SECOND EDITION

Contemporary Health Promotion

IN NURSING PRACTICE

Bonnie Raingruber




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Preface

WHY I WROTE THIS BOOK

Recent years have brought with them an amazing amount of new knowledge related to health promotion. An astounding number of innovative policies, emerging priorities, newfound disciplines, evolving research methods, and challenging settings confront all nurses who are engaged in health promotion practice. These innovations and challenges demand that nurses develop familiarity and expertise with a large amount of new content. This book was developed to address these newly emerging fields, content, methods, and settings, as well as the multitude of challenges confronting students and nurses engaged in health promotion practice. In reality, all nurses at all levels are engaged in health promotion, which is a key aspect of the profession.

The book includes a chapter on the history of health promotion, including recent critical developments, and a chapter on social determinants of health. Innovative content on genomics, epigenetics, plasticity, pharmacogenomics, and a discussion of how behavioral experience is inherited across multiple generations is included. An expanded theory chapter includes multiple interdisciplinary and nursing theories that inform health promotion practice. The book also contains a chapter on health literacy; a revised chapter on current health disparities and social capital; a chapter on nursing informatics (electronic medical records, biometric screening, technological devices, virtual reality, avatars, simulation, telehealth); and a chapter on recent events and legislation that will shape health policy work. An increased amount of content focuses on the Patient Protection and Affordable Care Act and summarizes recent legal challenges, individual/employer mandates, benefits offered, premium costs, provider networks, risk corridors, the Sunshine Act, hospital/provider reimbursement, and the importance of shared decision making. The book includes content on community-based participatory research, calculating quality-adjusted life years, common health screening tools used in practice, logic models, outcome evaluation, neighborhood mapping, and cost–utility/cost–benefit analysis. Also included is content on entrepreneurship and aesthetic/creative approaches to health promotion such as reminiscence therapy, mutual storytelling, street theater, photo-voice, motivational interviewing, and dance.

The nurse's role in health promotion is emphasized by using a historical, theoretical, policy-oriented, and philosophical perspective. The importance of social, linguistic, and cultural determinants of health is highlighted throughout the text. Each chapter is

updated with recent references and designed to address critical new information that shapes contemporary health promotion practice.

Health promotion has long been a central part of nursing practice, but at this juncture it is increasingly vital that nurses adopt an active role in promoting the health of individuals, families, communities, and nations. Empowering individuals and communities, facilitating public awareness of health disparities, advocating for the underserved, enhancing access to care, involving patients in their care, connecting individuals with community resources, and engaging in health policy work is critical if nurses are to have a role and a voice in the future of healthcare delivery. At no time in our history, have social pressures, stresses, economic and environmental uncertainties, legislation, political forces, and a complex healthcare delivery system posed more challenges to the health of individuals and communities than currently exist. This book is written to provide current content for nurses and to encourage them to empower, advocate for, and involve clients in their care. Nursing is a trusted profession with a broad knowledge base and a history of working with the community. As such, nurses are well situated to become leaders in health promotion, disease prevention, and healthcare advocacy. We need to prepare ourselves to adopt a visible role in shaping the future of health promotion practice. This book was developed to assist nurses to take on that leadership role.

Active learning is necessary if students are going to apply what they have learned in their practice. Therefore, each chapter in this book includes an introduction and learning outcomes, as well as end-of-chapter exercises that enable students to check their understanding. The end-of-chapter exercises include discussion questions that an instructor can use for essay assignments or group discussions, and students can use these discussion questions to reflect on the chapter content. The end-of-chapter exercises also include a section titled "Check Your Understanding," where students complete critical thinking activities, evidence-based applications, matching exercises, short essay questions, and fill-in-the-blank activities, and then compare their answers to responses offered by the authors. These activities can be used by students who are reviewing for a test or by instructors who are designing quizzes. Finally, the end-of-chapter exercises include a section titled "What Do You Think?" in which students are encouraged to reflect on and articulate their views and consider the significance of presented content. Each of these sections, as well as the case studies and clinical scenarios included in each chapter, are designed to involve students in the learning process, to highlight the relevance of the material to clinical practice, and to prepare students for their health promotion role. The book contains an abundance of clinical examples, critical thinking and reflective practice activities, and application exercises.

TARGET AUDIENCE

The primary target audience is nursing students enrolled in a health promotion, community health, health assessment, or health education course. Given the rapid nature of change within health promotion practice over the last few years, the book will also be an excellent resource for all nursing students, nurses, and nursing faculty who need a

concise resource that outlines recent practice-based changes. Other professionals as well may benefit by using this text as a reference and as a way to discover parallels between their practice and that of nurses who are engaged in health promotion.

USING THIS BOOK

The initial chapter describes why health promotion is an integral part of nursing practice. Three subsequent chapters—the history of health promotion, health promotion theories, and genetic and social determinants of health—form the basis for the remainder of the book. Other chapters can be read or assigned in any order, because they address freestanding content. The chapters on evaluation and health promotion policy are best left for last since they summarize content that was introduced in earlier chapters. The "Discussion Questions," "Check Your Understanding," and "What Do You Think?" sections can be used by both students and instructors to stimulate creative thoughts, to verify understanding, and to apply the content to practice.

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About the Author

Dr. Raingruber is a mental health clinical nurse specialist who has taught nursing for 30 years in bachelor's, master's, and Doctor of Nursing Practice (DNP) programs. She has done extensive research focused on health promotion and health disparities and has been funded by the National Institutes of Health, the Substance Abuse and Mental Health Administration, and the Health Resources and Services Administration, as well as private foundations. Dr. Raingruber maintains a private health promotion practice and has worked in university settings, county facilities, public and private hospitals, and community-based organizations. She is the author of over 37 peer-reviewed journal articles, two books, and six book chapters.

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Chapter 1

Health Education, Health Promotion, and Health: What Do These Definitions Have to Do with Nursing?

Bonnie Raingruber

Chapter Objectives

At the conclusion of this chapter, the student will be able to:

1. Define health education, health promotion, health, and wellness, and compare and contrast each concept.
2. Discuss criticisms of the accepted definitions of health.
3. Apply health promotion concepts to several case studies and identify how a nurse could work with a patient, family, or community to foster health.
4. Analyze health promotion core competencies.
5. Explain why health promotion is a vital part of nursing practice.

INTRODUCTION

Health promotion is a key component of nursing practice. As we will discuss, by promoting the health of individuals, families, communities, and populations, nurses help transform the health of individuals, our society, and our healthcare system. As one looks carefully at the varied definitions of nursing, it is interesting to see how often health promotion activities are highlighted as being a central nursing role.

Florence Nightingale influenced modern definitions of nursing by focusing on the triad of the person, health, and the environment while stressing the promotion of health and healing as being central to the definitions of nursing (Nightingale, 1859).

The American Nurses' Association (ANA) defined nursing as "the protection, promotion and optimization of health and abilities, prevention of illness and injury, alleviation of suffering through the diagnosis and treatment of human response and advocacy in the care of individuals, families, communities and populations" (ANA, 2010, para 2). In the ANA social policy statement (1995), we see that "nursing involves policies that are restorative, supportive, and promotive in nature . . . . Promotive practices mobilize healthy patterns of living, foster personal and family development, and support self-defined goals of individuals, families, and communities" (p. 11).

The International Council of Nurses (2010) defined nursing as "including the promotion of health, the prevention of illness and the care of ill, disabled and dying people" (para 1). Advocacy, promotion of a safe environment, research, participation in shaping health policy, and health systems are also described as key nursing roles (International Council of Nurses).

Irrespective of which definition of nursing is used, we see that health is the central concept and that health promotion is a key nursing activity. As Morgan and Marsh (1998) suggested, nurses promote the health of individuals, families, and communities by educating about needed lifestyle modifications and advocating for conditions that foster health.

HEALTH EDUCATION VERSUS HEALTH PROMOTION

Within the nursing literature and within practice, the terms health promotion and health education have mistakenly been used as interchangeable concepts. In reality, health education and health promotion are distinct activities. The concept of health promotion, which focuses on socioeconomic and environmental determinants of health and participatory involvement, includes the narrower concept of health education (Whitehead, 2008).

Health education involves giving information and teaching individuals and communities how to achieve better health, a common role within nursing. Health education has been defined as those "activities which raise an individual's awareness, giving the individual the health knowledge required to enable him or her to decide on a

particular health action" (Mackintosh, 1996, p. 14). Whitehead (2004) defined health education as "activities that seek to inform the individual on the nature and causes of health/illness and that individual's personal level of risk associated with their lifestyle behavior. Health education seeks to motivate individuals to accept a process of behavioral change through directly influencing their values, beliefs, and attitude systems" (p. 313). In contrast, health promotion "involves social, economic, and political change to ensure the environment is conducive to health . . . it requires a nurse educate an individual about his or her health needs, but also demands that the nurse play a role in attempting to address the wider environmental and social issues that adversely affect people's health" (Mackintosh, 1996, p. 14).

