

GREEN & TONES'
HEALTH
PROMOTION



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HEALTH
PROMOTION
Planning and Strategies

5TH
EDITION

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 Sage



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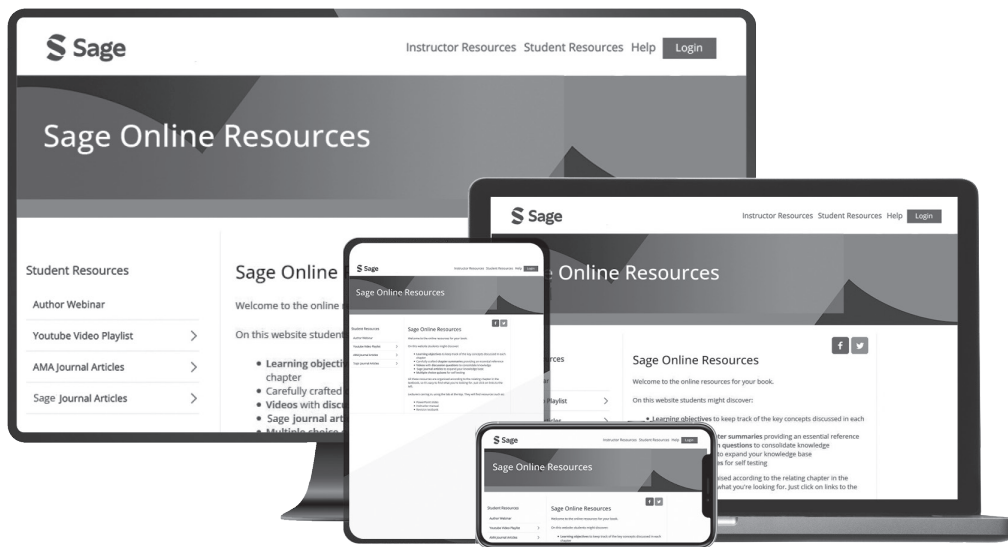
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HOW TO USE THE ONLINE RESOURCES



The fifth edition of *Health Promotion* is supported by a variety of online resources for students and lecturers to aid both learning and teaching. Further readings and weblinks provide a solid foundation through which to explore topics in the book in more depth. Using contributors from around the world, we also have nine original case studies that give an insight into practice and evaluation across a variety of different contexts.

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RESOURCES FOR LECTURERS

Seminar questions

- Seminar questions provide lecturers with general discussion points to use when teaching chapter-specific topics, and drill down into the sub-topics of the subject, with more critical thinking points and questions to explore with students.

RESOURCES FOR STUDENTS

Journal articles

- A selection of free SAGE journal articles that support each chapter to help deepen your knowledge and reinforce your learning of key topics. An ideal place to start for literature reviews/dissertations/assignments. Preceding each article is an annotation from the chapter editors, Ruth Cross and James Woodall, introducing its relevance for practice and/or revision.

International case studies

- International case studies, mapped against each chapter, written by contributors from around the world, map to each chapter and provide a unique insight into the challenges of health promotion across a range of socioeconomic and cultural contexts. Countries represented include Ghana, Jamaica, UK, The Gambia, Norway, Uganda and Zambia.

CASE STUDY SUMMARIES AND CHAPTER MAPPING

Case Study 1: Eve for Life Jamaica Mentor-Mom Programme

Antionette Barton-Gooden, Joy Crawford and Patricia Watson

Figueroa et al. (2020) reported that the Human Immune Virus (HIV) prevalence rate in Jamaican adults was 1.5%. Nevertheless, there are disproportional rates of infection in some at-risk populations. Females are one such group with a greater risk of HIV due to their anatomical features, cultural practices and socioeconomic factors. Globally, it appears that gender inequity is getting greater attention since the *Me-Too Movement*. However, Eve for Life Jamaica, which was established in 2008, has been a champion for gender empowerment, institutional support and advocacy prior to this. This health promotion strategy combines modelling, individual and community empowerment for girls and women infected and affected by HIV.

Relevant to Chapters 1, 5, 6, 7 and 9.

Case Study 2: Cash Transfer Programmes as a Health Promotion Strategy

Ebenezer Owusu-Addo, Sally Baba Owusu-Addo, Andren M.N. Renzaho and Ben J. Smith

A key development in health promotion has been the recognition of how social policy interventions influence population health and health inequities. It has been acknowledged that without appropriate interventions that address the social determinants of health (SDoH), the health of most people particularly in low- and middle-income countries will continue to deteriorate. The World Health Organization (WHO) in 2008 made a strong call for governments across the globe to develop culturally appropriate interventions to address health inequity through action on the SDoH. A particularly promising social intervention that could help in this direction is cash transfer programmes (CTs). The aim of this case study is to show how CTs can be used as a health promotion strategy to address the broader determinants of health and health inequalities.

Relevant to Chapters 2, 3, 4, 6, 9, 10 and 11.

Case Study 3: Employee-driven Shift Scheduling: A Case Study from Norway

Kari Ingstad

In Norway, over 70% of primary healthcare workers have part-time jobs, and staff shortages are expected to increase. A greater need for healthcare workers in combination with high stress levels among staff calls for new thinking around the organization of shift work. This study shows that staff involvement in drawing up shift rotas can lead to more full-time work, which again enhances job continuity and makes more staff take greater responsibility. One challenge of staff involvement in creating their own shift schedule is conflicting preferences. Employee-driven shift generation requires negotiation among staff members involving give and take.

Relevant to Chapters 1, 3, 10 and 12.

Case Study 4: Satellite Healthcare Services: The Jamaican Perspective

Sandra Chisholm-Ford, Sheryl Garriques-Lloyd and Mauvette Waite

The satellite healthcare model is a practical and 'best fit' healthcare service offered to the most vulnerable aggregate populations in various communities in Jamaica. An adapted version of the model is being utilized in the Whitfield Town community resulting in improvements in the immunization coverage, reduction in infant and maternal mortality and morbidity as well as improvements in mental and physical health and life expectancy of community members.

Relevant to Chapters 1, 4, 3, 6 and 9.

Case Study 5: COVID Vaccination: What Did We Miss in Relation to Public Health Messaging to Protect Pregnant Women?

Tendai Nzirawa

The first World Health Organization (WHO) official announcement was made on 31 December 2019, that a cluster of cases of pneumonia of unknown cause had been detected in Wuhan City, Hubei Province, China. Based on the patient samples it was later identified as coronavirus (SARS-CoV-2) (UK Health Security Agency, 2022). A wave of fear, worry and anxiety spread across the world. Little was known at the time on how this virus would affect pregnant women and other vulnerable people. This case study aims to highlight the impact coronavirus can make on a pregnant woman and their family when they are not COVID-19 vaccinated.

Relevant to Chapters 2, 3, 5, 6, 7 and 8.

Case Study 6: Alcohol Investment: A Public Health Risk of Disease Burden in Zambia

Philip Chimponda

In the recent past, increased investment in alcohol, especially in Africa and in particular Zambia by multinational corporation companies coupled with local alcohol industries, has resulted in increased alcohol production, availability and high consumption, subsequently increasing the disease burden and ill health within the general population. Lack of evidence-based policies to inform best practices and poor implementation of existing by-laws impact on prevention of health-related harms at individual level and within the general population.

Relevant to Chapters 1, 2, 3, 6 and 12.

Case Study 7: The Role of Research Officers in Promoting HIV/AIDS Research: A Case of Mbarara University of Science and Technology Grants Management Office

Jacqueline Karuhanga

Although the incidence of HIV/AIDS infection has declined in recent years, it continues to be the leading cause of disease and death in Uganda (Kazibwe et al., 2022); with Mbarara district among 13 HIV high-risk districts in the country; and some suburbs registering a prevalence rate (12.6%) that is twice the general district rate (Uganda Population HIV Impact Assessment, 2017). To avert this trend, Mbarara University of Science and Technology (MUST) and its collaborators remain committed to HIV/AIDS research. To further strengthen HIV research, the MUST UVA project was launched to substantially raise the external research award obtainment success rate for HIV/AIDS research programmes at MUST through human skills development and well-researched technological advances, and in doing this, has become a leader in the field.

Relevant to Chapters 2, 6 and 12.

Case Study 8: The Anglican Communion: Responding to a Health Emergency

Michael Beasley, Luke Pato, Janice Tsang, Rachel Carnegie, Ben Walker and Sally Smith

This case study describes how the Anglican Communion Health and Community Network (AHCN) was established during the COVID-19 pandemic, meeting the needs of its members for accurate information, connection and support during the pandemic, as well as launching advocacy for equitable access to vaccines and promoting COVID-19 vaccine uptake among its membership.

Relevant to Chapters 1, 4, 7, 8, 9 and 10.

Case Study 9: Results-Based Financing to Improve Utilization of Maternal and Child Health Services in The Gambia: A Case of Community Empowerment

Tahir Ahmad Touray and Yusupha Sangyang

Maternal and child health are major public health concerns in The Gambia, with a maternal mortality rate of 289 deaths per 100,000 live births in 2020 and an infant mortality rate of 40 deaths per 1000 live births in 2022 (The Gambia Bureau of Statistics, 2021). The Government of The Gambia has come up with interventions such as the Results-Based Financing (RBF) programme to increase access to and utilization of maternal and child health services in the country. The purpose of this case study is to show how the intervention reflects some values and principles of health promotion.

Relevant to Chapters 2, 3, 4, 7, 8, 9 and 10.

ABOUT THE EDITORS

Dr Ruth Cross is Course Director for Health Promotion in the School of Health at Leeds Beckett University. Ruth has authored and co-authored several books and book chapters on health promotion theory and practice. Ruth was Editor of the *International Journal of Health Promotion and Education* from 2015 to 2021.

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INTRODUCTION

The fact that health follows a social gradient is no longer contested (Bambra et al., 2010); a lot of robust evidence demonstrates this – people who are better off (economically and socially) fare better health-wise (Marmot, 2010; Marmot et al., 2020). In the wake of the global COVID-19 pandemic the world is further witness to this pattern of outcomes. New infectious diseases pose new challenges for everyone, yet the least well-off and most socially marginalized fare worst. Since late 2019 we are all living with the continued impact of COVID-19; however, it has not affected everyone equally. Contemporary public health problems are all too frequently attributed to individual behaviour such as poor diet, lack of exercise, unsafe sex and smoking, drinking alcohol and using other addictive substances. In the case of COVID-19 individual behaviour was again under focus – social distancing/isolating, handwashing, wearing a face covering, getting vaccinated. Interpretations of this sort tend to be associated with a biomedical discourse and a deficit model of health that equates it with the absence of disease, rather than more holistic interpretations of health that encompass positive well-being. Such attributions are clearly overly simplistic. Nonetheless, they are still potentially damaging with regard to public health practice as responsibility for unhealthy behaviour, and therefore by implication health, becomes delegated to the individual. Health promotion has challenged such a narrow focus on behaviour and has supported a more comprehensive analysis of the factors that influence health and well-being. In particular, it recognizes the fundamental importance of environmental influences on health and the complex interplay between these factors and health-related behaviour. Environmental factors are taken to include not only the physical environment, but also psychosocial aspects and, importantly, the socioeconomic environment. Acknowledging the importance of these wider determinants moves the primary focus of health promotion towards creating the conditions supportive of health and health behaviour. It also effectively involves the state in the responsibility for tackling the so-called upstream determinants of health and draws attention to the essentially political nature of health promotion. Returning to the example of COVID-19, all countries were impacted but some, due to political choices or ideologies, faced more extensive mortality and morbidity. Rather than being a matter of individual responsibility, health therefore becomes an issue of social justice. The key to addressing health inequalities is to tackle the root causes, including economic inequality.

The ‘big issues’ that are a threat to health at the global level include poverty and deprivation, discrimination and exploitation, and violence in all forms including terrorism. Additionally, there is the rise of ‘wicked’ or ‘super wicked’ health promotion problems and contemporary challenges to health such as climate change, environmental degradation, war and conflict, and emerging infectious diseases. Inequalities in health persist between high- and low-income countries and within countries too. A child born in Japan or Sweden can today expect to live to over 80 years of age whereas in some African countries life expectancy is still less than 50. The effects of global recession and climate change are being experienced disproportionately by poorer countries – despite the fact that the most affluent

nations carry the major share of blame for the problem. Tackling global health inequalities demands international commitment and coordinated action but this response is not always forthcoming.

At the national level, there are also major inequalities: ‘life expectancy at birth for males living in the most deprived areas in England was 73.9 years in 2016–18 compared with 83.4 years in the least deprived areas; the corresponding figures for females were 78.6 and 86.3 years’ (Marmot et al., 2020: 11). However, it is not only the poorest in society who experience worse health. There are gradations in health at all levels of the socioeconomic scale. This appears to be the case in all countries.

Attempts to improve public health may fail to be effective for a number of reasons – notably by focusing on individual behaviour rather than the social and environmental determinants of health and ill health. Clearly, inadequate understanding of the key determinants will risk interventions addressing inappropriate variables. In some instances, they are a knee-jerk reaction to addressing an emerging issue. They may, therefore, be poorly planned with insufficient attention to relevant theory and existing research and evaluation evidence. Interventions may also be under-resourced with unreasonable expectations of what might be achieved within the time frame.

Responses to tackling contemporary health problems are often driven by the political imperative to be seen to be doing something – regardless of whether or not it is the most appropriate means of achieving significant and sustainable improvements in health. They are often concerned with demonstrating early high-profile wins to fit in with political time frames dictated by electoral cycles rather than achieving long-term sustainable change. Furthermore, there is a marked reluctance to adopt unpopular measures that might risk alienating the electorate; for example, by requiring the majority to make cutbacks or major changes to their behaviour – hence the muted (some would argue wholly inadequate) response to tackling world poverty or climate change. We are advised to switch off the standby light on our televisions rather than take any serious action to reduce energy expenditure. Efforts to reduce health inequality tend to focus downstream on mitigating the effects of poverty and unequal life chances rather than upstream on tackling disadvantage itself through redistributive policy.

Health promotion has been characterized by a concern to create supportive environments for health through healthy public policy. Effectively, this shifted the emphasis away from health education. For many, health education had become associated with attempts to persuade individuals to change their behaviour and was criticized for failing to take account of the wider influences and, therefore, being victim-blaming in orientation. However, health promotion has been encapsulated as the synergistic interaction between health education and healthy public policy summed up as:

health promotion = health education × healthy public policy

The marginalization of health education effectively stifled debate about its continuing relevance to health promotion (Green, 2008). Yet a broader conceptualization of health education recognizes its potential for contributing to the major goals of health promotion – equity and empowerment. This broader conceptualization is concerned with enabling individuals and communities to gain control over their health and is, therefore, more radical and political in intent. We use the term ‘new health education’ to distinguish it from more traditional forms.

A basic premise of this text is that the new health education can be a major driver within health promotion with the capacity to:

- develop the knowledge, values and skills required for individual decision-making and voluntary action and, importantly, contribute to individual empowerment
- raise awareness of the need for environmental and policy change to support health and health choices
- develop critical awareness among communities about factors influencing their health and the skills and motivation required to take collective action – thereby contributing to critical consciousness-raising and community empowerment
- be part of professional education and training to enable professionals across a range of sectors to contribute to the health and well-being of their client groups and engage in advocacy on their behalf.

Green and Tones's rationale for producing the first edition of this book was that in order to be effective health promotion must be systematically planned. Their second edition updated this argument by drawing on contemporary examples and revisiting the various debates. The third and fourth editions, edited by Ruth Cross and James Woodall, retained Green and Tones's contention that planning should be more than a mere technical exercise. The fourth edition included a new chapter focusing on evidence-based health promotion and the necessity for health promotion to legitimize its approach and strategy. This fifth edition, again edited by Ruth Cross and James Woodall, provides a framework that allows initiatives to be grounded in the core values and principles of health promotion. Accordingly, it begins by identifying these values and principles to establish a foundation for detailed discussion of planning and its application to practice. Throughout, the importance of theory is emphasized. This is demonstrated by its application through the use of examples, research and case studies from a range of international contexts.

Notwithstanding the inclusion of contemporary research and case studies from around the world, no apology is given for including references to older 'classic sources' and seminal work; rather, this is viewed as a major strength of the book. Green and Tones argued in the introduction to the second edition that health promotion is in danger of losing sight of its roots and that there is an emerging tendency to 'reinvent the wheel' – not always as well as the first time round! It therefore remains the aim to maintain the visibility of some of the early innovative and radical thinking, which continues to be of relevance to contemporary health promotion.

Since the publication of the fourth edition of the book in 2019, the world has changed considerably and has highlighted further that tackling complex public health problems requires a multidisciplinary response. Health promotion has an essential and pivotal role in orchestrating that response. However, if it is to make a significant contribution to tackling contemporary health issues, it needs to re-engage with its radical agenda and core values and maintain its distinctive identity and purpose. This edition continues to examine the relationship between health promotion and modern multidisciplinary public health and establish its unique contribution.

The fifth edition maintains the overall coherence of the text as it has evolved through four iterations. The core themes underpinned by a commitment to equity and empowerment are retained. Like Jackie Green and Keith Tones, we consider these to be absolutely central and have, therefore, adhered to the principles set out in the earlier editions. As the editors of this new edition, our approach has again been to update and refresh the text by introducing new material on selected topics in order to

maintain the book's currency and relevance to health promotion practice. Readers familiar with previous editions will note that key sections remain unchanged; this is purposefully the case. We have also broadly kept the book's structure, albeit with the addition of a new chapter on evidence-based health promotion in the previous edition, and adopted the same style and approach while drawing on more international examples and instances.

As in the previous editions, a number of key themes run throughout the whole text. These are:

- the need to adopt a systematic approach to planning
- the importance of theory and other forms of evidence
- support for an empowerment model of health promotion
- health education as a major driving force within health promotion
- acknowledgement of the upstream social determinants of health – the 'causes of the causes'
- the complex interplay between agency and structure – between individuals and their environment
- the need to tackle health inequalities.

In addition, we have identified a number of more contemporary issues for health promotion and introduced or expanded on these in subsequent editions as follows:

- assets-based approaches, including the latest thinking on salutogenesis
- understandings of mental health promotion and well-being
- concepts of healthy communities
- nudge theory and choice architecture
- social media, social networks and the role of the Internet in health promotion
- new perspectives and debates in public health evidence
- developing debate on inequalities, equity and social exclusion
- health in all policies agenda
- ethics in health promotion
- evidence-based health promotion
- contemporary threats to health in the form of new infectious diseases
- climate change and sustainability.

