [144].

3.4.2.1. Discussion

Before the midwife decides on how to implement health education and health promotion, it is important that she knows how to explain what health is, because health can have different meanings for the individual. For some, health may mean the absence of disease and disability, while for others it means adaptability [50]. Health is defined in two ways. The first definition defines health as a positive or "wellness" approach, where it is necessary to look at health as means or ability to do something. The second defines health as a negative approach, in which health is the absence of disease [145]. One should keep in mind that individuals value their health in very different ways; health to some regards the highest value, while others rank health somewhat lower on the scale of values. Ranking of health as the highest on the scale of values by an individual does not mean that they act in accordance with this. This conclusion is also supported by findings that individuals desire to do more for their health even though they believe that they already care greatly for it [3].

Some experts have come to the conclusion that lifestyle and health are closely linked and that in order to achieve the highest possible level of health, behaviour harmful to health should be eliminated (unhealthy lifestyles) [146]. Lifestyle is a way to live one's life story – the creation of an individual, in which a constant interplay between the individual and society plays a major role. Lifestyle is a set of habits and use of goods, space and time by which people define themselves and other people; it is a characteristic of groups but also an individual experience [147]. Lifestyle connected to health regards attitudes and values, especially in terms of behaviour (conduct) in various fields, such as sexual health, regular physical activity, healthy and balanced diet, maintenance of normal body weight, stress management, and the cessation of smoking and consumption of alcohol and illicit drugs. Lifestyle cannot be changed quickly.

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It is formed in close interaction with one's living conditions. The literature most frequently mentions a pro-health/healthy lifestyle and a harmful/unhealthy lifestyle. The impact of lifestyle on health in individual socio-economic communities can be an indicator of social problems of particular groups of residents. Harmful health habits are said to be indicators of psychosocial stress, which poorer and less- educated people experience due to relative material deprivation and social and psychological deprivation [148].

In determining the lifestyle of the individual, Croghan [149] says that the need of the individual should be included in dialogues on issues related to lifestyle change, because the resulting data are crucial to the individual's attempt to change. When an individual decides to change, it is necessary to assess their readiness to change and the probability of it occurring in a plan for behaviour change. Black et al. [150] also point out that the approach of the nurse/midwife needs to be caring and, at the same time, provide a positive message. It is important that the nurse/midwife presents a positive image, makes a good first impression, provides a positive message, is a role model for individuals, is aware of their impact on others, and has sufficient knowledge and skills to deal with the unexpected; this indicates that in the process of health education, we should provide assistance to individuals so that they learn how to prevent health problems and how to follow the doctor's instructions.

Health professionals, doctors, nurses, midwives, physiotherapists, occupational therapists and others, play various roles in implementing health education, which are intertwined and complement and supplement each other. It is particularly important that they know how to transition from one role to another while establishing a relaxing and trusting relationship with the individual. Naidoo and Wills [56] state that the nurse/midwife requires two competences in the role of a health educator, namely education and caring. The first relates mainly to scientific knowledge, while the other regards values. Both are heavily dependent on the educator's personality structure. The midwife acquires scientific knowledge by going through technical and scientific literature. In addition, it is also important, as stated by Thiedke [151], that individuals desire consultation with health professionals who provide them with enough information regarding their medical condition or illness and involve them in decision-making. This can only be done if they have enough knowledge, through continual upgrading and supplementation of their existing knowledge. Black et al. [150] found that health professionals are more involved in health promotion and health education if they believe that they have the appropriate knowledge and skills, time, and the support of the environment and recipients. An additional factor that may affect the success of interventions for health promotion and health education is the credibility of health professionals.

Individuals when receiving information and during the learning process are very attentive to the communication that takes place with the midwife. Communication by the midwife requires self-control and self-organization. This improves the knowledge of individuals and leads to the effective improvement of health. People understand only 50% of what is said in the verbal communication of health professionals, leading to misunderstandings and incomplete understanding of the actual health status of the individual [31]. The hermeneutic phenomenological studies on communication between patients and nurses in general hospitals in Ireland

found that if nurses used a patient-oriented approach, evaluated and identified as appropriate in health care organizations, they could communicate well with their patients [131].

In the stage of acquiring data regarding the lifestyle of the individual, the midwife evaluates the former's health literacy, which is crucial for planning the health education process. This is also confirmed by Nutbeam [29, 152] and Peerson and Saunders [153], who consider that if a health- risk behaviour is to be eliminated, the health literacy of the individual must first be assessed, for high health literacy affects not only changes in lifestyle but also changes in social, economic and environmental factors of health.

