HEALTH PROMOTION

in Nursing Practice

SEVENTH EDITION

NOLA PENDER CAROLYN MURDAUGH MARY ANN PARSONS

Seventh Edition

Health Promotion in Nursing Practice

Nola J. Pender, PhD, RN, FAAN
Professor Emerita
University of Michigan
School of Nursing
Ann Arbor, Michigan

Carolyn L. Murdaugh, PhD, RN, FAAN
Professor Emerita and Adjunct Professor
University of Arizona
College of Nursing
Tucson, Arizona

Mary Ann Parsons, PhD, RN, FAAN
Professor Emerita and Dean Emerita
University of South Carolina
College of Nursing
Columbia, South Carolina

PEARSON

Boston Columbus Indianapolis New York San Francisco Upper Saddle River
Amsterdam Cape Town Dubai London Madrid Milan Munich Paris Montréal Toronto
Delhi Mexico City São Paulo Sydney Hong Kong Seoul Singapore Taipei Tokyo

Publisher: Julie Levin Alexander
Product Manager: Katrin Beacom
Program Manager: Erin Rafferty
Editorial Assistant: Erin Sullivan
Director of Marketing: David Gesell
Senior Marketing Manager: Phoenix Harvey
Marketing Specialist: Michael Sirinides
Pearson Project Manager: Patrick Walsh
Manufacturing Manager: Maura Zaldivar-Garcia
Art Director: Maria Guglielmo
Cover Design: Cenveo Publisher Services
Cover Art: Elena Rudyk/Fotolia
Full-Service Project Management: Mansi Negi/Aptara®, Inc.
Composition: Aptara®, Inc.
Printer/Binder: RR Donnelley/Harrisonburg
Cover Printer: RR Donnelley/Harrisonburg

Copyright © 2015, 2011, 2006 by Pearson Education, Inc. All rights reserved. Manufactured in the United States of America. This publication is protected by Copyright, and permission should be obtained from the publisher prior to any prohibited reproduction, storage in a retrieval system, or transmission in any form or by any means, electronic, mechanical, photocopying, recording, or likewise. To obtain permission(s) to use material from this work, please submit a written request to Pearson Education, Inc., Permissions Department, One Lake Street, Upper Saddle River, New Jersey 07458, or you may fax your request to 201-236-3290.

Library of Congress Cataloging-in-Publication Data
Pender, Nola J. – author.
Health promotion in nursing practice/Nola J. Pender, PhD, RN, FAAN, Professor Emerita University of Michigan School of Nursing, Ann Arbor, Michigan Carolyn L. Murdaugh, PhD, RN, FAAN, Professor Emerita University of Arizona College of Nursing, Tucson, Arizona, Visiting Professor, University of Alabama at Birmingham, Mary Ann Parsons, PhD, RN, FAAN, Professor Emerita and Dean Emerita University of South Carolina College of Nursing Columbia, South Carolina.—Seventh edition.
pages cm
Includes bibliographical references and index.
ISBN 978-0-13-310876-7—ISBN 0-13-310876-7
1. Health promotion. 2. Preventive health services. 3. Nursing.
I. Murdaugh, Carolyn L., author. II. Parsons, Mary Ann, author. III. Title.
RT67.P56 2015
610.73—dc23

2014012119

10 9 8 7 6 5 4 3 2 1

PEARSON

ISBN 13: 978-0-13-310876-7
ISBN 10: 0-13-310876-7

Dedication

To all nurses who practice and promote health, I wish you success as you strive to promote a healthier society.

—C. Murdaugh

To my grandsons Blake, Andrew, Sterling, Campbell, Graham, and Jennings for whom I wish a happy and healthy life.

—M. A. Parsons

This page intentionally left blank

CONTENTS

Foreword xv

Preface xvii

Introduction: The Changing Context of Health Promotion 1

Part 1 The Human Quest for Health

Chapter 1 Toward a Definition of Health 6

Health as an Evolving Concept 7

Health and Illness: Distinct Entities, or Opposite Ends of a Continuum? 9

Definitions of Health That Focus on Individuals 10

Health as Stability 10

Health as Actualization 11

Health as Actualization and Stability 13

Health as an Asset 13

An Integrated View of Health 15

Definitions of Health That Focus on the Family 15

Definitions of Health That Focus on the Community 16

Social Determinants of Health 18

Social Determinants and Global Health 19

Conceptions of Health Promotion 19

Measurement of Health 21

Considerations for Practice in the Context of Holistic Health 22

Opportunities for Research on Health 22

Summary 23 • *Learning Activities 23* • *References 23*

Chapter 2 Individual Models to Promote Health Behavior 26

Human Potential for Change 27

Use of Theories and Models for Behavior Change 27

Social Cognition Theories and Models 28

The Health Belief Model 29

Theory of Reasoned Action and Theory of Planned Behavior 31

Self-Efficacy and Social Cognitive Theory 32

The Health Promotion Model 34

Theoretical Basis for the Health Promotion Model 35

The Health Promotion Model (Revised) 35
Individual Characteristics and Experiences 36
Behavior-Specific Cognitions and Affect 36
Commitment to a Plan of Action 39
Immediate Competing Demands and Preferences 39
Behavioral Outcome 40
Stage Models of Behavior Change 40
Transtheoretical Model 41
Strategies for Health Behavior Change 42
Raising Consciousness 42
Reevaluating the Self 43
Setting Goals for Change 43
Promoting Self-Efficacy 44
Enhancing the Benefits of Change 45
Using Cues to Promote Change 46
Managing Barriers to Change 47
Tailoring Behavior Change Interventions 48
Maintaining Behavior Change 50
Ethics and Behavior Change 50
Considerations for Practice in Health Behavior Change 51
Opportunities for Research with Health Behavior Theories and Models 52
Summary 52 • *Learning Activities 53* • *References 53*

