© Jones & Bartlett Learning LLC, an Ascend Learning Company. NOT FOR SALE OR DISTRIBUTION.

Chapter 2

The History of Health Promotion

Bonnie Raingruber

Chapter Objectives

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

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

INTRODUCTION

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

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

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

© Jones & Bartlett Learning LLC, an Ascend Learning Company. NOT FOR SALE OR DISTRIBUTION.

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

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

GREEK ANTIQUITY

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

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

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

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

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

© Jones & Bartlett Learning LLC, an Ascend Learning Company. NOT FOR SALE OR DISTRIBUTION.

THE ROMAN EMPIRE

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

THE MEDIEVAL PANDEMICS

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

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

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

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

The World Health Organization (1948–Present)

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

© Jones & Bartlett Learning LLC, an Ascend Learning Company. NOT FOR SALE OR DISTRIBUTION.

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

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

© chelovek/iStock/Getty Images

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

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

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

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

© Jones & Bartlett Learning LLC, an Ascend Learning Company. NOT FOR SALE OR DISTRIBUTION.

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

The Lalonde Report (1974)

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

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

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

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

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

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

© Jones & Bartlett Learning LLC, an Ascend Learning Company. NOT FOR SALE OR DISTRIBUTION.

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

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

Healthy People (1979–2020)

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

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

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

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

© Jones & Bartlett Learning LLC, an Ascend Learning Company. NOT FOR SALE OR DISTRIBUTION.

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

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

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

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

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

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

© Jones & Bartlett Learning LLC, an Ascend Learning Company. NOT FOR SALE OR DISTRIBUTION.

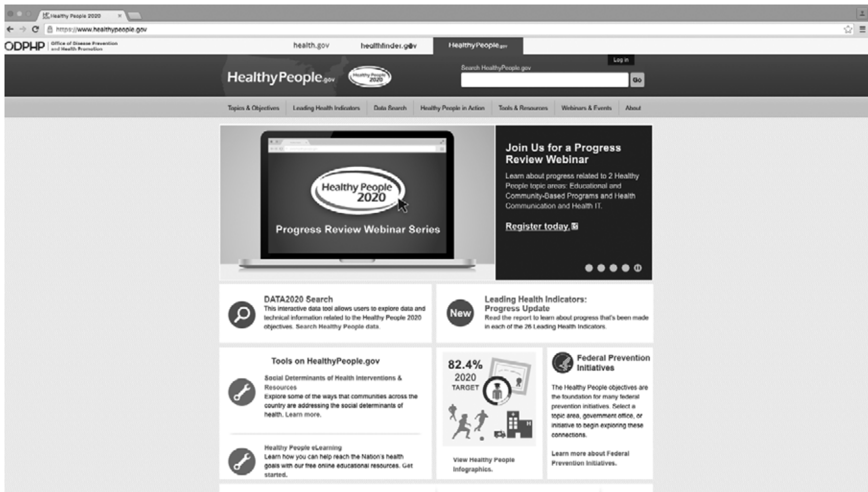
An external advisory committee of 13 public health and healthcare delivery experts provided input regarding the Healthy People 2020 goals. In addition, a public comment website was established for input from the public. Determinants of health that are addressed in Healthy People 2020 include: (1) social,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

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

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

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

© Jones & Bartlett Learning LLC, an Ascend Learning Company. NOT FOR SALE OR DISTRIBUTION.



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

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

Achieving Health for All: The Epp Report (1986)

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

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

© Jones & Bartlett Learning LLC, an Ascend Learning Company. NOT FOR SALE OR DISTRIBUTION.

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

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

WHO: Ottawa Charter for Health Promotion (1986)

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

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

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

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

© Jones & Bartlett Learning LLC, an Ascend Learning Company. NOT FOR SALE OR DISTRIBUTION.

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

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

WHO: Adelaide Recommendations on Healthy Public Policy (1988)

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

The New Public Health Movement (1980s)

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

© Jones & Bartlett Learning LLC, an Ascend Learning Company. NOT FOR SALE OR DISTRIBUTION.

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

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

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

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

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

© BraunS/Getty Images

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

© Jones & Bartlett Learning LLC, an Ascend Learning Company. NOT FOR SALE OR DISTRIBUTION.

WHO: Jakarta Declaration on Leading Health Promotion into the 21st Century (1997)

The Fourth International conference on health promotion was held in July 1997 in Jakarta, Indonesia. It was the first WHO conference to be held in a developing country and the first to involve the private sector. The Jakarta Declaration, which derived from that conference, emphasized that poverty is the greatest threat to health, while summarizing that peace, shelter, education, social relations, food, income, the empowerment of women, a stable ecosystem, sustainable resources, social justice, respect for human rights, and equity are requirements for health (WHO, 2010b).

