

GILLIAN ROWE  
DEBORAH GEE  
AMI JACKSON

# HEALTH PROMOTION

for Nursing Associates





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Chapter

1

# The principles of health promotion

Ami Jackson

## NMC STANDARDS OF PROFICIENCY FOR NURSING ASSOCIATES

This chapter will address the following platforms and proficiencies:

### **Platform 2: Promoting health and preventing ill health**

At the point of registration, the nursing associate will be able to:

- 2.1 understand and apply the aims and principles of health promotion, protection and improvement and the prevention of ill health when engaging with people.
- 2.2 promote preventive health behaviours and provide information to support people to make informed choices to improve their mental, physical, behavioural health and wellbeing.

## Chapter aims

After reading this chapter, you will be able to:

1. discuss notions of health and wellbeing;
2. understand the principles of health promotion;
3. explain the theoretical models of health promotion across the life span;
4. navigate the complexities of health promotion and be able to apply this in practice.

## Introduction

This chapter will examine the origins of health promotion and consider what health promotion is and how it is done. We will examine and discuss various health promotion models and compare their elements. We will also consider health promotion through the lifespan and examine health promotion

and mental health. As you work your way through the chapter, there are opportunities to engage in activities to help you reflect on your practice. 'Health is, therefore, seen as a resource for everyday life, not the objective of living' (WHO, 1986).

The first 50 years of the twentieth century were drenched in the blood of the First and Second World Wars. At the end of the Second World War, people had had enough and wanted a better world. Many global organisations were born from this desire, one of which was the World Health Organization (WHO). The WHO promoted the idea that health was a human right, and not something for the privileged wealthy few. They wrote their definition of health as being 'not merely the absence of disease, but a state of complete physical, mental, spiritual and social wellbeing'. Many argued that this statement was unachievable or utopian. So, in 1986, in Ottawa, Canada, the first International Conference on Health Promotion formulated the following statement to create an understanding from a health promotion perspective.

*Health promotion is the process of enabling people to increase control over, and to improve, their health. To reach a state of complete physical, mental, and social well-being, an individual or group must be able to identify and to realize aspirations, to satisfy needs, and to change or cope with the environment. Health is, therefore, seen as a resource for everyday life, not the objective of living. Health is a positive concept emphasizing social and personal resources, as well as physical capacities. Therefore, health promotion is not just the responsibility of the health sector but goes beyond healthy life-styles to well-being.*

(WHO, 1986)

The *Ottawa Charter* is considered to be 'holistic' which means it takes into account spiritual, mental and social factors, rather than just the physical symptoms of a disease. The NMC (2018) draws on these themes in its assertion of the role that nursing associates play in health promotion.

*Nursing associates play a role in supporting people to improve and maintain their mental, physical, behavioural health and wellbeing. They are actively involved in the prevention of and protection against disease and ill health, and engage in public health, community development, and in the reduction of health inequalities.*

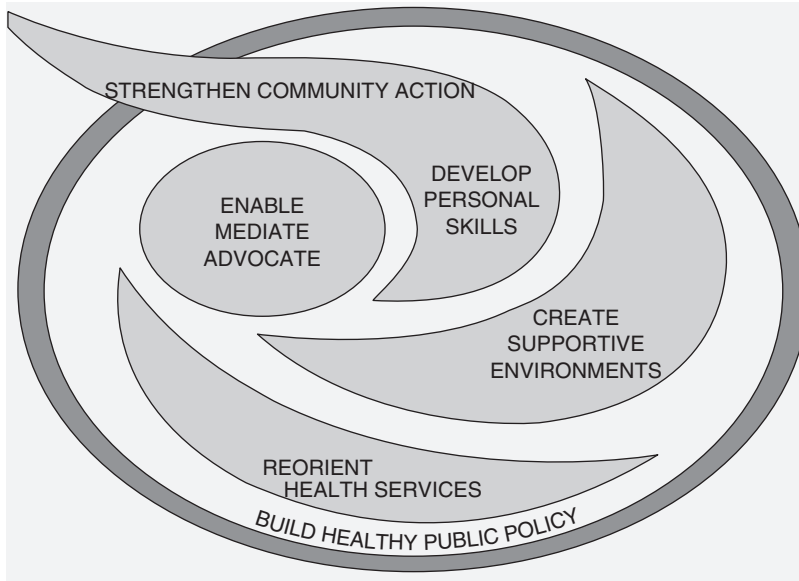
(NMC, 2018)

As described above, health promotion is the process of enabling people to increase control over, and to improve, their health. It moves beyond a focus on individual behaviour towards a wide range of social and environmental interventions (WHO, 2020b). Scott and Western (1998) recognised that the medical model is most frequently used when assessing individuals. It is disease-focused and is scientific in its approach. However, they point out that this is in strong contrast to the accepted ideology that the *Ottawa Charter* provides.

The *Ottawa Charter* (1986) identifies five action areas and three strategic areas for health promotion. It was the first charter for health promotion to address a global audience with the principles of health promotion. Let us first consider the five action areas, as shown in Figure 1.1.

## The five action areas

1. *Building health and public policy*: Create policy that helps protect the health of individuals and the communities in which they live, in order to help individuals to make healthier choices. A synchronised approach is needed, so this includes legislative, regulatory and organisational efforts. For instance, promoting health in the workplace might include forming healthy eating groups or a walking group.



**Figure 1.1** Building public health policy: The 5 action areas © WHO

Health policies are not created just for health departments, they are collaborative with other sectors such as local councils, government and charities.

2. *Creating supportive environments*: The environments in which individuals live are closely linked to their health. This element focuses on communities themselves, where individuals live, work or play. Enabling people to make health promoting choices is vital.
3. *Strengthening community action*: This means encouraging the collective efforts of communities to improve their health. Ever heard of the saying ‘strength in numbers’? It can sometimes take just one person to make a small change that encourages others to follow. This could be community lunch groups supporting specific health education activities. Another example could be inviting diabetes awareness outreach workers to give a talk to a community group or workplace.
4. *Re-orientating health services*: Health services were traditionally medically focused on the curative treatment needs of individuals. The *Ottawa Charter* (WHO, 1986) considers that refocusing on people in their communities is taking a more holistic approach to health promotion. The *Ottawa Charter* also indicates that strengthening protective factors, reducing risk factors and improving health determinants will improve the health of people globally. This can be achieved by introducing community health educator roles.
5. *Developing personal skills*: This means developing social and life skills, in tandem with information education, in order to make positive health choices. Good examples of this are online educational programmes, weight management classes and clubs and giving information leaflets in community settings, such as pharmacies.

Having looked at the action areas, now let us look at the three strategic areas.