Health is a nebulous and contested concept, meaning different things to different people. Clearly, those working to promote health should have a clear view of what they are aspiring to. The book begins by considering alternative conceptualizations of health and a simple working model is developed. This includes physical, mental and social dimensions. It also recognizes the existence of health – or its absence – at individual and societal levels. It acknowledges the split between negative approaches to conceptualizing health that focus on the absence of disease and positive approaches that incorporate well-being. However, it is contended that empowerment should be central to definitions of health and, further, that an emphasis on empowerment supports the achievement of both disease prevention and positive health goals.

The term 'health promotion' has variously been used to refer to a social movement, an ideology, a discipline, a profession and a strategy or field of practice delineated by commitment to key values.

Chapter 1 discusses the ideology of health promotion and seeks to identify its core values. It also reviews the major World Health Organization (WHO) documents that have contributed to shaping its development right up to the 10th Global Health Promotion Conference hosted online from Geneva in late 2020 and, in particular, the Ottawa Charter (WHO, 1986). It identifies different models of health promotion and argues on ethical, ideological and even pragmatic grounds that health promotion should subscribe to an empowerment model. Empowerment approaches recognize the reciprocal relationship between individuals and their environment and the complex interplay between agency and structure – one of the themes of this text. This chapter references the importance of mental health and well-being and contemporary agendas around these areas.

Following on from the discussion of health and health promotion, Chapter 1 then locates health promotion within the context of modern multidisciplinary public health and identifies its distinctive contribution to the public health endeavour. It also considers the importance of maintaining a separate identity for health promotion and discusses competency and professional standards for health promotion capacity including a section on ethics and ethical practice. It concludes by examining the relationship between health education and health promotion. It is argued that the “new” critical health education’ is the driving force in health promotion – another of the major themes that run through the book.

Chapter 2 focuses on identifying the determinants of health and various ways of assessing them. Importantly, it looks at the value of incorporating lay perspectives and distinguishes salutogenic from pathogenic explanations of health and ill health, focusing on well-being and assets-based approaches. It concludes by considering inequality and social exclusion and social capital.

Chapter 3 begins by looking at the uptake of new ideas and practices at the community level. It then goes on to consider, at the micro level, how various factors interact to influence decisions and behaviour. In order to do so, it draws on a number of psychosocial theories and particularly the health action model (HAM). In line with supporting an empowerment model of health promotion, it pays particular attention to the dynamics of empowerment. It considers issues associated with power and control and the reciprocal determinism between individuals and their environment. Revised content around choice architecture and nudge theory is included.

Chapter 4 sets out the argument supporting systematic planning and introduces a number of planning models. It emphasizes the central importance of developing clear objectives. It also recognizes that partnerships across different sectors are needed to tackle the multiple and complex determinants of health. This chapter also looks at what is involved in developing successful partnerships and collaborations.

Chapter 5 focuses on the first stage of the planning cycle – identifying health needs. It looks at different conceptualizations of need. Consistent with the values of health promotion, it supports participatory approaches to identifying and prioritizing health needs.

We continue to emphasize throughout the book the importance of environmental determinants of health. Chapter 6 explores in detail the role of healthy public policy in establishing supportive environments for health. It considers the process of policy development and identifies the important contribution of health education and advocacy. Clearly, policies across a whole range of areas – including, for example, education, agriculture, planning and transport – will potentially influence health. The chapter therefore focuses discussion on Health in All Policies, a concept vehemently espoused in recent WHO charters

and declarations. The chapter concludes by discussing the use of health impact assessment to assess the potential effects on health of policies at all levels, from the macro level down to local policies.

One of the major themes of the book is the central importance to health promotion of what Green and Tones termed the 'new' health education. Chapter 7 specifically focuses on the role of health education. It begins by examining the communication process and the design of messages before looking at different models of health education and types of learning. It then looks at methods of facilitating learning and specifically at the use of peer education and creative arts. It briefly discusses the use of health education for persuasion and attitude change – recognizing the potential conflict with empowerment. The chapter concludes by looking at health education as a strategy for social and political change, including reference to Freirean approaches.

Health education has, in the past, been associated with mass media campaigns. Chapter 8 analyses the potential and limitations of mass media interventions. It discusses relevant theories and also the technical issues involved in mass media campaigns. It also considers the more general influence of mass media on behaviour. A separate section revisits the contribution of social marketing, which has been receiving considerable attention. The role of social media, social networking and the use of mobile technologies are discussed. The chapter concludes by considering the use of mass media for advocacy purposes to shape public opinion and influence policy-makers.

Chapter 9 focuses on working with communities and in particular on community development and empowerment approaches. It identifies key aspects of good practice in working with communities and considers some of the challenges of putting the rhetoric of community development into practice. In particular, it draws attention to the need to ensure that disadvantaged and socially excluded groups are able to participate.

Chapter 10 looks at the settings approach and its potential for improving health. By focusing on the conditions that are supportive of health, the approach shifts the emphasis away from individual behaviour and towards organizations and structural factors. Having examined the principles of the approach, it goes on to consider in detail the health-promoting prison as an example, as well as making observations about a range of different settings.

Evaluation is an essential element of health promotion practice and the development of an evaluation strategy is clearly integral to systematic programme planning. Chapter 11 distinguishes between formative evaluation that contributes to the development and quality of programmes and summative evaluation to assess their overall effectiveness. It emphasizes that, in addition to measuring outcomes and the extent to which the goals of a programme have been achieved, evaluation should also comment on the process and identify those factors that may have contributed to the success and sustainability of programmes – or equally have resulted in failure. Chapter 11 considers the methodological debates about evaluation in order to make recommendations about appropriate methodology – that is, a methodology that is capable of identifying the range of potential health promotion outcomes and unpicking the complex pathways that lead towards them. Importantly, it must also be consistent with the values of health promotion and conform with ethical principles.

Following on from the discussion of evaluation, Chapter 12 considers the contribution of evaluation and empirical research findings to the evidence base for health promotion and the use of systematic reviews to synthesize the evidence. It also argues that the development of the evidence base should include practitioner expertise and insights and, importantly, should also incorporate

theory. Indeed, theory should constantly be updated and refined in the light of emergent empirical evidence as part of a continuing cycle of development. Finally, the chapter considers how evidence can be put into practice. By looking at how evidence can be used in systematic planning, we effectively come full circle.

Health promotion has been referred to as an idea whose time has come. It has the potential to make a major contribution to tackling contemporary health problems and improving the health of individuals and communities. The purpose of this book is to demonstrate how that potential can be maximized through systematic planning, with due regard to evidence, theory and values at each stage of the planning cycle.

In this fifth edition each chapter contains select abstracts that are indicative of how the concepts within in the chapter are operationalized, discussed and debated in the wider research literature. Key concepts are also indicated throughout the text by the light bulb icon.



The key concepts deemed central to health promotion, as the authors understand it, are empowerment, equity, participation, partnership and ethics. Each time a key concept is considered in some detail readers will see the icon in the margin to indicate this. Finally, a critical reflection section is included at the end of each chapter that offers readers an opportunity to think about how the contents of the chapter may relate to their health promotion practice. We trust you will find these features helpful in your reading and would welcome any feedback.

1 HEALTH AND HEALTH PROMOTION

OVERVIEW

This chapter focuses on three broad areas – the concept of health, setting out the distinctive features and values of health promotion, and establishing the position of health promotion vis-à-vis modern multidisciplinary public health and health education. It will:

- explore alternative conceptualizations of health
- develop a working model of health
- consider the ideology and core values of health promotion
- identify different models of health promotion
- set out the rationale for an empowerment model of health promotion
- locate health promotion within modern multidisciplinary public health
- propose a new 'critical' health education as the major driver and distinctive voice of health promotion.

INTRODUCTION

The primary concern of this book is to provide insight into the factors that contribute to the effective and efficient design of health promotion programmes. The way in which health is conceptualized has major implications for planning, implementing and evaluating programmes. Equally, the approach adopted at each of these stages will be influenced by the values of those working to promote health.

HEALTH AS A CONTESTED CONCEPT

Developing clear goals will depend on how health is defined. Yet, it is acknowledged that health is, as Gallie (1955) famously described, a contested and elusive concept, a notion which is widely accepted (Duncan, 2007). Its many, often conflicting, meanings are socially constructed. Lowell S. Levin likened the task of defining health to shovelling smoke. It is difficult, to say the very least, to provide precise definitions, largely because health is one of those abstract words, like love and beauty, that

mean different things to different people, a point reiterated by Warwick-Booth et al. (2021). However, we can confidently say that health is, and apparently always has been, of significant value in people's lives. If we do not acknowledge the contentious nature of health and have a sound understanding of the determinants of our preferred conceptualization, it is unlikely that we will be able to develop incisive strategies for promoting it.

Defining health: contrasting and conflicting conceptualizations

A number of tensions emerge in defining health. These include the relative emphasis on:

- disease or well-being
- holistic or atomistic interpretations
- the individual or the collective
- lay or professional perspectives
- subjective or objective interpretations.

One of the most persistent distinctions between definitions of health has been whether the focus is on wellness or on the absence of disease.

As Cross et al. (2021: 17) argue, it is very difficult, if not impossible, to reach a consensual definition of what health *is*. Probably the best known definition of health comes from the Constitution of the World Health Organization (1946, 2006a): 'Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity.' While this definition has been criticized because of its utopian nature, the use of the word 'complete' (Oleribe et al., 2018) and therefore as impossible to achieve (Blaxter, 2010), it extended the boundaries of health beyond the absence of disease to include positive well-being and firmly acknowledged the multidimensional, holistic nature of health. The Constitution further asserts that:

The enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition.

This assertion, also enshrined in numerous United Nations human rights treaties such as the International Covenant on Economic, Social and Cultural Rights (Office of the High Commissioner for Human Rights [OHCHR], 1966) and the Universal Declaration on Human Rights (UN, 1948), politicizes health and places pressure on governments to create the conditions supportive of health (WHO, 2007a). Furthermore, this emphasis on health as a fundamental human right focuses the attention of those seeking to promote health on equity and empowerment.

We have seen understandings about subjective health turn more towards notions of happiness, well-being, mental health, resilience and assets. This potentially makes the limits to health boundless, leading to all problems becoming 'health' problems and possibly unleashing unlimited demands for health services. It could arguably, therefore, undermine health and human rights arguments. Some argue for more attention to be paid to notions such as quality of life and, as seen in more recent trends, well-being (Ruggeri et al., 2020).



Lay interpretations of health

Notwithstanding the undoubted difficulties associated with measurement, from a health promotion perspective, the subjective element – health as it is experienced in people's lives – is of central importance. Buchanan (2006), who has defined health as synonymous with the 'good life' ('a life worth living, with the means to flourish and thrive' – Komduur et al., 2009: 307), emphasizes the importance of subjective, autonomous interpretations:

we should shift the emphasis in the field from the rather narrow focus on producing specimens of physical fitness, to a broader concern for human wellbeing, here understood in terms of enhancing moral judgment, promoting greater self-understanding, liberating people from scientific assumptions (perpetuating the belief that human behavior is determined by antecedent causes that only highly trained scientists can divine), advancing the cause of social justice, and promoting respect for the diversity of understandings of the good life for human beings. (2006: 302)

This draws attention to lay interpretations of health that will be considered more fully in Chapter 2. However, for now it is relevant to observe that lay interpretations are complex and multidimensional. The absence of disease is central to lay views, but resilience – the ability to cope with life – and functional capacity are also important (see Abstract 1.1). Social class differences have also been noted (Blaxter, 2010; Calnan, 1987; Hu et al., 2021), with a greater emphasis on the ability to function in lower social classes, a more multidimensional conceptualization including positive well-being in higher social classes as well as differences in perceptions of the ability to self-manage health (this increases with social class). Lay interpretations of health inequalities also differ (Garthwaite and Bambra, 2017). While lay interpretations are often taken to be different from more systematized 'professional' accounts, commonalities do exist. Lay accounts – particularly public as opposed to private accounts – tend to incorporate knowledge and understandings developed in expert paradigms (Shaw, 2002). One of the difficulties that we have in establishing lay beliefs about health is that much of the research that claims to explore these actually focuses on ill health and disease rather than on more positive notions of health (Hughner and Kleine, 2004).

ABSTRACT 1.1

Do conceptualisations of health differ across social strata? A concept mapping study among lay people. Stronks, K., Hoeymans, N., Haverkamp, B., den Hertog, F.R.J., van Bon-Martens, M.J.H., Galenkamp, H., Verweij, M. and van Oers, H.A.M. (2018)

Objectives: The legitimacy of policies that aim at tackling socioeconomic inequalities in health can be challenged if they do not reflect the conceptualizations of health that are valued in all strata. Therefore, this study analyses how different socioeconomic groups formulate their own answer regarding: what does health mean to you?

Design: Concept mapping procedures were performed in three groups that differ in educational level. All procedures followed exactly the same design.

Setting: Area of the city of Utrecht, the Netherlands.

Participants: Lay persons with a lower, intermediate and higher educational level (+/-15/group).

Results: The concept maps for the three groups consisted of nine, eight and seven clusters each, respectively. Four clusters occurred in all groups: absence of disease/disabilities, health-related behaviours, social life, attitude towards life. The content of some of these differed between groups; for example, behaviours were interpreted as having the opportunities to behave healthily in the lower education group and in terms of their impact on health in the higher education group. Other clusters appeared to be specific for particular groups, such as autonomy (intermediate/higher education group). Finally, ranking ranged from a higher ranking of the positively formulated aspects in the higher education group (e.g. lust for life) to that of the negatively formulated aspects in the lower education group (e.g. having no chronic disease).

Conclusion: The results provide indications to suggest that people in lower socioeconomic groups are more likely to show a conceptualization of health that refers to (1) the absence of health threats (vs positive aspects), (2) a person within his/her circumstances (vs quality of own body/mind), (3) the value of functional (vs hedonistic) notions and (4) an accepting (vs active) attitude towards life.

Adaptation, actualization, ends and means

Utopian visions of health, while aspirational and even inspirational, are ultimately unattainable. Humanity rarely, if ever, achieves stasis. People are constantly engaged in an often-problematic process of adaptation to their environments – to their physical, material, economic and social circumstances. The dynamic interaction between individuals and their environments is recognized in definitions of health promotion as enabling people to gain control over their lives and their health (WHO, 1984). Dubos's (1979) influential perspective on health supposes that positive health is a mirage. As reiterated by Blaxter (2010) – health is evanescent and unattainable, but worth pursuing. If health means anything, it resides in the pursuit, in engaging with these constantly changing and typically unpredictable environmental forces.

Aspects of Maslow's (1970) notion of self-actualization resonate with Dubos's perspective on the nature of health. Maslow defines it as follows:

Self-actualization ... refers to man's [*sic*] desire for self-fulfilment, namely, to the tendency for him to become actualized in what he is potentially. This tendency might be phrased as the desire to become more and more what one idiosyncratically is, to become everything that one is capable of becoming ... In other words, 'What a man *can* be, he *must* be.' (1970: 46)

Self-actualization is encapsulated as the full realization of one's creative, intellectual and social potential (Selva, 2021). Apart from providing a useful operational definition of psychological health and his emphasis on the importance of self-esteem, Maslow's work has considerable relevance for the empowerment imperative of health promotion. Furthermore, it raises the issue of whether health is an end in itself – a terminal value – or whether it is instrumental for the achievement of other valued

goals. The latter interpretation is encapsulated in the Ottawa Charter conceptualization of health as a 'resource for everyday life, not the objective of living' (WHO, 1986) and in the Declaration of Alma Ata (WHO, 1978) as a means of achieving a 'socially and economically productive life'. Whether desired goals in this context are defined by individuals themselves or by society generates further questions about the respective emphasis on self-actualization or collective responsibility.

Coherence, commitment and control: health as empowerment



In an article published posthumously, Antonovsky (1996) declared his concern about the dominant paradigm common to both medicine and health promotion. This, he argued, is based on the dichotomous classification of people into those who have succumbed to disease as a result of exposure to risk factors, and those who have not. He urged health promoters to move away from this obsession with risk factors and adopt a 'salutogenic model' that views health and disease as a continuum and focuses on the conditions leading to wellness.

'Salutogenesis' is a key concept that focuses on the 'salutary' – that is, health enhancing – rather than 'pathogenic' – that is, disease causing aspects of health. It incorporates Antonovsky's main theory about the factors that determine the extent to which people become healthy and experience well-being. Central to this theory is the challenge posed by coping with 'the inherent stressors of human existence' (1996: 15) – encapsulated in the notion of 'entropy' that refers to the level of disorder within systems. At a psychological level, it refers to *perceptions* that disorder exists. People's worlds may be more or less chaotic. Such 'chaos' is held to be undesirable, whether it exists in reality or only in people's perceptions. The salutogenic approach is, therefore, designed to reduce entropy and perceptions of entropy and, in so doing, generate a sense of coherence, which it identifies as a central attribute of a healthy person.

Antonovsky defines coherence as:

a global orientation that expresses the extent to which one has a pervasive, enduring though dynamic feeling of confidence that one's internal and external environments are predictable and that there is a high probability that things will work out as well as can reasonably be expected. (1979: 123)

The three main elements are comprehensibility, manageability and meaningfulness. These are concerned with how we make sense of the world around us and what we experience; how we feel about this and the extent to which we are able to manage or cope with the challenges of life (Sidell, 2010). Mittelmark and Bauer (2022: 11) note that 'in its most general meaning, salutogenesis refers to a *salutogenic orientation* ... focusing attention on the origins of health and assets for (positive) health, contra to the origins of disease and risk factors'. Salutogenesis has received increasing international attention in health promotion research and health policy over the past two decades led by work by the International Union of Health Promotion and Education (IUHPE). This has resulted in the second edition of *The Handbook of Salutogenesis* (Mittelmark et al., 2022). In the foreword to this book Margaret Barry, President of the IUHPE, writes 'an understanding of the nature of positive health, how it is created and can be sustained at a population level, is critically important to provide a theoretical base for health promotion and its implementation in practice' (Barry, 2022: v).

