Carolyn L. Murdaugh • Mary Ann Parsons • Nola J. Pender

HEALTH PROMOTION in Nursing Practice

EIGHTH EDITION

HEALTH PROMOTION IN NURSING PRACTICE

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Eighth Edition

Health Promotion in Nursing Practice

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Dedication

To nurse educators and practicing nurses who teach and role model health promotion. I bid you success as you face the challenges of promoting a culture of health for all.

— C. L. Murdaugh

To my family and friends for their support during the preparation of this edition; I wish all of you happy and healthy lives.

—M. A. Parsons

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FOREWORD

I am pleased to write the foreword for the eighth edition of *Health Promotion in Nursing Practice.* The promotion of health is recognized globally as essential to the well-being of the world population and to the achievement of health equity across diverse racial, ethnic, and economic groups. Many organizations speak of the need to develop a "culture of health" worldwide. Increasingly, health policies are being designed and implemented to move toward the goal of high-level health and wellness for all. Widespread adoption of this goal by health care providers would result in new models of care, decreased monies spent on acute illness, and a lower incidence of devastating chronic diseases. Access to innovative health promotion programs for all populations, particularly those most vulnerable, is a major focus of this eighth edition.

This book helps the nurse link health promotion practices with national health goals such as those articulated in *Healthy People 2020*. Nurses must lead positive change in health promotion and prevention policies and design health promotion programs as a multisectoral endeavor. Healthy environments, schools, and worksites with adequate air quality, water supply, housing, vector control, and shelter from the devastating effects of natural disasters are essential to quality living. Community-based health promotion strategies are the first lines of support for the health of all people. This new edition provides strategies that nurses can use to help communities activate their power to engage in competent individual, family, and community self-care. These strategies address the social and physical environments critical for healthy longevity. Approaches to evaluating the effectiveness of behavior change programs in communities and in primary care are also described.

New communication, tracking, and linking technologies are developing at a rapid pace, thus enabling widespread dissemination of health promotion information and innovative support of individuals and families who want to make positive lifestyle and environmental changes. Sporadic programs do not result in the continuity of care needed for real health behavior change at the family and community levels. In this edition, the authors speak to the importance of social media, mobile applications (apps), and other digital technologies to support better continuity of care and follow-up essential to effective long-term behavior change.

Cultural sensitivity to the health promotion needs of diverse populations is important as many communities are experiencing a wider array of languages, cultural practices, and lifestyles. Fitting health promotion services to individuals, families, and communities from diverse backgrounds requires listening to their priorities, respecting them as persons with dignity and worth, and adapting health promotion strategies and technologies to differing cultural values, levels of education, and life stages.

It is important that health promotion services be provided by nurses and other health care workers who maintain healthy lifestyles and healthy work environments. The American Nurses' Association declared 2017 as the year of the *Healthy Nurse*. Educational programs for nurses and other health professionals must provide healthy learning environments and preparation for healthy lifestyles to be consistent with valuing health promotion as an important aspect of nursing practice.

Knowledge about health promotion and effective interventions continues to emerge. This eighth edition integrates the results of the latest research and theoretical advances into useful, evidence-based information to help nurses provide scientifically sound health promotion and prevention services. Dr. Carolyn L. Murdaugh and Dr. Mary Ann Parsons, nurse experts in health promotion, will inspire you to incorporate new health promotion strategies into your organizational policies, create scientifically sound nursing protocols, and provide leadership in the development of a culture of health.

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PREFACE

The overall goal of the eighth edition is to provide nurses and other health promotion practitioners practical, evidence-based information to promote the health of racially, ethnically, and culturally diverse individuals, families, and communities. The book aims to (1) present a comprehensive approach to health promotion that is based on the most recent research and federal guidelines; (2) describe the role that digital technologies are playing in health promotion in all ages and populations; (3) integrate factors in the social and physical environments that influence health and health inequities; and (4) offer strategies to implement and evaluate programs to promote health in individuals across the life span, and in schools, worksites, and communities. We believe information in the book provides the foundation on which to build the practice of health promotion.

ORGANIZATION OF THIS BOOK

- *Part I, The Human Quest for Health:* Multiple conceptions of health are reviewed, and both individual and community models are described to guide the development of health promotion programs.
- *Part II, Planning for Health Promotion and Prevention:* Strategies are presented to assess health, health beliefs, and health behaviors, and develop a health promotion plan.
- *Part III, Interventions for Health Promotion and Prevention:* Four core health-promoting behaviors are addressed: physical activity, nutrition, stress management, and social support.
- *Part IV, Evaluating the Effectiveness of Health Promotion:* Practical methods for evaluating health promotion programs are described.
- *Part V, Approaches for Promoting a Healthy Society:* Four areas are included: empowering individuals for self-care; promoting health and health literacy and decreasing health inequities in diverse populations with culturally sensitive approaches; promoting health in schools, worksites, and communities; and building a healthy society through social and environmental change.

NEW TO THIS EDITION

- An overview of several theories and models that currently guide the development of digital health promotion applications.
- The role of technology in health assessment and health planning.
- The application of social media, mobile health, and other digital technologies in promoting healthy behaviors for physical activity, healthy eating, and stress reduction.
- The use of online communities to provide support.
- Strategies to empower individuals and communities for self-care.
- Federal plain language guidelines to promote health literacy.

- Updated information on environmental contaminants, including herbicides, lead, and shale gas extraction.
- Information about the Robert Wood Foundation goal to create a national movement to promote a culture of health which promotes health equity.
- Incorporation of *Healthy People 2020* midcourse evaluations and *Healthy People 2030*.
- Updated chapter content, tables, and figures based on the most recent literature.

For the learner, each chapter contains learning objectives, figures, tables, and displays to highlight and reinforce material covered in each chapter; suggestions for applying the information to practice; recommended avenues for research; and learning activities to provide experiences in health promotion activities and challenge the student to critically think about the chapter content. Last, an extensive reference list is available at the end of each chapter, and relevant websites are included throughout the book.

The book is ideally suited for undergraduate students in nursing and health promotion, graduate students in advanced practice programs, including the DNP, and nurses and other health care professionals who practice in health promotion settings.

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Our sincere appreciation is also extended to many persons at Pearson who have supported us in completing this revision. We are especially appreciative of Ashley Dodge, who guided the revision of the eighth edition, and Neha Sharma and Cheena Chopra at Noida, India, who worked closely with us during the final preparation and production stages. Neha's sensitivity to the stressors of writing and deadlines, and both Neha's and Cheena's expertise and attention to detail are sincerely appreciated. Last, we acknowledge the reviewers who provided valuable feedback on several chapters for this edition.

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INTRODUCTION

Health Promotion in a Changing Social and Digital Environment

The rapid expansion of digital technologies, along with rising health care costs, increasing population diversity, and persistent health inequities, has moved the need for health care reform and health promotion to center stage. Dramatic advances have occurred in health and health care over the past century, mainly due to public health efforts and new medical technologies. However, the health care system in the United States is no longer the best in the world, and persistent health care inequities have resulted in declining health for many Americans. The need to promote health brings both opportunities and challenges, as culturally diverse individuals and their social and physical environments must be addressed.

HEALTH EXPENDITURES AND HEALTH IN THE UNITED STATES

Expenditures for health care in the United States are higher than any other high-income country in the world, and were before the Affordable Care Act (Dieleman et al., 2016). In spite of the amount of money spent on health care, of 35 industrialized countries, the United States reports the highest child and maternal mortality rates, homicides, body mass index, sexually transmitted diseases, and major chronic diseases, including diabetes, ischemic heart disease, and chronic lung disease. Although the projected life expectancy is predicted to increase in most countries by 2030, life expectancy gains for the United States are projected to be one of the lowest. In addition, the United States is the first country to experience a reversal of height in adulthood, which is associated with greater longevity (Kontis et al., 2017). These findings have been described as the American "health care paradox," as the large number of dollars spent on health care in this country has not resulted in better health and longevity, compared to other countries (Bradley, Sipsma, & Taylor, 2017).

How health care dollars are spent matters. Countries projected to have greater longevity have higher ratios of social service to health care spending to address the social determinants of health. The ratio of social service to health care spending in the United States is the lowest of all 13 high-income countries, and the United States is the only one of the 13 countries without universal health coverage. In 2013, the second highest health care spending in the United States was for chronic illnesses, such as diabetes, ischemic heart disease, chronic lung disease, and cerebrovascular disease, all conditions with modifiable lifestyle factors. Pharmaceutical costs were highest for hyperlipidemia and hypertension, two risk factors that can frequently be reduced with lifestyle change. Most of public health spending went to manage communicable diseases, with little allocation to the promotion of healthy lifestyles (Dieleman et al., 2016).

HEALTH AND THE SOCIAL ENVIRONMENT

Where people live also determines their health. The contributions of the social, economic, and environmental conditions of communities to health and longevity are no longer questioned. Longevity increases with income. In research reported in 2016, a longevity difference of 15 years for men and 10 years for women was observed in persons who were in the top 1% income bracket compared to persons in the bottom 1%, and this inequality has increased over the past 12 years (Chetty et al., 2016). Geographic differences in longevity in low-income persons were observed; low-income persons who live in affluent cities have greater life expectancies that those who live in less affluent cities. Affluent cities are more likely to provide public services for all its citizens than poorer cities.

The role of social determinants in health was recognized in the *Healthy People 2020* goals; two overarching goals in the proposed *Healthy People 2030* framework are to achieve health equity for all and eliminate disparities, and to create social and physical environments that promote attainment of health and well-being for all (Office of Disease Prevention and Health Promotion, 2017).

THE SOCIAL ENVIRONMENT AND A CULTURE OF HEALTH

In 2010, the Robert Wood Johnson Foundation (RWJF) developed a long-term vision for a culture of health in all communities (Robert Wood Johnson Foundation & RAND Corporation, 2015). The major outcome of the culture of health action framework is improved population health, well-being, and equity. Priority areas include interventions to develop healthy children, increase access to affordable care, and address components of social and built environments that promote health.

Creating a culture of health presents opportunities for nurses who incorporate health promotion in their practice. Expanded skills, knowledge, and innovative practice models are required to integrate the social determinants of health into health promotion (Denham, 2017). Knowledge that promotes communication, collaboration, and leadership to foster community engagement, partnerships, and empowerment will enable nurses to improve the health of individuals in diverse communities. Becoming culturally competent and gaining skills to promote health literacy are also necessary. Interdisciplinary teams are essential to building a culture of health in a community, so nurses should also possess skills needed to work as a team member in a community and be able to provide team leadership.

