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CHAPTER 1

Contextualizing Health Promotion

Fiona Irvine

Objectives

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

- Discuss the main dimensions of health
- Explore the similarities and differences between health education, health promotion and public health
- Examine the main attributes of health education, health promotion and public health
- Justify the use of health education and health promotion approaches in nursing

Key terms

- Empowerment
- Health education
- Health promotion
- Public health
- Socio-political change

Introduction

‘Health promotion’ is now a well-established term, the strength of which lies in the fact that it is multidisciplinary – cutting across professional disciplines and drawing inspiration from a wide theoretical base. However, the eclectic nature of health promotion can often result in a lack of clarity about the meaning of the concept. Thus, it is well recognized that the term ‘health promotion’ can be ambiguous (Tones and Tilford 2001). Since the underpinning theory of health promotion...
emerges from a number of subject areas, it is no surprise that nurses can find it difficult to produce a clear-cut definition of health promotion. Indeed, Tones and Tilford (1994: 2) believe that health promotion:

means all things to all people – who are united only in their agreement that it is rather desirable.

Added to the confusion about health promotion is the fact that it can be hard to differentiate between ‘health education’, ‘health promotion’ and ‘public health’. Often, these terms are used interchangeably or to mean different things (Whitehead 2004; Earle 2007).

Whitehead (2004) contends that the paradigms of health education and health promotion might be closely related, but they are not inter-dependent. He separates the terms from one another – arguing that health promotion has developed in shape and focus, and that it is now possible to explore the paradigms of health education and health promotion in their own right. Moreover, a number of authors (Webster and French 2002; Scott-Samuel and Springett 2007) argue that public health and health promotion should be viewed as separate, but overlapping, domains.

The purpose of this chapter is to clarify the meaning of the terms ‘health education’, ‘health promotion’ and ‘public health’ as separate entities; to explore the relationship between the concepts; and to discuss the characteristics that distinguish them. It will give an exploration of the concepts to clarify their meaning and help prevent nurses from using the terms ambiguously and interchangeably. However, before we can start to explore these concepts, for which health is the core, we need to clarify our comprehension of health itself.

What is health?

An exploration of health education, health promotion and public health is predicated on an understanding of health. Health is a challenging concept to define as it means different things to different people, and our understanding of health is influenced by cultural, socio-economic and personal contexts (Seedhouse 2001; Scott-Samuel and Springett 2007). Writers, practitioners and individuals hold notions of health as a commodity, health as an ideal state, health as the ability to function normally and health as a basis for adaption. Seedhouse (2001) gives a full exploration and critique of these theories of health and, in so doing, demonstrates that each perspective has its limitations. He puts forward the notion that health is equivalent to a set of conditions that enable individuals to achieve their realistic, chosen and biological potential – and recognizes that the importance of these conditions depends on the individual context. In other words, he sees health as a flexible concept and the level of health that an individual holds varies depending on circumstances.

Seedhouse’s notion of health is in agreement with that put forward by the Ottawa Charter for Health Promotion (WHO 1986). The Ottawa Charter was the product of the first international conference on health promotion and is considered to be
highly influential in shaping health promotion from then to today. It portrays health as a resource for everyday life rather than merely the objective of living. In this case, Weare (2002) argues that free choice has to be at the centre of the concept of health, since it becomes a resource to enable individuals and communities to function in the way that they find acceptable. Thus, according to Seedhouse (2001), health has to be viewed as a ‘fuzzy’ concept, as it is given its definition by the inherently different social and personal context.

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**Tutorial brief 1.1**

Think about the term ‘health’. List the main things that would allow you to classify yourself as healthy.

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**What influences health?**

It is accepted that a number of social, biological, behavioural, environmental and economic factors influence health. Dahlgren and Whitehead’s (1991) much cited model demonstrates that the determinants of health are tied up with individual lifestyle factors; social and community networks; living and working conditions; and general socio-economic, cultural and environmental conditions. Similarly, Tones and Tilford (2001) present a model that focuses on the macro (large), meso (middle) and micro (small) influences on health. The general consensus is that the factors that influence health do not work in isolation; rather, they involve a complex web of interaction. The case of obesity provides an example of how determinants interact.

