HEALTH PROMOTION:

A Person-Centred Approach to Health and Well-being

By
Alberto Zucconi & Patty Howell

Preface

Seventeen years have passed since the Ottawa Charter called attention to international organisations and to all populations to acknowledge and support the value of Health Promotion as a fundamental social investment.

The Charter establishes fundamental criteria and urges political powers to consider themselves as the most valuable resource, both collectively and individually, and in reorienting public policies to promote a healthier lifestyle.

Since the Charter, activities for supporting and realising approaches for Health Promotion have sincerely increased. In the last years, the advantages of social, economic and individual development have aroused the interest of many people toward the reality of a better quality of life and its effect.

The authors of this book are inspired by their tireless work in Health Promotion over many years. They notice continually the deep, increasing and interminable changes that affect the lives of people in a world constantly developing, and the consequences caused by persistently ignoring the evident damage resulting from these changes and the major dangers of passivity.

They have confronted these issues from a wider perspective than the one offered by the traditional health approaches, and they have illustrated to the reader a paradigm—the bio-psychosocial model of health—which is the more comprehensive of the many determinants of health. Each of these determinants emerges from the bio-psycho and social dimensions of this model, which embeds health in a more holistic context. The assets of this approach are immense.

Particular emphasis is given to the need for each individual to understand that he is "the main carer" of his own life and "the centre of his own health". This empowerment is fundamental for the success of the Person-centred Approach to Health and well-being.

The percentage of absence in the workplace due to sickness have significantly increased in some countries, stress is evident everywhere. Nutrition and food habits keep changing. A healthy work force has become an essential requirement for efficiency, product quality and competitiveness of companies.

These issues and many others are deeply examined in the many chapters of this book, applying the bio-psychosocial model and supplying to the reader concrete examples as well as a practical application in each of the examined contexts.

The work is supported by good research; it reveals the grave aspects of problems and enlightens each of the many examined contexts. The book utilises an easily understandable

language which is translatable into other languages, even if some words and expressions may seem difficult for use in foreign idioms. It is an essential reading for all those who acknowledge the need for change and also for aspiring trainers in the field of Health Promotion.

Although the work has been challenging, the reader will be enthusiastic and stimulated by the variety of material presented.

Francis LaFerla

Francis La Ferla, M.D.—Medical doctor, international expert in the promotion of health in the workplace. Scientific consultant for IACP for Health Promotion programs. Former head of the World Health Organization Programs for the Promotion of Health in the Workplace in Europe.

Dedication

This book is dedicated to Carl R. Rogers whose esteem has given me the courage to be who I am.

A.Z.

For my mother, Dorothy R. Howell, at whose knees I learned my first lessons in Health Promotion. Now in her senior years, her vigour and zest reflect a lifetime of good health habits, an inspiration for which I am most grateful.

P.H.

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Luckily, the stress has been balanced by the passion and the enthusiasm determined by the fact that I did believe, as I do today, that promoting health is promoting social change, and this invitation gave me the opportunity and platform to widen the work in which I wanted to invest my personal and professional life.

This book is the result of my experience in the field and of what I could learn from the many significant people in my life. The contacts I had with anonymous persons in the field generously shared with me the outcomes of their work and allowed me to visit their projects.

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A.Z. & P.H.

Introduction

The second half of the twentieth century brought developments in science and human understanding that have given us, for the first time in history, a meaningful opportunity to promote human health. This book and the field of Health Promotion itself are rooted in the fertile soil of the World Health Organisation's Ottawa Charter for Health Promotion. Health Promotion thrives from advances in medicine, the psychosocial sciences, System Theory and the Person-Centred Approach. The rich fruit of Health Promotion, which the world has only just begun to sample, empowers professionals and the clients they serve throughout society.

This book is an ambitious undertaking which aims to give readers both a general overview of the comprehensive field of Health Promotion and a reference tool for future use. Intended both for health professionals and those from numerous other professions whose work impacts the health of others, we hope it will inspire and empower people to make health-benefiting changes in their personal lives as well.

A note on the book's structure: in chapters 7-10, we cover the key bio-psychosocial determinants of health and repeat them again in chapters 14-17. The earlier chapters contain the core concepts and research supporting their validity; the later chapters explore ways health professionals can work with these determinants to help clients—both individual and organisational—impact health in positive ways.

We hope that readers will take from this book whatever empowers them to promote health. Health Promotion is an exciting undertaking that provides a worthy challenge for all of us, both individually and collectively, and will, as we move ahead, be a measure of our advancement as human beings.

Alberto Zucconi & Patty Howell

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Section I
Health into the 21st Century

"Good health is a major resource for social, economic and personal development and an important dimension of quality of life."

WHO Ottawa Charter for Health Promotion

Chapter 1 – Our Present State of Health

1.1 Perspectives on Health

From time immemorial, people around the world have known the crucial importance of health. Simonides of Ceos wrote in the 6th century BC that "There's no joy even in beautiful Wisdom, unless one have holy Health".[1] Other writers have called health "the groundwork of all happiness",[2] "the vital principle of bliss",[3] "a blessing that money cannot buy".[4] Sir Walter Scott declared "Health alone is victory".[5] Traditional folk wisdom is straightforward: "Without your health, what have you got?"

A century ago, life expectancy was only about half what it is today, with many people dying from infectious diseases, unsafe water treatment and waste disposal practices. Amazing medical and public health advances during the 20th century, greater income and education, the development of antibiotics and immunisation, all have increased life expectancy. As a result, most people do not die now from infections. Nevertheless, there are new health problems, with the primary cause of death in developed nations now due to chronic diseases resulting from lifestyle factors.[6]

Meanwhile, health, a central component of human well-being, remains for large segments of the population, even well educated ones, somewhat mysterious

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[1] Simonides of Ceos. *Sextus Empiricus: Against the Mathematicians,* in: Bartlett, J. *Familiar Quotations* (Boston: Little, Brown and Company, 1941).
[2] Hunt, L. *Deaths of Little Children,* in: Bartlett, op. cit.
[3] Thomson, J. *The Castle of Indolence*, Canto II, Stanza 55, in: Bartlett, op. cit.
[4] Walton, I. *The Compleat Angler,* Chapter VIII, in: Bartlett, op. cit.
[5] Scott, W. (London: London and Westminister Review, Nov. 23, 1838), in: Bartlett, op.cit.
[6] DiClemente, R. J., Crosby, R.A., & Kegler, M.C. *Emerging Theories in Health Promotion Practice and Research*. (San Francisco: Jossey-Bass, 2002).

and somewhat outside the reach of conscious control. People tend to feel that they've been "blessed" with good health or not; that, somehow, health either comes to them or it does not. For most, the sense of feeling healthy is familiar, punctuated only occasionally with times of illness. Yet for many, health is a non-existent or rare commodity.

For the human species as a whole, health concerns are some of the greatest problems in life—for individuals, families, employers, communities and society at large. They are multi-dimensional in their impact and their costs throughout human society are truly staggering.

Because of the enormous impact of health—on human life, happiness, relationships, productivity and many aspects of society—the authors believe it crucial for us to challenge the assumption that we can indulge in passive attitudes toward health. Modern advances have opened a door enabling people to see, understand, and finally, to choose a variety of behaviours which can impact their own health in a multitude of positive ways, and likewise the health of their families, work associates and community. Advances in understanding the nature of health and healthy choices give this generation an opportunity to push back the shackles of passivity and realize that their own health, as well as the health of their families and even society at large, is to a very great extent in their own hands.

This book is about helping health professionals, and people from a variety of other professions whose work affects the health of others, seize the extraordinary and unprecedented opportunity to impact their own life and those of the people around them.

1.2 The Extent of Human Health Problems

If the Chinese word for "crisis" also means "opportunity," then there is no clearer way to describe the state of health in contemporary society. There are signs of crisis—and opportunity—from every quarter.

- Since the early 1970's, the main causes of death and illness have been **chronic, degenerative diseases** such as coronary heart disease, cancers, and accidents[7] that result in large part from behavioural choices. Approximately 50% of premature deaths now result from unhealthy lifestyles.[8] Because of their strong behavioural components, these illnesses have been called the "diseases of civilization."[9]
- Two million workers die each year through **work-related accidents and diseases**. For every fatal accident there are meanwhile 500-

[7] WHO. *Health Promotion in the Workplace: Strategy Options* (European Occupational Health Series No. 10, 1995), pg. 8.
[8] Michael, J.M. The Second Revolution in Health: Health Promotion and Its Environmental Base. (*American Psychologist*, 1982), 37, 8.
[9] Hamburg, D.A., Elliott, G.R. & Parron, D.L. *Health and Behaviour: Frontiers of Research in the Biobehavioural Sciences*. (Washington, D.C.: National Academy Press, 1982).