DIGITAL TECHNOLOGIES, HEALTH PROMOTION, AND HEALTH EQUITY

The high costs of health care and limited funds spent on social services to decrease health inequities place the burden on the federal government to eliminate unnecessary spending and invest in upstream determinants of health (Shortell & Rittenhouse, 2016). Investment in health promotion programs and services that address lifestyle risk factors instead of secondary and tertiary prevention can reduce costs and promote health. Incorporating digital technologies is a potentially powerful strategy to promote health and decrease health inequities for hard-to-reach, low-income, racially and ethnically diverse populations.

Digital technologies are widespread and found in all aspects of people's lives. Information and communication technologies are constantly expanding and influencing lives around the world. According to a Pew Research Center report, in 2016 the median for adults owning either a cellphone or a smartphone was 88% globally. Over 95% of adults in the United States had a cellphone in 2016, compared to 53% in 2000. Of the 95% having a cellphone, 77% owned a smartphone (Pew Research Center, 2017a). Mobile smartphones offer sophisticated technology and connection to the Internet. They enable users to browse the Internet to access information, run applications (apps), send and receive e-mail, and communicate health data to health care professionals (Singh & Landman, 2017). Smartphones may include video cameras, accelerometers, pedometers, and global positioning systems (GPS).

Traditionally, health promotion has been a low-tech area compared to innovations in medical technologies used in acute health care settings. However, health information technologies are one of the fastest trends in the health care system. The expansion of mobile wireless computer technologies, social media applications, telemedicine, and telehealth is having a significant influence on health promotion and prevention, unlike any in recent history. Mobile health (mHealth) applications, a subset of electronic health (eHealth), offer mobile computing for health care and represent a significant change in health promotion strategies. These apps enable clients to track health information, receive prompts, record, visualize, and communicate information, and interact in peer support groups. Internet coaches (eCoach) are also used in many health and wellness apps. Social media and social networking sites are also avenues for sharing health information.

In spite of the growth of Internet access and mobile phones, the economic, access, and literacy barriers have not been addressed, as they have been slow to spread to disadvantaged social groups, including persons with low income, low education, low health literacy, or limited English language skills; racial/ethnic minorities; the elderly; and persons living in rural areas (Pew Research Center, 2017b). The differences in access are described as the digital divide or digital inequality between disadvantaged and advantaged groups worldwide due to lack of Internet access and personal computer ownership. Digital inequalities are seen across the life span in socioeconomically disadvantaged children and adolescents, adults, and older persons. Internet access should be a priority for all citizens in all communities (Hicks, 2017).

mHEALTH, HEALTH LITERACY, AND HEALTH PROMOTION

Internet and mHealth applications are seen as potentially significant strategies to decrease health inequities and promote health, as they increase access to health professionals, health information, and health promotion apps, and empower clients to engage

in healthy self-care behaviors (Robinson et al., 2015). However, persons with low health literacy do not possess the skills needed to interact with technology-based apps. Poor health literacy is a health risk as persons with inadequate literacy skills have limited understanding of their health problems and treatments. Health inequities are decreased when individuals have access to the Internet and digital technologies and the necessary literacy and computer skills to interact with the health apps. Nurses play a role in making sure that mHealth apps address culturally appropriate health information and the literacy levels of their clients; designing and teaching health literacy programs that are sensitive to culturally diverse populations; and engaging community organizations to find solutions to address access and cost issues.

Some eHealth advocates view empowerment as a positive outcome of mHealth as clients take an active role in managing their health and lifestyle. Unfortunately, there is limited evidence that all clients are willing or capable of assuming responsibility for their health. Other critics warn about focusing solely on individual responsibility without attending to the social determinants of health. Information and quality remain a concern in social media platforms. Potential ethical and privacy issues signal caution and demand constant monitoring by health care professionals. Evidence clearly shows that mobile technologies, including mHealth and social media, have the potential to bridge the digital divide and play a significant role in promoting the health of all individuals and communities.

HEALTH PROMOTION: GOING FORWARD

The changing social and digital environment and persistent inequities in health and health care, along with the increasing burden of noncommunicable diseases, create tremendous health challenges for nurses and all health professionals. Individual lifestyle factors play a role in noncommunicable diseases, and persons with inequities in income, education, housing, employment, and safe communities are less likely to practice health behaviors (Davies et al., 2014). The need to address both individual and community level health has resulted in a call for a new wave in public health. The "fifth" wave is described as a shift to a culture of health to promote the health of all (Davies et al., 2014). In this wave, individuals and communities are interdependent and engaged to promote health equity. A culture of health has also been envisioned and supported by the RWJF in this country as described earlier.

Practicing nurses and nurse educators are challenged to envision a new wave in practice and education that promotes both individual behavioral change and healthy communities where healthy lifestyles can be practiced. Denham (2017) calls for "disruptive" changes in nursing education and practice to place an emphasis on societal concerns. In a new wave of health promotion practice, collaborative partnerships offer a powerful strategy to bring stakeholders together to address the many individual and social issues; they might include local and state organizations and governments and private and public agencies. Digital technologies also offer venues to promote communication and facilitate change at all levels. The pace of change in health care and the social and digital environments present many challenges; they also bring many new opportunities for nurses who have a desire to promote health for all.

References

Bradley, E., Sipsma, H., & Taylor, L. (2017). American health care paradox—High spending on health and poor health. *QJM: An International Journal of Medicine*, *110*(2), 61–65. doi:10.1093/qjmed.hcw187

Chetty, R., Stepner, M., Abraham, S., Lin, S., Scuderi, B., Turner, N., . . . Cutler, D. (2016). The association between income and life expectancy in the United States, 2001–2014. *JAMA*, *315*(16), 1750–1766. doi:10.1001/jama.2016.4226

Davies, S., Winpenny, E., Ball, S., Fowler, T., Rubin, J., & Nolte, E. (2014). For debate: A new wave in public health improvement. *The Lancet*, *384*(9971), 1889–1895. doi:10.1016/S0140-6736(13)62341-7

Denham, S. (2017). Moving to a culture of health. *Journal of Professional Nursing*, *33*(5), 356–362. doi:10.1016/j.profnurs.2017.07.010

Dieleman, J., Baral, R., Birger, M., Bui, A., Bulchis, A., Chapin, A., . . . Murray, C. (2016). US spending on personal health care and public health, 1996–2013. *JAMA*, *316*(24), 2627–2646. doi:10.1001/jama.2016.16885

Hicks, E. (2017). Digital citizenship and health promotion programs: The power of knowing. *Health Promotion Practice*, *18*(1), 8–10. doi:10.1177/1524839916676263

Kontis, V., Bennett, J., Mathers, C., Li, G., Foreman, K., & Ezzati, M. (2017). Future life expectancy in 35 industrialized countries: Projections with a Bayesian model ensemble. *The Lancet*, *389*(10076), 1323–1335. doi: 10.1016/S0140-6736(16)32381-9.

Office of Disease Prevention and Health Promotion. (2017). *Healthy People 2030*. Retrieved from https://healthypeople.gov

Pew Research Center. (2017a). *Mobile fact sheet. Who owns cellphones and smartphones.* Retrieved October 1, 2017, from www.perinternet.org/fact-sheet/mobile/

Pew Research Center. (2017b). *Digital divide persists even as lower-income Americans make gains in tech adoption*. Retrieved October 1, 2017, from http://www.pewresearch.org/fact-tank/2017/03/22/digital-divide-persists-even-as-lower-income-americans-make-gains-in-tech-adoption/

Robert Wood Johnson Foundation & RAND Corporation. (2015). *From vision to action: A framework and measures to mobilize a culture of health*. Robert Wood Johnson Foundation. Retrieved October 1, 2017, from https://www.cultureofhealth.org/content/dam/COH/RWJ000_COH-Update_CoH_Report_1b.pdf

Robinson, L., Cotten, S., Ono, H., Quan-Haase, A., Mesch, G., Chen, W., . . . Stern, M. (2015). Digital inequities and why they matter. *Information, Communication, & Society*, *18*(5), 569–582. doi:10.1080/1369118X.2015.1012532

Shortell, S., & Rittenhouse, D. (2016). The most critical health care issues for the next president to address. *Annals of Internal Medicine*, *165*(11), 816–818. doi:10.7326/M16-2471

Singh, K., & Landman, A. (2017). Mobile health. In A. Sheikh, K. Cresswell, A. Wright, & D. Bates (Eds.), *Key Advances in clinical informatics: Transforming health care through health information technology* (pp. 183–196). San Diego, CA: Elsevier.

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PART 1

The Human Quest for Health

CHAPTER 1

Toward a Definition of Health

OBJECTIVES

This chapter will enable the reader to:

1. Compare traditional and holistic beliefs about health.
2. Contrast stability and actualization concepts of individual health.
3. Discuss viewpoints of health by nurse theorists.
4. Summarize family and community definitions of health.
5. Describe the social determinants of health.
6. Discuss strategies to build a culture of health.
7. Justify the significance of global health.
8. Discuss the changing perspectives of health promotion to promote health.

Although health is one of the four concepts expressed in the nursing metaparadigm and a stated goal of nursing, different views about the meaning of health are common (American Nurses Association, 2010; Fawcett & Desanto-Madeya, 2013). These differences result from a greater understanding of determinants of health and the diverse social values and norms in our multiple ethnic, religious, and cultural groups. What many health professionals once accepted as the definition of health—the absence of diagnosable disease—is only one of many views of health held today. All people who are free of disease are not equally healthy. Furthermore, health can exist without illness, but illness does not exist without health as its context.

Health promotion, the central strategy for improving health, has shifted the paradigm from defining health as a dichotomy (presence or absence of illness or disease) to a multidimensional definition of health with social, economic, cultural, and environmental dimensions. In a multidimensional model, health benefits can potentially be

achieved from positive changes in any one of the health dimensions. This expanded health perspective encompasses multiple options for improving health and no longer places the responsibility for poor health entirely on the individual.

Definitions of health change over the life span. As children mature and move into adolescence, their explanation of health becomes more inclusive and more abstract. Health definitions of adolescents begin to expand to include physical, mental, social, and emotional health and not just the idea of absence of illness. Young adults ages 16 to 24 years report less priority on health and less engagement in health behaviors than adolescents ages 12 to 15 years and adults 25 years and older (Goddings, James, & Hargreaves, 2012). Older adults hold a more holistic definition of health, placing emphasis on physical, mental, social, and spiritual dimensions (Song & Kong, 2015).