The conference presenters highlighted the fact that transnational factors such as the global economy, financial markets, ease of access to communication technology, environmental degradation, and irresponsible use of resources also have a significant impact on health. A call for action to establish a global health promotion alliance was issued. Goals for that alliance were to: (1) raise awareness of changing determinants of health, (2) support collaborations dedicated to health promotion, (3) mobilize resources for health promotion, (4) accumulate best practice knowledge, (5) enable shared learning, (6) promote solidarity in action, and (7) foster transparency and public accountability in health promotion (WHO, 2010b).

WHO: Bangkok Charter for Health Promotion (2005)

In 2005, the WHO issued the Bangkok Charter, which built on the Ottawa Charter by adding a focus on coherence of health policy and a commitment to partnership within and between governments, international organizations, and the private sector. The Bangkok Charter encouraged people to "advocate for health based on human rights, invest in sustainable policies, actions, and infrastructure to address the determinants of health, target knowledge transfer and research, and address health literacy" (Howard, Nieuwenhuijsen, & Saleeby, 2008, p. 943). It advocated for equal opportunity for the health and well-being for all people. Health was now seen as a critical part of foreign policy, national security, trade, and geopolitics.

Documents that Impacted Public Health and Health Promotion Practice in the United States

Many of the documents we have discussed so far were global in their reach, but it is equally important to become familiar with historical documents within the United States that have shaped public health and health promotion practice. In 1850, Lemuel Shattuck, the first president of the American Statistical Society and a member of the Massachusetts legislature, published "Report of a General Plan for the Promotion of Public and Person Health," which later became known as the Shattuck Report. The report reviewed mortality data and documented survival rates based on age and social class in Massachusetts. Dramatic differences by social class were used to support the conclusion that health status could be modified. The Shattuck Report included

© Jones & Bartlett Learning LLC, an Ascend Learning Company. NOT FOR SALE OR DISTRIBUTION.

50 recommendations addressing, among others, the organization of local health boards, town planning, and the need for national health education. Nineteen years after the release of this report the Massachusetts legislature enacted a law based on the recommendations of the Shattuck Report that became a pattern for public health legislation across the United States (Winkelstein, 2009).

By 1932, the Committee on the Costs of Medical Care had been created. This committee commissioned a survey of health status and medical care utilization of 8,000 families nationwide who were followed for 12 months. The report of that study was titled "Medical Care for the American People". This report recommended that: (1) both preventive and medical care be provided for all citizens, (2) public health services be available to everyone based on need, (3) taxation and insurance should be used to ensure that medical care is based on group rates for all, (4) each state and local community health agency should evaluate their services, and (5) professional education of healthcare workers should include content on prevention and the social factors that influence health. The report was considered radical at the time: *The New York Times* claimed that it called for socialized medicine and the American Medical Association referred to it as incitement to revolution. This report served as the basis for President Franklin Roosevelt's failed attempt at passage of national health insurance (Winkelstein, 2009). Are any of these issues still being debated today in the United States?

In 1959, the U.S. Surgeon General wrote in the *Journal of the American Medical Association* that the weight of evidence implicated smoking as being the principal factor influencing the incidence of lung cancer. Following that commentary, presidents of the American Cancer Society, the American Public Health Association, the American Heart Association, and the National Tuberculosis Association contacted then-President Kennedy asking that a presidential commission be established to study smoking and health. A blue ribbon advisory committee was appointed. They issued a report that addressed biological effects of tobacco, epidemiological patterns, dose/response mortality ratios, and psychosocial implications associated with smoking. These documents had a major impact on tobacco-related advertising and taxation legislation while also serving as a model for future development of evidence-based health policy (Winkelstein, 2009).

SUMMARY OF HISTORICAL CHRONOLOGY

In the 1970s, the focus was on preventing disease and reducing risk behaviors through health education. Motivated by the Ottawa Charter, the 1980s saw increasing attention being given to the role of supportive environments, social influences, economic resources, health inequalities, and political action in creating health. During the 1990s, attention focused on the importance of setting and environment. Interventions within schools, workplaces, and community centers made it possible to reach large numbers of people and provide sustained interventions in a convenient location. Core values of the health promotion movement were identified as equity, participation, and empowerment (Eriksson & Lindstrom, 2008).

© Jones & Bartlett Learning LLC, an Ascend Learning Company. NOT FOR SALE OR DISTRIBUTION.

Specific capacity-building interventions focused on health-promoting hospitals, health-promoting universities, and health-promoting prisons (WHO, 1986). Health-promoting hospitals improve health by organizing rehabilitation efforts; empowering clients; encouraging links between community agencies, home health agencies, and hospital staff; and creating a healthy environment that supports a return to the highest level of functioning. An example of the latter is found in the adoption of smoke-free zones and healthy menus that support the health of both patients and staff.