Chapter 3 Community Models to Promote Health 56
The Concept of Community 57
Community Interventions and Health Promotion 58
Community Ecological Models and Theories 59
Social-Ecological Model 60
Social Capital Theory 63
Community Planning Models for Health Promotion 65
The PRECEDE-PROCEED Model 65
Community Dissemination Models to Promote Health 66
Diffusion of Innovations Model 66
Social Marketing Model 69
Considerations for Practice Using Community Models of Health 71
Opportunities for Research with Community-Based Models 72
Summary 72 • *Learning Activities 73* • *References 73*

Part 2 Planning for Health Promotion and Prevention

Chapter 4 Assessing Health and Health Behaviors 76

Nursing Frameworks for Health Assessment 81
Guidelines for Preventive Services and Screenings 83
Assessment of the Individual Client 84
Physical Fitness 84
Nutrition 86
Life Stress 88
Spiritual Health 90
Social Support Systems 91
Lifestyle Assessment 93
Assessment of the Family 95
Assessment of the Community 97
Practice Considerations in Assessing Health and Health Behavior 99
Opportunities for Research in Health Assessment and Health Behavior 100
Summary 100 • *Learning Activities 100* • *References 100*

Chapter 5 Developing a Health Promotion–Prevention Plan 103

Guidelines for Preventive Services and Screenings 104
The Health-Planning Process 105
Review and Summarize Data from Assessment 105
Emphasize Strengths and Competencies of the Client 105
Identify Health Goals and Related Behavior-Change Options 108
Identify Behavioral or Health Outcomes 110
Develop a Behavior-Change Plan 111
Reinforce Benefits of Change 111
Address Environmental and Interpersonal Facilitators and Barriers to Change 112
Determine a Time Frame for Implementation 112
Formalize Commitment to Behavior-Change Plan 112
The Revised Health Promotion-Prevention Plan 118
Community-Level Health Promotion-Prevention Plan 118
Considerations for Practice in Health Planning 118
Opportunities for Research in Behavior Change 119
Summary 119 • *Learning Activities 119* • *References 119*

Part 3 Interventions for Health Promotion and Prevention

Chapter 6 Physical Activity and Health Promotion 121
Health Benefits of Physical Activity 122
Potential Risks of Physical Activity 124
Genetics, Environment, and Physical Activity 124
Prescribing Physical Activity to Achieve Health Benefits 125
Promoting Physical Activity Across the Life Span 126
Promoting Physical Activity in Children and Adolescents 127
Physical Activity and Gender 127
Implementing Guidelines for Physical Activity 128
Promoting Physical Activity in Families 130
Promoting Physical Activity in Schools 130
Promoting Physical Activity in Adults and Older Adults 131
Gender and Physical Activity 133
Implementing Physical Activity Guidelines 134
Promoting Physical Activity in the Work Site 137
Promoting Physical Activity in Persons with Disabilities 138
Interventions in the Community to Promote Physical Activity 139
Changing the Built Environment to Promote Physical Activity 140
Designing Physical Activity Interventions for Diverse Populations 142
Considerations for Practice to Promote Physical Activity 144
Opportunities in Physical Activity Research 145
Summary 146 • Learning Activities 146 • References 147

Chapter 7 Nutrition and Health Promotion 151
Promoting Healthy Diet and Nutrition 152
Nutritional Health of Americans 152
Dietary Guidelines for Americans 153
MyPlate: A Visual Cue to Healthy Eating Habits 155
Issues in Undernutrition 156
Factors Influencing Eating Behavior 157
Genetic-Biologic Factors 157
Psychological Factors 159
Socioeconomic and Cultural Factors 160

Environmental Factors 161
Health Policy Factors 162
Nutritional Needs Across the Life Span 163
Infants and Children (0 to 8 years) 163
Adolescents (9 to 19 years) 164
Adults (19–50 years) 165
Older Adults (50 years and older) 167
Promotion of Dietary Change 168
Interventions to Change Eating Behaviors 168
Research-Tested Intervention Programs (RTIPs) 170
New Moves—Preventing Weight-related Problems in Adolescent Girls in a Group Randomized Study 170
Strong Women-Healthy Hearts 170
Promoting Healthy Living: Assessing More Effects (PHLAME) 170
Body and Soul 171
Strategies for Maintaining Recommended Weight 171
Strategies for Initiating a Weight-Reduction Program 171
Considerations for Practice in Nutrition and Health 173
Opportunities for Research in Nutrition and Health 174
Summary 174 • Learning Activities 174 • References 175

Chapter 8 Stress Management and Health Promotion 178
Stress and Health 181
Stress Across the Life Span 182
Children 182
Adolescents 183
Young and Middle-Age Adults 184
Older Adults 185
Workplace Stress 185
Approaches to Stress Management 186
Interventions to Minimize the Frequency of Stress-Inducing Situations 187
Interventions to Increase Resistance to Stress 188
Complementary Therapies to Manage Stress 191
Mindfulness-Based Stress Reduction (MBSR) 191
Progressive Relaxation without Tension 192
Relaxation through Imagery 192

Breathe Away Stress in 8 Steps 193
Use of Medicines 194
Considerations for Practice in Stress Management 194
Opportunities for Research on Stress Management 194
Summary 195 • Learning Activities 195 • References 195

Chapter 9 Social Support and Health 198
Social Networks 199
Social Integration 200
Social Support 200
Functions of Social Support Groups 202
Family as the Primary Support Group 202
Community Organizations as Support Groups 204
Peers as a Source of Support 204
Virtual Communities as a Source of Support 205
Assessing Social Support Systems 207
Social Support and Health 207
Social Support and Health Behavior 208
Autonomy Support and Health Behaviors 210
Enhancing Social Support Systems 211
Facilitating Social Interactions 211
Enhancing Coping 211
Preventing Social Isolation and Loneliness 212
Considerations for Practice in Social Support 213
Opportunities for Research in Social Support 213
Summary 213 • Learning Activities 214 • References 214