1. *Advocate*: This means using individual and political commitments, policy support and social actions to support a health goal.
2. *Mediate*: This is the process of uniting the statutory, private and voluntary sectors within communities, to reconcile them in ways that promote and protect health. Examples here

include NHS mental health services, private sector employers providing Improving Access to Psychological Therapies (IAPT), and the charity Mind.

3. *Enable*: In partnership with individuals, we need to empower people to engage in activities that will improve their health, such as joining an arts therapy group or exercise classes.

While the charter sets out clear actions regarding the importance of health promotion, we must ask ourselves how these evolved. To do this we need to understand the underlying theory of health promotion.

## Theory and models of health promotion

The *Ottawa Charter* (1986) highlights key messages in relation to actions and strategies, as we have discussed, in order for people to reach their ultimate health goals. However, what are the fundamental elements of health? The areas are categorised into physical, mental and social wellbeing. It is imperative the individual identifies their own aspirations and sets out clear goals to achieve this, with both a health professional's support and the support of others around them.

Naidoo and Wills (2016) state that 'Health is a broad concept which can embody a huge range of meanings'. The authors discuss how people's perceptions are formed as to what 'good health looks like'. For example, you may have certain views on what health promotion is for you, due to your own life experiences, this may be influenced by your social class or education. Naidoo and Wills (2016) refer to this as 'lay' concepts of health. Lay concepts have developed through the social constructs you have been exposed to within your home, community and society. The authors note that there are many different beliefs within communities, and they may have different notions of what constitutes health. Examine Activity 1.1 and consider your own cultural beliefs for health protection. The activity asks you to compare your previous beliefs and your current beliefs. Has anything changed or have your beliefs been reinforced?

### Activity 1.1 Reflection

What were the lay concepts of health that you were brought up with? Some lay health beliefs are entirely sensible and reasonable, while others have little basis in evidence or reality. These encompass family and community wisdom, such as eating sugar to get rid of hiccups, or taking honey and lemon when you have a cold.

What beliefs were you told would protect your health?

Reflect on your cultural health beliefs and compare them with the academic and theoretical knowledge you have now. What do you still believe and what has been discarded?

*As this answer is based on your own reflections, there is no outline answer at the end of the chapter.*

As you can see in your responses to Activity 1.1, we all have personal experience of lay explanations of health with our personal lay referral structure. Case Study 1.1 explores what this structure might look like, showing how we often consult a number of different people and authorities within our lives before turning to a health professional.

## Case study 1.1 Applying the theory

After a night out with friends, Nish wakes up feeling unwell. He has a headache and an upset tummy, so he considers likely causes:

*‘Probably the curry and beer I had last night’.*

### Self-explanation

When Nish’s symptoms do not go away after 12 hours, he asks his Mum and Nan for advice.

### Family authority

His Mum and Nan discuss this and then suggest there is probably a bug going around, and he may have picked it up from one of his friends. Nish rings his friends to find out if they are okay. He describes his symptoms to his friend Jake, who says, ‘Oh yes, Yasmin had that, she was proper poorly, but it went away after about a week’.

### Circle of intimates

The following day, Nish’s tummy feels better but he has started coughing and sneezing. His nextdoor neighbour has popped in for coffee and a chat and tells Nish that the local radio weather forecast says the pollen count is really high, and this might account for his sneezing.

### Community authority

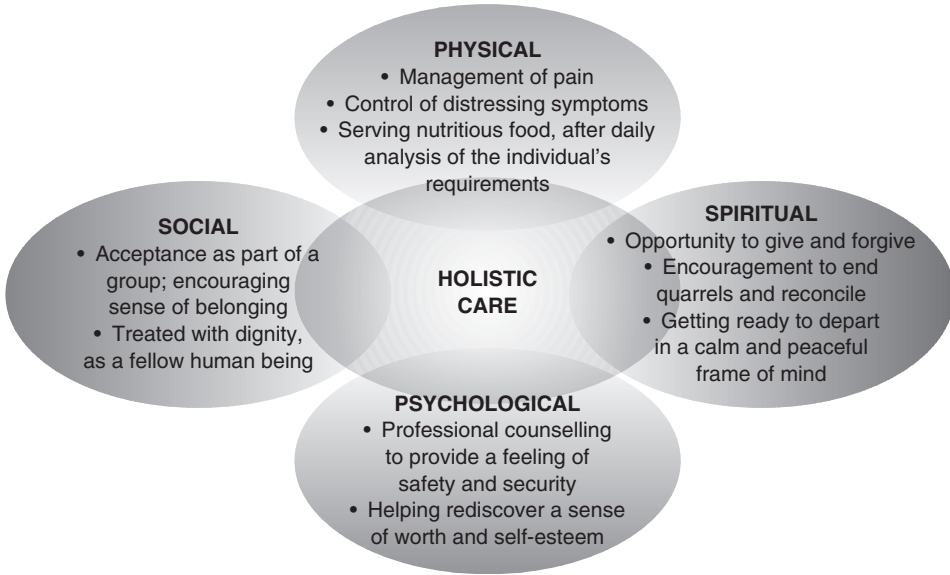
Only after the symptoms fail to clear within an expected time, or if they increase in severity, is a health professional consulted. This could be considered as a hierarchy of authority and drawn as a pyramid.

Health beliefs can be formed by cultural, historical and local influences, also emotional and behavioural factors. Recent emphasis centres on a personal individual responsibility model, but the above case study and an examination of your own beliefs leads us to consider that there are many more factors to health than just ‘looking after yourself’. Therefore, we shall examine the dimensions that also feature in the *Ottawa Charter*.

As you can see from Figure 1.2, there are four interacting dimensions of holistic care and thus we should consider *physical health*, *psychological health*, *spiritual health* and *social health*. As professionals, we must examine the distinct influences and connections between them.

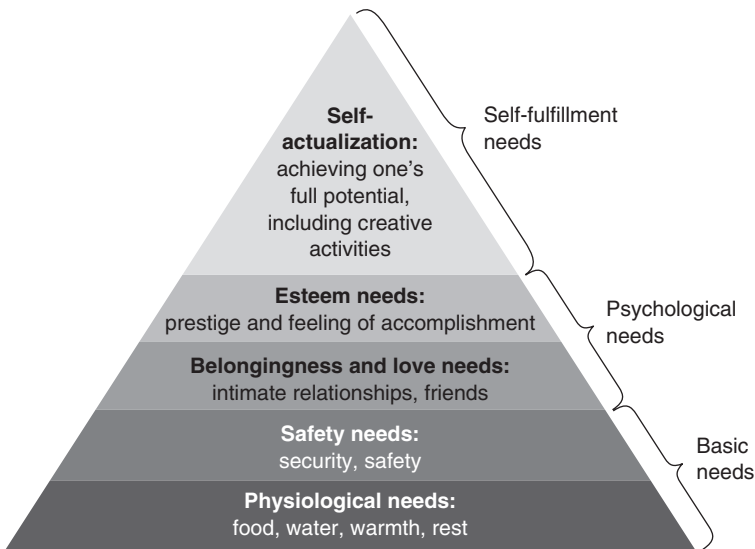
1. *Physical health*: focuses on the body: its anatomical and physiological state.
2. *Psychological/mental health*: focuses on a person’s psychological and emotional wellbeing.
3. *Spiritual health*: recognises moral or religious principles or beliefs that bring peace to individuals.
4. *Social health*: refers both to a distinctive characteristic of society, and of individuals themselves.

