Third Edition

Health Promotion and Public Health for Nursing Students

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SAGE | LearningMatters

Learning Matters
An imprint of SAGE Publications Ltd
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London EC1Y 1SP

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Thousand Oaks, California 91320

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Mathura Road
New Delhi 110 044

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Singapore 049483

First published in 2011
Second edition published in 2014
Third edition published in 2017

Library of Congress Control Number: 2016960202

British Library Cataloguing in Publication data

A catalogue record for this book is available from the British Library

Editor: Alex Clabburn
Development editor: Eleanor Rivers
Production controller: Chris Marke
Project management: Deer Park Productions
Marketing manager: Tamara Navaratnam
Cover design: Wendy Scott
Typeset by: C&M Digitals (P) Ltd, Chennai, India
Printed in the UK

ISBN 978-1-4739-7785-3 (pbk)
ISBN 978-1-4739-7784-6 (hbk)

Chapter 1
Thinking health promotion

NMC Standards for Pre-registration Nursing Education

This chapter will address the following competencies:

Domain 1: Professional values

2. All nurses must practise in a holistic, non-judgemental, caring and sensitive manner that avoids assumptions, supports social inclusion, recognises and respects individual choice and acknowledges diversity. Where necessary, they must challenge inequality, discrimination and exclusion from access to care.
3. All nurses must support and promote the health, well-being, rights and dignity of people, groups, communities and populations. These include people whose lives are affected by ill health, disability, ageing, death and dying. Nurses must understand how these activities influence public health.
7. All nurses must appreciate the value of evidence in practice, be able to understand and appraise research, apply relevant theory and research findings to their work, and identify areas for further investigation.

Domain 3: Nursing practice and decision-making

5. All nurses must understand public health principles, priorities and practice in order to recognise and respond to the major causes and social determinants of health, illness and health inequalities. They must use a range of information and data to assess the needs of people, groups, communities and populations and work to improve health, well-being and experiences of healthcare; secure equal access to health screening, health promotion and healthcare; and promote social inclusion.

NMC Essential Skills Clusters

This chapter will address the following ESC:

Cluster: Organisational aspects of care

9. People can trust the newly registered graduate nurse to treat them as partners and work with them to make a holistic and systematic assessment of their needs; to develop a personalised plan that is based on mutual understanding and respect for their individual situation promoting health and well-being, minimising risk of harm and promoting their safety at all times.

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By the second progression point:

3. Understands the concept of public health and the benefits of healthy lifestyles and the potential risks involved with various lifestyles or behaviours, for example substance misuse, smoking, obesity.
4. Recognises indicators of unhealthy lifestyles.

By the third progression point:

18. Discusses sensitive issues in relation to public health and provides appropriate advice and guidance to individuals, communities and populations, for example contraception, substance misuse, smoking, obesity.

Chapter aims

By the end of this chapter you will be able to:

- define health and health promotion;
- discuss the contribution of the World Health Organization (WHO) to the development and practice of health promotion;
- appreciate the contribution of health promotion strategies to the promotion of good health and well-being;
- understand and integrate theories and models of health promotion into nursing practice.

Introduction

This chapter will encourage you to think about health promotion in relation to your nursing practice. Thinking like a health-promoting nurse will enable you to integrate the principles and practice of health promotion into your nursing care. How do you think like a health promoter? To do so, you need to view patients beyond their presenting medical diagnosis or condition and be mindful that you can contribute and support patients to improve their health by adopting an **empowering** approach while delivering care related to recovery from illness.

The chapter explores the concept of health and how this informs your health promotion practice. It enables you to develop your knowledge and understanding of the health promotion concept and its contribution to improving the health and quality of life of the individual and the population at large. The chapter explores the origin of health promotion and discusses international and national health strategies and their contribution to the development of your health promotion practice. Theories and models of health are examined in order to enable you to structure your health promotion practice.

What does it mean to be healthy?

Case study: What does it mean to be healthy?

Peter, a 52-year-old school teacher, underwent pancreatectomy and chemotherapy following a diagnosis of an advanced pancreatic cancer. As a result of removing his pancreas he is on insulin injections. He says:

'I have accepted my diagnosis and now I want to live a normal life. I am confident and competent in self-injecting the prescribed insulin. Shahita, my partner, is my rock. We are able to set realistic and achievable daily goals. Since my illness we have adopted a healthy lifestyle. Our diet, including the diet of Leon (our dog), is much healthier and also we are more physically active. I take Leon for a walk in the nearby park daily. I enjoy the fresh air and meeting the regular dog walkers.

I am back to full-time work. I enjoy teaching and I get a lot of personal satisfaction knowing that I contribute to my pupils' learning and development. I value the daily structure and social interaction offered by my work. I receive encouragement and support from my colleagues. We are able to have a laugh. However, I am aware that some colleagues feel that I am too ill to be working. They all know that my expected survival time is 18 months.

I have accepted that I do not have long to live; however, 18 months is still a long time. I still have inspirations and dreams. I want the remainder of my life to be lived in full. Shahita and I decided to get married and to have a huge wedding in three months' time. We have booked our holiday to Australia where we are planning to have our honeymoon. I feel that I am doing the things I always wanted to do but somehow I never got around to doing. I have made a will: I want to put my financial and private affairs into order before the inevitable happens.

Shahita and I talk a lot about death. I am not afraid of dying but I am afraid of how I will die. Will I be in pain? I am very lucky to live next door to Helen, a retired midwife and health visitor. I have known her all my life. She actually delivered me! I have frequent conversations with Helen, updating her with my medical progress, and I am able to seek her advice. She is able to explain things to me. I find her a great emotional support. I have very open and confidential conversations with Helen. I can shed a tear in front of Helen without feeling embarrassed or less of a man.

In the evenings I feel quite tired. I tend to spend most evenings reading, for example, the Bible *or one of the many novels I have in my library. I also watch television, mainly the daily news programmes as I like to keep abreast of the day's events. Some evenings my siblings will come to visit. I enjoy reminiscing with them about the past and the good old days. Overall I have good and bad days like everybody else.'*

The case study illustrates that different people have different views of what it means to be healthy. For example, some of Peter's work colleagues view health as being free from disease. Peter, on the other hand, is in remission and views health as personal fulfilment.

