Exploring health promotion and health education in nursing

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Abstract

The term health promotion has been used in healthcare for several years. However, the meaning of this term is debated, particularly in nursing. Some nurses might believe that, because they are healthcare practitioners working in healthcare services, that they are ‘by default’ automatically involved in health promotion activities; however, this is often not the case. Instead, they are more likely to be engaging in health education activities; that is, simply providing individuals with health-related information, rather than seeking to empower individuals, families, groups and communities. While health education is related to health promotion, these terms are not interchangeable, since health education is a component of health promotion. This article clarifies these concepts and describes approaches to illness prevention and promoting well-being that nurses can use in their practice with patients across the lifespan.

Aims and intended learning outcomes

The aim of this article is to explore the concepts of health promotion and health education in relation to nursing practice. After reading this article and completing the time out activities you should be able to:

» Define health promotion and health education and explain the differences between the two concepts.
» Understand the core strategy areas of the Ottawa Charter for Health Promotion (World Health Organization (WHO) 1986) and how these relate to nursing practice.
» Outline the activities that nurses can undertake as part of health promotion and health education.
» Explain the lifespan and settings-based approach to health promotion and health education.

Introduction

The concepts of health promotion and health education are complex and ever-evolving (Laverack 2017). While they complement each other and are interrelated, there are differences between them. Nurses can be involved in both of these areas, although they are more likely to undertake health education activities than health promotion activities. This article clarifies the meaning of each concept and suggests examples of their role, use and context across a person’s lifespan and in various settings.

Defining health promotion and health education

Several authors have attempted to define health promotion and health education using various approaches such as concept analysis, discourse analysis and the Delphi technique (King 1994, Maben and Clark 1995, Whitehead 2004, 2008, 2011a, Perry et al 2017). However, there remains no universal consensus among healthcare practitioners and educators as to the specific meanings, similarities and differences between the concepts. Whitehead (2004) stated that health education is: ‘An activity that seeks to...
inform the individual on the nature and causes of health/illness and that individual’s personal level of risk associated with their lifestyle-related behaviour. Health education seeks to motivate the individual into a process of behavioural-change through directly influencing their value, belief and attitude systems, where it is deemed that the individual is particularly at risk or has been affected by illness/disease or disability already.’

In contrast, Whitehead (2004) explained health promotion as: ‘The process by which the ecologically-driven socio-political-economic determinants of health are addressed as they impact on individuals and the communities within which they interact. This serves to counter social inaction and social division/inequality. It is an inherently political process that draws on health policy as a basis for social action that leads to community coalitions through shared radical consciousness. Health promotion looks to develop and reform social structures through developing participation between representative stakeholders in different sectors and agencies.’

From these definitions, it can be identified that health education may be, and often is, a component of wider health promotion approaches, but that health promotion cannot be a component of health education. Thus, health promotion places increasing focus on the political and health policy drivers that dictate national health agendas and strategies, which, subsequently, target large sections of the population to enact and evaluate them, primarily at the community level (Whitehead 2011a). For example, Public Health England (PHE) (2018) state that one of their main responsibilities is ‘making the public healthier and reducing differences between the health of different groups by promoting healthier lifestyles, advising government and supporting action by local government, the NHS and the public’. Health promotion is linked to various concepts, including: population health; public health; primary health care; community health; and community development and empowerment.

Health education can be limited to biomedical and authoritarian approaches, because traditionally, healthcare has been dominated by the medical professions. However, it can also be wider, for example community-based professional or peer support groups, such as drug and alcohol counselling and support programmes, which are intended to be long-term and well-resourced rather than short-term ‘curative’ information-giving interventions.

The term ‘radical health promotion’ relates to empowering and collective forms of health promotion, health education and support that acknowledge the social context in which these activities are undertaken (Tones 2002). This is illustrated by Beattie’s (1991) model of health promotion, which classifies interventions according to their mode (authoritative or negotiated) and the focus (individual or collective), as shown in Figure 1. It could be suggested that the health education component of health promotion is represented on the left-hand side of this model, while health promotion, more broadly, is represented on the right-hand side. Figure 1 also shows examples of health promotion and health education activities.

**Figure 1. Beattie’s (1991) model of health promotion**

![Beattie's (1991) model of health promotion](image)

Parish (1995) suggested that before the late 1970s, the term health promotion was virtually unheard of, perhaps since the universal approach to healthcare previously was based on the biomedical model of disease treatment and/or the didactic approach of telling people what to do to change their ‘unhealthy’ lifestyle. Today, the widespread use of the term health promotion indicates that maintaining health and well-being is generally accepted to be a broader construct than the biomedical and didactic approaches suggest.