Health Education England (HEE, 2020) states ‘Being person-centred is about focusing care on the needs of [the] individual. Ensuring that people’s preferences, needs, and values guide clinical decisions, and providing care that is respectful of and responsive to them’. The care we deliver to individuals should always be holistic and patient-centred and should not assume that the apparent physical symptoms are the sole root cause of illness.



**Figure 1.2** Holistic care

Maslow's (1943) work on the theory of human motivation indicates that an individual's actions are focused on the direction of goal achievement. Maslow encapsulates the essence of what human beings need to survive (see Figure 1.3). For example, going out with friends for a meal in a restaurant satisfies an individual's physiological needs, however, it also meets belongingness and love needs, which enhances wellbeing. This was something we all missed during the time of the Covid-19 **pandemic**, with many of us feeling the desire to be with loved ones and friends, and for life to get back to normal.



**Figure 1.3** Maslow's hierarchy of needs (1943)

Wellbeing can be defined as how people feel and function, not only on a personal level but socially too. NHS (2019b) states there are five steps to wellbeing:



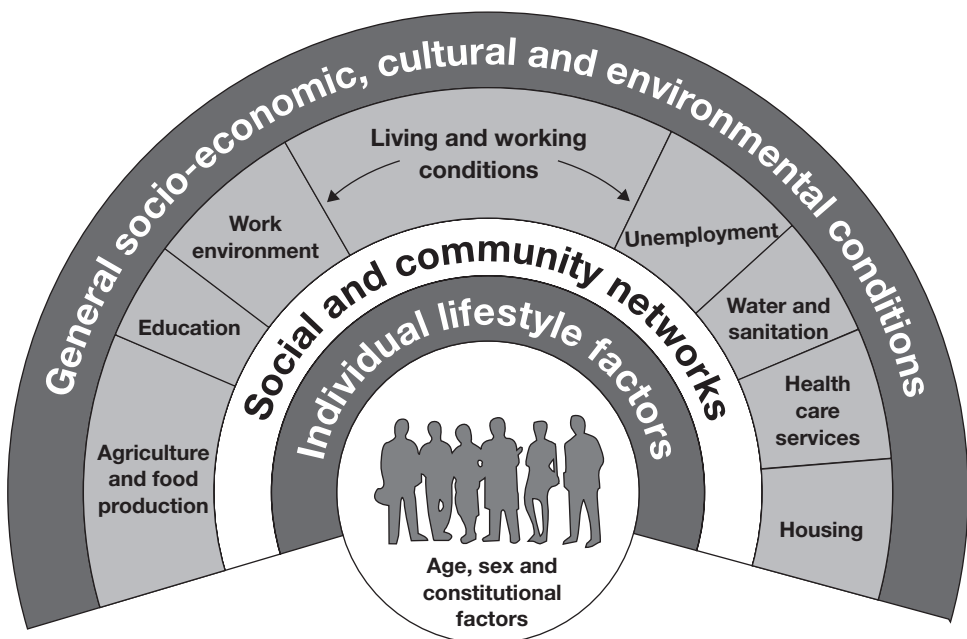
1. connect with other people;
2. be physically active;
3. learn new skills;
4. give to others;
5. pay attention to the present moment (mindfulness).

Pike and Forster (1995) identified that health promotion is delivered within the context of ongoing change. We must take into consideration other factors that relate to health promotion. In the next section, we introduce the concept of the determinants of health, which are further developed in Chapter 3.