Exploring the concept of health

You need to develop a comprehensive understanding of the health concept because it informs and shapes your health promotion practice. One important point to bear in mind is that an individual's health status is not static. It is constantly changing throughout the day and is evolving throughout a lifetime. Have you noticed how you feel different at different times of the day – for example, in the morning you may have felt very energetic and by midday you may feel exhausted – or how your mood fluctuates during the day?

Health encompasses the following different dimensions.

- **Physical**: this is quite obvious as it relates to the functions of your body, for example, 'I am not well because I have a headache.'
- **Emotional**: this can relate to how you cope with feelings, such as anxiety and depression, or your ability to recognise your own emotions, such as fear and joy.
- **Intellectual**: this means that you have the ability to think clearly and coherently.
- **Sexual**: this means that you have the ability and freedom to establish intimate, loving relationships as well as the choice and ability to procreate.
- **Social**: this means that you have the ability to make and maintain relationships with other people, for example, having friends.
- **Spiritual**: this means that you are able to achieve peace of mind or are able to be at peace with your own self. As a nurse you must recognise that this is not only associated with religion. People who do not have a religion can achieve spiritual health by adopting principles of behaviour that lead to spirituality.

Activity 1.1 is designed to enable you to develop a clear understanding of the above health dimensions.

Activity 1.1 *Critical thinking*

Review Peter's case study above and discuss either with your peers or with a member of your family the following questions regarding Peter's health.

- Is he physically healthy?
- Is he emotionally healthy?
- Is he intellectually healthy?
- Is he sexually healthy?
- Is he socially healthy?
- Is he spiritually healthy?

Were there any differences of opinion? Were all of you able to support your argument?

An outline answer is provided at the end of the chapter.

Activity 1.1 has demonstrated to you that health is a very difficult concept to define. When you discussed Peter's health dimensions, what personal factors influenced your own assessment?

The meaning of health can be influenced by a multitude of factors, such as family and cultural background, religion, educational level, gender, ethnicity and **social class**. Outside influences include the effects of the media, social environment and government policies. In addition, the individual's personal life experience will influence his or her views of health.

These influences apply equally to **lay** people and health professionals. For example, if you reflect back from the start of your nursing studies up to the present time, you may realise that your past and current views about health are different. This can be attributed to the influence of your professional socialisation in the clinical practice and the nursing knowledge you have gained. As a result your health views have been reshaped as you have been exposed to a new professional culture and have developed new expertise.

Lay perceptions of health

As a nurse you are working in **partnership** with patients and their families, aiming to establish an interactive therapeutic relationship that encourages patients and families to participate in their care and to take responsibility for their health. Therefore, you need to give 'voice' and 'choice' to patients (DH, 2006a). To facilitate this process you have to seek out their health views. Knowing their health views enables you to design and implement health promotion programmes relevant to patients and communities.

Lay people's perspectives of health have been researched extensively over the last 50 years. Some people may view health:

- *in terms of not being ill* – 'I am well today because I do not have a cold or a headache';
- *in the context of physical fitness* – taking regular exercise and being fit;
- *in terms of control and risk* – binge drinking is seen as a health risk while being able to drink 'normal' amounts of alcohol is seen as being in control and having the ability to manage health;
- *in terms of not having a health problem that interferes with daily life* – an elderly person may consider being healthy as being able to walk or cook or going out to visit friends;
- *in the context of social relationships* – having friends and family around for social support and interaction;
- *as psychosocial well-being* – emotional well-being is being happy and undertaking recreational activities such as going on holidays.

As you can see, lay people's concept of health is diverse, ranging from the functional and medical perspective to the psychosocial perspective. The different views are associated with social class issues, for example working-class people may see health from the functional perspective while the higher **socio-economic status** groups may see health from the psychosocial perspective. Age and gender are contributing factors; young men may view health from the physical activity perspective, while women may emphasise the social perspective of having friends and family

around them. You need to address these influences when you plan your health promotion practice (Chapters 4 and 7), aiming to deliver a personalised health promotion practice that empowers patients to improve their health status.

How do health professionals view the concept of health? Are there any differences between lay and professional views?

Professional perceptions of health

Health professionals view the concept in relation to the following health models. Understanding the different models of health will enable you to understand how the different health professionals with whom you work interpret health and working in partnership (see Chapter 7), to help you to develop a health promotion practice with common goals and objectives to improve patients' health.

Medical model

Under the medical model of health your practice has a disease orientation instead of a positive health orientation. You view patients only in terms of their presenting illnesses, therefore you focus on the physical dimension of health without taking into consideration the other dimensions previously discussed in this chapter. This means that you view each patient as a body (which includes brain function) in terms of possible defective parts and your aim is to repair the parts. It means that you manage the medical diagnosis of patients. Your health promotion will focus on teaching/coaching patients, on giving them information regarding their treatment and ensuring that they will understand the pathophysiology of the medical condition or disease concerned. You will be involved, for example, in teaching and demonstrating to patients such things as how to use their inhalers to improve their breathing without considering other factors that may influence recovery, such as personal circumstances and health inequalities.

The medical model of health can be criticised for having an authoritarian approach to patient care. The patient is seen as a passive participant. All decisions are made by the professionals 'who know best'. It encourages patients' dependency on doctors and nurses. However, you need to recognise the valuable and significant contribution of biomedical factors to health improvement in the arena of public health.

In summary, from the health promotion and public health perspective (Chapter 6), the main focus in the medical model is on treatment and cure. It provides the basis for encouraging patients' **concordance** with current treatment and also enables you to use this as a building-block when you are considering self-management strategies (Chapter 5).

Holistic model

A well-documented and widely used definition of health by many health professionals is that of the World Health Organization (WHO, 1948): *Health is a state of complete physical, mental and social wellbeing and not merely the absence of disease.* The combination of physical, social and mental well-being is known as the 'health triangle'.