Part 4 Evaluating the Effectiveness of Health Promotion

Chapter 10 Evaluating Health Promotion Programs 216
Purpose of Evaluation 216
Approaches to Evaluation of Health Promotion Programs 217
Efficacy or Effectiveness Evaluation 217
Process or Outcome Evaluation 218
Quantitative or Qualitative Evaluation 218

Deciding Which Outcomes to Measure 219
Nursing-Sensitive Outcomes 219
Individual, Family, and Community Outcomes 221
Short-Term, Intermediate, and Long-Term Outcomes 222
Economic Outcomes 224
Steps in Evaluation of Health Promotion Programs 226
Evaluating Evidence for Health Promotion Practice 227
Strategies for Promoting Effective Health Promotion Outcomes 229
Designing the Intervention 229
Selecting Outcomes 229
Deciding Time Frame 230
Sustaining Behavior Change 230
Considerations for Practice in Evaluating Health Promotion Programs 231
Opportunities for Research in Evaluating Health Promotion 232
Summary 232 • Learning Activities 232 • References 233

Part 5 Health Promotion in Diverse Populations

Chapter 11 Self-Care for Health Promotion Across the Life Span 234
Self-Care or Self-Management 235
Self-Care and Health Literacy 236
Orem's Theory of Self-Care 237
Self-Care to Promote Health Throughout the Life Span 238
Self-Care for Children and Adolescents 238
Self-Care for Young and Middle-Aged Adults 241
Self-Care for Older Adults 242
The Role of *Healthy People 2020* in Promoting Self-Care 244
The Process of Empowering for Self-Care 244
Mutually Assess Self-Care Competencies and Needs 246
Determine Learning Priorities 246
Identify Short- and Long-Term Objectives 247
Facilitate Self-Paced Learning 247
Use Autonomy Support to Increase Competence and Motivation for Learning 248
Create a Supportive Environment for Learning 249
Decrease Barriers to Learning 250

Evaluate Progress Toward Health Goals 250
Other Considerations in Self-Care Empowerment 250
The Role of the Internet in Self-Care Education 251
Considerations for Practice in Self-Care 252
Opportunities for Research in Self-Care 252
Summary 253 • Learning Activities 253 • References 253

Chapter 12 Health Promotion in Vulnerable Populations 256
Determinants of Health Disparities and Health Inequities 257
Socioeconomic Determinants 259
Promoting Equity in Health 260
Multilevel Interventions 261
Community Empowerment 261
Community-based Participatory Research 262
Policy Advocacy 262
Primary Care 263
Health Literacy and Vulnerable Populations 263
Medical Health Literacy or Health Literacy 263
Strategies to Promote Health Literacy 264
Health Literacy Training for Health Professionals 267
Health Care Professionals and Cultural Competence 268
Continuum of Cultural Competence 268
Strategies for Cultural Competent Communication 269
Considerations in Designing Culturally Competent Programs 271
Strategies for Culturally Competent Interventions 272
Considerations for Practice in Vulnerable Populations 274
Opportunities for Research in Vulnerable Populations 274
Summary 275 • Learning Activities 275 • References 275

Part 6 Approaches for Promoting a Healthier Society

Chapter 13 Health Promotion in Community Settings 278
Health Promotion to Improve the Health of Populations 278
Health Promotion in Families 279
Health Promotion in Schools 280
Health Promotion in the Workplace 283

The Community as a Setting for Health Promotion 288
Creating Health Partnerships 289
The Role of Partnerships in Education, Research, and Practice 291
Health Promotion in Nurse-Managed Health Centers 292
Considerations for Practice to Promote Health in Diverse Settings 294
Opportunities for Research in Multilevel Health Promotion Settings 294
Summary 295 • Learning Activities 295 • References 295

Chapter 14 Promoting Health Through Social and Environmental Change 298
Health as a Social Goal 298
Health in a Changing Social Environment 300
Promoting Health Through Public Policy 302
Addressing Obesity with Public Policy 303
Promoting Health in All Policies 305
Promoting Health by Changing the Physical Environment 305
Addressing Health-Damaging Features of Environments 305
Promoting Healthy Social and Built Environments 309
Promoting Health Through Legislation 311
Personal Choice versus Paternalism 311
The Patient Protection and Affordable Care Act 312
Considerations for Practice to Promote Social and Environmental Change 314
Opportunities for Research in Social and Environmental Change 314
Summary 315 • Learning Activities 315 • References 316

Index 318

This page intentionally left blank

FOREWORD

This seventh edition of *Health Promotion in Nursing Practice* is an essential tool for nurses as they develop and deliver evidence-based health promotion services to diverse populations. *Health promotion is for everyone*. Becoming healthier improves the quality of life for all individuals, including cancer survivors, persons with disabilities, those with chronic diseases, and those of advanced age. The American Heart Association (AHA) recently issued an advisory statement that nurses should routinely assess health behaviors, just like vital signs, and provide behavior change counseling as an integral part of services to all patients (Spring, Ockene, Gidding, Mozaffarian, Moore, Rosal, et al., 2013). Nurses, the largest health workforce in the nation, are strategic to the provision of health promotion services in diverse care settings such as primary care clinics, emergency rooms, school clinics, work sites, community health programs, and nursing homes. According to the AHA, unhealthy behaviors must be treated as aggressively as other risk factors. Nurses need to fully embrace this exciting challenge of leading the way to healthier lifestyles in our nation and around the globe.

