Chapter 8

Health Promotion

Health promotion is a cornerstone of professional nursing practice (Community Health Nurses Association of Canada, 2003). In the past two decades, the public has become increasingly aware of the relationship between lifestyle and illness. As people begin to adopt health-promoting habits, such as getting more physically active, balancing stress and relaxation, maintaining good nutrition, and controlling the use of tobacco, alcohol, and other drugs, nurses must understand what health promotion is in order to effectively promote health and prevent illness.

OBJECTIVES

After studying this chapter, you should be able to

1. Examine the development of health-promotion initiatives in Canada
2. Discuss the essential components of the following health-promotion models and documents: Lalonde Report, *Ottawa Charter for Health Promotion*, Epp's health-promotion framework, population health-promotion model, the *Jakarta Declaration*, and Pender's health-promotion model
3. Differentiate health promotion from health protection and health education
4. Identify various sites and types of health-promotion programs
5. Explain the six stages of change in Prochaska's transtheoretical model
6. Discuss the role of the nurse when using nursing process to assess a client's health and develop, implement, and evaluate plans for health promotion

Development of Health-Promotion Initiatives in Canada

Health promotion has a long tradition, dating back to 4000 B.C.E. and the Egyptians' sewage disposal system, feeding of the poor, and warnings about excessive alcohol consumption. Florence Nightingale was the very first nurse to promote clean air and hygiene during the Crimean War in the 1800s. In the early 1900s, public health movements in Canada focused on the control of communicable diseases. At the turn of the twentieth century, this work was exemplified by the Victorian Order of Nurses and public health nurses promoting nutrition and maternal and child health among the poor (Stamler & Yiu, 2008). See Chapter 1.

Changing Focus in Public Health (Post–World War II)

Since World War II, Canadians and people in other industrialized countries have benefited from marked improvement in health as a result of advances in scientific medicine and technology. Mandatory public health measures, such as immunization, sanitation, water purification, and the pasteurization of milk, to control communicable diseases have prevented many illnesses and deaths. Union movements helped improve working conditions and income; economic improvement in turn led to better housing and living conditions and improved nutrition. As Canadians enjoyed longer life expectancy, chronic diseases (e.g., as cancer and heart disease) and accidents gradually replaced tuberculosis, diarrhea, and influenza as the leading causes of death. Public health practice has now begun shifting its emphasis from infection control to health-promotion activities by addressing risk factors that contribute to various diseases, such as tobacco use, lack of physical activity, and poor eating habits (Stamler & Yiu, 2005).

Lalonde Report (1974)

With the passing of the Canada Health Act in 1968, governments became responsible for financing a universal health-care system with services that are accessible to all Canadians. By the late 1970s, they were troubled by the increasing gaps between escalating health-care costs and limited health outcomes. In an effort to control the escalating health-care costs, they began exploring factors that influenced the health of Canadians. This led to the first landmark health-promotion document in Canada *A New Perspective on the Health of Canadians* (Lalonde, 1974), known as the Lalonde Report.

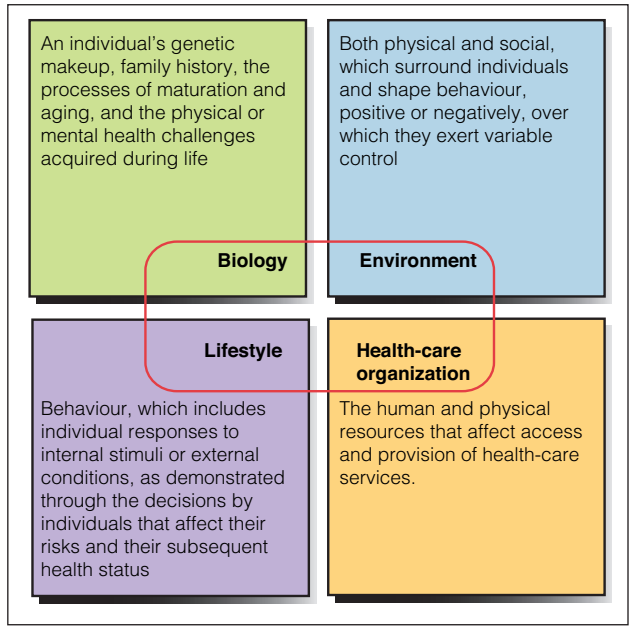

FIGURE 8.1 Lalonde's health field concept

Lalonde conceptualized the **health field concept**, which listed biology, lifestyles, environment, and health-care organizations as the four elements that determine health (see Figure 8.1). The concept marked a shift from a medical to a behavioural approach to health and put the emphasis on individuals' responsibility for their own health. Nevertheless, this approach was heavily criticized for blaming the victims for their poor health and failing to recognize the socioeconomic barriers to people to making healthy lifestyle choices.

The Epp Report (1986)

By the mid-1980s, health promotion had become a global discussion following the declaration of "Health for All by the Year 2000" by the World Health Organization (1978) at the Alma-Ata conference in Russia. In 1986, Canada hosted the first international conference on health promotion in Ottawa and released Jake Epp's (1986) *Achieving Health for All: A Framework for Health Promotion* (Figure 8.2). Epp identified three *health-promotion challenges*:

1. *Reducing inequities.* Members of disadvantaged groups have significantly shorter life expectancies, poorer health, and a higher prevalence of disability than the average Canadian.
2. *Increasing prevention.* Various forms of preventable diseases and injuries continue to undermine the health and quality of life of many Canadians.
3. *Enhancing coping.* Many Canadians suffer from various forms of chronic disease, disability, or

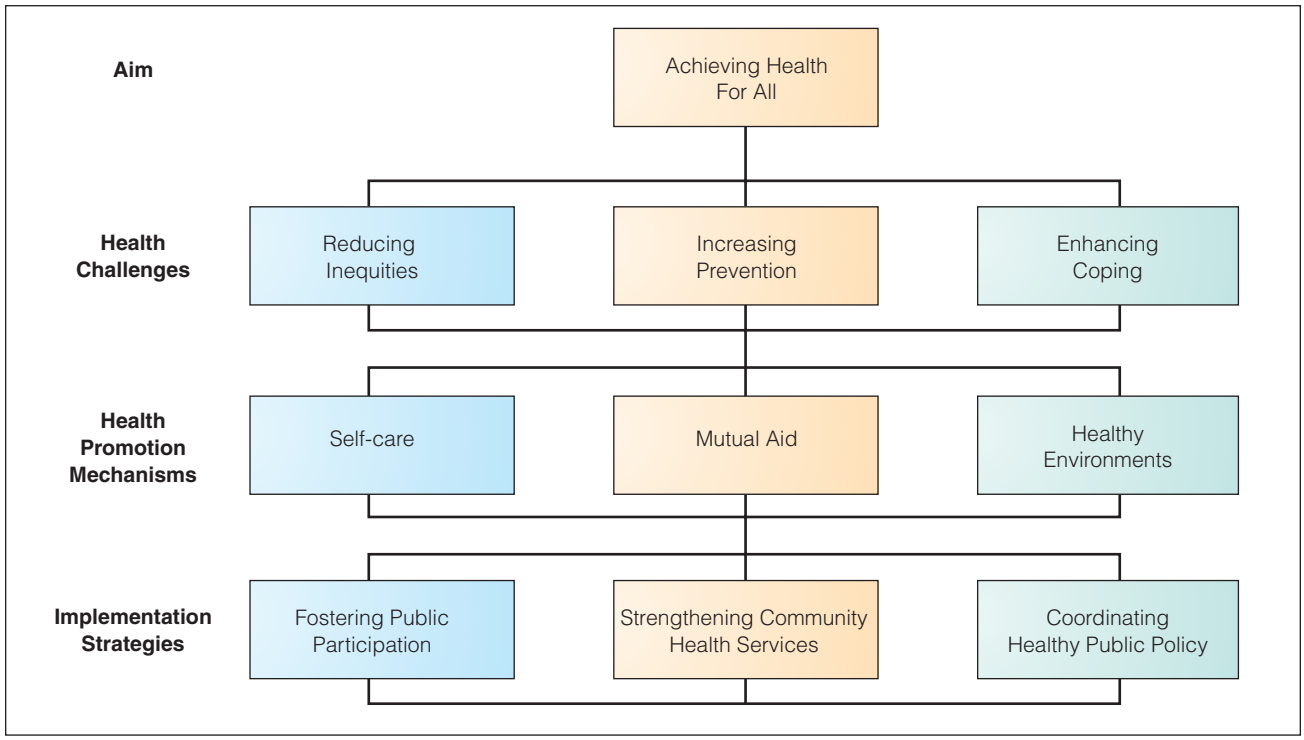

FIGURE 8.2 A framework for health promotion
(From Achieving Health for All: A Framework for Health Promotion (p. 8), 1986, by J. Epp, Ottawa: Health Canada. Copyright 1986 by Minister of Public Works and Government Services. Reprinted with permission.)

emotional stress, and they lack adequate community support to cope and live meaningful, productive, and dignified lives.

Epp (1986) proposed three *health-promotion mechanisms* to overcome these challenges:

1. Self-care, or the decisions and actions individuals take in the interest of their own health
2. Mutual aid, or the actions people take to help one another cope
3. Healthy environments, or the creation of conditions and surroundings conducive to health

Epp (1986) also suggested three key *health-promotion implementation strategies*:

1. Fostering public participation
2. Strengthening community health services
3. Coordinating healthy public policy

Epp (1986) stressed the importance of *public participation* in implementing health-promotion programs. He believed that decisions about health should not belong exclusively to either the experts or the governments, and what people needed were *partnerships in health* with all stakeholders. Communities began to see health as their prerogative and took collective action on what they saw as priorities for their well-being. This led to the *healthy communities* movement to improve social and working environments; it was initiated in Toronto in 1984 and later spread worldwide (Raeburn & Rootman, 1998).