For years, health education was seen as synonymous with health promotion, and the terms were used interchangeably. Whitehead (2003a), however, argued that there is in fact a paradigm war or tension between disease-centered health education and the larger concept of health promotion that includes a focus on environmental, educational, cultural, and sociopolitical determinates of health. Whitehead (2003b) explained that nurses working in inpatient settings are socialized to use the biomedical model, focusing to a greater extent on health education rather than health promotion. The biomedical model, according to Whitehead (2003b) is reductionistic, views the body and mind as separate, and promotes an illness perspective, not a health promotion perspective.

Although acute care nurses report that they are engaged in health promotion activities, they are often conducting behavioral, lifestyle-oriented, or risk-oriented health education (Whitehead, 2006). Whitehead (2006) suggested that nurses need to extend their activities into the realm of health promotion by becoming more involved in legislative reform, empowering communities, paying attention to ethnic/racial, or economic health disparities, facilitating public consciousness-raising, adopting a role as a political advocate for underprivileged individuals who cannot lobby for themselves, and influencing health-related policy development.

Many authors (Robertson, 2001; Tones, 2000) have argued that health education is a component of health promotion. Certainly, health education, a traditional nursing role, is an integral and essential part of health promotion. However, achieving health is not just about being educated or coached to change one's behavior by a healthcare provider. Oftentimes, patients have attempted to alter a health-related behavior before talking with a healthcare provider. In these situations, talking with a patient and developing a comprehensive understanding of what they want to change, what they have previously tried, and their barriers to change is vital.

Health is influenced by adaptive potential, perceptual capability, environmental stress, and coping resources (King, 1994). Therefore, health promotion includes empowering individuals and communities and implementing larger sociopolitical interventions designed to foster health (Whitehead, 2003a). These additional aspects of health promotion make it possible for nurses to play a role in reforming healthcare delivery systems, addressing the health needs of local communities, and improving the health of society overall.

Everyone's health is influenced by their family situation, their community, the environment, and the political climate in which they live. In fact, socioeconomic factors

often have a larger impact on a person's health than their individual health maintenance behaviors (Williamson & Carr, 2009). For that reason, health promotion must include health education plus the related legal, economic, environmental, educational, legislative, and organizational interventions necessary to facilitate health (Tones, Tilford, & Robinson, 1990). This does not mean a nurse must be a lobbyist, a senator or representative in Congress, an epidemiologist, a community organizer, a community health nurse, or work at the National Institutes of Health (NIH) to facilitate health promotion.

All nurses can engage in health promotion. Harm (2001) suggested that nurses who work in busy inpatient settings who wish to engage in health promotion need to integrate a holistic perspective into their practice. Health promotion requires individualizing care to match patient and family needs; assessing the economic, sociocultural, political, and organizational factors that shape health; involving patients in care planning; connecting them with community resources; serving in an advocacy role; and promoting continuity of care between inpatient and outpatient or community-based settings. In a study of emergency room (ER) nurses, Cross (2015) used a Q-sort methodology to survey nursing attitudes toward health promotion. Cross (2015, p. 478) reported that health promotion was seen by the ER nurses as "a philosophy which guides the way nurses . . . should support and care for people." How nurses viewed health promotion had a major impact on their practice. The nature of communication between the nurse and the patient was seen as having a major effect on the achievement of the patient's health promotion goals.

Larsson and colleagues (1991) stressed that the frequency and intensity of daily hassles in life affect health. Poverty brings with it a burden of chronic stress and predisposes people to make unhealthy lifestyle choices, including smoking; using drugs or drinking; not exercising; living in unsafe areas; and eating foods that are affordable, readily available, and typically high in calories. In addition, many individuals do not have access to regular, preventive health care or the educational background to fully understand what healthcare providers are trying to communicate. Therefore, a component of health promotion is paying attention to health literacy, issues of access to care, and poverty-related barriers that prevent individuals and communities from engaging in health-promoting activities.

Advocacy as an Aspect of Health Promotion

Cribb and Dunes (1993) stressed that empowerment and advocacy are vital aspects of health promotion that help individuals and communities make healthy choices. Maben and Macleod-Clark (1995) suggested that health promotion "is concerned with making healthier choices easier choices" (p. 1161). Health promotion involves lobbying for healthy communities, access to health care and nutritious food, safe homes, understandable healthcare information, and involvement of patients in care planning, and healthcare policy changes as needed.

Consider for a moment healthcare policies that nurses have been involved in implementing in your community. Do you know any nurses who have participated in seat belt or bicycle helmet safety campaigns, health screenings, discussions on water or air quality issues, dialogue about nurse–patient ratios, or debates about access to health care? Have

you talked with any of your patients about ways to incorporate healthier lifestyle choices into their routine while assessing the barriers they have to deal with on a daily basis? Have you advocated for a patient by helping them apply for food stamps or the Women, Infants, Children (WIC) program? Have you empowered a patient to believe they could make needed lifestyle modifications irrespective of the barriers that exist in their environment? If so, you were engaged in health promotion activities as part of your nursing role.

Assessing and Building on Patient Strengths as an Aspect of Health Promotion

Health promotion requires carefully assessing your client's background, challenges, and strengths and determining what they want to change, how they plan to modify their lifestyle, how they best learn, and what help they need from you as a nurse. It is critical to identify the strengths and past successes that individuals and communities have had in improving their health. As Eldh, Ekman, and Ehnfors (2010) commented, patients need to be active participants in their care, to feel like they are knowledgeable partners whose input is respected and believed, and to share in decision making about their health.

For example, it is important to assess how a patient lost weight in the past when discussing how they will begin their current weight loss program. You need to discuss what interfered with their weight loss program and what worked for them in the past. When talking with a patient who needs to decrease the amount of salt in his or her diet, it is very helpful to assess whether there are family members or friends who will help with that lifestyle modification. Are there situations, like eating at fast-food restaurants, that will make it harder to eat less salt? Do the patient and family understand why eating less salt is important? Are the patient and family committed to changing their behavior by buying foods that are low in salt? Do they have the financial resources necessary to modify their diet? Are fresh foods available in their community? Do they know which canned, frozen, and prepared foods are highest in salt? Are there any cultural preferences that influence their dietary habits?

As another example, when exploring how a patient will stop smoking it is necessary to talk about how the person tried to stop smoking in the past. What successes did they have? What challenges interfered with their success? Was it hardest not to smoke after meals or when going out on the town for the evening? Does the patient have enough money to purchase nicotine patches? Does he or she have insurance that will cover acupuncture or hypnosis for smoking cessation? Would text message reminders and motivational comments help the patient? Which smoking cessation method does the patient want to use?

At the community level, what would work when designing an HIV prevention program for young migrant farm workers age 19 to 25? Would HIV prevention information broadcast on a Spanish-speaking radio station work better than cell phone text messages sent directly to individual farm workers? Would posters placed in local health clinics be effective or are visits to health clinics too rare for young migrant workers? Should personal stories or novellas of how other migrant workers got HIV be used to motivate behavioral changes? Does the fact that a significant number of agricultural

employers bring professional sex workers to the migrant camps on a weekly basis create a challenge that needs to be addressed? Do commonly held beliefs like the idea that showering in beer after having sex kills the HIV virus need to be addressed? Should health education be provided by Spanish-speaking males or females? What resources exist within the farm worker community that could be used to design an effective HIV prevention program?

DEFINITIONS OF HEALTH PROMOTION

The term health promotion has been defined in myriad ways (Maben & Macleod-Clark, 1995). Tones (1985) defined health promotion as any intervention designed to foster health. Pender and colleagues (2002) defined health promotion as "increasing the level of well-being and self-actualization of a given individual or group" (p. 34). Others have defined health promotion as lifestyle coaching designed to promote optimal health, quality of life, and well-being (Saylor, 2004). Health promotion includes health education, identification and reduction of health risks for selected individuals and populations, empowerment, advocacy, preventative health care, and health policy development.

Although television commercials, billboards, and Twitter messages have all been used to promote the health of communities, health promotion does not mean "promoting" in the sense of marketing or selling (Maben & Macleod-Clark, 1995). In fact, a danger associated with viewing health as a commodity or as capital is that health is then seen as having no inherent value unless it generates positive returns such as economic productivity. Such a stance can provide the rationale for denying health care to the disabled, unemployed, or elderly if their years of productive life do not warrant an expensive operation or treatment (Williamson & Carr, 2009).

Rather than being a commodity to be marketed, health promotion includes health education and motivating lifestyle and behavior change based on a careful understanding of the patient's situation, economic resources, educational background, social supports, cultural beliefs, and environmental factors within their community. To motivate individuals, families, and communities to make lifestyle changes, it is necessary to understand the factors that keep people from changing, as well as those that prompt them to adopt new behaviors. It is vital to understand the perspective of the patient or the community with whom one is interacting.

Definitions of health promotion and health include numerous subjective components that require careful assessment (Sullivan, 2003). Health is influenced by feelings such as pain levels, energy levels, and the ability to perform one's job or social role. Some people describe their health as poor, even if they don't have a major disease, when they can no longer do what they want to do on a daily basis. Likewise, people who have some degree of disease can still consider themselves to be in good health. In addition, one's view of whether they are healthy changes depending on the culture and age of the person (Larson, 1999). A nurse must begin by understanding what a patient understands about their current health condition, what lifestyle change(s)

the patient is willing to make, what barriers they will encounter, and how best to motivate the person to make those modifications. For example, does the 30-year-old patient you are working with regarding their exercise routine hope to return to being a marathon runner after his or her broken leg heals, or does the 80-year-old patient hope to be able to take a 5-minute walk without experiencing pain? The nurse should find out what activities bring satisfaction and enjoyment to the patient so that changes can be planned that build on existing health habits; incorporate social supports; substitute realistic alternatives to unhealthy behavior given the patient's preferences; and consider relevant economic, cultural, and environmental influences (Saylor, 2004).

