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PART I

ISSUES CONCERNED WITH THEORY AND PRACTICE

INTRODUCED AND EDITED BY ANGELA SCRIVEN

Part I of this book examines issues surrounding theory and practice in health promotion, and as such is intended to introduce a range of ideas and arguments that create a context for what follows in the remaining sections.

Tones, in the first chapter, opens with a wide-ranging discussion of the concept of health promotion. While recognising that any analysis of the meaning of health promotion has traditionally resulted in dispute, Tones offers us a contentious view, describing health promotion as a militant wing of public health. In doing this, he presents his own well-established formula for health promotion, which is a combination of healthy public policy and health education. His justification for this explanation involves taking the reader on a potted history of the international policies that have shaped the development of health promotion to its current position. His assessment of empowerment is detailed and enlightening, making a strong case for moving beyond an ideological commitment to a technology incorporated seamlessly into health promotion work.

There are clearly issues in this chapter that have resonance in other parts of the book, such as the voluntary sector elements, Anderson in Chapter 16 presenting a case for the participative nature of voluntary services, reflecting the more empowering models of health promotion. Moreover, the section on the education and youth work setting, which offers an assessment of the health-promoting school and the new National Curriculum guidelines for personal and social education, reflects the action competencies and empowerment debates presented by Tones.

Marwell and Speller continue the discourse around recent developments in health promotion, with a particular emphasis on policy relating to partnership working. This chapter provides an important backdrop to the specific chapters on professional settings that follow. The various policy documents that give direction to the wide range of current initiatives that come under the aegis of health promotion are identified, outlined and evaluated. The authors present the background to the current position in which individuals, groups and organisations are not only encouraged, but also expected to work in collaborative ways to achieve goals outlined in the new public health

agenda. The difficulties and pitfalls of engaging in collaborative partnerships are examined in some depth. The impression given is that there is still much to do to overcome these difficulties, including the development of programmes of education and training that facilitate new ways of working that will harmonise and integrate health promotion activities across professional and organisational boundaries. The new Verona Initiative is outlined and clearly offers exciting opportunities for improving the quality and scope of partnership working. Overall, Tones and Marwell and Speller provide excellent insights into the range of debates that permeate the current environment in which health promoters operate. These chapters form a necessary framework from which to study the professional perspectives that are the focus of this book.

CHAPTER 1

Health Promotion: The Empowerment Imperative

KEITH TONES

This chapter will briefly review the essentially contested concept of health promotion and examine the formulation that the World Health Organization (WHO) has developed, largely since the launch of the movement to achieve Health for All by the Year 2000 (HFA2000) at the 30th World Health Assembly in 1977. More particularly, it will consider the empowerment imperative contained within this formulation and provide an ideological model of health promotion based on the assertion that health promotion's primary concern should be with helping people to gain control over their lives and their health. An examination of both community empowerment and self-empowerment will be followed by a brief reference to the ways in which these principles might be applied to health promotion settings and methods.

The meaning of health promotion

Health promotion is an essentially contested concept: it is used in a variety of ways by different individuals and organisations, typically in the context of special pleading or in support of some cherished viewpoint or philosophy. It is not uncommon to consider health promotion as being synonymous with health education, or to view health education as part of health promotion. The term 'health development' is, on occasion, used as being equivalent to health promotion, and recently the concept of health promotion has been seen to differ little from that of public health. Indeed, health promotion is sometimes considered to be part of public health or, conversely, public health is sometimes viewed as a component of health promotion. Over 10 years ago, Green and Raeburn (1988: 30) provided a rather appropriate description of the ways in which various individuals and groups made their bids for ownership:

Ideologues, professionals, interest groups, and representatives of numerous disciplines have attempted to appropriate the field for themselves. Health and education

professionals, behavioural and social scientists, holistic health and self-care advocates, liberals, conservatives, voluntary associations, funding agencies, governments, community groups, and many others all want something from health promotion, all want to contribute something, and all bring their own orientation to bear on it.