Ottawa Charter for Health Promotion (1986)

The *Ottawa Charter for Health Promotion* (World Health Organization, Health and Welfare Canada, & Canadian Public Health Association, 1986), shown in Figure 8.3, was conceived and signed by delegates from 38 countries at the end of the 1986 First International Conference on Health Promotion in Ottawa. This charter addresses the importance of a socio-environmental approach to achieving equity in health. It viewed health as a "resource for everyday living" and identified the fundamental conditions or prerequisites for health as peace, shelter, education, food, income, social justice, equity, sustainable resources, and a stable ecosystem. The charter also stressed that individuals, government, and nongovernment sectors must work in partnership for health. It outlined five health-promotion strategies:

1. Build healthy public policy.
2. Create supportive environments.
3. Strengthen community action.
4. Develop personal skills.
5. Reorient health services.

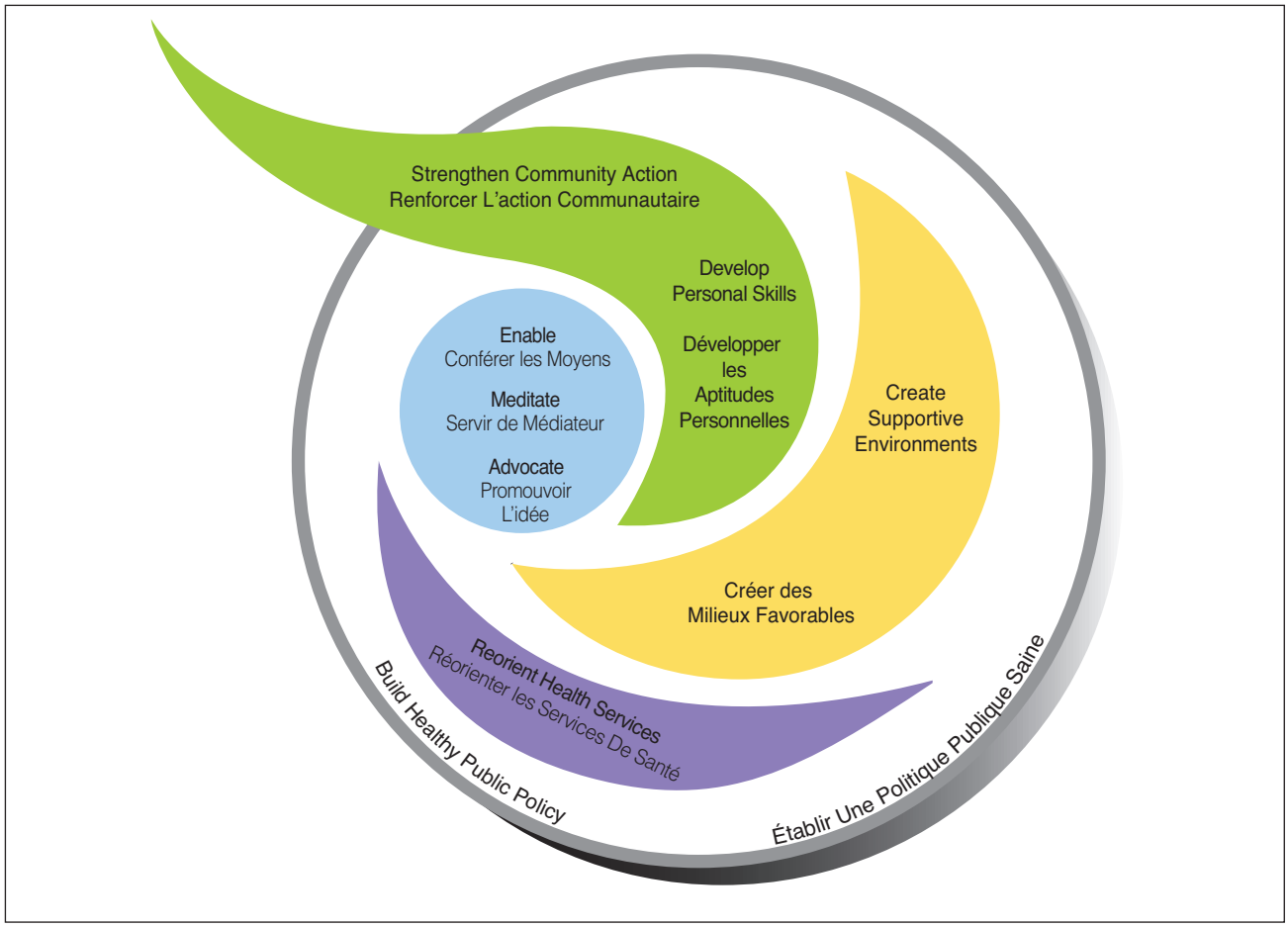

FIGURE 8.3 The *Ottawa Charter for Health Promotion*
(From The Ottawa Charter for Health Promotion, by the World Health Organization, Health and Welfare Canada, and Canadian Public Health Association, 1986, Geneva, Switzerland: World Health Organization. Retrieved July 28, 2006, from http://www.who.int/healthpromotion/conferences/previous/ottawa/en/index4.html)

Strategies for Population Health (1994)

Between 1991 and 1996, the progress of health promotion was set back by the severe global economic recession. The need for all health services to demonstrate evidence of health outcomes, accountability, cost-effectiveness, and efficiency was more important than ever. The Canadian Institute of Advanced Research released a report, *Strategies for Population Health: Investing in Health of Canadians* (Federal, Provincial, and Territorial Advisory Committee on Population Health, 1994), which set the *determinants of health* at the centre of the *framework for population health* (Figure 8.4). In this framework, the 12 determinants of health were divided into five groups that lent direction to population health initiatives (see Table 8.1). All known individual and collective factors, including their conditions and the interactions that determine people's health, must be considered in planning action to improve health. Information and research are part of community action research. Tracking results and outcomes through research and information augments the broad, long-term effects of health initiatives and enables the formulation of public policy.

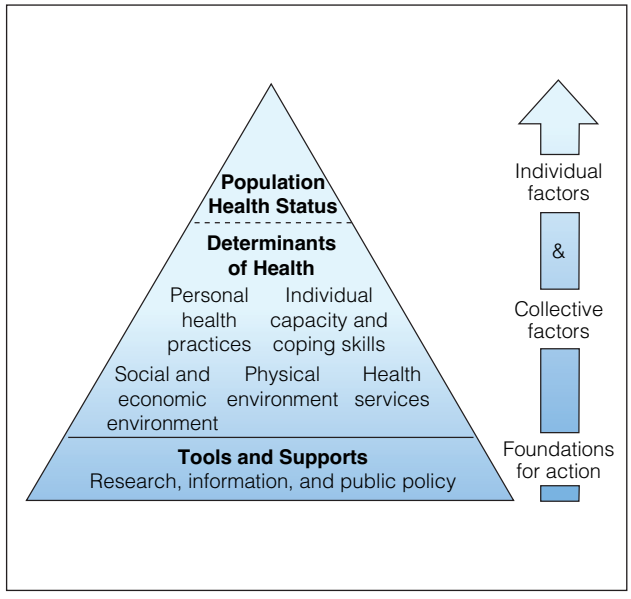

FIGURE 8.4 Framework for population health
(From Population Health Approach: Underlying Premises and Evidence Table, by Health Canada, 2002, Ottawa: Author. Copyright 2002 by the Minister of Public Works and Government Services Canada. Adapted and reproduced with permission.)

TABLE 8.1 Population Health Initiatives and Determinants of Health

Population Health Initiatives	Determinants of Health
Social and economic environments	Education Employment and working conditions Income and social status Social support networks Social environments
Individual capacity and coping skills	Healthy child development Biology and genetic endowment Gender
Health services	Health services
Physical environments	Physical environments
Personal health practices	Personal health practices and coping skills Culture

Population Health-Promotion Model (1996)

Hamilton and Bhatti (1996) developed a population health-promotion model shown in Figure 8.5, to improve population health. The model integrated the concepts of health-promotion strategies from the *Ottawa Charter for Health Promotion*, the determinants of health from the strategies for population health, and the levels of potential clients for intervention. These clients may be individuals, families, communities, groups, or societies. This model presented four key questions for examination when implementing health-promotion actions (1) *what* action are we taking, (2) *how* can we take action, (3) *with whom* can we act, and (4) *why* take such an action. It also emphasized the importance of research and evidence-based decision making.

Jakarta Declaration and *Toronto Charter for a Healthy Canada* (since 1997)

In late 1990s, poverty, social and economic inequities, globalization, and environmental degradation gained increasing recognition as threats to health. Social determinants of health became the key themes in health-promotion discussions and resulted in the adoption of the 1997 *Jakarta Declaration on Health Promotion* (World Health Organization [WHO], 1997). Canada, together with other nations, affirmed social justice, equity, and sustainability as new commitments for health promotion at local, national, and international levels. The *Jakarta Declaration* endorsed the *Ottawa Charter for Health Promotion*, as its principles were grounded in primary health care, social justice, and community empowerment; and it presented five priorities for health promotion in the twenty-first century:

1. Promote social responsibility for health.
2. Increase investment for health development.
3. Consolidate and expand partnerships for health.
4. Increase community capacity and empower the individual.
5. Secure an infrastructure for health promotion.

Building on the *Jakarta Declaration,* the 2002 *Toronto Charter for a Healthy Canada* (Raphael & Curry-Stevens, 2003) addressed social determinants of health, their implications, and policy development in such areas as early childhood development, education, employment and working conditions, food security, health-care services, housing shortages, income and its equitable distribution, social safety nets, social exclusion, unemployment, and job security. Today, the challenges facing health-promotion initiatives involve helping communities to take responsibility for their own health, using new technologies (e.g., the internet and telehealth) to reach the population being served, and attaining evidence or measurable outcomes within the fiscal constraints. The emergence of new communicable diseases, such as the West Nile virus, bovine spongiform encephalitis (mad cow disease), and severe acute respiratory syndrome (SARS), and threats of bioterrorism and natural disasters also have put more demands on the public health system in Canada (Kirby, 2003). The Public Health Agency of Canada was launched in September 2004 with the mandate to protect and promote the health of the public.