Over the course of several decades, health promotion has shifted from the perspective that healthcare professionals need to educate individuals to a stance where involving people in decision making, program design, intervention, and evaluation is the priority. A 2007 synthesis of eight research reviews presented at the Bangkok WHO conference summarized that: (1) investing in public policy is key, (2) supportive environments are critical, (3) community-based action needs additional research, (4) personal skills development should be paired with other interventions, (5) multi-level interventions are most effective, and (6) collaborations and partnerships supported by political commitments, nongovernmental organizations, and local stakeholders are vital to the success of health promotion programs (Jackson, Perkins, Khandor, Cordwell, Hamann, & Buasi, 2007).

A 2008 summary of the literature (Howard, Nieuwenhuijsen, & Saleeby, 2008) suggested that three themes are found in published studies on health promotion. Those themes are: (1) that health promotion is a broad and complex concept, (2) that health promotion requires addressing environmental factors with particular attention being given to barriers that interfere with health promotion, and (3) that focusing on the concepts of social capital, social support, and networking improves health. Barriers are a major predictor of involvement in health promotion activities. Barriers can include concerns over transportation, family responsibilities, language and cultural differences, and scheduling (Howard, Nieuwenhuijsen, & Saleeby, 2008).

Social capital has been defined as "the features of social organization such as networks, norms, and trust that facilitate coordination and co-operation for mutual benefit" (Howard, Nieuwenhuijsen, & Saleeby, 2008, p. 944). Social capital includes peer support and professional support, as well as the input of family and friends.

SIX PHASES IN THE EVOLUTION OF PRIMARY CARE/PREVENTION

Awofeso (2004) suggested there have been six major historical approaches to providing primary health care. These approaches included attention to health protection, sanitary control, contagion control, prevention, primary health care, and health promotion. The health protection era, which continued until the 1830s, relied on religious and cultural rules, spiritual practices, community taboos, and quarantine of contagious individuals, including those with leprosy and Black Death.

The sanitary control era between 1840 and 1870 was ushered in following the Industrial Revolution, when filthy working conditions, unsafe water supplies, poor drainage

© Jones & Bartlett Learning LLC, an Ascend Learning Company. NOT FOR SALE OR DISTRIBUTION.

systems, and inadequate sewage disposal resulted in deaths. During this period, modern epidemiological methods were used to track disease outbreaks.

The contagion control era between the 1880s and 1930s followed Robert Koch's publication on germ theory. Attention was on infectious diseases like cholera, and vaccination and improved water filtration processes were used to improve health.

The preventative medicine era between 1940 and 1960 brought awareness of disease vectors, an understanding that some microbes are necessary for healthy bodily function, and knowledge that nutritional deficiencies, such as inadequate intake of iodine, influenced health. High-risk groups such as pregnant women, the elderly, and factory workers were often target groups during this period. Disease vectors such as mosquitoes were researched. Advances in clinical pathology were used to design interventions.

The primary healthcare era of 1970–1980 saw a focus on preventive health care; an emphasis on equity, community participation, and access to services; and an understanding of the social determinants of health. Links were forged between health care and socioeconomic development. Multicultural and participatory, community-based interventions were priorities.

The health promotion era that began in the 1990s brought attention to advocacy efforts with individuals and communities. Economic and political interventions were used to create supportive environments, strengthen community action, and develop personal skills (Awofeso, 2004).

MESSAGING TO ENGAGE THE PUBLIC IN HEALTH PROMOTION EFFORTS

In spite of multiple health promotion policies and programs that have been implemented, obesity rates are projected to increase by an additional 33% between 2015 and 2035. Today, more individuals are employed in sedentary jobs and spend their leisure time playing video games or watching television. New tobacco products such as e-cigarettes and hookahs are advertised widely. Public health professionals have stressed that health promotion messaging needs to make use of advertising strategies that are as sophisticated as those used to sell fast foods and e-cigarettes in order to counter the influence that commercials have on people's behavior (Royne & Levy, 2015).

From 1932 to 1957, weekly radio "lectures, monologues, round tables, question and answer sessions, and dramas were all used by health departments to communicate ideas and knowledge about preserving health" (Mooney, 2015, p. 1317). Health dramas featured interesting characters such as a respected physician who broadcast from the imaginary town of Utopia. Radio carried the power and drama of the human voice into the privacy of the home, using an entertainment format to provide education about preventing conditions such as tuberculosis or syphilis; promoting diphtheria immunization; and preserving health. The popularity of the characters in these weekly dramas captured peoples' imagination in an era before television was prevalent, even when liberties were taken in terms of the historical or scientific accuracy of the messaging (Mooney, 2015).