To compound the confusion regarding the concepts of health promotion and health education, a large body of nursing-related literature, especially from the US and Asia, refers to ‘behavioural...
health promotion’ (Whitehead 2011a). However, the term behavioural implies lifestyle change strategies that are more commonly associated with traditional health education approaches – underpinned by seminal social learning theory and social cognitive theory models, such as Becker’s (1974) health belief model, Ajzen and Fishbein’s (1980) theories of reasoned action and planned behaviour, Prochaska and DiClemente’s (1984) transtheoretical (stages of change) model and Tones’ (1987) health action model. Pender et al’s (2006) model is the most widely known nursing-related example of this type of model. Broadly, these models identify common principles related to an individual’s internal and external motivations and their capacity to change their health-related behaviour, as well as barriers to and enablers of change related to concepts such as self-efficacy (Whitehead 2001a, 2001b).

Ottawa Charter for Health Promotion

The Ottawa Charter for Health Promotion (WHO 1986) remains the most influential global movement and strategy for defining and refining health promotion reform. It was borne out of a recognition that most ill-health, disease and disability is ‘socially-constructed’ and is often outside of the control of individuals. This includes what are known as the ‘social determinants of health’, which include:

- Socio-economic status.
- Education.
- Food production.
- Housing.
- Living and working conditions.
- Public safety.
- Public services, for example sanitation and water.
- Public transport.
- Social welfare.

Access to healthcare services is also considered a social determinant of health and is often related to the availability of healthcare services and barriers and enablers to patients accessing them; for example, if people live in rural and remote areas with a lack of services. This also includes the quality of the services available to individuals.

Porter (2006) stated that the Ottawa Charter: ‘...steered health promotion away from dominant health education models of individual behaviour change towards a “socio-ecological” version of health promotion that addresses structural determinants of health. It (re)defined the assumptions of and widely expanded the scope and goals of health promotion practice. It played a central role in constructing a new health promotion discourse, one encompassing socio-economic contexts, going beyond individual lifestyle to wellbeing and embracing community empowerment and participation.’

The five core strategy areas of the Ottawa Charter are (WHO 1986):

- Building healthy public policy.
- Creating supportive environments.
- Strengthening community actions.
- Reorienting healthcare services.
- Developing personal skills.

In practice, most nurses are often not actively involved in the first three strategy areas, unless they are truly community-based and/or they represent their communities on a voluntary basis. However, there are exceptions and most nurses will know and understand the type of health promotion programmes in which they are involved. For nurses who are based in acute hospitals or clinics, opportunities for them to engage in health promotion probably relate to the areas of reorienting healthcare services and developing personal skills.

Reorienting healthcare services

Reorienting healthcare services was envisioned in the Ottawa Charter (WHO 1986) as a move away from healthcare services that were governed and funded by reactive, treatment-based, and biomedically-driven healthcare service agendas. The intention was for healthcare services to be redirected away from ‘traditional’ acute services towards an increasing focus on community-based services – particularly from a primary care and public health perspective (Whitehead and Irvine 2011). The transition was designed to enable healthcare services to evolve from a biomedical model of health towards a socio-ecological model, driven by social determinants of health. A commonly used term to describe this change in direction is ‘refocusing upstream’.

Healthcare services remain reliant on acute services and, subsequently, it has been suggested that much nursing practice remains biomedically driven (Roden and Jarvis 2014). However, healthcare as a discipline has generally become increasingly open to the principles and practices of illness prevention and public health. Where possible, an increasing number of hospital-based services are being relocated to community settings and more outreach programmes are now available than in the past. An increasing number of nurses practise in the community, although these settings may still have a focus on acute care, such as GP clinics. There is also a wider variety of roles in the community than previously, for example health visitors, community...
nurses, public health nurses and primary care nurses. Furthermore, advanced nurse practitioner roles have been designed to work seamlessly between hospitals and the community, especially in rural areas. In some areas, drop-in nurse-led community clinics have been effective, because they are usually located in areas of high need, are user-friendly and are not reliant on medical referrals (Newhouse et al 2011).

**TIME OUT 2**

Philip is a 58-year-old man who has experienced a myocardial infarction. He was treated in the emergency department, cared for in a critical care unit, and was discharged home after four days in hospital. He and his family have experienced significant stress resulting from this event. Health education might be offered now, for example information on lifestyle changes he could make to improve his cardiac health. What factors might influence how effective health education activities are? What follow-up care and ongoing support could be offered to Philip and his family to promote his health, for example a cardiovascular rehabilitation programme that includes biopsychosocial management strategies. You may wish to discuss this with a colleague.