The model expands on the medical model of health by embracing the concept of well-being. However, the definition implies a utopian view of achievement of health. It is therefore, arguably, idealistic in that it is impossible to attain a 'complete state' of health. One may also argue that it excludes people such as Peter (who has a terminal illness), or people with chronic diseases (for example, schizophrenia, Parkinson's) or a disability (for example, visual impairment or learning disabilities), or people who, due to circumstances beyond their control, such as poverty, are unable to achieve optimum health.

In health promotion terms the **holistic** approach emphasises the need to integrate health education and prevention activities that constitute evidence-based practice. Your practice has to be informed not only by the medical aspects of health but also by local and national health strategies. The model encourages a reorientation of NHS provision from the acute health **sector** to primary care (community health sector).

Wellness model

The WHO, moving with social trends and political ideologies, furthered the concept of health by developing a wellness model, which is built on the principles of the holistic model.

The Ottawa Charter for health promotion considered health to be not just a 'state', but a *resource for everyday life, not the objective of living. It is a positive concept emphasising social and personal resources, as well as physical capabilities* (WHO, 1986). This definition is relevant to current health promotion practice, which strives to improve quality of life of all people regardless of their health status. It includes healthy people, people with disabilities, people with mental health issues, people with learning disabilities and people with long-term conditions. It highlights the need for the individual to be resilient by adapting to life changes such as illnesses and changes in socio-economic circumstances.

The model encourages health professionals to promote **anti-discriminatory** practice. For example, you as a health promoter, through the application of an empowering approach to your practice (Chapter 5), will support people with physical impairment, such as wheelchair users, to manage their condition effectively and lead independent lives. You will act as an enabler to facilitate them to adapt positively to life's changes and to strive for personal growth and fulfilment by developing problem-solving skills and increasing their **self-esteem**. The model encourages patients' active participation in the decision-making process by encouraging them to value their own expertise and experience.

Thinking about the complexities of health through the different perspectives of the three models discussed above could be confusing. We suggest that you consider the WHO (1948) definition of health in combination with its 1986 definition as a resource.

In this way nurses can act in partnership with other healthcare professionals, patients and their families, to devise an eclectic model of health incorporating the three components of body (physical), mind (mental) and community (social) aspects of health, as well as the ability of people to gain control of their own health (adapting and growing). To assist you we will be looking in future chapters at:

- enabling patients to change their health behaviours (Chapter 2);
- empowering them to understand their illnesses (Chapter 4);
- supporting them to 'self-manage' their illnesses (Chapter 5).

However, before you develop your nursing practice to integrate health promotion principles, you need to have a deeper understanding of the health promotion concept.

Defining health promotion

Health promotion is about improving the health status of individuals and the population as a whole. Key to the term 'health promotion' is the word 'promotion'. This means placing the notion of the absence of disease and well-being at the forefront of your nursing practice. This shift in emphasis will help you think about improving, advancing, encouraging and supporting your patients to achieve optimum health. These activities are all part of a health-promoting perspective.

Today health promotion is an important focus of UK public policy in all sectors, with an emphasis on the social and environmental aspects as much as the physical and mental-health perspectives. Therefore, nurses have to view health promotion from both a holistic and a wellness model of health. It is helpful to understand the major socio-economic determinants of health. Very often these are outside the control of the individual, but they can have an enormous effect on the individual's health; for example, employment redundancy may lead to poverty and may affect the individual's physical and mental health by, for example, increasing the chances of developing coronary heart disease or depression.

The fundamental aim of health promotion is to empower an individual or a community to take control of aspects of their lives that have a detrimental effect on their health. The WHO (1986) defines health promotion as *a process of enabling people to increase control over, and to improve, their health.* This definition implies that you need to act as an enabler by strengthening knowledge, attitudes, skills and capabilities of your patients to overcome negative health. Additionally, governments are urged by the WHO to formulate health strategies to facilitate this enabling process.

Activity 1.2 aims to encourage you to explore the scope of health promotion by considering a selection of possible health-promoting activities.

Activity 1.2 *Critical thinking*

Which of the following activities do you consider to be health-promoting by enabling or empowering?

- A TV advertisement around the Christmas period that encourages the public 'not to drink and drive'.
- A radio message on your local radio encouraging young people to ring a helpline if they feel that they are victims of abuse.
- Practice nurses delivering a smoking cessation programme.

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- Nurses teaching carers how to feed their loved one at home via a PEG (percutaneous endoscopic gastrostomy) feeding tube.
- Legislation on the compulsory use of car seat belts.
- The Alcohol Health Alliance, representing all major medical and nursing organisations, **lobbying** the government to increase the minimum price for alcoholic drinks.
- Local authorities organising park walks for young mothers.
- Health agencies such as Age UK giving information during winter on how to keep warm.
- Environmental health officers inspecting restaurants and cafés to monitor hygiene standards.
- Restaurants providing food information on their menus such as the fat content of their lamb moussaka.
- Practice nurses immunising older people against the flu virus.
- Nurses washing their hands.
- Student nurses receiving training on moving and handling.
- Supporting people with learning disabilities to use public transport.

An outline answer is provided at the end of the chapter.

Health promotion encompasses a very broad range of activities that aim to facilitate people to achieve a full and healthy life, which is based on the broader view of health. Nowadays, the emphasis is on acting on the socio-environmental, as well as physical, influences of health. Thus, there is a need for a variety of professionals (i.e., not only healthcare professionals), organisations and government departments to work together to promote health in all sorts of ways, as indicated in Activity 1.2 and as you will see in the next section. This modern view of the potential for improving health began in the 1980s with an international shift in emphasis to give this broader range.

The origin of health promotion

Health promotion gained momentum in the global **health agenda** in the later part of the twentieth century. This took place against a backdrop of discontent and frustration in international political and public opinion with the status quo of the medically dominated healthcare systems. Those systems were failing to combat ill health and to meet the health needs of the populations they were serving, despite a constant increase in financial investment.

Health promotion emerged as a process to shift healthcare provision away from a hospital setting centred on the medicalisation of health towards a community setting informed by the principles of public health (Chapter 6). This transition was facilitated as the holistic and wellness models of health started to gain momentum and the dominant medical model started to be eroded.