Canada has established itself as the world leader in health promotion. The current health-promotion focus is on building an infrastructure for collaborative research in health among various disciplines and on developing knowledge and translating it to practice. Policies are being created to address major health issues, such as tobacco and drug use, obesity, mental health, poverty, early childhood development, diabetes, heart disease, and Aboriginal peoples' health. To improve the

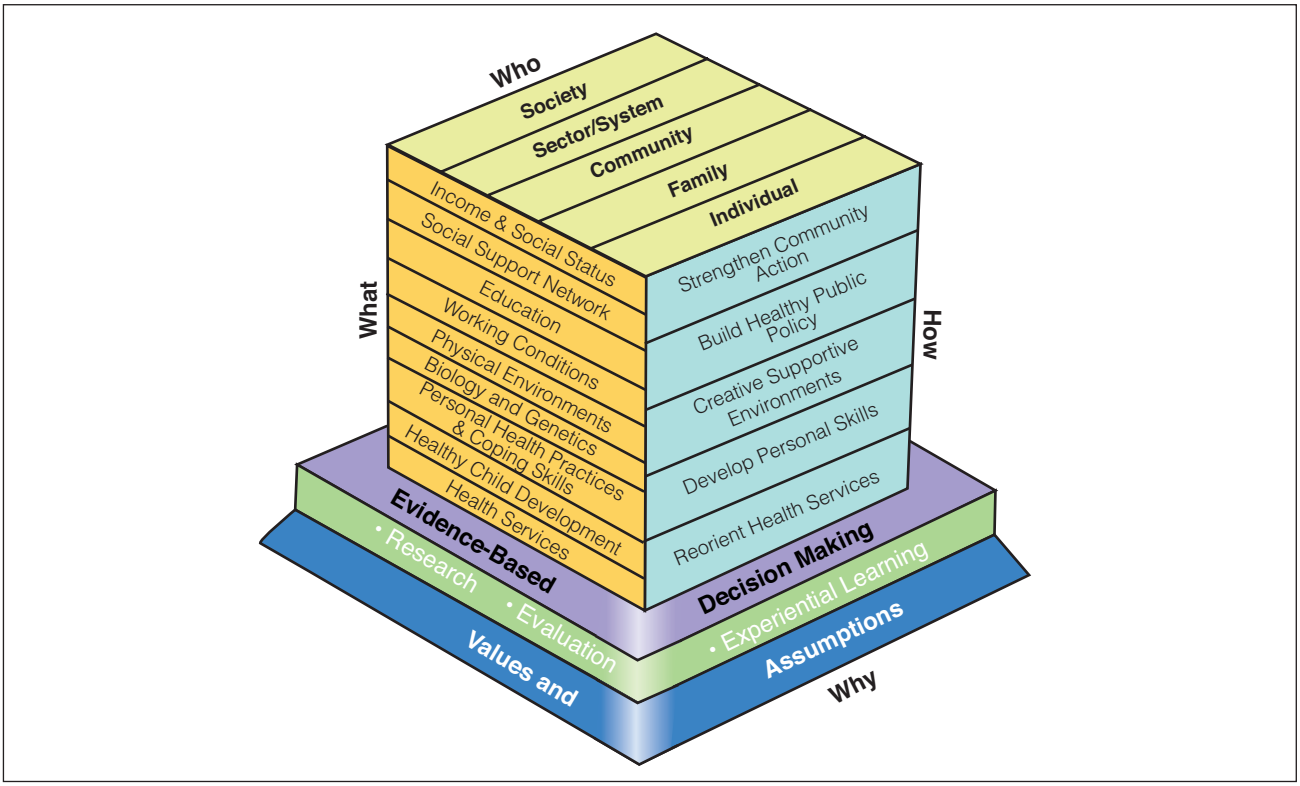

FIGURE 8.5 An integrated model of population health and health promotion
(Adapted from Population Health Promotion: An Integrated Model of Population Health and Health Promotion, by N. Hamilton and T. Bhatti, 1996, Ottawa: Health Canada, Health Promotion and Development Division. Copyright 1996 by the Minister of Public Works and Government Services Canada. Adapted and reproduced with permission.)

health of Canadians, nurses must understand the implications of various health-promotion initiatives for their practice (O'Neill & Dupéré, 2005), as shown in the Nursing and Canadian Society box.

Nursing and Canadian Society

Fact	Implications for Nursing Practice
The 1974 *New Perspective on the Health of Canadians,* also known as the Lalonde Report, is often cited as the beginning of health promotion.	Nurses must appreciate and understand the historical development and achievements of health promotion in order to promote its vision and future directions, and continue to explore what determines Canadians' health.
Jake Epp's *Achieving Health for All: A Framework for Health Promotion* (1986) reinforced the WHO's goal of health for all by 2000.	Nurses must continue to investigate ongoing health-promotion challenges and mechanisms to plan and implement participatory actions to achieve equity in health.
The 1986 *Ottawa Charter for Health Promotion* marked the shift from traditional treatment and prevention health care to health-promotion strategies that feature empowerment.	Nurses must focus on the broader definitions of health, go beyond health education, and work with intersectoral partners to empower clients to take control of their lives through policy changes and supportive environments.
Hamilton and Bhatti's 1996 population health-promotion model outlined who, what, where, and how to promote population health and stressed the importance of evidence-based practice.	Nurses must acquire the knowledge and skills needed to promote health for individuals, families, groups, and communities in various settings. Accountable actions and ongoing monitoring and evaluation while striving for evidence-based outcomes must be emphasized.
The 2002 *Toronto Charter for a Healthy Canada* expanded on the 1997 *Jakarta Declaration on Health Promotion* to address the importance of social determinants of health, their implications, and policy development.	Nurses must advocate and be politically active from local to international levels to address the broader determinants of health and work and move toward sustainability, social justice, and equity in health.

Defining Health Promotion

What, then, is health promotion? **Health promotion** is "a *strategy* that aims at informing, influencing, and assisting both individuals and organizations so that they will accept more responsibility and be more active in matters affecting mental and physical health" (Lalonde, 1974, p. 66). It involves any *activity* or *program* designed to improve the social and environmental living conditions that enhance people's well being (Labonte, 1992). Health promotion is also a *process* of enabling or empowering people to increase control over and to improve their health by maximizing positive changes to their physical, economic, social, and political environments (Epp 1986; Health Canada, 2005; WHO, 1984). **Empowerment** is "a social action process in which individuals and groups act to gain mastery over their lives in the context of changing their social and political environment" (Wallerstein & Bernstein, 1994, p. 142). Health promotion, therefore, is a philosophy, a process, and a multisectoral and sociocultural approach that aims to enhance the health and well-being of individuals and communities through policy formulation, supportive environments, and health education (see the Reflect on Primary Health Care box).

Health promotion is not synonymous to health education. WHO (1998) defined **Health education** as "consciously constructed opportunities for learning designed to facilitate changes in behavior towards a predetermined goal, and involving some form of communication designed to improve health literacy, knowledge, and life skills conducive to individual and community health" (p. 14). Health education, therefore, is a strategy of health promotion; it is concerned with the communication of information and the fostering of motivation, skills, and confidence to take action to improve health.

REFLECT ON PRIMARY HEALTH CARE

Health promotion is a principle of primary health care. Nurses adopt the primary health care approach to provide promotive, preventive, curative, rehabilitative, and supportive or palliative care to their clients. The focus of their care is on preventing illness and promoting health. In promoting the health of individuals, families, group, and communities, nurses must help their clients understand factors that determine their health and develop effective skills to improve and maintain their own health and well-being. Consider how you can work with your clients and interdisciplinary health-care providers to provide health-promotion services that are culturally sensitive and accessible to your clients. Also, examine whether the educational material is written in a language and at a level that can be understood by clients from another culture.

Central to health promotion is prevention. Leavell and Clark (1965) described *three levels of prevention* during a course of disease progression (see Chapter 7 for primary, secondary, and tertiary levels of prevention). The notions of *health promotion, health protection,* and *disease prevention* are significantly different. Pender, Murdaugh, and Parsons (2006) define health promotion as "behaviour motivated by the desire to increase well-being and actualize human health potential." **Health protection** involves activities focused on preventing, avoiding, or minimizing injuries that individuals have little or no control over and preventable illnesses. **Disease prevention** is concerned with taking measures to prevent and control common risk factors for diseases. Behaviours in both *health protection* and *disease prevention* as are "motivated by a desire to actively avoid illness, detect it early, or maintain functioning within the constraints of illness" (p. 7). The major difference in these terms lies with the underlying *motivation* for the individual behaviour (Table 8.2).

TABLE 8.2 Differences between Health Promotion and Health Protection and Disease Prevention

	Health Promotion	Health Protection and Disease Prevention
Aim	To attain a higher level of wellness by modifying own behaviours and improving social environmental and economic conditions	To increase resistance to harm by modifying the environment to minimize preventable illness or injury
Motivation	Motivated by personal, positive desire for wellness	Motivated by avoidance of harm or illness
Examples of activity focus	• Stress management • Physical activity • Nutrition • Parenting on child health • Sexual health (e.g., HIV, sexually transmitted infections [STIs]) • Problematic substance use, tobacco and alcohol use • Chronic disease management • Injury prevention	• Emergency responses • Vehicle, water, food, and drug safety • Infectious disease control • Occupational health safety • Early detection of cancer (e.g., breast health) • Health hazard investigation (e.g., chemical, radiation, and water)

Activities for health promotion, health protection, and disease prevention are complementary processes and are carried out for numerous reasons. For example, suppose a 40-year-old male begins a program of walking five kilometres each day. If the goal of his program is to decrease his risk of cardiovascular disease, then the activity is considered disease prevention. By contrast, if the motivation for walking is to increase his overall health and feeling of well-being, then it is considered health-promotion behaviour.

Health promotion can be offered to all clients regardless of their age or state of health. Age-specific health-promotion activities are discussed in Chapters 16 to 19. See Box 8.1 for some sample activities.

Types of Health-Promotion Programs

Information dissemination uses a variety of media to educate the public and raise their awareness about the risks of particular lifestyle choices and personal behaviours, as well as the benefits of changing those behaviours and improving the quality of life. Billboards, posters, brochures, newspaper features, books, and health fairs all offer opportunities for the dissemination of health-promotion information. See Box 8.1 for health-promotion teaching topics and the Evidence-Informed Practice box for an example.