Health and empowerment

The concept of empowerment will receive further consideration throughout this book. For now, we will confine the discussion to the relationship between empowerment and health. If we accept that having control is central to definitions of health, a number of alternatives follow. First, empowerment could be seen as synonymous with (positive) health. In other words, to be healthy is to be empowered! Alternatively, empowerment could be seen as instrumental – that is, as a means to achieving (positive) health. A third conceptualization is also possible. Empowerment could be viewed as both a terminal and an instrumental value. The standpoint here is that empowerment will necessarily be a key component of positive health as an end. At the same time, it will be a means, if not the most important means, to achieving disease prevention and management goals that are components of holistic interpretations of health.



The Commission on Social Determinants of Health (2007) emphasizes the importance of empowerment as a means to achieving health equity. It identifies three key dimensions of empowerment – material, psychosocial and political – and focuses attention on the structural factors necessary for empowerment. It particularly notes the disadvantaged position of women. A health equity perspective on empowerment is highlighted further by Popay (2021: 2), who argues that community empowerment should be understood as a sociopolitical process which disrupts power dynamics in order that ‘people bearing the brunt of social injustice [can] exercise greater collective control over decisions and actions that impact their lives and health’.

We might make two further observations on empowerment in the context of salutogenesis. First, two of the three key requisites of a sense of coherence – notably, comprehensibility and manageability – are concerned with beliefs about control and these also figure prominently in conceptualizations of empowerment. Second, there is potential conflict between empowerment and the sense of meaningfulness, which is the third element of a sense of coherence. In short, while the feeling that ‘all is for the best in the best of all possible worlds’ will doubtless make people feel better, and that life, from a salutogenic perspective, is more meaningful, it may well be delusory and hence disempowering.

HEALTH: A WORKING MODEL

As may be seen in Figure 1.1, for all practical purposes, health is defined as having both positive and negative aspects. The term ‘well-being’ is used as shorthand for the positive dimension. Rather than seeing well-being and disease as opposite ends of a single spectrum, they are represented as coexisting. Furthermore, although each may influence the other, they can vary independently. For example, although well-being may be affected by the presence of negative disease states, it is possible, even desirable, to have high levels of well-being regardless of disease being present. Conversely, there may be high or low states of well-being in the absence of disease. We are quite clear that preventing and managing disease and disability is a laudable goal in its own right and a central concern of those who are professionally involved in healthcare and health promotion. However, it is equally clear that the more positive dimensions must also figure prominently in the formulation of a satisfactory definition of health. In the first place, those involved in public health and health promotion cannot ignore its

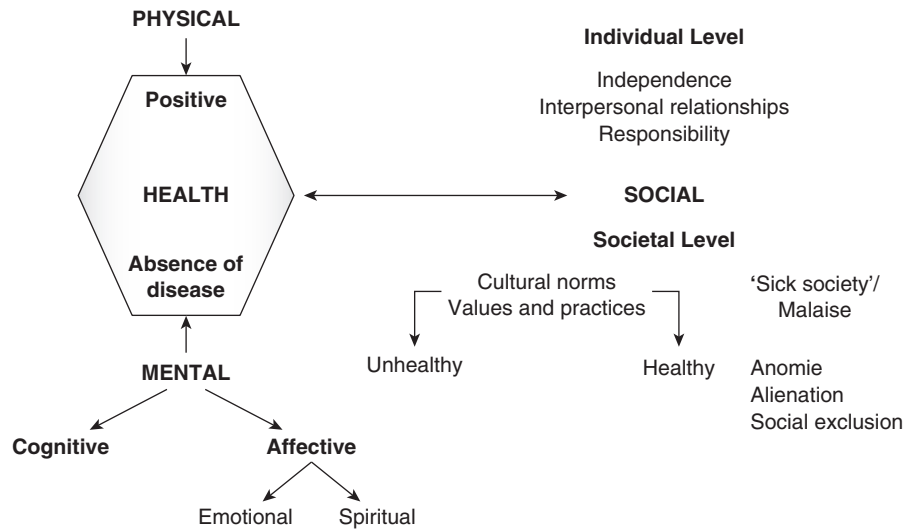


Figure 1.1 A working model of health

importance. But also, those measures that result in the achievement of positive goals are frequently more effective in achieving preventive outcomes than the more limited tactics employed by espousing a narrow disease prevention model.

Being all that you can be

The three components that make up WHO's holistic conception of health are featured in the model. Following Maslowian self-actualization principles, it is tempting to argue that maximal health status involves 'being all that you can be'. Healthy individuals would thus be those who had fulfilled their mental, physical and social potential. As we have argued, the attainment of complete mental, physical and social health is logically and practically impossible. Furthermore, it would be feasible to achieve high levels of potential in relation to one component of health at the expense of others. For example, the degree of commitment required to achieve maximal physical fitness might not only militate against social health and, possibly, be inconsistent with cultural norms, it might also be viewed as evidence of obsessional neurosis! Equally, a lifestyle characterized by sloth and self-abuse might lead to considerable happiness and a very successful social life, but result in an early death.

Accordingly, health must involve some kind of balance between mental, physical and social components. How, though, is such a balance to be determined? Do individuals themselves make the decision or should society decide for them? As the second option is inconsistent with the principles of empowerment (which are intrinsically healthy), only the first option is a serious contender. We will, however, emphasize later in this book the importance of healthy individuals being guided by commitment to a considerate way of life. Thus, individuals should be in a sufficiently empowered position to enable them to choose a course of action, provided only that the rights of other people are not damaged and, ideally, take action to support those who may be disadvantaged.

Mental, social and spiritual health

The definition of physical health is comparatively straightforward. On the one hand, it is associated with minimizing disease and disability; on the other hand, it may involve having a sufficient level of fitness necessary for achieving other (more important) life goals and/or the experience of high-level wellness or, more realistically, the feelings of well-being (allegedly) associated with a high degree of physical fitness. Well-being may thus be associated with fitness, but is by no means an identical dimension of health. A person might, for example, exhibit high levels of fitness, but limited feelings of well-being or, alternatively, high levels of well-being but minimal fitness!

Defining mental health is rather more complicated and problematic. We will confine the current discussion to making just two observations. First, it is useful to consider mental health as having both cognitive and affective dimensions. The affective dimension includes emotions and feelings and most discourse on mental health centres on this aspect. The cognitive dimension rarely features in definitions of mental health, but might be incorporated in a holistic model. 'Being all you can be' in cognitive terms refers to the extent to which individuals fulfil their intellectual potential. The reasons for failure to fulfil intellectual potential have been a source of considerable study and evidence of inequity in this regard has provoked concern. It is thus intimately associated with broad-based health promotion initiatives designed to address general social inequalities and break cycles of deprivation. Second, many people have asserted that any serious consideration of positive health must include the spiritual dimension. This is itself open to several interpretations, but features in Figure 1.1 in the context of mental health and well-being. It has both a cognitive element, consisting of the doctrinal aspects of, for instance, a religious system, and the emotional commitment associated, in this case, with the value system central to the notion of faith which can be integral to meaningfulness and the sense of coherence that is central to salutogenesis. Furthermore, religious values can underpin personal health choices and a sense of responsibility towards upholding the rights of others to health. Spiritual health, while variously defined (Jaberi et al., 2019), receives increasing attention, as does spiritual health promotion. Spiritual health is viewed by many as an important aspect of human health alongside physical, mental and social health (Nunes et al., 2018). However, the ambiguities and vagueness of the term spiritual health have been noted and a comprehensive definition is lacking (Ghaderi et al, 2018). Hanrieder (2017) noted the shift to discourses around religious health assets and the 'faith factor', recognizing the value, benefits and advantages that these bring to subjective health experience and general well-being in a range of different global contexts.

The importance of mental health and well-being was highlighted by the publication of the *Perth Charter for the Promotion of Mental Health and Wellbeing* (2012), which resulted from the 7th World Conference on the Promotion of Mental Health and the Prevention of Mental and Behavioural Disorders. While acknowledging the importance of the holistic stance of the Ottawa Charter for Health Promotion, the Perth Charter argues that 'health promotion in practice has largely been confined to physical health promotion' and that therefore the Perth Charter should be viewed as 'a first step towards the eventual integration of physical and mental health promotion' (*Perth Charter for the Promotion of Mental Health and Wellbeing*, 2012). It sets out seven key principles as follows:

- *Principle 1:* Mental health is more than the absence of mental illness. Mental health promotion includes both preventing illness and increasing well-being.

- *Principle 2:* The foundations of social and emotional well-being develop in early childhood and must be sustained throughout the lifespan.
- *Principle 3:* Mental health promotion must be integrated with public health and requires a cross-sectional approach.
- *Principle 4:* Mental health and illness are constructed, experienced and viewed as different to physical health and illness.
- *Principle 5:* Mental health and mental illness are a dynamic balance.
- *Principle 6:* Destigmatization of mental illness and addressing discrimination are essential components of mental health promotion.
- *Principle 7:* Mental health promotion must take place at the individual and societal levels.

Lay interpretations of mental health are also central to the promotion of mental health. In a Danish study exploring lay understandings of mental health a participant defined mental health as ‘what makes life worth living’ (Nielsen et al., 2017: 26). This points to the importance of mental health for subjective health experience.

Social health: individual and society

The social dimension of health is equally complex. As can be seen from Figure 1.1, there are two categories. The first of these refers to the social health of the individual; the second is concerned with the health of society itself. Three main aspects of individual social health have been identified.

Independence: a socially mature individual acts with greater independence and autonomy than a relatively immature individual.

Interpersonal relationships: a socially healthy individual is characterized by the capacity to relate to a number of significant others and cooperate with them.

Responsibility: a person who is socially mature accepts responsibility for others.

The distinction between the social health of individuals and the health of society is recognized in everyday parlance with references to ‘sick societies’ and ‘social malaise’. We will make further reference to this dimension of social health later in this chapter and at a number of points in this book when we consider the concerns in health promotion with powerlessness, meaninglessness, normlessness, isolation and self-estrangement that are characteristic of ‘sick societies’ and contribute to social exclusion.

PROMOTING HEALTH: COMPETING IDEOLOGIES

No science is immune to the infection of politics and the corruption of power.

Dr Jacob Bronowski, *The Ascent of Man*, BBC2, 1973

Defining health promotion

A key issue in defining health promotion is whether it is viewed as an umbrella term, covering the activities of a range of disciplines committed to improving the health of the population, or as a discipline in its own right. Bunton and Macdonald (2002: 6) suggest that 'recent changes in the knowledge base and the practice of health promotion are characteristic of paradigmatic and disciplinary development'. They take a discipline to involve an ordered field of study embracing associated theories, perspectives and methods. A discipline would be expected to have its own ideology that would also inform standards of professional practice. Prior to our analysis of the ideology of health promotion and the values integral to different models, we will briefly clarify the distinction between health education and health promotion.

Although the generic use of the term 'health promotion' to describe any activity that improves health status can be traced back earlier, Terris (1996) noted that in 1945 Henry Sigerist described the four tasks of medicine as the promotion of health, prevention of illness, restoration and rehabilitation of the sick (cited by French, 2000). However, it was not until the late 1970s that this term began to be applied in a more specific way to a concept, movement, discipline and, indeed, profession. While a systematic account of the history of health promotion is beyond the scope of this text, we should note that the roots of contemporary health promotion are in health education.

The earliest examples of health education in the context of public health would now be described as health propaganda. This typically took the form of pamphleteering, which was intended to generate political change in support of a variety of environmental health measures designed to combat squalor and provide clean water supplies. Early health education was thus seen as an adjunct to public health efforts. Indeed, Wills (2023: 56) notes that, by the 1920s, health education had become associated with 'diarrhoea, dirt, spitting and venereal disease!' With this increasing focus on personal rather than public health, health educators continued their adjuvant role in support of the medical profession. Their activity during this period essentially involved giving information and persuading people using mass communication strategies.

The dominant themes in the early health education journals of the 1950s and 1960s centred on methods of delivering information in ways that would attract attention and interest people in the substantive content of health messages. The primary concern was very much with the technicalities of delivering information. The assumption was that if people were given the 'right' knowledge, they would act appropriately. As we will see in Chapter 3, this grossly underestimated the complexity of the task.

Two broad paths can be traced in the subsequent development of health education. One, the *preventive approach*, sought ever more sophisticated ways of achieving behaviour change by means of the application of psychological theory. The other, which was more in tune with progressive educational philosophy, was concerned with enabling people to make informed choices, the so-called *educational approach*.

In the period following the Lalonde Report (Lalonde, 1974) on the health status of the population of Canada, a renewed interest in the importance of the social and environmental influences on health status – both directly and indirectly by shaping behaviour – brought health education under fierce critical scrutiny (see, for example, Navarro, 1976; Ryan, 1976). Of particular concern were

the emphasis on individual responsibility and the failure to recognize constraints on individuals' behaviour – most notably their economic and material circumstances. Health education was accused of 'victim-blaming' – a term attributed to Ryan. The essence of victim-blaming lies in attempts to persuade individuals to take responsibility for their own health while ignoring the fact that they are victims of social and environmental circumstances. It is now several decades since these criticisms were levelled at health education yet we still often see the focus on individual responsibility at the expense of taking into account the social and structural determinants of health (Lee, 2019). The emergence of health promotion was in response to the need to address the environmental as well as the behavioural determinants of health – the so-called upstream determinants. In effect, it marked a shift from being concerned with healthy choices to making 'the healthy choice the easy choice'.

Health promotion includes efforts to tackle the social and environmental determinants of health by means of healthy public policy. The scope of health promotion can, therefore, be summed up in a simple formula:

$$\text{health promotion} = \text{health education} \times \text{healthy public policy}$$

We will review different models of health promotion later in this chapter. At this point, we will consider the influence of the WHO on the development of health promotion.

The contribution of the World Health Organization (WHO) to the definition of health promotion

The evolution of health promotion has been accompanied by considerable debate about its nature and purpose – debate that has exposed its core underlying values. The WHO has been a major voice in shaping the development of health promotion. Not only have its documents been a source of reference for health promotion practice, but they have also been assimilated into professional training courses – that is, they have become part of the doctrine of health promotion.

As mentioned above, the WHO has taken a holistic view of health from its inception. The 'Health for All' movement was launched at the 30th World Health Assembly in 1977. The following year saw the *Declaration of Alma Ata* (WHO, 1978), which identified primary healthcare (PHC) as the principal means to attaining 'Health for All' targets. Primary healthcare – as distinct from primary medical care – was envisaged as embracing all the services that impact on health, including, for example, education, housing and agriculture.

A number of key issues in the *Declaration* have informed subsequent thinking. In addition to emphasizing the importance of a holistic view of health, the following assertions figure in many WHO publications and declarations:

- health as a fundamental right
- the unacceptability of inequality in health within and between nations
- health as a major social goal
- the reciprocal relationship between health and social development
- the need to involve a number of different sectors in working towards health

- the rights and duties of individuals to participate individually and collectively in their own healthcare
- education as the means of developing communities' capacity to participate.

In January 1984, the WHO set up a new programme on 'health promotion'. A discussion document on health promotion (WHO, 1984) saw it as a 'unifying concept', bringing together 'those who recognize the need for change in the ways and conditions of living, in order to promote health'. It defined health promotion as 'the process of enabling people to increase control over, and to improve, their health'.

Income, shelter and food were acknowledged to be primary requisites for health. Importance was also attached to the provision of information and life skills, the creation of supportive environments providing opportunities for making healthy choices and the creation of health-enhancing conditions in the economic, physical, social and cultural environments.

The document outlined the key principles of health promotion as:

- the involvement of the whole population in the context of their everyday life and enabling people to take control of, and have responsibility for, their health
- tackling the determinants of health – that is, an upstream approach, which demands the cooperative efforts of a number of different sectors at all levels, from national to local
- utilizing a range of different, but complementary, methods and approaches – from legislation and fiscal measures, organizational change and community development to education and communication
- effective public participation, which may require the development of individual and community capacity
- the role of health professionals in education and advocacy for health. (WHO, 1984)

Action was, therefore, seen to require an integrated effort to encourage individual and community responsibility for health along with the development of a health-enhancing environment. The document reflected a commitment to voluntarism and formally acknowledged the risk of dictating how individuals should behave. This has been referred to as 'healthism' – a notion that we will return to later. Other potential problems included an overemphasis on individual behaviour rather than the social and economic determinants of behaviour and the possibility of increasing social inequality if the varying capacity of different social groups to exercise control over their health was not tackled. A further concern was that health promotion might be appropriated by particular professional groups to the exclusion of others and lay people.

A series of major international conferences followed. The Ottawa Charter, developed at the 1st International Conference on Health Promotion (WHO, 1986), built on many of the key principles set out in the WHO discussion document and has been a constant source of reference. It identified three broad strategies for working to promote health:

- **advocacy** to ensure the creation of conditions favourable to health
- **enabling** by creating a supportive environment, but also by giving people the information and skills that they need to make healthy choices
- **mediation** between different groups to ensure the pursuit of health.

The Ottawa Charter listed five main action areas that have been central to the conceptual framework of health promotion:

- build healthy public policy
- create supportive environments
- strengthen community action
- develop personal skills
- reorient health services.

There is potentially some tension between individual and societal responsibility for health, between individual and collective responsibility, and between voluntarism and control. The Ottawa Charter handled this by seeing individuals as having responsibility for their own health, but also a collective concern for the health of others. However, there is an overriding societal responsibility to create the conditions that enable people to take control of their health. Recognition that health is created where people ‘learn, work, play and love’ heralded the ‘settings approach’ to health promotion.

The 2nd International Conference on Health Promotion in Adelaide (WHO, 1988) focused on healthy public policy as a means of creating supportive environments that would be health-enhancing in themselves and would also – in the words of the much-used phrase – contribute to making the healthy choice the easy choice. In particular, it acknowledged the importance of addressing the needs of underprivileged and disadvantaged groups and emphasized the responsibility of higher-income countries to ensure that their own policies impacted positively on lower-income countries. It saw healthy public policy as ‘characterized by an explicit concern for health and equity in all areas of policy and an accountability for health impact’. The Adelaide Conference identified the need for strong advocates and also saw community action as a major driving force.

The Sundsvall Conference (WHO, 1991) addressed the issue of supportive environments for health. In addition to the physical environment, it recognized the importance of the social environment and the influence of social norms and culture on behaviour. It also noted the challenge to traditional values arising from changing lifestyles, increasing social isolation and lack of a sense of coherence. The need for action at all levels and across sectors was recognized and, in particular, the capacity for community action.