In order to avoid further ideological argument, health promotion will, for the purpose of this chapter, be considered to be a kind of militant wing of public health. Its essential components are twofold and give rise to the following formula:

$$\textit{Health Promotion} = \textit{Healthy Public Policy} \times \textit{Health Education}$$

The term ‘healthy public policy’ is borrowed from the Ottawa Charter, its major purpose being to create legislation, economic and fiscal measures and various forms of social and environmental engineering in order to make the healthy choice the easy choice. Without appropriate health policy, health education will in many instances be unable to influence healthy choices. On the other hand, without health education, it will frequently be impossible to develop and implement healthy public policy, especially those policies which are politically problematic. Health education is readily defined as follows:

Health education is any intentional activity which is designed to achieve health or illness related learning, i.e. some relatively permanent change in an individual’s capability or disposition. Effective health education may, thus, produce changes in knowledge and understanding or ways of thinking; it may influence or clarify values; it may bring about some shift in belief or attitude; it may facilitate the acquisition of skills; it may even effect changes in behaviour or lifestyle. (Tones and Tilford, 1994: 11)

In the model of health promotion proposed below, the purpose of healthy public policy and health education should be to empower individuals and communities, and reduce or remove the various barriers preventing the attainment of health for all.

A comprehensive account of health promotion and its history is beyond the scope of this chapter, and more complete analyses may be found elsewhere (see, for example, Anderson, 1984; Tones, 1985; Minkler, 1989). However, since the empowerment imperative is central to the WHO’s conviction about the purpose of health promotion and its definition, the following important milestones marking progress from the 1977 initiation of HFA2000 will be briefly noted.

Milestones in health promotion

At one level, it could be argued that the roots of health promotion are to be found in the WHO's original and classic definition of health (WHO, 1946), with its holistic emphasis on well-being. It is, on the other hand, important also to note the change of emphasis embedded in HFA2000: health is no longer viewed as the ultimate purpose of health promotion but instead a means to an end, namely the attainment of a socially and economically productive life. This clearly begs the question of the nature of social and economic productivity, but it is nonetheless a rather more manageable concept than perfect well-being!

The most obvious precursor to health promotion is undoubtedly the Declaration of Alma Ata (WHO, 1978), which, *inter alia*, asserted that the existence of gross inequalities between advantaged and disadvantaged peoples was politically, socially and economically unacceptable. The proposed solution to this problem was to be Primary Healthcare (PHC). This is not to be confused with primary *medical* care since *demedicalisation* was to be an important thrust of PHC and, subsequently, health promotion. Moreover, given the perspective of the present book, we should also acknowledge how Alma Ata popularised the notion of intersectoral collaboration.

If Alma Ata and PHC were the prototypes, the emergence of health promotion as a major movement was formalised with the publication by WHO's European Region of its concepts and principles in 1984. Kickbusch (1986: 438) described this event as 'a new forcefield for health [which] integrates social action, health advocacy and public policy'. The first full blossoming of the principles incorporated in the 1984 publication was arguably to take place in Ottawa, when 200 delegates from 38 nations made a commitment to health promotion in what has, since that time, been celebrated as the Ottawa Charter (Kickbusch, 1986; WHO, 1986).

The specific features of the Charter may be consulted elsewhere, and its principles will feature in the more extended review that is presented below. It is, however, worth noting that although reference was made to the importance of developing people's personal skills, health education was dislodged from the centre-stage position it enjoyed under the aegis of PHC and was virtually replaced by the enthusiasm for building healthy public policy. As we will note later, this was a fundamental flaw. The other most important ideological principle to emerge from Ottawa was its reiteration that the empowerment of individuals and communities should be a major focus of future work: community action must be strengthened and decision making facilitated by creating supportive environments. The theme of demedicalisation was also maintained and found expression in the argument for the reorientation of health services in order to both expand their scope and make them more user friendly.

Health promotion's progress was maintained by both attempts to activate the 38 targets for achieving HFA2000 (WHO, 1985) and a number of subse-

quent conferences and major initiatives. A second international conference on health promotion was, for example, held in Adelaide (Green and Raeburn, 1988) which pursued ways of building healthy public policy, and, most recently, a third international conference was held in Sundsvall (WHO, 1991). The Sundsvall Declaration focused on the need to provide supportive environments for health and highlighted four aspects: the social dimension, the impact of cultural norms and social processes; the political dimension, the requirement on governments to guarantee democratic participation in decision making and make a commitment to human rights and peace; the economic dimension, the need to re-channel resources to achieve health for all; and finally, the need to recognise women's skills and knowledge.