Health risk appraisal and **wellness assessment programs** are used to apprise individuals of the risk factors that are inherent in their lives in order to motivate them to reduce specific risks and develop positive health habits. Wellness assessment programs focus on more positive methods of enhancement, in contrast to the risk-factor approach used in health appraisal.

Lifestyle and behaviour change programs require the active participation of the individuals and are geared

Evidence-Informed Practice

Do Parents Use Child Safety Restraint Systems Correctly?

Motor vehicle accidents are the leading cause of death and injury in children under 14 years of age in Canada. Snowdon, Polgar, Patrick, and Stamler (2006) surveyed 1263 parents of children aged birth to 9 years in two Ontario communities on their use of child safety restraint systems; only 68% of 2199 children had the correct seats for their weight, and the rate of premature transitioning into safety seats inappropriate for the child's height and weight increased with the age of the child. Data showed that parents had limited knowledge concerning the correct use of safety seats and tended to use nonprofessionals for vehicle safety information.

NURSING IMPLICATIONS: Nurses play a critical role in health promotion through safety promotion and injury prevention in childrearing families. They can prevent premature deaths by reinforcing the mandatory child safety restraint systems, providing the needed information to enhance parents' awareness of the importance of securing children safely in vehicles and using the correct safety seat for the child's height, weight, and age.

Source: Based on "Parents' Knowledge about and Use of Child Safety Systems," by A. Snowdon, J. Polgar, L. Patrick, and L. Stamler, 2006, *Canadian Journal of Nursing Research, 38*(2), pp. 98–114.

BOX 8.1 EXAMPLES OF HEALTH-PROMOTION TEACHING TOPICS FOR VARIOUS AGE GROUPS

Nurses can use the following age-specific topics to teach clients about health-promotion strategies:

Infants	Children	Adolescents	Adults	Older Adults
• Infant–parent attachment and bonding • Breastfeeding • Activities to stimulate development • Activity and sleep patterns • Immunizations • Safety promotion and injury prevention	• Nutrition • Dental health • Vision, hearing, speech • Discipline • Activity and sleep patterns • Immunizations • Safety promotion and injury prevention	• Communicating with teens • Hormonal changes • Nutrition • Exercise and rest • Peer group influences • Self-concept and body image • Sexuality and sexual health • Accident prevention	• Smoking cessation • Alcohol and drug use • Family relationships • Lifestyles • Weight control • Stress and coping • Regular health screening and examination • Workplace safety	• Adequate sleep • Dental and oral health • Foot health • Hearing aid use • Immunizations • Medication management • Mental health • Nutrition • Exercise • Safety promotion and injury prevention

toward enhancing their quality of life and extending their lifespan. Individuals generally consider lifestyle changes after they have been informed of the need to change their health behaviours and have become aware of the potential benefits of the process. These programs are available, both on group and on individual bases, and they address such issues as stress management, nutrition awareness, weight control, smoking cessation, and exercise.

Environmental control programs address contaminants in the air, food, and water that will affect the health of future generations. The most common concerns of community groups are toxic and nuclear wastes, nuclear power plants, air and water pollution, and herbicide and pesticide spraying.

Sites for Health-Promotion Activities

Health-promotion programs and activities can be offered to individuals and families in the home or in the community setting, such as in schools, hospitals, or worksites. Individual teaching or home visits can be costly; while group teaching is more cost effective and can offer a setting for socialization and peer support.

Community health-promotion programs are frequently offered by health units, community health centres, and nonprofit health agencies. They may include immunization programs or blood pressure screenings, fire prevention information, bicycle safety program for children, or a safe-driving campaign for young adults.

School health-promotion programs form a foundation of good health practices for children of all ages. They are cost-effective and offer a convenient setting for health-promotion programs. The school nurse works with teachers to plan and deliver information on various health topics, such as basic nutrition, dental care, activity and play, problematic drug and alcohol use, domestic violence, child abuse, and issues related to sexuality and pregnancy.

Worksite programs may include programs that address air quality, accident prevention, back-saving programs, blood pressure screening, fitness information, and relaxation techniques. Benefits to the employees can include an increased feeling of well-being, fitness, weight control, and decreased stress. Benefits to the employers can include an increase in productivity and morale, a decrease in absenteeism, and a lower rate of employee turnover, all of which can help to decrease business and health-care costs.

Effective health-promotion activities must be guided by models or conceptual frameworks for practice. The rest of this chapter presents two common practice models in health promotion, as well as the use of the nursing process in health promotion.

Pender's Health-Promotion Model

Nola Pender's revised health-promotion model (HPM), shown in Figure 8.6, considers the motivational source for behaviour change to be based on how the client perceives the benefits of changing the given health behaviour. Unlike the health belief model (see Chapter 7 for Rosenstock's and Becker's health belief model), the HPM does not include "fear" or "threat" as a motivating source for changing health behaviour (Pender et al., 2006, p. 48). Variables in the revised HPM are described here.

Individual Characteristics and Experiences

The importance of an individual's unique personal factors or characteristics and experiences depends on the target behaviour for health promotion. Personal factors are categorized as biological (e.g., age, strength, balance), psychological (e.g., self-esteem, self-motivation), and sociocultural (e.g., race, ethnicity, education, socioeconomic status). Some personal factors can influence health behaviours, while others, such as age, cannot be changed. Prior related behaviour includes previous experience, knowledge, and skill in health-promoting actions. Individuals who received benefits from previous health-promoting behaviours will engage in future health-promoting behaviours. In contrast, a person with a history of barriers to achieving the behaviour remembers the "hurdles" and will avoid making changes. Nurses can assist by focusing on the positive benefits of the behaviour, teaching how to overcome the barriers, and providing positive feedback for the client's successes.

Nursing interventions usually focus on factors that can be modified. It is just as important, however, to focus on factors that cannot be changed, such as family history. For instance, nurses could direct more support and information to women with a strong family history of breast cancer by emphasizing the importance of early detection and treatment and offering more hope for a cure. Helping to transform that fear into hope for early detection can make a difference in health attitudes and behaviours.

Behaviour-Specific Cognitions and Affect

Behaviour-specific cognitions and affect have major motivational significance for acquiring and maintaining health-promoting behaviours. Behaviour-specific cognitions and affect constitute a critical core for participation because they can be modified through nursing interventions. They include the following:

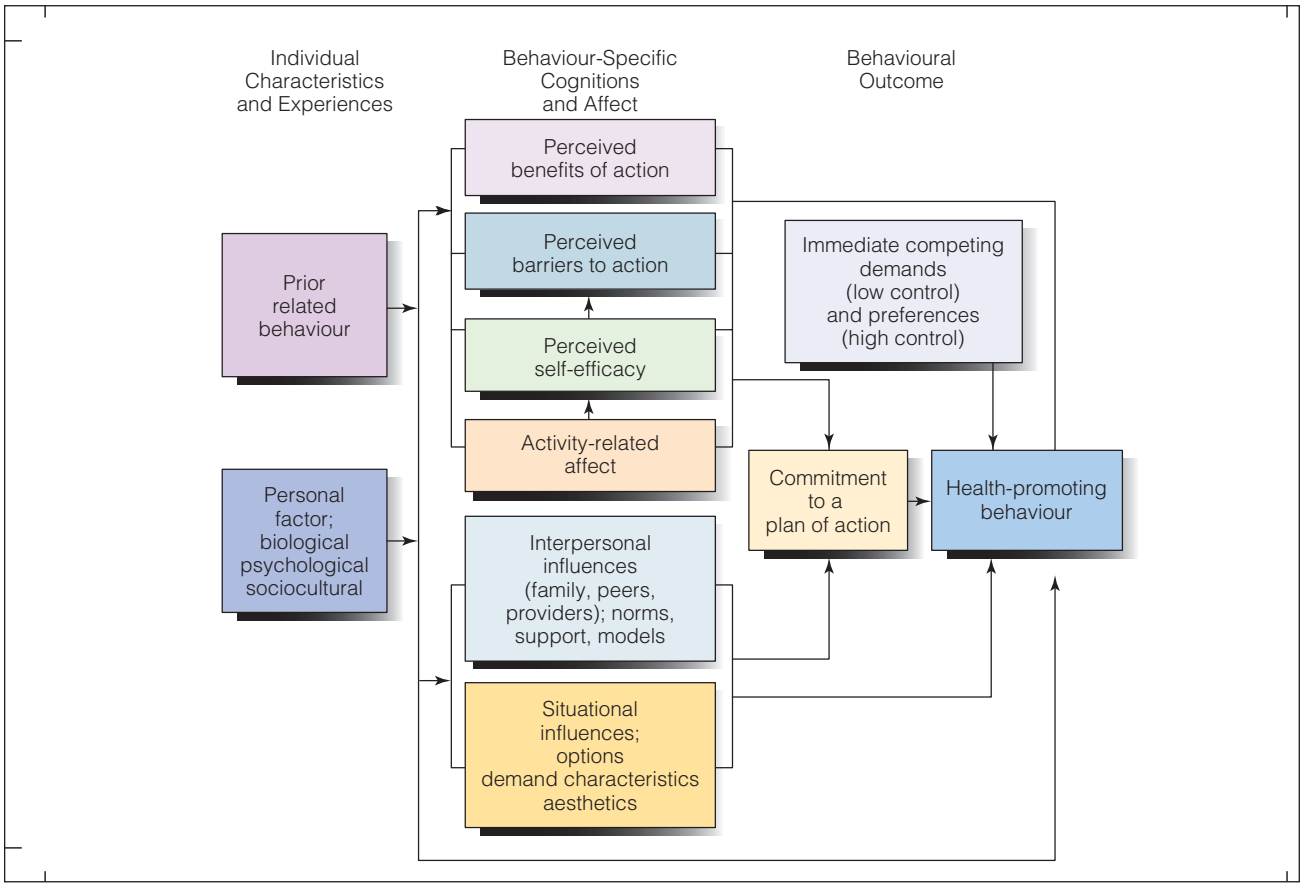

FIGURE 8.6 The health-promotion model (revised)
(From Health Promotion in Nursing Practice, 5th ed. (p. 50), by N. J. Pender, C.L. Murdaugh, and M. A. Parsons, 2006, Upper Saddle River, NJ: Prentice Hall. Copyright 2006 by Prentice Hall. Reprinted with permission.)