MEDICAL MODEL AND WORLD HEALTH ORGANIZATION DEFINITIONS OF HEALTH

Health, in the medical model, has been defined primarily as an absence of physical and mental disease. The illness paradigm typically emphasizes disease rather than health and well-being (Larson, 1999).

Health has also been defined much more broadly by the World Health Organization (WHO) (1948) as a complete state of physical, mental, social, and emotional well-being, not merely the absence of disease. The Ottawa Charter of the WHO (1986) stressed that peace, shelter, education, food, income, a stable ecosystem, sustainable resources, social justice, and equity are necessary for health. Therefore, their definition of health included attention to conditions where peace is uncertain because of war, areas ravaged by natural disasters such as earthquakes and floods, countries where infectious disease abounds, situations where pollution is widespread, and locales where education is not available to everyone. Included in the WHO definition is the idea that physical, mental, and social health is a fundamental right of all people (Larson, 1999).

Since few of us are in a complete state of physical, mental, social, and emotional well-being at all times, the WHO definition gives us a goal to motivate us to grow in a multitude of ways. Consider for a moment what physical challenges, mental constructs, social obligations, or emotional feelings are keeping you from a holistic sense of well-being as you pursue your nursing studies.

The following case study about Jane illustrates how nursing school affected her well-being. Jane was delighted when she was admitted to nursing school, but she had a persistent worry that someday a clinical instructor would recognize what she didn't know and she would then be abruptly removed from the program. The stress of worrying about exams and late night clinical write-ups kept Jane from sleeping as much as her body required. She was so busy with school work that she felt isolated from her family and friends. Jane gained 5 pounds in one semester just by snacking during late night study sessions in the weeks before exams. She went into each exam believing she would get the lowest grade in the class and be humiliated. What else would you want to know about Jane before you began a conversation about promoting her well-being and health? What barriers could be interfering with Jane's health promotion goals?

Additional Definitions of Health

The WHO definition of health is the most accepted definition, but numerous other definitions of health have been proposed. Authors have defined health as a capacity for living (Carlson, 2003); an optimal individualized fitness so that one lives a full, creative life (Goldsmith, 1972); as having a good quality of life (Brown et al., 1984); or as "actualization of inherent and acquired human potential through goal-directed behavior, competent self-care and stratifying relationships with others . . . while maintaining harmony with relevant environments" (Pender, Murdaugh & Parsons, 2002, p. 22). Yet other definitions of health include: (1) the state of optimum capacity to perform roles and tasks one has been socialized into; (2) a joyful attitude toward life and a cheerful acceptance of one's responsibilities; and (3) "the capacity to maintain balance and be free from undue pain, discomfort, disability, or limitation of action including social capacity" (Goldsmith, 1972, p. 13).

Meaning and Purpose as Part of Health

The concept of health also includes a sense of meaning and purpose or knowledge that one's life makes a difference (Pender, Murdaugh, & Parsons, 2002). Nurses need to explore what brings a sense of meaning to the patients and communities they work with to effectively design health interventions that will be satisfying. Perception is a vital aspect of health that nurses must consider. Nurses should explore how a patient's lifestyle will be altered by their illness, what that change will mean to the patient, how the patient previously coped with similar challenges, and which family members/friends will be influenced by this illness.

Many authors have argued that illness can be a catalyst for health and growth. Illness often prompts individuals to reflect on their life, to consider what is most important to them, and to imagine how life will be after the acute phase of their illness is over and their health is restored (Diemert-Moch, 1998). Relationships, health behaviors, and daily routines that the individual previously took for granted are now redefined by the current threat to their health. Illness can offer individuals an opportunity to re-create and shape their health. Karvinen and colleagues (2015) described that oncology nurses believe that cancer survivors are "receptive to receiving guidance on health behaviors during teachable moments after diagnosis" (p. 602). However, patients don't typically ask for guidance. Nurses need to initiate health promotion conversations and offer ongoing support throughout the cancer trajectory.

Likewise, health crises that affect entire communities can bring an opportunity to rebuild infrastructures, laws, and policies that support health. Consider how the people of New Orleans were affected by Hurricane Katrina, which flooded their hospitals, schools, homes, and places of employment. Have there been any improvements to that community since the hurricane? What remains to be done? Think about the economic, social, and physical devastation faced by the people of Germany in the years following World War II. Were there any economic, social, or political changes that followed decades later that helped reorganize their society in a positive way?

CRITIQUES OF DEFINITIONS OF HEALTH

Each of the commonly used definitions of health, along with the WHO definition, is holistic and includes aspects of well-being. However, these definitions have been criticized for being difficult to measure, idealistic, and hard to implement in busy health-care settings.

The RAND Health Insurance Experiment used quantitative methods to assess whether the WHO definition of health was practical and measurable. Physical health was measured by a standardized functional health status tool and the ability to complete daily self-care, household work, and leisure activities. Mental health was measured using depression scales, anxiety scales, measures of positive well-being, and self-control. Social health was measured in terms of participation in social activities. Physical and mental health was found to be an independent dimension of health that could be measured. Social well-being in the RAND study was not found to be an independent dimension of health. RAND researchers summarized that although social factors affect health, they should not be used to define personal health status. It is important to remember the RAND study summarized findings from only one study (Ware, Brook, Davies, & Lohr, 1981).

Other authors have criticized the WHO definition for being too Utopian and abstract, emphasizing that there is no consensus about the meaning of well-being, and commenting that meanings of health differ in different countries and cultures (Larson, 1999; Saylor, 2004). Even though different cultural views influence how health is defined and what interventions are acceptable, and in spite of the fact that well-being can be measured in multiple ways, still the WHO statement is the most accepted and comprehensive definition of health worldwide. Some have suggested that the WHO definition represents a goal more than a guideline for concrete action (Larson, 1999).

Each individual nurse must reflect on the concepts included in the WHO definition (physical, mental, social, and emotional well-being) and apply them in an individualized manner in their daily practice (Larson, 1999). Nurses also need to think about the organizational, environmental, economic, and sociocultural factors that influence the health of patients, families, communities, and populations.

Do you agree that social factors are a defining part of health for individual patients? Have you worked with a patient who struggled with social factors that influenced his or her health? Have you ever seen the discharge of a heart patient delayed or a rehabilitation facility transfer be needed because the patient's spouse had Alzheimer's disease and could not assist in the recovery? Have you worked with homeless patients who did not have anyone to help them pick up a prescription or change a dressing after they left the hospital? What other examples of social factors have you observed that have influenced the health of patients?

Organizational Factors Affecting Health

Considering which organizational factors influence health is an important aspect of what nurses do when promoting the health of their patients. Think about an organizational factor that affected the health of a patient you cared for during the last year.

Did you encounter anyone who had to wait a long time for a healthcare appointment, schedule a health visit at a time that was really difficult for them, wait to get their medications refilled, or work to understand what a busy healthcare provider was actually saying?

Consider the case of Ramon, who spoke very little English. When he came to the Urgent Care Clinic, he had difficulty registering because he did not feel comfortable standing at the front counter, where everyone could hear, and saying that frequent urination brought him to the clinic. Once he met with the nurse practitioner (NP) and a urine screen showed he had a urinary tract infection, he did not know how to tell the busy NP he did not have enough money to get the antibiotic prescription filled for 5 more days. Frustrated, he left the clinic and went home. Discomfort, burning, and frequency prompted him to go to the emergency room later that night, where he had to wait 12 hours before being seen. Which organizational factors interfered with Ramon getting adequate care? What could a nurse do to advocate for Ramon?

Think about the introduction of electronic medical records, the use of bar codes for dispensing medications in hospitals, and pill bottles that buzz to remind patients to take their medications at home. How have those organizational changes affected the health of patients and the workload of nurses who care for those patients? What are the advantages and challenges associated with these changes? Has the hospital where your clinical placements are scheduled incorporated nursing notes, pharmacy orders, laboratory results, pain assessment inventories, fall risk tools, pressure ulcer rating systems, and advance directives as part of their electronic medical record system? How has the introduction of each of those components affected the health of the patients you have cared for in that hospital? Have you used bar code scanning as part of medication administration? If so, what did you like about bar code scanning? What sort of errors could occur with bar code scanning for medication administration? Have you seen wristband reminders or pill bottle caps that include a microchip used to remind patients to take their medication at home? So far these devices have been used with blind, noncompliant, congestive heart failure, organ transplant, and elderly patients. Are there other populations in which talking pill bottles might be useful?

Environmental Factors Affecting Health

It is necessary for nurses to consider environmental factors that influence health before working with clients. Think about an environmental factor that affected the health of a client you cared for in the last year. The two case studies that follow illustrate environmental factors that impact the health of two very different 10-year-old children. What would you, as a nurse, do in each case to promote the health of the child?