The prevalence of obesity in Western society has risen significantly over the past few decades and there is clear evidence that obesity gives rise to ill health. Obesity has been shown to cause high blood pressure, heart disease, type-2 diabetes mellitus and various cancers (Reidpath et al. 2002). In short, obesity is shown to lessen life expectancy markedly. It is clear that various factors are associated with obesity. In relation to lifestyle, dietary factors such as limited consumption of fruit and vegetables as well as high fat and sugar intake have been shown to lead to obesity. Moreover, a sedentary lifestyle is associated with being overweight and having a high body saturated fat percentage. There is evidence also of obesity being associated with causal genes (Rankinen et al. 2006). However, a genetic predisposition does not invariably lead to obesity, and lifestyle factors are not always down to individual choice. Socio-economic factors such as family and peer group behaviour and socio-economic status (SES) are known to have direct influence on levels of obesity. For example, Reidpath et al. (2002) demonstrate that as SES declines, the risk of obesity increases. One explanation put forward for this is the tendency for the poor, perhaps out of necessity, to eat cheaper processed energy-dense foods.

Living and working conditions also have an effect on dietary intake and obesity. For example, the notion of the obesogenic environment (namely, an environment
that encourages the consumption of food and/or discourages physical activity) is now well recognized. In effect, an environmentally induced change in energy balance results in an increased risk of obesity. In turn, political, social and economic forces shape the conditions in which people live. A case-in-point is the proliferation of fast food outlets, which enable access to relatively cheap, high energy, high fat foods. The irony of this is that these outlets have flourished because of the political and economic environment that has encouraged the growth of fast food companies – which evidently make a positive contribution to the overall economic climate and help to improve standards of living. Thus, we can see the complex interaction that takes place between the macro, political and economic factors; the meso, community-related factors; and the micro, individual factors that have led to the obesity epidemic (Tones and Tilford 2001).

Inequalities in health

A major concern for health promotion is that, although overall the health of the population is improving and people are living longer, health inequalities are ever widespread and the health status of different groups varies considerably. In Chapter 8, a detailed account is given of the different patterns of global health between populations. Here, this section will consider differences within populations.

Sociological factors including social class, poverty, gender and race directly influence health status. In the 1970s, some 30 years after the development of the welfare state and the establishment of the National Health Service (NHS) in the United Kingdom (UK), a growing concern about the gap in health status between the social classes led to the establishment of a government working-group and the subsequent publication of the Black Report (DHSS 1980). The Black Report showed a clear relationship between occupational class and morbidity and mortality. For almost every type of illness and disability that was investigated, a positive association between social class and health status was shown, whereby those in higher social classes were far less likely to suffer from illness or disability and more likely to live longer than their counterparts in lower social classes. The Report also gave evidence of other variations in health status. It showed regional variations (North versus South divide) in health, gender differences (usually more marked in men than women) in patterns of health, and higher incidence of a range of diseases (such as heart disease) amongst individuals from ethnic minority groups. Since the Report, societal changes (such as the advent of ‘girl power’) have adjusted and changed health status between different members of the population. Young females today, within a more liberal social environment, are more likely to adopt high-risk lifestyle choices than previously. In the twenty-first century, the existence of social inequalities in health, in the UK, is not disputed and striking differences between groups persist. However, this is not just a feature of UK society. In 2005 the Commission on Social Determinants of Health (CSDH) was set up by the World Health Organization (WHO) to marshal the evidence on what can be done to promote health equity and to foster a global movement to achieve it. Its recent report on the social determinants of health offers compelling evidence to
demonstrate the continued existence of health inequalities within populations (CSDH 2008). It states that:

In countries at all levels of income, health and illness follow a social gradient: the lower the socioeconomic position, the worse the health.

There is abundant evidence from around the world to uphold the position that inequalities in health related to race, gender and SES exist and have a major impact on the health status of individuals and communities. CSDH (2008) cites a number of examples of such inequalities, as shown in Table 1.1.

This stark evidence of health inequalities leads the CSDH (2008: 1) to state that:

This unequal distribution of health-damaging experiences is not in any sense a ‘natural’ phenomenon but is the result of a toxic combination of poor social policies and programmes, unfair economic arrangements, and bad politics.

If health inequality is not a natural phenomenon, but one that global society has created, then it follows that action can be taken to tackle inequalities and bring about health equity. Nurses, who form a sizeable professional group (the largest by far of health professionals) within global health services, have an important contribution to make in tackling these issues. To promote health effectively, nurses need to understand how determinants of health interact, why inequalities exist and what measures can be taken to bring about changes to these factors to affect health in a positive way. Thus, they need to define their health-promoting work and establish systematic processes for their practice (see Chapter 4).

**Differentiating the concepts of health education, health promotion and public health**

It is important to make a conceptual distinction between health education, health promotion and public health in order to allow a clear foundation from which nurses can define their work, and identify and evaluate their roles. Douglas (2007) provides a useful distinction between individual and structuralist approaches to health promotion, suggesting that individual approaches focus on encouraging and empowering
people to change their behaviour and adopt a healthy lifestyle, whereas structuralist approaches focus on efforts to change the wider determinants of health – such as the physical, social and economic environment. Douglas (2007) also acknowledges that some health protection approaches – such as the provision of immunization or screening – lay between individual and structuralist approaches, since they require an element of change on the part of both the individual and service provision.