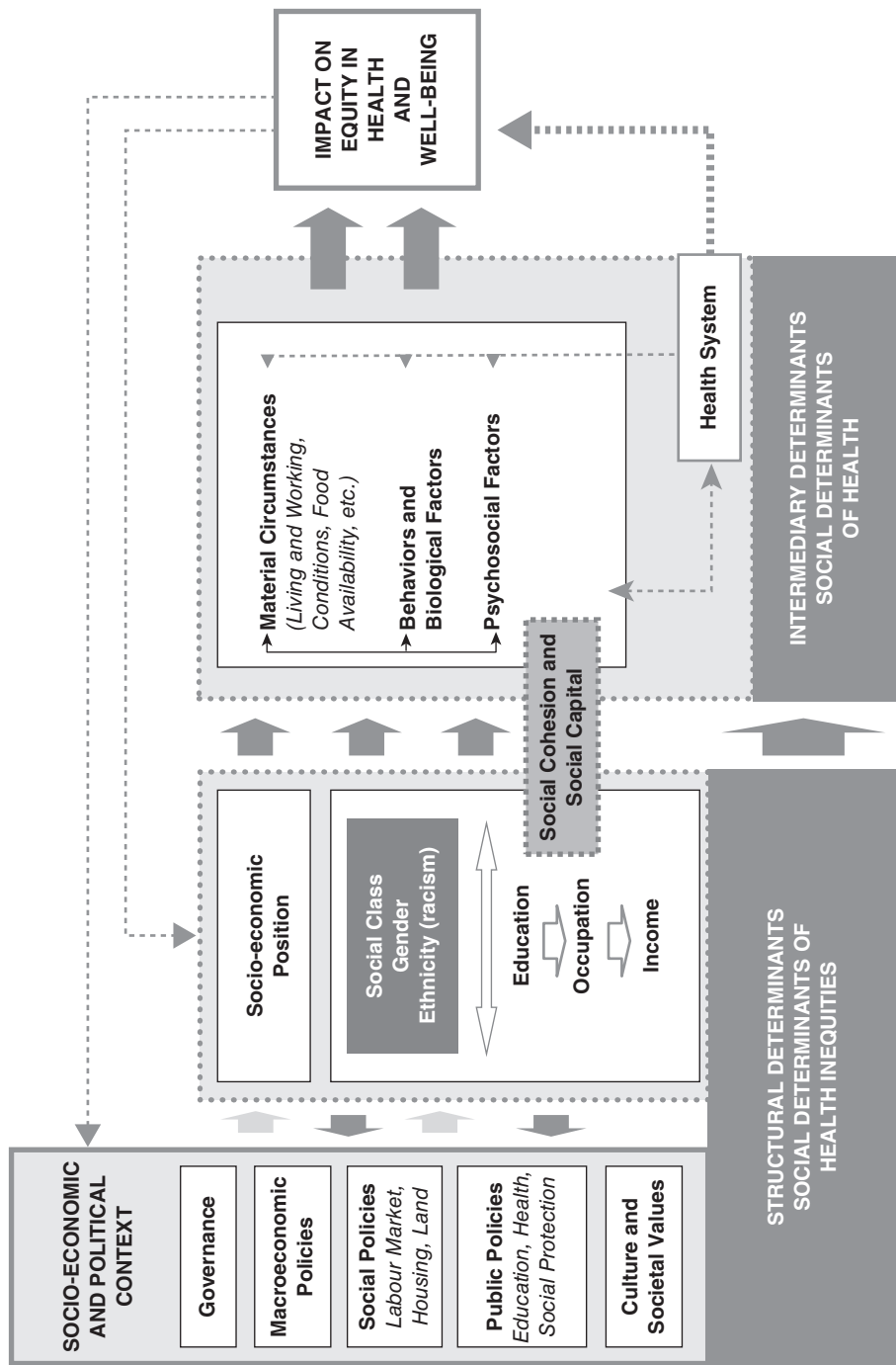
## Determinants of health

The concept of the determinants of health are not only about individuals but of populations too. Marmot et al. (2020) explain that people living in different socio-economic environments face different risks of ill health and even death. For example, those in a higher social class have a greater life expectancy.

Determinants of health are variable between individuals and across population groups in terms of life expectancy and health outcomes. To understand the determinants of health, we must first address the factors that influence health. Factors that influence a person's health include those that are more fixed, such as age, sex and genetic factors. They also include the good or poor health behaviours people engage in, such as smoking, excessive alcohol intake, physical activity and diet. Health is also influenced by the conditions people are born into, work, live and grow up in. This includes their social networks, socio-economic status, cultural, environmental state and the health systems they can access. Collectively, these factors are called the social determinants of health (WHO, 2020b) and are helpfully illustrated in Dahlgren and Whitehead's (1991) 'policy rainbow' which you can see in Figure 1.4.



**Figure 1.4** Dahlgren and Whitehead, social determinants of health



**Figure 1.5** Structural and intermediary determinants © WHO

Social determinants of health are ultimately shaped by the distribution of money, power and resources at an international, national and local level. They have a profound influence on health inequities and avoidable health differences between different groups of people within countries and between countries. As you can see in Figure 1.4, the way in which the social determinants of health work involve complex interactions between them, and the WHO (2010) provides a useful framework to help us understand this in more depth.

As shown in Figure 1.5, there are two broad types of social determinants that can lead to health inequities: structural and intermediary determinants.

*Structural determinants are categorized into sections, the first being the socio-economic and the political context. Within these sections are further subsections to consider:*

1. *Governance: how society makes decisions about health*
2. *Macroeconomic policies: how the overall economic market operates on a large scale*
3. *Public policies: how education can support health and social protection*
4. *Culture and societal values: how these can shape or impact health outcomes.*

(WHO, 2010)

Structural determinants can lead to the unfair distribution of material and monetary resources that shape a person's *socio-economic position*. Position infers a person's place in society, which can affect their exposure, vulnerability and outcomes to conditions that have an impact on their health. Socio-economic position includes education, occupation income, gender, ethnicity and social class, and in turn affects the *intermediary determinants* of health's material circumstances. For example, an individual on a lower income may live in inadequate housing conditions, which may in turn impact their psychological health and relationships. One important thing to point out is that social cohesion and social capital can bridge the socio-economic and intermediary positions. During the Covid-19 pandemic, social cohesion encouraged communities to make sacrifices and cooperate with each other for the wider benefits of access to provision.

## Access to healthcare

We should consider how health systems can influence how easy it is for people to access care. There are different approaches to how individuals access healthcare. For example, the UK follows the Beveridge model (the NHS) which is paid for by taxation and is free at the point of provision. The United States operates a health insurance system which requires its citizens to purchase insurance to access healthcare provision. Europe generally has a mixed approach called the Bismarck model, which is a social health insurance model, paid for by both the employee and government. There are critiques of all these systems, and none is perfect in terms of access to provision and waiting times. Interestingly, research by Edwards (2018) indicates that funding mechanisms have little direct impact of the quality of care.

Geophysical location can impact access to healthcare. Some areas have access issues when centres of excellence or specialisms are located in cities which may be many miles away from a small, countryside village. Some centres, like Great Ormond Street Children's Hospital (GOSH), acknowledge this by providing parents with accommodation. Many others, however, do not.

Intermediary determinants influence health and health inequities. The links between these determinants are not linear; they are complex and can work in both directions. We know that low income and poor education can impact health. Equally, poor health can impact the ability to go to work, which leads to a lower income.

If a population is affected by high levels of disease, it can have a wider effect on socio-economic and political contexts. An example of this is Covid-19, which has devastated communities across the globe, both from a health and economic perspective.

During the early days of the Covid-19 pandemic in the UK (February–March 2020), great efforts were made to house street homeless (rough sleepers), as they were classed as vulnerable. Homeless hostel users were also rehomed to reduce the spread of infection, and infection control in homeless settings was closely monitored. However, in subsequent waves, provision became patchy as the national government cancelled the ‘Everyone in’ strategy. Examine Activity 1.2 and consider the young man’s social determinants of health. What factors might have led to him being homeless?

## Activity 1.2 Critical thinking

A young man attends the local A&E department. He appears unkempt and disorientated. You are working with the triage nurse. Prior to the patient coming into the room, the nurse tells you he is a regular attender to the department and that he just likes to visit for company.

The man reveals to you that he is homeless and has no family or friends he can go to for help. You notice there is blood on the sleeve of his lower arm. You take him into the minor injuries unit and begin his initial assessment.

- What social determinants could be factors in this situation?
- What is available in your service to support your patient?

*An outline answer is given at the end of the chapter.*

People become homeless for many different reasons. The structural and intermediary causes would include social and socio-economic reasons, such as poverty, a lack of affordable housing, unemployment and insecure employment (the so-called gig economy). Life events also play an important role, such as family breakdown, poor mental health, substance misuse, leaving care, leaving prison and being an army veteran with no home to return to.