Gender is also an important sociocultural determinant of health throughout the life span (Diaz-Morales, 2017). Many factors contribute to gender differences in health, including genetic, biological, social, and behavioral factors such as risk-taking behaviors, health-seeking behaviors, and coping styles (Caroli & Weber-Baghdiguian, 2016; Diaz-Morales, 2017). The social context of men and women is also a major determinant of gender differences. Gender equality is considered a major social determinant of health and crucial to improving the health of women and transgender individuals. In addition, a greater understanding is needed of the influence of gender on health behaviors.

A positive model of health emphasizes strengths, resiliencies, resources, potentials, and capabilities. The nature of health as a positive life process is less commonly discussed; attention still focuses on forces that undermine health, rather than factors that lead to health. Morbidity (prevalence of illness) and mortality (death) continue to be used to define the health of a population. Although these indicators are essential, they do not provide a complete picture, as they reflect disease burden and the need for health care, not health. Complex interwoven forces within the social and physical environmental context of people's lives also determine health. Health cannot be separated from one's life conditions, as neighborhood, social relationships, work, and leisure, which lie outside the realm of health practices, positively or negatively influence health long before morbid states are evident.

HEALTH AS AN EVOLVING CONCEPT

The historical development of the concept of health provides the background for examining definitions of health found in the professional literature. The Greeks were the first to write that health could not be separated from the physical and social environments and human behavior (Tountas, 2009). Their philosophy maintained that harmony, equilibrium, and balance were the key elements to health, and illness resulted when this balance was upset. Plato considered health to be a state of being in complete harmony with the universe. Hippocrates went on to define health as a balance between environmental forces and individual habits. Illness was considered an upset of this equilibrium (Tountas, 2009).

The word *health* as it is commonly used did not appear in writing until approximately AD 1000. It is derived from the Old English word *health*, meaning being safe or sound and whole of body (Sorochan, 1970). Historically, physical wholeness was important to be accepted in social groups. Persons suffering from disfiguring diseases, like leprosy, or congenital malformations were ostracized from society. This was due to

others' fear of contracting contagious diseases as well as discrimination against those whose appearance was altered due to disease or deformity. Being healthy was considered natural or in harmony with nature, while being unhealthy was thought of as unnatural or contrary to nature.

Society became concerned about helping individuals escape the catastrophic effects of illness beginning with the scientific era that produced new medical discoveries and treatments. *Health* was described as "freedom from disease." Because disease could be traced to a specific cause, often microbial, it could be diagnosed. The notion of health as a disease-free state was extremely popular into the first half of the 20th century. Health and illness were viewed as extremes on a continuum; the absence of one indicated the presence of the other. This gave rise to "ruling out disease" to assess health, an approach still prevalent today. The underlying erroneous assumption is that a disease-free population is a healthy population.

The concept of mental health did not exist until the latter part of the 19th century. Individuals who exhibited unpredictable or hostile behavior were labeled "lunatics" and ostracized in much the same way as those with disfiguring physical ailments. Being put away with little or no human care was considered their "just due," because mental illness was often ascribed to evil spirits or satanic powers. The visibility of the ill only served as a reminder of personal vulnerability and mortality, aspects of human existence that society wished to ignore.

The psychological trauma resulting from the high-stress situations of combat during World War II expanded the scope of health to include the mental status of individuals. Mental health was seen as the ability of an individual to withstand stresses imposed by the environment. When individuals succumbed to the rigors of life around them and no longer were able to carry out the functions of daily living, they were declared to be mentally ill. Despite efforts to develop a more holistic definition of health, the dichotomy between individuals suffering from physical or mental illness persisted for many years. In 2011, the World Health Organization (WHO) published an expanded view of mental health as a state of well-being in which individuals realize their potential, can cope with normal life stresses, work productively, and are able to make a contribution to their community (World Health Organization, 2014).

In 1946, the WHO proposed a landmark definition of health that emphasized "wholeness" and the positive qualities of health: "Health is a state of complete physical, mental, and social well-being and not merely the absence of disease and infirmity" (World Health Organization, 2005). The definition was revolutionary in that it

1. Reflected concern for the individual as a total person
2. Placed health in the context of the social environment
3. Overcame the reductionist definition of health as the absence of disease.

The breadth of this historical definition mandated a comprehensive approach to health promotion, and inherently created an imperative for health equity (Friel & Marmot, 2011).

Many continue to think that the WHO definition is utopian, too broad, and the absoluteness of the term "complete" renders health impossible to achieve (Bok, 2017; Huber & Bok, 2015). The definition was formulated when acute infectious illnesses were the major health burden. However, chronic diseases have replaced acute illnesses as the major cause of disability and death, and people are living with chronic diseases for decades. This

change is not accounted for in the definition. In addition, the influence of the genome in disease, the inability to separate individuals from their environment, and the relationship of the earth's climate and human health cannot be ignored. Despite multiple acknowledged influences on health, the WHO definition of health continues to be the most popular and comprehensive definition of health worldwide and was reaffirmed at the 2005 assembly (World Health Organization, 2005). It is now accepted that individual health cannot be separated from the health of society. Moreover, the relationship of human health to the health of the earth's ecosystem is also recognized as an important dimension. In other words, one cannot be healthy in an unhealthy society or world. Within these dimensions, health has more recently been defined as "the ability to adapt and to self-manage in the face of social, physical and emotional challenges" (Bok, 2017). Health is not a fixed state, as it varies depending on an individual's life circumstances.

In the following sections, health definitions are discussed that focus on the individual and the community. Although health care professionals cannot ignore individual health, the health of the individual's larger community is also critical, as the health of the community influences the overall health status of its members.

DEFINITIONS OF HEALTH THAT FOCUS ON INDIVIDUALS

Health as Stability

Stability-based definitions of health are based on the physiological concepts of homeostasis (internal stability) and adaptation. Dubos (1965), an early advocate of the stability position, defines health as a state that enables the individual to adapt to the environment. The degree of health experienced is dependent on one's ability to adapt to the various internal and external tensions that one faces. Dubos considered optimum health to be a mirage because in the real world individuals must face physical and social forces that are forever changing, frequently unpredictable, and often unsafe. An early scientist who viewed the environment as a major influence on health, Dubos considered the closest approach to optimum or high-level health to be a physical and mental state that permits one to function effectively within the environment (Flannery, 2009).

Definitions of health based on normality can be considered stability oriented. Norms represent average states rather than excellence in human functioning (Ereshefsky, 2009). Health is considered a normal function and disease represents an impairment of normal function. A major issue with normative definitions of health is that they leave little room for incorporating growth, maturation, and evolutionary emergence into a definition of health.

Environmentally focused models of health can also be considered stability oriented, as these models are based on adaptation to one's environment. Health is considered an individual's ability to maintain a balance with the environment. Health exists when one is able to adapt to the environment successfully and is able to grow, function, and thrive. In contrast, lack of adaptation is seen as a gap between one's ability to adapt and the demands of the environment.

Parsons' conceptualization of health is compatible with a stability-oriented environmental model. More than 50 years ago, Parsons defined health in terms of social norms rather than physiological norms, describing health as individuals' effective performance of roles and tasks for which they have been socialized (Parsons, 1958).

A number of nurse theorists have proposed definitions of health emphasizing stability beginning with Florence Nightingale. Nightingale viewed health as being the best that one could be at any point in time (Selanders, 2010). Levine, an early nurse theorist, defines health as a state in which there is balance between input and output of energy and in which functional, personal, and social integrity exists (Schaefer, 2014). Johnson, in her behavioral system model, does not explicitly define health. However, a view of health that focuses on stability can be inferred from her conceptualization of internal homeostasis (Holaday, 2014). Behavioral system stability is demonstrated by efficient and effective behavior that is purposeful, goal directed, orderly, and predictable.

Roy also subscribes to a stability definition of health. The central concept in Roy's model is adaptation. Health is a state and process of successful adaptation that promotes being and becoming an integrated whole person. The four adaptive modes through which coping energies are expressed are physiological, self-concept, role performance, and interdependence. Adaptation promotes integrity, which implies soundness or an unimpaired condition that can lead to completeness and unity. In an adapted state, one is freed from ineffective coping attempts that deplete energy. Available energy can be used to enhance health (Doucet & Merlin, 2014).

Health as Actualization

When individual health is defined more broadly as actualization of human potential, some prefer to use the term *wellness*, as it is considered less restrictive than the concept of health. Halbert Dunn, the creator of the modern-day definition of wellness, was an early advocate for emphasizing actualization in a definition of health. Dunn coined the term *high-level wellness*, which he described as integrated human functioning that is oriented toward maximizing an individual's potential. This requires that individuals maintain balance and purpose within the environment where they are functioning (Dunn, 1959, 1980). Although the definition identifies balance as a dimension of wellness, major emphasis is on the realization of human potential as individuals move toward their personal optimum level based on their capabilities and potential.

Definitions of wellness have evolved since Dunn initially defined the concept and launched the wellness movement. The dominant view is that wellness is holistic and includes multiple positive dimensions of health. These dimensions include social, emotional, physical, spiritual, and intellectual wellness. The wellness definition includes building on one's strengths and optimizing one's potential. The terms health, well-being, and wellness are used interchangeably in the literature, although each concept is thought to have distinguishing features. Consistencies across the definitions of health and wellness include the following:

1. Health and wellness are not merely the absence of disease.
2. Health and wellness consist of multiple dimensions that are holistic and interrelated.
3. There is a dynamic balance among the dimensions of health and wellness.
4. Health and wellness represent optimal functioning.

The WHO Regional Office in Europe convened an expert group to define well-being and develop objective and subjective measures of the domains of well-being. The

first meeting was held in 2012 (World Health Organization, 2013a). The definition that was developed is considered to support the original WHO definition of health. They defined well-being as comprising individuals' experiences of their lives as well as a comparison of life circumstances with social norms and values (World Health Organization, 2013a). Wellness contains both subjective and objective dimensions. Health is considered a separate concept that influences subjective well-being, and well-being is linked to health (World Health Organization, 2013b).