Health promotion has many different interpretations and perspectives. It refers to a set of principles that rely on particular underlying values as well as describing ways of working. Central to contemporary health promotion practice is an emphasis on social action, tackling the determinants of health and addressing key issues such as inequalities in health and disempowerment. The purpose is, therefore, to make a difference to the causes of ill health rather than simply focusing on the consequences of it. This can be a challenge for nurses, many of whom face the consequences of ill health in their daily practice and whose work priorities might constrain them from focusing on the causes of ill health. Writers, such as Tones and Green (2004), believe that health education is tied up with activities that are designed to facilitate health related learning and, ultimately, lifestyle or behaviour change for people. To some extent, then, it is concerned with helping people to help themselves – an approach that sits comfortably in nursing.

Public health in its most simplistic form refers to the health of a population. However, there are various interpretations of public health that identify its different priorities and approaches. For some, public health is an umbrella term referring to all activities aimed at improving the health of the public, to which health promotion makes a major contribution (Macdonald and Bunton 2002). For others, public health is synonymous with a medical model and is concerned with preventive medicine, which focuses on measuring, controlling and preventing illness and disease (Scott-Samuel and Springett 2007). Because of these conflicting perspectives, it is not possible to give an authoritative definition of public health. The examination of health education, health promotion and public health by various authors helps to offer some distinction between the three concepts. This chapter now moves on to offer a more detailed exploration of each.

**Summary point**

Health promotion falls into the structuralist approach discussed earlier. Health education is concerned with the individual approach, and public health sits between the two approaches.

**Health education**

One way of identifying the distinguishing features of health education is to consider it as a process – how the service operates, and an outcome – what the service produces. In the case of health education, the process entails the imparting of health related information; the outcome involves influencing the knowledge and attitudes
of individuals, empowering individuals and, ultimately, bringing about behavioural change and subsequent improved health.

**Health education as information-giving**

From the many definitions of health education that are found in the literature, it is evident that health education is tied up with information-giving. However, while this might sound simplistic, information-giving in health education is a complex process. It moves beyond imparting information and advice, to developing a cooperative process between the professional and the client; this involves clarifying values, exploring attitudes, motivational techniques and enabling processes (Sidell 2000; Tones and Tilford 2001). Health education focuses on change at the individual level, but can take the form of group work or mass media campaigns to reach the individual (Whitehead 2000). The health educator uses communication, together with educational and counselling methods, to motivate individuals and groups to bring about health related change. When effective, individual approaches can help to reduce people’s risk of ill health but the nature of the intervention, normally with individuals or small groups, means that the effect on the total population is limited.

**Health education as self-empowerment**

There is a growing body of literature arguing that empowerment is a desirable outcome of health education (Tones and Green 2004), where the goal is to encourage personal growth through the enhancement of self-esteem and assertiveness (Sidell 2000). However, the discussion of empowerment can lead to some confusion when trying to distinguish between health promotion and health education. For example, Whitehead (2004) identifies empowerment as an element of progressive health education, whereas Rissel (1994) believes that empowerment embodies the basis (raison d’être) of health promotion. Rissel’s (1994) contention – that two forms of empowerment exist; namely, self-empowerment and community-empowerment – helps to clarify how empowerment relates to both health education and health promotion. Gibson (1991: 359) defines self-empowerment, as:

> the social process of recognizing, promoting and enhancing people’s ability to meet their own needs, solve their own problems and mobilize the necessary resources in order to feel in control of their own lives.

Self-empowerment requires intrapersonal aspects – such as the development of self-esteem and self-efficacy, and the enhancement of decision-making abilities. It also contains an interpersonal component, involving sharing, helping and partnerships that enable people to make autonomous decisions about their health.

According to the *Ottawa Charter for Health Promotion*, empowerment enables people to take control over their own lives and health status (WHO 1986). It is evident that the WHO’s form of self-empowerment centres on people’s ability to develop skills, understanding and awareness. This, in turn, facilitates individuals to...
use personal resources to maximize their chances of developing healthy lifestyles and is more consistent with the concept of health education (Laverack 2007).

Bracht et al. (1999) identify empowerment as a continuum and this helps to further distinguish the relationship of empowerment to health education and health promotion (see Figure 1.1). Bracht and colleagues suggest that empowerment, at the individual (health education) level, involves personal development – advancing into empowerment at the structural (health promotion) level, where coalitions are developed to bring about political and social action.