The key elements of a ‘democratic health promotion approach’ were seen to be empowerment and community participation. The importance of education as a means of bringing about political, economic and social changes was recognized as well as its being a basic human right.

The Jakarta Declaration on Leading Health Promotion into the 21st Century (WHO, 1997) was developed at the 4th International Conference on Health Promotion. It viewed health both as a right and as instrumental to social and economic development. It envisaged the ‘ultimate goal’ of health promotion as increasing health expectancy by means of action directed at the determinants of health in order to:

- create the greatest health gain
- contribute to reduction in inequities
- further human rights
- build social capital.

The Jakarta Declaration built on the commitments of the previous documents and provided clear endorsement of the value of comprehensive approaches and involving families and communities. It called for strong partnerships to promote health including – for the first time – the involvement of the private sector.

Overall, the priorities set out for the twenty-first century were to:

- promote social responsibility for health
- increase investments for health development
- consolidate and expand partnerships for health
- increase community capacity and empower the individual
- secure an infrastructure for health promotion.

The first resolution on health promotion, which was passed at the 51st World Health Assembly in May 1998 (WHO, 1998a), incorporated the thinking of the Jakarta Declaration.

As it moved into the twenty-first century, the WHO (1998b) identified the following key values underpinning the ‘Health for All’ movement:

- providing the highest attainable standard of health as a fundamental human right
- strengthening the application of ethics to health policy, research and service provision
- equity-orientated policies and strategies that emphasize solidarity
- incorporating a gender perspective into health policies and strategies. (1998d: v)

The 5th Global Conference on Health Promotion held in Mexico City in 2000 focused on ‘bridging the equity gap’. It issued a Ministerial Statement signed by some 87 countries, including the United Kingdom (WHO, 2000a), that acknowledged that ‘the promotion of health and social development is a central duty and responsibility of governments that all sectors of society share’ and concluded that ‘health promotion must be a fundamental component of public policies and programmes in all countries in the pursuit of equity and health for all’. The Mexico City conference emphasized the need to ‘work with and through existing political systems and structures to ensure healthy public policy, adequate investment in health, and facilitation of an infrastructure for health promotion’ (WHO, 2000b: 21).

The Bangkok Charter for Health Promotion in a Globalized World (WHO, 2005) responded to emerging global issues by focusing attention on increasing inequalities between countries, commercialization and new patterns of consumption and communication, and also global environmental change and urbanization. It identified the following required actions:

- advocate for health based on human rights and solidarity
- invest in sustainable policies, actions and infrastructure to address the determinants of health
- build capacity for policy development, leadership, health promotion practice, knowledge transfer and research, and health literacy
- regulate and legislate to ensure a high level of protection from harm and enable equal opportunity for health and well-being for all people

- partner and build alliances with public, private, non-governmental and international organizations and civil society to create sustainable actions.

It further demanded four key commitments, to make health promotion:

- central to the global development agenda
- a core responsibility for all of government
- a key focus for communities and civil society
- a requirement for good corporate practice.



While the primary concern of these documents has been with identifying appropriate action, they are underpinned by clear values. Indeed, it could be said that unless activity is consistent with these values, it should not be regarded as ‘health promotion’. These values include equity and empowerment – the twin pillars of health promotion – along with health as a right, voluntarism, autonomy, participation, partnerships and social justice. Consideration of rights and responsibilities, power and control generates some interesting paradoxes in relation to health education and policy interventions, which we discuss more fully later.



The 7th and 8th WHO conferences on health promotion were held in Nairobi in 2009 and Helsinki in 2013, respectively. Importantly, the Nairobi conference was the first to be held on the continent of Africa. The Nairobi Call for Action specifically addresses action needed to close the implementation gap in health and development through health promotion (Catford, 2010; WHO, 2009). One of the key themes of this conference was mainstreaming health promotion in health policy (Eriksson, 2010). Empowerment remained central. The key urgent responsibilities were outlined as follows:

- strengthen leadership and workforces
- mainstream health promotion
- empower communities and individuals
- enhance participatory processes
- build and apply knowledge. (WHO, 2009)

The importance of policy was again highlighted in the Helsinki conference. Intersectoral action and healthy public policy were identified as key requirements for health promotion. The conference statement emphasizes the ‘Health in All Policies’ approach, calling for cross-governmental action and political will (WHO, 2013e).

The significance of non-communicable diseases was emphasized at the Nairobi conference in 2009 and this was picked up in 2011 at the UN High-Level Meeting of the General Assembly on the Prevention and Control of Non-Communicable Diseases (NCDs). NCDs kill three in five people globally (UN, 2011) and are becoming much more of a challenge in lower-income countries. A political declaration ensued from this meeting specifically aimed at tackling NCDs. In the same year, the WHO held a world conference in Brazil on the Social Determinants of Health (WHO, 2011). This resulted in the adoption of the *Rio Political Declaration on Social Determinants of Health* (WHO, 2012). The declaration upholds the core principles established by the Alma Ata conference in 1978 and the

Ottawa Charter (WHO, 1986) that have been reinforced by the subsequent WHO conferences on health promotion as detailed previously.

The 9th Global Conference on Health Promotion took place in Shanghai in late 2016. The resulting declaration focuses on promoting health in the 2030 Agenda for Sustainable Development in recognition that ‘health and well-being are essential to achieving the United Nations Development Agenda and its Sustainable Development Goals and reinforces the importance of structural factors and of the wider determinants of health’ (see Box 1.1).

BOX 1.1 THE SHANGHAI DECLARATION

We reaffirm health as a universal right, an essential resource for everyday living, a shared social goal and a political priority for all countries. The UN Sustainable Development Goals (SDGs) establish a duty to invest in health, ensure universal health coverage and reduce health inequities for people of all ages. **We are determined to leave no one behind.**

Call to action

We recognize that health is a **political choice and we will counteract interests detrimental to health and remove barriers to empowerment** – especially for women and girls. We urge political leaders from different sectors and from different levels of governance, from the private sector and from civil society to join us in our determination to promote health and wellbeing in all the SDGs. Promoting health demands coordinated action by all concerned, it is a shared responsibility. With this Shanghai Declaration, we, the participants, pledge to accelerate the implementation of the SDGs through increased political commitment and financial investment in health promotion.

Source: WHO (2016a)

The 10th Global Conference on Health Promotion took place in December 2021 – *Health Promotion for Well-being, Equity and Sustainable Development* – ‘marking the start of a global movement on the concept of well-being in societies’ (WHO, 2021a: npn). Given the global impact of the COVID-19 pandemic the conference met virtually for the first time. The conference resulted in the *Geneva Charter for Well-being*, which highlights the importance of well-being, not just for people and society but for the planet itself. Five key action areas were identified, as follows (WHO, 2021a):

- design an equitable economy that serves human development within planetary boundaries
- create public policy for the common good
- achieve universal health coverage
- address the digital transformation to counteract harm and disempowerment and to strengthen the benefits
- value and preserve the planet.

The charter re-emphasized the importance of many of the themes of the preceding WHO conferences, such as intersectoral working, the importance of partnership and political will. Planetary health and sustainability were key concerns and there was a call to reframe health as ‘an investment in our common future’ (WHO, 2021a: npn).

Ideology, social construction and competing discourses

Defining ideology



The original meaning of ‘ideology’ was merely the scientific study of human ideas. It has been transformed over time into a concept that includes cognitive, affective and action dimensions. Although ideologies are value laden – and it is not unusual for the term to be used synonymously with value systems – the contemporary construction of the word ‘ideology’ is much more complex.

De Kadt, discussing the ideological dimensions involved in implementing WHO’s ‘Health for All’ agenda, states that ideologies are an amalgam of fact and unsubstantiated assertion. He observes that ‘comprehensive ideologies (as opposed to partial ideologies) are commitment-demanding views about societies, their past history and present operation, which contain a strong evaluative element and hence provide goals for the future’ (de Kadt, 1982: 742).

In order to clarify the central meaning of ‘ideology’, Eagleton contrasts the emotionally charged nature of ideology, which has a ‘partial and biased view of the world’, with an ‘empirical’ or ‘pragmatic’ approach. There is, of course, a tendency for those espousing political causes to describe their ‘pragmatic’ construction of reality as rational and based on common sense whereas opponents’ views are characterized by ideological zealotry involving, as Eagleton notes, their:

judging a particular issue through some rigid framework of preconceived ideas which distorts their understanding. I view things as they really are; you squint at them through a tunnel vision imposed by some extraneous system of doctrine. There is usually a suggestion that this involves an oversimplifying view of the world – that to speak or judge ‘ideologically’ is to do so schematically, stereotypically, and perhaps with the faintest hint of fanaticism. (1991: 3)

Ideology, values and ethics

Belief systems and doctrine are major parts of the territory of ideology. However, values and value systems feature with equal prominence. Rokeach defines values as ‘an enduring belief that a specific mode of conduct or endstate of existence is personally or socially preferable to an opposite or converse mode of conduct or endstate of existence’ (1973: 10). Following Guttman’s (2000) review, the major ethical values assumed to underpin health promotion (or, more specifically, ‘public health communication interventions’) are:

- beneficence, or ‘doing good’
- non-maleficence, or ‘doing no harm’
- respect for personal autonomy

- justice or fairness
- utility and the public good
- (possibly) community involvement and participation.

These central ethical values have stood the test of time even though they, arguably, 'favour a biomedical paradigm with an individualistic focus' rather than 'a relational paradigm with a collective focus' (Smith et al., 2015: 232). As we will see, the extent to which these values are actually central to the ideology of health promotion will depend on the preferred model. At this point, it is interesting to note the remarkable degree of resonance between the empowerment model of health promotion and the stewardship model (see Box 1.2) developed by the Nuffield Council on Bioethics. It sets out the ethical principles that should underpin the development of healthy public policy and achieve a balance between individual and government responsibility.

BOX 1.2 THE STEWARDSHIP MODEL

Acceptable public health goals include:

- reducing the risks of ill health that result from other people's actions, such as drinking and smoking in public places
- reducing causes of ill health relating to environmental conditions, for instance provision of clean drinking water and setting housing standards
- protecting and promoting the health of children and other vulnerable people
- helping people to overcome addictions that are harmful to health or helping them to avoid unhealthy behaviours
- ensuring that it is easy for people to lead a healthy life, for example by providing convenient and safe opportunities for exercise
- ensuring that people have appropriate access to medical services
- reducing unfair health inequalities.

At the same time, public health programmes should:

- not attempt to coerce adults to lead healthy lives
- minimize the use of measures that are implemented without consulting people (either individually or using democratic procedures)
- minimize measures that are very intrusive or conflict with important aspects of personal life, such as privacy.

Source: Nuffield Council on Bioethics (2007)

The centrality of power



Given the emphasis on empowerment in this book, it is axiomatic that individual and community power are pivotal issues in the ideology of health promotion and central to the design of health promotion programmes. Questions of power feature prominently in discussions of ideology. Giddens and Sutton are quite explicit about this:

Ideology refers to the influence of ideas on people's beliefs and actions ... [it] is about the exercise of symbolic power – how ideas are used to hide, justify or legitimate the interests of dominant groups in the social order. (2021: 789)

Eagleton provides a comprehensive account of the mechanisms whereby a dominant group exerts its power and creates 'false consciousness':

A dominant power may legitimate itself by *promoting* beliefs and values congenial to it; *naturalizing* and *universalizing* such beliefs so as to render them self-evident and apparently inevitable; *denigrating* ideas which might challenge it; *excluding* rival forms of thought, perhaps by some unspoken but systematic logic; and *obscuring* social reality in ways convenient to itself. (1991: 5–6)

The relevance of ideology is not only measured in terms of the ways in which the power of dominant social groups is legitimized. More significant for health promotion are the ways in which subordinate groups are 'de-powered' by dominant groups. Indeed, the radical ideology underpinning the model of health promotion proposed in this book is substantially concerned with empowering subordinate and oppressed social groups. Pursuing the matter of false consciousness, Eagleton reminds us of the subtle and potentially insidious ways in which people may be de-powered:

The most efficient oppressor is the one who persuades his [*sic*] underlings to love, desire and identify with his power; and any practice of political emancipation thus involves that most difficult of all forms of liberation, freeing ourselves from ourselves. (1991: xiii)

He does, however, caution against exaggerating the power of this 'hegemonic' process and optimistically notes that nobody is ever wholly mystified. Despite a capacity for self-delusion, human beings are at least moderately rational and, unless the process of domination provides sufficient gratification over time, the dominated will rebel. If this were not true, health promotion's emancipatory strategies for critical consciousness-raising would be seriously compromised.

Ideology and discourse

Although, as Wodak (2008) argues, the term 'discourse' is used in various ways, there is general agreement that it is concerned with a set of 'connected sentences or utterances' (Litosseliti, 2006: 47) and patterns or systems of language (Lock and Strong, 2010). The notion of discourse has its roots in linguistics. It is more than mere language – rather, the thought underlying language. Accordingly, 'discourse analysis' involves penetrating beneath the surface of language or images and seeking out subtexts and meanings relating to wider beliefs and value systems – often their social and political

contexts. As Parker (2005) argues, discourse analysis enables scrutiny of how language is mobilized to maintain (or challenge) power relations.

Discourse analysis has relevance for health promotion by providing insight into the way in which people's ideas about health – or indeed health promotion messages – are constructed, along with their underpinning values and motivations. The concern with challenging structures of power also renders it directly relevant. It can equally be applied to professional discourse to identify the underlying ideology.

Scott-Samuel and Springett draw attention to the interrelationship between discourse and power. Increase in the prominence of discourse may increase the power of groups that it represents and conversely power relations among different groups may shape the level of influence of discourse. They assert that the dominance of public health medicine has influenced the public health discourse and led to 'hegemonic suppression of the radical element within the public health agenda' (2007: 212).

Critical discourse analysis focuses on power and dominant ideologies and the way these are both reflected in and perpetuated by language (Lupton, 1992; Wood and Kroger, 2000). Fairclough has referred to it as 'discourse analysis "with an attitude"' (Fairclough, 2001, cited by Porter, 2006) reflecting critical examination of social cultural processes as well as the scrutiny of structures within society and issues of power/control (Litosseliti, 2006; Wodak, 2001; Wood and Kroger, 2000). Porter (2006) examined the Ottawa and Bangkok Charters using critical discourse analysis. She identified a shift from a "new social movements" discourse of ecosocial justice in Ottawa to a "new capitalism" discourse of law and economics in Bangkok' (2006: 75). She also contends that while the Bangkok Charter proposes actions to tackle the problems of a globalized world, its discourse may serve to perpetuate the structural determinants of those very problems. The importance of analysing how discourse shapes, creates and maintains power is also emphasized by Garneau et al. (2019), who contend that 'attention to discourses that sustain inequities ... is required to mitigate health inequalities and related power differentials' (p. 746).

Medical discourse and the preventive model

The history of health promotion has been marked by a struggle to distance itself from the medical model that has dominated twentieth-century discourse on health and illness. Some would contend that this break is more evident in the rhetoric than in the practice of health promotion (Kelly and Charlton, 1995). Although the medical model has been alluded to earlier, it is worthwhile considering – in the context of our discussion about ideology, power and control – the nature of the model and the origins of concern about its applicability to health promotion. The key features of the medical model have been variously seen as including:

- a mechanistic view of the body
- mind–body dualism
- disease as the product of disordered functioning of the body or a part of it
- a focus on pathogenesis – that is, the causes of disease
- the pursuit of the causal sequences of disease and an emphasis on micro-causality
- specific diseases having specific causes.

The medical model is, therefore, very much in tune with modernist rational thought and characterized by a reductionist view of the causes of ill health, together with a mechanistic focus on micro-causality.

The medical model is inextricably linked with medical practice and, more generally, with biomedicine. It shares common ideological origins and has acquired added authority as a result of its association with the power and authority of the medical profession. The dominance of medicine has itself been the subject of an extensive sociological critique – for example, its role in supporting a capitalist value system (Doyal and Pennell, 1979; Navarro, 1976); the monopolization of healthcare (de Kadt, 1982); the commodification of health and appropriation of authority over the areas that influence health (Illich, 1976); and maintaining gendered power structures in society (Doyal and Pennell, 1979; Ehrenreich and English, 1979). Deborah Lupton offers a critique that carefully explicates the social and cultural construction of modern medicine and healthcare (Lupton, 2012).

The medical model belongs to a group that Rawson has termed ‘iconic models’ – that is, ‘simplified descriptions of some aspect of known reality, portraying a literal or isomorphic image of nature’ (1992: 210). It is possible, in principle, to identify a number of different models within medical practice and, equally, the medical model can be recognized within a range of different types of professional practice. It is also worth noting, in passing, that the ascendancy of high-tech medicine in the twentieth century and marginalization of preventive medicine has not gone unchallenged within medicine itself. The work of McKeown is well known in this regard (see, for example, McKeown, 1979). The emergence of ‘The New Public Health’ has been an attempt to retreat from an emphasis on individual responsibility for health and health actions and refocus on the factors that collectively influence health status. However, critics such as Petersen and Lupton (1996) contend that ‘The New Public Health’ has not entirely freed itself from the ethic of individual responsibility. Nor has it mounted an effective challenge to the increasing disparity in wealth and power within many societies.

Application of the medical model to health promotion leads to an emphasis on prevention. This association with prevention effectively ‘rebadges’ the medical model as the preventive model.

The dominant concept is that of risk, whether viewed as a ‘property of individuals or as an external threat’ (Petersen and Lupton, 1996: 174). Furthermore, the conceptualization of risk is often narrow, ignoring the wider social and environmental determinants of health. The emphasis is on individual responsibility, which – as noted above in our comments on ‘victim-blaming’ – places the onus on individuals to reduce their exposure to risk by avoiding risky behaviour and contact with risks in the environment. The individual is increasingly held to account for managing risk and uncertainty (Arnoldi, 2009). Attempts to improve health primarily take the form of health education interventions to persuade individuals to adopt healthy behaviours and lifestyles, and avoid risk.

The preventive model has a number of consequences. As we noted above, it results in an essentially ‘victim-blaming’ approach in its disregard for the social, environmental and political factors that shape and, indeed, constrain behavioural choices.