In late 2013, the U.S. Preventive Services Task Force convened an invitational forum of behavioral counseling and primary care research experts, agencies that fund health promotion research, and experts that develop guidelines on behavioral counseling interventions (S. Curry, personal communication, September 24, 2013). The goal of the meeting was to seek recommendations about how to optimize the development and dissemination of prevention and health promotion evidence-based guidelines and to identify research opportunities and gaps in knowledge about how to improve public health and well-being. Another task force, the Community Preventive Services Task Force, provides evidence-based recommendations on programs and policies to advance environmental/community health. Together, the guidelines of both task forces are intended to assist nurses and other health care personnel to reach the goals of *Healthy People 2020*. However, dissemination of guidelines is only the first step. Nurses need to be a part of the leadership team that integrates health promotion and prevention research findings and guidelines from all sources into policies and practices in key health care settings. Further, nurses can capitalize on the rapidly growing use of electronic media, particularly among the younger generation, to create innovative programs for self-monitoring and decisional support for healthy choices. Nurses must be bold and creative in health promotion programming, modeling healthy lifestyles as they shape health promotion strategies and provide care.

Although progress in health promotion is evident in improved outcomes in some domains, many challenges remain. For example, the current U.S. population still has a high percentage of obese adults and children. This trend presents major challenges to improving health and quality of life. Further, poverty and cultural differences create inequalities in the health and safety of living and working environments. In order to flourish, diverse populations need environments free from crime and other health threats, as well as adequate access to quality care. An additional concern is the plight of women in many countries where they are suppressed and victimized. A transition in values and policies is needed to provide freedom of choice and opportunities for women to experience their full health and human potential.

Health policies and programs should be evidence-based. Research findings must continue to enlighten our approaches to health promotion and prevention. For example, in the October 6, 2013, issue of the *Chicago Tribune* (Section 6, Page 11), new research regarding the "world of the newborn" indicated that predisposition toward a healthy diet may start before birth. Taste and

smell filter through the amniotic fluid so that a mother's diet may shape the food preferences of the newborn. According to research conducted in France, when women were given a designated spice during their pregnancy, infants turned toward the odor after birth, showing preference. Infants of mothers not given the spice turned away from the odor. If these findings are replicated, food aromas experienced *in utero* may influence food preferences throughout life. This makes promoting healthy diets for pregnant women of even greater importance due to the direct influence of their diets on the emerging lifestyles of their infants.

Nurses are exemplary in addressing the health and well-being of the whole person: physical, psychological, social, and spiritual. This text provides valuable information to help nurses carry out this mission. Commendable features of this new edition include a greater emphasis on practice, new information about emerging technology to support health promotion, presentation of new research to undergird evidence-based practice, expanded discussion of culturally competent interventions, and new learning activities and websites to support nurses in their health promotion efforts. Drs. Murdaugh and Parsons have a rich background of experience in promoting health among diverse populations. Their exceptional work in crafting this seventh edition is highly commendable. I trust that this text will inspire nurses to lead the way to a health care system that places health promotion at the forefront of health services provided throughout the life span.

Nola J. Pender, PhD, RN, FAAN
Distinguished Professor
Marcella Niehoff School of Nursing
Loyola University Chicago
Professor Emerita
School of Nursing
University of Michigan

Reference

Spring, B., Ockene, J. K., Gidding, S. S., Mozaffarian, D., Moore, S., Rosal, M. C., et al; on behalf of the American Heart Association Behavior Change Committee of the Council on Epidemiology and Prevention, Council on Lifestyle and Cardiometabolic Health, Council for High Blood Pressure Research, and Council on Cardiovascular and Stroke Nursing. Better population health through behavior change in adults: a call to action. *Circulation.* 2013 Nov; 128. DOI: 10.1161/01.cir.0000435173.25936.e1. [Epub ahead of print].

PREFACE

Major challenges continue to influence health promotion and health care reform as we complete the seventh edition. Health care disparities are ongoing barriers to promoting the health of a large segment of our population. The expanding "obesogenic" environment promotes unhealthy foods and inactive lifestyles across the life span. Health promoting lifestyles must begin in early childhood to reverse the devastating trend toward increasing chronic illnesses, escalating health care costs, and shorter life spans for the first time in many generations.

The purpose of the text is to (1) present an overview of the major individual and community models and theories to guide health promotion programs and interventions; (2) offer evidence-based strategies to implement and evaluate health promotion programs for diverse populations across the life span; and (3) encourage critical thinking about the most effective interventions and methods for health promotion practice. We believe information in the text helps provide the foundation on which to build the practice of health promotion.

The content of the text is organized into six sections. In Part I, The Human Quest for Health, health and health promotion are defined, and individual and community models to guide health promotion programs and research are described. In Part II, Planning for Health Promotion and Prevention, strategies are described to assess health, health beliefs, and health behaviors and develop a health promotion plan. In Part III, Interventions for Health Promotion and Prevention, four core areas are targeted to promote health: physical activity, nutrition, stress management, and social support. In Part IV, Evaluating the Effectiveness of Health Promotion, models for program evaluation are addressed. Part V, Health Promotion in Diverse Populations, addresses strategies for self-care across the life span and culturally sensitive approaches to promote health and health literacy in vulnerable populations. In Part VI, Approaches for Promoting a Healthier Society, community partnerships for health promotion and policies to promote social and environmental changes for a healthier society are described.

Each chapter contains considerations for practice, opportunities for research, and learning activities. The content in all chapters has been updated, based on published research evidence. The *Healthy People 2020* goals, an ecological approach to health promotion, and the role of technology in promoting health have been integrated throughout the text. The text is ideally suited for undergraduate students in nursing and health promotion programs, graduate students in nurse practitioner and doctor of nursing practice programs, and health promotion practitioners.

The term *client* is used rather than *patient* throughout the text to refer to individuals, families, and communities who are active participants in health promotion. *Health* and *wellness* are used interchangeably. *Health protection* and *prevention* also are used interchangeably throughout the text.

Our sincere appreciation is extended to Michael Giacobbe, Maria Reyes, and Patrick Walsh at Pearson Health Science, who have worked with us in the preparation of the text, and to Mansi Negi at Aptara and Bret Workman who worked with us on production. We are very appreciative of Patrick's expertise in the final stages of preparation and Bret's and Mansi's attention to detail in the production phase. We are also deeply indebted to Alice Pasvogel, PhD, Research Specialist, College of Nursing, University of Arizona, who spent countless hours editing, formatting, and preparing the tables and figures. Her willingness to step in and take over the editorial work, attention to detail, and expert editorial assistance enabled us to finish the text in a timely manner.