2000 additional injuries; for every fatal work-related disease there are 100 other illnesses causing absence from work. The World Health Organization (WHO) reports 160,000,000 annual new cases of work-related diseases worldwide, including respiratory and cardiovascular diseases, cancer, hearing loss, musculoskeletal and reproductive disorders, mental and neurological illnesses;[10] 68,000,000 - 157,000,000 new cases are attributed to hazardous exposures of workloads.[11] The International Labour Organization (ILO) reported in 2002 that the number of annual deaths among workers has increased significantly since 1990, especially work-related cancer and circulatory diseases.[12]

- Although **women** make up 42% of the estimated global working population, their needs are seldom adequately met even when they have access to some occupational health services.[13] Specific workplace risks for women include adverse effects on reproduction, musculoskeletal disorders because tasks and equipment used are designed for men, stress-related disorders from job discrimination, the double burden of work from both the workplace and home, and sexual harassment.[14]
- Of the 250,000,000 **working children in developing countries** aged 5-14, nearly 70% work under hazardous conditions;[15] 12,000 of these children die annually as a result of working conditions.[16]
- The ILO estimates that **approximately 4% of the world's Gross Domestic Product (GDP) is lost as the result of diseases**, absences from work, sickness treatment, disability and survivor benefits. Added to this are the tremendous emotional and financial difficulties experienced by families of workers.[17] Depending on country, type of economic activity and enterprise, approximately 30% of workers worldwide, and 50-70% in developing countries, are exposed to heavy physical workload, hazardous physical, chemical, biological or ergonomic factors.[18]
- **Psychological stress** at work is an increasing trend, particularly in industrialized countries. The European Union predicted that in 2002 work-related stress would affect at least 40,000,000 workers in its 15

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[10] WHO. *Occupational Health: Fact Sheet No. 84,* (1999, rev.). (www.who.int/inf-fs/en/fact084.html 10/6/02).
[11] WHO. *Occupational Health: The Workplace* (<<www.who.int/peh/Occupational-health>> April 2, 2002.)
[12] Takala, J. *Decent Work—Safe Work, Introductory Report to the XVI World Congress on Safety and Health at Work*. (Geneva: International Labour Office, 2002).
[13] WHO. *Occupational Health*: *Fact Sheet No. 84*, op. cit.
[14] Ibid.
[15] Ibid.
[16] Ibid.
[17] Ibid.; Takala, op. cit.
[18] WHO. *Global Strategy on Occupational Health for All* (World Health Organization, 1995), pg. 20.

member States and cost the EU at least 20 billion Euros annually.[19] More than 40,000,000 working days in the UK are lost each year due to stress-related disorders; in the U.S., more than half of the 550,000,000 working days lost each year are due to stress-related absenteeism.[20] Stress hazards cause loss of health, well-being, working capacity and "affect the productivity, quality of working life, and economic status of individuals, companies and nations."[21] **Social conditions** such as gender and ethnic inequalities or segregation, pressure from managers, clients, customers or the public can also increase the psychological stress of work.[22]

- **Other psychological factors** associated with work have increasingly become health hazards with up to half of all workers in industrialized countries evaluating their work as "mentally heavy." Time pressures and hectic work schedules are part of the problem; other adverse psychological factors include heavy responsibility for human or economic concerns, monotonous work, shift-work, and work requiring constant concentration, irregular working hours, working under threat of violence, sexual or ethnic harassment, and physical isolation. Stress and overload have been associated with sleep disturbances, burn-out syndromes and depression, in addition to elevated risk of cardiovascular disorders, particularly coronary heart disease and hypertension.[23]

- Occupational injuries and diseases play an even more important role in **developing countries** where 75% of the working population of the world lives[24] and more than 90% of occupational diseases and injuries remain unreported.[25] The **least developed countries** face the most severe occupational health problems—heavy physical work, often combined with heat stress, occupational accidents, pesticide poisonings, organic dusts and biological hazards. These factors are aggravated by numerous non-occupational factors such as parasitic and infectious diseases, poor hygiene and sanitation, poor nutrition, general poverty and illiteracy.[26] Ten to thirty percent of the workforce in industrialized countries, and up to 80% in developing and newly industrialized countries, are exposed to these physical factors—and in some high-risk sectors such as mining, manufacturing and construction, all workers may be affected.[27] Noise-induced hearing loss is one of the most prevalent occupational health effects throughout the world.[28]

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[19] Di Martino, V., Gold, D. & Schaap, A. *Managing Emerging Health-Related Problems at Work* (Geneva: International Labour Organization, 2002), pg. 1.1.
[20] Op. cit., pg. 3.7.
[21] WHO. *Global Strategy on Occupational Health for All*, op. cit., pg. 20.
[22] WHO. *Occupational Health: The Workplace*, op. cit.
[23] WHO. *Global Strategy*, op. cit., pg. 25-26.
[24] WHO. *Declaration on Occupational Health for All* (1994), pg. 2.
[25] WHO. *Occupational Health: Fact Sheet No. 84, op. cit.*
[26] WHO. *Global Strategy*, op. cit., pg. 21.
[27] Ibid.
[28] WHO. *Occupational Health: The Workplace*, op. cit.

- Over 100,000 different **chemical products** are used in modern work environments and the number grows constantly.[29] Health effects include metal poisoning, damage to the central nervous system and liver, pesticide poisoning, dermal and respiratory allergies, dermatoses, silicosis and other lung diseases, cancers and reproductive disorders.[30] Reproductive hazards in the workplace include 350 chemicals[31] known to be mutagenic or carcinogenic. Adverse effects include infertility in both sexes, spontaneous abortion, foetal death, foetal cancer, toxic damage to the foetus and retarded development of the foetus or newborn.[32]
- Exposure to 3000 **allergenic agents** in the environment is a significant occupational hazard, especially allergic skin and respiratory diseases. Cases of occupational respiratory diseases, including occupational asthma, have risen steadily in industrialized countries.[33]
- **Traffic hazards** are approaching epidemic dimensions in many countries,[34]adding to the stress and health risks for those commuting to work daily.

There are numerous alarming and revealing statistics available, all pointing to the clear connection between human behaviour and health status. Everything human beings do affects their health—where we live, what we eat and drink, where we work and what we do at work, who we associate with and how we relate to them, what physical exercise we get, how we handle stress, how we relate to the various aspects of reality. It would appear that in modern society we have developed many diseases of civilization—and an almost endless number of ways to endanger our health and well-being.

1.3 The State of Modern Health Care

When people find they aren't feeling right or experience some kind of health problem, most see a doctor. They tell the doctor about the problem, its symptoms, and the doctor makes an examination. This is followed by a diagnosis made by the doctor along with a treatment plan. Most—but not all—patients follow the treatment plan and wait—patiently—to get better. This is a familiar pattern. Fortunately, much of the time it works well, thanks in part to many advances in medicine over the past several decades. Unfortunately, results are sometimes less than satisfactory, for a variety of reasons.

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[29] WHO. *Global Strategy*, op. cit., pg. 23.
[30] WHO. *Occupational Health: The Workplace*, op. cit.
[31] WHO. *Occupational Health: Fact Sheet No. 84*, op. cit.
[32] Ibid.
[33] Ibid.
[34] WHO. *Global Strategy*, op. cit., pg. 22.

Patients' complaints about health care have become increasingly loud and there is ample evidence of a real crisis in modern health care. Complaints run the gamut: Long waits at the doctor's office, inadequate time with the doctor, high cost of medicine and treatment, medical maltreatment, inadequacy of health insurance coverage, side effects of medication and treatment, impersonal care shown by the physician and other health practitioners, being sent home from the hospital too early. Additionally, doctors and other health professionals experience numerous wrenching problems with the system itself.

> The current U.S. public health investment strategy "directs 100 times more resources toward medical services than it spends for population-based prevention strategies even though treatment strategies contributed only five of the thirty years increase of life expectancy at birth that has been achieved in the U.S. since 1900."
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> Turnock, J.B. *Public Health*. (Gaithersburg, MD: Aspen Publishers, Inc., 2002.)

Despite common amazement at the advances made in modern medicine, there is an overriding sentiment of frustration, disappointment, annoyance, anger, and even a sense of betrayal by the modern health care system.

Much of that anguish is directed at the cost of health care. Advances in technology and increases in the cost of health insurance have interacted to create skyrocketing medical care costs.[35] Davies and Felder reported a general consensus in 1990 that "the costs of the American care system are out of control",[36] and there has been no decline since then.