In addition to the conferences and declarations, attempts to translate rhetoric into practice are especially relevant to the aims of this book. The most significant of these was perhaps the Healthy Cities movement, which initially sought to establish test beds for health promotion in 11 European cities. A more extended discussion of Healthy Cities may be consulted elsewhere (see, for example, Fryer, 1988 and Kickbusch, 1989). Suffice it to say that this WHO-inspired development acted as a stimulus for the emergence of more than 300 local initiatives in various European cities. In addition to the focus on the city, the principles of health promotion were applied to a number of more specific institutions, organisations and contexts, a development that has become widely known as the Settings Approach.

The most recent and important of WHO's milestones has been the Jakarta Conference (WHO, 1997, 1998). In short, the Jakarta Declaration reiterated the importance of the Ottawa Charter principles.

Ottawa: key principles

WHO has consistently advocated a positive and holistic view of health and asserted that it comprises mental, physical and social elements rather than merely being concerned with the prevention and control of disease. In addition, Ottawa and Jakarta have identified the following major concerns for health promotion:

- *Equity.* The ultimate concern of health promotion lies with the achievement of equity and social justice; avoidable inequalities in health between and within nations are intrinsically unacceptable. Equity is not only a worthwhile goal in its own right but a means to the end of preventing disease and premature death.
- *Empowerment.* Helping people to gain control over their lives is both a prime goal in its own right as well as the major means of achieving equity. In order to achieve this goal, a supportive environment must be created at all levels. This will be achieved in two main ways:

- building healthy public policy to address the major determinants of health and illness that reside in the physical, cultural and socio-economic environment in which people live and work;
- strengthening individuals' personal competencies and capacities.
- The achievement of active participating communities.
- *The reorientation of the health services.* Health is too important to be left to the medical profession: there must be a reorientation and reframing of health services. Since medical services often do not meet population needs and can be disempowering, they should be reformed. Demedicalisation is an important goal of health promotion. Not only is it concerned with shifting the balance of power from doctors and the medical establishment towards patients and clients, but it also seeks to acknowledge the substantial contributions made by other services to health and illness. Services such as housing, transport, leisure and recreation, and economic development, may all influence health for good or ill. Since so many organisations, contexts, settings and services can influence health, collaborative working is, by definition, likely to maximise their impact. Intersectoral collaboration is therefore a key instrumental principle for maximising the health-promoting potential of these services and for influencing the development and implementation of healthy public policy.

Health promotion, empowerment and reciprocal determinism

The concept of empowerment is complex and, as with health promotion, comprises an amalgam of ideological and technical attributes. A full discussion is not therefore possible here, and a more complete analysis may be found elsewhere (Tones, 1992, 1994, 1998a; Tones and Tilford, 1994). Figure 1.1 seeks to demonstrate the relationship between health promotion, empowerment and the attainment of health.

In the last analysis, the concept of *reciprocal determinism* (Bandura, 1982, 1986) lies at the very heart of the empowerment imperative in health promotion. Reciprocal determinism is one of the central tenets of social learning theory and asserts that people's capacity for action, and ultimately their health, is determined by the nature of their environment. On the other hand, however, it is usually possible for people to exercise at least some degree of control over their circumstances. The relationship between environment and individual is thus one of reciprocity, except for those individuals who are continually overwhelmed by so many negative events and oppressive circumstances that their degree of choice is effectively zero.

As noted earlier, health is ultimately determined by the existence of equity and social justice, and this is in turn rooted in people's material, social, economic and cultural circumstances. Following the Ottawa mandate, the