In recent years, health promotion experts have stressed that the use of narratives, personal stories, and testimonials aired on television are an effective way to persuade

© Jones & Bartlett Learning LLC, an Ascend Learning Company. NOT FOR SALE OR DISTRIBUTION.

the public to engage in healthy lifestyles. Narratives invite the public "into story actions and immerse them in real or plausible life experiences" (Shen, Sheer, & Li, 2015, p. 105). Affective engagement reduces the viewer's motivation to disagree with the health message presented in the narrative. These stories have been used to illustrate the danger of tanning beds and encourage vaccination against the human papillomavirus (HPV). Narratives have been determined via meta-analysis to be an effective way to present disease prevention and detection messages but have not been useful in decreasing addictive behaviors (Shen, Sheer, & Li, 2015).

THE ROLE OF NURSING LEADERS IN HEALTH PROMOTION

In addition to examining historical documents, conferences, and organizations, and considering messaging options, it is also important to focus specifically on the role of nursing in shaping health promotion practice. In 1862, when Florence Nightingale established a school to educate district nurses, a full year was devoted to promoting the health of communities. Self-care and an emphasis on active involvement in social and health reforms were included in the curriculum. Training addressed how to "depauperize" individuals in poverty by addressing their self-image and by becoming involved in social reform designed to minimize economic disparities. Nightingale argued that health dollars would be better spent maintaining health during infancy and childhood than by building hospitals. She was active in health promotion activities and policy development related to air pollution reduction in factories (Falk-Rafael, 1999).

In the early 20th century, Lillian Wald established the Henry Street Settlement. Nurses in the Henry Street Settlement were active in political lobbying to obtain health care for individuals living in poverty, establishing school nursing and rural nursing, and influencing the development of child labor laws. Wald supported the development of community coalitions to influence social and health policy. She felt nurses were in a pivotal position to link agencies and communities in an effort to support social betterment. Wald viewed nurses as the trusted partner of those in need and she saw nurses as being able to link community needs with resources in support of health (Falk-Rafael, 1999).

The Flexner report, distributed in 1910, promoted the adoption of a reductionist, biomedical, cause-oriented, disease-focused explanation of illness that moved away from a focus on the broad determinants of health. As a result, public health nursing came to be viewed as outdated and out of step with scientific advances. Public health nurses found themselves operating under new philosophies and policies controlled by bureaucracies that were themselves under medical control. A reduction in public health nursing services followed, and a narrow, medicalized definition of health promotion as being exclusively focused on primary prevention was adopted (Falk-Rafael, 1999). Public health nurses who had previously treated individuals recovering from heart disease, stroke, and other chronic conditions were no longer allocated time on their caseloads to work with these clients.

Mary Breckinridge created the Frontier Nursing service to provide health care and health promotion in rural Kentucky. As a child, she traveled to Russia when her father was

© Jones & Bartlett Learning LLC, an Ascend Learning Company. NOT FOR SALE OR DISTRIBUTION.

appointed minister there. During those years, she developed a sense of the challenges that come with poverty. As a young mother, she lost a daughter and son to illness, which motivated her lifelong interest in the health of mothers and children. Toward the end of World War I, she worked as a volunteer in France. Between nursing school and midwifery school, she spent a summer exploring the Appalachian Mountains on horseback to learn about rural Kentucky health needs. In 1925, she created a nurse-managed midwifery service in Kentucky that provided prenatal care, attendance at births, vaccines, and health promotion. She involved the community in designing the model of care, based her midwifery service, and kept detailed statistical records. Her program exemplified a community-based participatory intervention and became a model for health professionals around the world.

© Matt Beck/iStockphoto

In 1994 in Canada, a nursing union facing layoffs brought a lawsuit claiming that health promotion was exclusively nurses' work. The arbiter cited federal health policy documents to conclude that although nurses have always been involved in health promotion, current nursing practice did not support their claim that lesser skilled workers should not be assigned health promotion duties. Falk-Rafael (1999) emphasized that this decision, political pressures, global influences, and history itself provide evidence that it is critical for nurses to reclaim their health promotion legacy, become knowledgeable about all the factors that influence the field of health promotion, and educate the public about ways that nurses are involved in health promotion. Falk-Rafael argued that nurses must be attentive to whose voice is silent and whose voice is heard when health-policy decisions are being made and restrictions are created about which clients can be served and by whom. Nurses must understand external influences that are shaping the way that health promotion is being practiced within and beyond the nursing profession if they are going to retain health promotion as a dominant aspect of nursing practice. Otherwise, Falk-Rafael claims nurses who do not educate themselves and voice their opinions when political decisions are being made run the risk of seeing their practice confined by prevailing ideologies, administrative directions, economic cutbacks, and political pressures.