Although the United States spends a higher proportion of its national wealth on health care than any other country, a survey released in 2000 by the World Health Organization ranked the U.S. 37th among 191 nations whose health care system was analyzed by the study. One factor reducing the ranking of the U.S. was the unequal distribution of health care services.[37]

Yet there's little room for pride among those European countries heading the list. Dr. David Evans of the WHO's Global Program on Evidence for Health Policy said that even in Italy and Spain, countries ranked second and third on the list, "people don't believe their health systems are doing very well."[38]

The study also sounds a general note of alarm: "Virtually all countries are underutilizing the resources available to them. This leads to large numbers of preventable deaths and disabilities, unnecessary suffering, injustice, inequality and a denial of an individual's basic rights to health."[39]

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[35] Ogden, J. *Health Psychology: A Textbook*. (Buckingham, UK: Open University Press, 1996), pg. 9.
[36] Davies, N.E., & Felder, L.H. Applying brakes to the runaway American health care system (*Journal of the American Medical Association,* 1990), 263, 73-76.
[37] *San Diego Union-Tribune* (July 21, 2000).
[38] Ibid.
[39] Ibid.

Moreover, it is not medical treatment but public health efforts that are largely responsible for advancements in life expectancy—specifically social policies, community actions and personal lifestyle changes.[40]

1.4 Hidden Dangers of Being a Patient

In addition to the grim evidence that the health care system in developed nations is both more expensive and less effective than desirable, there is a further, somewhat obscured cost in our way of relating to health care in the industrialized world. This can be called the hidden dangers of being a patient.

Modern medical practice is structured with the doctor at the top of the ladder, other health care professionals below this, and the patient at the bottom rung. A consequence of this way of shaping reality is the disempowerment of the patient. There may be no simpler way to express this than by reviewing synonyms of the word *patient*: submissive, calm, susceptible, long-suffering, invalid. Indeed, there is an essential invalidation of the person that occurs as a by-product of our health care practices, including ways of relating to patients that discount their concerns, observations, needs, their human dignity, and their potential for regaining health. These problems are exacerbated by hospital practices organized around the needs of health practitioners, and practices that dehumanize the people whose health is actually on the line.

The invalidation of patients is not just a matter of semantic cleverness. The helpless, passive role expected of patients is, in fact, bad for their health. Social critic Ivan Illich, writing as far back as 1976, saw modern technological medicine as overextending itself and becoming "medical imperialism"—insisting that anything remotely connected with health belonged under the supervision of the medical profession. The disabling impact of professional control, he wrote then, had already "reached the proportions of an epidemic."[41] Illich went even further, seeing the medical establishment as a major threat to health itself.

The costs of passivity are both economic and personal: for example, the Rand Corporation has estimated that unnecessary tests add more than $50,000,000,000 yearly to U.S. health costs. Many patients receive unnecessary treatments that injure or even end their lives. A Rand study found that 2/3 of patients received carotid endarterectomies for questionable reasons with almost 10% suffering a stroke or dying as a result of the procedure.[42]

But the costs go even beyond that. The modern patient has learned to be a patient, passive recipient of whatever health-affecting circumstances are meted out to him by the medical system and life in general—whether they are life-enhancing or life-damaging. The by-product of modern medical practice is that the locus of

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[40] Turnock, B.J. *Public Health: What It Is and How It Works*. (Gaithersburg, MD: Aspen Publishers, Inc. 2001), pg. 21.
[41] Illich, I. *Medical Nemesis: The Expropriation of Health.* (New York: Pantheon Books, 1976), pg. 3.
[42] Winslow, R. AMA, Rand go after modern ill: Unneeded procedures (*The Wall Street Journal*, March 22, 1990), pp. B1, B5.

control for health has been handed over to the medical establishment. Most people do not view themselves as the person primarily responsible for their own health. Consciously or unconsciously, they have externalized that responsibility and assigned it to medical professionals—on whom they rely to cure them when they're ill. Then, typically people go on about their lives until illness arrives again, followed by another trip to the medical centre looking for another cure.

Whether healthy or ill, most people in industrialized countries don't experience being in charge of their own health. They have fallen into a pattern of "learned helplessness" in regard to their health and well-being. Like benumbed dogs in early research experiments that learned shock was inevitable regardless of their actions, people accept working and environmental conditions that threaten their health, and then rely on whatever medical care is available. They have become so benumbed, passive and patient that there is little recognition of the right and the need to take action on their own behalf when living or working environments jeopardize their health or health support systems are less than adequate.

People have given their power over to others—to employers, political leaders, to the health care establishment—oftentimes without realizing it. To further compound the damage, people commonly commit a profound act of self-denial by thinking they do not have the power to create change. By delegating this power to others, people have made themselves health illiterate and self-care illiterate.

1.5 The Seductiveness of Passivity & Helplessness

We shouldn't blame anyone for this passivity, but it is important that people come to recognize it. It grew in part as a by-product of the amazing wizardry of modern medicine. The 20th century brought endless breakthroughs in medicine—vaccinations against scourges that decimated previous generations, cures for diseases beyond imagination, surgeries of incredible technique and impact, miraculous new medications, mapping of the human genetic code and its promising possibilities, and countless other breakthroughs. It is no wonder the average person feels inadequate in comparison to this incomparable wisdom and skill. To this we must include the time immemorial tradition of honouring the wisdom of the healer, and the crucial importance of belief and hope regarding the efficacy of the treatment being offered—a practice that heightens patients' sense of awe about the health professional while denigrating their own powers.

We must also add to this list the never-ending move toward efficiency in modern life—streamlining practices that enhance health professionals' ability to minister to the needs of many while devaluating the needs of the individual. Moreover, medical health insurance policies and managed care programs have significantly changed the way medicine is practiced, in many cases causing further disregard for patients' needs and a greater sense of helplessness.

It is hardly possible to overestimate the impact of these factors. Yet, we must add the seductiveness of passivity as an additional factor. Almost everyone likes to be taken care of—at least people like to be taken care of well! And most like to be able to turn over certain aspects of their lives for others to handle. They look to their

spouses to handle many aspects of their personal and emotional life; they look to secretaries and other associates at work to handle aspects of life at work, so why not look to the medical establishment to handle their health? It makes a certain amount of sense, and it's appealing as a concept.

Finally, we need to recognize that much of human behaviour is regulated by attractive short-term gains that have negative long-term consequences. The temptation will always be there for people to do nothing about matters such as health, a choice which in the short run reduces through avoidance and procrastination, the anxiety they might otherwise feel about behaviours that have a direct bearing on their lives.

1.6 The Costs of Powerlessness & Avoidance

Collectively, this passivity and avoidance has resulted in the widespread failure to seize opportunities to promote health. Ultimately, we cannot afford this position—personally, economically, or as a society. The costs of retaining the status quo, abdicating responsibility for one's own health, remaining passive recipients of health determinants and health status, then looking for fixes whenever health ruptures occur, are intolerable in every imaginable way.

The United States spent a staggering $1.3 Trillion in 2000 on health care expenses, and if current growth rates continued, would mean that by the year 2055 health care costs consumed 100% of the gross national product.[43] This intolerable result would cause every hour, every minute, and every second of human production to be devoured by medical costs."[44] And much of that mountain of money would be spent on damage repair with very little allocated to prevention.

Despite the enormity of money being spent on health care, less than 5% is spent on public health, and only a fraction of that is spent on *Health Promotion*. Although cardiovascular disease was in 1999 the number one killer of Americans, with 1,000,000 annual deaths and associated health care costs of $286.5 billion,[45] only 1% was spent on the prevention of coronary heart disease (CHD).[46] Similarly, CHD is the main cause of death in the UK, costing the British health care system about 1.6 trillion pounds (2.6 billion Euros) in 1996, in addition to associated production losses of more than 10 billion pounds (16 billion Euros a year),[47] with only 1% of the UK health care expenditures for prevention. An effective resolution of this situation will not come from more economic investment but by an approach that enables us to get at the root of the problem.

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[43] World Health Organization. *The World Health Report, 2002*. (Geneva: WHO, 2002).
[44] Sheridan, C.L. & Radmacher, S.A. *Health Psychology: Challenging the Biomedical Model.* (New York: John Wiley & Sons, Inc., 1992), pg. vii.
[45] <<www.ageworks.com>> (April 9, 2002).
[46] National Heart Forum. (<<www.heartforum.org.uk >> April 9, 2002.)
[47] *British Heart Foundation, Statistics Database 2002*. (Oxford: British Heart Foundation Health Promotion Research Group, Department of Public Health), 2002.

Perhaps the most powerful fuel for Health Promotion efforts is our awareness that most illness and death are created by the ways human beings live their lives—not by inherent malfunctioning of the human body but by the abuses people perpetrate on themselves through their work and lifestyle choices. We can no longer allow denial and a sense of powerlessness to endorse continuation of behaviours that undermine people's health and well-being, and ultimately that of society. Ultimately, it is intolerable to allow human beings to live in polluted environments, work in high stress/high risk jobs, consume foods, drink, and drugs known to be harmful, operate cars and other machinery in ways that endanger, engage in high risk sexual practices, and demand their bodies perform without the supportive benefits of regular exercise.