Carolyn Murdaugh
Mary Ann Parsons

Reviewers

Terese Blakeslee, MSN Ed, RN
Nursing Instructor
UW Oshkosh College of Nursing
Oshkosh, WI

Mary Brown, MSN, MEd, RN, CNE
Nursing Program Director
Yavapai College
Prescott, AZ

Ann Denney, MSN, RN
Associate Professor of Nursing
Thomas More College
Crestview Hills, KY

Michele Dickens, MSN, RN
RN to BSN Program Instructor
Campbellsville University
Campbellsville, KY

Susan England, MSN, RN
Professor
Texas State Universty
Round Rock, TX

Janice Johnson-Umezulike, RN, BSN, MN, CNS, ANP, DNS
Professor
Lee College
Baytown, TX

Sherry Lovan, PhD, RN
Associate Professor, BSN Program Coordinator
Western Kentucky University School of Nursing
Bowling Green, KY

Margaret McAllister, PhD, FNP-BC, FAANP
Dir. Post Master's Certificate Program and Co Dir. DNP Program
Clinical Associate Professor
University of Massachusetts Boston
College of Nursing and Health Sciences
Boston, MA

Vicki Moran, MSN/MPH, CNE, RN
Instructor
Saint Louis University
St. Louis, MO

Jean Rodgers, RN, MN
Course Coordinator
Hesston College
Hesston, KS

Ira Scott-Sewell, RN, MSN, MHA, MS
Professor
Alcorn State University School of Nursing
Natchez, MS

Nancy Simpson, MSN, RN-BC, CNE
Professor
University of New England
Portland, ME

Pamela Wendall RN, MSN
Instructor
Gila Community College
Payson, AZ

Rhonda M. White, MSN, RN
Associate Professor, Nursing Program Clinical Coordinator
BridgeValley Community & Technical College
South Charleston, WV

INTRODUCTION

The Changing Context of Health Promotion

The major goals of health promotion are to help people of all ages stay healthy, optimize health in cases of chronic disease or disability, and create healthy environments. These goals require strategies that not only improve the health of individuals within the context of their families and communities, but also address the environments in which they live, work, and play.

Even though the United States is one of the wealthiest nations in the world, it lags behind other high-income nations in life expectancy and health for all its citizens. Likely explanations for these differences include the following:

- *Health systems.* Americans have more limited access to primary care, report lapses in quality of care outside of hospitals, and are more likely to be uninsured than people in peer nations.
- *Social and economic conditions.* The United States has higher levels of poverty and income inequality, lower rates of social mobility, and lack of a safety net for the poor and disadvantaged as compared to peer nations.
- *Physical environments.* Americans are more likely to live in environments that discourage physical activity and contribute to obesity compared to other high-income nations.
- *Health behaviors.* While Americans are less likely to smoke, and consume less alcohol than people of peer countries, they consume more calories per person, are less likely to use seat belts, and have higher rates of drug abuse, alcohol-related traffic accidents, and gun violence.

Upper-income, advantaged Americans' health also lags behind that of their counterparts in other high-income nations (Institute of Medicine, 2013).

The current health disadvantages experienced by Americans will have even greater health and economic consequences unless the United States takes action. To build a healthier America, health promotion and prevention must become priorities using innovative approaches, partnerships, and capacity building. If we are to move the health care system from *sick* care to *health* care, we must develop effective solutions that result in better health for *all* stakeholders: individuals, families, schools, and communities (Levi, Segal, Miller, & Lang, 2013). In addition,

the solutions must enable individuals and communities to take control over the personal, socioeconomic, and environmental factors that affect their health, including the physical, mental, social/cultural, and spiritual dimensions (Bauman, Finegood, & Matsudo, 2009).

Health professionals recognize the need to change the context of health promotion and prevention and have started to engage in promising new strategies to help people of all ages stay healthy. Factors that are changing the context of health promotion to decrease disparities and inequities in health include the following:

- Multilevel interventions and strategies
- Mobile wireless computer technologies
- Community/sociopolitical partnerships

MULTILEVEL INTERVENTIONS AND STRATEGIES

Given the magnitude of the challenges in health promotion, the multilevel, comprehensive interventions and strategies that are more likely to succeed address a health issue(s) across all levels, individuals, families, schools, communities, worksites, and populations, and incorporate personal, socioeconomic, and environmental factors. Critical to the success of health promotion is consideration of multiple social and environmental factors, whether the focus is on the actions of individuals, families, schools, communities, or governments.

Each of these levels requires an evidence base that accounts for the contextual factors that influence outcomes. For example, successful individual-level, evidence-based interventions provide guidance to practitioners in providing direct health promotion activities. Interventions and programs targeting the school or community level provide evidence of adoption of positive health behaviors by students and families. While there are efforts to ensure coherence and coordination across these levels, the success of these efforts in terms of effecting sustained behavior change is not evident. Long-term maintenance of health behavior change is difficult without concomitant support from the social and built environments.

Population level change is critical to improve health across all ages. This is difficult, as "active living" approaches are expensive and have a limited evidence base. Population-level behavior change may require structural solutions over evidence generation to have the kind of sustainable impact on health behaviors that is vital for a healthier America (Bauman, Finegood, & Matsudo, 2009).

MOBILE WIRELESS COMPUTER TECHNOLOGIES

The expansion of mobile wireless computer technologies and social media applications, including telemedicine and telecare, has had a major influence on health promotion and prevention, unlike any in recent history. E-health (electronic health) or m-health (mobile health) includes a diverse set of informatics tools that have been embraced as a promising new way to prevent health problems and promote healthy behaviors at all levels, with particular enthusiasm for addressing population-level change.