## A closer look at the models

### Pender’s model

In 1982 (revised in 1996) Nola Pender created a health promotion model (HPM) to compliment traditional models of health promotion. The aim of her model is to support nurses and nursing associates in understanding the major determinants of health behaviours as a basis to promote healthy lifestyles. Pender noted that health professionals only intervened when an individual was already unwell, so her model focuses on motivation, positivity and prior life experiences. Pender et al. (2011) state that ‘Health is positive, comprehensive, unifying, and humanistic. Health includes a disease component but does not make disease its principal element’ (p. 4). The theory covers the life span for optimal health. Pender believed that by identifying wellness factors, and by influencing health behaviours, people and healthcare systems could save money.

People are the sum of their experiences, which then influence future choices. The social interactions that people have, and the competing demands they face, lead to behavioural outcomes. If you reflect back to Activity 1.1 and lay beliefs, you can see how Pender's model, outlined in more detail below, unites lay belief thinking with the social determinants of health.

## Seven assumptions of Pender's model (2011)

1. People are motivated to affect conditions so they can achieve their human potential.
2. People can assess their competencies: they are self-aware.
3. People seek value in personal growth, they seek balance between stability and change.
4. People are active in regulating their actions.
5. People effect and are affected by their environment.
6. People are influenced by healthcare professionals.
7. Self-motivation is key to success.

## Thirteen theoretical statements

1. Prior behaviour and characteristics influence belief and behaviours.
2. Benefits are instrumental in behaviour change.
3. Barriers play an important role in behaviour change.
4. Self-efficacy and competence increase the likelihood of behaviour change.
5. Self-efficacy reduces barriers to health behaviour.
6. Positive affect towards behaviour increases self-efficacy.
7. Increased commitment and action result from positive emotions and affect.
8. Significant others are influential in behaviour.
9. Interpersonal influences impact health promoting behaviour.
10. Situational influences impact health promoting behaviour.
11. The greater commitment to a plan of care the more likely the health promoting behaviour can be maintained over time.
12. Competing demands that require immediate attention will reduce the likelihood of engaging with the desired behaviour.
13. Cognition affect and environment can be modified to create incentives for health action.

## The health belief model

In 1952, Hochbaum, Rosenstock, and Kegels contributed to the development of the health belief model (HBM) which suggests that an individual's willingness to change their health behaviors is primarily due to their perceptions of health. The model was developed after Hochbaum and colleagues noticed a significantly low response rate to tuberculosis screening. They believed that low uptake of the screening programme was driven by the two elements: firstly, an individual's motivation and secondly their perception of the illness. This combination produced what they refer to as a health belief. This theory is an early construct of the health belief model; however, the idea is still very much present in today's society.

The questions that Hochbaum et al. (1952) posed were:

- How will this disease affect me?
- How will a behaviour change benefit me?
- Do I have the skills necessary to change my own health behaviours?

Health behaviours are complex. We must ensure that any information we give is correct, and that it will meet the needs of the target audience. Demographic variables include children, young people, adults and older people, and must be inclusive of those with mental health issues and learning difficulties.

Hochbaum et al. refer to the six constructs that affect the thought process of the health belief model. These are explored in the box below in relation to problem drinking.

## The six constructs applied to problem drinking:

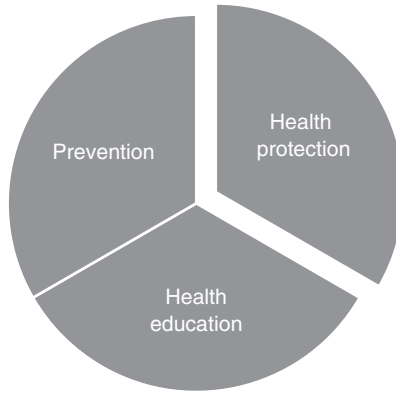
1. *Perceived susceptibility*: The individual feels threatened or at risk enough for the behaviour to change. For instance, the danger resulting from alcoholism. There were almost 1.3 million alcohol-related hospital admissions in the UK in 2020.
2. *Perceived severity*: The individual develops an understanding that engaging in these unhealthy behaviours will be severe and that urgent action to change their behaviour is necessary. For instance, the knowledge that chronic alcoholism leads to death. In 2018, there were 7,551 alcohol-specific deaths. This is the second-highest level since the records began in 2001 (NHS, 2020).
3. *Perceived benefits*: The belief that positive outcomes can occur by changing behaviour. For example, by reducing alcohol dependence, the individual increases their life expectancy.
4. *Perceived barriers*: The actual or manifested cost, this can be monetary or material. Reminding the individual of the huge costs to their wealth and health will help to motivate and maintain the behaviour change.
5. *Cues to action*: These are external events that motivate the individual to want to change. The goal is to support people in their belief they can make the change. Individuals are supported to take responsibility for their own choices. This might be prompting them to consider the impact drinking has on a cherished relationship.
6. *Self-efficacy*: This is about the individual having the confidence to change. By taking small manageable steps and setting goals that are realistic to achieve.

You should note that this is an individual, personal health maintenance theory, and so not applicable to social or environmental issues. There will be some disparity between populations and individuals as not as everyone has the same access to health services, education or income. Using just one approach for one group or individual will not always lead to a successful outcome.

We will now discuss Tannahill and Beattie's models and compare all the models with Naidoo and Wills typology.

## Tannahill's model

Tannahill (1985) defined health promotion as three overlapping spheres, which includes prevention, health education and health protection. A relatively simple idea, this model lays the foundations of the fundamental principles of health promotion but does not consider an individual's wellbeing.



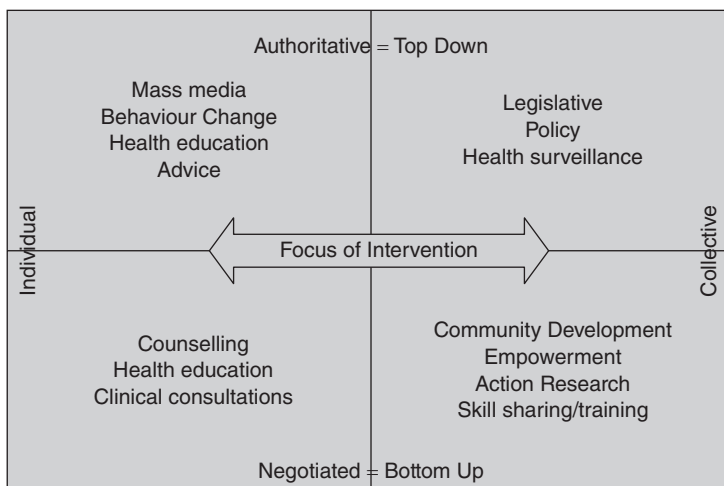
**Figure 1.6** Tannahill’s model

## Beattie’s model

Beattie’s (1991) model looks at health promotion from two different approaches.