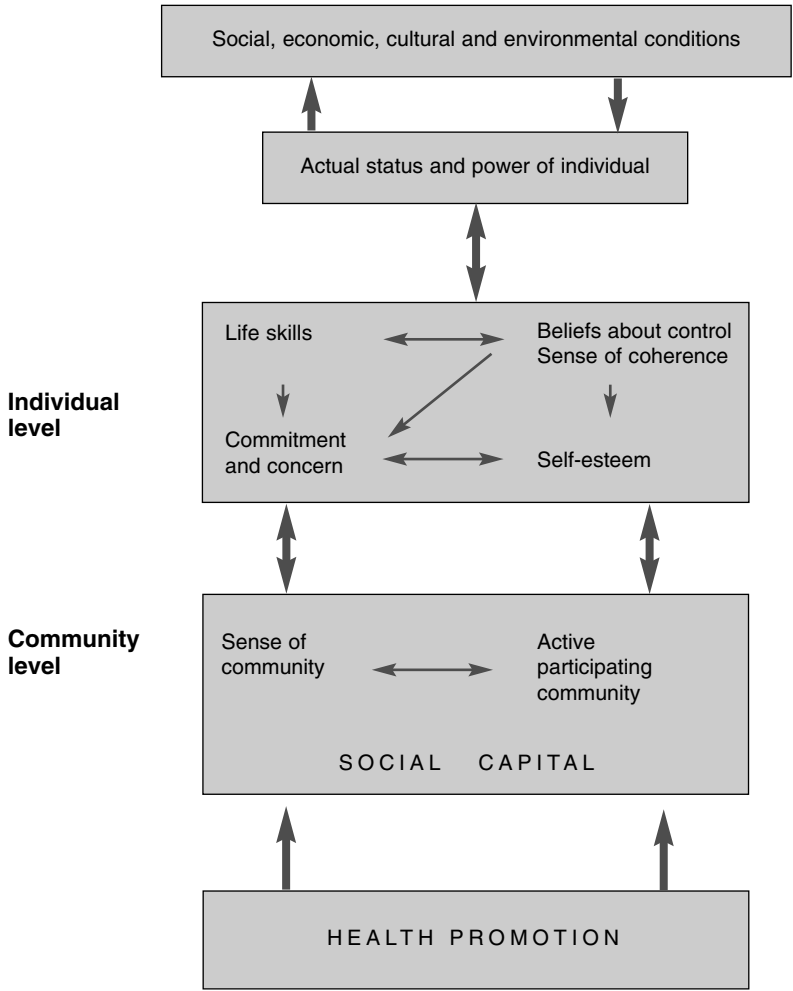


Figure 1.1 The reciprocal influence of empowerment and the environment

creation of healthy public policy is the prerequisite for changing adverse environments in order to facilitate the achievement of health. Empowerment best describes how the barriers to implementing healthy public policy might be overcome.

In short, two interrelated forms of empowerment ultimately contribute to the achievement of health status; these are individual empowerment and community empowerment. Community empowerment is most readily characterised by the terminology of the Ottawa Charter as an active participating

community. Individual empowerment, or self-empowerment, might be defined as follows:

Empowerment is a state in which an individual actually possesses a relatively high degree of power: that is having the resources which enable that individual to make genuinely free choices. Power cannot be absolute – and even if it could, it would be undesirable since it would militate against the right of other people to make choices. Indeed, one of the key features of empowerment is that system of checks and balances which safeguards the rights of others.

Individual empowerment is associated with certain beneficial psychological characteristics of which the most significant are: beliefs about personal control – including realistic causal attributions – together with a relatively high level of self esteem based on a realistic self concept; valuing other people and their rights to self determination; possession of a repertoire of health and life skills. (Tones, 1994: 169)

Figure 1.1 shows a reciprocal relationship between community empowerment and individual empowerment. This relationship is based on the premise that an active, participating community to some extent comprises the sum of empowered individuals within that community. Certainly, empowered individuals are needed to mobilise communities in their quest to challenge adverse circumstances. On the other hand, an empowered community will also generate norms and a social support system that will reinforce individual empowerment, and individuals within an empowered community are more likely to acquire the competencies and characteristics that lead to self-empowerment.

Figure 1.1 also shows two related features of empowered individuals and communities. The first of these is a *sense of community*, a state characterised by four key dimensions:

- membership – a feeling of belonging;
- shared emotional connection – the commitment and belief that members have shared and will share history, common places, time together, and similar experiences;
- influence – a sense of mattering;
- integration and fulfilment of needs – a feeling that members' needs will be met by the resources received through their membership in the group. (McMillan and Chavis, 1986: 9, cited from Tones, 1998b: 189)

We might note here that aspects of this sense of community and, indeed, the notion of an empowered community in general are closely related to the currently popular formulation of *social capital* (Putnam et al., 1993), a desirable state in its own right and a state that is considered to be health promoting and, at the same time, conducive to self-empowerment for its members.