Orem uses *health* and *well-being* to refer to two different but related human states in her self-care theory (Orem & Taylor, 2011; Shah, 2015). She defines *health* as a state characterized by soundness or wholeness of human structures and bodily and mental functions. *Well-being* is considered an ideal state characterized by experiences of contentment, pleasure, and happiness; by spiritual experiences; and by continuing personalization. Personalization refers to movement toward maturation and achievement of human potential (self-actualization). Engaging in responsible self-care and continuing development of self-care competency are qualities of personalization. Individuals can experience well-being even under conditions of adversity, including disease. In describing her man-living-health theory of nursing, Parse defines health as an open process of becoming (Doucet & Merlin, 2014; Parse, 2011), which is consistent with health as actualization.

Newman, building on the grand theory of Martha Rogers, defines health as the totality of the life process, which is evolving toward expanded consciousness (Bateman & Merryfeather, 2014; Neuman & Fawcett, 2012). This definition emphasizes the actualizing properties of individuals throughout the life span. Health encompasses the entire life process, which evolves toward a higher and greater frequency of energy exchange. Newman's model of health addresses holistic characteristics of human beings. However, similar to Roy's theory, there is no intent to create strategies to measure many of the terms, limiting potential testing and clinical applicability of her definition.

Both Newman and Parse build on Martha Rogers' theory of unitary person. Both represent attempts to define health in terms of holism as opposed to defining health in components or parts. The emergent nature or actualization potential of the healthy individual and the capacity for open energy exchange with the environment are characteristics of both Newman's and Parse's definitions of health.

Actualization or wellness models have been criticized because of the difficulties in measuring subjective perceptions. In addition, perceptions of health and wellness vary according to age and sociocultural context. Some believe that the expanded definitions of health in some of the wellness models do not differentiate health from happiness, quality of life, and other global concepts. In spite of these limitations, the wellness definitions provide a holistic focus and promote the positive aspects of health.

Health as Actualization and Stability

Models of individual health also incorporate both stability and actualization. In these models, health is defined as a feeling of well-being, a capacity to perform to the best of one's ability, and the flexibility to adapt and adjust to stressful situations created by one's environment. King, an early nurse theorist, proposes a definition of health that emphasizes both stabilizing and actualizing tendencies. She identifies health as the goal of nursing and defines *health* as a dynamic state in the life cycle of a person that implies

TABLE 1–1 Nurse Theorists' Conceptualizations of Health

Nurse Theorist	Health Conceptualization
Health as Stability	
Florence Nightingale	The best that one could be at any point in time
Myra Levin	A state of balance between inputs and outputs of energy in which functional and personal integrity exists
Dorothy Johnson	Internal homeostasis; balance and stability among all behavioral systems demonstrated by purposeful, goal-directed behavior
Calista Roy	Process of successful adaptation that promotes being and becoming integrated to function as a whole person
Health as Actualization	
Dorothea Orem	Wholeness of physical and mental functions as one progresses toward maturation and achievement of human potential
Margaret Newman	The totality of life processes that are evolving toward expanded consciousness (self-actualization)
Health as Stability and Actualization	
Imogene King	A dynamic state in which one is successfully adjusting to environmental stressors to achieve maximum potential for everyday living

adjustment to stressors in the environment through optimum use of resources to achieve one's maximum potential for daily living (Gunther, 2014; King, 1990, 2007). In King's model, a holistic health perspective relates to the way individuals handle stressors while functioning within the culture to which they were born. King views health as a functional state in the life cycle, while illness interferes in the life cycle. Table 1–1 summarizes the conceptualizations of health by the early nurse theorists.

A definition of health must be applicable to everyone—to the well, to those with an acute illness, and to those with chronic disease or disability. The authors of this text believe a definition of health should incorporate both actualizing and stabilizing tendencies, and define *health* as the realization of human potential through goal-directed behavior, competent self-care, and satisfying relationships with others, while adapting to meet the demands of everyday life within one's social and physical environments. The definition is based on the assumptions that health is an expression of person and environment interactional patterns that become increasingly complex throughout the life span. These interactional patterns are influenced by conditions of daily living as well as the economic, political, and sociocultural context. The authors of this book believe health and illness are qualitatively different, interrelated concepts that may coexist. In Figure 1–1, multiple levels of health are depicted in interaction with episodes of illness. Illnesses, which may have a short (acute) or long (chronic) duration, are represented as discrete events within the life span. Health can still be an aspiration to

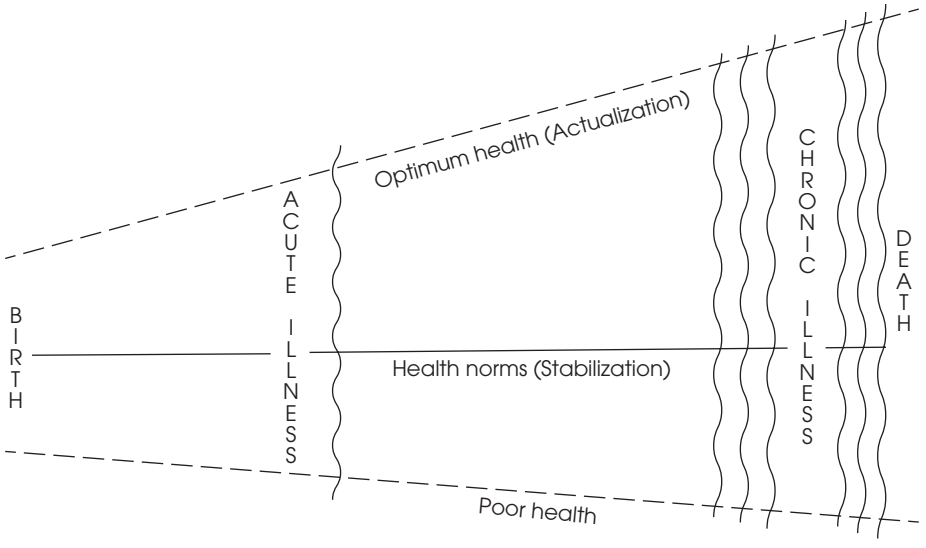

FIGURE 1–1 The Health Continuum Throughout the Life Span

those with a chronic illness or disability, and health can be achieved despite being diagnosed with a disease or living with a disability. Illness experiences can either hinder or facilitate one's continuing quest for health. Thus, good health or poor health may exist with or without overt illness.

Health as an Asset

The conceptualization of health as a resource or asset was introduced in 1986 at the First International Conference on Health Promotion (World Health Organization, 1986a), when health was defined as not an end in itself but a resource for daily living. This conception was further described as the capacity to engage in various activities, fulfill roles, and meet the demands of daily life. This definition builds on the WHO recognition of health as the strengths and capabilities inherent in individuals. Health as an asset has also been described as the internal and external attributes of the individual that mobilize positive health behaviors and optimum outcomes (Rotegard, Moore, Fagermoen, & Ruland, 2010). Health as an asset was noted in Schlotfeldt's early model of nursing. She described health as an asset and stressed focusing on individual strengths, rather than problems. Internal attributes are characteristics that are inherent within individuals, such as personality, attitude, and motivation. Internal attributes are influenced by an individual's external attributes, which include the social and cultural environments. Inclusion of external assets is consistent with the focus on the social determinants of health.

An Integrative View of Health

Although the biological model provides technological excellence and sophisticated medical care, it has led to a narrow focus on disease. An expansive view of health goes

beyond disease prevention and risk reduction and emphasizes mind, body, and spirit: personal and social resources as well as physical capacities (Witt et al., 2017). When this view is integrated with traditional biomedical models (disease) and public health models (mortality, morbidity, and risks) of health, a holistic biopsychosocial view is possible. Understanding the relevance of an integrative definition of health for individuals in their everyday life experiences in different social contexts acknowledges the social determinants of health. An integrative definition of health acknowledges the need to expand traditional health promotion programs to empower individuals to improve the health of their communities.

DEFINITIONS OF HEALTH THAT FOCUS ON THE FAMILY

The complexity of the family and the diversity of family life in different ethnic, cultural, and geographic settings pose a challenge for defining and promoting family health. The traditional definition of family as two or more persons living together who are related by marriage, blood, or adoption is no longer adequate in American society. Families may be defined by biological, legal, or emotional ties, whether or not they are living together. Families may include nuclear families, single-parent families, blended families, same-sex partnerships, families without children, and sibling families. One broad definition of *family* now accepted is two or more persons who depend on one another for emotional, physical, or financial support. In this definition, family members are self-defined and may include any individuals who make a significant commitment to each other outside of marriage. Variation in family structure is essential when defining, measuring, and promoting family health.

A biopsychosocial definition of *family health* describes family health as a dynamic changing state of well-being, including biological, psychological, sociological, spiritual, and cultural factors of the family system. In this definition, an individual's health affects the functioning of the family, and in turn, family functioning affects the health of the individual. Thus, both the family system and the individual members must be part of the health assessment.

A family model of reciprocal determinism also takes into account the complexity of the family environment in promoting health (Knowlden & Sharma, 2016). In this model, health behaviors of individuals are a function of the environment that is shared with other family members and their behaviors and personal characteristics. Health information is shared and behaviors are learned, practiced, and reinforced in the daily routine, which are facilitated or hindered by family values and beliefs. In other words, the interaction of the individual with other members of the family or other units in society, including work and play, is emphasized.

Characteristics of healthy families have been described and include affirmation and support for one another, a shared sense of responsibility, shared leisure time, shared religious core, respect, trust, and family rituals and traditions. These qualities address stability of family functioning and balance in interactions among family members. Family typologies have also been developed to identify common profiles that may be linked to health in families. Typologies also suggest that health promotion interventions must be compatible with family values, beliefs, and orientations.

Many factors influence how family health is defined. Social, cultural, environmental, and religious/spiritual factors play a central role in determining how families view

their health. Families' strengths, resources, and competencies are also an integral part of a positive view of health. Implementing and evaluating family models of health will assist nurses in promoting family health.

DEFINITIONS OF HEALTH THAT FOCUS ON THE COMMUNITY

Communities are usually defined within one of two frameworks: spatial/geographical area or relational/functional. Geographical definitions are based on legal or geopolitical areas such as cities, towns, or census tracts. Relational definitions are based on how people interact to achieve common goals. The WHO defines community as a social group determined by both geographical area and common values, with members who know each other and interact within a social structure (World Health Organization, 1974). Members of the community create norms, values, and social institutions for its members. The WHO definition focuses on both the spatial and relational/functional dimensions of a community.