Marcella was a 10-year-old girl who lived in a low-income, urban area where gang activity, prostitution, and drug abuse was rampant. Her mother would not let her go outside after 4 PM because several other children in her neighborhood had been shot while riding their bikes. Marcella lived in a small apartment with her three sisters and her mother. Due to their limited budget, her mother routinely bought foods that were high in calories because they were convenient and affordable. There was no space inside the crowded apartment to exercise. However, the school nurse kept telling Marcella that she was 25 pounds overweight, so she had to exercise and change what she ate. What else could the school nurse do to actually be helpful to Marcella? What could the school nurse learn by placing a telephone call to Marcella's mother or scheduling a home visit?

Aboyo was a 10-year-old girl who lived in a rural village outside of Kumasi, Ghana, in West Africa. The power went out in her village on a regular basis, leaving the community without water when the electric pumps stopped working. To earn money for food, children in the village regularly went to the dump barefoot to collect plastic water bottles that had been discarded. The children would refill the bottles with stagnant water and superglue the lids back on the bottles before reselling them in the market. All of the bottles that were discarded went to the same area for disposal irrespective of who had previously used them. One day Aboyo cut her foot on a piece of glass while collecting water bottles and was taken to the village clinic. Besides attending to Aboyo's cut, what should the nurse at the village clinic teach Aboyo? What else could the village nurse do besides working with Aboyo and getting her perspective? How could the Queen Mother (the most influential female in the village) and the village elders be involved to improve the health of the village children?

Economic Factors Affecting Health

Economic factors have a major impact on health and health promotion activities. For example, sometimes elderly patients on limited incomes have to decide which of their medications they will get refilled. Or, elderly clients only take half the medications prescribed by their physician or NP because they can't afford to fill the entire prescription.

Think about Louise's situation. Her husband worked on and off as a carpenter in a state with 8% unemployment. For the last year, he had been unable to find steady work due to a downturn in the construction industry. They did not have health insurance through her husband's employment or the federal Affordable Care Act exchange. Louise began having heavy menstrual periods at the age of 57, two years after she had gone through menopause. A doctor determined that she had uterine cancer and performed a hysterectomy. The cost of the surgery, on top of the decrease in her husband's employment, resulted in the family losing their home to foreclosure. They had to move into a travel trailer on the property of one of their long-time friends. Two years after her surgery, Louise noticed a lump in her breast. Because she could not afford regular visits with her physician, and did not qualify for low-income medical care due to her husband's at times substantial and constantly fluctuating income, she relied on the emergency room for her health care when absolutely necessary. After a needle biopsy determined the lump in her breast was not a cyst, Louise's doctor ordered a

mammogram. The results came back indicating Louise now had breast cancer. If you were the emergency room nurse working with Louise, how would you approach her? What would you say to her? What economic factors influenced Louise's health and health promotion activities?

Consider how Thomas, a community health nurse, became involved in promoting the health of Oak Park, a low-income area where he worked. As Thomas made home visits, he was consistently frustrated by the lack of grocery stores that sold fresh fruits and vegetables in Oak Park. He attempted to do health education about nutrition with families on his caseload only to hear over and over that local convenience stores only stocked prepared foods, cigarettes, and alcohol. Most of his families did not own a car and had difficulty traveling the 5 miles to the nearest grocery store that stocked fruits and vegetables. Walking was out of the question as well, due to the active presence of gang violence in Oak Park. Finally, Thomas volunteered to participate in a community development task force that was being organized. The task force interviewed key community members and then presented their findings to the mayor. As a result of the key informant interviews, the Senior Gleaners (a community organization that harvests leftover vegetables from surrounding fields) partnered with a well-respected local church to use their parking lot to distribute free farm produce each Saturday. In addition, the task force successfully advocated for increased police presence in Oak Park. The task force also partnered with developers and submitted a grant to renovate a square block of buildings in a dilapidated Oak Park strip mall. Within two years, the grant was funded and construction began for a library branch, a grocery store, and a healthcare complex surrounded by ample lighting within a park-like setting. Thomas concluded that the hours he had volunteered had a major impact on the daily life of the families he worked with in the Oak Park community.

Sociocultural Factors Affecting Health

Sociocultural factors can have a major impact on health beliefs, health practices, health communication, and the trust that patients have in healthcare providers. Consider, for example, Oleg's perspective about taking medications. Oleg was a 45-year-old Russian male admitted to the hospital for a blood pressure of 215/110 mmHg. His NP had prescribed a spectrum of blood pressure medications at increasing dosages over the last few months without seeing any change in his blood pressure. When Oleg was admitted to the cardiac floor, his inpatient nurse followed the written orders in his chart, which were based on the last dosage of blood pressure medication that his NP had tried. Thirty minutes after the nurse gave him the medication, Oleg's blood pressure dropped so dramatically that he had to receive a bolus of fluid to bring it back within normal ranges. When a Russian-speaking nurse interviewed Oleg, he shared that he got the prescriptions his NP ordered filled because he worried that she would not continue to see him if he did not fill the prescriptions. However, Oleg did not take the medications because he shared a common view among Russian individuals that he was too young to have to take medication on a daily basis for the rest of his life. Which sociocultural factors should his NP and nurse have considered when working

with Oleg? What else could the NP have done? What else should the staff nurse do in this situation?

Behavioral Factors Affecting Health

A variety of behavioral factors influence whether patients comply with their ordered treatments. Sometimes lack of compliance or adherence with ordered care is based on previous negative experiences with the healthcare system. Consider the example of Judy, a 350-pound, 84-year-old woman who had hip surgery the previous year. During that hospitalization, the lift team was delayed and the nurses who were moving her from the gurney to the bed dropped her. Her back was broken and required numerous painful injections to manage the fracture and the associated pain. When Judy left the hospital after that surgery she vowed to never return to any hospital. One year later her friend called on the phone and noticed Judy was confused. After arriving at her home, the friend called the paramedics because Judy was disoriented and had a fever of 103°F. When the paramedics arrived at her home, Judy refused to go to the hospital. Finally, after almost 30 minutes, her friend persuaded Judy to go to the emergency room just long enough to get checked out and she consented. At the hospital, it was determined Judy had a severe urinary tract infection. After one day in the hospital, Judy insisted that she be discharged. Her temperature had gone down to 99°F and her mental status was back to normal. When Judy arrived home she got a call that her best friend had just passed away. In addition, the pharmacy employee who was supposed to deliver her antibiotics made a mistake, and a day and a half went by before she was able to get her antibiotic prescription delivered. When Judy's friend called, she said she felt too nauseated to eat or take her antibiotics. Judy said "when life isn't fun anymore, there is no reason to be around." Which experiences, feelings, attitudes, behaviors, and medical conditions were influencing Judy at this moment? How might a visit by a home health nurse help Judy?

As the case studies here illustrate, health promotion requires empowerment, collaboration, and participation by the client. Sometimes health promotion requires community-level intervention if effective health goals are to be accomplished. Health promotion can also require the nurse to take an active role in promoting environmental, organizational, or social change at the local, regional, or national level (Maben & Macleod-Clark, 1995).

THE RELATIONSHIP BETWEEN HEALTH, HEALTH PROMOTION, AND ILLNESS PREVENTION

Defining health as well-being laid the foundation for health promotion practice and expanded the role of nursing and medicine beyond just disease prevention and treatment (Saylor, 2004). Including a focus on well-being and wellness expanded health care from disease prevention and treatment to a consideration of the patient's capacity to cope with stress, choose healthy behaviors, recognize their health-related

limitations, participate in lifestyle modifications, and manage changes in their health status (Manderscheid, Ryff, Freeman, McKnight-Eily, Dhingra & Strine, 2010).

Wellness

Dunn (1959), the father of the wellness movement, advocated for maximizing human potential by simultaneously focusing on the mind, body, and spirit. He stressed the importance of personality, motivation, environment, and capacity for change. Dunn advocated for improving quality of life and active engagement of individuals and communities in health promotion, health maintenance, and disease prevention.

Primary, Secondary, and Tertiary Prevention

The terms primary, secondary, and tertiary prevention came from an epidemiological understanding of risks experienced by particular groups. Primary prevention has averting the occurrence of disease as its goal. Interventions occur before the disease process starts. Primary prevention includes health promotion and protecting at-risk individuals from threats to their health. Harris and Guten (1979) describe five dimensions of health protective behavior, including personal health practices, safety practices, preventive health care, environmental hazard avoidance, and harmful substance avoidance. Primary prevention and health promotion both focus on protecting individuals and communities from disease and increasing health and well-being. Disease prevention typically targets specific disease processes, while health promotion is focused on general health and well-being, not necessarily one specific disease (King, 1994).

Secondary prevention aims to halt disease progression before it becomes more acute and is designed to lessen complications and disability (Breslow, 1999). Early diagnosis and prompt treatment are the priority. Tertiary prevention is often called rehabilitation. It begins once a disease has been stabilized and aims to restore the individual to their highest level of functioning (King, 1994).

Health promotion includes health education, health maintenance and protection, community and environmental development, and health policy advocacy (King, 1994). Given the provided definitions of health, health promotion, wellness, and primary prevention, which healthcare professionals are well prepared to implement these health promotion activities both at the individual and community level?