The WHO has been instrumental in the development of health promotion. Its commitment to using health promotion to improve global health is seen in a number of international charters and declarations. The most significant are the Ottawa Charter, the Adelaide Conference and the Bangkok Charter.

Concept summary: The Ottawa Charter

This charter (WHO, 1986) created the following principles for health promotion action, which are still relevant today.

Build healthy public policy
Health promotion goes beyond healthcare. **Policy** makers across all government sectors must consider health consequences and accept responsibility for health. This means that, when considering transport, housing or employment policies at local or national level, they should be asking about their health implications. In addition, central governments should make policy decisions that improve health such as, for example, the smoking ban and wearing car seat belts.

The key issue in achieving a successful health promotion policy is joint action between the different sectors at a national level and interprofessional working at a local level. All of the diverse parties involved in policy making have to ensure that these policies enable all people to make healthier choices.

Create supportive environments
The environment we live in affects our health; for example, changing patterns of life, work and leisure and our natural environment have a significant impact on our health. Therefore, health promotion has to influence the generation of living and working conditions that are safe, stimulating, satisfying and enjoyable (Chapter 7).

Strengthen community action
Health promotion works through concrete and effective community action in setting priorities, making decisions, and planning and implementing them to achieve better health. At the heart of this process is community empowerment (Chapter 7).

Develop personal skills
Health promotion supports personal and social development through the provision of information, education or health-enhancing **life skills**. It has to enable people to learn, throughout life, to prepare themselves for all their health-related problems and to cope with long-term conditions and injuries (Chapters 4 and 5).

Reorient health services
The role of the health sector must move beyond its traditional responsibility for providing curative and clinical health. In the UK the NHS should focus more on the prevention of illness and the promotion of positive wellness.

Reorientation also involves changes being made to professional education in order to meet the health needs of the population. This can be seen in the current changes taking place in nurse education, which has moved to a graduate level – a change that aims to prepare nurses to be appropriately qualified and equipped to meet and serve the health needs of people in the twenty-first century.

The Ottawa Charter remains one of the most influential charters within the field of health promotion and public health. It is based on a **strategy** of enabling people to control health, advocating that health must be prioritised in all sectors and mediating between possible partners to improve health.

Following on from Ottawa, the Adelaide Conference (WHO, 1988) brought health promotion practice to new levels with health being viewed as a 'human right'. Health was no longer to be seen as a mere commodity. The conference introduced the concept of **equity**, highlighting that all people and patients have to be treated the same.

Later, the Bangkok Charter (WHO, 2005) urged all global governments to integrate effective health promotion interventions into their domestic and foreign policies. They are asked to implement interventions that have been proven to contribute to positive health and well-being into everything they do, whether it is town planning, road expansion or financial cutbacks. Policies, not only in times of peace but also in times of war and conflict, need to be 'healthy', so, for example, nurses who are working in the armed forces in war zones such as Iraq, Afghanistan and Syria have to use a repertoire of evidence-based health interventions to promote a sense of well-being in the soldiers.

The WHO, in addition to international charters and declarations, has placed health promotion at the heart of its current global health agenda by its *Health-for-All Policy for the Twenty-first Century* (World Health Assembly, 1998), by continuing the previous vision of the *Health for All by the Year 2000* strategy (WHO, 1981).

Concept summary: *WHO Health-for-All Policy for the Twenty-first Century*

The *Health for All* (HFA) policy calls for social justice, which means that each person should be treated fairly and equitably. It lists ten global health targets set out in three domains, reflecting the most prevalent health problems in the world.

Improving health outcomes

- Health equity: this will be assessed by measuring a child's growth, i.e. height and weight levels for age (children under five years).
- Survival: to improve maternal mortality rates, child mortality rates (under five years) and life expectancy.
- Reverse global trends of five major pandemics (TB, malaria, HIV/AIDS, tobacco-related diseases and violence/trauma) by implementing disease control programmes.
- Eradicate and eliminate certain diseases (measles, leprosy and vitamin A and iodine deficiencies).

Determinants of health

- Improve access to water, sanitation, food and shelter.
- Measures to enhance healthy lifestyles and weaken damaging ones.

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Health policies

- Develop, implement and monitor national HFA policies.
- Improve access to comprehensive, essential quality healthcare.
- Implement global and national health information and surveillance systems.
- Support research for health.

Each region of the WHO (Africa, Americas, Southeast Asia, Europe, Eastern Mediterranean and Western Pacific) and subsequently individual countries have modified and incorporated this strategy into their own plans to meet the health needs of the populations they serve. The WHO (1998) developed a strategy for Europe known as Health 21. The following case study outlines the different global health challenges.

Case study: Different global health challenges

Mrs Shah, a registered nurse, has returned to England after spending two years working as a volunteer nurse in one of Africa's underdeveloped countries. She gives a seminar to her work colleagues, aiming to share her working experience in Africa.

Her account supports the need for a global health strategy and highlights the importance of gaining the political commitment of international organisations, as well as national governments, to implement the WHO's strategy. In summary, Nurse Shah highlighted the following issues:

'Every day, people of all ages in sub-Saharan Africa die unnecessarily. The main cause is infectious diseases such as malaria, tuberculosis, HIV/AIDS and diarrhoea. One of the biggest challenges healthcare providers face is the delivery of adequate healthcare for people living with chronic lifestyle conditions. People in rural areas have to walk many miles to access care. Many die in transit.

Another frustrating thing for me was the fact that healthcare professionals work in isolation, particularly those working in rural settings, and they could not keep abreast of the latest information on epidemics. This also precludes them from sharing their information with the global health community. Nurses in the region are increasingly faced with the burden of providing healthcare to rural populations, much more than the doctors. Enhancing health professionals', especially nurses', access to relevant accurate and up-to-date clinical information is vital to improving healthcare.'

Recognising aspects of the international view of health promotion will help you to understand the global background and how this influences the UK's health agenda. As a member state of WHO (European Region) and the European Union (at the time of writing) the UK is instrumental in helping to formulate international strategies and in making decisions as to how to implement those strategies at a regional level within the European Union countries and also at a national (UK) level.