One axis looks at the level of intervention that individuals, population or communities require. The other axis looks at the approach taken to health promotion. If you examine Figure 1.7, you can see that at one end the approach is authoritative, while the other end is negotiated.

Combining the axis together creates four quadrants. These are health persuasion, legislative action, community development and personal counselling. Beattie argues these are the components that make up health promotion. An example of this is the national smoking ban. This is a policy which has a top-down approach. However, it is aimed at the collective population. Smoking cessation clinics, on the other hand, are negotiated and mediated by the individual via the counselling approach.



**Figure 1.7** Beattie’s model

# Naidoo and Wills' typology of health promotion

Naidoo and Wills (2000) developed a typology of health promotion. Their typology is derived from components of previous research and identifies elements of similarity. Naidoo and Wills argued that health promotion has five different elements to it:

1. *Medical*: A medical preventative approach (for instance annual health checkups for individuals at risk);
2. *Education*: Providing people with information to make informed choices about their health;
3. *Behaviour change*: Encouraging individuals to change their attitudes towards their own health and in turn adopt healthier behaviours;
4. *Empowerment approach*: Offering support to develop a sense of self belief and self-efficacy;
5. *Social change approach*: Using research to influence policy (local and national) regarding accessible resources for health and social care.

## Activity 1.3 Reflection

Look back over the models of health promotion and make notes of the main principles. Are all of these principles covered by Naidoo and Wills' typology? What other principles or elements of health promotion would you include if you were writing your own typology?

As this activity is based on your own ideas, there is no model answer provided.

## Health promotion and children

So far, we have looked at health promotion theory and models. Now let us think about children and young people and where health behaviours begin. Children are influenced by their environment and the people who care for them. Health promotion principles are applied within the early years and health behaviours are intrinsically formed when we are young.

Bandura et al.'s work on social cognitive theory (1961) emphasised the importance of social learning. His work strongly denotes that learning and cognitive development relies on social influence. Bandura indicates that an integral part of human development is observation and the influence of those around us. If these elements are lacking or missing, people are unable to develop the appropriate social cognitive skills. Bandura categorises the principles of social cognitive theory:

1. *Observational learning*: By socialising, this teaches children many different behaviours through observation, observational learning is a key component of behavioural psychology.
2. *Modelling and imitation*: This refers to children observing the actions of others around them, in turn they learn how to behave. Modelling was discovered during Bandura's research. It demonstrated how children observe and imitate the actions of adults.
3. *Shaping*: The process of modifying a child's behaviour. This process is accomplished through instructing a child how to behave and rewarding them when they have succeeded. This was influenced by B.F. Skinner's notions of operant conditioning.



In his research, Bandura separates observational learning into four stages. These stages reflect the process of observing a behaviour in someone else and adopting the observed behaviour.

## The four stages of observational learning

1. *Attention:* To learn a behaviour through social learning, the behaviour must first grab a child's attention. For the behaviour to attract a child's attention, it must be attractive to them in some way. Attraction then leads to attention. Sometimes children are drawn to the consequence of the behaviour they are seeing.
2. *Retention:* When a child's attention has been captured, they may retain what they saw. By retention, this can mean whether the observer will remember what they observed. The more the person remembers the behaviour, the more likely they are to imitate it.
3. *Reproduction:* When the observer has watched and remembered a model for behaviour. If the observer appreciated the behaviour, they may try to recreate it. An observer will hold the skills needed to reproduce the observed behaviour.
4. *Motivation:* This is the final stage of observational learning. Motivation is a crucial component in observational learning. For a behaviour to be reproduced regularly, there must be incentive for the behaviour.

Bandura's work on how we learn behaviours has important implications for health promotion. Indeed, his social cognitive theory shifts the field of health from a disease-based model to a health-based model that focuses on strategies for disease prevention and health promotion that enable healthier behaviour (Bandura, 1998).

To recap so far, we have looked at the different health promotion models and approaches, the theory of learned behaviour and how health promotion strategies can enable healthier lifestyles. We have already established that the most appropriate health promotion approach will depend on both the individual and the distinct circumstances you are working in; one size does not fit all.

## Health promotion and mental health

We have looked at the application of health promotion models in relation to lifestyle changes. What if your patient engages in health behaviours that have developed due to a mental health condition but which are now impacting their physical health?

For instance, an eating disorder, such as anorexia or bulimia, is a mental health condition that can have significant implications for one's physical health. How can the health promotion models considered in this chapter be applied in practice to support a patient with an eating disorder?

Anorexia and bulimia are serious mental health conditions which have many similarities in origin. Men and women of any age can develop anorexia, but it is more common to develop in young women and typically starts in the mid-teens (NHS, 2020).

Walsh (2013) recognises that adolescence is a turbulent time, and his research has shown that individuals are most sensitive to the idea of reward during this time in their lives. Greenfield (2014) makes an interesting point in relation to social learning theory and the way in which it connects to anorexia. The media portrays images of excessively skinny women and men as positive. For developing adolescents, this sends a message that skinny is the dominant cultural image and some will go to extreme lengths to emulate that image.

Linking this to Bandura's social cognitive theory and learned behaviours in children, this has the potential to continue into adolescence. Walsh suggests that this increased sensitivity and rewarding element may contribute to, and explain why, adolescents are susceptible to developing eating disorders.

Walsh describes positive and negative reinforcements combined with increased sensitivity to rewarding actions. He outlines a number of reasons which may indicate what he describes as

restricting patterns towards eating, which in turn can lead to a deep-seated unhealthy relationship with food. Walsh (2013) identifies these reasons below:

1. *Persistent and repeated dieting*: This leads to overtrained and highly practiced entrenched behaviour.
2. *Intermittent rewards*: These provide a strong reinforcement and the positive effects of the individual feeling they have accomplished something. By eating less (achieving a goal) and the effects of numbing emotions are much more reinforcing.
3. *Onset of anorexia nervosa*: This usually coincides with stress and some individuals learn better when they are stressed. So, behaviours that are acquired during a time of stress are more likely to become habits than when they are learned at other times.
4. *Weight loss*: This can lead to compulsive, obsessive and rigid patterns of thought and behaviour. The most cited example of this is the 'Minnesota starvation study' (1945), where healthy subjects developed symptoms of obsessionality much like anorexia nervosa patients following a period of starvation.



**Figure 1.8** Cycle of intervention

When we feel stress, we need to release that stress. The mind, therefore, will naturally take us back to similar situations when we dealt with stress. Stress affects many of us for an array of reasons, for instance, due to relationships, school or work. For individuals who suffer from an eating disorder, additional factors such as environmental and social aspects may increase stress levels, causing harmful mental and behavioural patterns. Bennett and Murphy (1998) explain that stress is not a singular concept. It is a process that involves complex connections between the environment, physiological and psychological processes. Establishing the relationship between stress and health can allow individuals to define stressors for themselves, for them to truly address stressful triggers.