THE IMPORTANCE OF A TRAINED HEALTH PROMOTION WORKFORCE

Authors have argued for making health promotion a specialized practice and profession. Those who support this view argue that professions other than nursing, medicine, and health education should be trained in health promotion practices. They argue for a need for identifying health promotion competencies, accreditation standards for health promotion, and development of professional standards of practice.

Core competencies for such a role include the ability to: (1) catalyze change and empower individuals and communities to improve their health; (2) provide leadership in developing public health policy and building capacity in systems for supporting health

promotion; (3) assess the needs and assets in communities to analyze the behavioral, cultural, social, environmental, and organizational determinants of health; (4) develop measurable goals after assessing needs and assets and identifying evidence-based interventions; (5) carry out efficient, culturally sensitive strategies to improve health; (6) evaluate the effectiveness of health promotion policies and disseminate results; (7) advocate on behalf of individuals and communities while building their capacity by incorporating an understanding of their assets; and (8) work collaboratively among varied disciplines to promote health (Barry, Allegrante, Lamarre, Auld & Taub, 2009).

Given the scope and definitions of nursing practice, do you think health promotion competencies are part of the role of a nurse? The WHO in the Munich Declaration called for active involvement of nurses in health policy development. But as Whitehead (2003c) stressed, nurses often struggle with finding the time and having the skills needed to take an active role in shaping health policy. As Smith and colleagues (1999) commented, the immediacy of the situation in most inpatient settings diverts nurses from participating in community-level interventions, environmental assessments, and health policy development. Most health policy design occurs with little input from nurses, even though health policy has a profound influence on their nursing practice (Whitehead, 2003c).

A number of nurses who work in the community in public health settings, nurse researchers, and some advanced practice nurses (APNs) are engaged in health policy development and evaluation. However, many acute care nurses who work in busy inpatient settings do not see health promotion as part of their role. Activities such as political involvement, health policy development, and community advocacy are not typically easy to do in an inpatient setting (Casey, 2007a). In addition, within the literature, too few examples are presented of how inpatient nurses might engage in these expanded activities that are part of health promotion.

A variety of authors have begun to describe how inpatient nurses might fulfill some of these broader health promotion–oriented roles. Wilson-Barnett (1993) suggested nurses need to view health promotion as a guiding philosophy about advocacy, participatory involvement, enhanced social support, and individualized care. By incorporating advocacy, considering social support, involving patients in care planning, and providing individualized care, nurses are promoting health. Casey (2007b) agreed that by engaging in active listening, checking with the patient and/or family, eliciting patient involvement in care planning and daily care, and individualizing care based on patient priorities, nurses are engaging in participatory care, an important component of health promotion. Since developing a therapeutic nurse–patient relationship

requires patient participation, this too is part of health promotion. Nursing interventions that foster social support, decrease barriers to care, and improve self-efficacy are also health promoting. Determining the client's and family's perceived needs based on their societal position, along with developing realistic objectives and ways to monitor progress, is a vital part of health promotion (Whitehead, 2001). By mediating and advocating for a patient's rights or needs with other healthcare professionals or community organizations, especially during daily rounds or discharge planning activities, nurses are fulfilling these broader health promotion–oriented roles (Casey, 2007a).

However, Whitehead (2001) has cautioned against busy inpatient nurses ignoring the complexity underlying health behavior by offering overly simplistic patient education without exploring barriers to behavior change or environmental/cultural influences. He argued that nurses must explore why patients adopt a particular lifestyle, what would work for them, and how to engage the patient in setting realistic goals.

Discussion Questions

1. Do you think nurses should focus exclusively on health education for individual patients or should they also assess sociocultural, organizational, political, and environmental aspects of health promotion? Please explain your answer.
2. Do sociocultural factors like educational status, employment status, marital status, place/country of residence or birth, access to health care, and cultural beliefs/customs impact the health status of individuals? Please explain your answer.
3. Do you believe that individual health behaviors such as smoking, drinking, drug use, exercise/eating patterns, and access to preventative care primarily determine a person's health? Please explain your answer.
4. Should a separate health promotion practitioner role be created? Or should health promotion be retained as an integral part of nursing practice? Please explain your answer.
5. Do the definitions of health, health education, and health promotion have any influence on your nursing practice? Please explain your answer.
6. Imagine how health care will be provided 10 years from now. Describe how the different definitions included in this text could influence how you practice nursing 10 years into your professional career.

Check Your Understanding

How many of these health promotion competencies do you see as being part of nursing practice? Complete the following chart by writing "yes" or "no" in the grid next to each competency. Provide in the middle column an example of a time you observed a nurse demonstrate the given competency at the local, national, or international level.

Is this competency an aspect of nursing practice? Write "yes" or "no" in this column next to the given competency	Describe a scenario you have observed where a nurse demonstrated the given competency	Health Promotion Competency
		1. Catalyze change and empower individuals and communities to improve their health.
		2. Provide leadership in developing public health policy and building capacity in systems for supporting health promotion.
		3. Assess the needs and assets in communities to analyze behavioral, cultural, social, environmental, and organizational determinants of health.
		4. Develop measurable goals after assessing needs and assets and identifying evidence-based interventions.
		5. Carry out efficient, culturally sensitive strategies to improve health.
		6. Evaluate the effectiveness of health promotion policies and practices and disseminate results.
		7. Advocate on behalf of individuals and communities by building their capacity and incorporating an understanding of their assets.
		8. Work collaboratively among varied disciplines to promote patient health.

In your list of scenarios where nurses performed these nursing competencies, did you include the following examples?

- For Competency 1, have you ever seen a nurse catalyze change in a community and empower individuals by offering a health screening fair in a local church to motivate individuals with high blood pressure to seek out a primary care physician or NP to manage their blood pressure?
- For Competency 2, did you include a description of how nurses in California lobbied the governor to support the nurse–patient ratio law to increase the capacity of hospitals to provide quality health care?
- In terms of Competency 3, did you include an example of a nurse researcher who interviewed community members to determine the behavioral, cultural, social, environmental, and organizational determinants of childhood obesity and how to best prevent it?
- Did you include a description of your own clinical write-ups or concept mapping when listing examples of Competency 4? Have you developed measurable goals after assessing patient needs and assets by using evidence-based nursing interventions that you learned about in your lectures?
- As an example of Competency 5, did you describe patient care that you have provided in an efficient and culturally sensitive manner? Have you ever allowed a Spanish-speaking or Hmong-speaking patient to have family visits beyond the scheduled visiting hours because it was more convenient for the families' schedules or needs? Have you ever altered your teaching method based on the patient's culture?
- In terms of Competency 6, did you describe a poster or a podium presentation from a professional nursing conference where the researcher was discussing the effectiveness of health promotion practices and disseminating the results?
- Did you describe a public or community health nurse who you observed demonstrating Competency 7 when advocating for a mother by building on one of her existing parenting strengths?
- In terms of health promotion Competency 8, did you mention that nurses work collaboratively with social workers, psychologists, occupational therapists, speech pathologists, physical therapists, physicians, and pharmacists when promoting patient health?

What Do You Think?

Think about what health means to you. Rank-order the concepts that others have identified as being central to definitions of health by placing a 1 next to the best definition of health from your point of view, placing an 11 next to the definition of health that is least meaningful for you, and numbering the remaining definitions accordingly. Look over the list and enter a "yes" or a "no" next to the aspects of health you would include in a definition. Describe your rationale for including or excluding the given aspect of health from a definition.

Rank Order	I would include this aspect in my definition of health—yes or no	Rationale	Defining Aspect of Health
			1. The absence of physical and mental disease.
			2. Living well despite illness or disability.
			3. A complete state of physical, mental, social, and emotional well-being, not merely the absence of disease.
			4. The capacity for living.
			5. Individualized fitness that allows one to live a full and creative life.
			6. Good quality of life.
			7. Actualization of inherent and acquired human potential through goal-directed behavior.
			8. Competent self-care and satisfying relationships with others while maintaining harmony with relevant environments.
			9. The state of optimum capacity to perform the roles and tasks one has been socialized into.
			10. A joyful attitude toward life and a cheerful acceptance of one's responsibilities.
			11. The capacity to maintain balance and be free from undue pain, discomfort, disability, or limitation of action including social capacity.

Review the common aspects of health in the grid presented. Are any of them unique to a given society and not a definition that would be acceptable in any society? Which aspect would not apply to all cultures and societies? For example, do all cultures value individualized fitness, self-care, and maintaining balance? Of individualized fitness, self-care, and maintaining balance, which aspect of health is typically least valued within the United States? In your view, which aspect of health is least valued in Asian countries?

Health is a phenomenon that most of us understand, yet it remains difficult to define. Imagine your health as a large soap bubble surrounding your body that goes everywhere you go. Also, think back to a time when your health was suffering for a short period. Now, write the title "Health," followed by seven sentences that describe your health on different days when you felt the healthiest during your life. Select specific phrases that capture what it means and what it is like to be healthy. Just write without censoring your thoughts and feelings. You can go back afterward to edit your responses.