Rissel (1994) views empowerment at the community or structural level, where a macro component exists, as community empowerment. He interprets community empowerment as self-empowerment ‘plus’, where social and political action is taken for the redistribution of resources in favour of the community in question. From the discussions so far, it is evident that community empowerment is viewed as a discrete attribute of health promotion and I will return to this later in the chapter.

Skelton (1994) is sceptical of the reasons for signing up to an ethos of empowerment. He believes that many professionals use the term ‘empowerment’ when, in reality, they are adopting a strategy that is essentially based on coercing clients to engage in behaviours that are advocated by the health educators. This is an approach that is labelled by Laverack (2007) as ‘power-over’. MacDonald (1998) mirrors this. He replaces the term empowerment with impowerment; this is where power is conferred on clients by someone in authority – that is, health professionals.

A key theme for nurses is the authority that they hold that enables them to empower their clients. Nurses work in bureaucratic and hierarchical systems that are characteristically disempowering and, consequently, they can lack autonomy and control. If nurses have no power to relinquish, then they are in no position to empower others. Someone can only possess a certain amount of power if another person loses an equivalent amount. However, this position is dismissed by authors such as Laverack (2005), who contends that empowerment does not involve bestowing power; rather, it is an enabling process that involves an interpersonal dimension of sharing resources, helping each other and developing constructive relationships. This approach to empowerment is identified as ‘power-with’ – one in which nurses can readily engage (Laverack 2007).

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**Tutorial brief 1.2**

Identify the types of power that are relevant to you and your clients in your practice. To what extent might they prevent/promote health education and health promotion practices?
Dilemmas that relate to the relationship between power and empowerment are clearly pertinent for nurses. Whitehead (2004) claims that nurses are making some advances in the promotion of individuals’ health through empowerment. It is clear from the literature that empowerment is seen as a positive concept that is intuitively appealing and a desirable outcome of health education (Sidell 2000). However, it is also fair to say that empowerment is not the desired ultimate outcome of health education but, rather, a means of ensuring that individuals develop the knowledge, attitudes, personal skills and self-esteem to be able to adopt a lifestyle that is conducive to good health. This leads to another key attribute of health education – that of behavioural change.

Health education as behaviour-change

There is considerable evidence available that demonstrates that lifestyle behaviour influences health (Kemm 2003). The justification underpinning this body of evidence is based on the fact that, since the 1970s, in Western society people have mainly died of diseases of affluence. These diseases include coronary heart disease, cerebro-vascular disease, chronic obstructive pulmonary disease and strokes – which are principally caused by unhealthy lifestyles (see Chapter 8 for greater detail on morbidity rates at a global level). McQueen (1987) identifies four critical behaviours that adversely affect health: smoking, sedentary lifestyle, poor nutrition and alcohol misuse. He ascribes these to a group that he labels the ‘Holy Four’. More than twenty years on from McQueen’s (1987) observations, the magnitude of the ‘Holy Four’ is still in evidence, with recent research demonstrating that avoiding smoking, engaging in physical activity, consuming only moderate amounts of alcohol, and a healthy diet can add up to fourteen years to people’s life expectancy (BBC 2008). Bennett and Murphy (1997) add high-risk sexual activity to this list – a behaviour that has emerged as a significant contributory force to morbidity and mortality rates since the early 1980s, especially linked to HIV/AIDS in sub-Saharan Africa.

One way of addressing the increased morbidity and mortality rates associated with potentially harmful health-related behaviours is to adopt a behaviour-change approach to health education. Tones and Tilford (1994: 14) define such an approach as:

the persuasion of individuals to adopt behaviours believed to reduce the risk of disease.

The literature is full of accounts of interventions that aim to help and support individuals to alter their risky behaviour – either before or after the onset of illness, disease or disability. A cursory exploration of recent health education publications provides details of smoking cessation interventions in Northern Ireland (Thompson et al. 2007), weight-loss support in Greece (Georgiadis et al. 2006), a healthy-eating and physical-activity project in New Zealand (Williden et al. 2006) and anti-drug interventions in France (Peretti-Watel 2005). All these studies use structured and theoretically-informed strategies, designed to work with target groups to bring about a change in behaviour. They report varying levels of success.
Health promotion in action

Thompson et al. (2007) evaluated the success of a community nurse-led smoking cessation clinic – conducted in one National Health Service Trust in Northern Ireland. The clinic operated a group therapy approach. The study employed quantitative and qualitative methods of data collection. The authors found that the smoking cessation clinic helped 29.2 per cent of those who registered at the clinic to quit smoking at the end of the six-week course. Results indicated that participants had gained motivation from the ‘group’ experience, from the lowering of their carbon monoxide readings and from the positive attitude of the smoking cessation support nurses. However, the six-month follow-up suggested that a number of those who had given up smoking had relapsed into their previous smoking habit.