UK national strategic policies for public health and health promotion

In the UK the concept of health promotion can be traced as far back as the nineteenth century, forming part of the public health movement for sanitary reforms to improve the ill health of people living in overcrowded industrial towns. Florence Nightingale embraced the principles of public health to inform nursing practice (Nightingale, 1859).

The first ever public health strategy published in the UK was *The Health of the Nation* (DH, 1992) by the then Conservative government. It has to be commended for responding to the call for 'health for all by the year 2000' by the World Health Organization (WHO, 1981). It provides an example of an effort being made at a policy level to improve health by encompassing both prevention and health promotion. However, it could be criticised for adopting a medical approach (that is, by aiming to prevent premature death due to ill health) to the detriment of addressing the broader economic and social factors that influence health.

This was superseded by the strategies of the new Labour government in *Saving Lives: Our Healthier Nation* (DH, 1999) and, later, *Choosing Health: Making Healthier Choices Easier Choices* (DH, 2004b). The former set targets to be achieved by 2010, continuing the theme set by its predecessor to tackle ill health. It also took into consideration health inequalities (Acheson, 1998) by addressing **social exclusion**. The strategy embraced a social model of health by promoting collaboration between health and local authorities. The latter strategy goes further by recognising the social, environmental, economic and cultural impacts on health. However, there was an absence of national policies (social and economic) to tackle the fundamental causes of inequality. The focus was on lifestyle issues aiming to change individual behaviour, thus introducing the notion of **victim blaming**. Scotland, Wales and Northern Ireland had their own similar strategies.

All these health strategies use health promotion to facilitate the achievement of **health improvement** and to encourage people to 'make healthy choices easier choices', political jargon originated by the WHO and used to achieve **health gain**. The policies aim to improve the health of the individual and the population by addressing the wider issues that affect health, such as health inequalities and environmental issues.

The UK coalition government (2010 – 2015) produced its own strategy, *Healthy Lives, Healthy People: Our Strategy for Public Health in England* (DH, 2010b), which is still relevant at the time of writing (2016). It focuses on behaviour-change strategies that encourage individuals to engage in healthy behaviour and to take more control and responsibility for their own health, thereby moving away from the notion of the 'nanny state', whereby people expect the state to take care of their own health (Chapters 2 and 6). Scotland, Wales and Northern Ireland constructed their own strategies based on that of England.

As the various successive governments endeavour to improve people's health and to promote positive health, healthcare professionals have witnessed the establishment of the following.

- **NHS Direct:** launched in 1998 as a nurse-led telephone helpline and internet service providing information and advice on health to the public. The coalition government phased out NHS Direct. In April 2013 the NHS 111 free-of-charge service was launched. It operates 365 days a year, aiming to improve access to the NHS when patients are in need of medical help or advice, but in circumstances where the need is not urgent enough to justify making a 999 call. It is staffed by fully trained advisers supported by nurses and paramedics. It is driven by the ideology to manage patients in a more cost-effective and integrated way. Its launch has already been controversial. Healthcare professionals and patients have criticised the system as being a 'cut-price' replacement of NHS Direct nurses, with telephone advisers lacking professional training in healthcare, thereby leading to delays in treatment and putting patients' lives at risk. Since its launch the non-emergency 111 hotline has attracted a plethora of adverse publicity regarding its performance. Examples of such criticisms are:
    - Callers have complained about delays in their call been answered;
    - Callers have been asked inappropriate questions such as 'are you conscious?'. This is due to the fact that call handlers have to follow and adhere to an automated computerised questionnaire system leaving callers feeling vulnerable, patronised and very frustrated. The automate computer system questionnaire has also contributed to clogging up the accident and emergency departments by sending patients to those departments unnecessarily.

However the 111 service does provide a valuable service to the public, as it provides a single point of contact whereby patients or their carers can get urgent help and advice regarding their health problem as presented at the time of the call.

- **NICE (National Institute for Health and Care Excellence)**: responsible for providing national guidance on promoting good health, and preventing and treating ill health.
- **Public health observatories**: established in 2000 in each NHS region. Their role is to ensure that health and social care systems are equipped with health intelligence to improve health and reduce inequalities, to promote research and to set up disease registers.
- **Health Protection Agency (HPA)**: set up in 2003 to protect the public from infectious diseases and environmental hazards. The HPA is one of a number of quangos (quasi-autonomous non-governmental organisations) that were abolished on 1 April 2013. This protection function was transferred to central NHS control.
- **Patient Advice and Liaison Services (PALS)**: designed to bring citizens more closely into decision-making processes.
- **Expert Patients Programme (EPP)**: to help people manage their own illnesses (see Chapter 5, pages 101-3).
- **NHS walk-in centres**: launched in 1999, aiming to provide the general public with more convenient access to NHS services matching modern living patterns, and managed by local community health organisations to deal with minor illnesses and injuries. They are predominantly nurse-led. As from April 2013 such centres have been financed by the area's Clinical Commissioning Groups.

- **Polyclinics** (more recently called multi-centres): established on the recommendations of Lord Darzi (a parliamentary undersecretary in the House of Lords), they are a network of GPs in multi-purpose health centres, which provide some hospital services such as X-rays, minor surgery and outpatients' treatment.

As well as these strategic innovations, we have seen a focus on addressing **inequalities in health**, which has been informed by WHO's work (see Chapter 6 for a fuller explanation).

We now go on to look at health promotion theories and models to guide your work. We previously looked at theories of health; however, theory is also important in 'thinking health promotion', as without it we may act randomly and without the evidence to support practice. Theoretical structures are based on ideas from philosophical or organisational constructs and, more recently, are deduced from practice itself. You will find health promotion theories used throughout this book; here we give an overview of the most important ones. A model, as compared with a theory, is a framework that derives from theory and attempts to represent reality, rather like a model of a building representing the building's parts and functions. Models provide a systematic, well-researched approach to health promotion practice.