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Chapter 2

The History of Health Promotion

Bonnie Raingruber

Chapter Objectives

At the conclusion of this chapter, the student will be able to:

1. Describe the ancient Greek approach to health promotion.
2. Discuss how the health promotion movement was influenced by historical developments, critical documents, and international conferences.
3. Identify which perspectives about health promotion correspond to a given historical era, document, or organization.
4. Analyze how historical developments in health promotion have influenced nursing practice.

INTRODUCTION

Numerous historical practices, key documents, important task forces, and international conferences have shaped the nature of health promotion practice as it exists today. Each period and accomplishment has helped delineate the depth and breadth of health promotion practice. A number of key time periods, documents, and conferences are described in the next section. Although the latter part of the 20th century is typically viewed as being most critical in shaping the nature of health promotion practice (Tountas, 2009), we will first begin with an overview of older influences.

ANCIENT HEALTH PROMOTION PRACTICES: INDIAN, CHINESE, EGYPTIAN, AND HEBREW

Indian systems of medicine trace back to 5000 BC, where Ayurvedic practices focused on personal hygiene, sanitation, water supply, and engineering practices that supported health. Chinese medicine dates back to 2700 BC and included attention to

hygiene, diet, hydrotherapy, massage, and immunization. From 200 BC, the Egyptians developed community systems for collecting rainwater, disposing of waste, inoculating people against small pox, and methods of avoiding the plague by controlling the rat population. They also used mosquito nets, encouraged frequent bathing, and advocated against excess use of alcohol (Kushwah, 2007).

Early references to health promotion are found in the Code of Hammurabi and Mosaic Law. These references address disease prevention, disposal of waste, and segregation of infectious persons, including those suffering from leprosy. Mosaic Law encouraged a weekly day of rest for health, as well as for religious reasons, and recognized that eating pork could result in illness (Moore & Williamson, 1984).

GREEK ANTIQUITY

The ancient Greeks (460 to 136 BC) were the first civilization to emphasize that health is a function of physical and social environments, as well as human behavior. They empowered individuals and communities to establish conditions and practices that supported health, because being strong and beautiful was highly valued in Greek society (Tountas, 2009).

The Pythagoreans suggested that harmony, equilibrium, and balance were key factors in maintaining health. They felt that living life in a way that minimized disturbance would promote health. The Pythagoreans also placed a great deal of emphasis on hygiene. They ate little meat, practiced moderation, and worked on maintaining self-control and calmness at all times. Plato suggested that health is a state of being in harmony with the universe and experiencing a sense of completeness and contentment. Hippocrates defined health as equilibrium between environmental forces (such as temperature, water, and food) and individual habits (diet, alcohol, sexual behaviors, work, and leisure). Health was seen as a matter of balancing the perpetual flux of the body. Hippocrates suggested that a person's most valuable asset was health, so knowing how to modulate one's thoughts to maintain health was a critical skill. An epidemiologist, Hippocrates coined the term "endemic"—to describe diseases that were consistently present in a population—and the word "epidemic"—to describe diseases that occurred at select times.

A Greek physician was tasked with evaluating the season and climate; the location of a person's home; the wind; water sources; geography; and whether people ate well, drank to excess, got adequate rest, and exercised on a regular basis. The trainer, the physician, and the educator were closely linked roles in Greek society.

Social, political, and economic influences were seen as critical in Greek society in terms of achieving empowerment, autonomy, self-sufficiency, and health. Donations from the rich were used to subsidize health care for the poor. Physicians had an obligation to treat the rich and poor alike (Tountas, 2009).

Asklepieions, temples to the god of Medicine, were found throughout the country where Hippocratic medicine was practiced, and were situated in beautiful areas next to rectangular pools of water, auditoriums where entertainment and oratory was available, and close to gymnasiums and stadiums. This proximity allowed for simultaneous attention to physical, psychological, social, and spiritual well-being (Tountas, 2009).

THE ROMAN EMPIRE

The Romans focused on community health measures, including the transportation of clean water, paved streets, street cleaning, and sanitary waste disposal. According to Roman philosophy, the state—not the individual—had the greatest influence on health. Public baths were provided to support community health. A census of both citizens and slaves was used to plan community health programs and structures. Ventilation and central heating were also required by building codes of the day. A Roman physician, Galen, described health as "a condition in which we neither suffer pain nor are hindered in the functions of daily life such as taking part in government, bathing, drinking, eating, and doing other things we want" (Moore & Williamson, 1984, p. 196). He suggested that disease was caused by predisposing, exciting, and environmental factors (Kushwah, 2007).

THE MEDIEVAL PANDEMICS

Between 1000 and 1453 AD, bubonic plague (Black Death) and pulmonary anthrax moved from Asia to Africa, the Crimea, Turkey, Greece, and then Europe. Quarantine was used, in which travelers from plague-infested areas had to stop at designated spots and remain there for 2 months, without demonstrating any symptoms, before being allowed to continue their journey (Kushwah, 2007).

KEY ORGANIZATIONS, CONFERENCES, TASK FORCES, AND DOCUMENTS THAT HAVE INFLUENCED THE NATURE OF HEALTH PROMOTION IN MODERN TIMES

Next we will review a number of modern-day organizations, movements, conferences, task forces, and documents that have helped shape the nature of health promotion. Many have argued that social and political developments such as civil rights, women's movements, self-care, and the human potential movement during the 1960s influenced the onset of the health promotion era by advocating for increased knowledge, participatory control over one's life, and equal access for all (Morgan & Marsh, 1998). It is also likely that the greater than 50% increase in life expectancy that occurred during the 20th century helped fuel the health promotion movement: People were now living longer and a need existed to focus on improving quality of life (Breslow, 1999).

Many of the key organizations, conferences, and documents we will review have had global impact, influencing not only health promotion within one country but also around the world. Timeframes associated with each organization are provided in the headings so you can gain a sense of the chronology of historical influences that have shaped health promotion practice.

The World Health Organization (1948–Present)

Since the United Nations created the World Health Organization (WHO) in 1948, it has been focused on global health promotion. The WHO advocates for legislation,

fiscal change, and organizational and community efforts to promote health. In 1984, the WHO defined health promotion as the process of enabling people to take control over maintaining and improving their health. With the issuance of this definition, a decade of focus on the impact of lifestyle on health shifted to attention on the structural factors in society that support health. These societal factors included things such as income, housing, food security, employment, and working conditions.

In 2001, the WHO published an International Classification of Functioning, Disability, and Health (ICF) to encourage the attainment, monitoring, and enhancement of health and functioning. This document focuses on functional abilities, activities, participation levels, and environmental factors that contribute to health promotion. Self-determination and autonomy, as well as personal and environmental factors, are seen as key in shaping health, according to the ICF (Howard, Nieuwenhuijsen, & Saleeby, 2008).

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The International Union for Health Promotion and Education (1951–Present)

The International Union for Health Promotion and Education (IUHPE) is a global, professional, nongovernmental organization dedicated to advancing health promotion (Mittelmark, Perry, Wise, Lamarre, & Jones, 2007). Its mission is to promote global health and equity between and within countries around the world. Globalization, transboundary influences on health, urbanization, consumerism, chemical/radiological/biological threats to health, and population growth are issues of key interest to the IUHPE (Mittelmark, 2007). By partnering with Oxford University Press, the IUHPE currently publishes *Health Education Research* and *Health Promotion International* to support health promotion research and dissemination. In addition, the IUHPE publishes *Promotion and Education* along with sponsoring regional and global conferences dedicated to health promotion. They also maintain a health promotion website and sponsor health promotion research. Since 1998, IUHPE has been involved in lobbying for social clauses to be added to trade agreements in an effort to protect poor countries from exploitation.

A specific focus of the IUHPE is health impact assessment and evaluating the effectiveness of health promotion programs (Mittelmark, Perry, Wise, Lamarre, & Jones, 2007). The IUHPE believes health promotion programs are best evaluated when linked to the daily life of communities, when the research is in sync with local traditions, and when it is led by community members (Mittelmark, 2007).

The IUHPE and the WHO coordinate the Global Programme for Health Promotion Effectiveness (GPHPE). The goals of the GPHPE are to: (1) improve standards of health-promoting policymaking; (2) review evidence of program effectiveness

in terms of political, economic, social, and health impact; and (3) disseminate evidence to policymakers, teachers, healthcare practitioners, and researchers (Corbin & Mittelmark, 2008).

The Lalonde Report (1974)

The first authoritative policy statement to suggest that health promotion was determined by issues other than those associated with the healthcare system or medical care came from the Lalonde Report (Lalonde, 1974). As a result, Canada became recognized as a leader in the conceptual development of health promotion policy. This report is credited with bringing the term *health promotion* into prominence (Morgan & Marsh, 1998).

The Lalonde Report introduced the health field model, which emphasized that lifestyle/behavior, biology, environment, and healthcare organizations all impacted health. It advocated for viewing preventative care as important as treatment and cure. Mortality statistics were used to summarize the number of unnecessary diseases and illustrate that chronic disease, rather than infectious disease, accounts for the preponderance of disability and death.

Within Canada, the Lalonde Report influenced the government to shift public policy from a focus on disease treatment to health promotion. The Lalonde Report had the goal of prompting individuals and organizations to accept more responsibility for their health, and it resulted in interventions to decrease automobile accidents, eliminate drunken driving, increase seat belt use, and minimize alcoholism (MacDougall, 2007).