Given the evidence that demonstrates the link between lifestyle and ill health, it might seem appropriate that behavioural-change approaches have a significant position in health education. Indeed, according to Caraher (1994), nurses make behavioural-change approaches the mainstay of their health related work. More recently, Irvine (2007) and Casey (2007) both demonstrate that nurses continue to adopt strategies that focus on lifestyle risk factors. Widespread adoption of this approach essentially perpetuates the ethos that individuals are responsible for their own health. However, the position and impact of behavioural-change approaches in health education is contested, because changing a client’s health related behaviour is notoriously problematic and, as argued earlier in this chapter, individual behaviour is not the primary determinant of health. At worst, the lifestyle and behaviour-change approach is considered by some to be unethical because it gives rise to ‘victim-blaming’– where people are made to feel responsible and culpable for any developing ill health status (Tones and Green 2004). In this context, a behavioural-change approach is arguably one that is best avoided. However, behaviour-change should not be totally dismissed by nurses, as it can be reasonable to expect behavioural change in individuals – if careful consideration is given to the underpinning theoretical and practical constructs (Whitehead and Russell 2004).

Summary point

The attributes of health education can be categorized into those that relate to the process and those that relate to the outcome. The focus of health education generally is on the individual.

Tutorial brief 1.3

Can you identify the main elements of health education? Write a list of their main strengths and limitations that could affect your health-related work.
Making health education effective

In order to be effective health educators, nurses need a sound knowledge of what is meant by ‘health education’. They should be conversant with the underlying principles of health education and knowledgeable of the various processes that can be effectively adopted to educate for health – as well as the outcomes that should realistically be expected when adopting a health education approach. For instance, the recipient of health education needs to be ready to receive health advice, and they must have the ability to assimilate it and to act on that advice to change or modify their behaviour (Whitehead 2004). Other factors – such as resources, time, support of colleagues and a personal commitment to health education – will also need to be present to enable nurses to engage effectively in health education.

Consequences of health education

Ultimately, health education should lead to the improvement of the health of individuals. However, it is likely that this aim will be achieved incrementally and will be determined by the outcomes of health education related to knowledge gain, awareness-raising, individual empowerment and behavioural change. While it is clear that health education now stands as a discrete concept, it nevertheless, makes a significant contribution to health promotion (Rawson 2002; Tones and Green 2004). Indeed, Kemm (2003) argues that an educational element features in nearly all health promotion activities. Knowing this, it is possible to move on to the distinct concept of health promotion.

Tutorial brief 1.4

Think of a health education campaign or programme in which nurses are most likely to be involved. Identify, in increments, the consequences of the intervention that you could expect.

Summary point

Health education can be viewed as a process and an outcome. The process entails informing individuals about health and illness, and the risks and benefits associated with unhealthy and healthy lifestyles. The outcomes of health education are self-empowerment and behavioural change to embrace a healthy lifestyle. Health education requires effort on the part of the individual and the health educator. The consequence of health education is the improvement of the health of individuals.
Health promotion

Definitions of health promotion are diverse and represent many different conceptualizations of health. The *Ottawa Charter* (WHO 1986) sees improving health as the outcome of health promotion and the various measures put in place to enable people to increase control over their health as the process. The values underpinning the health promotion process are participation, enablement and empowerment, equity and social justice (Scott-Samuel and Springett 2007). These values represent a progressive notion of health promotion involving processes that seek to address the wider determinants of health as part of community development and collective social action.

Health promotion as community development

Community development is highly regarded in the health promotion literature. For example, Labonte and Robertson (1996) believe that community development is the best strategy for remedying underlying social determinants of health – such as economic, fiscal, political, environmental and ecological issues. This contention is supported by a number of authors, who identify community development as the most ‘authentic’ or ideal form of health promotion (Rawson 2002) and ‘central’ to health promotion (Tones and Green 2004). In the health promotion literature, there appear to be two main orders of community development. The first centres on what Labonte and Robertson (1996) refer to as a ‘community-based’ approach. Here, a lead agency mobilizes the local community to work in collaboration on a disease-specific or behaviour-orientated issue (Mittlemark 1999). Labonte and Robertson (1996) indicate that, when this approach is adopted, the health problem is identified by the mobilizing agency. There are many examples of this type of work, focusing on issues such as smoking (Ritchie et al. 2004), young people and alcohol (Huckle et al. 2005) and classic coronary heart disease programmes, such as the North Karelia Project in Finland (Puska 1995). Community empowerment programme activities normally involve agendas that are pre-determined by health promotion professionals and include strategies such as involvement of the public in task forces, mass media campaigns, health fairs and public events.