It is important that your patients are supported to understand the relationship between their stressful experiences and poor eating habits. Elements of intensive adolescent focused

psychotherapy includes health promoting educational interventions. This includes supporting the patient to understand what they need to do to be healthy and teaching an understanding of the physiological effects of under or over-eating. You can draw on the health promotion models we have covered to do this, such as Pender's model and Naidoo and Wills' typology. Gleissner (2017) states that 'Engaging in habitual patterns can develop into a coping mechanism'. Aspects of Pender's model refer to self-efficacy beliefs supporting individuals to develop the confidence to change by taking small manageable steps, and by setting goals that are realistic to achieve for healthier lifestyle choices.

## Coping mechanisms

Researchers such as Ekern (2016) and Chowdary (2020) have defined three kinds of coping: problem-focused, emotion-focused and perception-focused coping. Depending on the situation, the individual will differ as to how they will respond:

1. *Problem-focused coping: The individual will take direct action on their surroundings or themselves to remove or attempt to change the threat.*
  2. *Emotion-focused coping: When the individual uses actions or thoughts to control unpleasant feelings brought on by the threat.*
  3. *Perception focused coping: Cognitive attempts to reduce or alter the severity of a threat.*
- (Ekern, 2016)

Chowdary (2020) states that 'In psychology, coping skills or coping strategies are a set of adaptive tools that we proactively administer to avoid burnout. These tools can be our thoughts, emotions, and actions and are dependent on our personality patterns' (p. 1).

There is increasing evidence to suggest that due to mental health issues, such as depression and anxiety, individuals engage in unhelpful behaviours. Holland (2019) states that

*alcohol use disorder and depression are two conditions that often occur together. What is more, one can make the other worse in a cycle that is pervasive and problematic if not addressed and treated. Alcohol use can cause or worsen symptoms of mood disorders. Depression may even cause people to begin consuming large amounts of alcohol.*

The WHO have a clear vision for mental health promotion 'Mental health is an integral part of health; indeed, there is no health without mental health' (WHO, 2018).

Mental health promotion encompasses actions that aim to improve wellbeing from a psychological perspective. The WHO indicates a variety of ways to promote mental health:

- early childhood interventions and support to children;
- socio-economic empowerment of women;
- social support for elderly populations;
- programmes targeted at vulnerable people;
- mental health promotional activities in schools;
- mental health interventions at work;
- housing policies;
- violence prevention programmes;
- anti-discrimination laws and campaigns.

Mental health promotion is a fundamental aspect of health promotion and links with the wider agenda of public health and the socio-economic agenda. 'Mental health promotion should be mainstreamed into governmental and nongovernmental policies and programmes. In addition to

the health sector, it is essential to involve the education, labour, justice, transport, environment, housing, and welfare sectors' (WHO, 2020a).

## Older people and health promotion

As the population grows older and people live for longer, preventative health education programmes are key to keeping the older population healthy.

The WHO has stated that health promotion is for the entire population. However, there is increasing evidence to suggest that health promotion is not always as inclusive as it could be in relation to the older population.

Age is a protected characteristic under the Equality Act (2010) and thus health promotion polices should be inclusive. However, Golinowska (2016) stated that the elderly have long been neglected as the addressee of health promotion activities. The need to promote health among older people was first highlighted in the 1990s, before which it was commonly assumed that older generations were not a good target for health promotion as it was thought to be too late to change their lifestyle. Requiring the elderly to radically change their diet and start exercising was perceived as disturbing to their peace and wellness and thus a waste of resources that would not improve the quality of people's lives.

Research undertaken by Strumpel and Billings (2006) indicated that exercising, smoking cessation, limiting alcohol consumption, participating in learning activities and integrating in the community can help to prevent the development of many diseases. Cognitive activities are shown to inhibit the loss of functional capacity and ultimately improve quality of life and extend life expectancy. It is important to highlight that the engagement of health promotion activities in this study was among people under the age of 85. Health promotion for those aged over 85 was focused on ensuring that they had appropriate medical attention and that their carers were offered support, rather than making changes to their health behaviours.

Health promoting strategies for older people have three aims:

1. maintain and increase functional capacity;
2. maintain or improve self-care;
3. improve social experiences.

The thinking behind these aims contributes to and promotes independence of the elderly and aims to improve quality of life for individuals.

Working with older people requires sensitive and tactful communication skills. The WHO (2020a) suggests adopting the following points for more effective health promotion activities.

- *Make messages more relevant to older people. Tailored messages (for example, about the importance of physical activity in later years) can make the message appear more relevant and appealing.*
- *Target messages at specific groups of older people, such as gendered screening sessions. Matching information to an individual's characteristics can influence how older people think and feel about a health issue.*
- *Manage emotional distress. Emotional distress can be both a catalyst for and a saboteur of change; hence, it needs to be managed successfully to encourage behavioural change and maintenance of that change.*
- *Consider an older person's social support. As people age, their social networks decrease in size and networks may be more effective at promoting stability than change.*

The NHS Long Term Plan (LTP) (2019a) aims to relieve the pressure on services across England, so the first priority of the many areas identified is prevention.

*Each element of the long-term plan has prevention at its heart, emphasizing an effort to move away from a system that simply treats, into one that also helps to keep people well for longer. The LTP recognizes good health is about more than healthcare alone, and that to be implemented effectively the NHS must work in partnership with local government.*

(NHS, 2019a)

In many respects, physical and mental health are one entity, one in turn affects the other. 'Making every contact count' (MECC) is an approach to behavioural change that utilises the millions of day-to-day interactions that organisations and individuals have with other people to support them in making positive changes to their physical and mental health and wellbeing (HEE, 2016). Look at Activity 1.4, how could you use MECC to support Mrs Kowalski during her health review?

## Activity 1.4 Evidence-based practice

You are on placement in a GP surgery, and you are asked to support the practice nurse with her chronic disease review patients. You meet Mrs Kowalski who has come to have her blood pressure review.

You begin the review and approach the question of how often Mrs Kowalski exercises. She tells you that prior to her being diagnosed with high blood pressure she enjoyed walking, and although her walks were not particularly long in duration, she felt better for getting out in the fresh air.

Mrs Kowalski tells you that she is worried that if she walks her blood pressure will go up. She then tells you she has not gone for a walk for the last three months.

1. Why do you think she feels this way?
2. What could you do to change Mrs Kowalski's way of thinking?
3. Which health promotion models could you use to guide your thinking?