- *Perceived benefits of action:* Anticipated benefits or outcomes (e.g., physical fitness, stress reduction) affect the person's plan to participate in health-promoting behaviours and may facilitate continued practice. Prior positive experience with the behaviour or observations of others engaged in the behaviour is a motivational factor.
- *Perceived barriers to action:* A person's perceptions about available time, inconvenience, expense, and difficulty performing the activity can act as barriers (imagined or real) to the individual's commitment to a plan of action.
- *Perceived self-efficacy:* This concept refers to the person's conviction in successfully carrying out the behaviour needed to achieve a desired outcome, such as maintaining an exercise program to lose weight. Often people who have serious doubts about their capabilities decrease their efforts and give up, whereas those with a strong sense of efficacy exert greater effort to master problems or challenges.
- *Activity-related affect:* The subjective feelings, such as reaction to the thought of the behaviour, perceived enjoyable, or unpleasant activities, that occur before, during, and following an activity can influence whether a person will repeat the behaviour or maintain the behaviour. A positive affect or emotional response to a behaviour is likely to be repeated, and behaviours associated with a negative affect are usually avoided.
- *Interpersonal influences:* Interpersonal influences are a person's perceptions concerning the behaviours, beliefs, or attitudes of others. Family, peers, and health professionals are sources of interpersonal influences that can shape a person's health-promoting behaviours. Interpersonal influences include the expectations of significant others, social support (e.g., emotional encouragement), and learning done through observing others or modelling.
- *Situational influences:* Situational influences have direct and indirect effects on health-promoting behaviours. They include perceptions of available options, demand characteristics, and the aesthetic features of the environment. An example of an individual's perception of available options is easy access to healthful alternatives, such as vending machines and restaurants that provide healthful menu options. Demand characteristics can directly affect healthy behaviours through policies, such as a company regulation that demands safety equipment to be worn or that establishes a nonsmoking environment. Individuals are more apt to perform health-promotion behaviours if they are comfortable in the environment versus feeling alienated. Environments that are considered safe as well as

those that are interesting are also desirable aesthetic features that facilitate health-promotion behaviours.

Commitment to a Plan of Action

Commitment to a plan of action involves dedication and the identification of specific strategies for carrying out and reinforcing the behaviour. Strategies are important because commitment alone often results in good intentions but not actual performance of the behaviour.

Immediate Competing Demands and Preferences

Competing demands are those behaviours over which an individual has a low level of control. For example, an unexpected work or family responsibility may compete with a planned visit to the health club and not responding to this responsibility may cause a more negative outcome than missing the exercise routine. *Competing preferences* are behaviours over which an individual has a high level of control; however, this control depends on the individual's ability to be self-regulating or to not give in. For example, a person who chooses a high-fat food over a low-fat food because it tastes better has given in to an urge based on a competing preference.

Behavioural Outcome

Health-promoting behaviour, the outcome of the health-promotion model, is directed toward the client attaining positive health outcomes, such as improved health, enhanced functional ability, and better quality of life at all stages of development (Pender et al., 2006).

The Transtheoretical Model: Stages of Health Behaviour Change

Health behaviour change is a cyclic phenomenon in which people progress through several stages. In the first stage, the person does not think seriously about changing a behaviour; by the time the person reaches the final stage, he or she is successfully maintaining the change in behaviour. If the person does not succeed in changing behaviour, relapse occurs. The Prochaska's transtheoretical model (TTM) (Prochaska, Redding, & Evers, 2002), shown in Figure 8.7 and commonly known as *change theory*, describes six stages of change.

Precontemplation Stage

In the precontemplation stage, the person does not think about changing his or her behaviour in the future 6 months. They may be uninformed or underinformed about the consequences of the risk behaviours. Or the person may have tried changing and been unsuccessful and now sees the behaviour as their fate or feels that change is hopeless. Individuals in this stage tend to avoid reading, talking, or thinking about their high-risk behaviours.

Contemplation Stage

During the contemplation stage, the person acknowledges having a problem, seriously considers changing a specific behaviour, actively gathers information, and verbalizes plans to change the behaviour in the near future (e.g., next 6 months). The person, however, may not be ready to commit to action. Some people may stay in the contemplative stage for months or years before taking action. When contemplators begin the transition to the preparation stage, their thinking is clearly marked by two changes: focusing on the solution rather than the problem and thinking more about the future than the past.

Preparation Stage

The preparation stage occurs when the person intends to take action in the immediate future (e.g., within the next month). Some people in this stage may have already started making small behavioural changes, such as buying a self-help book. At this stage, the person makes the final specific plans to accomplish the change.

Action Stage

The action stage occurs when the person actively implements the behavioural and cognitive strategies of their action plan to interrupt previous health-risk behaviours and adopt new ones. This stage requires the greatest commitment of time and energy.

Maintenance Stage

During the maintenance stage, the person strives to prevent relapse by integrating newly adopted behaviours into his or her lifestyle. This stage lasts until the person no longer experiences temptation to return to previous unhealthy behaviours. Without a strong commitment to maintenance, the person will relapse, usually to the precontemplation or contemplation stage.

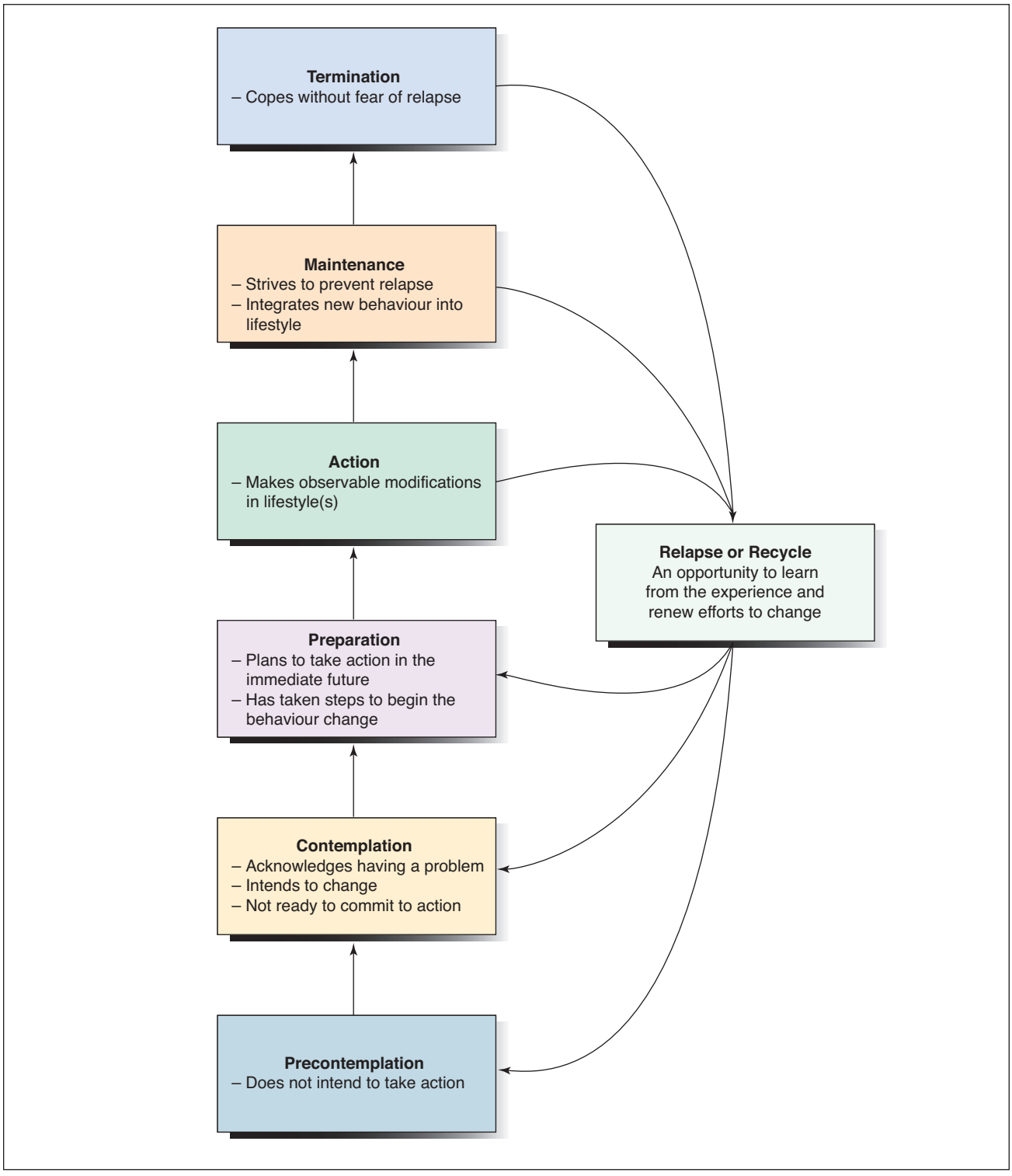

FIGURE 8.7 The transtheorectical model: Stages of change. The stages of change are rarely linear. It is more common for people to recycle several times through the stages. The person who takes action and has a relapse (recycles through some or all of the stages) is more apt to be successful the next time than the individual who never takes action.

(Based on content from Changing for Good by James O. Prochaska, John C. Norcross, and Carlo C. DiClimente, 1994, New York: HarperCollins Publishers. Copyright 1994 by James O. Prochaska, John C. Norcross, and Carlo C. DiClimente; "The Transtheorectical Model and Stages of Change," by James O. Prochaska, Colleen A. Redding, and Kerry E Evers in Health Behaviors and Health Education: Theory, Research, and Practice, 3rd ed., by Karen Glanz, Barbara K. Rimer, and Frances Marcus Lewis (Eds.), 2002, San Francisco, CA: Jossey-Bass.)

Termination Stage

The termination stage is the ultimate goal, at which the individual has complete confidence that the problem is no longer a temptation or threat. It is as if they had never acquired the habit in the first place. Experts debate whether some behaviours can be terminated versus requiring continual maintenance.

These six stages are cyclical; people generally move through one stage before progressing to the next. However, at any point a person can relapse or recycle to any previous stage. In fact, the average successful self-changer recycles through the stages several times before they exit the cycle. Most individuals who relapse return to the contemplation stage. During this time they can think about what they have learned and plan for the next action.