The Lalonde Report was used by the WHO and numerous governments as the rationale for expanding the definition and understanding of health promotion to include both environmental and lifestyle factors. This report was the source of the best known definition of health promotion, which is that it is the art and science of helping people change their lifestyle and move toward an optimal state of health. Influential as the Lalonde Report was, it was criticized for emphasizing lifestyle issues more than environmental, economic, social, and health system–related influences. For example, it stressed the importance of self-imposed risks and individual blame associated with poor lifestyle choices (Raphael, 2008).

WHO: Declaration of Alma-Ata on Primary Health Care (1978)

In 1978, the WHO issued the Alma-Ata declaration in support of the idea that health promotion was not entirely in the purview of the healthcare sector. The Alma-Ata declaration also emphasized that (1) global cooperation and peace were vital, (2) local and community needs must drive health promotion activities, (3) economic and social needs shape health, (4) prevention must be an integral part of health care, (5) equity in terms of health status is needed, and (6) multiple sectors and players must be involved to improve health (Awofeso, 2004). It emphasized the need for health promotion, as well as curative and rehabilitative services. The Alma-Ata declaration suggested that evidence indicates that healthcare resources are too concentrated in centralized,

professionally dominated, highly technological institutions, which limits care available at local and community levels (King, 1994). The Alma-Ata declaration put forth many ideas that later appeared in the Ottawa Charter.

The Alma-Ata declaration emphasized issues of particular importance to developing countries to a greater extent than other documents had done. For example, issues of food security, affordable health care, global peace, safe water, proper nutrition, and family planning were highlighted (Awofeso, 2004).

Healthy People (1979–2020)

Motivated by the Canadian Lalonde Report, the United States' Surgeon General developed a comprehensive public health policy with associated 10-year prevention strategies and outcome targets designed to decrease mortality and morbidity. Health promotion was separated from disease prevention, and both targets were given priority (Morgan & Marsh, 1998). This policy was called Healthy People 1979. Healthy People consists of national objectives for promoting health and preventing disease and was designed to encourage collaborations across sectors, to guide people in making healthy choices, and to measure the impact of U.S. policy. A unique aspect of Healthy People 1979 was establishing measurable target goals for improvements in population health, which resulted in improvements in seat belt use, decreased alcohol consumption, and lower rates of smoking (MacDougall, 2007).

"Healthy People 1979 argued that 50% of mortality in 1976 was due to unhealthy behavior or lifestyle, 20% to environmental factors, 20% to human biology, and 10% to inadequacies in health care" (MacDougall, 2007, p. 958). Healthy People 1979 became a roadmap for public health activities and prevention strategies across the United States. Prior to its issuance, no national guide for primary prevention had existed (Brown, 2009). Healthy People 1979 called for a reexamination of U.S. priorities for national health spending, since only 4% of funding was previously allocated to prevention. The report argued for the development of community-based and individual interventions to help promote healthy lifestyles and enhance a state of well-being.

The Healthy People 1979 Report was followed by the development of Healthy People 1990, 2000, 2010, and 2020, with each report building on the previous agenda. Healthy People 1990 focused on reducing mortality across the lifespan with priority being assigned to accident/injury prevention, control of stress/violent behavior, family planning, fluoridation of drinking water, high blood pressure, immunization, alcohol and drug abuse, physical fitness, pregnancy, sexually transmitted diseases, smoking, and toxic agents. In addition, in Healthy People 1990, it became clear that there were subpopulations within the United States who experienced greater health disparities and need for care. Equal access became a priority (Brown, 2009).

Can you think of a type of cancer that is related to a health disparity? If you mentioned (1) African American women are more likely to die from breast cancer, (2) African American men have the highest incidence of prostate cancer, (3) Hispanic women have the highest incidence of cervical cancer, (4) Asian Americans and Pacific Islanders have the highest incidence of liver cancer, and (6) American Indians have

the highest incidence of kidney cancer, then you would have correctly identified a cancer-related health disparity (Office of Minority Health, 2012).

Healthy People 2000 focused on increasing years of healthy life, reducing health disparities, and increasing access to preventative services. Priority areas were cancer, diabetes, community-based programs, environmental health, food and drug safety, heart disease and stroke, HIV infection, maternal and infant health, mental health, surveillance and data systems, and violent/abusive behavior, in addition to previously unmet target goals from 1990 (Brown, 2009).

During the period between 2000 and 2010, the Behavioral Risk Factor Surveillance System and the National Health Interview Survey were implemented so that quantitative data could be used to evaluate progress and shape future priorities of the Healthy People agenda (Brown, 2009).

Healthy People 2010 was based on the same goals as Healthy People 2000, with priority being given to access to health services, arthritis, osteoporosis, kidney disease, health communication, medical product safety, public health infrastructure, and respiratory diseases, in addition to all previously unmet target priorities (Brown, 2009). Another goal was increasing quality and years of healthy life by assisting people to gain knowledge, motivation, and opportunity to make informed decisions about their health. Eliminating health disparities or gaps between two or more groups in terms of health outcomes continued to be a priority of Healthy People 2010. Healthy People 2010 includes a number of indicators, such as physical activity, obesity, tobacco use, and mental health, so that health promotion successes can be tracked (Howard, Nieuwenhuijsen, & Saleeby, 2008).

In order to provide a structure for integrating Healthy People 2010 objectives, the U.S. Department of Health and Human Services (USDHHS), the Centers for Disease Control and Prevention, the Office of National Drug Control Policy, and the Fordham Institute created a roadmap called Mobilizing, Assessing, Planning, Implementing and Tracking, or MAP-IT. The MAP-IT structure is available for use by anyone, including government officials, community leaders, and healthcare professionals, who want to create positive change in a community. There is a MAP-IT website, which includes action plans and successful models of using MAP-IT techniques. MAP-IT is designed to help groups map out, implement, and evaluate a community-level change. These techniques were created to help bring individuals and organizations into a coalition to improve health; to assess community needs, resources, and strengths; to plan interventions that are congruent with community needs and wants; to implement the plan using measurable goals; and to track process and report outcome measures (Jesse & Blue, 2004).

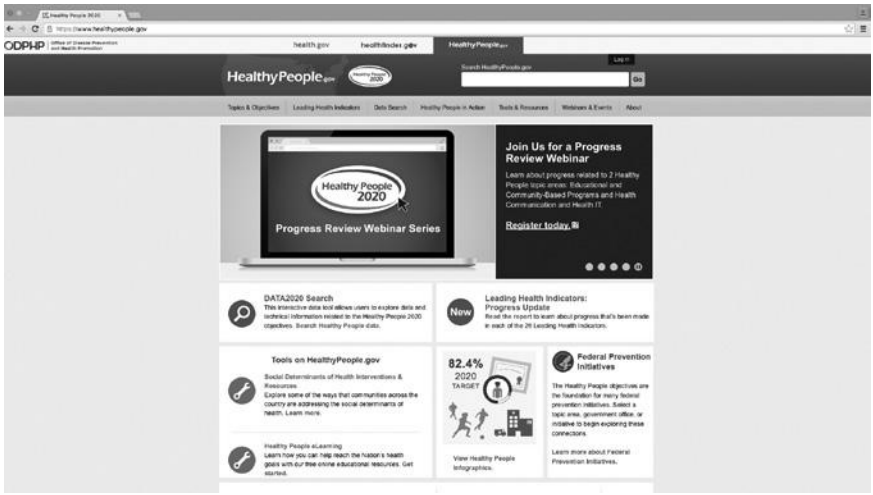
One example of a MAP-IT strategy described on the website involves a community task force organized in Lafayette, Louisiana, after the Columbine school shootings. The task force consisted of school officials, psychologists, and community members. They proposed closer monitoring of indications of adolescent anger and provision of early professional intervention to defuse potentially dangerous situations (Healthy People, 2010).

An external advisory committee of 13 public health and healthcare delivery experts provided input regarding the Healthy People 2020 goals. In addition, a public comment website was established for input from the public. Determinants of health that are addressed in Healthy People 2020 include: (1) social, economic, cultural, and environmental conditions and policies of global, national, state, and local levels; (2) living and working conditions; (3) social, family, and community networks; and (4) individual behaviors and traits, such as age, gender, race, and biological heritage that shape health.

The priorities of Healthy People 2020 are to: (1) eliminate preventable disease, disability, injury, and premature death; (2) achieve health equity by eliminating health disparities; (3) create social and physical environments that promote health; and (4) support healthy development and behavior across the lifespan (MacDougall, 2007). Many of the objectives of previous years are retained along with a focus on disability and secondary conditions: dementias; global health: Lesbian, Gay, Bisexual and Transgender health; preparedness; social determinants of health; community-based programs: genomics; and health care–associated infections (Manderscheid & Wukitsch, 2014).