Illich’s (1976) critique of the extension of medical control beyond legitimate concern with disease to include ordinary aspects of human experience – so-called ‘social iatrogenesis’ or medicalization of life – is well known. Including exposure to risk within the medical remit and, along with it, a whole range of behavioural and lifestyle factors, extends the notion of medicalization even further and brings substantial areas of life under expert, rather than autonomous, control. Kelleher et al. note that, along with the decline in organized religion, this has led to:

doctors being cast more and more in the role of secular priests whose expertise encompassed not only the treatment of bodily ills but also advice on how to live the good life, and judgements on right and wrong behaviour. (1994: xii)

Moreover, the acknowledgement of expert authority over areas of life normally managed by individuals, families and communities erodes confidence in their own capacity to take responsibility for their health. By undermining self-reliance, communities and cultures are disempowered. Illich refers to this as ‘cultural iatrogenesis’, which he sees as ‘destroy[ing] the potential of people to deal with their human weaknesses, vulnerability, and uniqueness in a personal and autonomous way’ (1976: 42).

Horrobin’s (1978) riposte to Illich accepts the existence of some undue dependence on the medical profession in matters of sickness, but notes the remarkable resistance of the healthy to accept medical advice and the over-exaggeration of the power of medicine to influence people.

Furthermore, he contends that Illich’s portrayal of society as ‘an ignorant and unwilling victim of medical imperialism’ (1976: 29) is a misrepresentation. Here in 2022 we are witnessing something of a shift in power relations as noted by Eric Topol (2015) in his book *The Patient Will See You Now: The Future of Medicine is in Your Hands*, where he discusses the democratization of medicine that has occurred with rapidly changing technology centring on the increasing use of mobile devices (such as smartphones) to monitor, test and diagnose.

Notwithstanding these arguments, medicine is still accorded considerable expert power, a point endorsed by Lupton (2012). Healthy lifestyles/healthy behaviours are prescribed by experts (Ayo, 2012). Deference to such authority provides further legitimation. It reinforces the dominance of the medical model and *ipso facto* the preventive model, even when the view espoused is at odds with the experiences of individuals.

What, then, is the source of this medical authority? De Kadt suggests that:

Expertise and the ‘life and death’ responsibilities of the physician are used to provide ideological justification for physician dominance in the doctor–patient (healing) context. (1982: 746)

Parsons’s (1958) concept of the ‘sick role’ throws further light on the doctor–patient interaction. When people are ill, they are unable to fulfil their normal social roles and everyday activities. Diagnosis will medically legitimate their adoption of the sick role that exempts them from their normal social obligations. However, there is a concomitant obligation to attempt to get better, by seeking and complying with medical advice. The sick role, therefore, requires submission to medical authority and compliance with a therapeutic regimen.

Formalization of the ‘at-risk’ role within the preventive model makes equivalent demands in terms of an obligation to modify behaviour and exposure to risk (Barić, 1969). Individuals are held responsible for their exposure to risk and failure to act accordingly may be attributed to ignorance at best or deliberate fecklessness at worst. Unlike the sick role, the at-risk role does not confer any rights. The outcome of this is twofold. On the one hand, it labels as deviant those who cannot or choose not to comply with admonitions on how to live their life, and holds them responsible for the consequences. The categorization of more and more areas of life as healthy or unhealthy effectively creates its own dogma about ways of living, coupled with the associated moral sanction of disapproval if unhealthy options are chosen. As Petersen and Lupton note:

The idealization of the ‘normal’, ‘healthy’ subject as one endowed with certain ‘natural’ capacities and inclinations fails to recognize the multiplicity of possible subject positions, and can serve to coerce, marginalize, stigmatize and discriminate against those who do not or cannot conform with the ideal. This ideal denies difference – whether this is based on social class, gender, sexuality, ‘race’ ethnicity, physical ability, or age – and the kinds of personal commitments and demands that are required of those who are called upon to conform to it. (1996: 178)

On the other hand, it creates a remorseless pressure to improve health. The responsibility for health lies with the individual (Bolam et al., 2003; Katainen, 2006). The identification of a number of lifestyle ‘risk factors’ linked to chronic ill health results in an emphasis on individual responsibility (Brown et al., 2019). As a result it has become a requirement, or moral imperative, for the contemporary citizen to strive for health (Nettleton, 2020; Petersen et al., 2010).

An overemphasis on keeping healthy has been referred to as ‘healthism’ – a term attributed to Crawford, who defines it as:

the preoccupation with personal health as a primary – often the primary – focus for the definition and achievement of wellbeing; a goal which is to be attained primarily through the modification of lifestyles, with or without therapeutic help. (1980: 368)

Despite healthism’s emphasis on positive health, its focus on individual responsibility can be seen to have some parallels with victim-blaming. The no-fault principle enshrined in the notion of the sick role does not apply and is replaced by a ‘your fault dogma’. Those, therefore, who fail, or refuse, to seek health-promoting ways of life become ‘near pariahs’ (Crawford, 1980: 379). Furthermore, preoccupation with health elevates it in status to a super value – health becomes an end in itself rather than a means of achieving other values, and positive health behaviour acts as a hallmark of good living. Crucially, the emphasis at the individual level draws attention away from government and social responsibility for health (Cross and O’Neil, 2021; Room, 2011).

Reference to our earlier discussion of health promotion will indicate that the preventive model and healthism are both inconsistent with the two central tenets of health promotion – equity and empowerment. The emphasis on individualism and lack of attention to the social and environmental factors that impinge on health – both directly and indirectly as a result of their influence on behaviour – could, in fact, increase rather than decrease the health gap in society. Health gains will inevitably be greatest in those who are most able to make changes by virtue of their relatively advantaged position.

However, even though we have argued that a preventive model is inconsistent with the values position of health promotion, we should finish on a word of caution. Rejection of the preventive model does not necessarily imply rejection of the need for biomedical knowledge or appropriate preventive action. Furthermore, evidence about cause is necessary to much health promotion practice – indeed, any attempts to influence behaviour in the absence of evidence that this will be beneficial would be unethical. The problem lies not so much with a biomedical interpretation *per se*, but with too exclusive a reliance on it and dismissal of other perspectives – that is, with the imbalance of power and the dominance of medical expert authority. Our discussion of empowerment in Chapter 3 also draws attention to the importance of knowledge and the ability to access and interpret accurate knowledge as key components of empowerment. Such knowledge and understanding can give people greater



control over their own lives. It also enables them to enter into a circle of shared understanding with professionals, thereby breaking down power structures and facilitating dialogue.

Education and the discourse of voluntarism

Health education is a key component of health promotion. We propose the following ‘empirical’ definition, which centres on the process of learning:

health education is any planned activity designed to produce health- or illness-related learning.

‘Learning’ has frequently been defined as a relatively permanent change in capability or disposition – that is, the change produced is not transitory and, after the educational intervention, people are capable of achieving what they were not capable of achieving before the intervention and/or feel differently about ideas, people or events. Accordingly, effective health education may result in the development of cognitive capabilities such as the acquisition of factual information, understanding and insights. It may also provide skills in problem-solving and decision-making and the formation or development of beliefs. It might also result in the clarification of existing values and the creation of new values – and, quite frequently, in attitude change. Health education also aims to foster the acquisition of health-related psychomotor or social interaction skills. It may even bring about changes in behaviour or lifestyle or create the conditions for the adoption of healthy public policy.

One of the most important and enduring sources of ideological argument centres on the question of rationality and voluntarism. For example, Hirst (1969) asserted unequivocally that the central purpose of *all* education should be rationality. The educational philosopher Baelz contrasts education with manipulation and with indoctrination:

The educator encourages his [*sic*] pupil to develop the capacity to think for himself, while the indoctrinator wishes to make it impossible for his pupil ever to question the doctrine that he has been taught. (1979: 32)

The concept of doctrine is equated with the notion of dogma and typically refers to some creed or body of religious, political or philosophical thought that is offered for acceptance as truth. The purpose of indoctrination is, therefore, to present a body of ideas in an appealing way such that the ideas are accepted. The distinction between indoctrination and education is, therefore, fundamental.

Health education, voluntarism and choices for health

For many health educators, voluntarism is an ideological *sine qua non*. Note, for instance, Green and Kreuter’s influential definition:

Health education is any combination of learning experiences designed to facilitate *voluntary* actions conducive to health ... *Voluntary* means *without coercion* and with the full understanding and acceptance of the purposes of the action. (1999: 27)

Faden and Faden (1978) made the point even more forcibly in their discussion of the ethics of health education. They cited the Society of Public Health Education (SOPHE) *Code of Ethics* (1976), noting its affirmation of the importance of voluntary consumer participation:

Health educators value privacy, dignity, and the worth of the individual, and use skills consistent with these values. Health educators observe the principle of informed consent with respect to individuals and groups served. Health educators support change by choice, not by coercion.

According to the educational model of health education, coercive strategies and techniques are, therefore, unacceptable. Coercion occurs when an individual's or group's freedom of action is constrained. It frequently results from externally imposed sanctions or other barriers.

It is important, then, to recognize the existence of two varieties of coercion. The first of these is externally imposed. For instance, it involves the implementation of policy measures imposing a potentially wide range of restrictive regulations, in the form of legislation, fiscal measures and environmental engineering. Examples of such 'healthy public policies' would include banning smoking in public areas; redesigning roadways and traffic calming measures; the inclusion of vitamins in popular food products; regulation of the food industry to reduce the fat content of products; increase in the price of alcohol; and so on. The attraction of these various coercive strategies is doubtless self-evident, but McKinlay summarized it succinctly as follows:

One stroke of effective health legislation is equal to many separate health intervention endeavours and the cumulative efforts of innumerable health workers over long periods of time. (1975: 13, in Guttman, 2000: 85)

The second form of coercion is perhaps less obvious and may be designated as psychological rather than environmental manipulation. It involves the use of certain techniques to create a particular kind of learning that lacks the element of genuine informed choice that characterizes the principle of voluntarism. Figure 1.2 locates these techniques on a continuum ranging from high degrees of coercion to maximal potential for facilitating 'free' choice. Accordingly, 'brainwashing' is seen as highly coercive while 'facilitation' is, by definition, seeking to assist learners to achieve their own goals. 'Persuasion' is generally viewed as an intervention concerned with achieving the goals of the persuader rather than helping the persuadees to make up their own minds.

In the case of psychological coercion or 'persuasion', personal choice is modified in some way without the knowledge of the person in question. In proposing this latter description, Faden and Faden (1978) had in mind Warwick and Kelman's (1973) definition of persuasion as a 'form of interpersonal influence, in which one person tries to change the attitudes or behaviour of another by means of argument, reasoning, or, in certain cases, structured listening'. In fact, it is somewhat misleading to define coercion of this kind solely in terms of the persuadee's lack of knowledge of what is going on. 'Insight' might be a better term as it is clear that, in many instances, individuals are well aware that someone is trying to influence them. Indeed, the most blatant form of psychological coercion, brainwashing, leaves the unfortunate recipient under no illusion that some fairly dramatic coercive techniques are being applied!

It may at first glance seem surprising that brainwashing has been partnered with primary socialization. This represents both an expression of doubt about the power of brainwashing to fundamentally

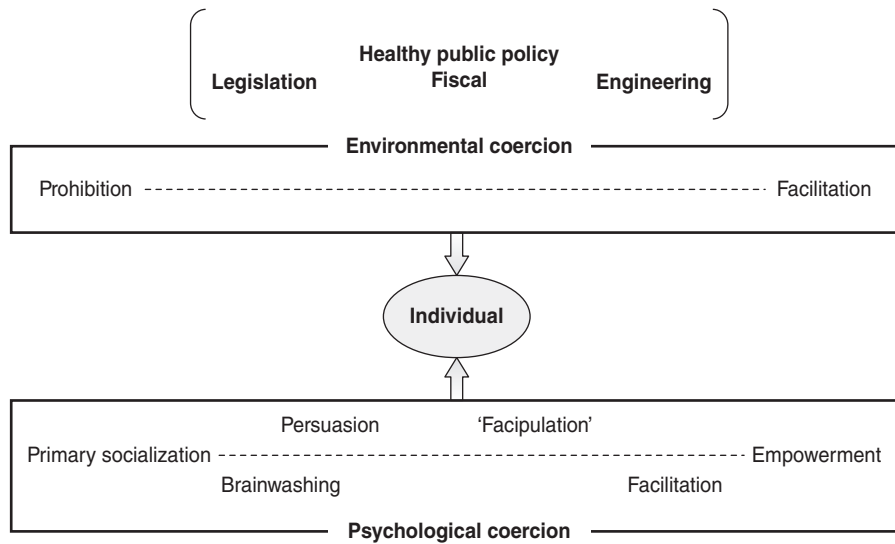


Figure 1.2 A spectrum of coercion

affect firmly grounded values and, at the same time, seeks to acknowledge the potentially greater power of the processes of ‘shaping’, conditioning and modelling that are part and parcel of the child-rearing experience.

At a more mundane level, people exposed to persuasive advertising also know that the advertiser is seeking to influence them. They may, however, lack insight into the influence process – for instance, why the advertiser is manipulating certain images or using certain presenters. This lack of insight into the psychodynamics of the attempt to influence militates against the principle of voluntarism, albeit in a rather more subtle way than the deliberate presentation of misleading information or the partial presentation of evidence supporting the attitude or behaviour change the persuader is seeking to induce.

Limits to freedom of choice

One of the avowed aims of an empowerment model of health promotion is to remove obstacles to rational decision-making and freedom of choice. In some instances, overcoming such barriers is relatively simple – for example, the barrier created by ignorance. Others are more substantial – consider, for example, the case of addiction or other compulsive behaviours that sap freedom of choice. As McKeown pointed out:

it is said that the individual must be free to choose [whether they wish to smoke]. But he [*sic*] is not free; with a drug of addiction the option is open only at the beginning. (1979: 125)

Environmental barriers to voluntaristic action have received considerable recognition and, in part, have contributed to the formulation of the contemporary ideology of health promotion. Indeed, probably the greatest progress in health promotion in recent years has been acknowledgement of the fact

that material, social and cultural environments can both damage health and limit people's capacity to take action to promote their own health and the health of their communities. It is quite apparent that various natural disasters, such as famine and war, may damage health both directly and indirectly by removing the possibility of making empowered health-related decisions. Climate change and environmental degradation also pose major challenges (WHO, 2021a) and their effects are likely to be experienced disproportionately by the most disadvantaged in society.

Poverty and social inequality damage individuals' and communities' capacity for action and are now recognized as being major determinants of public health. On a smaller scale, lack of access to affordable healthy food will largely nullify the effects of health education initiatives about the importance of a healthy diet. Less obviously, the complementary effects of culture and childrearing may effectively block choice and genuine decision-making. For instance, in the process of socialization, cultural values may result in certain foods being classified as 'taboo', thus creating a moral imperative against consumption, regardless of the nutritional value of the food in question.

In the face of these many and varied psychological and environmental obstacles to the achievement of health, the emphasis on 'healthy public policy' is hardly surprising. Policy measures typically involve fiscal, economic and legislative measures and associated environmental change. On the one hand, they can create the conditions that support health and individual health choices. On the other hand, as is apparent from Figure 1.2, other more draconian measures that have been proposed can militate against freedom of choice. The Nuffield Council on Bioethics suggests that individual consent may not be required if measures are not 'very intrusive' or 'prevent significant harm to others'. Further, collective approval through democratic processes can replace individual consent when there is only limited interference with individuals' liberty (2007: paras 2.22–2.26). Although it is argued that healthy public policy makes the healthy choice the easy choice, it may effectively make the healthy choice the only choice! How can such attacks on freedom be reconciled with the discourse of voluntarism, which characterizes an 'educational model'?

The fact is, of course, that unbridled freedom is only the prerogative of the despot and, possibly to a lesser extent, of certain privileged groups. There are inevitably and appropriately limitations on freedom of choice. The national lockdowns across the world during the COVID-19 pandemic illustrate this. It could well be argued that 'true' education should encourage people to think in a systematic way about what is of most importance to them in their lives so that they might consistently act in accordance with the values they have clarified. It is also important that educated individuals should be helped to make decisions rather than uncritically absorb dogma. There are, however, obvious limitations to freedom of choice. As noted elsewhere (Tones, 1987), all values are not equally acceptable in a given society: antisocial behaviour would not normally be considered acceptable.

Health promotion would certainly not subscribe to unfettered freedom of choice. It is avowedly committed to certain major values to which most nations subscribe (or to which they at least pay lip service) and that have been incorporated into the various doctrines and discourse propagated by the WHO. This position is, or should be, non-negotiable. While cultural sensitivity is part of a concern for people in general, where cultural practices are inconsistent with the overriding values of health promotion, they must be challenged – take, for example, the issue of female genital mutilation or cutting. In the context of the principles of voluntarism, we must therefore observe two major qualifying principles. People should have a right to self-fulfilment, provided that this does not impede others'

right to fulfilment and/or otherwise damage the well-being of the community at large. A good deal of consideration has, in fact, been given to the question of imposing limitations on liberty. The resulting ideological principles are most usefully expressed in terms of utilitarianism and paternalism. These principles provide support for the occasional overriding of personal liberty, either for the greater good or because some people seem incapable of exercising choice.

Utilitarianism, paternalism and the justification of coercion

There are two broad approaches to defining the ethics of interventions. One of these supports the principle that the integrity of a moral principle should be of prime consideration, whatever the consequences. For example, it is always wrong deliberately to provide inaccurate information, even if this might seem to be in the interests of the recipient of that information. The alternative view is that it is the results of actions that are most important (Guttman, 2000). This latter moral principle is generally described as utilitarianism.

There is an obvious and generally acceptable rationale underpinning actions based on the principle of utilitarianism. In short, people's freedom of action should be respected, so long as it does not interfere with the general good (for example, Mappes and Zembar, 1991). Indeed, it provides a simple baseline value for health education that legitimately espouses the imperative of self-actualization. However, personal gratification should not limit others' equal right to self-actualization.

It follows logically, therefore, that it is quite legitimate to use many of the varieties of coercion identified in Figure 1.2 where individuals' actions can be shown to damage others. The restriction on smoking in public places, for example, is therefore entirely justifiable in that smoking is not merely a public nuisance, but puts non-smokers at risk as a result of passive smoking.