Traditionally, health promotion has been a low-tech area in comparison with innovations in medical technologies used in health care settings. The expansion of the Internet for personal and professional use has increased its application for health promotion strategies, program delivery, and research. Social media, such as YouTube, Twitter, Facebook, and blogs, and smartphones and tablet computers promote the "personalizing" of health messages—"reaching into individuals' everyday lives" by sending, for example, tailored messages about individual health concerns

or problems, or a "happy note" to acknowledge a positive change in "step counts" delivered by an accelerometer. With geographical applications, individuals can be located and body movements can be recorded. Because m-health devices can be taken almost everywhere, the user is usually connected and accessible (Lupton, 2012).

The use of m-health represents a significant change in health promotion strategies and research methodologies. Health and nursing journals now report the importance of e-health in health promotion research. Researchers have described using m-health to access, recruit, and deliver health interventions to adolescents and young adults as well as hard-to-reach minority and underserved populations (Lori, Munro, Boyd, & Andreatta, 2012; Park & Calamaro, 2013). The benefits of text messaging include improvements in self-care outcomes. The use of automated telephone monitoring has been shown to improve chronic disease management outcomes in low- and middle-income countries (Piette, Lun, Moura, Fraser, Mechael, Powell, & Khoja, 2012). Web-based, self-administered questionnaires and the ability to access wide and diversified populations with quick returns have resulted in cost advantages (Hercberg, 2012). The use of m-health has also been linked to greater acceptance of individual responsibility for healthy lifestyles (Lupton, 2012).

Nevertheless, concerns about promoting m-health to shift the responsibility of health from health care professionals to individuals require careful examination. Some e-health advocates view client empowerment as a positive outcome of m-health. Unfortunately, there is limited evidence that all clients are willing, or capable of, assuming this level of health responsibility. The focus on individualized health messages reduces health problems to a micro level rather than attending to the broader sociocultural/political dimension. In addition, home monitoring–based telecare has the potential to coerce older people into isolation, unless redesigned systems promote creative engagement with technology (Mort, Roberts, & Callen, 2012). Also of significance is the digital divide, which demonstrates limited adoption of these technologies based on socioeconomic group and health literacy level. Other moral, ethical, and privacy issues signal caution to the health promotion community concerning an immediate total buy-in of m-health. However, e-health, when used appropriately, will play a significant role in improving the health of the public.

COMMUNITY/SOCIOPOLITICAL PARTNERSHIPS

Two 2013 global conferences, the World Health Organization's (WHO) Eighth Global Conference on Health Promotion and the 21st International Union for Health Promotion and Education World Conference (IUHPE), highlighted key challenges confronting health promotion. The WHO conference focused on "Health in All Policies" to encourage governments to adopt an approach that considers the health impact of *all* policies, regardless of where in the system the policy originates. This approach allows considerations of the contextual influences of policy to move from a sole focus on the health sector to all government sectors.

The theme of the IUPE conference was "Best Investments for Health." Concepts of sufficiency, efficiency, effectiveness, and equity were all included in the concept of "best," while financing, capacity building of human resources, systems, and interventions were included in the concept of "investments." Outcomes of this conference support a framework for governments to build healthy public policies (Sparks, 2013). Some countries have committed to one or more of the concepts, while others are lagging behind. However, many countries are forming partnerships to examine their public health policies.

Community/socioeconomic/political partnerships have the human capacity and political power to bring national attention to the many promising strategies that address the public's

health. *Healthy People in Healthy Communities*, a national partnership initiated by the U.S. Department of Health and Human Services, involves the federal government, the states, local communities, and many public and private sector groups. This partnership guides national health promotion and disease prevention efforts to improve the health of all people in the United States. Each decade, *Healthy People* sets objectives and provides science-based benchmarks to track and monitor progress in order to motivate and focus action on identified health issues. *Healthy People 2020* represents the fourth generation of this partnership, building on a foundation of three decades of work.

Healthy People 2020 is committed to a vision of a society in which all people live long, healthy lives. New features in the 2020 initiative, noted below, will help make this vision a reality.

- Health equity is emphasized by addressing social determinants of health and promoting health across all stages of life.
- Traditional print publications have been replaced with an interactive website as the main vehicle for dissemination.
- A website is maintained to enable users to tailor information to their needs and explore evidence-based resources for implementation However, real progress depends on whether the public and political communities are willing to make a social commitment of effort and resources to improve the overall health of Americans.

NURSING AND HEALTH PROMOTION: A NATURAL PARTNERSHIP

Nurses, the largest segment of health care professionals, are in a key position to take a leadership role to meet the national health promotion goals, which are to:

- help people of all ages to stay healthy.
- optimize health in cases of chronic disease or disability.
- create healthy environments.

Many disciplines contribute to meeting these goals. However, nursing, which is grounded in a holistic approach, offers a bridge between individual health promotion and promoting the health of families, communities, and populations. Nurses are educated to care for all persons within the context of the individual's culture and community. Four key elements of the nurse's role promote and support health promotion:

- *An individual perspective.* Nurses facilitate individuals and families in their health decisions and support their health promotion activities.
- *A philosophy of empowerment.* Nurses collaborate with individuals, groups, and communities to enable them to increase control over their health.
- *Knowledge of social and health policy.* Nurses advocate for and support local, state, national, and international policies to promote health equity.
- *A community orientation.* Nurses collaborate with all health professionals and community leaders to promote healthy communities.

Nurses need advanced skills and knowledge to implement health promotion activities, including (1) interprofessional knowledge; (2) communication, collaboration, and political skills; and (3) an advocacy orientation. In addition, nurses need to practice health behaviors and role model a healthy lifestyle (Kemppainen, Tossavainen, & Turunen, 2012). Health promotion activities should occur in all practice settings. In every client encounter, nurses can both model

and teach positive health promotion and prevention practices. Nurses need not only to be knowledgeable of the importance of individual-level health promotion, but also to demonstrate their political knowledge to help change the socioeconomic and physical environments. Nurses, collaborating with colleagues, should champion a culture where health promotion principles are integrated, valued, and practiced in all settings (Savage & Kub, 2009). Nurses are essential to shaping the future of health promotion. As new challenges warrant new approaches, nurses should be prepared to take leadership roles in promoting the health of all.