### Developing personal skills

Developing personal skills is the area of the Ottawa Charter (WHO 1986) with which most nurses are likely to be engaged (Whitehead and Irvine 2011). Through educating and instructing patients and their families or carers, it is hoped that they will learn and develop skills to self-manage and/or improve their health. For example, this could involve teaching a patient who has been newly diagnosed with diabetes mellitus how to inject insulin. However, such specific treatment-based skills were not the intention of the Ottawa Charter. Instead, the intention was to develop individual empowerment strategies that aided improved management of long-term conditions by patients and their families or carers, for example self-care in relation to long-term conditions such as diabetes.

In between biomedical models of health and socio-economic models of health are chronic models of health and management. The aim of chronic models of health and management is for individuals with long-term conditions and their families and/or carers to receive the required education and resources to self-manage their condition as best they can in their home and community setting (Stellefson et al 2013). Thus, this type of approach is in line with the ‘developing personal skills’ strategy area of the Ottawa Charter (WHO 1986).

### Health education

There are various forms of health education, with varying levels of effectiveness. Examples could include: teaching patients specific treatment-based skills, for example inhaler techniques for patients with asthma; discussing the importance of monitoring blood glucose levels with patients who have diabetes; and delivering support sessions for low-income groups on healthy nutrition. It should be noted that simply providing a patient with health-related information is not the same as health education, because health education should ideally involve long-term, well-resourced, carefully planned and evaluated programmes. However, encounters with patients and their families and/or carers are often short-term, reactive and opportunistic and, therefore, work counter to effective health education processes.

Whitehead and Russell (2004) identified a variety of strategies to ensure health education programmes are likely to result in positive outcomes such as realistic goal-setting, negotiating goals and follow-up evaluation of progress. These strategies include ensuring that health education programmes are: systematically planned and evaluated using structured theories and models for guidance; based on realistic goals and outcomes; and not confined to singular processes of information-giving and behavioural-change activities. Health communication

### Health communication

Health communication is one fast-emerging approach to health promotion and health education. Health communication is an approach that encompasses both the dissemination of health information and health literacy (the ability of individuals to understand healthcare information so that they can make appropriate health-related decisions) (Health Literacy Centre Europe 2015). One form of health communication is health promotion campaigns, which are often championed by government health departments, national charities and support groups, and aim to improve health literacy (Freeman et al 2015). One example of such a campaign is Sport England’s ‘This Girl Can’ campaign (www.thisgirllcan.co.uk), which aims to encourage women and girls to participate in sporting activities. Improving health literacy is at the forefront of healthcare professional agendas and in the nursing literature in terms of expanding the provision of health education to patients and families (Hughes 2016). For example, there is increasing focus on providing health education to individuals and groups with low education levels or from people from various cultural backgrounds.

### Lifespan and settings-based approach to health promotion and health education

Health promotion takes place in various ‘settings’ – the environments where people learn, work, play and love (Hesman 2007). In addition, these settings sit and vary across the individual’s lifespan. Whitehead (2011b) proposed a health promotion lifespan and settings-based approach aimed at nurses, which seeks to capture the common health promotion and health education journeys (continuums) that people encounter throughout their lives (Figure 2). It begins with preconception health (a woman’s health before she becomes pregnant) and continues through to end of life considerations. Identifying and linking these continuums acknowledges that various settings overlap in individuals’ lives. For example, a person who has experienced effective health promotion at school is likely to expand on what they have learned at university or in the workplace. This type of lifespan approach is in accordance with PHE’s (2016).
emphasis on the importance of using ‘a life course approach, promoting a holistic view of an individual’s total health and wellbeing needs at every stage of life’.

TIME OUT 3
Looking at the lifespan and settings continuums in Figure 2, where do most healthcare professionals practise? Are some points on the continuums more important than others in terms of illness prevention, health promotion and health education programmes, and if so, why?

The ‘health-promoting hospitals’ movement – in which hospitals enact policy related to a healthier workforce and healthier services for patients, for example non-smoking organisations – is established in the literature (Whitehead 2005). However, it does not sit in any particular place on the lifespan and settings continuums, because people may attend these hospitals throughout their lives, at different points in their lives, or not at all. Health-promoting hospitals are considered to be central to the ‘reorienting healthcare services’ strategy area of the Ottawa Charter (WHO 1986), whereby healthcare services are primarily redirected towards priorities based on preventative social determinants of health, rather than the biomedical model.

TIME OUT 4
Are there certain points or settings on the lifespan and settings continuums in Figure 2 where you think individuals might be increasingly vulnerable to mental health issues, such as older people or low socio-economic communities? What could you do to improve mental health promotion among these individuals or communities?

Expanding health promotion and health education across healthcare
In addition to the lifespan and settings-based approach, health promotion and health education in different fields of healthcare should be considered. For example, take the case of mental health promotion. Mental health issues are prevalent throughout society and in communities, and their incidence is increasing internationally (Kobau et al 2011). Mental health issues can affect any person at any time along the lifespan and settings continuums, for example children might experience bullying at school and long-term consequences into adulthood, such as depression, while adults might experience bullying in the workplace (Dresler-Hawke and Whitehead 2009, Castronovo et al 2016).