We must recognize the overwhelming evidence showing these practices as dangerous to human health. We must not allow the perpetuation of health-damaging practices by tolerating ignorance about the likelihood that anything bad can happen. The illusion of invulnerability is a quality we disparage in adolescents, yet huge numbers of adults throughout the world persist in lifestyles that damage or kill. Likewise, others operate on the basis of human expendability, and refuse to take action against conditions damaging to health.

Humans seem reluctant to look soberly at their own behaviour and recognize that what they do is likely to hurt them. It seems similarly difficult for corporations to examine the impact of their work practices on the lives of workers. Who is willing to look at the impact of transportation systems and do something meaningful to curtail the damage from auto exhausts? Who will deal with habitat destruction and its impact on the environment and human ecology?

The difficulties of grappling with health problems—personal or societal—seem so great that most people gasp in despair and push them out of their thoughts. They remain passive and helpless, perpetuating behaviours and conditions that take a great toll on human health. Yet, when we examine the data, it is impossible to escape the connection between human behaviour and health, and between health and the environment—both internal and external. To operate from the notion that health is beyond our control has become a naïve notion we can no longer afford to hold.

To a great extent, the thrust of this book will apply to developed countries, yet effective Health Promotion efforts are desperately needed in many third world countries. In sub-Saharan Africa, infectious diseases, especially HIV/AIDS and tuberculosis, and lack of reproductive care for women are major killers that bring enormous economic, social and political consequences. We must summon the personal and political will to deal with health problems everywhere.

For the individual, health problems entail the loss of well-being, livelihood, happiness, satisfaction, even life itself, added to which are concomitant losses to the family. For business and industry, the losses are measured in direct costs, production losses and countless intangible costs. For society, the cost of unnecessary damage to health and life, compounded year after year over the lives of millions of people, is truly incalculable.

"We need a new model of health that does not entail more medicine, more doctors, more hospitals, more drugs, or more money. We need an approach that involves us and empowers us, as individuals and institutions, to be integral and responsible participants in our own health, to help others who are less fortunate, and to help the nation as a whole."

Pelletier, KR. *Sound Mind, Sound Body: A New Model for Lifelong Health* (New York: Simon & Schuster, 1994), pg. 231.

As we look at the scope of the health crisis in contemporary society, it is hard to overestimate the extent of the problem. However, when we examine the degree to which illness and death are directly linked to human behaviour and are therefore potentially controllable and changeable, it is hard to overestimate the extent of the opportunity available to us.

1.7 Health Promotion as the Answer

Fortunately, there are forces at work that will support us as we work toward transforming our approach to health:

- International bodies are setting enlightened and empowering goals;
- A systemic paradigm allows us to recognize a sweeping array of health determinants we can now address;
- Understandings about how reality is created give us tools for creating social change;
- Pioneers from many fields have developed innovative working models applicable to all levels of society;

This book explores all of these facets of Health Promotion and the opportunities available for transforming our health, our lives and the world we live in.

Chapter 2 – The New Vision

"(We) acknowledge people as the main health resource… and … recognize health and its maintenance as a major social investment and challenge."

WHO Ottawa Charter for Health Promotion

2.1 Goals Set by International Bodies

The World Health Organization has recommended that member nations shift their vision about health. The Ottawa Charter, drafted in 1986 by delegates from around the world, crafted a policy on Health Promotion that has set the standard for a more effective way to deal with reality. Its opening paragraph rings with vision and intention:

> *"Health promotion is the process of enabling people to increase control over, and to improve, their health. To reach a state of complete physical, mental and social well-being, an individual or group must be able to identify and to realize aspirations, to satisfy needs, and to change or cope with the environment. Health is, therefore, seen as a resource for everyday life, not the objective of living. Health is a positive concept emphasizing social and personal resources, as well as physical capacities. Therefore, health promotion is not just the responsibility of the health sector, but goes beyond healthy life-styles to well-being.[48]"*

With the view that health is a resource, the WHO argues that governments should "plan to maximize its production by social and economic development across agricultural, trade, education, industrial and communication policy areas."[49] WHO emphasizes the role of Health Promotion in helping individuals develop personal capacities and in identifying resources and strategies to improve communities.[50]

Other inspirational declarations have followed: The United Nations, WHO and ILO have stated the principle that "every citizen of the world has a right to healthy and safe work and to a work environment that enables him or her to live a socially and economically productive life."[51]

The Rio Summit, focusing on sustainable development to meet the needs of the present world population without adverse effects on health, declared that

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[48] WHO. *Ottawa Charter for Health Promotion (Charte D'Ottawa Pour La Promotion de la Santé*). (1986). (See Appendix for complete text.)
[49] Bennett, P. & Murphy, S. *Psychology and Health Promotion.* (Buckingham, UK: Open University Press, 1997), pg. 82.
[50] Ibid., pg. 82-83.
[51] WHO. *Global Strategy on Occupational Health for All*, op. cit., pg. 6.

"Human beings are at the centre of concern for sustainable development. They are entitled to a healthy and productive life in harmony with nature."[52] The convocation viewed occupational health at the core of sustainable development and emphasized prevention of occupational accidents and injuries, safe and low-waste production technology, reducing waste of energy and materials, and reducing other environmental hazards and burdens. The Rio Summit called for "a healthy, productive and well-motivated workforce" as the key to overall socioeconomic development.[53] The Johannesburg World Summit of 2002 focused on linkages between business and sustainable development since the Rio Summit and looked to the next point on the business curve—when business becomes more competitive by being more sustainability driven.[54]

Despite compelling cases that can be made in support of these declarations—morally, ethically, environmentally and in terms of business success—these goals have yet to penetrate the consciousness of most people.[55] Health objectives of the United States which were adopted for the period 1990-2000 did not receive high visibility in the public media and were not discussed systematically with patients by health professionals or in public by political leaders. Likewise, the 38 targets for health set by WHO Regional Office for Europe "to be reached by the Member States of the Region by the year 2000";[56] there is scant evidence of more vibrant health throughout Europe as a result. What of Africa, Australia, Asia, the Middle East, and Latin America? Clearly there is a gulf between the vision of health leaders and the health reality of ordinary citizens.

2.2 Personalizing the Challenge

The concept of "Compression of Morbidity" helps personalize the challenge of Health Promotion. It has to do with extending the time of functional health and delaying the onset of debilitating illness as long and as much as possible. The phrase itself is not immediately appealing, but it actually reflects what every human being hopes for: Dying young, as late as possible.

Most people don't have a sense of being able to compress their morbidity or even the hope of doing so. As a result, many envision old-age as a time of diminished health, capacities and satisfactions, accompanied by increased pain, physical limitations, frustration, deformity, isolation, and expense. Many people

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[52] Op. cit., p. 7.
[53] Op. cit., pg. 8
[53] Bennett & Murphy, loc. cit.
[53] Ibid.
[54] Johannesburg World Summit: 2002. World Summit on Sustainable Development www.wwbcsd.org/summit/index.htm
[55] Timberlake, L. (ed.). *The Business Case for Sustainable Development: Making a Difference Towards the Johannesburg Summit, 2002 and Beyond*. (Switzerland: World Business Council for Sustainable Development, 2002.)
[56] Kickbusch, I. *Action on Health Promotion: Approaches to Advocacy and Implementation.* (Copenhagen: World Health Organization Regional Office for Europe, 1989), pg. 8.

express no interest in living to an old age because the spectre of aging is not a pretty one.

As gerontologist Walter Bortz has said, "the one thing we know for certain is that most human beings are not dying of old age."[57] Evidence presented earlier clearly suggests that we are dying because of continually engaging in a variety of behaviour patterns that damage our health, and because we fail to acknowledge the connection between our self-chosen behaviour and our health. Interestingly, James F. Fries of the Stanford University School of Medicine believes that for healthy people who live a long life, their related health care costs for late life diseases may be reduced, as the longer a healthy person lives the more likely s/he will experience compression of morbidity—dying more quickly and with less related cost.[58]

Statistics on illness and death show that most people currently live a generally healthy life until their fifth or sixth decade, at which point they experience one or more chronic illnesses. Health then continues to decline for the next 15-30 years until death. If people compress their morbidity by engaging in behaviours that delay the onset of illness from, say, age 60 to age 75, time with lifestyle-curtailing illness is compressed until a briefer period closer to the end of life.

This is a change that empowers people in profound of ways. By increasing the years of healthy life, people have more capacity to pursue work and personal interests in ways that bring accomplishment, satisfaction, and richness of experience to their lives.