Theories informing health promotion

As with nursing, there are a number of theories that underpin the practice of health promotion. These are informed by a multitude of academic disciplines such as **epidemiology** and **demography**, ethics and law, health psychology and politics.

Epidemiology and demography

These disciplines provide information about a population's health status. The information focuses on the severity, range, frequency and duration of diseases, and the associated social disability and mortality. They also inform you about the relationship between ill-health and socio-demographic variables such as age, culture, economic status, educational attainment, employment status and ethnicity, including the geographical variable (north–south divide). They enable you to identify priorities, set targets (Chapters 4 and 7), plan and implement health promotion interventions suitable for a target group based on an assessment of its health needs and, finally, to evaluate their efficacy. For example, if the locality where you are working has a large older population with a high incidence of falls at home, you need to deliver health promotion programmes that enable them to avoid falls at home. Another example is organising child immunisation programmes if the locality has many families with young children.

Within the field of mental health, epidemiology and demography will enable you to ascertain the complexities of mental health and to deliver appropriate services to improve the health and social function of individuals suffering with mental illness. This can be achieved by providing local services for early detection, care, treatment and rehabilitation. Engagement in community health education programmes, in order to tackle the social stigma, myths and misconceptions surrounding mental health, is setting the ground for resettling people with mental illness back into the community, thereby safeguarding their human rights and dignity.

Modern epidemiology is shifting from a population level (traditional epidemiology), which was informed by a public health model taking into consideration the cultural and historical perspective of diseases, to an individual level informed by a model of science (tissues, cells, and anatomy and physiology). This has implications for health promotion policy as the focus will be on targeting solely the **pathophysiology** of disease to the exclusion of addressing and tackling the social determinants and their impact on health. Prevention will focus on behaviour change with the inherent notion of victim blaming.

In summary, epidemiology and demography together provide you with a scientific basis to determine the distribution and determinants of health and disease of the population you serve, and to determine the scope for health promotion practice.

Ethics and law

Ethics and law are concerned with making a series of value judgements about what health means to the individual or to the community and about whether, when and how to intervene. A central ethical question for you is what is acceptable or unacceptable. Ethics and law enable you to consider principles such autonomy, respect for the individual, freedom to make decisions without coercion, voluntary participation, confidentiality, informed consent, social justice, equity and the mental capacity of patients. These principles inform you how to develop a non-discriminatory and **non-judgemental** practice. You need to ensure that the patient is changing behaviour on a voluntary basis and by exercising free will. For example, if a smoker decides to continue smoking, after receiving health education on the risks of smoking and the accessibility and availability of smoking cessation programmes, you have to accept that he or she is exercising free will and choice without blaming him or her for failure to conform, known as victim blaming.

Your practice can be informed by the principles of *beneficence* and *non-maleficence*. These mean that your health promotion interventions promote good and also prevent, remove and avoid harm to your patients. These principles place the common (majority) good before individual considerations. An example is fluoridisation of drinking water supplies to promote dental health. This is beneficial to the majority even though it may not further benefit a minority.

You will be engaging in a diversity of health promotion practices across the different fields of nursing (Adult, Mental Health, Child and Learning Disabilities). Each field imposes a variety of ethical dilemmas. You will need to address these by using a collaborative approach (involving patients, families, doctors and other health professionals) and critically appraising your health promotion interventions using available evidence to consider the following questions.

- Does this health promotion practice impinge on the freedom or autonomy of the patients, for example implementation of a 'non-smoking policy' in a long-stay mental health unit?
- Is this health promotion intervention a source of collective good or benefit for patients, for example the provision of immunisation services for young children, bearing in mind the well-publicised controversy over MMR (measles, mumps and rubella) immunisation and its current health implications, or the screening for Down's syndrome during pregnancy?

- Does this health promotion practice encourage victim blaming and stigmatisation, for example health education focusing on lifestyle?
- Are the benefits of this health promotion provision equally distributed among all the people living in the area, for example access to health services for screening by people with learning disabilities, available resources in different languages, and policy setting that acknowledges different rules of faith?
- Does this health promotion practice safeguard confidentiality, dignity and mental capacity, for example in the cases of contraception and teenagers, or contraception and people with learning disabilities?

In summary, ethics and law inform your health promotion practice by ensuring that people should be free to achieve well-being. They must have real opportunities to live and act in accordance with their values and capabilities, and their participation must be voluntary.

Health psychology

Health psychology is a subdivision of psychology that seeks to explain how people behave in relation to their health. In promoting health we are interested in how people change to healthy behaviours. There are many individual theories to explain this, briefly explained below.

Theories of reasoned action and planned behaviour

These theories (Ajzen and Fishbein, 1980) increase understanding of the factors that influence people's intention to behave in a certain way, which in turn enables you to develop interventions that meet individuals' needs, for example the use of **peer education**. These theories do not explain the impact that emotions and religious beliefs have on behaviour, for example religious beliefs may contribute to stigmatisation of certain diseases such as HIV/AIDS.

The health belief model

This model (Becker, 1974) demonstrates that behaviour change is dependent upon the individual's belief about his or her susceptibility to a disease, severity of the illness, and the cost and benefit analysis involved in any change of behaviour. Becker's health belief model enables you to understand and predict why individuals will or will not participate in different prevention activities such as health screening programmes. Therefore, the model is useful in planning preventative services. However, it has very limited value in planning health promotion interventions to tackle addictive behaviours such as drug addiction because there is a lack of information on how to modify complex health beliefs associated with long-term and socially determined behaviours.

The health locus of control theory

This theory (Rotter, 1966) explains the extent to which people feel that they have control over events and how their personalities are shaped as a result of these beliefs. The theory suggests that people who feel in control of their lives (**internal locus of control**) are more likely to change their behaviour than people who feel powerless (**external locus of control**). This theory contributes

to our understanding of people's engagement in the process of behaviour change. However, it lacks reliability as it is very difficult to predict behaviour on the grounds of attitude alone without taking into account the interaction between people and their environment.