Some individuals are particularly vulnerable to mental health issues, such as those with a low socio-economic status. They are increasingly likely to encounter stigma and discrimination, for example as a result of unemployment, and are increasingly likely to experience accidents and violence (Whitehead 2017). Programmes such as the eMenthe Project (Doyle et al 2018) demonstrate the advantages of moving away from biomedical approaches towards mental health promotion initiatives based on developing resilience through a wellness paradigm, which focuses on empowerment, wellness and well-being – rather than illness, disease or disability. Such advantages include increased community integration and self-management.

Many healthcare practitioners, including nurses, have been critical of the limited role of their profession in health promotion. This is primarily because of workload constraints, inadequate education or training in health promotion, and a traditional focus on biomedical models of health and disease treatment (Whitehead 2011a, Aldossary et al 2013, Brobeck et al 2013, Kemppainen et al 2013, Maijala et al 2016, Roden et al 2016, Lundberg et al 2017). It is important that health education extends beyond merely health ‘information-giving’, while health promotion should seek to empower individuals, families, groups and

Figure 2. Examples of lifespan and settings continuums

(Adapted from Whitehead 2018b)
It is essential nurses understand the concepts of health promotion and health education, including their role, use and context across a person’s lifespan and in various settings. Importantly, it may not be whether nurses deliver health education or health promotion, but how effectively they deliver them and how much patients, families and/or carers, and communities benefit from such activities. From this perspective, nurses can be actively involved in team-working, networking, implementing and evaluating effective health education and health promotion reforms and processes, in all settings and across the lifespan continuum. This strengthens the nursing profession both in collaborating with relevant allied healthcare professionals, and in providing effective care for their patients and communities.

**References**


Health promotion and health education

TEST YOUR KNOWLEDGE BY COMPLETING THIS MULTIPLE-CHOICE QUIZ

1. Health education is:
   a) Broader than health promotion □
   b) A term that is interchangeable with health promotion □
   c) One component of health promotion □
   d) A term that should be used instead of health promotion □

2. Where are health promotion activities primarily undertaken?
   a) Community settings □
   b) Tertiary care services □
   c) On the internet and via social media □
   d) Clinical commissioning groups □

3. In Beattie’s (1991) model of health promotion, health persuasion activities are classified as:
   a) Authoritative and individual □
   b) Negotiated and individual □
   c) Authoritative and collective □
   d) Negotiated and collective □

4. What is one example of a health promotion activity related to legislative action?
   a) Tailored support, advice and action plans □
   b) Recommended alcohol consumption levels □
   c) Group fundraising to improve local support services □
   d) Food labelling □

5. Which of the following is not one of the core strategy areas of the Ottawa charter?
   a) Building healthy public policy □
   b) Creating supportive environments □
   c) Increasing investment in medicines optimisation strategies □
   d) Strengthening community actions □

6. Which of these is a social determinant of health?
   a) Education □
   b) Housing □
   c) Living and working conditions □
   d) All of the above □

7. Reorienting healthcare services involves:
   a) Teaching patients new skills to self-manage and/or improve their health □
   b) Redirecting services away from ‘traditional’ acute services based on a biomedical model of health towards an increasing focus on community-based services based on a socio-ecological model of health □
   c) Identifying obstacles to the adoption of health promotion policies in non-health sectors and developing ways to overcome these obstacles □
   d) Protecting natural and built environments, and conserving natural resources □

8. Which statement is true?
   a) Health education must be short term, reactive and opportunistic to be effective □
   b) Health education should ideally involve long-term, well-resourced, carefully planned and evaluated programmes □
   c) Health education should be confined to singular processes of information-giving and behavioural-change activities □
   d) Health education must be undertaken in accordance with the biomedical model and didactic approach □

9. The lifespan and settings-based approach to health promotion and health education:
   a) Focuses on developing resilience through a wellness paradigm, which focuses on empowerment, wellness and well-being □
   b) Considers health promotion and health education in different fields of healthcare, for example mental health promotion □
   c) Aims to capture the common health promotion and health education journeys (continuums) that people encounter throughout their lives □
   d) Identifies common principles related to an individual’s internal and external motivations and their capacity to change their health-related behaviour □

10. Why might some nurses have a limited role in health promotion?
    a) Workload constraints □
    b) Inadequate education or training in health promotion □
    c) The traditional focus on biomedical models of health and disease treatment in healthcare □
    d) All of the above □

This activity has taken me ____ minutes/hours to complete. Now that I have read this article and completed this assessment, I think my knowledge is:

Excellent □
Good □
Satisfactory □
Unsatisfactory □
Poor □

As a result of this I intend to: ____________________________