2.3 The New Health Promoters

WHO delineates the concept of vigorous health in its *"Targets for health for all"* document adopted by the Member States of the European Region, which advocates action to:

- ✓ *ensure equity in health*, by reducing the present gap in health status between countries and groups within countries;
- ✓ *add life to years*, by ensuring the full development and use of people's integral or residual physical and mental capacity to derive full benefit from and to cope with life in a healthy way;
- ✓ *add health to life*, by reducing disease and disability;
- ✓ *add years to life*, by reducing premature deaths, and thereby increasing life expectancy[59]

This is a broad and enabling vision for Health Promotion. The implications are profound—affecting the quality of life for individuals, families, communities,

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[57] Ibid.
[58] Pelletier, K. *Sound Mind, Sound Body: A New Model for Lifelong Health.* (New York: Simon & Schuster, 1994), pg.247.
[59] WHO. *Targets for health for all* (Copenhagen: World Health Organization, 1985.)

societies—and this vision calls for sweeping changes in the way health issues are addressed throughout the world.

The Ottawa Charter's definition of Health Promotion as the process of enabling people to increase control over, and to improve, their health[60] emphasizes command over resources as important both for the individual and for society, and illuminates the importance of *individual empowerment*. Health is seen as *a state of being capable,* having the capacity to impact one's own organism, environment, the lives of others, and society in ways that enhance health. Health Promotion emerges as more than just a focus on diseases and their prevention: *Health Promotion becomes the promotion of social change. A central and essential part of that change is for each individual to see him/herself as a health promoter*. Health Promotion necessitates personal empowerment and seeing oneself as entrusted with the right and the responsibility to work toward the creation of conditions that benefit one's own health and that of others.

This will entail a radical change in how health issues are managed. As we come to see health as determined by a network of personal, social, environmental and biological factors, we realize Health Promotion is embedded in every aspect of society—from our social and political institutions to the personal behaviours of each individual. Health Promotion thus sweeps through society at all levels—from the macrocosmic to the microcosmic—from society's structures and systems to the personal lifestyle of each individual.

Health Promotion becomes not only an important arena for bettering the lives of human beings; it becomes one of the most meaningful measures of how effectively our social systems are working and which need improvement. The nature of the challenge is both profound and clear: As we work to add years to the life and life to the years of every person, all aspects of society become the terrain of Health Promotion and every person becomes a health promoter.

Health Promotion thus equates to social change, and health moves into a dramatically larger arena, beyond the relatively narrow confines of medicine into a larger world where a multitude of factors which impact health must be recognized, viewed critically and organized so that health is enhanced. Health Promotion becomes a matter of identifying new ways to help individuals and society reach beyond current limits and develop new systems of mutual support and benefit. New horizons must be envisioned and new social systems developed which make them a reality.

To realize the promise of the Ottawa Charter we need to address these issues and change the way we direct our resources to these important goals.

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[60] WHO. *Ottawa Charter*, op. cit., pg. 1.

Section II
Changing Paradigms: From a Biomedical to a Biopsychosocial Model

Chapter 3 – The Biomedical Model

> *"The role of the health sector must move increasingly in a health promotion direction beyond its responsibility for providing clinical and curative services."*
>
> WHO Ottawa Charter for Health Promotion

3.1 Introduction to Biomedical Model

Modern western medicine is the expression of a worldview that originated in past centuries and which, at that time, appeared the most effective way to define a set of medical conditions. This worldview found its confirmation and expansion with the mechanistic, reductionisict theories developed in the 19th and 20th centuries. For those theories, human bodies, as any other aspect of reality from the atom to the universe, were seen as being like a machine. Within this perspective, an understanding of the principles and dynamics of human functioning enables you to repair a body like any other machine. If the appendix gets inflamed, it can be removed surgically; pneumonia can be suppressed with antibiotics; occluded coronary arteries can be repaired by transplanting a vein from another part of the body; regardless the disturbance, a skilful medical doctor can "mechanically" intervene with a repair.

This view affirms medicine as a science. To acquire a scientific view of medicine required the objectification of human beings—making the subject into an abstract concept of illness. The perspective with which medicine looks at reality is focused on illness, not on the person. The patient's role is to inform the doctor of malfunctioning and to defer to medical/scientific expertise as the responsible agent of health and illness. The objectification of the person with an illness within a mechanistic, reductionistic perspective is inseparable from scientific progress.

The mechanistic, reductionistic view upon which this progress has developed has its roots in the gravitational laws of Newton and the Cartesian assertion that if one investigates matter deeply enough, one can understand and solve any physical problem. These theories generated the belief that the universe is regulated by the laws of mechanics, and operates in predictable ways, based upon cause-effect

principles. Further, that it is possible to isolate the elements of reality and render them to their fundamental characteristics. The scientific method developed by Francis Bacon was developed upon this postulate, in which one creates hypotheses and confirms or invalidates them by carefully controlled experiments.

The biomedical model was furthered thanks to the contribution of Koch and Pasteur in the 19th century with the development of germ theory and bacteriological science. The biologizing of medicine made considerable sense then since a major part of morbidity and mortality at the time was from infective pathology for which vaccination became the most effective cure.[61]

Medicine, with the progress of scientific knowledge and the development of diagnostic and therapeutic tools, has tended to specialization delineating a field of observation independent and isolated from the larger context, and which undervalues the importance of the context. The need to objectify the person and the process of specialization require that medicine concretize the separation between mind and body. Only a body "separated from the mind" can become the basis for objective experimental research.

This leads to research results that identify a direct causality, typical of the mechanistic paradigm. And extraordinary technological development during the last century has permitted medicine to progress from the epoch of bloodletting to the epoch of computer microsurgery.

The biomedical model that has revolutionized knowledge and treatment of illness still continues to have great success. Yet, starting in the 1950s, thanks in part to the lengthening lifespan made possible by victories over infective illness, a new challenge occurred. Degenerative illness began to emerge as the main causes of morbidity and mortality: heart disease, hypertension and cancer. The biomedical model began to show limitations. It became evident that people were getting sick for reasons other than direct contact with pathogenic agents, and scientists had to realize that some kinds of pathology could not be attributed to biological factors.

3.2 Some Limitations of the Biomedical Model

> "Obviously being a way of seeing, a theory can also be a way of not seeing, a potential drawback of theory-driven research. Theory can clearly bias or even blind the researcher."
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> Wallender, J.L. Theory-driven research in pediatric psychology: A little bit on why and how. (*Journal of Pediatric Psychology, 17,* 1992) pg. 521-535.

The biomedical model fails to address the interaction between mind and body, and this limitation that has become increasingly apparent with the accumulation of data from the fields of psychosomatic medicine and more recently, Psychoneuroimmunology. Because these data have not fit comfortably within the

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[61] Bloom , L.B. *Health Psychology: A Psychosocial Perspective* (Englewood Cliffs, NJ: Prentice Hall, 1988).

confines of the biomedical model, they have been put aside and remain greatly unutilized.

Meanwhile, technological progress of the last century has impacted health greatly. The pervasive use of the automobile and its impact on air quality, urban planning, commerce, production, preservation and access to food, family and social relations, and physical exercise—is an example of many phenomena that we cannot understand fully if we consider reality in a mechanistic way.

We have begun to recognize the inherent interdependence of different aspects of reality and to realize many non-biological factors that impact health, like stress and other job hazards, air pollution, population density, hygienic conditions, eating habits, social support and lifestyle. Because the biomedical model is inadequate to address these health factors, we are under-equipped to deal with them.

3.3 Iatrogenic Effect: When Therapy Becomes Pathology

Within the health establishment itself, another unfortunate by-product of the biomedical model is the harm sometimes done by medical procedures. This phenomenon, called the "iatrogenic effect," refers to unfavourable responses to medical treatment that are induced by the treatment itself—when the cure becomes part of the problem. Medical patients suffer complications from surgeries and side-effects from drugs: "successful" surgeries can result in lives so degraded that the intervention seems unfortunate; some elderly patients kept alive by machines are unable to recognize or interact with loved ones or engage in meaningful activity; healthy people elect surgical procedures to change their looks, follow questionable treatments to lose weight, increase strength, or enhance sexual vigour, endangering their health and even their lives; and the frequency of reported accidents in hospitals is intolerably high. Ivan Illich, a strong critic of these phenomena, reports that one in five patients admitted to a typical research hospital acquires an iatrogenic disease requiring special treatment, with one in thirty leading to death.[62] The Institute of Medicine (IOM) of the National Academy of Sciences reported in 1999 that 98,000 Americans died from medical mistakes in hospitals, in addition to which tens of thousands were more who suffered permanent injuries from such errors and the billions of dollars spend on the treatment.[63]

Many of these problems stem from overworked staff and long shifts—especially during medical training—poor communication among people taking care of the same patient, mistakes by individual providers, and budget pressures that force doctors, nurses and administrators to cut corners.[64]

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[62] Illich, op cit., pg. 32.
[63] Kohn, L.T., Corrigan, J.M. & Donaldson, M.S. (eds.), for the Committee on Quality of Health Care in America, Institute of Medicine, *To Err Is Human: Building a Safer Health System*. (Washington, D.C., National Academy of Sciences, 1999), pg. 42, in: Gibson, R. & Singh, J.P. *Wall of Silence*. (Washington, DC.: LifeLine Press, 2003).
[64] Op. Cit., pg. 78