The community-based approach to health promotion is subject to some criticism. For example, approaches that are based on disease or a lifestyle orientation often have little reference to one another and can lead to omission or duplication of efforts in reaching individuals (Berentson-Shaw and Price 2007). Moreover, focusing on measurable objectives and risk factor targets in community-based health promotion can trivialize some problems and overlook others. Jensen (1997) contends that community-based health promotion often fails to consider the wider social and economic issues that are normal social determinants of people’s health. What are health priorities to health service agencies might well not reflect the health priorities of the communities themselves. This type of community-based activity bears close resemblance to health education; the difference being that one is at the individual level, while the other targets the whole community.
Pelletier et al. (1997) claim that ‘true’ community development aims to empower the community, and that the decision-making processes that relate to the objectives and activities of a strategy are owned by that community. Thus, it enables communities to identify problems, develop solutions and facilitate change. In other words, community development is user-led and, as such, demands innovative ways of working that challenge the traditional medical or behavioural-change approaches (see Chapter 2 for greater detail on the different approaches to health education and health promotion). Asked to identify its main health priorities, most communities will not rank highly lifestyle-related behavioural programmes (for example, smoking cessation). Instead, they will often target issues centred on crime, justice, policing, pollution, welfare, transport, housing and so on. Based on the work of Henderson and Thomas (1980), Tones and Green (2004) outline key steps and stages in the community development process, which involve:

- Planning and negotiating entry
- Getting to know the community
- Working out what to do next
- Making contacts and bringing people together
- Forming and building organizations
- Helping the community to clarify goals and priorities
- Keeping organization going
- Dealing with friends and enemies
- Leavings and endings.

Adopting the community development approach means that an interactive dialogue takes place in a community and that action takes place across the community as a whole, with professionals sharing authority and responsibility with the community (Mittlemark 1999).

**Health promotion in action**

Ritchie et al.’s (2004) study evaluated the effect of a community-based approach to health promotion entitled ‘Breathing Space’. The initiative aimed to produce a significant shift in community norms towards non-toleration and non-practice of smoking in a low-income area in Edinburgh, Scotland. The authors used a quasi-experimental design, which incorporated a process evaluation in order to provide a description of the development and implementation of the intervention. Drawing on qualitative data from the process evaluation, their paper explored the varied, and sometimes competing, understandings of the endeavour held by those implementing the intervention. The data illustrate how different understandings of community development had implications for the joint planning and implementation of Breathing Space objectives. In addition, they show that the varied understandings raise questions about the appropriateness and viability of utilizing community development approaches in the context of a behaviour-orientated issue such as smoking.
Health promotion as community empowerment

The previous discussions assist in demonstrating that community development is the desirable process of health promotion and is the means by which the expected outcome of community empowerment is reached (Bracht et al. 1999). Mittlemark (1999) defines community empowerment as communities making choices and becoming involved in the political processes that affect their lives. A similar position is taken by Laverack (2007), who believes that community empowerment entails communities gaining more control over the decisions and resources that influence their lives – and this includes the determinants of health and well-being status. Therefore, Laverack (2007) argues that health promotion involves a redistribution of power so that health professionals act as the facilitators of community participation, community action and, ultimately, community empowerment.

Community empowerment, however, is not without its limitations, which feature in a similar vein to the criticisms directed at self-empowerment. The issue of the agenda of health promoters is of relevance here. Difficulties can exist because of the discrete community dynamics that manifest in community development work. The loyalties of health promoters are often to their organization, rather than to the community. Thus, problems can develop because of the different health rationales and priorities that exist between communities and health promotion agencies. This problem however, is not insurmountable. As Lazenbatt et al. (2000) demonstrate in their study, nurses are engaging in community development work that identifies health needs, targets health and social needs through health promotion, addresses the structural factors that affect health and establishes social support networks. They demonstrate that careful selection of community development workers, who have personal allegiances to the community, will serve to avert the problems that arise because of different understandings of life processes within that community. Nevertheless, with these measures in place, the question of power is still likely to surface in community development work.