CRITIQUE AND PROMISE ASSOCIATED WITH NURSING'S ROLE IN HEALTH PROMOTION

Numerous authors have suggested that nurses should use the WHO's declarations along with input from professional and governmental organizations to guide their health promotion activities. However, research has shown most nurses are not familiar

© Jones & Bartlett Learning LLC, an Ascend Learning Company. NOT FOR SALE OR DISTRIBUTION.

with these health promotion documents and do not know how to apply them to their practice (Benson & Latter, 1998; Kemppainen, Tossavainen, & Turunen, 2012; Whitehead, 2011). Whitehead (2008), who has been active in the health promotion literature within nursing for over a decade, commented that nursing has continued to primarily rely on the traditional health education paradigm rather than the health promotion paradigm in guiding practice, research, and education. He cited the main reason for this being a lack of theoretical, educational, and conceptual clarity in the literature and within educational institutions. He also claimed that nurses continue to view health promotion as a single-discipline endeavor rather than view it as a multiagency intervention, a perspective consistent with current agendas (Whitehead, 2009).

Citing nursing's potential, Whitehead (2001) also argued that nursing is a sleeping giant, large enough to have a substantial impact on the health of people throughout the world if the profession adopts an active role in advocating for social change, returning to their humanistic roots, and promoting well-being. Nurses, because of their knowledge base, access to the community, sustained interaction with patients, experience working with underserved and vulnerable groups, and public trust/credibility, are well suited to become leaders in the new health promotion movement (Whitehead, 2009). In addition, nurses have traditionally maintained an egalitarian attitude toward patients and are skilled at engaging patients in self-care. Nurses often rely on their own rich life experience to motivate others and are traditionally perceived to be healthy role models (Kemppainen, Tossavainen, & Turunen, 2012).

Morgan and Marsh (1998) emphasize that the nursing process is based on a medical model that supports providing generic health education rather than offering individualized care that builds on patient perspectives and goals. They argue for expanding the scope of nursing practice, incorporating an appreciation of sociopolitical and cultural environments that impact health, focusing on building social capital, providing individualized care, and increasing health equity. Doucette (1989) declared that nurses must shift from their traditional roles and adopt a greater responsibility in a wider arena of action that supports healthy people and healthy environments. She commented that nursing needs to focus on community equity, participatory involvement, and empowerment.

Butterfield (1990) stated that nursing has to adopt an upstream view in which a nurse works to understand and modify contextual factors that lead to poor health if nurses are to become leaders in health promotion. Maglacas (1986) highlighted how important it is that nurses understand the agendas and priorities of key decision makers and become involved in public policy as it relates to health.

Northrup and Purkis (2001) suggested that if nurses are to sustain their claim to having a unique role in promoting health, the discipline must clearly articulate the philosophical and theoretical underpinnings of their health promotion practice. Berg and Sarvimaki (2003) agreed that there "is a need to clarify, refine and redefine health promotion in nursing because the concept is partly non-specific and has not been used to identify a specific nursing focus" (p. 384).

© Jones & Bartlett Learning LLC, an Ascend Learning Company. NOT FOR SALE OR DISTRIBUTION.

WHAT ARE THE NEXT STEPS FOR NURSING?

Falk-Rafael (1999) argued that nursing voices should not be invisible, absent, or silent within public and academic discourse about health promotion. She stressed that nurses should maintain strong community ties, challenge administrative constraints, reclaim their legacy in terms of health promotion, remain current regarding forces that are shaping health promotion, and educate the public and other disciplines about the contribution of nurses.

At present, the American Association of Colleges of Nursing and the National Organization of Nurse Practitioner faculty are part of the Healthy People Curriculum Task Force. The aim of this task force is to increase the proportion of schools of nursing, medicine, and health professional training that are teaching health promotion based on Healthy People goals (Jesse & Blue, 2004). There are many other examples of the active presence of nurses in shaping health policy and advocating for the needs of individuals with fewer economic and educational resources. The core values and vision for health promotion in the future includes a focus on health equity, social justice, empowerment, and participatory planning with the goal of helping everyone get more out of life (Terry, 2015).

WHAT WILL YOU DO?

The majority of this chapter has been devoted to describing documents and task forces that have had a major impact on health promotion practice. Consider how influential volunteering to belong to a committee, joining a task force, or authoring a report can be in shaping the nature of practice. Think about what it must have been like to attend and actively participate in one of the pivotal conferences that shaped the future of health promotion.

Discussion Questions

1. When you graduate, what do you hope to accomplish in your career that could help shape the nature of health promotion practice? List both a short-term goal and a long-term goal related to health promotion that you have for yourself and your career.
2. Think of a statement or perspective you have heard expressed in the media during a commercial or a news program. Did any of the documents discussed in this chapter (Healthy People, U.S. Surgeon General's Report on Tobacco, The Lalonde Report, The Ottawa Charter, etc.) strongly influence that statement or perspective you noticed in the media?
3. As you look to the future, what constraints do you see limiting health promotion practice? What resources will those engaged in health promotion be able to use to support their work?
4. What group or sector has the greatest responsibility for health promotion? Talk about the role of the healthcare sector, the nursing profession, the legislature, local governments, the federal government, the police, the military, local

© Jones & Bartlett Learning LLC, an Ascend Learning Company. NOT FOR SALE OR DISTRIBUTION.

communities, school personnel, volunteer organizations, the media, industry, and other influential groups.