In Figure 1.1, individual empowerment has been associated with *sense of coherence*. This term was coined by Antonovsky (1979: 123), who defines it as:

a global orientation that expresses the extent to which one has a pervasive, enduring though dynamic feeling of confidence that one's internal and external environments are predictable and that there is a high probability that things will work out as well as can reasonably be expected.

While both a sense of community and a sense of coherence are related to empowerment, it is important to strike a cautionary note. Antonovsky uses the term 'negentropic' when describing the results of a sense of coherence. In other words, a sense of coherence militates against the perception of life in general. A sense of coherence, on the other hand, creates the impression that life is comprehensible: the world is ordered, consistent, structured and clear, and the future predictable.

However, while an empowered individual or community is likely to hold such views, it is possible also to conceive of individuals and communities who are not empowered also holding such beliefs! It is possible, for example, for oppressed masses to believe that their dreadful circumstances are the will of God (who, of course, moves in mysterious ways but tends to offer the tantalising prospect of future rewards in some better place); to quote Voltaire's Doctor Pangloss, 'All is for the best in the best of possible worlds.' Marxists make a similar point in their reference to the concept of *false consciousness*. As we will note below, health promotion must be concerned with achieving social and political change; a sense of community and a sense of coherence must also be challenged where these are based on false consciousness.

The dynamics of self-empowerment

Figure 1.2 shows the relationship between some of the factors traditionally associated with the state of self-empowerment.

The reciprocal relationship between environment and individual is again prominently displayed. Beliefs about control are central to the empowered state, and the conviction that people are in charge of their destiny *in general* has been consistently associated with empowerment. This personality trait, associated with Rotter's (1966) well-known construct of *perceived locus of control* has been extensively researched and associated, with several beneficial health outcomes.

The concept of self-efficacy (Bandura, 1982) is, however, more useful in devising health promotion programmes for individuals. In short, apart from acquiring an appropriate knowledge and understanding of the implications of health actions and having a positive attitude to the relevant health-related behaviours, people must actually believe that they are capable of carrying out those health actions. The best way to influence self-efficacy beliefs is of course

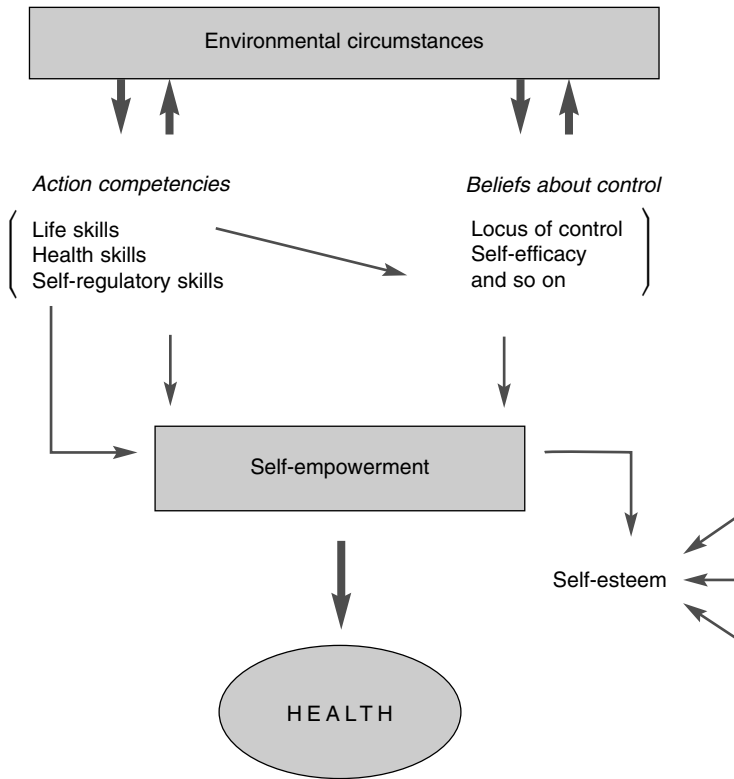


Figure 1.2 The dynamics of self-empowerment

to provide individuals with experience of success (the second-best procedure being to provide them with credible models who have already experienced success and with whom they can identify).