Authors, such as Dixon and Sindall (1994), contest that lip service is often paid to the issue of control, and that the external sponsors of health promotion fail to recognize the amount of power that they exert on the community. This power exists by virtue of the fact that health professionals specify – and, in some cases, supply – the goals, target groups, timescales, resources, and the organizing and accountability structures of the community development programmes. Tones and Tilford (2001) identify with this problem, referring to ‘facipulation’, whereby the community agenda is manipulated to effect influence on the community action. In this instance, the facilitation of an empowered community is essentially a means to an end. Such actions can be viewed as the antithesis of empowerment, which should be the primary outcome of community development (Rissel 1994; Laverack 2007). While community empowerment is clearly a desirable outcome of health promotion, its eventual aim is health improvement for the community through collective social action and political reform (Whitehead, 2004).
Health promotion as collective social action

Mittlemark (1999) asserts that an empowered community is one that has the capability to mount and manage action to improve the basic foundations for a thriving community and, often, to reduce inequity and inequality. Essentially, this embodies the intention to bring about social and political change (Laverack 2007). In doing so, collective action positively influences a community’s social determinants of health (Tones and Tilford 2001). For example, Mittlemark (1999) suggests that the community might focus on equal access to education, economic security, social connectedness and the development of public policy that supports agreed objectives. Therefore, according to Whitehead (2004), health promotion is a radical socio-political process that involves activities that reinforce community action and build healthy public policy to strengthen social cohesion and social capital. These are the social components that enable belonging and trust, and can lead to improved economic performance and better health in society overall.

As Ritchie et al. (2004) point out, it is commonly agreed that appropriate leadership and effective organizational structures are crucial to successful community participation. The challenge for health promoters is to recognize the criticality of community members in the process, and to use and increase the capabilities and resources within the community. Furthermore, if they are to afford effective action, health promoters must recognize that health agendas arise from ‘grass roots’. However, it would be naïve to assume that such recognition alone will lead to effective social action. Evidently, such recognition also requires a political climate that nurtures and facilitates the social-action approach, and facilitates access to education programmes, research, training and necessary resources (Ritchie et al. 2004). Furthermore, it is important to recognize that, within a community, conflicts of interest (real or imagined) might exist between disempowered people. This means that they can potentially divert the energies of disadvantaged groups into self-defeating and mutually disempowering activity. These conflicts of interest frequently require mediation by an impartial individual or group in order to facilitate empowerment.

Health promotion in action

Heenan (2004) uses evidence from a community health project that highlights the benefits and difficulties with a community development approach that aimed to facilitate community action. The community development project, based in Northern Ireland, aimed to put health on the agenda for the community and adhered to key principles of community involvement, empowerment, training, project ownership and partnership working. Heenan (2004) suggests that partnerships can positively influence a community’s health status but, in order to be effective, they require considered planning and long-term commitment from both the state (political and fiscal resources) and the local community.
Making health promotion effective

The radical interpretation of health promotion is based on the assumption of the existence of power deficits or social problems in need of attention, and that these have an adverse effect on health (Bracht et al. 1999). Empowered communities have a greater impact on community health than health related work with individuals or small groups (Whitehead 2004). Together, with the commitment of professionals and communities to engage in activities, the success of ‘radical’ health promotion depends on the understanding that collective, rather than individual, action is needed, together with an appreciation of the relationships between power and empowerment (Tones and Tilford 2001). Health promotion is a dynamic process in which there is an acknowledgement of the necessity for collaboration and multi-agency involvement. If health promotion is to be successful, the issues of concern should be identified by the community. Therefore, there is ownership of the project by the community and active involvement of consumers at all stages. By definition, community development is linked with community, and the pre-existence of a community is clearly crucial to the success of health promotion. The capacity and capability of the community to engage in effective collective action is also a pre-requisite of radical health promotion, as this will enhance citizen participation in groups, and facilitate organizational and social action (Bracht et al. 1999).

Tutorial brief 1.5

Think of a health promotion activity that nurses might contribute to. Identify what will need to be put in place before embarking on such an initiative.

Consequences of health promotion

The consequences of progressive health promotion are a raised level of community empowerment and the participation of empowered community members in collective political action. The attainment of outcomes that are usually sought by the community groups clusters around the desired achievement of necessary redistribution of resources, or decision-making and changes in policy to generate positive influence on social determinants of health which, ultimately, bring about the improved health of the community (Bracht et al. 1999).

Summary point

Health promotion can be viewed as a process and an outcome. The process of health promotion involves all actions that enable people to take control over their lives and their health. Progressive health promotion involves
engaging in community development, either through a community-based approach that focuses on lifestyle or illness issues, or through ‘true’ community development where the agenda is set and the desired outcomes are identified by the community. The focus of activities is on the socio-political determinants of health and the intention is to counter the power deficits or unattended social problems that exist. The consequences of health promotion are community empowerment and participation in activities that bring about socio-political changes that positively affect the community’s health.