5. Identify one intervention that has been implemented to improve the health of U.S. citizens within the last decade. At the time that intervention was implemented, which of the following groups had the most influence on its adoption: (A) an international body, (B) the U.S. government, (C) a professional organization, (D) a politician or political party, (E) a healthcare profession or group of healthcare professionals, (F) a community-based organization, (G) experts in public health, (H) the media, (I) nonprofit organizations, (J) private foundations that support health promotion, (K) citizen groups, (L) one committed citizen, or (M) industry/the business sector? If a coalition of interested partners helped implement your identified health promotion intervention, describe why a coalition was needed. Talk about what the vision was that motivated the individual or group, how the need for the project was assessed, and how progress was measured.

Check Your Understanding

Exercise 1

A list of activities designed to promote health follows. Please match the numbered items with the most appropriate entry on the alphabetized list of health promotion paradigms and documents. Select the health promotion document that first and most uniquely gave support to the given activity. For example, the Adelaide Recommendations (J) first introduced the concept of health literacy into the definition of health promotion, so the provision of language-specific educational handouts targeted to a person's reading level (4) would most appropriately be matched with this document, although the Bangkok Charter also later supported health literacy.

Activities Designed to Promote Health

1. Billboards about the risks of drunk driving
2. Taking a yoga class to increase one's level of wellness
3. Lettuce recalls associated with *E. coli* infection reported on the nightly news
4. Providing educational handouts in a person's primary language targeted to a person's reading level
5. Taxation on cigarettes, creation of smoke-free areas, and bans on tobacco advertising
6. Having 98% of at-risk individuals obtain H1N1 vaccines in the upcoming year
7. Attending a diabetic self-help group and learning about how to count "carbs"
8. Posting calorie counts and fat/salt/carbohydrate contents in restaurants
9. Limiting high sugar beverages in school vending machines
10. Scheduling regular mammograms

© Jones & Bartlett Learning LLC, an Ascend Learning Company. NOT FOR SALE OR DISTRIBUTION.

11. Fluoridation of municipal drinking water
12. Conflict resolution in Nigeria to promote peace
13. Having the wealthy contribute to the health care of the poor
14. Tailoring health information to cultural norms
15. Making food stamps available to low-income individuals
16. Using immunizations to protect against disease
17. Conducting a regular census to plan for health infrastructure needs
18. Supporting solar power and other interventions related to sustainable growth

Health Promotion Paradigms and Documents

A. Greek philosophy
B. Healthy People
C. Ottawa Charter
D. The Lalonde Report
E. The Bangkok Charter
F. The Alma-Ata Declaration
G. Chinese medicine
H. The Roman Empire
I. The Epp Report
J. The Adelaide Recommendations
K. The Sundsvall Statement
L. The Jakarta Declaration
M. The U.S. Surgeon General's Report on Tobacco

Exercise 2

Review the following quotations from healthcare professionals and match them with the document that comes from the historical period in which the comment would have been likely to have been accepted/expected.

Quotes about Health Promotion and Health

1. "Providing health care for everyone from taxpayer dollars is the first step toward socialism."
2. "If health promotion is supposed to be focused on disease prevention and you serve people who have already had a stroke, that doesn't make sense."
3. "We need to decrease HIV exposure by 20% in the next year."
4. "Childhood obesity is caused by lack of access to healthy foods, safe places to exercise, and constant promotional exposure to television ads about high-calorie food."
5. "We should focus on the causes of disease rather than a spectrum of health determinants if we are to be successful in increasing years of productive life."

© Jones & Bartlett Learning LLC, an Ascend Learning Company. NOT FOR SALE OR DISTRIBUTION.

6. "Young women must be able to walk to the market without being shot or blown up if we are going to achieve progress."
7. "Business leaders, governmental agencies, and communities must all work together to develop a coherent health policy and well-being for all."
8. "Women are the primary people who promote health. We need to ensure that women are equal partners who participate in developing health promotion policy."
9. "Poverty is the most immediate and critical threat to health."
10. "Indigenous people have a unique wisdom and spiritual understanding that must be accessed if we are to create environments that support health and sustainable development."
11. "Maintaining balance and harmony is essential for health."
12. "Not wearing seat belts accounts for the majority of highway deaths."

Historical Period Dominated by the Following Documents

A. Greek philosophy
B. Healthy People
C. Ottawa Charter
D. The Lalonde Report
E. The Bangkok Charter
F. The Alma-Ata Declaration
G. The Adelaide Recommendations
H. The Jakarta Declaration
I. The Sundsvall Statement
J. Medical Care for the American People
K. The Flexner Report
L. The Greeks

What Do You Think?