A prerequisite for success is the provision of training for the acquisition of essential skills, described here generically as *action competencies*. In Figure 1.2, action competencies are subdivided into three categories of skill. The first of these is labelled life skills and refers to general capabilities that can enhance people's success and survival in everyday living. Life skills typically include a number of key social interaction skills in addition to specific psychomotor skills that might be needed, for example, to adopt a safe and effective exercise regime. Some of the more frequently described life skills have to do with relaxation, time management and assertiveness.

The term 'health skill' has been employed where the skills are associated with achieving preventative outcomes. Self-regulatory skills, on the other hand, relate to the long-established tradition of behaviour modification. This has been increasingly exploited to help people to control difficult decisions and the nega-

tive effects resulting from them, typically the loss of gratification and gain in discomfort from quitting unhealthy practices such as smoking or excessive alcohol consumption.

The resulting mix of skills and beliefs contributes both to beliefs about being in control of life and health and, more importantly, to acquiring the actual power to influence one's environment. Moreover, through empowerment, the individual's self-esteem is likely to be enhanced. Apart from being an important mental health goal in its own right, a realistically based and relatively high level of self-esteem is associated with making healthy choices in general. Figure 1.2 reminds us that self-esteem is not only influenced by empowerment, but is affected by a number of other factors, such as feeling respected and loved by significant others.

An empowerment model of health promotion

Figure 1.3 seeks to encapsulate the key philosophical and strategic elements of the health promotion enterprise envisioned by the WHO and the author of this chapter. It is based on the interpretation of health promotion as a synergistic interaction of health education and healthy public policy. In addition to generally demonstrating the centrality of education, it shows the ways in which individual and community empowerment influences the social, economic and environmental determinants of health through healthy public policy.

The Ottawa Charter emphasised the importance of *lobbying, advocacy and mediation* in achieving healthy public policy. Lobbying is a well understood procedure and needs no further explanation here. Advocacy is the form of lobbying that occurs when relatively powerful individuals or agencies act to produce change on behalf of those lacking in such power, such as dispossessed communities or patients experiencing the often intimidating encounter with doctors.

The Ottawa Charter recognised that there was often, and perhaps inevitably, a conflict of interest between health promotion policies and other political imperatives concerned with, for example, fostering economic growth. Accordingly, mediation between conflicting interests was an important aspect of the process of policy development. The importance of intersectoral collaboration at the macro level is also acknowledged in Figure 1.3 by demonstrating the influence of 'coalitions' of the 'great and the good' and the powerful on the policy creation process.

Reference was made earlier to the need not only to reorient the health services to make them more accessible and user friendly but also to broaden the definition of the ways in which services other than medical services contribute to health. Accordingly, the health policy is necessary in order not only to reorient but also to reframe the perception of health services.