Public health

While it is relatively straightforward to tease out the relationship between health education and health promotion through their identifying attributes, the same cannot be said for public health and health promotion. Tones and Tilford (2001) attest to the confusion by highlighting two conflicting positions: public health comprises both health promotion and public health medicine; and health promotion is the envelope that incorporates public health and public health medicine. In some respects this uncertainty might be deliberate, as there is an acknowledged – and, as yet, unresolved – power struggle between public health and health promotion (Scott-Samuel and Springett 2007). Webster and French (2002) believe this power struggle results in ‘conspiratorial confusion’ as health promotion specialists and public health specialists strive to protect their ‘territory’. The continuing debate about the relationship between health promotion and public health could be viewed as an unnecessary preoccupation with semantics. However, the concern of a number of authors is that, rather than merely being an issue of terminology, the struggle represents intense differences over purpose and scope. The wholesale takeover of health promotion by public health – which Wills (2008) argues is the case in a number of countries – will lead to a model that moves away from the guiding values of the Ottawa Charter (participation, enablement and empowerment, equity and social justice) to a position that privileges epidemiology, health protection and health services improvement (Wills 2008).

It might be that nursing offers a solution to the disquiet between health promotion and public health. In 2004, in the UK, the Nursing and Midwifery Council (NMC) (the regulatory body for nursing, midwifery and health visiting) opened a three-part professional register, the Part 3 of which relates to ‘specialist community public health nursing’ (SCPHN). The NMC (2008) state that SCPHN’s not only work with individuals and families, they also direct their work at the population level. Here, they are involved in health promotion, working in partnership and making decisions that influence the whole population. SCPHNs are engaging in community level work through projects such as ‘Sure Start’, an initiative established to tackle disadvantage and inequity (DfEE 1999). One of Sure Start’s four main objectives is to strengthen families and communities, and it gives SCPHNs licence to work in
proactive and innovative ways. The establishment of Part 3 of the NMC’s register is a promising development for nurses, offering scope for work that transcends the health promotion/public health divide and enables nurses to take a legitimate role in collective social action. However, there is a danger that health promotion and public health nursing are seen solely as the business of the SCPHN, and that nurses working in other health care settings might, by default, be withdrawn from their health promotion work (see Chapter 5 for settings-based health promotion). The challenge for nursing, then, is to celebrate the success of SCPHNs as they bridge the divide between health promotion and public health, and be guided by their successes to develop health promotion initiatives in other areas of nursing.

Applying the concepts: the challenges for nurses

Health promotion researchers and practitioners recognize that the rhetoric of what is viewed as ‘radical’ health promotion does not always correspond with the reality of practice. Despite the fact that social, economic and environmental factors have the greatest impact on individual health, nurses’ involvement in the structural level of health promotion is limited (Whitehead 2006). Because nurses’ work is often tied up in dealing with ill health, they are inclined to focus on individually orientated health education activities that tend to be more compatible with ‘traditional’ nursing practice. This position is supported by findings from various studies that consider nurses’ understanding and experiences of health promotion. For example, in the UK, Irvine (2005) and Casey (2007) both found that nurses generally impart health related information in an effort to influence the knowledge, attitudes and behaviour of their patients – thereby conforming to an individualized, health education framework. In the USA, Flocke et al. (2007) revealed a low level of utilization of team approaches and resources outside the health care setting. They concluded that a dominant acute-care approach to seeking, delivering and reimbursing health care reinforces a reactive, rather than a proactive, stance towards health promotion. Kemm (2003) points out that, in England, successive policy statements have advocated health education rather than health promotion activities, and this has probably driven nurses into a pattern of continued engagement with individual approaches. Certainly, this reported situation is not unique to any one country. However, this is not to criticize strategies that are directed at the individual, or dismiss their utility in contributing to improved health. The empowerment of individuals brings about health improvement and is a crucial step towards community empowerment. What this chapter has shown is that health education, health promotion and public health are distinct concepts, and that structural approaches lead to greater health improvement of the total population.

Conclusion

Nurses need to ensure that their health promotion interventions are based on a clear conceptual framework. The literature that has been drawn on in this chapter
demonstrates that, although it is hard to pin the concepts down and produce authoritative definitions of each, it is possible to mark out boundaries that distinguish between health education, health promotion and public health. This chapter establishes the fact that nurses and other health professionals are engaged in a wealth of activities that seek to improve the health of individuals and communities. Also, depending on their process and outcome, these activities can be classified as health education, health promotion or public health. The next chapter explores health education and health promotion further by considering the theories and models that can be used to guide effective health care practice.

**Additional resources**


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