Social ecological theories of community health emphasize the interaction and interdependence of individuals with their family, community, social structure, and physical environment (Golden, McLeroy, Green, Earp, & Lieberman, 2015). A social ecology model described in the *Ottawa Charter for Health Promotion*, a landmark health promotion policy statement, outlines the essential dimensions of community health (World Health Organization, 1986b). Fundamental to community health are peace, shelter, education, food, income, a stable ecosystem, sustainable resources, social justice, and equity. The Healthy Cities project in the United States, Europe, and Australia is based on a social ecological view that the roots of ill health lie in social and economic factors. The international project supports the premise that the responsibility for health is widely shared in the community with collaborative decision-making about health issues (de Leeuw, Tsouros, Dyakova, & Green, 2014). Cultivating healthy communities continues to be a priority for WHO, which maintains that four key ingredients are essential:

1. There must be local investment in communities.
2. Venues need to be provided for communities to learn about effective change strategies.
3. Partners need to be mobilized for change.
4. Communities need resources for local health promotion.

Informed political action and healthy public policies are also essential to a healthy community. At the 9th Global Conference on Health Promotion, in Shanghai, a continuing commitment to a Healthy Cities program was supported as a comprehensive approach for health (World Health Organization, 2016).

Community health has also been defined as meeting the collective needs of its members through identifying problems and managing interactions within the community and between the community and the larger society (Stanhope & Lancaster, 2016). Community health is more than the sum of the health states of its individual members; the characteristics of the community as a whole must be included. Individual, family, and community health are intimately related. The health of the community depends on individual health as well as the availability of social, physical, and political resources to

enable individuals to live healthy lives. The relationship between social and economic conditions and the health of individuals in a community is widely documented and addressed in the *Healthy People 2020* objectives as well as the *Healthy People 2030* overarching framework (U.S. Department of Health and Human Services, 2013).

Social capital is considered to be a major determinant of health in communities. This term, which includes trust, reciprocity, and cooperation among families, neighborhoods, and entire communities, is discussed in more detail in Chapter 3. Healthy communities support healthy lifestyles. Likewise, the collective attitudes, beliefs, and behaviors of individuals who live in the community influence the health of the community. All social and physical environmental components of a community must be assessed prior to developing strategies to create healthier communities.

A body of evidence supports an expanded view of health that is inseparable from the community and larger society. Effective health promotion interventions are based on an assessment of a community's social, economic, and physical resources recommended in the *Healthy People 2020* document, as these factors affect the health of individuals, families, and communities (U.S. Department of Health and Human Services, 2013).

SOCIAL DETERMINANTS OF HEALTH

More than 100 years ago, Florence Nightingale understood that the environment in which people live was a major contributor to health and disease (Koffi & Fawcett, 2016). She also believed that environments could be altered to improve health. Her observations during the Crimean War and working in poor communities led to these observations. Of the four broad determinants of health (biological attributes, health care access, life style, and the social, economic, and physical environments), the social, economic, and physical environments in which people live are considered to be the most significant, as they influence health directly and indirectly (Mariner, 2016).

The social determinants of health are the conditions in which people are born, live, work, and age, including the health care system (Bircher & Kuruvilla, 2014). They are responsible for the differences in health seen within and between individuals, families, communities, and countries (World Health Organization, 2008). The social conditions under which people live, including poverty with its accompanying inadequate housing, poor sanitation, suboptimal food, lack of education, and social discrimination, have a dramatic impact on health. Differences in health can be attributed to socioeconomic, political, cultural, and geographic dimensions as they are driven by inequities in power, money, and resources (Friel & Marmot, 2011). The influence of these factors is evident when comparing the health of those at the top of the social ladder with those at the bottom. The *Ottawa Charter for Health Promotion* stated eight fundamental conditions and resources for health, including peace, shelter, education, food, income, a stable ecosystem, sustainable resources, social justice, and equity. The social determinants are discussed in detail in Chapter 12.

Both downstream and upstream determinants of health should be identified prior to planning and implementing interventions to promote health. Individual factors, including knowledge, beliefs, attitudes, and behaviors, are downstream factors that are shaped by upstream determinants. Upstream determinants include living and working conditions, and economic and social opportunities and resources (Braveman & Gottlieb, 2014). A conceptual framework developed for the Robert

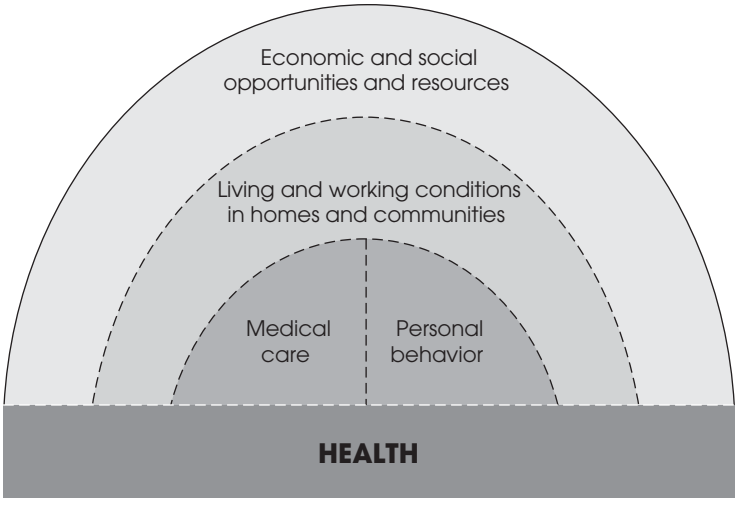

FIGURE 1–2 A Conceptual Framework for Describing Downstream and Upstream Determinants of Health

Wood Johnson Commission to Build a Healthier America depicts how downstream factors are shaped by an individual's upstream factors. This framework (see Figure 1–2) highlights a critical need to address downstream factors within an individual's socio-environmental context.

In *Healthy People 2020*, the national health agenda, one of the four major goals is to create social and physical environments that promote health (U.S. Department of Health and Human Services, 2013). The *Healthy People 2020* agenda documents the multiple determinants of health and health behaviors, including personal, social, and physical environments and the interrelationships among these different levels of health determinants. The need for multilevel (individual, family, community) interventions is emphasized to promote health and well-being.

Use of the term *social determinant* has been criticized based on the thinking that the expanded focus results in a loss of individual identity. Others state that the term *social* should not be used. Rather, determinants of health should be the focus to avoid the politicized view of health. Regardless of the terms used, it is now understood that a broader view of health that takes into account the social, cultural, and physical environments is necessary to improve the health of all. An understanding of the social determinants is important for nurses and other health care professionals to effectively intervene in neighborhoods, organizations, and communities to improve individual health. This is discussed in more detail in Chapter 14.

SOCIAL DETERMINANTS AND GLOBAL HEALTH

Global health is described as the health of the world's population resulting from worldwide interconnectedness and interdependence (Frenk, Gomez-Dantes, & Moon, 2014). Global health places a priority on improving and achieving equity for all (Koplan et al., 2009). Global health issues include the vulnerability of refugee populations, the marketing of

harmful products such as tobacco, the erosion of social and environmental conditions, the exacerbation of income differences, pandemics such as the Ebola virus outbreak, the emergence of superbugs and antibiotic resistance, and global climate change.

Globalization has resulted in health threats extending across borders, bringing about health interdependence of nations to promote health and reduce health threats (U.S. Department of Health and Human Services, 2017). Global health security is more important than ever, as no country is immune to global health threats as noted with the Ebola virus outbreak in 2015. Solutions to global health security include the development of new technologies, such as vaccines; improved capacities and resources, including workforce training; new health care systems to promote population health; improved global governance and coordination; and a global identity that promotes global solutions (Horton & Das, 2015). The goal of a global health agenda is to improve the health of all people in all nations by promoting wellness and eliminating avoidable diseases, disabilities, and deaths. Although the major drivers in global health are government and nongovernment agencies, health care providers play a crucial role in assisting in identifying and addressing community and population health issues through community activism and civic engagement.

BUILDING A CULTURE OF HEALTH

In 2013, Robert Wood Johnson Foundation (RWJF) proposed a 20-year agenda to address the health of individuals and communities by building a national movement to create a national Culture of Health (Lavizzo-Mourey, 2015; Plough, 2014). A culture of health builds on the WHO definition of health that recognizes its social, cultural, economic, and political determinants. Ten core principles support the foundation for a culture of health. These principles are listed in Table 1–2. The RWJF states that a culture of

TABLE 1–2 Principles Underlying a Culture of Health

1. Good health flourishes across geographic, demographic, and social sectors
2. Attaining the best health possible is valued by our entire society
3. Individuals and families have the means and the opportunity to make choices that lead to the healthiest lives possible
4. Business, government, individuals, and organizations work together to build healthy communities and lifestyles
5. No one is excluded
6. Everyone has access to affordable, quality health care because it is essential to maintain or reclaim health
7. Health care is efficient and equitable
8. The economy is less burdened by excessive and unwarranted health care spending
9. Keeping everyone as healthy as possible guides public and private decision-making
10. Americans understand that we are all in this together

Source: Accessed from the Robert Wood Johnson Foundation culture of health website (http://cultureofhealth.org). Copyright 2017. Robert Wood Johnson Foundation. Used with permission from RWJF.

health is a set of ideas and practices that promote the health of individuals, families, communities, and nations (Chandra, Acosta, et al., 2016). A culture of health exists when individuals and organizations are able to:

1. Promote individual and community well-being
2. Create environments that prioritize health
3. Support access to opportunities for healthy lifestyles and high-quality health care (Chandra, Acosta, et al., 2016).

In communities where a culture of health is valued, its members work together to address the social determinants to improve the collective well-being of everyone.

Collaborating with the RAND Corporation, RWJF developed a Culture of Health Action Framework to motivate dialogue and collaboration among individuals, communities, and organizations in order to change the health of the nation by enabling everyone to lead a healthier life (Trujillo & Plough, 2016). The RWJF's goal is to mobilize a social movement to build a national culture of health. The action framework consists of four drivers that are expected to generate health, well-being, and equity for all. The drivers include:

1. Making health a shared value
2. Fostering cross-sector collaboration to improve well-being
3. Creating healthier, more equitable communities
4. Strengthening integration of health services and systems (Chandra, Miller, et al., 2016).

The framework is currently being implemented in multiple communities throughout the United States. Ongoing individual and community level evaluations will closely examine the process for building a culture of health to identify successful strategies for moving to a national culture of health (Trujillo & Plough, 2016). Changing cultures to value health will not occur overnight, as a social change that moves the emphasis from disease and illness to health will take many years. Nurses will play a major role in helping to shift the nation's values and actions to promote health through activities such as implementing health promotion programs and advocating for policies to decrease health inequities in communities.