Less clear-cut perhaps is the argument that seeks to restrain self-destructive behaviour on the grounds that the prudent in society should not have to pay for the excesses of the imprudent. More generally, economic arguments have indicated how self-inflicted illness damages the economy in terms of reduced productivity due to working days lost and increases the burden on already hard-pressed health services. Legislation can, therefore, be justified. For instance, in the UK, legislation enforcing seatbelt use and the wearing of protective headgear by motorcyclists has been in place for some time and is demonstrably effective. The situation regarding smoking is more equivocal. Certainly, many arguments have been used to demonstrate that smokers cover the cost of their morbidity and early mortality as a result of the finances levied by taxation and should actually be treated as social benefactors.

The cost-benefit analysis of smoking is a matter for health economics and so will not be debated here. However, a serious point is frequently made that those indulging in high-risk activities should be allowed to do so, providing that this does not damage the well-being of others and that possible social and medical costs are covered by insurance. The financial argument would not, of course, apply to those who impose a financial burden on the state because of illness for which they cannot be blamed.

The principle of utilitarianism, then, does not prove as unambiguous as it first appears. The question of limitations to free choice again proves problematic and leads us to consider the second principle, which may justify coercive methods. If people are not really responsible for their actions, then society must make decisions on their behalf, for their own good. These decisions will inevitably

involve the restriction of liberties and involve some degree of coercion. This principle of paternalism (Nikku, 1997), though, proves even more difficult to justify than the appeal to utilitarianism. Beauchamp cites John Stuart Mill's (1961) treatise on liberty and his assertion that utilitarianism is the only justification for coercion:

The only purpose for which power can be rightfully exercised over any member of a civilized community, against his [*sic*] will, is to prevent harm to others. His own good, either physical or moral is not a sufficient warrant. He cannot rightfully be compelled to do or forbear because it will be better for him to do so, because it will make him happier, because in the opinion of others, to do so would be wise, or even right. These are good reasons for remonstrating with him, or reasoning with him or persuading him or entreating him, but not for compelling him. (Beauchamp, 1978: 244)

However, as Daniels indicates:

Even a view that holds the individual to be the best architect of his [*sic*] ends and judge of his interests rests on important assumptions about the information available to the agent, the competency of the agent to make these decisions rationally, and the voluntariness of the decisions he makes. It is because these assumptions are not always met that we require a theory of justifiable paternalism. (1985: 157, in Guttman, 2000: 52)

Pollard and Brennan (1978), in discussing the basis for governmental intervention in cases of self-regarding behaviour – that is, behaviour affecting only the individual but not others – cite Dworkin's justification of paternalistic behaviour on the grounds that some adults may not be capable of rational thought because 'at some point in the future the individual will see the wisdom of the paternalistic intervention, even though at present he or she is not aware of its value' (1972: 71).

The intervention thus, in some way, protects the 'real' will of the individual. At first glance, such a proposition looks distinctly dubious. However, it is undoubtedly true that most societies routinely take responsibility for certain categories of individual. For instance, the very young and those having a substantial degree of mental impairment would routinely be protected in many societies. Again, the notion of protecting someone's real will is not as Machiavellian as it might appear. For instance, it would seem fairly clear that a substantial majority of smokers would prefer not to smoke and it is appropriate to recall McKeown's observation that 'the critical decision to smoke is taken not by consenting adults but by children below the age of consent' (1979: 125). Paternalistic intervention to limit people's freedom to choose to smoke might make some sense ethically. Furthermore, even if suicide were legal, a depressed person might be legitimately prevented from taking his or her life on the reasonable supposition that, when no longer depressed, (s)he would not wish to do so.

Choice architecture positions itself as being 'libertarianism paternalism' (Thaler and Sunstein, 2008). While at first glance this combination appears to be a contradiction in terms, Thaler and Sunstein (2008) argue that the meaning of the word paternalism changes when preceded by the word 'libertarianism' in that the focus becomes about preserving liberty. Choice architecture and the concept of 'nudge' are discussed further in Chapter 10.

The question of choice versus coercion in the interest of public health is very real. On the one hand, the principle of voluntarism urges freedom of choice unless good reason can be provided for

coercive measures on the basis of utilitarianism, paternalism or ‘social justice’. On the other hand, it seems particularly difficult to reach consensus about when, where and to what extent these principles can be used to justify coercive interventions in the interest of public health. Those of a left-wing orientation might object to any infringement of liberty of disadvantaged people, but wholeheartedly support paternalistic (or should it be ‘maternalistic’?) measures by the nanny state on the grounds of social justice and equity. Equally, the more tough-minded advocates of market forces would vocally object to interventions that restricted their own freedom of action, but might well subscribe to the utilitarian restriction of the liberty of people of a different political persuasion! Public attitudes about individual versus government responsibility for health were explored by the British Social Attitudes Survey (NatCen Social Research, 2017) (see Box 1.3).

BOX 1.3 PUBLIC OPINION ON THE DETERMINANTS OF, AND RESPONSIBILITY, FOR HEALTH

- The vast majority of the people surveyed (96%) considered ‘free health care’ to have a ‘large’ or ‘quite large’ impact on health.
- 93% of those surveyed thought that individual behaviours have an impact on health.

The support of family and friends, safety in the local area, area quality, inherited characteristics, being employed, education and friendly neighbourhood/community were also viewed as having an impact on health but to a lesser extent than the previous two factors.

In terms of responsibility for health:

- 61% thought that individuals had a greater responsibility for health than the government.
- Only 9% thought that the government had more responsibility than individuals.
- Young people, and those with poorer health, were more likely to view the government being more responsible for health (36% of those surveyed over the age of 75 years thought that individuals were entirely responsible for health compared to 9% of 18–24 year olds).

Source: Holt-White (2019) Health Foundation analysis of NatCen Social Research’s British Social Attitudes Survey 2017.

The debate about who is responsible for health continues and is inextricably tied up with ideological and political perspectives. In 2011, England saw the introduction of the ‘Responsibility Deal’, a voluntary agreement designed to encourage healthier lifestyles relating to four key areas – physical activity, food, alcohol and health at work. By 2015, 776 companies, including manufacturers and supermarkets, had signed up. Since the end of the Coalition government in 2015 the Public Health Responsibility Deal has not been driven forward. Nevertheless, this light-touch approach contrasts somewhat with that taken in the USA, where a healthcare law was passed in 2010 requiring calorie counts to be put on menus and vending machines. Despite some cities having enforced this (led by

New York City in 2010), there have been significant delays in its implementation in some sectors for a number of complex reasons.

The stewardship model described in Box 1.2 (see p. 25) provides a framework for considering the balance between individual freedom and state responsibility in relation to public health. We may be able to move some way towards resolving the dilemma by promoting self-empowerment. However, we should take account of Beauchamp's noteworthy observation that 'Public health should – at least ideally – be suspicious of behavioural paradigms for viewing public health problems since they tend to "blame the victim" and unfairly protect majorities and powerful interests from the burdens of prevention' (Beauchamp, 1976, reprinted in Beauchamp and Steinbock, 1999: 106). Accordingly, our analysis later in this chapter and discussion of empowerment will emphasize the importance of *community* participation and *community* empowerment.



Ethics and ethical practice

Guttman (2017) contends that the debate on ethics in health promotion practice can be summarized in two key questions: first, does it indeed promote people's health and second, whom does it actually benefit? These two questions relate respectively to evidence of what works (discussed in more detail in Chapter 12) and issues of fairness and equity. Underpinning these questions are some of the well-known biomedical ethical principles that Beauchamp and Childress (2019) espouse: namely beneficence, non-maleficence and justice. Beauchamp and Childress's (2019) final principle is respect for autonomy or the rights of the individual. Arguably, being able to exercise such rights is the literal outworking of empowerment (at an individual level at least) but there are limits to the extent to which this might be possible; for example, when the rights of others are impinged upon. In addition, as Parker et al. (2007) argue, health promotion interventions should achieve positive outcomes and avoid, where possible, any negative unintended outcomes that might harm the things that people value. Robust evaluation strategies can help in this regard (see Chapter 11 for further details).

The biomedical ethics model has value in health promotion, as discussed. In contrast, however, Sindall (2002) points out that the social model of health necessitates a broader macro-ethical framework, which moves away from the individual responsibility and accountability for behaviour change inherent in a lot of public health policy. Communitarian ethics 'moves beyond the principles derived from bioethics, to incorporate theories from social and political philosophy' (Sindall, 2002: 202). Communitarianism recognizes that the individual cannot be separated from their social context and, therefore, rejects the privileging of the individual promoting the notion of common good and the necessity for collective action to achieve this. In keeping, but notwithstanding the challenges of collaborative and facilitative methods for promoting health, Tengel (2012) illustrates how the ethical dilemmas of the behaviour change approach can be countered by using an empowerment approach since it respects and promotes autonomy.

Wills (2023: 86) asserts that health promotion 'raises many questions over its ends and means' such as:

- Good health is a relative concept, so whose definition should take precedence? Is it ethical for a practitioner to persuade someone to adopt their perception of a healthier lifestyle?

- What means are justifiable to promote good health in the population? Should the interests of the majority always prevail?
- Since most ill health is avoidable, should those who knowingly adopt unhealthy behaviours be refused treatment?

Questions such as these can, and should, guide and influence health promotion practice. More generally, Gardner (2014) outlines a further three questions about key ethical issues for health promotion, which can serve as a general prompt for reflective practice:

1. What are the ultimate goals for public health practice, i.e. what 'good should it achieve'?
2. How should this good be distributed in the population?
3. What means may we use to try to achieve and distribute this good?

It is not possible to address questions such as these without considering the sociological concepts of agency and structure, as reflected in debates about responsibility for health – namely, individual responsibility for health versus state responsibility. Indeed, 'the growing public-health threats of non-communicable diseases, including those caused in part by unhealthy behaviours such as smoking, poor diet or lack of exercise, have raised the question of the extent to which (public-health) authorities should interfere with personal choices on health' (Coleman et al., 2008: 578). However, Coleman et al. (2008) also contend that the structural context needs to be considered in terms of the factors that create healthy communities and societies, which is a principle embedded in health promotion's overriding concern with the wider social determinants of health.

Several authors point to ethical concerns in health promotion interventions, many of which are raised in this chapter and throughout this book. For example, Guttman (2017, npn) notes that 'interventions can have repercussions in multicultural settings since members of diverse populations may hold beliefs or engage in practices considered by health promoters as "unhealthy" but which have important cultural significance'. In addition, Cross et al. (2017a) outline a number of ethical dilemmas in health promotion such as the use of persuasive communication, emotional appeal, shock tactics, and the tension that arises between personal freedom (the right for an individual to behave in an autonomous way) and the greater good tenet of utilitarianism.

There is increasing recognition that ethics and evidence in health promotion are inextricably linked (Carter, 2012; Carter et al., 2011b). Tannahill (2008: 388) proposed an 'ethical imperative' for health promotion – 'to make decisions based on the explicit application of ethical principles, using available evidence and theory appropriately to inform judgements'. Ethical practice, therefore, has to relate to the evidence about what works, the point reiterated by Guttman (2017) earlier. Carter et al. (2011b) propose five principles for planning and evaluating health promotion based on these two central and important features of health promotion practice (ethics and evidence), as follows:

1. Recognize that health promotion thinking must be responsive to particular situations – it cannot be universal.
2. Formally recognize and implement two iterative systems of reasoning, an evidence-based system and an ethical system, each containing explicit values.

3. Clearly specify the evidential and ethical concepts that are valued or devalued in each situation, and the dimensions along which these vary. Use both existing theory and detailed empirical study of the practice of health promotion in the situation.
4. Be specific about trade-offs occurring along the identified dimensions – consider how valued or devalued concepts interact.
5. Prioritize procedural transparency: be certain that processes used for reasoning, defining and trading off can be explained clearly.

For further exploration of this framework and an application of it to a specific health promotion campaign, please see Carter et al. (2011b, p. 468).

There is currently no specific or universal code of ethics for health promotion, although a number of frameworks or guidelines have existed. In preparation of developing a code of ethics, the International Union of Health Promotion and Education (IUPHE) carried out a survey of IUPHE members regarding the need for a code of ethics for health promotion (Bull et al., 2012). The findings supported the development of a code of ethics, based on the evidence that ethical dilemmas were frequently encountered in health promotion practice (Bull et al., 2012). The subsequent IUPHE core competencies and professional standards for health promotion (IUPHE, 2016: 6) are underpinned by a set of ethical values and principles – namely, ‘a belief in equity and social justice, respect for the autonomy and choice of both individuals and groups, and collaborative and consultative ways of working’. For a more in-depth exploration of ethical considerations in health promotion please see Guttman (2017).

Health promotion and the discourse of empowerment



The assertion that the main concern of health promotion should be that of empowerment is becoming increasingly acceptable, although this acceptance often takes the form of lip service rather than practice and policy! Certainly, as noted above, most of the key documents published by the WHO since the inception of ‘Health for All by the Year 2000’ placed emphasis on individuals gaining control over their lives and their health and on the importance of active participating communities. In his Harveian Oration, Marmot (2006: 2081–2) recognized the central importance of the social environment and empowerment, asserting that: ‘Failing to meet the fundamental human needs of autonomy, empowerment and human freedom is a potent cause of ill health.’ In subsequent work led by Sir Michael Marmot, *Fair Society, Healthy Lives* (Marmot, 2010), a key theme was to create conditions in which people could take control over their lives – prioritizing empowerment. In *Health Equity in England: The Marmot Review 10 Years On* (Marmot et al., 2020) the importance of community control and empowerment was still at the forefront.

It is axiomatic from our earlier discussion that empowerment is based on the principles of voluntarism. The key issue for health promotion is how people who lack power can become more powerful and actually gain a reasonable degree of control over their lives. How can they compete with, and resist coercion by, those who already have power?

ABSTRACT 1.2

Behavior change or empowerment: on the ethics of health promotion goals. Tengland, P. (2016)

One important ethical issue for health promotion and public health work is to determine what the goals for these practices should be. This paper tries to clarify what some of these goals are thought to be, and what they ought to be. It specifically discusses two different approaches to health promotion, such as behaviour change and empowerment. The general aim of this paper is, thus, to compare the behaviour-change approach and the empowerment approach, concerning their immediate (instrumental) goals or aims, and to morally evaluate the strengths and weaknesses of these two goal models, in relation to the ultimate goals of health promotion. The investigation shows that the behaviour-change approach has several moral problems. First of all, it is overly paternalistic and often disregards the individual's or group's own perception of what is important – something that also increases the risk of failed interventions. Furthermore, it risks leading to 'victim-blaming' and stigmatization, and to increased inequalities in health, and it puts focus on the 'wrong' problems, i.e. behaviour instead of the 'causes of the causes'. It is thereafter shown in the study that the empowerment approach does not have any of these problems. Finally, some specific problems for the empowerment approach are discussed and resolved, such as, the idea that empowering some groups might lead to power over others, the objective that the focus is not primarily on health (which it should be), and the fact that empowered people might choose to live lives that risk reducing their health.

Further reflections on power

Empowerment, by definition, has to do with people acquiring a degree of power and control. Self-empowerment describes the extent to which individuals have power and control over their interactions with their physical and social environment. Further, an empowered community is an identifiable group of people that also possesses power and control. It is a matter of some importance to understand the different circumstances under which people acquire power, wield it and yield to it.

Definitions of power and related concepts

The notion of power may manifest itself at macro, meso and micro levels. All three levels have some degree of relevance for health promotion. Studies of power at the micro level are concerned with influences on, and exerted by, individuals or small groups; meso-level power might refer to the power exerted by organizations or communities; the influence of national policy would be a macro-level influence – as would the kinds of ideological controls discussed above.

The classic Weberian analysis identifies three forms of power:

- **social power** based on such factors as prestige, family status, lifestyle and patterns of consumption
- **economic power** based on a group's relationship to the mode of production, its position in the labour market and general life chances
- **political power** based on affiliation to parties, bureaucracy and legal structure.

Naturally, there are a number of different ideas associated with power. For instance, concepts such as ‘control’, ‘authority’ and ‘influence’ may be used almost interchangeably with power.

Bachrach and Baratz (1970) acknowledge the variations in the nomenclature and meaning of these various terms and offered a useful typology of influence that still has currency (see Box 1.4).

BOX 1.4 A TYPOLOGY OF INFLUENCE

Force The individual or group is obliged to comply by removing all choice.

Coercion Compliance is achieved by the threat of deprivation where conflict exists regarding values or courses of action.

Manipulation This is a ‘subconcept’ of force. Compliance results in the absence of recognition by those who comply or the source of nature of the demand made.

Influence This term is used when an individual or organization succeeds in causing others to change their intended actions, but without overt or tacit threat of deprivation.

Authority This form of power operates when people comply because they accept that commands are reasonable in terms of their own values or because an appropriate and acceptable procedure has been adopted.

Source: Bachrach and Baratz (1970: 28)

Lukes (2021) reminds us that dominant groups shape people’s needs and wants – by means of mass media, ‘indoctrination’ at school or, more powerfully, by socialization. Lukes’s analysis is clearly consistent with our earlier discussion of the often-subtle means whereby dominant ideologies are perpetuated, including the creation of false consciousness. These observations are not only relevant to our discussion of ideologies in general, but, as we noted earlier in this chapter, more particularly to questions of utilitarianism and paternalism. They also have an important bearing on our later examination of the assessment of health needs. Moreover, these two notions underpin thinking about empowerment, bearing in mind Kindervatter’s definition of empowerment as: ‘People gaining an understanding of and control over social, economic and/or political forces in order to improve their standing in society’ (1979: 62). A clear understanding of the different constructions of power also has special significance in, for example, determining the success or failure of lobbying and advocacy for the implementation of healthy public policy at macro and meso levels.

Notwithstanding the relevance of these macro- and meso-level influences on the development of healthy public policy, at this juncture we will focus on the individualistic perspective and the micro-level exercise of power. After all, continuing pressure is placed on individuals from a variety of sources, both explicitly and implicitly, to modify their behaviours in ways that may – or equally may not – be healthy.