The social cognitive theory

This theory (Bandura, 1977) provides a framework for understanding, predicting and changing behaviour. Bandura explored the concept of **self-efficacy**, or the belief an individual has in her or his ability to change or overcome difficulties. He claimed that human behaviour change is governed by the following principles:

- **self-efficacy**: an individual's confidence to carry out a certain behaviour;
- **expectancy**: the belief that a certain action will result in the desired outcome;
- **incentives**: where behaviour is guided by the value the individual places on the perceived outcome.

This will vary with different situations; for example, a smoker may be confident that he or she can resist smoking when other people smoke at work, but may be less confident that he or she can do this when in the pub socialising with smoker friends. This theory provides a powerful link between the individual, the environment and behaviour. However, the challenge is around the development of self-efficacy skills.

Overall, health psychology theories provide you with a sound understanding of human behaviour based on attitudes, beliefs, values, power and control, which can be used to help people change from risky behaviour and to adopt healthy behaviour by making healthier choices. However, reliance solely on behaviour change is restrictive and has been criticised as 'victim blaming' for placing the onus of change solely on the individual.

All these theories from other disciplines inform health promotion theory construction, just as theories from psychology, sociology, ethics and medicine all inform nursing theory. The next section looks at two models developed for planning health promotion initiatives: the first is a strategic planning model for community health promotion and the second is a model for encouraging behaviour change in individuals and groups.

Health promotion models

There is a variety of models that are informed by different theoretical perspectives such as health psychology; most acknowledge the need to improve health through education, prevention of illness, and promotion of positive wellness. Some models emphasise one aspect or another, but most can be adapted to incorporate thinking about the broader aspects of health improvement and address the Ottawa Charter principles and inequalities in health (Marmot, 2010).

Tannahill's (1985) model gives an overview of the three main organisational aspects of health promotion (see Chapter 2 for further explanation). It presupposes that health education has

existed for many years, in schools for children and, for adults, mainly through health professionals and the media. It acknowledges the historical and current importance of preventive services in public health, such as immunisation and screening. In addition, following the WHO imperative to generate healthy policies, the model incorporates policy making as its third part. Overall, this model can be seen as a very useful planning, implementing and evaluating device for health promotion practice – educating about smoking, screening for smoking-related diseases and setting no-smoking policies. You can use this model as a thinking tool to imagine the whole of what you can set up as you plan health promotion for one patient, for groups of patients or for communities. According to Tannahill:

- *Health education* aims to facilitate positive health by increasing peoples' knowledge and therefore changing their beliefs, attitudes, values and behaviour leading to a positive health outcome.
- *Health protection* aims to promote positive health and the enhancement of well-being by the introduction of fiscal controls and the implementation of legislative action. For example, increased taxation on cigarettes facilitates the cessation of smoking; the introduction of the national living wage (HM Government, 2016a) reduces inequalities. Other examples include the 2012 Health and Social Care Act (DH, 2012a) that introduced a radical reorganisation of the health services in order to meet the needs of the population in the twenty-first century. Another legislative example is food labelling by introducing the inclusion of physical activity alongside calorie content on food packaging to combat obesity (NHS Choices, 2016).
- *Disease prevention* aims to reduce risks of ill health and to minimise the consequences of diseases. Traditionally, it can be categorised into three different levels. This is useful for thinking of the scope of preventive services and strategies.
    - *Primary prevention* targets healthy people and aims to empower them to continue their healthy status, for example by the uptake of flu vaccination. As a nurse you will be involved in activities that aim to reduce/minimise the incidences of illness in your serving population.
    - *Secondary prevention* targets people who are at risk of developing ill health, aiming to persuade them to seek screening such as, for example, cervical screening. Your aim is early detection. As a nurse operating in a clinical environment you are already involved in early detection by, for example, carrying out clinical activities such as urinalysis to detect diabetes.
    - *Tertiary prevention* targets unhealthy people, aiming to empower them through self-management of their illnesses by, for example, complying with medication. During the course of your nursing studies you will have participated in rehabilitation programmes designed to help patients regain their independence and return to normal life, for example after suffering a cardio-vascular accident.

The above classification of prevention enables you to address a variety of health issues, ranging from physical health problems and mental health to disability, across the different

stages of people's life span and to design appropriate health promotion interventions. There is an enormous potential for nurses to play a more proactive role in the prevention of ill health by engaging in evidence-based activities as opposed to simply providing information and advice. Examples of good practice can be seen in smoking cessation programmes whereby personal counselling, pharmaceutical interventions and interprofessional working contribute to a successful outcome. Tannahill (2009) revised his original model to encompass a more holistic approach to health and to minimise the medicalisation of health by incorporating the following health-influencing aspects into the model's original three areas of activities:

- *Environmental, socio-economic and cultural factors* (see Chapter 7): environmental factors include the whole spectrum of structures that contribute to health, for example people's occupations, provision of recreational activities, health services and religion, all of which play a vital role in people's health and health behaviour;
- *Education and learning*: this is an important aspect as it enables you to acknowledge that people are individuals and have very personal educational needs as well as styles of learning when planning and devising your teaching programme (see Chapter 4);
- *Equity and diversity*: both these aspects are an integral part of your everyday nursing practice. As a nurse working in a multicultural and diverse society you are involved in promoting equal opportunities and fairness of care and treatment to all patients by respecting their diversity and responding to their health needs;
- *Community-led and community-based health promotion activity*: these aim to enable communities to take control of decisions relating to health issues as they are identified and determined by the population and not by the professionals.

Tannahill's revised model advocates health promotion interventions that promote empowerment by involving people in the decision-making process and in the development of life skills.

In summary, Tannahill's model provides a structured approach for organising, delivering and evaluating health promotion. Nurses can draw on practical experience to distil the model as health education, prevention and health policy form an integral part of nursing practice. It does not, however, inform you about what motivates individuals to change behaviour or how to sustain this change. It could be argued that it has a paternalistic approach to health promotion practice. The revised model considers the wider influences of health and it enables health promotors to use an empowering approach to their health promotion practice.

Prochaska and DiClemente's (1982) model is one that incorporates many aspects of health psychology (see Chapter 2 for further explanation). This model was developed to explain how individuals move towards adopting behaviour that will maintain good health. It uses stages of change as its core construct and integrates processes and principles of change derived from different theories, hence it is called 'transtheoretical'. The model presumes the individual will go through stages of changing health behaviour that are cyclical and shows that, having completed one change, the person may well go on to feel that she or he can make another.