The Nursing Process and the Role of the Nurse in Health Promotion

The increasing emphasis on health promotion has created opportunities for nurses to work with individuals, families, groups, and communities in diverse settings. The **role of the nurse in health promotion** may involve advocacy, consultation, teaching, facilitation, or coordination of health services. The nurse applies the nursing process to assess clients' health and assist them in setting goals and plans and to take responsibility for positive health changes. Refer to Chapter 22 "Overview of the Nursing Process."

Assessing the Health of Individuals

A thorough assessment of the individual's health status is basic to health promotion. Components of this assessment are the health history and physical examination, physical fitness assessment, health-risk appraisal, lifestyle assessment, health beliefs review, and life stress review.

HEALTH HISTORY AND PHYSICAL EXAMINATION The health history and physical examination discussed in Chapter 27 provide guidelines for detecting any existing problems. The medical history, age, gender, race, ethnicity, and culture of the individual must be considered when collecting data. For example, an environmental safety assessment and immunization history must be appropriate to the person's age and gender. Also, when doing a nutritional assessment, the nurse must consider how age, lifestyle, and cultural practices influence the dietary patterns of the client (see Chapter 10, the section "Selected Cultural Parameters for Nursing").

LIFESTYLE ASSESSMENT **Lifestyle assessment** focuses on the personal lifestyle and habits of the client as they affect health, such as physical activity, nutritional practices, stress management, and such habits as smoking, alcohol consumption, and drug use. Lifestyle assessment provides a basis for decisions related to desired behaviour and lifestyle change.

SPIRITUAL HEALTH ASSESSMENT **Spiritual health** is the ability to develop our inner nature to its fullest potential, including the ability to discover and articulate a basic purpose in life, to learn how to experience love, joy, peace, and fulfillment, and how to help ourselves and others achieve their fullest potential (Pender et al., 2006). Individuals' spiritual beliefs can affect their interpretation of events in their life and, therefore, an assessment of spiritual well-being is a part of evaluating their overall health (see Chapter 46).

SOCIAL SUPPORT SYSTEMS REVIEW Through interpersonal relationships, individuals and groups can provide comfort, assistance, encouragement, and information. **Social support** fosters successful coping and promotes satisfying and effective living. **Social support systems** create an environment that encourages healthy behaviours, promotes self-esteem and wellness, and provides feedback that the person's actions will lead to desirable outcomes. Examples of social support systems include family, peer support groups, computer-based support groups, community organized religious support systems (e.g., churches), and self-help groups (e.g., Alcoholic Anonymous, Weight Watchers). The nurse and client discuss and evaluate the adequacy of the client's support system and, if necessary, mutually plan options for enhancing the support system.

HEALTH-RISK APPRAISAL The principle behind health-risk appraisal (HRA) is that each person faces certain health hazards and that average risks are applicable to a client if the health professional knows the client's characteristics and the mortality of a large group of cohorts with similar characteristics (Pender et al., 2006). The objectives of most HRAs are twofold:

1. To assess risk factors that may lead to health problems
2. To change health behaviours that place the client at risk of developing an illness

Risk factors are features that can cause a client to be vulnerable to developing a specific health problem, such as cancer. An **at-risk aggregate** refers to a subgroup within the community or population that is at greater risk of illness or poor recovery.

HRAs focus on the assessment of lifestyle factors and health behaviours. Risk factors can be categorized according to (1) age, (2) genetic factors, (3) biological characteristics, (4) personal health habits, (5) lifestyle, and (6) environment. Clients cannot control some of the risk factors, such as age, gender, and family history; oth-

ers, such as blood pressure, stress, and cigarette smoking, can be partially or totally controlled.

HEALTH BELIEFS REVIEW Assessment of clients' health-care beliefs reveals how much the clients believe or perceive they can influence or control health through personal behaviours. Some cultures have a strong belief in fate: "Whatever will be, will be." An example is diabetic teaching, which often requires many lifestyle changes in diet and exercise, and close control of blood glucose levels to prevent complications. If the person believes he or she has no control over the outcome, it is difficult to motivate the client to make the necessary changes. Awareness of these differences in beliefs can provide a better indication of readiness and motivation on the part of the client to engage in healthy behaviours.

LIFE STRESS REVIEW Abundant literature and a variety of stress-related tools can measure the impact of stress on mental and physical well-being. High levels of stress are associated with an increased possibility of illness (see Chapter 47, the section "Concept of Stress").

VALIDATING ASSESSMENT DATA Following the collection of assessment data, the nurse and client jointly review the client's current health practices and attitudes. This allows for validation of the information by the client and may increase awareness of the need to change behaviour. The nurse and client should consider the following:

- Any existing health problems
- The client's perceived degree of control over his or her health status
- The client's level of physical fitness and nutritional status
- Illnesses for which the client is at risk
- Any health beliefs related to cultural and spiritual practices
- The client's current health practices
- Any sources of stress and the client's ability to handle stress
- The client's social support systems
- The information the client needs to enhance his or her health-care practices

Diagnosing

Wellness nursing diagnoses, or *strength-oriented diagnoses,* provide a clear focus for planning interventions and can be applied at all levels of prevention. When the nurse and client conclude that the client has positive function in a certain pattern area, such as adequate nutrition or effective coping, the nurse can use this information to help the client reach a higher level of functioning. Examples of wellness diagnoses are the following:

- Health-seeking behaviours, such as physical fitness
- Effective breastfeeding
- Anticipatory grieving

Planning

Health-promotion plans need to be mutually developed according to the needs, desires, and priorities of the client. The client chooses the health-promotion goals; the frequency, duration, and course of actions; and the method of evaluation. The nurse acts as a resource person, an adviser, and a counsellor. The nurse provides information, emphasizes the importance of small steps in making behavioural changes, and helps the client to set realistic and measurable goals.

Pender et al. (2006) outline several steps in the process of planning health promotion, which are carried out jointly by the nurse and the client (see Box 8.2 for an example of an individual prevention and health-promotion plan):

1. *Review and summarize the data from the assessment.* The nurse shares with the client a summary of the data collected from the various assessments (e.g., physical health and fitness, nutrition, sources of stress, spirituality, health practices).
2. *Reinforce strengths and competencies.* The nurse and the client come to consensus about areas in which the client is doing well and areas that need work.
3. *Identify health-care goals.* The client selects two or three priority goals and reviews the behaviour change options. These goals are formulated during the planning phase and a date is determined for attaining them.
4. *Identify behavioural or health outcomes.* For each of the selected goals or areas in step 3, the nurse and client determine what specific behavioural changes are needed to bring about the desired outcome. For example, to reduce the risk of cardiovascular disease, the client may need to change behaviours, such as stopping smoking, losing weight, and increasing his or her activity level.
5. *Develop a behaviour change plan.* A constructive program of change is based on client ownership of the behaviour changed (Pender et al., 2006). Clients may need help in examining value-behaviour inconsistencies and in selecting behavioural options that are most appealing and that they are most willing to try. The client's priorities will reflect personal values, activity preferences, and expectations of success.
6. *Reiterate the benefits of change.* The benefits will probably need to be reiterated even though the client is committed to the change. The health-related and non-health-related benefits should be kept before the client as central motivating factors.
7. *Address environmental and interpersonal facilitators and barriers to change.* Environmental and interpersonal factors and available resources that support positive change should be explored and used to reinforce the client's efforts to change his or her lifestyle. All people experience barriers, some of which can be anticipated and planned for, thereby making the change more likely to occur.
8. *Determine a time frame for implementation.* Setting a time frame helps the client target when to develop

BOX 8.2 EXAMPLE OF AN INDIVIDUAL PREVENTION AND HEALTH-PROMOTION PLAN

Designed for: James Moore
Home Address: 714 George
Home Telephone Number: 222-3333
Occupation (if employed): Building services supervisor
Work Telephone Number: 445-6666
Cultural Identification: African Canadian
Birth Date: 3/14/59 Date of Initial Plan: 1/15/2010

Client strengths	Satisfactory peer relationships, spiritual strength, adequate sleep pattern
Major risk factors	Elevated cholesterol, mild obesity, sedentary lifestyle, moderate life change, multiple daily hassles
Nursing diagnoses (derived from assessment of functional health patterns)	Deficient Diversional Activity Imbalanced Nutrition: More than Body Requirements Caregiver Role Strain (elderly mother)
Medical diagnoses (if any)	Mild hypertension
Age-specific screening recommendations	Blood pressure, cholesterol, fecal occult blood, malignant skin lesions, depression
Desired behavioural and health outcomes	Become a regular exerciser (3×/week), lower my blood pressure, weigh 75 kg

Personal Health Goals (1 = highest priority)	Selected Behaviours to Accomplish Goals	Stage of Change	Strategies/Interventions for Change
1. Achieve desired body weight	Begin a progressive walking program	Planning	Counterconditioning Reinforcement management Client contracting
	Decrease caloric intake while maintaining good nutrition	Action (eating 4 fruits and 4 vegetables daily; using low-fat dairy products for last 2 months)	Stimulus control Cognitive restructuring
2. Decrease risk for hypertension-related disorders	Change from high- to low-sodium snacks	Contemplation	Consciousness raising Learning facilitation
3. Learn to manage stress effectively	Attend relaxation classes and use home relaxation tapes	Contemplation	Consciousness raising Self-reevaluation Simple relaxation therapy
4. Increase leisure-time activities	Join a local bowling league	Contemplation	Support system enhancement

Source: From *Health Promotion in Nursing Practice,* 5th ed. (pp. 129–130), by N. J. Pender, C. L. Murdaugh, and M. A. Parsons, 2006, Upper Saddle River, NJ: Prentice Hall. Reprinted with permission.

the needed knowledge and skills for implementation of a new behaviour. The time frame may be several weeks or months. Scheduling short-term goals and rewards can offer encouragement to achieve long-term objectives. Clients may need help to be realistic and to deal with one behaviour at a time.

9. *Commit to behaviour change.* Commitments to changing behaviours are usually verbal, but increasingly a formal, written behavioural contract is being used to motivate the client to follow through with selected actions. Motivation to follow through is provided by a positive reinforcement or reward stated in the contract. *Contracting* is based on the belief that all people have the potential for growth and the right of self-determination, even though their choices may be different from the norm.