The use of prescription drugs has become so widespread that 50-80% of Britons now take a medically-prescribed chemical every 24-36 hours. Besides the problems associated with side effects, some people take the wrong drug, get an old or contaminated batch, or receive treatments with inadequately sterilized needles. Drugs can be addictive, mutilating or mutagenic with other chemicals; antibiotics alter the normal bacterial flora and can induce super infection; other drugs contribute to the breeding of drug-resistant strains of bacteria.[65]

As Illich wrote more than a quarter century ago:

> *The pain, dysfunction, disability, and anguish resulting from technical medical intervention now rival the morbidity due to traffic and industrial accidents and even war-related activities, and make the impact of medicine one of the most rapidly spreading epidemics of our time.*[66]

Managed care organizations have recently added another layer of complication to these matters. As a result, some patients can't get access to tests or treatments they need because of restrictions imposed by managed care organizations while other people are given procedures they don't need. Physicians have maddening limits placed on the amount of time they can spend with an individual patient. Afraid of costly lawsuits and extended legal action, some physicians have begun to practice "defensive medicine," wherein the first concern is not the health of the patient but the health of the medical practice. In these circumstances, the Hippocratic Oath has become transformed to mean, "Above all, take no risks." Illich noted, sadly, that such attempts to avoid litigation and prosecution may do more damage than any other form of iatrogenic problem.[67]

Defensive medicine, with its encouragement of testing, treatment, and "seeing your doctor" for every ache and pain tends to undermine patients' sense of being in charge of their own health. The psychological dependence on medical professionals encourages sickness by reinforcing a morbid society that encourages people to become consumers of medical care. Illich calls this phenomena "social iatrogenesis" and considers these over-medicalisations as an expropriation of health. A third form of the problem he calls "cultural iatrogenesis", wherein health practices create a "culturally health-denying effect" that damages people's capacity for dealing with human weakness, vulnerability, and uniqueness in a personal and autonomous way.[68] In this manner, people learn to discount and distrust their own judgment and become unduly dependent on those who treat them. This dependency damages people's natural abilities to deal with health matters—and results in the "medicalising" of natural functions such as pregnancy, childbirth and aging.

The jargon of the medical profession reinforces this phenomenon. Doctors speak in a Latin-based polysyllabic language that is difficult for patients and their

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[65] Illich, op. cit., pg. 28.
[66] Illich, op. cit., pg. 26.
[67] Illich, op. cit., pg. 33.
[68] Ibid.

families to comprehend, and perform medical procedures that can be confusing. Typically, patients are

> *dressed in dehumanizing gowns, stripped of their watch and other personal possessions, bedded in sterile environments devoid of the characteristics of normal life, cut off from family, dignity and self-esteem. The patient is examined and given a diagnosis by the doctor—which intensifies his stress, delineates his incapacity, imposes inactivity, increases apprehension about recovery, and heightens his dependence upon the doctor.*[69]

Within this context of ignorance and helplessness, added to which may be mind- and mood-altering drugs, patients have difficulty being rational and making appropriate decisions. The doctor becomes a god-figure because the patient is rendered so helpless. This "triumph of therapeutic culture," says Illich, can turn the independence of the average healthy person into an intolerable form of deviance.[70]

"Billions of dollars are spent and other billions wasted in treating diseases and emergency-room traumas resulting from underlying social pathologies, which only remain unaddressed. Chronic unemployment, the breakdown of the family structure, increasing domestic violence ranging from rape to handgun deaths, poverty, homelessness, drug abuse, and environmental contamination are the base causes of the vast majority of conditions that we attempt to treat by increasingly expensive and ineffective medical interventions. *These social pathologies become real medical problems, but they are not inherently biological diseases*. They end up in emergency rooms, intensive care units, and morgues—not at all appropriate to where they begin and where it is possible to make a difference."

Pelletier, op. cit., pg. 245.

3.4 The Need for a Wider Paradigm

Despite its benefits, the biomedical model has created serious problems that block our progress. There are critical health issues for which the biomedical model does not provide the most helpful perspective, overlooks important data, causes harm, or limits human beings from reaching their full potentialities.

Furthermore, there are significant changes occurring in society which affect the patient-doctor relationship (see figure below[71]) and which health professionals must address.

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[69] Illich, op. cit., pg. 96.
[70] Ibid.
[71] Ontario Medical Association Committee on Medical Care and Practice. Strategic goals: Report on the doctor-patient relationship and doctor-patient communication. (Toronto, Ontario: Unpublished report, 1992), from Stewart, M. et al. *Patient-Centred Medicine: Transforming the Clinical Model.* (Thousand Oaks, CA: Sage Publications, 1995), pg. xviii.

Social Changes Affecting the Patient-Doctor Relationship

- Rise of consumerism in medicine
- Shift of care from hospital to community
- Increased attention to prevention and patient education
- Changing status of women in society
- Emphasis on patient autonomy
- Doctor's role as trustee regarding disability benefits
- Increased awareness of physician's sexual abuse of patients
- Increased hospital liability for doctor's care
- Administrative containment of medical care costs
- Increasingly litigious environment
- Increased use of technology
- Social acceptance of physician-assisted suicide
- Multiculturalism
- Social concerns about assault and violence against women
- Holistic and alternative health movement
- Increased emphasis on informed consent
- Change in status of all professions in society—decline of role of medicine and expansion in role of other professionals
- Attacks on professional self-regulation
- The rise of a disabled culture of affirmative action and pride

[Figure #1—Social Changes Affecting the Patient-Doctor Relationship]

As a result of all these developments, the biomedical paradigm has become unacceptably limited and limiting. A paradigm which reaches the limit of its capacities results in the tension and distress creating the space for a new paradigm that has greater reach.[72] For us to make advances in addressing the complexities of human health, we need a more encompassing and effective construct that includes psychological and social dimensions in the equation, sees health from the perspective of the organism and its relationship to the environment, and recognizes the importance of personal empowerment. Such a paradigm does not abandon the important advances made by means of the biomedical viewpoint. It simply enlarges our perspective and increases our capacities.

[72] Kuhn, T.S. *The Structure of Scientific Revolutions.* (Chicago: University of Chicago Press, 1962).

Chapter 4 – The Biomedical Model and the Biopsychosocial Model

> *"People cannot achieve their fullest health potential unless they are able to take control of those things which determine their health. "*
>
> WHO Ottawa Charter for Health Promotion

4.1 The Present and the Future

How did health care become so problematic and how do we address these problems?

To answer this we shall analyze the bio psychosocial model as an alternative to the biomedical model, both in regard to its scientific foundations and the promise it represents for the future. A fundamental characteristic that differentiates the two is that the biomedical model is based upon a reductionistic approach and the bio psychosocial model is based upon a systemic approach. The salient characteristic of the bio psychosocial model is its direct applicability to society, a condition that validates this model. To understand this more fully, we will look at the way we interpret reality—i.e., the way reality is construed. And since both are models—theoretical and operative representations of reality configured as scientific paradigm, we will examine the concept of paradigm.

4.2 The Concept of Paradigm

In this book, paradigm is synonymous with model; we have adopted the terminology of paradigm used by the philosopher and historian of science Thomas S. Kuhn: "Some accepted examples of actual scientific practice—examples which include law, theory, application, and instrumentation together—provide models which spring from particular coherent traditions of scientific research." [73]

For Kuhn, a paradigm is considered valid as long as it is able to function adequately in exploring that aspect of nature it intends to investigate. Often evidence emerges of phenomena that cannot be understood or problems that cannot be explained by the current paradigm. This leads to intense research and scientific

[73] Kuhn, op. cit., pg. 10.

speculation, resulting in the formulation of a new paradigm better able to explain the new data, along with an array of more capable tools and modes of intervention.

Kuhn affirms that for paradigms to become accepted they must be innovative and open in ways which attract a sufficient part of the scientific community. The science produced from the new paradigm does not have as its purpose the production of change per se, but the resolution of problems, extending the knowledge of key elements of the paradigm and providing experimental confirmation. "Normal research", he says, "is cumulative and owes its success to the capacity of scientists to choose problems that can be solved with conceptual and instrumental techniques that are closely connected with those already in existence."[74] For this reason, it is evident that any focus on scientific problems without recognition of how the related research is dependant upon and oriented by the paradigm upon which it is based can, paradoxically, be a barrier to scientific development.