Review the priorities of each of the Healthy People initiatives (1979, 2000, 2010, and 2020). Which priority do you see as being most critical to health promotion in the United States within the next decade? Jot down your reasons and how you would make progress toward that goal using a health promotion perspective.

Review the priorities of the WHO conferences on health promotion. Which priority do you believe is the most relevant to U.S. health promotion policy? Which priority do you believe is most relevant to global health promotion? Provide a rationale for each of your answers.

What do you think the differences would have been in your role had you been working as a health promotion practitioner in ancient Greece as compared to that same role in 2010–2020 in the United States?

Do you think health promotion is best accomplished by a single discipline or multiple agencies and groups working together? Explain your answer.

© Jones & Bartlett Learning LLC, an Ascend Learning Company. NOT FOR SALE OR DISTRIBUTION.

What do you think would need to happen to shift the focus more toward prevention within the U.S. healthcare system?

Consider the impact that health dramas had during the era of radio. Would you have tuned in for the weekly broadcast? Which health promotion public service announcement currently airing on television do you believe is most effective? Discuss your rationale.

References

Awofeso, N. (2004). What's new about the new public health? *American Journal of Public Health, 94*(5), 705–709.

Benson, A., & Latter, S. (1998). Implementing health promoting nursing: The integration of interpersonal skills and health promotion. *Journal of Advanced Nursing*, 27, 100–107.

Berg, G. V., & Sarvimaki, A. (2003). A holistic-existential approach to health promotion. *Scandinavian Journal of Caring Sciences, 17,* 384–391.

Breslow, L. (1999). From disease prevention to health promotion. *JAMA, 281*(11), 1030–1033.

Brown, D. W. (2009). The dawn of Healthy People 2020: A brief look back at its beginnings. *Preventive Medicine, 48,* 94–95.

Butterfield, P. (1990). Thinking upstream: Nurturing a conceptual understanding of the societal context of health behavior. *Advances in Nursing Science, 12*(2), 1–8.

Corbin, J. H., & Mittelmark, M. B. (2008). Partnership lessons from the Global Programme for Health Promotion Effectiveness: A case study. *Health Promotion International, 23*(4), 365–371.

Doucette, S. (1989). The changing role of nurses and the perspective of the medical services branch. *Canadian Journal of Public Health, 80*(2), 92–94.

Epp, J. (1986) Achieving health for all: A framework for health promotion. *Health Canada,* 23–33.

Eriksson, M., & Lindstrom, B. (2008). A salutogenic interpretation of the Ottawa Charter. *Health Promotion International, 23*(2), 190–199.

Falk-Rafael, A. (1999). The politics of health promotion: Influences on public health promoting nursing practice in Ontario, Canada from Nightingale to the nineties. *Advances in Nursing Science, 22*(1), 23–39.

Fielding, J., & Kumanyika, S. (2009). Recommendations for the concepts and form of Healthy People 2020. *American Journal of Preventive Medicine, 37*(3), 255–257.

Healthy People (2010). MAP-IT: A strategy for creating a healthy community. Chapter 2. Retrieved from http://www.healthypeople.gov/publications/HealthyCommunities2001/Chapter_2.htm

Howard, D., Nieuwenhuijsen, E. R., & Saleeby, P. (2008). Health promotion and education: Application of the ICF in the US and Canada using an ecological perspective. *Disability and Rehabilitation*, *30*(12–13), 942–954.

Irvine, L., Elliott, L., Wallace, H., & Crombie, I. K. (2006). A review of major influences on current public health policy in developed countries in the second half of the 20th century. *The Journal of the Royal Society for the Promotion of Health*, *126*(2), 73–78.

Jackson, S. F., Perkins, F., Khandor, E., Cordwell, L., Hamann, S., & Buasai, S. (2007). Integrated health promotion strategies: A contribution to tackling current and future health challenges. *Health Promotion International*, *21*(S1), 75–83.

© Jones & Bartlett Learning LLC, an Ascend Learning Company. NOT FOR SALE OR DISTRIBUTION.

Jesse, E., & Blue, C. (2004). Mary Breckinridge meets Healthy People 2010: A teaching strategy for visioning and building healthy communities. *Journal of Midwifery and Women's Health, 49*(2), 126–131.

Kemppainen, V., Tossavainen, K., & Turunen, H. (2012). Nurses' roles in health promotion practice: An integrative review. *Health Promotion International*, 28(4), 490–501.

Kickbusch, I., McCann, W., & Sherbon, T. (2008). Adelaide revisited: From healthy public policy to health in all policies. *Health Promotion International*, *23*(1), 1–4.

King, P. M. (1994). Health promotion: The emerging frontier in nursing, *Journal of Advanced Nursing, 20*, 209–218.