Implementing

Implementing is the "doing" part of behaviour change. Self-responsibility is emphasized in implementing the plan. Depending on the client's needs, the nursing strategies may include supporting, teaching, consulting, coordinating, facilitating, counselling, and modelling to enhance behaviour change.

PROVIDING AND FACILITATING SUPPORT The focus of providing support is on the desired behaviour change. The nurse must be nonjudgmental when offering support, whether on an individual basis or in a group setting. The nurse can also facilitate the development of support networks for the client, such as family members and friends.

Individual Counselling Sessions Counselling sessions may be routinely scheduled as part of the plan or may be provided if the client encounters difficulty in carrying out interventions or meets insurmountable barriers to change. The nurse acts as a facilitator, supporting the client's decision making in regard to the health-promotion plan.

Telephone or Computer Counselling Telephone or computer counselling may be provided to the client to help in answering questions, reviewing goals and strategies, and reinforcing progress. This form of support can be useful and convenient for the busy client who may not have the time for regular in-person sessions.

Group Support Group sessions provide an opportunity for participants to learn the experiences of others in changing behaviour. Regular group contacts give individuals a renewed commitment to their goals.

Facilitating Social Support Social networks, such as family and friends, can facilitate or impede the efforts directed toward prevention and health promotion. The nurse's role is to communicate the client's needs and goals, and assist the client to assess, modify, and develop the social support necessary to achieve the desired change.

PROVIDING HEALTH EDUCATION Health education programs on a variety of health-promotion topics can be provided to groups, individuals, or communities. The health-promotion topics must be based on the health needs of the people. Specific health-promotion goals must be set and outcomes evaluated after the program implementation.

ENHANCING BEHAVIOUR CHANGE Whether people will make and maintain changes to improve health or prevent disease depends on many interrelated factors. To help clients succeed in implementing behaviour changes, the nurse needs to understand the stages of change and effective interventions that focus on moving the individual through the stages of change. Figure 8.8 provides suggested strategies for helping clients, depending on their stage of change. Guidelines for assisting the client toward behaviour change are in Box 8.3. The nursing goal is not necessarily to change behaviour but to advance the client to the next stage of change.

HARM REDUCTION **Harm reduction** is a health-promotion approach that aims to minimize harm or reduce the negative consequences of risk behaviour by keeping people as safe and healthy as possible in their current lifestyle realities (Canadian Nurses Association [CNA], 2002). The nurse provides the needed knowledge, skills, resources, and support to those who are at risk, to reduce

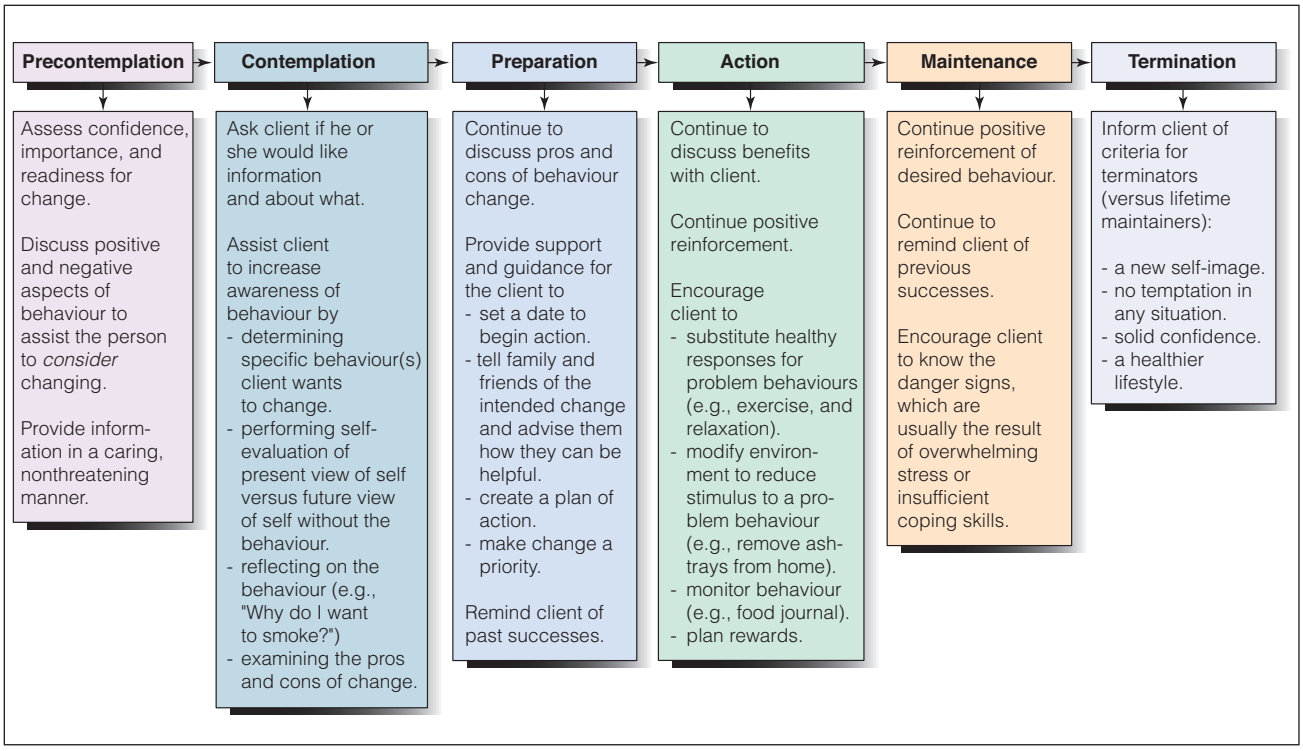

FIGURE 8.8 Strategies to promote behavioural change for each stage of change

(Data are from "The Transtheorectical Model and Stages of Change," by James O. Prochaska, Colleen A. Redding, and Kerry E Evers in Health Behaviors and Health Education: Theory, Research, and Practice, 3rd ed., by Karen Glanz, Barbara K. Rimer, and Frances Marcus Lewis (Eds.), 2002, San Francisco, CA: Jossey-Bass; Changing for Good by James O. Prochaska, John C. Norcross, and Carlo C. DiClimente, 1994, New York: HarperCollins Publishers. Copyright 1994 by James O. Prochaska, John C. Norcross, and Carlo C. DiClimente; Health Behavior Change: A Guide for Practitioners by S. Rollnick, P. Mason, and C. Butler, 1999, Edinburgh, UK: Churchill Livingstone; "Patient Teaching to Promote Behavioral Change," by L. Saarmann, J. Daugherty, and B. Riegel, 2000, Nursing Outlook, 48(6), 281–287.)

BOX 8.3 GUIDELINES FOR ENHANCING BEHAVIOUR CHANGE

Nurses can use the following guidelines to help clients move to the next stage of change to achieve the desired outcome:

ESTABLISH A RAPPORT AND SET THE AGENDA

- Establish a trusting relationship with the client.
- Identify the client's presenting problem or current situation and concerns.
- Ask which behaviour he or she feels most ready to *think* about changing and focus on one specific behaviour at a time.

ASSESS IMPORTANCE, CONFIDENCE, AND READINESS

- Assess the importance the client gives to the behaviour change and his or her confidence level and readiness for change.
- *Importance* refers to the personal value of change. Ask, "How do you feel at the moment about [state the change]?" "How important is it to you to [state the change]?" "On a scale of 1 to 10, with 1 being 'not important' and 10 'very important,' what number would you give yourself?"
- *Confidence* relates to the mastering of the skills needed to achieve the behaviour and the situations in which behaviour change will be challenging to the client. Ask, "If you decided right now to change, how confident would you feel about succeeding?"

EXCHANGE INFORMATION AND REDUCE RESISTANCE

- Present information in a nonjudgmental manner and avoid using the word *you* too much. Referring to other people (versus *you*) and what happens to them makes the information less threatening to the client. Ask for the client's interpretation of the information presented.
- Reduce resistance to change by
  - Emphasizing personal choice and control
  - Re-examining the client's feelings about importance and confidence regarding making the specific change
  - Reflecting, understanding, and respecting how the client feels

Source: Adapted from *Health Behavior Change: A Guide for Practitioners,* by S. Rollnick, P. Mason, and C. Butler, 1999, Edinburgh, UK: Churchill Livingstone. Adapted with permission from Elsevier.

the harm done to those engaging in these behaviours and the overall community. Examples of harm reduction are the PARTY programs to promote responsible drinking and needle exchange program to prevent spread of AIDS or hepatitis C.

Some nurses may experience value conflicts and be concerned that they are not providing health-promoting behaviours with this approach. Regardless, they need to recognize that clients have rights to accessible, nonjudgmental, and noncoercive treatments (see Chapter 5, the section "Ethical Decision Making"), and that prevention activities are best aimed at people engaging in high-risk behaviours (CNA, 2002).

ROLE MODELLING Through observing a role model during the early stages of learning and change, the client acquires ideas for behaviour and coping strategies for specific problems. The nurse and client should mutually select role models with whom the client can identify and whom he or she respects. Nurses can be models of wellness by demonstrating good health habits.

Evaluating

Evaluation of the plan is an ongoing, collaborative effort between the nurse and the client, both during the attainment of short-term goals and after the completion of long-term goals. During evaluation, the client may decide to continue with the plan, reorder priorities, change strategies, or revise the health-promotion contract.

Promoting Canadians' Health

Canada has been at the forefront of influencing health promotion. Canadian nurses must understand the historical development of health promotion and its significant contributions nationally and internationally. The goal of nursing is to promote clients' health and to reduce inequities in health. Canadian nurses must, therefore, possess the necessary knowledge and skills in health promotion to address the social determinants of health, to promote positive behaviour change in their clients, and to develop healthy public policies at the community level. Through the use of the nursing process (see Chapter 22, the section "Overview of the Nursing Process"), nurses work with individual clients of all ages, families, groups, and communities and help them attain the highest level of functioning (see Chapter 7, the section "Health"; Chapter 22, the section "Overview of the Nursing Process"; and the Lifespan Considerations box in this chapter).