Five varieties of power: an individual perspective

One of the classic, and still valid, analyses of power at the micro level was provided by French and Raven (1959), who distinguished five varieties of power. This scheme (which has similarities to Weber's analysis of charismatic, traditional and rational–legal power) is frequently used to illuminate interactions when analysing small group dynamics and discussing leadership functions. Their analysis comprises the following five varieties of power:

- **Legitimate power:** authority is derived from legitimate status formally bestowed by a given social system.
- **Expert power:** authority derives from the actual and perceived expertise of the individual in question. It may or may not be associated with legitimate authority or be an informal adjunct of referent power (see below).
- **Reward power:** authority derives from the individual's capacity for providing rewards.
- **Coercive power:** authority derives from the individual's capacity to sanction.
- **Referent power:** authority derives from the referent's individual characteristics, which, for some reason, are valued by the person who is influenced.

Stardom and charisma

Alberoni (1962, in McQuail, 1972) also discusses the characteristics of individuals who, despite lacking legitimate authority, can nonetheless exert quite a powerful influence over other people. He describes this 'powerless "élite"' as 'stars'. Their 'institutional power is very limited or nonexistent, but [their] doings and way of life arouse a considerable and sometimes even a maximum degree of interest'. He likens their personal characteristics to Weber's notion of charisma:

By charisma we mean a quality regarded as extraordinary and attributed to a person ... The latter is believed to be endowed with powers and properties which are supernatural and superhuman, or at least exceptional even where accessible to others; or again as sent by God, or as if adorned with exemplary value and thus worthy to be a leader. (Weber, 1968: 241)

It is sometimes said, with a degree of acrimony, that many celebrities in contemporary society are 'famous for being famous'! It is certainly the case that these charismatic characters may well exert a quite dramatic degree of influence on people. They may influence taste and preferences and act as models. This phenomenon will be revisited in Chapter 7, when we consider the influence of source credibility and attractiveness in persuading individuals to adopt healthy or unhealthy courses of action.

We might legitimately conclude that empowered individuals would be more able and willing to resist pressure and not submit to unreasonable demands, particularly those that run counter to their existing values.

While analyses such as French and Raven's are undoubtedly useful in designing health promotion programmes, it is essential to ask how someone comes to wield legitimate authority, how they are in a position to reward, how they acquire the power to coerce, how they acquire expert authority or come

to be treated as referents by their communities. As we noted earlier, power does not rely only on the crude application of force and coercion, but can also be exerted by the ideological control of culture and the hegemony of political and state institutions.

Self-empowerment, community empowerment and reciprocal determinism



Earlier in this chapter, we emphasized the dramatic effects an oppressive environment can have on individuals' health and their capacity to make choices.

It is, therefore, self-evident that empowerment – people's opportunities to make genuinely free choices – is not possible unless physical, socioeconomic and cultural circumstances are favourable. Thus, it is imperative that empowerment policy and the ensuing strategies must engage with the thorny question of environmental change. However, it is clear that individuals are, in many situations, capable in principle of making choices even when the environment is not especially conducive to individual action. Three different perspectives on human agency can be identified (see Figure 1.3).

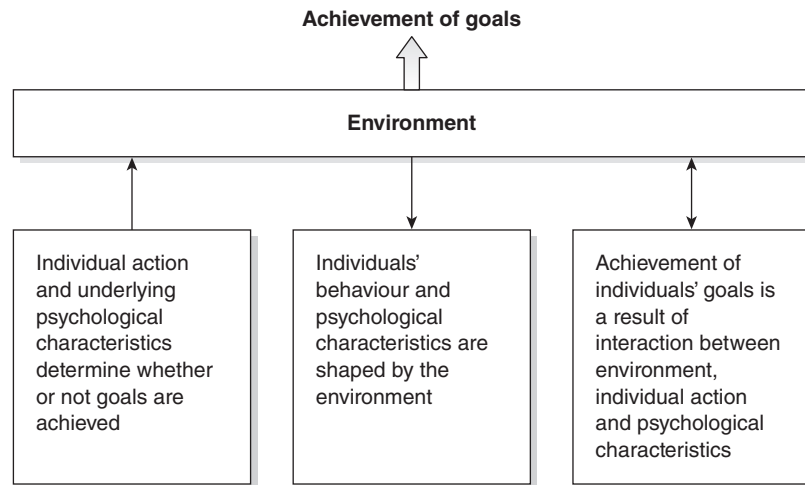


Figure 1.3 Three perspectives on human agency

In the first situation, the focus of attention is centred on individuals and those characteristics that explain their behaviour. The theorist may be interested only in psychological phenomena or even be effectively blind to the existence of the environment. Some forms of counselling may be characterized by this approach. In the second instance, individuals are viewed as being largely controlled by their circumstances – directly or indirectly.

The third formulation of human agency asserts that humans (and animals) interact with their environments. They are, on the one hand, affected by environmental forces but, on the other, typically capable of having at least some impact on the various physical, socioeconomic and cultural factors that influence them. The ideology and practice of empowerment ultimately derives from this last

standpoint and has been a central feature of social learning theory. Its major exponent and advocate is Bandura (1986), who described the interactive process as ‘reciprocal determinism’ and contrasted it with the Skinnerian assertion that ‘A person does not act upon the world, the world acts upon him [*sic*]’ (Skinner, 1971: 211). Bandura argues that a process of ‘triadic reciprocity’ operates when humans engage with life. In short, there is an often complicated system of interaction between psychological factors (such as beliefs and attitudes), behaviour and the environment. A more comprehensive account of this system is given and discussed in Chapter 3.

We should also note that this archetypal psychological analysis of human agency is by no means inconsistent with the broader perspectives of sociology. For instance, Giddens (1991: 204) observes that ‘actors are at the same time creators of social systems yet created by them’.

Individual and community dimensions of empowerment

The logic of reciprocal determinism for an empowerment model of health promotion is inescapable. If empowerment is about facilitating voluntaristic decision-making and achieving free choices (or those that are consistent with moral imperatives), then it must operate at both the level of the environment and at the level of the individual. Furthermore, it is important to recognize that the environment itself has many levels – from macro to meso, from the level of national policy to the level of regional organizations and institutions, down to the level of the neighbourhood or village. At each level, individuals exist within a web of social systems. At the neighbourhood level, the community is a social system that has particular significance for health promotion. Figure 1.4 gives an indication of this complexity within the context of commenting on both individual and community empowerment. These, as South and Woodall (2010) argue, should be viewed as inextricably linked. Indeed, in terms of approaches, there is evidence that the two are connected. For further discussion about community empowerment and health equity please see Popay (2021).

As may be seen from Figure 1.4, the community may mediate individual agency in relation to the general physical, socioeconomic and cultural environment. The community is an especially important social system within the lexicon of empowerment and health promotion. Following the doctrine of the Ottawa Charter, an active, empowered community is perhaps seen as the most important of the desirable empowerment outcomes of health promotion activities. In short, it enables people to take an active part in influencing policy. Three key features of an empowered community are also shown: namely, a sense of community – that is, a therapeutic feeling of identification with fellow community members; an active commitment to achieve community goals; and what is increasingly termed ‘social capital’ (see Chapter 2 for more about this).

Individual or self-empowerment, however, comprises a cluster of attributes related to a personal capacity for voluntaristic action:

Self-empowerment is a state in which an individual possesses a relatively high degree of actual power – that is, a *genuine* potential for making choices. Self-empowerment is associated with a number of beliefs about causality and the nature of control that are health promoting. It is also associated with a relatively high level of realistically based self-esteem together with a repertoire of *life skills* that contribute to the exercise of power over the individual’s life and health. (Tones and Tilford, 2001: 40)



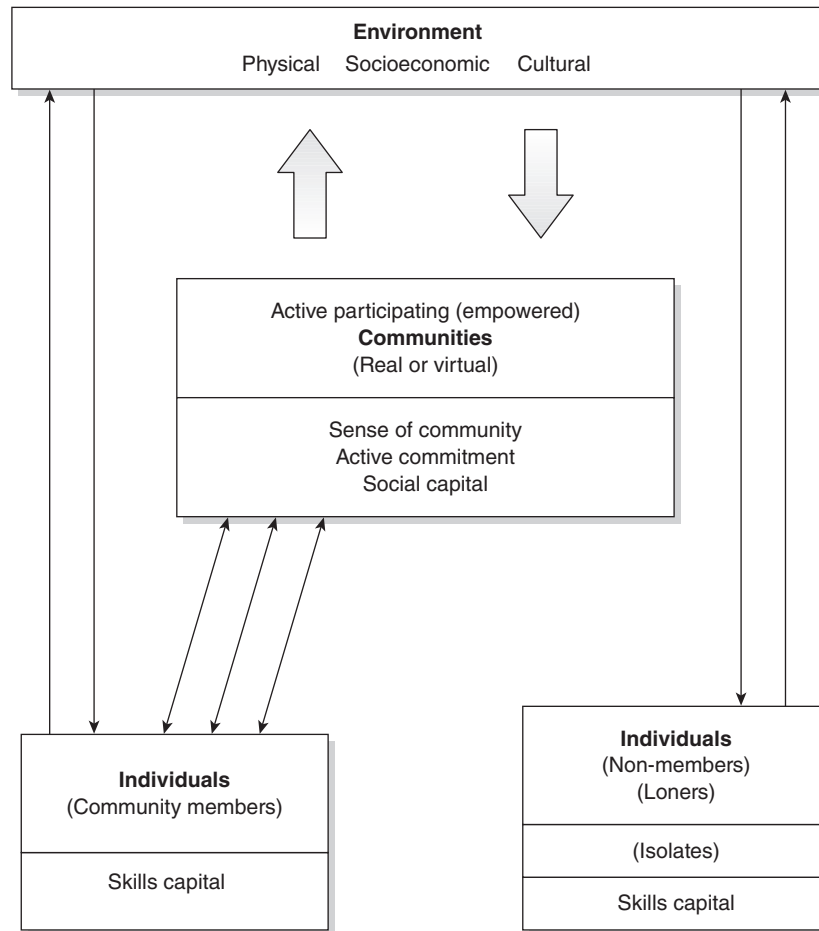


Figure 1.4 Reciprocal determinism and empowerment of communities and individuals

Clearly, a community is composed of its membership – and it is arguable whether or not a community is more than the sum of the individuals making up this membership. In all events, a community is generally considered to be beneficial for its individual members, and the characteristics and capabilities of these individuals will contribute to the power of the community as a whole.

Figure 1.4 makes a distinction between ‘real’ and ‘virtual’ communities. The former represents a traditional idea of community as a group of people within a relatively small geographical area having a sense of identity and a network of relationships. A virtual community may lack the narrow geographical dimension of a real one, but otherwise has a shared identity. For instance, we can realistically talk about the LGBTQIA+ community or about communities comprising of people connected through social media. A virtual community may actually have more power at its disposal than a real community and, moreover, with technology such as the Internet, may benefit from different kinds of interaction.

Although often ignored in discussions of communities, Figure 1.4 reminds us that some individuals may not be part of any community – real or virtual. We have labelled as ‘non-members’ individuals who exist in relative isolation because no community exists. By contrast, and borrowing terminology from the domain of sociometry, we have used the term ‘loner’ to distinguish people who do not wish to belong to a community from those whose felt need is to belong, but who are not accepted or rejected – so-called ‘isolates’. Figure 1.4 also notes that individuals are affected by, and in turn affect, their environments at different levels without the mediation of community groups.

We might also note that environments do not exert their effects in a unidimensional way. It is more realistic to consider any given environment as exerting both facilitative and inhibitory influences of different strengths on communities and individuals. The sum total of both positive and negative pressures might be described in terms of these macro or meso influences ‘making the healthy choice the easy choice’ or, alternatively, being fundamentally oppressive. The specific, technical, detailed aspects of both community and individual empowerment will be explored at some length in Chapter 3.

One of the factors most closely associated with empowerment – with respect to both ideological and technical aspects – is that of participation. The WHO has frequently commented on the importance of an active, participating community and the desirability of individual involvement in decision-making is virtually taken for granted as a healthy development. We will also note in Chapter 5 the centrality of participation to the needs assessment process. How does participation actually contribute to empowerment? It is almost a matter of common sense! A community that takes action – that is, participates in action to influence policy or practice at local or national level – feels that it has actually achieved something, even if the outcome is not dramatic. Similarly, individuals who are actively involved are likely to experience at least some degree of control. Obviously, there are many different degrees of involvement and Figure 1.5 indicates an assumed relationship between degrees of participation/involvement and empowerment. It draws on the classic analyses of Arnstein (1969) and Brager and Specht (1973).

It should be noted that Figure 1.5 applies equally not only to communities but also to settings such as health-promoting hospitals and health-promoting schools and, at the micro level, to interactions between individuals, such as doctor and patient.

Empowerment and health and well-being

A review by Woodall et al. (2010) assessed the evidence in relation to empowerment and its effect on health and well-being. Based on the available literature, the review suggested that there are five key areas where empowerment strategies or interventions had improved individual health-related outcomes. These areas were identified as:



- improved self-efficacy and self-esteem
- greater sense of control
- increased knowledge and awareness
- behaviour change
- a greater sense of community, broadened social networks and social support.

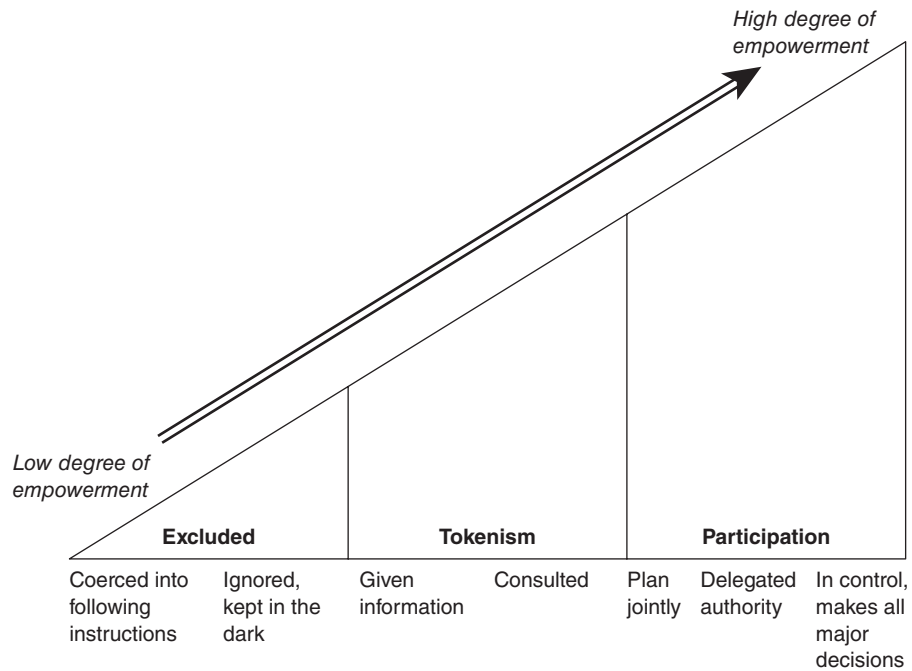


Figure 1.5 Participation and the empowerment gradient

The review found fewer instances where empowerment approaches had made a difference to the actual health and well-being of communities, although there was good evidence showing that community engagement was beneficial for social cohesion, social capital and strengthening relationships and trust among participants. The authors suggested that further research is needed to establish the evidence for links between empowerment and improvements in the health status of communities. Since the publication of the review numerous studies from around the world have reported associations between the empowerment of communities and benefits to health. More recent examples include Abbas et al. (2021) for Pakistan, Coan et al. (2020) for the UK and Guli and Geda (2021) for Ethiopia.

An empowerment model of health promotion



We have considered the medical discourse associated with public health and a preventive model of health promotion or, rather, health education. We have also explored ideas related to the discourse of voluntarism, which might be said to give rise to an educational model of health promotion. Both of these models are limited in that they are inconsistent with the ideological thrust of health promotion. They are also technically limited in their capacity to explain what would be involved in achieving the empowerment goals of health promotion. Figure 1.6 sets out the main components of an empowerment model of health promotion and their interrelationships.

The central dynamic of the empowerment model is the interplay of education and healthy public policy. The development and implementation of policy are the essential precursors to the creation of health-promoting environmental influences. The relationship is multiplicative, as we noted earlier in the ‘formula’: health promotion = health education × healthy public policy. The empowering function of education not only strengthens individual capabilities for health-related action, but also makes a major contribution to the establishment of healthy public policy.

Action to achieve healthy public policy

We discussed the five action areas of the Ottawa Charter earlier in this chapter, including the imperative to reorientate health services. Accordingly, Figure 1.6 shows how policy initiatives are necessary to improve service provision to meet the health needs of particular populations. More importantly, it identifies the significance of policy initiatives to address physical, socioeconomic and cultural circumstances. This position is reinforced in the Health in All Policies thrust of subsequent WHO international health promotion conferences (WHO, 2009, 2013e, 2016a). The focus is more on reframing than on reorientation. In tune with modern multidisciplinary public health, it recognizes the contribution to health of a range of services whose primary *raison d’être* may not be health in any formal sense; for example, transport, housing, economic development. However, all of these have a major impact on health and, indeed, on disease.

Two major action strategies are included in the model. One is the traditional means of seeking to influence policy, such as lobbying. Advocacy is defined here as lobbying those who exercise power by those who have power but who are doing so on behalf of the relatively powerless. The term ‘mediation’, which was incorporated into the Ottawa Charter list of major actions, refers to the process of mediating between competing interests. By way of illustration, we might consider the different concerns of the owners and producers of mass media programmes and health professionals. On the one hand, the main goal of the former is to entertain the public and advertise products in order to make profits. On the other hand, the interests of the health promoters are to control advertising and any representation of health issues in ways that are considered to be damaging to the public health.

The second – and ultimately the most powerful – means of producing policy change is to create a sufficient level of public pressure so that decision-makers and politicians at the national or local level feel obliged to change. In a democracy, this might, in the final analysis, result in change by means of the ballot box.

The catalyst for change is health education, but emphatically not the variety of health education that has been tarred with the same brush of victim-blaming! Rather, following the precepts of critical theory, it might usefully be called ‘critical health education’ and its purpose is radical and political. Again, the nature of education and its technology will be reviewed in Chapters 7 and 8 and particular attention will be devoted to its radical and critical manifestations.

Health education and individual empowerment

Figure 1.6 includes an analysis of the essential contribution made by education to individual action. A training function has also been included in the model to demonstrate the continuing importance of providing skills – not only to communities, but also to the professionals who work in the various



They are also more likely to engage with the various services contributing to health in an assertive and productive fashion. They are almost certainly more likely to adopt a lifestyle conducive to achieving the objectives of preventive medicine than if they were not empowered! Indeed, one of our more forceful assertions here is that the successful adoption of an empowerment model of health promotion is not only more likely to achieve positive health outcomes in an ethical fashion, but also to be more efficient in attaining the important outcomes associated with the prevention and management of disease and disability.