CONCEPTIONS OF HEALTH PROMOTION

Expanding definitions of health have led to changing views of health promotion. Early health promotion efforts focused on individual responsibility for health and emphasized behavioral determinants and educational approaches. However, evidence has shown that health promotion programs must also address social and physical environments, as these also contribute to poor health. This view was expressed in the *Ottawa Charter for Health Promotion*, the first document to focus on health promotion, which was defined as a process to enable people to overcome challenges and increase control over their environments to improve their health (World Health Organization, 1986b). The Ottawa document laid the foundation for the theory and practice of health promotion and emphasized the role of social and personal resources, physical capabilities, and the need to achieve equity in health. The *Ottawa Charter* also documented the responsibility of nongovernment and government agencies in creating supportive environments and health public policy.

The *Bangkok Charter for Health Promotion* updated the *Ottawa Charter* to make health promotion central to the global development agenda and a core responsibility of all governments (World Health Organization, 2005). The *Bangkok Charter* addressed the changing context of health promotion that had occurred since the adoption of the *Ottawa Charter*. The document has been described as moving health promotion from an individual health lifestyle education model toward a socioecological model that addresses social determinants of health. In the *Bangkok Charter*, many challenges are recognized due to the multiple determinants of health in a globalized world; health promotion is considered a core responsibility of all governments.

The 9th Global Conference on Health Promotion resulted in the *Shanghai Declaration*, where health as a universal right was reaffirmed. The document also recognizes that health and well-being are essential to achieving the United Nations Development Agenda 2030 and sustainable development goals (SDGs). The SDGs establish a duty to invest in health (World Health Organization, 2016). Although the document is a commitment to promote universal health coverage and health equities for people of all ages, challenges are ahead to achieve the goals. The *Shanghai Declaration* is similar to the RWJF call for a culture of health, as the declaration promotes cities and communities as critical settings for health promotion and recognizes the role of governments in addressing health equity. It also recognizes the role of health literacy and the new global context for health promotion.

Health promotion and *health education* are often used interchangeably. Although the terms are closely linked, they are not the same. Health education focuses on learning activities and experiences for individuals and groups. It is a component of health promotion and is an essential part of communication between health care professionals and clients. Health education has progressed from health care professionals providing information they think the client should know to a shared decision-making process. The *Ottawa Charter* was the catalyst that moved health promotion beyond being defined as an educational activity to a broader concept that also focused on the social and political environment. The expanded definition of health promotion is evident in the principles defined to guide health promotion programs (Tremblay, Richard, Brousselle, & Beaudet, 2013). These seven principles are summarized in Table 1–3.

Health protection has also been used interchangeably with health promotion. Health protection refers to legal or fiscal controls and other regulations to enhance health and prevent disease (Tannahill, 2009). Health protection interventions emphasize worker safety to prevent disease. Disease prevention has also been used interchangeably with health promotion (Mittelmark, Kickbusch, Rootman, Scriven, & Tones, 2017). Disease prevention activities stress modifying individual or environmental factors to reduce or eliminate risk (primary prevention) for a specific disease such as cardiovascular disease or cancer, or lifestyle change to reduce risk factors present in the early stages of a disease (secondary prevention), such as dietary modifications for hypertension. Disease prevention is focused on specific diseases, while health promotion targets changing lifestyles and promoting healthy environments. Health promotion can include disease prevention when the focus is on reducing risks for healthy living.

TABLE 1–3 Core Principles of Health Promotion

Principle	Explanation
Participation	Involve the stakeholders at all stages of the project
Empowerment	Enable individuals and communities to take control over the personal, socioeconomic, and environmental factors that affect their health
Holism	Consider all health components: physical, mental, social, and spiritual
Intersectoral	Ensure collaboration from all the disciplines and areas concerned
Equity	Seek fairness in health and social justice
Sustainability	Implement changes that can be maintained after programs have ended
Multiple strategies	Rely on several approaches in combination

Source: Adapted from Rootman, I., Goodstadt, M., Hyndman, B., McQueen, D. V., Potvin, L., Springett, J., & Ziglio, E. (2001). *Evaluation in health promotion: Principles and perspectives*. WHO Regional Publication, European Series No. 92. Denmark: World Health Organization.

Health promotion has moved from being considered a goal or desired end point to a process to facilitate movement toward accomplishment of health goals. It is both the art and science of supporting people to make lifestyle changes and creating environments that are conducive to health (Mittelmark et al., 2017). A combination of health promotion strategies is needed to address the multiple determinants of health. Ecological strategies address the social, economic, and physical environments that influence health. Health promotion spans from the prevention of disease to empowering individuals, to promoting environmental and policy change. Settings for health promotion include the workplace, schools, hospitals, prisons, and communities—where individuals spend their everyday lives.

Multiple factors in society influence how the delivery of health promotion is changing and will continue to do so in the 21st century (Edington, Schultz, Pitts, & Camilleri, 2016). Evolving lifestyles and relationships occur with each new generation. These are influenced by where individuals choose to work and live. New discoveries in the neurosciences about the mind–body connection and brain plasticity and epigenetics offer new insights into the interplay of lifestyle, environment, and health. Technology continues to expand at an accelerated rate, including wearable technology, mobile health (mHealth), health monitors with wireless modules to track fitness and monitor and analyze behaviors and send alarms, and many applications to facilitate healthy behaviors.

Information and communication technologies are changing the way health information is shared and health promotion programs are being delivered. The increase in use of the Internet has resulted in social network communities that are providing instant information and health promoting programs (Ortega-Navas, 2017). The technologies offer many benefits for health promotion, including easier access to information and support for healthy behaviors. The technologies are also changing the nurse–client relationship, including the degree of engagement in the health promotion process. In addition, information accessed may not have a scientific background and should be followed up with a health care professional (Ortega-Navas, 2017).

Currently, the research base documenting the role of technology in improving health is limited so it should be considered a tool or adjunct to health promotion efforts until there is more evidence of its role in lifestyle change (Patrick et al., 2016). In spite of the limitations of the research designs (no traditional education control group, no random assignment, biased samples), potential benefits have documented short-term behavior change and cost effectiveness (Oosterveen, Tzelepis, Ashton, & Hutchesson, 2017). Nurses and other health care professionals have opportunities to create new roles in health promotion incorporating these information and communication technologies to promote healthy behaviors.

MEASUREMENT OF HEALTH

On the basis of the WHO definition of health, five distinct dimensions have been proposed as a minimum standard for a comprehensive measure of health: physical or functional health, mental health, social functioning, role functioning, and well-being. Multiple issues are raised when measuring these concepts, as they include both objective and subjective indicators. They are not static; they are constantly changing as life circumstances of individuals change, also challenging measurement.

One type of self-rated health assessment is the enduring self-concept or stability measurement of health. These scales measure a reflection of one's established beliefs about one's health. In this view, self-rated health is stable over time and is based on one's self-concept. Self-concept health measures may not reflect the objective indicators of health, as individuals' beliefs about their health are often incongruent with their physical status. This view is compatible with an expansive definition of health, as an individual's self-evaluation of overall health is related to an overall sense of well-being. However, if one takes the view that health depends on an individual's circumstances, then the social and physical context must also be considered when assessing health.

Measures of wellness that encompass a holistic assessment are available. Most of these measures assess the major dimensions of wellness, including physical, social, emotional, spiritual, and intellectual. Some measures also assess occupational, environmental, and financial dimensions. Many of these scales have over 100 items and the reliability and validity are not reported for others. However, the holistic approach to measuring health is a major strength. The WHO continues to convene experts to develop and test measures of health and well-being (World Health Organization, 2013a).

The focus on social determinants of health has generated the need to develop accurate, easy-to-use measures of the social and built environments. Community assessment indexes have been designed to measure policies, programs, and practices in the community that affect healthy behaviors as well as characteristics of neighborhoods. An example of one effort is the Community Healthy Living Index. This assessment identifies the extent to which the community supports active living and healthy eating across a variety of venues (Kim et al., 2010). Measures of communities that document both healthy and unhealthy food, and physical and social environments commonly include the number of grocery stores, fast-food restaurants, and convenience stores; and access to parks and/or recreational or fitness centers for physical activity; crime, and rental occupied housing (Myers, Denstel, & Broyles, 2016). Progress has also been made in measuring walkability in communities using new technologies, such as global positioning systems, smartphones, and Web-based tools. Although major challenges remain

and the technology changes rapidly, the measures provide valuable health information for public policy.

The multiple components of health and its determinants point to the need for standardized, simple indicators of the health components. Decisions first need to be made about which elements of health and well-being are appropriate to measure. Often, a direct measure may not be available, so decisions have to be made about proxy measures. For example, in measuring community health, proxy measures may include the number of grocery stores, presence of health care facilities, and safe walking spaces. Measures should be relevant for the individuals who will be assessed. Important factors to consider include age, educational level, language primarily spoken, and health literacy. Multiple health measures may be needed to assess individual, family, and community levels. Measurement of health and its many determinants is complex; it becomes even more so when all perspectives are taken into account. These challenges pose multiple opportunities for developing or adapting and testing new measures.

CONSIDERATIONS FOR PRACTICE IN THE CONTEXT OF HEALTH

The definition of *health* has evolved from traditional usage in a medical, curative model to a multidimensional concept with physical, social, spiritual, environmental, and cultural dimensions. Nurses and other health care professionals need to understand and assess all dimensions in their health assessments. The assessment information can then be used to identify health needs and develop strategies to promote health. For example, a biomedical assessment may be useful in guiding genetic counseling or screening interventions. Information collected from a cultural assessment can provide valuable knowledge in developing health promotion programs in communities with diverse populations. An assessment of the social and physical environments will provide useful information about aspects of the environment that may be positively or negatively affecting the health of the individual or community. In an integrative view of health, an assessment is not complete unless it involves the individual, family, and community in which individuals live and function. Nurses work in partnership with clients to provide the knowledge and skills needed to empower them to achieve their health goals or adapt to circumstances to move toward their health goals. Health should be viewed from a positive perspective when conducting an assessment or designing health promotion strategies. This means that the focus should be on available resources, potentials, and capabilities. When health is viewed in a positive model, strategies can be developed that concentrate on strengthening resources and decreasing risks.