As mentioned previously, following an assessment of health literacy, the midwife together with the individual plans the change of the latter's unhealthy lifestyle. This can be done by using TTM, which, according to Miller and Rollnick [154], is a comprehensive conceptual model and explains how and why changes occur. TTM according to Prochaska and DiClemente [88] is considered an intervention strategy in the treatment of problems related to lifestyle and disease [126]. The positive effects of using TTM have been researched in numerous randomized controlled studies. Researchers found that TTM from initial studies on smoking quickly spread to behavioural research in the broader field of health and mental health, including studies on alcohol and other substance abuse, anxiety and panic disorders, bullying, delinquency, depression, eating disorders and obesity, diets high in fat, prevention of HIV/AIDS, coping with stress, various medical interventions (e.g. vaccinations), impact on healthy sexual behaviour, mammography and other cancer screening, compliance with the use of various medication, prevention of unintended pregnancies, pregnancy and smoking, inactive lifestyle, sun exposure, etc. Researchers were also interested in determining what the connection with behaviour modification is when it comes to changing multiple risky behaviours [155, 156, 157]. A literature review of numerous meta-analyses concluded that risk factors can be successfully prevented by using TTM [157]. Researchers further found that if individuals changed a single behaviour, such as physical activity, this had a positive effect on another behavioural area such as nutrition [158, 159]. This is especially important when dealing with individuals who require a change in a large number of risky behaviours, which is very frequent. The successful change of one behaviour can effect a change in a second behaviour [159].

The individual transitions through a series of stages during the behavioural change process with their motivation for change being of key importance. We can motivate them by using motivational interviewing, which is regarded as an intervention strategy in the treatment of problems related to lifestyle and disease [126]. This is based on the assumption that people become more committed to what they say themselves or what they have heard from others. This, in fact, gives people the opportunity to express arguments for change (conversations regarding change), which predicts that the behaviour will change [160, 161, 162].

During the behavioural change process, it is very important that midwives and other health professionals be a role model for individuals. Individuals expect midwives and other health professionals to behave in a healthy manner. Black et al. [150] suggest that the health professional be involved in the change process along with the individual, for this will enable the health professional to give recommendations to others, while individuals will be more motivated to change their behaviour if their therapist is their role model.

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Personal experience in the change process represents a big challenge for the midwife because it requires skills and knowledge regarding a healthy lifestyle and the manner in which to achieve it. Therefore, it is very important that lifelong education/learning be a priority and commitment for the midwife. It is important that she obtain knowledge and skills through various trainings, seminars, and professional and scientific literature. Researchers [150] found that health professionals are more involved in health promotion and health education if they believe that they have the appropriate knowledge and skills, time, and the support of the environment and recipients. An additional factor that may affect the success of interventions for health promotion is the credibility of health workers.

3.5. Conclusion and recommendations

Health education is a discipline that relies on knowledge of different disciplines such as andragogy, pedagogy, didactics, and psychology and sociology; nevertheless, it remains within the scope of the health profession, drawing on the profession's principles in processes related to both healthy and ill individuals. It can be a daily aid for midwives and other health professionals in the processes of preserving and fortifying health as well as treatment and rehabilitation. With health education, the midwife can influence the individual's behaviour and life habits in a positive way, thus contributing to an improved life, reduced health inequality and improved health of the population. Using the knowledge gained through health education, individuals will be able to understand, clarify their position or create new ones, become acquainted with new values and respect them, and pay attention to their health-related behaviour.

We can find a variety of health behaviours in individuals, which may also be harmful to them, such as unhealthy sexuality, an unbalanced diet, increased body weight, physical inactivity, smoking, stress, etc. In this case, we are talking about an unhealthy lifestyle which the individual with the help of a health care professional (midwife) can successfully eliminate. Individuals behave in a variety of different ways (behaviour); some respond to health care messages that promote the maintenance, enhancement and restoration of health, while others ignore them. Planning models based on behavioural health theories can prove to be of great assistance to midwives in eliminating behaviour which represents health risks. TTM is very frequently used by midwives and assists them in determining which of the six stages of behavioural change an individual is in. It also helps them in creating effective strategies for coping with change and encouraging individuals to transit through the individual stages. Due to the fact that individuals are more or less motivated to change, the midwife can use motivational interviewing to significantly increase the inner motivation of individuals to change their behaviour. When an individual passes through the stages of behaviour change, it is extremely important that they adopt the decision to change themselves and not the midwife. During the change process, the individual should be active in solving their own problems while understanding that the midwife understands them and is committed to the individual's development and progress. The individual is able to take a resolution to overcome their problems if the midwife encourages and helps them only to the extent necessary. The midwife should act as a facilitator and never as a "traditional" teacher where the individual is in a

subordinate position. Individuals desire a fair and respectful attitude, the opportunity to converse and active listening on the part of the midwife, adequate time for questions and the ability to cope with their current problems.

We should not forget that the process of health education begins with the selection of a suitable space (room). The room should be bright, airy, spacious, and equipped with the appropriate furniture and teaching aids (posters, models, schemes, various brochures, leaflets, books). No one should bother the midwife in the room during the implementation of health education (no ringing phones or visits by colleagues or other clients). The midwife should focus her attention on the individual the moment they enter the room. The midwife should begin the introductory meeting with a greeting, introduce herself, explain the purpose of the visit and tell the individual that they will obtain information. This should be followed by the setting of objectives, creation of a plan and evaluation of the level of health education. It is important that the midwife is flexible when planning and implementing health education, meaning that she continuously adapts to the individual's needs and expectations. During the teaching process, she should always give the individual written materials (e.g. leaflets, brochures, booklets) which she explains to them in advance, giving them the opportunity to ask additional questions and request explanations. The midwife should record everything that is happening with and to the individual promptly in the documentation earmarked for this purpose.

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