The empowerment model: critiques and reservations

The empowerment model of health promotion is not without its critics. For instance, some might reasonably argue that empowerment is a fashionable term, distinguished by its lack of clarity in conceptualization and use (the same criticism could, of course, be levelled at health promotion itself and even the notion of public health). A second objection derives from the assertion that empowerment lacks a theoretical base. This assertion is fundamentally incorrect, as we are in the process of demonstrating!



What is undoubtedly more problematic is translating the rhetoric into action.

Unresolved challenges are also seen to exist in terms of the definition and operationalization of empowerment (Woodall et al., 2012a). A lack of consensus around defining empowerment leads to challenges in its measurement at whatever level it occurs (Cross et al., 2017a; Popay, 2021). In a paper that posits a critical stance on whether empowerment has, in fact, lost its power, Woodall et al. (2012a) contended that the concept of empowerment has become diluted in contemporary health promotion and has somewhat lost touch with its radical social roots. Christens (2013) was in agreement with Woodall et al.'s (2012a) conclusions that empowerment needs to be defined more precisely, that multilevel approaches are needed and that research is required that links changes at structural levels to changes at individual levels. However, Christens (2013) also added to the debate, pointing out some potential oversights in Woodall et al.'s arguments. He asserts the need to distinguish carefully between the use of the terms 'individual' and 'psychological' empowerment and argues that critical consciousness is crucial to bringing empowerment back to its radical, liberationist roots, noting that this first takes place at the individual level. Christens et al. (2016: 15) note that empowerment and critical consciousness are 'concepts with shared roots' as 'both are associated with attempts at overcoming oppression and fostering human development, community participation, and wellbeing'. In his 2019 book *Community Power and Empowerment* Christens analyses collective empowerment in detail, addressing previous limitations in the literature such as the overemphasis on psychological empowerment and the relative lack of attention given to processes of community empowerment.

It should hopefully be clear from the observations made in this chapter that power and politics are central to health promotion. It would be a mistake to underestimate the difficulties of challenging power structures. Nonetheless, we believe that sophisticated analysis grounded in sound theory can result in the development of empowering strategies that can achieve results. The empowerment model of health promotion is advocated here on grounds of both ideological soundness and practical effectiveness. Moreover, it stands up well to ethical scrutiny.

PUBLIC HEALTH, HEALTH PROMOTION AND HEALTH EDUCATION

Health promotion and modern multidisciplinary public health

We have considered at some length the ideology of health promotion and have argued in favour of an empowerment model that recognizes the primacy of the broader social, cultural, economic and environmental determinants of health. To conclude this chapter, we will briefly examine the relationship between health promotion and modern multidisciplinary public health and the position of health promotion as a profession. We will also consider the future role of health education.

For some, there is no distinction between health promotion and public health. Kickbusch (2007) reminds us of the subtitle to the Ottawa Charter for Health Promotion – *the move towards a new public health*. Indeed, the Ottawa Charter has been hailed as heralding the third public health revolution. Potvin and McQueen (2007) have characterized revolutionary change as affecting three fundamental dimensions of systems:

- the direction or finality of the system – the target, objectives and goals
- knowledge base – including the conditions that support the production of knowledge as well as substantive knowledge itself
- actions – including design, implementation and evaluation.

Terris (1983) identified the first public health revolution as concerned with tackling communicable disease and the second with non-communicable disease. Breslow (1999, 2004, 2006) puts the case that the emphasis on health as a resource for living constitutes the third revolution.

However, for some authors, health promotion and public health, although related, are not synonymous. Raeburn and MacFarlane refer to some governments seeing public health as health protection plus health promotion, where health protection comprises ‘the more regulatory, centralized and reactive aspects of public health’ (2003: 245) and health promotion is more self-determined, community-based and developmental. In this interpretation, public health is the umbrella term and health promotion a defined sphere of activity within it.

The Bangkok Charter refers to health promotion as a ‘core function of public health’ (WHO, 2005). Potvin and McQueen see health promotion as ‘a strategy for public health that reflects modernity’ (2007: 14). They note that subsequent to its emergence in the 1970s and more formal adoption in the 1980s, health promotion rapidly spread through public health organizations and institutions internationally. However, latterly, while the principles and strategies remain relevant, the term ‘health promotion’ appears to be becoming ‘outmoded’ in some parts of the world. Here in England between 1980 and 2000 specialist health promotion declined and attempts at professionalization failed during the period (Duncan, 2013). However, in other contexts, health promotion is thriving, for example in Canada and Australia. In addition, in the African context, Zambia and Ghana’s changes in government in the second decade of this century saw a renewed focus on health promotion as a means to achieving sustainable development. There was a renewed interest in health promotion in the UK with

the creation of the new Office for Health Promotion in early 2021, which was tasked with leading improvements in the public's health through healthy public policy and cross-governmental working. Subsequently however, the name was changed to the Office for Health Improvement and Disparities. Its primary purpose is to tackle health inequalities as well as focusing on prevention (Department of Health and Social Care [DHSC], 2022).

Potvin and McQueen argue that while some countries may have a cadre of health promotion professionals, health promotion activity involves a wide range of groups, including lay people, and that health promotion is 'not a discipline, nor an institution, nor a profession' (2007: 16). They see health promotion as embracing a 'structured discourse and a set of practices' and identify its two characteristic features as 'a distinctive perspective on health; and a critical orientation towards action' (2007: 16).

However, our position, set out earlier in this chapter, is that health promotion is a discipline with its own ideology and we will at later points in this book identify the theories, perspective and methods that characterize it as an 'ordered field of study'. A study of the views of key informants in the UK by Tilford et al. (2003) found that they associated health promotion with a clear set of values as well as a set of activities. These included instrumental values associated with ways of working as well as terminal values, notably a holistic conceptualization of health, equity, empowerment, autonomy/self-determination and justice/fairness. While there was felt to be some degree of consensus between the values of public health and health promotion, there was a much stronger emphasis for health promotion on empowerment and autonomy with the associated instrumental values of involvement and participation. Prevention and protection featured more prominently in relation to public health, along with a clear population focus and greater attention to 'ends'. In contrast, health promotion was more concerned about means and had a broader focus that included individuals as well as communities. Tilford et al. (2003) conclude that within the context of the move to multidisciplinary public health, health promotion makes a distinctive contribution through its core values (see Box 1.5). By virtue of its more radical orientation, health promotion has in the past been described as the militant wing of public health. The emphasis on attention to process might also lead to it being seen as the critical conscience of public health.



BOX 1.5 VALUES AT WORK

Values influence the ways that health issues are understood, the ways that knowledge and theoretical bases are developed and the nature of strategies identified for health improvement. Values also influence the selection of activities that are undertaken to promote health and the priorities accorded to actions, the balance between activities at individual and population levels, the relationships with individuals and communities who participate in initiatives, the goals which are being sought, and decisions about means and ends in achieving goals.

Source: Tilford et al. (2003: 120)

As we noted above, the early emergence of health promotion was characterized by a struggle to distance itself from public health, held to be associated with the preventive medical model of health. Furthermore, it also sought a separate identity from health education – viewed as the ‘handmaiden of public health’ and tainted by association with approaches deemed to be victim-blaming in orientation. The move towards ‘The New Public Health’, which subscribed to a social model of health, brought about greater alignment with health promotion. The social model of health reflects, as we have seen, an attendant emphasis on issues such as inequality and sustainability (Duncan, 2013). Most of those who claim to be ‘health promoters’ would see commonalities with the broad statement of purpose used for public health:

- to improve health and well-being in the population
- to prevent disease and minimize its consequences
- to prolong valued life
- to reduce inequalities in health. (Skills for Health and Public Health Resource Unit, 2009)

Within England, the origins of modern multidisciplinary public health can be traced back to the Acheson Report, which defined public health as: ‘the science and art of preventing disease, prolonging life and promoting health through the organized efforts of society’ (Department of Health, 1988). The report also recognized that public health:

works through partnerships that cut across disciplinary, professional and organizational boundaries and exploits this diversity in collaboration, to bring evidence and research based policies to *all areas* which impact on the health and well being of populations. (1988)

The specialist health promotion workforce in the UK has depleted over the past three decades. Duncan (2013) argues three key reasons as to why this is the case. First, he points to a lack of a collective identity and a unified purpose among the health promotion workforce; second, the lack of a permanent organizational ‘place’ from which health promotion could sustainably operate; and, finally, the powerful dominance of medicine, or more specifically public health medicine. The structure of public health in England has subsequently undergone rapid change in the last few years. At the beginning of April 2013, Public Health England (PHE) came into being, established to ‘protect and improve the nation’s health and wellbeing, and to reduce inequalities’ (Department of Health, 2012). In 2021 Public Health England was replaced by two new organizations – the Office for Health Improvement and Disparities and the UK Health Security Agency. Nowhere in the PHE structure was the term ‘health promotion’ actually used, rather ‘health protection’, ‘health improvement’ and ‘population health’. The new title of the Office for Health Improvement and Disparities has been criticized for losing ‘public health’ and for using the term ‘health disparities’ rather than health inequalities (Scally, 2021). Nevertheless, the use of terms in the finer detail such as ‘levelling up’, acting on the wider factors that impact on health, and a commitment to working in partnership perhaps remains indicative of a health promotion ethos.



Towards a competent health promotion workforce

Where does health promotion feature in this? Should health promotion have a separate identity and should there be distinct career pathways for those engaged in health promotion? As observed, towards the end of the old millennium, the term 'health promotion' started being used less frequently in both policy documents and job titles, despite the fact that the sphere of activity that had hitherto been described as health promotion was receiving more attention. Scott-Samuel and Springett (2007: 212) refer to this as the 'semantic eclipse of health promotion'. Further, health promotion courses began to disappear from universities' portfolios of provision to be replaced by a variety of titles, including Public Health and Public Health Promotion (Scriven, 2007). In many instances, this was merely a rebadging exercise rather than a significant change in content, but still generated concerns about the future of health promotion as a discipline and a profession. A review of specialist health promotion practice in England and Wales conducted by Griffiths and Dark concluded that: 'Specialised health promotion is a discipline integral to public health' but 'has been eroded in recent years' (2005: 6). They recommended that the specialist health promotion workforce requires recognition and advocacy along with systematic skills and competency development. A collaborative programme, 'Shaping the Future of Health Promotion', was set up in 2006 to implement these recommendations and:

- achieve recognition and identity for specialized health promotion
- develop an agreed career pathway for specialized health promotion staff.

Specification of core competencies and systems for professional registration can serve to define areas of professional practice and ensure standards. A statement on priorities for action issued by the International Union for Health Promotion and Education (IUHPE) and the Canadian Consortium for Health Promotion Research identified a specialist health promotion role as well as the need for a multisectoral response. It emphasized the importance of building a competent health promotion workforce. A number of countries have developed their own competency standards. In Australia there has been considerable work on the professionalization of the health promotion workforce (Shilton et al., 2008). The Australian Health Promotion Association has produced a national competencies framework aimed at a graduate level of competency. Five broad areas of competency are identified, as follows:

1. Programme planning, implementation and evaluation.
2. Partnership building.
3. Communication and report-writing.
4. Technology.
5. Knowledge.

There is some debate about the use of a competency-based system. Wills (2023), for example, argues that the narrow mechanistic focus of competencies is not an adequate basis for assessing professional practice because it overlooks not only the theoretical base but, importantly, the values which underpin

critical reflective practice. An international review of the literature in this area pointed to the uneven progress that has been made in developing competency frameworks for health promotion and health education (Battel-Kirk et al., 2009). For example, in relation to the African context, Onya (2009) writes about the slow and inconsistent development of health promotion competencies and, with specific reference to South Africa, Wills and Rudolph (2010) point to a lack of occupational standards or competencies. In South East Asia, there has been work around developing competencies in health promotion specifically in academic education programmes for health promotion and a call for a consistent approach across the region (Van der Putten et al., 2012).

There are also dissenting views about maintaining a separate identity for health promotion. Ashton, for example, is concerned that it is inconsistent with 'an inclusive, holistic and integrated approach to public health practice' and risks 'health promotion apartheid' (2007: 207). The alternative position is that 'health promotion has been the subject of hegemonic absorption by an increasingly individualistic public health discourse' (Scott-Samuel and Springett, 2007: 211). The consequence of not acknowledging the distinctive contribution of health promotion will be failure to nurture – and risk losing – the specific set of skills and values that it brings to modern multidisciplinary public health. It will also result in the suppression of what has long been regarded as the more radical and militant wing of public health. Responding to contemporary challenges to health, both nationally and internationally, has never before put so much emphasis on the importance of health promotion. For many, it is seen as an idea whose time has come (Scriven, 2007). Rising to this challenge requires recognition of the distinctive contribution of health promotion; the development of proper career pathways; and support for the professional development of a specialist cadre of health promotion staff – that is to say, those who see their role as entirely concerned with health promotion.

The Galway Consensus Conference aimed to encourage 'global exchange and understanding concerning domains of core competency in the professional preparation and practice of health promotion and health education specialists' (Barry et al., 2009: 5). The identification of core competencies, standards and quality assurance systems was seen to be essential for developing and strengthening the capacity to improve public health in the twenty-first century. Eight domains of core competency were identified:

- Catalysing change
- Leadership
- Assessment
- Planning
- Implementation
- Evaluation
- Advocacy
- Partnerships.

A European-wide project led by Professor Margaret Barry established a framework of core competencies for health promotion in Europe (Barry et al., 2012). The CompHP Core Competencies Framework for Health Promotion sets out the key requirements for effective health promotion practice and is intended as a resource for workforce development in health promotion in Europe.

Reflecting a European commitment to health promotion, it identifies nine professional standards for health promotion underscored by ‘a core base of professional and ethical values integral to the practice of health promotion’ (Speller et al., 2012: 15). The nine standards are as follows:

- Standard 1: Enable change
- Standard 2: Advocate for health
- Standard 3: Mediate through partnership
- Standard 4: Communication
- Standard 5: Leadership
- Standard 6: Assessment
- Standard 7: Planning
- Standard 8: Implementation
- Standard 9: Evaluation and research.

In 2016, the International Union of Health Promotion and Education published the IUHPE Core Competencies and Professional Standards for Health Promotion, which reflects these nine domains of competency (IUHPE, 2016). It will be clear from our earlier discussion that defining a competent health promotion workforce should go beyond skills to include the values and ethical principles integral to health promotion – in short, it must be shaped by the discourse of health promotion and more specifically, by an empowerment model of health promotion. For a broader critique of competency frameworks in health promotion as a whole please see Cross et al. (2017a).

The ‘new’ critical health education

We have touched on health education at a number of points in this chapter. To bring the chapter to a close, we will briefly summarize our position on the role of health education vis-à-vis health promotion. The emergence of health promotion effectively marginalized health education by shifting attention towards the broader determinants of health and the need for a policy response. Yet this begs the question of how change is to be instigated and what processes should be put in place to improve the health of populations and, indeed, individuals. Our contention here is that the primary driver has to be health education. While it is acknowledged that health education requires a supportive environment to achieve its goals, the converse is all too often overlooked. The development of healthy public policy to create a supportive environment is dependent on health education. As Figure 1.6 makes clear, the development of healthy public policy requires some form of learning – and *ipso facto* education – be it among policy-makers themselves, advocates or communities seeking change.

Critiques of health education have centred on its individualistic, victim-blaming orientation. However, what the critics are actually attacking is the preventive medical model of health education. Alternative, coexisting models of health education – especially the more radical, empowering

models – are overlooked. Health education has a key role in tackling the structural determinants of health. Even at the individual and community level, health education can have an empowering and emancipatory function. It can also facilitate the voluntary adoption of health-enhancing behaviour. The review by Tilford et al. of the values of health promotion supports the continued relevance of health education that is empowering and in tune with the precepts of critical theory:

We have also concluded that health education, especially using a critical empowerment model, still has an important part to play in health promotion and public health. (2003: 120)

Health education can thus be a major driver within an empowerment model of health promotion – shedding its behaviourist, victim-blaming associations. To emphasize the distinction, we refer to health education that incorporates this wider vision as the ‘New Health Education’. Subsequent chapters, which address planning and strategies for health promotion in more detail, will provide the opportunity to examine its potential more fully.

KEY POINTS

- There are alternative conceptualizations of health. A working model is proposed that includes physical, mental, social and spiritual health and incorporates positive well-being as well as the absence of disease.
- Although health is influenced by human agency, structural factors have a major influence on health and health-related behaviour.
- Health promotion is a discipline with its own ideology and core values. These include equity and empowerment along with health as a right, social justice, voluntarism, autonomy, participation and partnerships.
- Ethical health promotion practice requires attention to these core principles along with the more general principles of beneficence, non-maleficence and the pursuit of the public good.
- Power is a key factor in relation to individuals’ health behaviour and health choices. Power also shapes discourse about health and health promotion.
- While different models of health promotion exist, the case is put forward for an empowerment model.
- Health promotion should generally uphold the principle of voluntarism, but the use of more coercive methods may exceptionally be justified on the grounds of utilitarianism, paternalism or social justice.
- Health promotion has a specialist role within a wider, multidisciplinary response to improving public health.
- Critical and empowering, the ‘New Health Education’ is a major driver within health promotion.

CHAPTER 1: INTERNATIONAL CASE STUDIES

The following case studies on the online resources website are relevant to the content of this chapter: 1, 3, 4, 6 and 8.

CRITICAL REFLECTION AND APPLICATION TO PRACTICE

This chapter discusses a range of concepts that are key to health promotion including ethics. What, in your opinion, are the key ethical issues in health promotion? Can you identify any specific ethical challenges in your practice? How might you address these using the principles that have been discussed in this chapter? Brown (2018) argues that health promotion can moralize people's lifestyles. Reflect on your own morals and values. Where do they come from? How might they influence your practice? Which of the ethical frameworks in this chapter have most utility in terms of your practice?

ONLINE RESOURCES

Please visit <https://study.sagepub.com/greentones5e> for all the online resources for the book, including recommended further reading on each chapter subject, useful weblinks (both introduced by the authors), as well as the abovementioned case study material.