OPPORTUNITIES FOR RESEARCH ON HEALTH

The fundamental purpose of nursing research is to build knowledge to improve health. The contribution of nursing to health promotion depends, in part, on the way in which health knowledge is grounded in science. Nursing research has been active in knowledge development to improve the health of all. However, many questions remain unanswered. What are the gender, culture, and racial differences in the expressions of health? What interactive conditions between persons and their environment enhance or deplete health? Which social determinants are critical to assess the health of families? Which social determinants are key to improving the health of communities? How

does global health security affect the health of individuals and communities? Generating knowledge will advance the scientific base to enable nurses to implement effective health-promoting interventions and begin policy discussions for change.

Multilevel models of health that incorporate ethnic, cultural, social, and environmental factors are needed to examine the determinants of health. Longitudinal studies are needed to describe the role of social determinants across the life span in diverse populations. Multidisciplinary research teams will facilitate the development and testing of multilevel interventions to address the social determinants of health. A good example is the RWJF program that is building a national culture of health.

Summary

Varying definitions of *health* have been presented to provide the foundation on which health promotion programs for individuals, families, and communities can be based. An assessment begins with learning how health is defined by the individual, family, or community and identifying realistic strategies to achieve the desired health goals. Evidence has shown that individual health cannot be separated from the health of the family, community, nation, and world. A shift to this broader perspective of health facilitates development of proactive policies to improve health. The complexity of factors known to determine the health of individuals also raises many challenges. However, the challenges are not insurmountable and are being tackled at local, national, and international levels.

Learning Activities

1. Based on the definitions provided in the chapter, write your own definition of *health* and state the rationale for the factors you considered in developing the definition.
2. Interview three persons at varying points in the life span (adolescent, young adult, elderly person) to obtain their perspective of health and the health promotion strategies they perform to stay healthy. Ask them to identify any personal, social, and environmental barriers to pursuing a healthy lifestyle.
3. Suggest health promotion strategies to help overcome the barriers stated by the interviewees in learning activity 2.
4. Develop a plan to conduct an assessment to determine the health of a family or a community using the social determinants of health.
5. Design a clinical experience for students assigned to a community-based organization that incorporates the principles of health promotion.

References

American Nurses Association. (2010). *Nursing's social policy statement: The essence of the profession* (3rd ed.). Washington, DC: Author.

Bateman, G. C., & Merryfeather, L. (2014). Newman's theory of health as expanding consciousness: A personal evolution. *Nursing Science Quarterly*, *27*(1), 57–61. doi: 10.1177/0894318413509725

Bircher, J., & Kuruvilla, S. (2014). Defining health by addressing individual, social, and environmental determinants: New opportunities for healthcare and public health. *Journal of Public Health Policy*, *35*(3), 363–386. doi:10.1057/jphp.2014.19

Bok, S. (2017). WHO definition of health, rethinking the. In S. R. Quah (Ed.), *International encyclopedia*

of public health (2nd ed., Vol. 7, pp. 417–423). New York, NY: Elsevier.

Braveman, P., & Gottlieb, L. (2014). The social determinants of health: It's time to consider the cause of the causes. *Public Health Reports*, *129*(Suppl 2), 19–31.

Caroli, E., & Weber-Baghdiguian, L. (2016). Self-reported health and gender: The role of social norms. *Social Science & Medicine*, *153*, 220–229.

Chandra, A., Acosta, J. D., Carman, K. G., Dubowitz, T., Leviton, L., Martin, L. T., . . . Plough, A. L. (2016). *Building a national culture of health. Background, action framework, measures, and next steps*. Santa Monica, CA: RAND Corporation.

Chandra, A., Miller, C. E., Acosta, J. D., Weilant, S., Trujillo, M., & Plough, A. (2016). Drivers of health as a shared value: Mindset, expectations, sense of community, and civic engagement. *Health Affairs*, *35*(11), 1959–1963. doi: 10.1377/hlthaff.2016.0603

de Leeuw, E., Tsouros, A. D., Dyakova, M., & Green, G. (Eds.). (2014). *Healthy cities promoting health and equity evidence for local policy and practice.* Copenhagen, Denmark: WHO Regional Office for Europe.

Diaz-Morales, J. F. (2017). Gender-based perspectives about women's and men's health. In M. Sanchez-Lopez & R. Liminana-Gras (Eds.), *The psychology of gender and health: Conceptual and applied global concerns* (pp. 55–83). St. Louis, MO: Elsevier.

Doucet, T. J., & Merlin, M. D. (2014). Conceptualization of health in nursing practice. *Nursing Science Quarterly*, *27*(2), 118–125. doi: 10.1177/0894318414522665

Dubos, R. (1965). *Man adapting.* New Haven, CT: Yale University Press.

Dunn, H. L. (1959). What high-level wellness means. *Canadian Journal of Public Health*, *50*(11), 447–457.

Dunn, H. L. (1980). *High-level wellness.* Thorofare, NJ: Charles B. Slack Inc.

Edington, D. W., Schultz, A. B., Pitts, J. S., & Camilleri, A. (2016). The future of health promotion in the 21st century: A focus on the working population. *American Journal of Lifestyle Medicine*, *10*(4), 242–252. doi: 10.1177/1559827615605789.

Ereshefsky, M. (2009). Defining 'health' and 'disease'. *Studies in History and Philosophy of Biological and Biomedical Sciences*, *40*(3), 221–227. doi:10.1016/j.shpsc.2009.06.005

Fawcett, J., & Desanto-Madeya, S. (2013). *Analysis and evaluation of nursing models and theories.* Philadelphia, PA: F.A. Davis Company.

Flannery, M. C. (2009). The mirage of health. *The American Biology Teacher*, *71*(9), 558–561. doi: 10.2307/20565381

Frenk, J., Gomez-Dantes, O., & Moon, S. (2014). From sovereignty to solidarity: A renewed concept of global health for an era of complex interdependence. *The Lancet*, *383*, 94–97.

Friel, S., & Marmot, M. G. (2011). Action on the social determinants of health and health inequities goes global. *American Review of Public Health*, *32*, 225–236. doi: 10.1146/annurev-publhealth-031210-101220

Goddings, A., James, D. R., & Hargreaves, D. R. (2012). Distinct patterns of health engagement in adolescents and young adults: Implications for health services. *The Lancet*, published online November 23, 2012.

Golden, S. D., McLeroy, K. R., Green, L. W., Earp, J. L., & Lieberman, L. D. (2015). Upending the social ecological model to guide health promotion efforts toward policy and environmental change. *Health Education and Behavior*, *42*(1S), 8S–14S. doi: 10.1177/1090198115575098

Gunther, M. (2014). King's conceptual system and theory of goal attainment in nursing practice. In M. R. Alligood (Ed.), *Nursing theory: Utilization and application* (pp. 160–180). St. Louis, MO: Elsevier.

Holaday, B. (2014). Johnson's behavioral system model in nursing practice. In M. R. Alligood (Ed.), *Nursing theory: Utilization and application* (pp. 138–159). St. Louis, MO: Elsevier.

Horton, R., & Das, P. (2015). Global health security now. *The Lancet*, *385*, 1805–1806.

Huber, M., & Bok, L. (2015). Health: Definitions. In *International encyclopedia of the social and behavioral sciences* (2nd ed., Vol. 10, pp. 607–613). Amsterdam: Elsevier.

Kim, S., Adamson, K. C., Balfanz, D. R., Brownson, R. C., Wiecha, J. L., Shepard, D., & Alles, W. F. (2010). Development of the Community Healthy Living Index: A tool to foster healthy environments for the protection of obesity and chronic disease. *Preventive Medicine*, *50*, S80–S85.

King, I. M. (1990). Health as the goal for nursing. *Nursing Science Quarterly*, *3*(3), 123–128.

King, I. M. (2007). King's structure, process and outcome in the 21st century. In C. L. Sieloff & M. A. Frey (Eds.), *Middle range theory development using King's conceptual system* (pp. 3–11). New York: Springer.

Knowlden, A., & Sharma, M. (2016). One-year efficacy testing of enabling mothers to prevent pediatric obesity through Web-based education and reciprocal determinism (EMPOWER) randomized control trial. *Health Education & Behavior*, *43*(1), 94–106. doi: 10.1177/1090198115596737

Koffi, K., & Fawcett, J. (2016). The two nursing disciplinary scientific revolutions: Florence Nightingale and Martha E. Rogers. *Nursing Science Quarterly*, *29*(3), 247–250. doi: 10.1177/0894318416648782

Koplan, J. P., Bond, T. C., Merson, M. H., Reddy, K. S., Rodriguez, M. H., Sewankambo, N. K., & Wasserheit, J. N. (2009). Towards a common definition of global health. *The Lancet*, *373*, 1993–1994. doi:10.1016/S0140-6736(09)60332-9

Lavizzo-Mourey, R. (2015). Why we need to build a culture of health in the United States. *Academic Medicine*, *90*(7), 846–848. doi: 10.1097/ACM.0000000000000750

Mariner, W. K. (2016). Beyond lifestyle: Governing the social determinants of health. *American Journal of Law & Medicine*, *42*, 284–309. doi: 10.1177/0098858816658268

Mittelmark, M. B., Kickbusch, I., Rootman, I., Scriven, A., & Tones, K. (2017). Health promotion. In S. R. Quah (Ed.), *International encyclopedia of public health* (2nd ed., Vol. 3, pp. 450–462). New York: Elsevier.

Myers, C. A., Denstel, K. D., & Broyles, S. T. (2016). The context of context: Examining the association between healthy and unhealthy measures of neighborhood food, physical activity, and social environments. *Preventive Medicine*, *93*, 21–26.

Neuman, B., & Fawcett, J. (2012). Thoughts about the Neuman systems model: A dialogue. *Nursing Science Quarterly*, *25*(4), 374–376. doi: 10.1177/0894318412457055

Oosterveen, E., Tzelepis, F., Ashton, L., & Hutchesson, M. J. (2017). A systematic review of eHealth behavioral interventions targeting smoking, nutrition, physical activity, and/or obesity for young adults. *Preventive Medicine*, *99*, 197–206.