Additionally, Healthy People 2020 has incorporated a number of new digital communication strategies, including apps for smartphones and tablets; LinkedIn and Twitter feeds; animated graphics illustrating social determinants of health such as poverty and discrimination; an email subscriber service offering news blasts; and the Health and Human Service Department YouTube channel. In phase 2 of Healthy People 2020, additional innovations are planned. Included in phase 2 will be an interactive tool linking leading health indicators and populations; search functionality connecting topics to health-related journals; e-learning opportunities offered via webinars; benchmarking functions that allow comparison of local and state level data with national data; online chat groups; and instant messaging. The inclusion of these digital communication strategies derives from a belief that health objectives cannot be achieved by the national government alone. Engagement of stakeholders, advocacy by state/local officials, and involvement of citizens in planning, organizing, and advocating for health policy is a necessity. Digital connectivity allows for frequent messaging and enables people from one locality to connect with individuals and groups in other regions that are challenged by the same health problems (Manderscheid & Wukitsch, 2014).

The Healthy People initiative has been criticized for focusing excessively on individual responsibility for lifestyle choices while giving less credence to the ethnic, gender, environmental, and socioeconomic factors that influence health (MacDougall, 2007). Morgan and Marsh (1998) suggested this perspective, in which health promotion is seen as being based in personal behavior, and is a reflection of the strong current of responsibility and rugged individualism that is part of U.S. culture and history. There have also been concerns about the measurability of target indicators, the quality of data being collected, the lag time associated with data analysis, the reality that too many objectives dilute the impact of the policy, and the fact that each priority is assigned an equal weighting.



Source: U.S. Department of Health and Human Services (USDHHS). Office of Disease Prevention and Health Promotion. *Healthy People 2020.* Washington, DC. Available at http://www.healthypeople.gov/2020/default.aspx. Accessed 8-22-2012

Nonetheless, Healthy People was the first document to include outcomes that were designed to be measurable. Healthy People has played a major role in public health in the United States, and it has a major impact on federal and private funding for health promotion programs (Brown, 2009). Healthy People has helped increase public awareness and understanding of determinants of health, engaged multiple sectors to take action to promote health, and identified continuing research and data collection needs (Fielding & Kumanyika, 2009).

Achieving Health for All: The Epp Report (1986)

In 1986, the Canadian Minister of National Health and Welfare created a report titled "Achieving Health for All: A Framework for Health Promotion," which has come to be known as the Epp Report. This report documented that disadvantaged groups have lower life expectancies and poorer health than those with more resources. The Epp Report posited that self-care, mutual aid from others, and healthy environments were major influences on health promotion. Mutual aid included emotional support and the sharing of ideas, information, and experience in the context of a family, a neighborhood, a community organization, or a self-help group (Epp, 1986).

The Epp Report advocated for reducing inequities, increasing prevention, and enhancing an individual's coping skills. The importance of fostering public involvement in policymaking, strengthening community-based health services, and coordinating

public policy were also stressed (McIntyre, 1992). Epp (1986) stated that all policies that impact health need to be considered, including income security, employment, education, housing, business, agriculture, transportation, criminal justice, and technology.

Epp (1986) asserted that "people often associate health promotion with posters and pamphlets but this simplistic view is akin to associating medical care with white coats and stethoscopes . . . health promotion is a strategy that synthesizes personal choice, social responsibility, and an environmental focus to create a healthier future" (p. 27). The Epp Report ended with an admonition to avoid "blaming the victim" and to stop underestimating social and economic determinants of health (Falk-Rafael, 1999; McIntyre, 1992). Although the Epp Report was released at the same time as the Ottawa Charter, it was never fully realized due to budget cuts in the 1980s and the new Canadian government that came to power in 1993.

WHO: Ottawa Charter for Health Promotion (1986)

The first international health promotion conference sponsored by the WHO was held in Ottawa, Canada, in 1986. It resulted in the Ottawa Charter for Health Promotion, which is a quintessential document in the international health promotion arena. The Ottawa Charter emphasized that individuals need to have supportive environments and economic resources to lead healthy lives and experience well-being. It addressed the role of health inequalities and the importance of political, economic, and social influences on health (Scriven & Speller, 2007). This perspective expanded attention from individual lifestyles alone to the influence of groups.

The Ottawa Charter put forth the ideas that health promotion: (1) includes the concept of well-being; (2) rests on political, economic, social, cultural, environmental, behavioral, and biological advocacy; (3) necessitates attention be given to equity; (4) requires action by governments, voluntary organizations, local authorities, industry, health care, and the media; and (5) should be adapted to local needs and cultural/economic norms (Irvine, Elliott, Wallace, & Crombie, 2006). The Ottawa Charter asserted that to reach a state of complete physical, mental, and social well-being, "an individual or group must be able to identify and realize aspiration, to satisfy needs, and to change or cope with the environment . . . . Health is a positive concept emphasizing social and personal resources as well as physical capabilities" (WHO, 1987, p. iii).

This report was instrumental in stressing that health includes a state of physical, mental, and social well-being. It focused on caring, holism, advocacy, and mediation of differing social priorities as the cornerstones of health promotion (Falk-Rafael, 1999).

The Ottawa Charter stressed that health promotion is not the sole responsibility of the healthcare sector but rather requires political, economic, and social interventions as well as the involvement of voluntary organizations, local authorities, industry, and the media. The Ottawa Charter encouraged the use of community-based participatory research and the empowering of communities to take control of their own health (Scriven & Speller, 2007). An example of community involvement is including parents, youth, and community leaders in identifying health promotion strategies for youth at high risk of obesity, then involving those stakeholders in providing and evaluating the selected interventions.

It has been argued that involving diverse groups such as government, volunteer organizations, industry, community groups, and the media yields more creative, holistic, realistic, and relevant health promotion programs. Shared resources, relationships, and ideas result in outcomes that could not be achieved by any one group working alone. It is also true that maintaining effective multifaceted partnerships requires substantial communication, commitment, and time. Research has indicated that close to 50% of community-based partnerships dissolve within the first year. Issues of loss of focus, loss of control, consensus-building, and accountability are constant challenges that must be overcome (Corbin & Mittelmark, 2008).

Health promotion was defined by the Ottawa Charter as the "process of enabling individuals and communities to increase control over the determinants of health, thereby improving health to live an active and productive life" (Eriksson & Lindstrom, 2008, p. 194). The Ottawa Charter moved health promotion away from a focus on health education alone to increased attention to public policy, supportive environments, community action, personal skills, and the reorientation of healthcare services. The health promotion fulcrum shifted from an individual to a social, cultural, political, economic, and environmental perspective with this document (McQueen, 2008).

WHO: Adelaide Recommendations on Healthy Public Policy (1988)

The Second International Conference on Health Promotion was held in April 1988 in Adelaide, South Australia. It emphasized the necessity of supportive environments in promoting health. In addition, a call was issued for collaborations among governmental and private sector interests associated with agriculture, trade, education, industry, and communications to the extent that health was given priority over economic considerations. Conference presenters stressed that concern for equity in all areas of policy development results in substantial health benefits. They argued for equal healthcare access for indigenous peoples, ethnic minorities, and immigrants. They also stressed that education levels and literacy be taken into account when health policy is being designed. The importance of creating health information systems capable of evaluating the impact of policy change was highlighted. An argument was made for developing nationally based women's health policies that supported women's choice in terms of birthing practices. They also advocated for parental/dependent healthcare leaves, and they created a larger role for women in the development of health policy. Issues such as the ecological impact of raising tobacco as a cash crop and how such practices limit food production were discussed (Kickbusch, McCann, & Sherbon, 2008).

The New Public Health Movement (1980s)

The New Public Health Movement (NPHM) was inspired by the Ottawa Charter on health promotion and by the growth of the field of population health. The NPHM embodies a number of the concepts just discussed, emphasizing that a socioecological rather than a biomedical approach is the most effective way to promote health. This

socioecological view focuses on preventing rather than curing disease by examining root causes of disease such as economic inequalities, social problems, and environmental issues. The priority is on establishing health policy, services, and educational programs to prevent disease before it occurs.

The NPHM represents a shift from the "lifestyle" era in health promotion policy, where the focus was on individual behaviors, to a "public health" era where the primary focus is on population-level issues such as social, cultural, and environmental factors that affect health. Falk-Rafael (1999) suggested the new public health movement signaled a return to the values and philosophy regarding health and health promotion that are consistent with a nursing paradigm.

WHO: Sundsvall Statement on Supportive Environments for Health (1991)

The Third International Conference on Health Promotion was held in June 1991 in Sundsvall, Sweden. The conclusion of the conference was that a supportive environment is of paramount importance to health. Supportive environments meant both the physical and social aspects of where one lives, works, socializes, is educated, and seeks care. Four main aspects of supportive environments were emphasized: (1) the social dimension, including norms, customs, purpose, and heritage; (2) the political dimension, including participation in decision making and a commitment to human rights and peace; (3) the economic dimension, including sustainable development; and (4) the need to recognize and use women's skills and knowledge.

The conference highlighted growing inequities between rich and poor countries as well as the relationship between social justice and health. Creating equity was identified as a priority for creating supportive environments. There was also a focus on sustainable development and a call for the involvement of indigenous peoples in developing health promotion policies. The wisdom and spiritual relationship that indigenous peoples maintain with their environment was presented as a model for the rest of the world.

The conference also called for four key public health action strategies: (1) strengthening advocacy through community action, (2) empowering and educating communities to take control of their own health, (3) building alliances between environmental- and health-oriented groups, and (4) mediating conflict to ensure equitable access to healthy environments (WHO, 2010a).