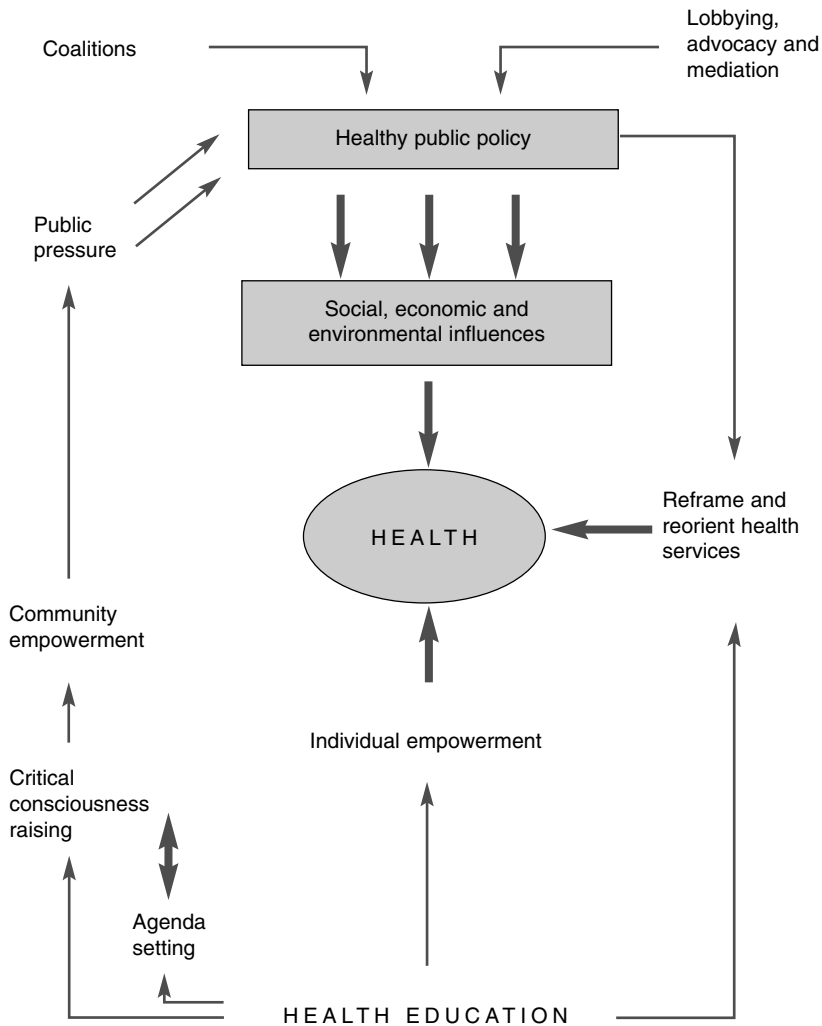


Figure 1.3 An empowerment model (adapted from Tones and Tilford, 2001)

The contribution of health education cannot be overestimated; it involves a focus on the individual, a focus on the community and a focus on the health services. The individual focus differs dramatically from health education’s traditional and often ‘victim-blaming’ stance. Instead of seeking to persuade people to adopt preventative behaviours and *comply* with the prescriptions of health professionals, the aim is to empower by strengthening individual capabilities, as detailed above, and facilitating choice of action.

Health education still has a part to play in working with health services, but rather than persuading individuals to make appropriate use of those health services, it instead seeks to alert decision makers to the health promotion role of the services they manage. Again, health promotion specialists might be expected to provide training and resources to assist with tasks associated with that role.

Most importantly of all, however, health education has a critically important and radical function that can be encapsulated in the notion of community empowerment. At one level, it is charged with agenda setting. This is defined here as a process that alerts the public to important but politically sensitive health issues such as the fluoridation of water supplies. Its purpose is primarily to create a climate of opinion that will enable government, for example, to institute and claim the credit for change without risking electoral unpopularity.

Much more difficult to tackle are those fundamental health issues such as poverty and disadvantage which governments and other agencies are unwilling to address, either because of ideological conviction or, again, through fear of courting electoral disaster. Accordingly, the strategy of critical consciousness raising is needed to generate public indignation and concern about health in order to generate a pressure for change, or preferably public outcry, that those in authority cannot resist.

Settings and strategies

A discussion of the settings and contexts of health promotion is beyond the scope of this chapter and will receive further attention in the rest of this book. We will merely note here that the settings approach developed by the WHO differs in certain important respects from earlier conceptualisations, especially the view that schools or the workplace, for example, provide an ideal opportunity for delivering health education to an often captive population.

In short, the current view is that a genuine settings approach does not involve the mere delivery of health education but instead adopts an ecological approach in which the whole environment and ethos of a particular setting is geared to promoting health in a coherent and integrated fashion. Furthermore, a health-promoting setting should relate in a collaborative manner to the community in which it is situated.

The empowerment initiative is, of course, central to the settings approach and various specific empowering strategies might well be used within different contexts. Three of these will now be briefly summarised below:

- *Media advocacy.* The most important role for the mass media is in the support of interpersonal initiatives and, above all, in raising critical consciousness about health issues generally, a process now typically described as media advocacy. For a more complete discussion of this, see Tones (1996a) and Chapman and Lupton (1994).