Orem, D. E., & Taylor, S. G. (2011). Reflections on nursing practice science: The nature, the structure, and the foundation of nursing sciences. *Nursing Science Quarterly*, *24*(1), 35–41. doi: 10.1177/0894318410389061

Ortega-Navas, M. (2017). The use of new technologies as a tool for the promotion of health education. *Procedia—Social and Behavioral Sciences*, *237*, 23–29. doi: 10.1016/j.sbspro.2017.02.006

Parse, R. R. (2011). The human becoming modes of inquiry: Refinements. *Nursing Science Quarterly*, *24*(1), 11–18. doi: 10.1177/0894318410389066

Parsons, T. (1958). Definitions of health and illness in the light of American values and social structure. In E. G. Jaco (Ed.), *Patients, physicians and illness* (pp. 165–187). New York, NY: Free Press.

Patrick, K., Hekler, E. B., Estrin, D., Mohr, D. C., Riper, H., Crane, D., . . . Riley, W. T. (2016). The pace of technologic change: Implications for digital health behavior intervention research. *American Journal of Preventive Medicine*, *51*(5), 816–824.

Plough, A. L. (2014). Building a culture of health: Challenges for the public health workforce. *American Journal of Preventive Medicine*, *47*(5S3), S388–S390.

Rotegard, A. K., Moore, S. M., Fagermoen, M. S., & Ruland, C. M. (2010). Health assets: A concept analysis. *International Journal of Nursing Studies*, *47*, 513–525.

Schaefer, K. M. (2014). Levine's conservation model in nursing practice. In M. R. Alligood (Ed.), *Nursing theory: Utilization and application* (5th ed., pp. 181–199). St. Louis, MO: Elsevier.

Selanders, L. C. (2010). The power of environmental adaptation. Florence Nightingale's original theory for nursing practice. *Journal of Holistic Nursing*, *28*(1), 81–88. doi: 10.1177/0898010109360257

Shah, M. (2015). Compare and contrast of grand theories: Orem's self-care deficit theory and Roy's adaptation model. *International Journal of Nursing Didactics*, *5*(1), 39–42.

Song, M., & Kong, E. (2015). Older adults' definitions of health: A metasynthesis. *International Journal of Nursing Studies*, *52*, 1097–1106.

Sorochan, W. (1970). Health concepts as a basis for orthobiosis. In E. Hart & W. Sechrist (Eds.), *The dynamics of wellness.* Belmont, CA: Wadsworth Inc.

Stanhope, M., & Lancaster, J. (Eds.). (2016). *Public health nursing: Population-centered health care in the community* (9th ed.). St. Louis, MO: Elsevier.

Tannahill, A. (2009). Health promotion: The Tannahill model revisited. *Public Health*, *123*, 396–399. doi:10.1016/j.puhe.2008.05.021

Tountas, Y. (2009). The historical origins of the basic concepts of health promotion and education: The role of ancient Greek philosophy and medicine. *Health Promotion International*, *24*(2), 185–192. doi:10.1093/heapro/dap006

Tremblay, M. C., Richard, L., Brousselle, A., & Beaudet, N. (2013). How can both the intervention and its evaluation fulfill health promotion principles? An example from a professional development program. *Health Promotion Practice*, *14*, 563–571. doi: 10.1177/1524839912462030

Trujillo, M. D., & Plough, A. (2016). Building a culture of health: A new framework and measures for health and health care in America. *Social Science & Medicine*, *165*, 206–213.

U.S. Department of Health and Human Services. (2013). *Healthy People 2020.* Washington, DC: U.S. Government Printing Office. Accessed at http://www.healthypeople.gov

U.S. Department of Health and Human Services. (2017). *Global health security*. Washington, DC: U.S. Government Printing Office.

Witt, C. M., Chiaramonte, D., Berman, S., Chesney, M. A., Kaplan, G. A., Strange, K. C., . . . Berman, B. M. (2017). Defining health in a comprehensive context: A new definition of integrative health. *American Journal of Preventive Medicine, 53*(1), 134–137. doi:10.1016/j.amepre.2016.11.029

World Health Organization. (1974). *Community health nursing: Report of a WHO expert committee*. Technical Report Series No. 558. Geneva, Switzerland: Author.

World Health Organization. (1986a). *Alma Alta 1978: Primary health care*. Geneva, Switzerland: Author.

World Health Organization. (1986b). Ottawa Charter for Health Promotion. *Health Promotion*, *1*(4), ii–v.

World Health Organization. (2005). *Constitution of the World Health Organization* (55th ed.). Accessed at http://www.who.int/governance/eb/who_constitution_en.pdf

World Health Organization. (2008). *Closing the gap in a generation: Health equity through action on the social determinants of health*. Geneva, Switzerland: Author.

World Health Organization. (2013a). *Joint meeting of experts on targets and indicators for health and well-being in Health 2020*. Copenhagen, Denmark: WHO Regional Office for Europe.

World Health Organization. (2013b). *Promotion of well-being. Pursuit of happiness*. New Delhi, India: Regional Office for Southeast Asia.

World Health Organization. (2014). *Mental health: A state of well-being*. Accessed at http://www.who.int/features/factfiles/mental_health/en

World Health Organization. (2016). *Shanghai Declaration on promoting health in the 2030 agenda for sustainable development*. 9th Global Conference on Health Promotion, Shanghai, China.

CHAPTER 2

Individual Models to Promote Health Behavior

OBJECTIVES

This chapter will enable the reader to:

1. Discuss the rationale for using behavior change theory to structure interventions.
2. Describe commonalities and differences in the individual models of behavior change.
3. Apply the stages of change model to designing interventions to promote health behaviors.
4. Discuss the revised health promotion model and its usefulness for nursing practice.
5. Describe the role of behavior change theories in digital interventions.
6. Discuss theory-based strategies to promote healthy behaviors in face-to-face and mobile technology encounters.

Health promotion activities enable individuals, families, and communities to achieve their full health potential. Health promotion supports lifestyles and behaviors that enable persons to maximize their health and well-being through individual, organizational, and community change. As the number of persons who are living with a chronic illness continues to increase, health promotion in secondary prevention, which focuses on persons who are already diagnosed with a disease, is receiving more attention. While primary prevention strategies reduce the occurrence or prolong the onset of diseases, such as diabetes, secondary prevention activities promote health within the limits of an illness or disability. Health promotion and primary prevention have been shown to have substantial benefits in improving quality of life and longevity. Both health promotion and primary prevention should be based on models of health that recognize the effects of multiple systems on health outcomes.

Health protection refers to the use of regulatory measures to promote health. Historically, health protection included measures to address public health issues such as safe drinking water. However, health protection measures have extended to other aspects of the environment, such as automobile safety and consumer product safety. Health protection strategies are addressed by government regulations.

The goal of improving population health is best served by emphasizing health promotion and primary prevention throughout the life span. Progress toward this goal requires an understanding of the motivational dynamics of actions that enhance health. This chapter focuses on models and theories that have been found useful in explaining and predicting individual health behaviors. Examples of how the models and theories have been used to explain, predict, or change health behaviors are described.

Health behavior may be motivated by a desire to protect one's health by avoiding illness or a desire to increase one's level of health in the presence or absence of illness. For many health behaviors, both "approaching a positive state" and "avoiding a negative state" serve as sources of motivation. Health behaviors of middle-age and older adults can be explained by approach and avoidance. In contrast, children and young people are more likely to be motivated toward positive health behaviors. In young people, avoidance is not perceived to be relevant, as negative states (illnesses) are considered unlikely to occur for many years.

INDIVIDUAL POTENTIAL FOR CHANGE

Individuals have tremendous potential for self-directed change due to their capacity for self-knowledge, self-regulation, decision-making, and problem solving. Almost everyone has the capacity and skill to change unhealthy behaviors or modify health-related lifestyles. The nurse's role is to promote a positive climate for change, serve as a catalyst for change, assist with steps in the change process, and increase the individual's motivation to maintain change.

USE OF THEORIES AND MODELS FOR BEHAVIOR CHANGE

Theories and models of health behavior are systematic attempts to explain how or why individuals do or do not engage in health behaviors. Behavior change theories and models specify concepts (theoretical or abstract ideas) and their relationships to predict or explain health behaviors. Understanding the predictors of behavior change is necessary to develop effective health promotion programs. In addition, it is essential to understand the possible mechanisms of change by examining possible mediators and moderators (intervening variables). Mediator variables explain how the change occurs, while moderator variables help explain when or under what conditions the change occurs. Mediators and moderators help to explain the processes underlying behavior change and enable health care professionals to develop and deliver effective, theoretically driven interventions. The scientific knowledge gained from testing theories and models also informs public policy, as the research evidence is used to improve health promotion practice.

To date, no one theory or model completely predicts behavior or behavior change, so multiple theories and models are presented. The models and theories presented focus primarily on individual, intrapersonal, and interpersonal influences to promote

health. These models originated in educational and social psychology and expectancy-value, social cognitive, and decision-making theories. Cognitive processing of information is important in all of the models as the perceptions and interpretations of individuals directly affect their behaviors. Knowledge of the elements and mechanisms of behavior change theories enables nurses to design programs that are more likely to produce positive outcomes. When theories have been extensively tested, and evidence exists to explain or predict health behaviors across multiple populations and conditions, they are relevant for clinical settings to plan health promotion programs.

SOCIAL COGNITION THEORIES AND MODELS

Social cognition models consider cognitive (mental) and affective (emotional) factors as the primary determinants of behavior. They are called social cognition models because of the focus on cognitive or thought processes, such as attitudes and beliefs, as the major determinants of individual health behaviors. Social cognition models attempt to account for factors that determine behavior and behavior change. The proposed determinants are amenable to change, so they are the focus of interventions. Social cognition models include the health belief model, the theory of reasoned action and planned behavior, social cognitive and self-efficacy theory, and the health promotion model. These models are similar in their determinants of health behavior, although they are described differently in the various models. The shared model concepts are described in Table 2–1. Each model describes the determinants or potential causes of health behaviors and behavior change. However, in most cases, they do not provide direction for how to change behavior. Bandura's social cognitive theory and Pender's health promotion model are the only two that incorporate the environment. However, neither model has described and operationalized these factors as major determinants of change. Lack of environmental

TABLE 2–1 Shared Psychosocial Concepts in Five Individual Theories/Models of Health Behavior

Theories/Models	Psychosocial Concepts			
	Self-Efficacy	Outcome Expectations	Evaluation of Benefits and Barriers	Health Behavior Goals
Health belief model (revised)	+	+	+	−
Theory of reasoned action	−	+	+	+
Theory of planned behavior	+	+	+	+
Health promotion model	+	+	+	+
Social cognitive model	+	+	+	+

Key: (+) Concept present; (−) concept absent in theory/model.