Kuhn sees scientific progress as proceeding not according to successive accumulation of knowledge but through scientific revolution. Such a revolution is heralded by a growing sensation that an existing paradigm has ceased to function adequately in the exploration of an aspect of nature for which the paradigm had previously been adequate. This sensation is felt only by a small sector of the scientific community. Revolution constitutes an exceptional moment in respect with what Kuhn calls *normal science*, "founded on one or more results achieved by the science of the past to whom a specific scientific community for a certain period of time recognize the capacity to be the foundation of its own future practice."[75]

> *The success of a paradigm is at the start largely a promise of success discoverable in selected and still incomplete examples. Normal science consists in the actualization of that promise, an actualization achieved by extending the knowledge of those facts that the paradigm displays as particularly revealing, by increasing the extent of the match between those facts and the paradigm's predictions, and by further articulation of the paradigm itself.*[76]

For example, in the 18th century, under the premise of optics, an important and integral part of Newtonian physics, light was considered to be composed of material particles. Scientists were convinced they understood the fundamental principal of nature: Atoms are the bricks with which the natural world is built, Newton's laws explain motion, the major portion of physics problems seem resolved. This explanation held until the beginning of the 21st century when experiments of Einstein and Planck contradicted some certitude upon which Newtonian physics is based. A new theory emerged, attributing light with the dual nature of both wave

[74] Kuhn, op. cit.
[75] Kuhn, op. cit.
[76] Kuhn, op. cit., pg. 23-24.

and particles, with such theory finding its formalization in the new paradigm of Quantum Mechanics.

4.3 A Brief History of General System Theory

Albert Einstein's Theory of Relativity along with Quantum Mechanics constitutes one of the fundamental paradigms of contemporary physics. Einstein introduced the concept of Time as a fourth dimension along with the three spatial dimensions, specifying that the description of physical phenomena needs to be represented in four dimensional space. It is interesting to notice that the theory presented by Einstein in 1905 was not accepted immediately because of its revolutionary impact on the accepted scientific formulations of Newton and Galileo. Yet, stunning advances in the scientific understanding of reality springing from the Theory of Relativity were supported by new instruments of observation such as electron microscopes and gigantic telescopes that enabled physicists and astronomers to explore the smallest and largest reaches of the universe. What they found were phenomena such as subatomic particles and black holes whose actions and characteristics bore little resemblance to Newtonian mechanics or Descartes' notion of reducing matter to an understandable building block. Scientists such as Neils Bohr and Werner Heisenberg struggled with interpreting the seemingly chaotic and decidedly counter-intuitive phenomena found in the subatomic realm and called their area of investigation Quantum Theory, from the meaning of quanta as the smallest possible quantity.

Gradually, as the twentieth century progressed, order began to be perceived in the seemingly random and unpredictable behaviours of the subatomic particles. Discoveries such as physicist David Bohm's that every particle is part of a pair which influence each other instantly even when separated by vast distances, combined with other discoveries to generate a new, integrated view of the universe as a system made up of subsystems ranging from galaxies, to human beings, to the atom.

Parallel to research developments and the theoretical formulations emerging from such research, one of the most significant paradigms tackled the concept of wholeness: the systemic paradigm that emerged between the 1940s-1950s, thanks to the work of many researchers. Among those, biologist Ludwig von Bertalanffy, author of a fundamental text, *General System Theory*, intended to furnish an integrated structure for all scientific activities. Such theory allows for seeing an integrative framework for scientific activity, viewing the biosphere as a whole, and for coping with ecological crises created by technology, population explosion and political divisions.

This concept has significant implications for our work. One of the most particular aspects of the systemic conception of reality is that it is both general and adaptable, so that it applies to physiochemical phenomena, biological phenomena, as well as psycho-social-cultural phenomena.

> *Modern science is characterized by its ever-increasing specialization, necessitated by the enormous amount of data, the complexity of techniques and of*

theoretical structures within every field. Thus science is split into innumerable disciplines continually generating new sub disciplines. In consequence, the physicist, the biologist, the psychologist and the social scientist are, so to speak, encapsulated in their private universes, and it is difficult to get word from one cocoon to the other…

This, however, is opposed by another remarkable aspect. Surveying the evolution of modern science, we encounter a surprising phenomenon. Independently of each other, similar problems and conceptions have evolved in widely different fields…

It is necessary to study not only parts and processes in isolation, but also to solve the decisive problems found in the organization and order unifying them, resulting from dynamic interactions of parts, and making the behaviour of parts different when studied in isolation or within the whole…

In short, "systems" of various orders are not understandable by investigation of their respective parts in isolation. [77]

As further developed by others, system theory is "based on awareness of the essential interrelatedness of all phenomena—physical, biological, psychological, social and cultural."[78] It can be seen as a *total ecology model* wherein the human organism is best understood as a system that is part of a bigger whole (e.g., one's family of origin, community, socio-economic status, profession, culture, the environment, etc.) and is itself made up of smaller systems (e.g., one's cardiovascular system, lymphatic system, skeletal system, immune system, etc.). This ecological systemic view has profound implications for the health of individuals and society, as we shall see.

Because the perspective of System Thinking sees all living structures as comprised of extensive subsystems that are in constant interaction with each other, any impact on Society affects the Family and the Individual, and vice versa. The figure below illustrates this concept.

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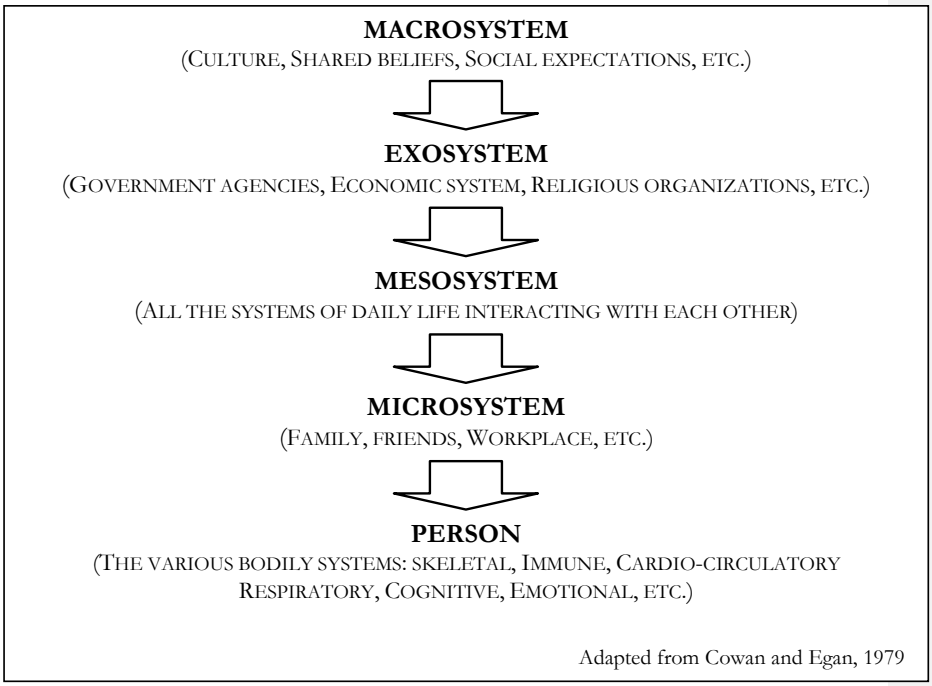
[77] Von Bertalanffy, L. *General System Theory: Foundations, Development, Applications*. (New York: George Braziller, 1969), pg. 30, 37.
[78] Capra, op. cit., pg. 265.



[Figure #2—Systems Impacting Human Beings]

To illustrate the interconnectedness of health within a whole system, let us take the following example: If the percentages of atmospheric pollutants increase in a given city, damage to the respiratory tracts of individual inhabitants will increase, along with asthma and bronchitis, as well as absenteeism due to sickness. The productivity of workers and firms will decline, and health expenditures increase. The most vulnerable citizens, such as children and the elderly, will suffer most. The consequences resulting from the reduction in the quality of life are even more extensive, affecting all the components of the "city system", including commerce, tourism and legislation.

4.4 Health as a Social Construct

The sociology of knowledge interprets human reality as "socially construed reality".[79] For the common man, reality is the world of his daily life, yet this occurs largely without an awareness that this world "is originated in his thought and his

[79] Berger, P.L. & Luckmann, T. *The Social Construction of Reality: A Treatise in the Sociology of Knowledge*. (New York: Anchor Books, Doubleday Company, Inc., 1966).

action and that thanks to this he maintains his own reality."[80] What is perceived as real varies from society to society and is produced, transmitted and conserved through social processes. In other words, our perception of reality is largely modelled from beliefs and a conceptual assumption that is typical of the society and culture in which we belong. What we know, what we consider true and right, the behaviours we adopt, all are profoundly influenced by the social/cultural environment in which we live. This process happens through the internalization of reality that occurs during the socialization process (by parents or other significant persons).

Our reality is determined by the roles played by the people that surround us, by the roles that they give us, and from the way in which we relate with ourselves, others, and society at large. The social environment influences individual behaviour through societal norms and through adherence and respect for the social model of control. From this understanding, we can see the concept of health as a *social* construct in the sense that it is closely correlated with the dominant culture.