References

Bauman, A., Finegood, D., & Matsudo, V. (2009). International perspectives on the physical inactivity crisis-Structural solutions over evidence generation? *Preventive Medicine, 49*, 309–312.

Hercberg, S. (2012). Web-based studies: The future in nutritional epidemiology (and overarching epidemiology) for the benefit of public health? *Preventive Medicine, 55*, 544–545.

Institute of Medicine. (2013). *U.S. Health in International Perspective.* Washington, DC: National Academy of Sciences.

Kemppainen, V., Tossavainen, K., & Turunen, H. (2012). Nurses' roles in health promotion practice: An integrative review. *Health Promotion International Advance,* 1–12. doi:10.1093/heapro/das034

Levi, J., Segal, L., Miller, A., & Lang, A. (2013). *A Healthier America 2013.* Princeton, NJ: Trust for America's Health.

Lori, J., Munro, M., Boyd, C., & Andreatta, P. (2012). Cell phones to collect pregnancy data from remote areas in Liberia. *Journal of Nursing Scholarship, 44*(3), 294–310.

Lupton, D. (2012). M-health and health promotion: The digital cyborg and surveillance society. *Social Theory & Health, 10*, 229–244. doi:10.1057/sth.2012.6

Mort, M., Roberts, C., & Callen, B. (2012). Ageing with telecare: Care or coercion in austerity? *Sociology of Health & Illness, 35*(6), 799–812. doi:10.1111/shil.2013.35

Park, B., & Calamaro, C. (2013). A systematic review of social networking sites: Innovative platforms for health research targeting adolescents and young adults. *Journal of Nursing Scholarship, 45*(3), 256–264.

Piette, J., Lun, K., Moura, L., Fraser, H., Mechael, P., Powell, J., & Khoja, S. (2012). Impacts of e-health on the outcomes of care in low- and middle-income countries: Where do we go from here? *Bulletin of the World Health Organization, 90*(5), 365–372. doi:10.2471/BLT.11.099069

Savage, C., & Kub, J. (2009). Public health and nursing: A natural partnership. *International Journal of Environmental Research and Public Health, 6*, 2843–2848. doi:10.3390/ijerph6112843

Sparks, M. (2013). The changing context of health promotion. *Health Promotion International, 28*(2) Editorial. doi:10.1093/heapro/dat034

CHAPTER 1

Toward a Definition of Health

OBJECTIVES

This chapter will enable the reader to:

1. Compare traditional and holistic definitions of health.
2. Contrast conceptions of individual health.
3. Describe conceptions of health by nurse theorists.
4. Discuss family and community definitions of health.
5. Describe the social determinants of health.
6. Discuss the significance of global health.
7. Describe the changing conceptions of health promotion.

Health, person, environment, and nursing constitute the commonly accepted metaparadigm of the discipline of nursing (American Nurses Association, 2010; Fawcett & Desanto-Madeva, 2012). Although health is the frequently articulated goal of nursing, different conceptions about the meaning of health are common. These differences result from the increasingly diverse social values and norms that shape conceptualizations of health in societies with many distinct ethnic, religious, or cultural groups. What many health professionals once assumed was a universally accepted definition of health—the absence of diagnosable disease—is actually only one of many views of health held today. All people who are free of disease are not equally healthy. Furthermore, health can exist without illness, but illness does not exist without health as its context.

The emergence of health promotion as the central strategy for improving health has shifted the paradigm from defining health in traditional medical terms (the curative model within a biologic perspective) to a multidimensional definition of health with social, economic, cultural, and environmental dimensions. In a multidimensional model, health benefits can potentially be achieved from positive changes in any one of the health dimensions.

This expanded perspective of health opens up multiple options for improving health and no longer places the responsibility for poor health entirely on the individual. During the course of human development, the definition of health changes over the life span. As children mature and move into adolescence, their definition of health becomes more inclusive and more abstract. Health definitions of adolescents show a trend toward greater thematic diversity (physical, mental, social, and emotional health) and less emphasis on the absence of illness with increasing age. As children mature, the focus on health also changes. Young adults ages 16 to 24 years report a lower priority on health and less engagement in health behaviors than do adolescents 12 to 15 years and adults 25 years and older (Goddings, James, & Hargreaves, 2012). Older adults hold a more holistic definition of health that integrates physical, mental, spiritual, and social aspects, reflecting how health is embedded in everyday life experiences and surroundings (Goins, Spencer, & Williams, 2011).

In addition, gender is a critical sociocultural determinant of health throughout the life course (Gelb, Pederson, & Greves, 2011). Gender differences in health are due to genetic and biologic factors, as well as social and behavioral factors such as risk-taking behaviors, health-seeking behaviors, and coping styles (Eriksson, Dellve, Eklof, & Hagberg, 2007; Evans, Frank, Oliffe, & Gregory, 2011). The social structural context of men and women has been documented to be a major determinant of gender differences in health. The promotion of gender equality and empowerment interventions is crucial to improving women's health. In addition it is vital to increase understanding of the influence of masculinity in shaping men's health and health behaviors (Gelb, Pederson, & Greaves, 2011). Nursing can play a significant role in provision of education and knowledge sharing to increase the health and well-being of women and men.

In a positive model of health, emphasis is placed on strengths, resiliencies, resources, potentials, and capabilities rather than on existing pathology (resilience reference). Despite a philosophic and conceptual shift in thinking about health, the nature of health as a positive life process is less understood empirically, as attention continues to focus on forces that undermine health and lead to disease, rather than factors that lead to health. Morbidity (prevalence of illness) and mortality (death) are still commonly used to define the health of a population. These indicators more accurately reflect disease burden and the need for health care, not health. A focus on disease morbidity and mortality frames health within a biologic definition: the body without disease. However, evidence indicates that complex interwoven forces embedded in the social and environmental context of people's lives determine health. Health cannot be separated from one's life conditions, as neighborhood, social relationships, food, work, and leisure, which lie outside the realm of health practice, positively or negatively influence health long before morbid states are evident (Reutter & Kushner, 2010).