*Compare your answer with the model answer at the end of the chapter.*

## Screening programmes

As we have established, there are many health promotion models, theories and educational programmes. However, screening programmes support health promotion from a proactive and preventative standpoint. This reflects Naidoo and Wills' typology of integrating medical preventative measures into health promotion. The example given in Activity 1.4 around Mrs Kowalski's blood pressure review is an integration of medical prevention and the opportunity to engage with MECC to promote not just physiological health but mental health also.

Health education interventions are expected to enhance screening, and early detection and in turn reducing mortality and morbidity rates. The Office for National Statistics (2020) reported on avoidable mortality and identified deaths from causes which could have been avoided through timely and effective healthcare and public health interventions.

NHS screening programmes proactively approach millions of individuals offering individual testing for one of a range of serious diseases. Screening is medically proactive and is different

from other health promotion activities. An example is the *Promotion of the Cervical Screening Programme*, which raises women's awareness of cervical cancer prevention and encourages women to have regular cervical cancer screening through various health promotion activities and in collaboration with other partners (NHS, 2020).

## Statistics

1. *Since the early 1970s, cervical cancer mortality rates have decreased by three-quarters (75 per cent) in females in the UK.*
2. *Over the last decade, cervical cancer mortality rates have decreased by around a fifth (21 per cent) in females in the UK.*
3. *Cervical cancer deaths in England are more common in females living in the most deprived areas.*

(Cancer Research, 2020)

There are many screening programmes in the UK. Following the appropriate training and competency-based assessment, you may undertake cervical smears when working within general practice settings.

Enhancing the skill base of registered nursing associates, with the appropriate competency-based training in cervical screening, will:

1. *Increase the number of sample takers across the country.*
2. *Improve access to screening.*
3. *Support screening's aim to reduce the incidence of cervical cancer and reduce the number of women who die from it.*

(PHE, 2019)

As a nursing associate, you will play an especially important role in engaging and encouraging women to attend their test as well as undertaking the procedure. Research has indicated that there are a number of barriers that prevent women from attending appointments, including embarrassment and worrying about the outcome of the test.

There is a clear link here with Hochbaum et al. and the six constructs within the health belief model on page 15. Improving knowledge and educating women about the benefits of attending testing is vital to the prevention and detection of cervical cancer. It is estimated by UK researchers that in England, cervical screening currently prevents 70 per cent of cervical cancer deaths. However, if everyone attended screening regularly, 83 per cent could be prevented (Cancer Research, 2020).

## Chapter summary

This chapter has examined the core principles of health promotion and shown they are dependent on the individual's needs and situation. We have discussed and examined the various theories and models and examined Naidoo and Wills' typology, which synthesises many elements of these models. You have also been encouraged to reflect on which elements of the models are most useful to you in your setting. This chapter has examined issues that are relevant across the life span, and the intrinsic links of physical health and mental health within individuals and groups. Through engagement with the activities included in this chapter, you can reflect on and develop your own practice.

## Activities: brief outline answers

### Activity 1.2 Critical thinking (page 14)

Homelessness is associated with enormous health inequalities, including lower life expectancy, higher morbidity and greater usage of acute hospital services. Homelessness is a key driver of poor health, but homelessness itself results from accumulated adverse social and economic conditions. Addressing this man's housing needs would reduce his reliance on the NHS and reduce costs to the health service. Very few NHS trusts have pathways for homeless people, and it is likely he will represent with street acquired injuries.

### Activity 1.4 Evidence-based practice (page 23)

Hypertension (high blood pressure) is the second biggest known global risk factor for disease, after poor diet. In the UK, high blood pressure is the third biggest risk factor for disease after tobacco smoking and poor diet. Around a third of adults in the UK have high blood pressure and it usually does not present with symptoms. All adults over the age of 40 are advised to get their blood pressure checked every five years. Addressing Mrs Kowalski's way of thinking, offering reassurance, combined with regular blood pressure monitoring and health education, would increase her level of exercise and reduce her blood pressure levels. MECC could be talking about her enjoyment of walking and how much it makes her feel better to get out in the fresh air.

## Further reading

In order to understand the concept of the social determinants of health and how health is predicated on life chances, read Dahlgren, G. and Whitehead, M. (1991) *Policies and Strategies to Promote Social Equity in Health* found at [www.euro.who.int/\\_\\_data/assets/pdf\\_file/0010/74737/E89383.pdf](http://www.euro.who.int/__data/assets/pdf_file/0010/74737/E89383.pdf)

To familiarise yourself with the work of Albert Bandura and social cognitive theory, you might start with Bandura, A. (1998) 'Health promotion from the perspective of social cognitive theory', as it will introduce you to the concepts in an accessible format. This can be found at [www.uky.edu/~eushe2/Bandura/Bandura1998PH.pdf](http://www.uky.edu/~eushe2/Bandura/Bandura1998PH.pdf)

It would be helpful for you to read the NHS long term plan, so you get an understanding of the aims and goals behind many of the health promotion interventions discussed in this chapter. This can be found at [www.longtermplan.nhs.uk/](http://www.longtermplan.nhs.uk/)

## Useful websites

Below are websites that will help in your research. They include NHS and WHO sites for information about different populations. Also included are websites for PHE and NHS health promotion campaigns. Always ensure that you get your information from academically acceptable sites and use original sources where possible.

Resources for information on global and UK populations:

Community profiles: [fingertips.phe.org.uk/profile/health-profiles](https://fingertips.phe.org.uk/profile/health-profiles)

National statistics: [www.nomisweb.co.uk/](https://www.nomisweb.co.uk/)

The World Health Organization, coronavirus: [www.who.int/health-topics/coronavirus#tab=tab\\_1](https://www.who.int/health-topics/coronavirus#tab=tab_1)

Public Health England: [www.gov.uk/government/organisations/public-health-england](https://www.gov.uk/government/organisations/public-health-england)

NHS health promotion resources:

Anorexia nervosa – Treatment – NHS: [www.nhs.uk](https://www.nhs.uk)

Change4Life: [www.nhs.uk/change4life](https://www.nhs.uk/change4life)

Change for Life Evidence Review: [assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment\\_data/file/774106/Change4Life\\_Evidence\\_review\\_26062015.pdf](https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/774106/Change4Life_Evidence_review_26062015.pdf)

Exercise as you get older: [www.nhs.uk/live-well/exercise/exercise-as-you-get-older/](https://www.nhs.uk/live-well/exercise/exercise-as-you-get-older/)

MECC fact sheet: [www.makingeverycontactcount.co.uk/media/27613/mecc-resources-fact-sheet-v9-20180601.pdf](https://www.makingeverycontactcount.co.uk/media/27613/mecc-resources-fact-sheet-v9-20180601.pdf)