Kushwah, S. S. (2007). Public health learning and practice from hygiene to community medicine, health management and beyond issues: Challenges and options. *Indian Journal of Community Medicine*, *32*(2), 103–107.

Lalonde, M. (1974). *A new perspective on the health of Canadians.* Ottawa, Canada: Government of Canada.

MacDougall, H. (2007). Reinventing public health: A new perspective on the health of Canadians and its international impact. *Journal Epidemiology and Community Health*, *61*, 955–959.

Maglacas, A. M. (1986). Health for all: Nursing's role. *Nursing Outlook 36*(2), 66–71.

Manderscheid, R., & Wukitsch, K. (2014). Healthy People 2020: Developing the potential of mobile and digital communication tools to touch the life of every American. *Journal of Communication in Healthcare.* 7(1), 8–16.

McIntyre, L. (1992). The evolution of health promotion. *Probe*, *26*(1), 15–22.

McQueen, D. V. (2008). Self-reflections on health promotion in the UK and the USA. *Public Health*, *122*, 1035–1037.

Mittelmark, M. B. (2007). Shaping the future of health promotion: Priorities for action. *Health Promotion International*, *23*(1), 98–102.

Mittelmark, M. B., Perry, M. W., Wise, M., Lamarre, M., & Jones, C. M. (2007). Enhancing the effectiveness of the International Union for Health Promotion and Education to move health promotion forward. *IUHPE Promotion and Education Supplement 2*, *14*(33), 33–35.

Mooney, G. (2015). Washington and Welch talk about race, public health, history and the politics of exclusion. *American Journal of Public Health*, 105(7), 1317–1328.

Moore, P. V., & Williamson, G. C. (1984). Health promotion: Evolution of a concept. *Nursing Clinics of North America*, *19*(2), 194–207.

Morgan, I. S. & Marsh, G. W. (1998). Historic and future health promotion contexts for nursing. *Image: Journal of Nursing Scholarship*, *30*(4), 379–383.

Northrup, D. T. & Purkis, M. E. (2001). Building the science of health promotion practice from a human science perspective. *Nursing Philosophy*, *2*, 62–71.

Office of Minority Health, U.S. Department of Health and Human Services (2012). Minority populations. Retrieved from http://www.minorityhealth.hhs.gov/omh/browse.aspx?lvl=2&lvlid=26

Raphael, D. (2008). Grasping at straws: A recent history of health promotion in Canada. *Critical Public Health, 18*(4), 483–495.

Royne, M. B., & Levy, M. (2015). Reaching consumers through effective health messages: A public health imperative. *Journal of Advertising*, 44(2), 85–87.

Scriven, A., & Speller, V. (2007). Global issues and challenges beyond Ottawa: The way forward. *Promotion and Education, 14*, 194–198.

Shen, F., Sheer, V. C., & Li, R. (2015). Impact of narratives on persuasion in health communication: A meta-analysis. *Journal of Advertising*, 44(2), 105–113.

© Jones & Bartlett Learning LLC, an Ascend Learning Company. NOT FOR SALE OR DISTRIBUTION.

Terry, P. E. (2015). Purpose, core values and vision for health promotion. *American Journal of Health Promotion,* 29(3), TAHP9-10.

Tountas, Y. (2009). The historical origins of the basic concepts of health promotion and education: The role of ancient Greek philosophy and medicine. *Health Promotion International*, *24*(2), 185–192.

Whitehead, D. (2001). Health education, behavioural change and social psychology: Nursing's contribution to health promotion? *Journal of Advanced Nursing*, *34*(6), 822–832.

Whitehead, D. (2008). Health promotion: An international Delphi study examining health promotion and health education in nursing practice, education, and policy. *Journal of Clinical Nursing, 17,* 891–900.

Whitehead, D. (2009). Reconciling the differences between health promotion in nursing and general health promotion. *International Journal of Nursing Studies, 46,* 865–874.

Whitehead, D. (2011). Health promotion in nursing: A Derridean discourse analysis. *Health Promotion International,* 26, 117–127.

Winkelstein, W. (2009). The development of American public health, a commentary: Three documents that made an impact. *Journal of Public Health Policy. 30*(1), 40–48.

World Health Organization. (1986). *The Ottawa Charter for Health Promotion.* Copenhagen, Denmark: Author.

World Health Organization. (1987). Ottawa Charter for Health Promotion. *Health Promotion, 1*(4), iii–v.

World Health Organization. (2010a). *Sundsvall statement on supportive environments for health.* Retrieved from http://www.who.int/healthpromotion/conferences/prevous/sundsvall/en/index.html

World Health Organization. (2010b). *Jakarta declaration on leading health promotion into the 21st century.* Retrieved from http://www.who.int/healthpromotion/conferences/prefious/jakarta/declaration/en/