Its main focus is on the individual's readiness to change or attempt to change towards a healthy behaviour. The key concepts of this model are: pre-contemplation, contemplation, decision and determination, action and maintenance.

- At first the individual does not think of making a change – 'I'm OK as I am' – perhaps influenced by health belief and attribution theory.
- Then something may happen to make her or him consider a change – 'Maybe I should do something about it.' The influence here could be what others say (social cognitive theory).
- Having made a tentative decision, the individual then wonders how to make the change – 'I'll look into it.' The internal locus of control is becoming stronger.
- The individual engages in a new behaviour, trying it out.
- Sustaining the change over time takes inner strength. Social support and self-efficacy help with this stage.
- At any time in the cycle, the individual may revert to unhealthy behaviour, known as a 'relapse stage'. It is important to acknowledge the individual's effort and achievements so far and instil in her or him a sense of self-worth for accomplished achievement during the process of change.

Many practitioners within the field of health promotion have supported the Prochaska and DiClemente (1982) model as it allows the practitioner to tailor interventions according to individuals' specific needs. However, you need to be aware that implementation of these interventions may be time-consuming, expensive and complicated. Therefore, the model's use may not be suitable in a very busy acute clinical setting, where patients stay for a short period of time and require rapid treatment, unless the aim of the encounter is refocused on just moving the patient from one stage to another. It will be appropriate for use in clinical areas such as mental health or in a community setting where rapid behaviour change is not necessary.

In summary, this model is useful from a programme planning perspective, as it enables you to plan health promotion activities that will influence behaviour change according to patients' stage of change and motivation to change. Examples will be the use of written material, use of media, organisation of health and/or social support events, providing personal counselling and follow-up consultations, aiming to raise awareness of a behaviour's risk and benefits, and providing support to facilitate change. Health psychology and health promotion models may explain some aspects of behaviour, but do not expect them to solve the problem! You have to be discerning with regard to your choice of model by being eclectic and flexible in your mode of approach, by being able to move from a bottom-up to a top-down approach according to the situation and problem.

There are other models and theories of health promotion and public health to be found in the literature. We have chosen to focus on these two examples, but encourage you to read around the subject and to think about which model or theory is being used when you read about health promotion initiatives (see Further reading at the end of this chapter).

Activity 1.3 *Reflection*

You are working as a registered nurse in a community-based health centre located in a diverse social and cultural setting. You have been designated as the lead nurse to design a health promotion programme for overweight young adults. Obesity has been identified by the annual local health report as a major health problem. You believe that a community-based health promotion programme that involves the locality's young adults in the planning of the programme will be more beneficial. You are of the opinion that their involvement will promote ownership and engagement. The programme will be funded by the local clinical commissioning group in partnership with the local authority.

Reflecting on this chapter's content, what theories/models will inform the programme's health promotion interventions?

An outline answer is provided at the end of the chapter

Chapter summary

This chapter has enabled you to develop an understanding of the health promotion concept, its origin and development in the UK up to the present day. It has explained how the perceived concept of health by patients and health professionals can influence health outcomes. The WHO views health promotion as instrumental in achieving global health and has identified nurses as key players who, working in partnership with others, can have a positive impact on health improvement. The WHO states that nurses can achieve this by acting as patients' advocates, mediators and enablers.

The promotion of positive health is the mutual responsibility of the individual, who has to take responsibility for his or her own health by adopting healthy behaviour, and of the state, which also has responsibility through the development and implementation of national and local health policies to address the wider determinants of health in order to improve the health status of the nation.

The chapter has examined different health promotion theories and models that enable you, as a nurse, to plan and implement health promotion within your nursing practice in order to empower patients to achieve optimum health.

Activities: brief outline answers

Activity 1.1: Critical thinking (page 8)

- **Physical**: No, Peter is not physically healthy as he has cancer and diabetes. However, according to Peter, he is physically healthy as he feels well and he is in remission. He is able to walk and go to work.
- **Emotional**: Yes, he has the ability to recognise his emotions, i.e. fear of death.

- **Intellectual**: Yes, he is healthy as he has the capacity to think clearly and coherently. He can make decisions about his personal affairs and he can do his work.
- **Sexual**: Yes, he has an intimate and loving relationship with his partner.
- **Social**: Yes, he is healthy as he has a strong friendship circle.
- **Spiritual**: Yes, he reads the *Bible*, he has a religious faith and considers himself spiritually healthy, a view shared by his family and colleagues.

Overall, then, although his health professionals and his work colleagues may say he is not, Peter considers himself to be healthy.

Activity 1.2: Critical thinking (page 12)

All of them are health promotion activities. Consider the range of people involved and types of activity – education, prevention measures and policies. All will educate for health, prevent disease or protect the public.

Activity 1.3: Reflection (page 26)

The following theories and models may inform the programme's interventions:

- use epidemiology and demography to assess obesity as a health problem;
- assess the concepts of health of the client group;
- consider the social and cultural/educational background of your client group;
- what are the environmental issues/factors?
- examine local and national health policies;
- consider the infrastructure of health service provision;
- include interventions that address the needs of the young people;
- focus on equity;
- use Tannahill's model as a framework for planning, implementing and evaluating interventions;
- use Prochaska and DiClemente to ascertain the clients' stage of commitment and to assess progress.

Further reading

Naidoo, J and Wills, J (2010) *Developing Practice for Public Health and Health Promotion* (3rd edn). Oxford: Elsevier.

This is a good overview of health promotion, which also explains a range of health promotion models.

Ogden, J (2012) *Health Psychology: A Textbook* (5th edn). Milton Keynes: Open University Press.

This is a good review of health psychology theory and research.

Useful websites

www.who.int/publications/en/

This is a good website for keeping abreast of global health promotion developments.

https://www.gov.uk/government/latest?departments%5B%5D=department-of-health

Here you can get updates regarding the latest developments on a variety of health-related issues.