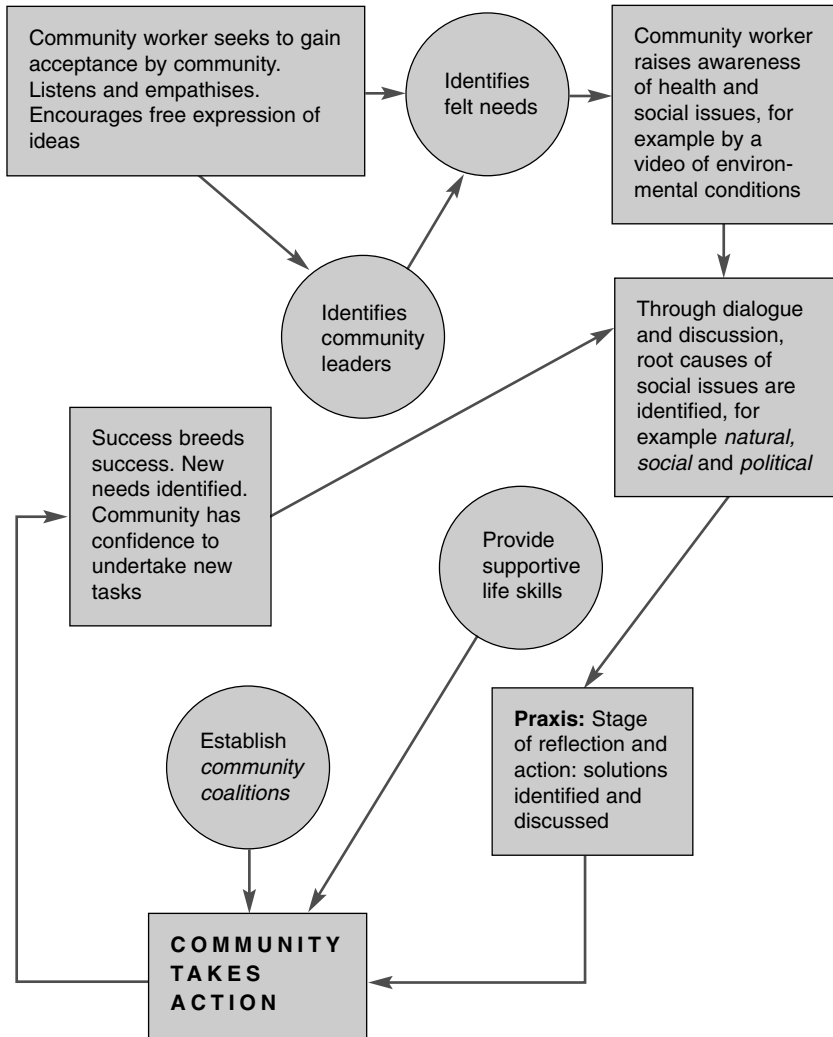


Figure 1.4 Praxis and community action

- *Community development and critical consciousness raising.* Figure 1.4 summarises the key processes involved in a community empowerment approach operating within a community development context.

Figure 1.4 (Tones, 1996b) incorporates Freire’s (1972) recommendations on what is sometimes called emancipatory education. This is a dialectical process that involves critical consciousness raising, subsequently leading to praxis, that is, the translation of critical thinking about social issues into action. Freirean dialectics are, however, supplemented by the

provision of supportive life skills, and community coalitions are established to provide support from people and agencies that exercise power in the given setting. The empowering role of the community worker/health promoter is consistent with community development practice.

- *The empowering face-to-face encounter.* Table 1.1 provides an analysis of an empowering encounter. The one-to-one encounter clearly involves two people. Only the task of the health professional is shown; the task of the client has been omitted for the sake of simplicity.

Table 1.1 is intended to remind us that face-to-face work is the most common health promotion situation and is to be found in virtually every setting. It seeks to demonstrate that empowerment strategies at the micro level should be embedded into these encounters. Empowerment is not just an ideological commitment: it is a technology that should be incorporated into all health promotion in an appropriate but seamless fashion.

Table 1.1 The role of the health professional in an empowering encounter

Communication

Check felt needs/need for information
 Establish rapport using counselling skills: active listening and so on
 Take account of non-verbal messages
 Check for understanding
 Check intelligibility of any written information provided
 Take steps to maximise recall and provide aide-memoire if necessary

Motivation: facilitating decision making

Explore existing beliefs, attitudes and skills; seek to modify beliefs, especially beliefs about control. Explore attitudes and underlying values
 Provide information; provide skills: decision making, psychomotor, social and life skills
 Check learning and recall
 Analyse environmental circumstances
 Negotiate and agree 'contract'

Provide support

Provide opportunity for acquiring supportive knowledge and social and self-regulatory skills
 Help mobilise social and environmental support
 Act as advocate for social and environmental change
 Check client's progress

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