HEALTH AS AN EVOLVING CONCEPT

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

The word *health* as it is commonly used did not appear in writing until approximately 1000 AD. It is derived from the Old English word *health,* meaning being safe or sound and whole of body (Sorochan, 1970). Historically, physical wholeness was of major importance for acceptance in social groups. Persons suffering from disfiguring diseases, like leprosy, or congenital malformations were ostracized from society. Not only was there fear of contagion of physically obvious disease, but also repulsion at the grotesque appearance. Being healthy was construed as natural or in harmony with nature, while being unhealthy was thought of as unnatural or contrary to nature.

With the advent of the scientific era and the resultant increase in medical discoveries, society became concerned about helping individuals escape the catastrophic effects of illness. *Health* was defined as "freedom from disease." Because disease could be traced to a specific cause, often microbial, it could be diagnosed. The notion of health as a disease-free state was extremely popular into the first half of the twentieth century and continues to be recognized by some in the medical community as *the* definition of health (Miller & Foster, 2010). Health and illness were viewed as extremes on a continuum—the absence of one indicated the presence of the other. This gave rise to "ruling out disease" to assess health, an approach still prevalent in the medical community today. The underlying erroneous assumption is that a disease-free population is a healthy population.

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

For several decades, the importance of mental health became obscured in the rapid barrage of medical discoveries for treatment of physical disorders. However, the psychologic trauma resulting from the high-stress situations of combat during World War II expanded the scope of health as a concept to include consideration of the mental status of the individual. Mental health was manifest in the ability of an individual to withstand stresses imposed by the environment. When individuals succumbed to the rigors of life around them and could no longer carry out the functions of daily living, they were declared to be mentally ill. Despite efforts to develop a more holistic definition of health, the dichotomy between individuals suffering from physical illness and those suffering from mental illness persisted for many years. In 2011, the World Health Organization (WHO) defined mental health as a state of well-being in which individuals realize their potential, can manage usual life stresses, work effectively, and participate in their community (World Health Organization, 2011). This definition is consistent with the WHO definition of health.

In 1946, the WHO proposed a landmark definition of health that emphasized "wholeness" and the positive qualities of health: "Health is a state of complete physical, mental, and social well-being and not merely the absence of disease and infirmity" (World Health Organization, 2005). The definition was revolutionary in that it (1) reflected concern for the individual as a total person, (2) placed health in the context of the social environment, and (3) overcame the reductionist definition of health as the absence of disease. The breadth of this historical definition mandated a comprehensive approach to health promotion, and inherently, created an imperative for health equity (Friel & Marmot, 2011).

The WHO definition continues to be criticized by many who think that it is utopian and too broad, and that the absoluteness of the term "complete" makes health impossible to

achieve (Huber et al., 2011). The definition was formulated when acute disease presented the major burden to society. However, people living with chronic diseases for decades are increasing worldwide, and this is not accounted for in the definition. Despite the criticisms and calls for reformulation, the WHO definition continues to be the most popular and comprehensive definition of health worldwide and was reaffirmed at the 2005 assembly (World Health Organization, 2005). In spite of its universal recognition, recommendations continue to revise the definition and to view the WHO definition only as a historical document. Many authors think that more current, less utopian, measurable definitions are needed (Bok, 2008; Huber et al., 2011). It is now accepted that individual health cannot be separated from the health of society and that individuals are interdependent with the totality of the world. Moreover, the relationship of human health to the health of the earth's ecosystem is also recognized as an important dimension. In other words, one cannot be healthy in an unhealthy society or world. Within these dimensions health has been defined as the ability to adapt to one's environment. Health is not a fixed state, as it varies depending on an individual's life state. This conception, originally proposed by Georges Canguilhem in 1943, enables the changing context to be taken into consideration to understand the meaning of health (Huber et al., 2011).

In the following sections, definitions of health are discussed that focus on the individual, the family, and the community. In the past, defining health for individuals received more attention than defining health for families and communities. However, it has become clear that individual health is almost inseparable from the health of the larger community, and the health of every community influences the overall health status of the nation.

HEALTH AND ILLNESS: DISTINCT ENTITIES, OR OPPOSITE ENDS OF A CONTINUUM?

Health and illness have been presented as a continuum with reference points such as (1) optimum health, (2) suboptimal health or incipient illness, (3) overt illness and disability, and (4) very serious illness or approaching death (Niebroj, 2006). These descriptors have only one point representing health, whereas multiple points on the scale represent varying states of suboptimum health or illness. Dunn, the first author to provide a definition of wellness, maintains that health and illness are separate concepts, and continua must allow the differentiation of varying levels of health as well as varying levels of illness (Dunn, 1977; Roscoe, 2009).

When health and illness are assumed to represent a single continuum, it is difficult to discuss healthy aspects of the ill individual. The presence of illness ascribes the "sick role," and the individual is expected to direct all energies toward finding the cause of the illness and engage in behaviors that will result in a return to health as soon as possible. However, health can be manifested in the presence of illness. Poor health can exist even if disease is not present, and good health can be present in spite of disease.

The authors of this text believe that health and illness are qualitatively different, interrelated concepts that may coexist. In Figure 1–1, multiple levels of health are depicted in interaction with episodes of illness. Illness, which may have a short (acute) or long (chronic) duration, is represented as discrete events within the life span. Health can still be an aspiration to those with a chronic illness or disability, and health can be achieved despite being diagnosed with a disease or living with a disability (Institute of Medicine, 2012). Illness experiences can either hinder or facilitate one's continuing quest for health. Thus, good health or poor health may exist with or without overt illness.