Lifespan Considerations

Factors Affecting Health Promotion and Illness Prevention

CHILDREN

Childhood obesity is becoming a serious health problem. In 2004, Statistics Canada reported that 26% of children and youth aged 2 to 17 years were overweight, and 8% were obese. Between 1979 and 2004, rates of overweight and obesity among 2- to 5-year-olds increased by 21%; they doubled among 6- to 17-year-olds and tripled among adolescents aged 12 to 17 years (Shields, 2005).

Obesity and overweight in children contribute to long-term health problems, such as heart disease and diabetes mellitus. Healthy eating habits and adequate exercise patterns form the basis for healthy growth and prevention of too much weight gain in children. It is the responsibility of parents and caregivers to provide children with healthy food choices and an environment that makes eating a pleasure. Adults must be role models for their children, eating well and exercising regularly themselves.

OLDER ADULTS

In older adults, health promotion and illness prevention are important, but often the focus is on learning to adapt to and live with increasing changes and limitations. Maximizing strengths continues to be of prime importance in maintaining optimal function and quality of life. Factors to be aware of that might indicate a need for additional information or resources include these:

- An increase in physical limitations
- The presence of one or more chronic illnesses
- A change in cognitive status
- Difficulty in accessing health-care services because of transportation problems
- A poor support system
- The need for environmental modifications for safety and to maintain independence
- An attitude of hopelessness and depression, which decreases the motivation to use resources or learn new information

Case Study 8

The Canadian Medical Association conducted a telephone survey with 293 parents of children under the age of 18, between June 20 and July 9, 2006. Parents were asked to rate the overall health of their children. Although only 6% of parents gave the overall health of Canadian children an A grade, at least 40% gave their own children's level of physical activity and diet an A grade. Only 9% of parents considered their children overweight or obese, as compared with the 26% of children reported by Statistics Canada. Although these parents, regardless of their cultural backgrounds and socioeconomic status, tended to see their own children as healthier than other Canadian children, they endorsed implementing measures that would improve the health, diet, and physical activity of Canadian children.

Critical Thinking Questions

1. Why do parents see their own children as healthier than is reported by the government?
2. Discuss your roles in the prevention of children obesity.
3. Review key elements in the health-promotion documents in this chapter. Discuss possible health-promotion approaches to preventing obesity in children.

After working through these questions, go to the MyNursingLab at **http://www.mynursinglab.com** to check your answers.

Sources: Based on *2006 National Report Card: General Population. Final Summary Report* by Canadian Medical Association, 2006, Ottawa: Ipsos-Reid Corporation; "Overweight and Obesity among Children and Youth," by M. Shields, 2005, *Health Reports, 17*(2), Catalogue No. 82–003-XIE, Ottawa: Statistics Canada.

KEY TERMS

health field concept
health promotion
empowerment
health education
health protection
disease prevention
information dissemination
health risk appraisal
wellness assessment programs
lifestyle and behaviour change programs
environmental control programs

role of the nurse in health promotion
lifestyle assessment
spiritual health
social support
social support systems
risk factors
at-risk aggregate
wellness nursing diagnoses
harm reduction

CHAPTER HIGHLIGHTS

- Canada is a world leader in health promotion and has taken a sociocultural approach to examining what determines health.
- Five key documents have influenced health promotion in Canada: the Lalonde Report, the *Ottawa Charter for Health Promotion, Achieving Health for All,* the *Jakarta Declaration on Health Promotion,* and the *Toronto Charter for a Healthy Canada.*
- Health promotion is defined as client behaviour directed toward developing well-being and actualizing human health potential. Health protection is client behaviour geared toward preventing illness, detecting it early, or maintaining function.
- Health-promotion activities are directed toward developing client resources that maintain or enhance well-being. Health-protection activities are geared toward preventing specific diseases, such as immunization to prevent poliomyelitis.
- Health promotion includes (1) information dissemination, (2) health appraisal and wellness assessment, (3) lifestyle and behaviour change, and (4) environmental control programs. These programs can be carried out in the home, schools, community centres, hospitals, and worksites.
- Pender's health-promotion model depicts the multidimensional nature of persons interacting with their interpersonal and physical environments as they pursue health. The major motivational variables that are modifiable through nursing interventions include perceived benefits of action, perceived barriers to action, perceived self-efficacy, activity-related affect, interpersonal influences, and situational influences.
- Prochaska et al. proposed a six-stage model for health behaviour change: (1) precontemplation, (2) contemplation, (3) preparation, (4) action, (5) maintenance, and (6) termination. If a person is not successful in changing behaviour, relapse occurs. At any point in these stages, people can move to any previous stage. An understanding of these stages enables the nurse to provide appropriate nursing interventions.
- The nurse's role in health promotion is to act as a facilitator of the process of assessing, planning, implementing, evaluating, and understanding health. Nurses seek opportunities to strengthen the profession's influence on health promotion, disseminate information that promotes an educated public, and help individuals and communities to change long-standing adverse health behaviours.
- A complete and accurate assessment of the individual's health status is basic to health promotion. Assessments or reviews of a client's spiritual health, social support, health beliefs, and life stress are also important because they affect a person's health.
- Health-promotion activities are mutually planned and directed according to the client's needs, desires, and priorities.
- The nurse provides ongoing support and supplies additional information and education in order to help individuals change their lifestyles or health behaviours.
- During the evaluation phase of the health-promotion process, the nurse assists clients in determining whether they will continue with the plan, reorder priorities, or revise the plan.
- As role models for their clients, nurses should develop attitudes and behaviours that reflect healthy lifestyles.

ASSESS YOUR LEARNING

1. Which of the following is the aim of health promotion?
   a. Reduce premature death
   b. Empower and expand positive potential for health
   c. Minimize the occurrence of harms to health and well-being
   d. Avoid illness and maintain health functioning

2. Which of the following is a health-promotion priority today?
   a. Securing an infrastructure for health promotion and consolidating and expanding partnerships for health
   b. Developing personal skills and orienting health services
   c. Developing population health models
   d. Creating new determinants of health

3. Using a condom during sexual activity is an example of which if the following?
   a. Health promotion
   b. Health protection
   c. Disease prevention
   d. Empowerment

4. What is the best way for the nurse to promote safe sexual practices in a group of adolescents?
   a. Provide condoms.
   b. Encourage abstinence.
   c. Teach ways to prevent pregnancy.
   d. Teach safe sex practices.

5. Which of the following statements reflects the contemplation stage of behaviour change?
   a. "I currently do not exercise 30 minutes three times a week and do not intend to start in the next 6 months."
   b. "I have tried several times to exercise 30 minutes three times a week but am seriously thinking of trying again in the next month."
   c. "I currently do not exercise 30 minutes three times a week, but I am thinking about starting to do so in the next 6 months."
   d. "I have exercised 30 minutes three times a week regularly for more than 6 months."

6. A female client is 20 kg overweight. She previously attended two programs that guaranteed weight loss. Although she lost the weight, she gained it back and more after each program. She tells you, "I was just born to be fat. I don't have the willpower." According to Pender's health-promotion model, the nurse should focus on which of the following behaviour-specific cognition and affect variables for this client?
   a. Perceived barriers to action
   b. Perceived self-efficacy
   c. Interpersonal influences
   d. Situational influences

7. If a client fails to follow the information or teaching provided, how should the nurse respond?
   a. Give up as the client does not want to change his behaviour.
   b. Tell the client that he must follow your instructions.
   c. Act as the role model for the client so that he can imitate the expected behaviour.
   d. Assess what the barriers are and allow the client to determine what he can or will do.

8. Which of the following individuals would have an increased possibility of illness in the near future?
   a. A 25-year-old man who recently married his high school sweetheart
   b. A 35-year-old man who was fired from his job
   c. A 40-year-old woman who started a nursing program
   d. A 50-year-old woman whose husband died a month ago

9. A client is very worried about how his business is doing while he is hospitalized. He spends much time on the phone and with colleagues instead of resting. To promote the client's health, what should the nurse do first?
   a. Assess the client's physiological needs.
   b. Assess the client's perception of his health status.
   c. Discuss with the client the plans for the needed behavioural change.
   d. Eliminate stress and distraction by offering the client a private room.

10. Which of the following provides data that indicate whether the person has an increased chance of acquiring a specific disease?
    a. Lifestyle assessment
    b. Health risk appraisal
    c. Health beliefs review
    d. Health education

After working through these questions, go to the MyNursingLab at ***http://www.mynursinglab.com*** *to check your answers and see explanations.*

SUGGESTED READINGS

Maville, J. A., & Huerta, C. G. (2008). *Health promotion in nursing* (2nd ed.). Clifton Park, NY: Thomson Delmar Learning.

This book provides a comprehensive view of health promotion. It includes conceptual frameworks, theoretical approaches to health promotion, relevant nursing concepts, and health-promotion interventions and strategies throughout the life cycle.

O'Neill, M., Pederson, A., Dupéré, S., & Rootman, I. (2007). *Health promotion in Canada: Critical perspectives* (2nd ed.). Toronto: Canadian Scholars' Press.

This book provides a detailed account of health promotion, both globally and nationally. It challenges the readers to analyze various issues and perspectives related to the current state of health promotion and for the future of humanity.

WEBLINKS

Centre for Health Promotion: University of Toronto

http://www.utoronto.ca/chp/

This health-promotion site is internationally recognized for leading and linking community and academia into partnership in education, evaluation, and research. It develops and evaluates innovative health-promotion approaches and best practice guidelines and conducts various health-promotion educational programs.

Public Health Agency of Canada

http://www.phac-aspc.gc.ca/new_e.html

The role of this federal website is to promote and protect the health of Canadians through leadership, partnership, innovation, and action in public health through dissemination of latest comprehensive information, resources, and government releases.

Health Canada

http://www.hc-sc.gc.ca

A federal government site that provides health information, related issues, and resources to help Canadians to maintain and improve their health.

Ontario Ministry of Health Promotion

http://www.mhp.gov.on.ca/english/about.asp

Established in 2005, this site provides information that targets specific sectors of society. It aims to help Ontarians to live healthier by making healthy choices and choosing healthy lifestyles.

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