For example, in Chinese medicine, health is intended as an harmonic presence of matter (Xing) and energy (Qi;). The extent to which the individual is able to attain equilibrium between these two factors determines, according to this principle, his state of health. Health is the result of a perfect equilibrium of two opposing and complementary forces inside the Tao. When Xing and Qi are in harmony, health is preserved; illness happens where protective energy is weak. In contrast, the concept of health in western culture is generally viewed as an absence of illness and is strongly influenced by the biomedical view that has largely medicalised society and dominates the three fundamental events of life: being born, suffering, and death.

In every society the majority of people live their lives with experiences whose meanings are socially shared, and where daily behaviour is familiar and predictable. Because people take for granted the reality of their life, the organization of society, per se, is not put under scrutiny. One implication of this is that social constructions are not perceived as such, and therefore are not criticized or modified when aspects of them are not functional. A consequence is the persistence of dysfunction attitudes and behaviours—both in individuals and society. The influence of such unexamined beliefs and behaviours on the field of health can be significant, as suggested in the following scenario:

> The fact that the author's mother (influenced by *her* background and culture) served tasty, fat-filled food, that she was worried if I looked "skinny", that she urged me to be a "good boy" and eat more even if I was not hungry … that my peers urged me to smoke and drink ("as real men do") and derided me as unmanly if I did not conform … that I learned the social expectation of being a passive patient at the doctor's office and that I was led to believe that health simply meant not being sick… all helped build my perception of "reality". These social experiences had real health consequences for my life just as did

[80] Ibid.

the physical construction of my school's buildings and the consequences of asbestos in its insulation… the advertisements that urged us to spray with DDT to kill pests… and watching glamorous movie stars smoke on the screen.

4.5 A Change of Paradigms: The Systemic Approach to Health Promotion

As happens with other fields of scientific exploration, the conditions are ripe in the field of medicine for a paradigm shift. On one side is the mechanistic, reductionistic medical paradigm that has survived for 300 years and is seen now as less likely to offer effective answer to emerging health problems; on the other side is a new frame of reference founded upon the systemic approach. From a systemic perspective, the classical treatment of illness is still applicable in the proper context, and can and must be integrated into the larger framework. This new framework is characterized as a system of total ecology and takes in consideration every aspect of life, from lifestyle of individuals to the environment in which they live. This new vision of health, understood as a system composed by sub-systems, hierarchically inclusive and functionally interdependent, allows us to impact health at every level, personal, family, workplace, community and the larger context.

From this new frame of reference is created a new paradigm defined as the bio psychosocial model, created to integrate all the interdependent factors that determine health: biological, psychological and social. Its dynamic field of action is called Health Promotion and is understood as a process of empowerment of individuals and institutions for the purpose of fostering the maximum possible health. Both terms, *Bio psychosocial Model* and *Health Promotion,* will be employed in this book to illustrate this new paradigm.

Since the essential premise of this paradigm shift is the concept that health and illness are determined by numerous interrelated biological, psychological and social factors, it is necessary that initiatives be created that help individual citizens assume a proactive role in the adoption of new healthy behaviours. The approach is by means of synergetic strategies, focused to help people develop their potentiality, to prevent illness, and promote health and well-being. At the same time, professionals that work in the health sector need to acquire a new view of their profession—one that encompasses seeing themselves as *agents for social change*, who assist individuals, communities and institutions in weaning themselves from passivity and dependency, and become protagonists in the promotion of health.

The bio psychosocial model recognizes that health is socially construed within the context of human behaviour and relationships. As we will explore in the next chapter, this viewpoint enables us to recognize that health is largely created by human beings…

… *within the settings of their everyday life:* <u>*where they learn, work,*</u>

play and love. Health is created by caring for oneself, and others, by being able to take decisions and have control over one's life circumstances and by ensuring that the society one lives in creates conditions that allow the attainment of health by all its members.[81]

This view of health and its determinants is a radical departure from the mechanistic biomedical approach, and while it will certainly continue to include doctors treating people with illness, it requires that we go much further. Health professionals must foster a significant change in the way people understand health to be created and promoted. They must help people and their institutions to become aware of some key concepts:

- that health is created by behaviours and actions that to a large extent are determined by individual human choices;
- that these choices are important to people's lives, the lives of their loved ones, and to the community itself;
- that decisions and actions which affect the environment have important consequences for health;
- that business recognize that virtually every action taken will promote or damage health;
- that government leaders support programs and regulations that benefit human health;
- and that health is a priority for our society.

To do this, health professionals must adjust their perspective, relinquish expert status to those they serve and become practitioners of learning and empowerment. For the health promoter, the focus now includes single individuals, the health system, the workplace, governmental agencies, and the community and society in general.

4.6 Is Change Necessary?

Were it not for the exponentially spiralling costs of the biomedical paradigm, wouldn't that model suffice?

As attractive as it always is to stay with familiar notions, and the biomedical paradigm is one of the most pervasive, important and familiar foundations of modern thought and societal structure, its non-systemic view of health imposes limitations that are too costly to ignore. Without a systemic approach to health—recognizing that human life is embedded in a constellation of bio psychosocial systems that work as a whole to impact the health of individuals—the mechanistic,

[81] *Gesundheitsförderung: Eine Investition für die Zukunft.* (Bonn: Internationale Konferenz, 17-19 December 1990).

reductionistic model overlooks too many opportunities and entails too many dangers to remain acceptable.

To illustrate, let us examine two well-known examples of interventions based on pre-system thinking:

After World War II, the development of pesticides and chemical fertilizers was seen as a scientific breakthrough for feeding humanity and building a better and more prosperous world. The unlimited use of these chemicals fit with the prevailing expectation of scientific progress for the betterment of society.

Unfortunately, this mechanistic view did not take into account the interrelationship of nature. Although the massive use of pesticides and chemical fertilizers initially expanded the production of food, robust success encouraged one-crop cultivation that soon impoverished the soil, necessitating an ever greater use of chemicals which created a downward spiral of increasing chemical usage and decreasing soil vitality.

Moreover, there were unexpected effects of those powerful chemicals. After boosting crop production and killing unwanted pests and weeds, it became apparent that the pesticides had a long period of continued action on the environment, affecting the cohesiveness of the soil's organic matter, creating topsoil run-off, pollution of drinking water, and negatively impacting the whole food chain. Traces of DDT have been found in human breast milk and in the livers of penguins in the Arctic, sites far removed from their original targets, causing immeasurable, unanticipated degradation of the environment and threats to human health.

It is now evident that our simplistic approach to the use of chemicals for the improvement of food production was a tactic that backfired in a tragic way, opening our eyes to the costs of ignoring the complex structure of relationships involved in growing our food.

Another example of well-intentioned myopia is the highly esteemed heart by-pass operation, a procedure that entails risk and has a significant fatality rate. Though often experienced by patients as a miracle bring a new lease on life, this procedure does nothing to improve the factors creating the problem, and patients' arteries will eventually re-occlude if that remains the only intervention.

An ecological or systemic approach includes changes in lifestyle—a low saturated fat, low cholesterol diet, no tobacco usage, appropriate exercise, and improved ways of handling stress. Such an approach, which has been shown to reverse the build up of arterial plaque without surgical intervention,[82] allows the patient to understand and deal with his health problem in a bio psychosocial way and produce a better long-term result.[83]

Must we change? Must we adopt the new bio psychosocial paradigm? Of course we must. Rather than continuing to rely on a model that is limited, comfortable and beneficial though it has been, we must move forward. The tools of the biomedical model need to be reconsidered and absorbed into a paradigm more complete and dynamically more effective for understanding and dealing with our

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[82] Pelletier, op. cit., pg. 252.

[83] Ornish, D. *Dr. Dean Ornish's Program for Reversing Heart Disease.* (New York: Random House, 1990).

challenges and finding more effective solutions. In the next chapter, we will analyze the bio psychosocial model of Health Promotion.

Section III
The Determinants of Health

Chapter 6 –What Determines Health?

> *"People cannot achieve their fullest health potential unless they are able to take control of those things which determine their health."*
>
> WHO Ottawa Charter for Health Promotion

6.1 Defining Health

As we explore the factors that determine health, we should recognise that health is a concept without a universal definition. Like all social constructs, it is viewed and experienced differently by each person and is dependent upon social, cultural, class, gender, and ethnic factors. Researchers d'Houtaud & Field found that in France, for example, higher classes valued health in a personal way, as a value in and of itself, whereas working classes perceived health more in terms of one's ability to work productively.[84]

Researchers have identified three traditional common perspectives about health: *Health-in-a-vacuum* (health as a quality of "being"); *the reserve of health* (health as a quality of "having"), and *health as an equilibrium* (health is a quality of "doing".)[85] Badura and Kickbusch describe these perspectives:

> *1) **Health-in-a-vacuum** is simply the absence of illness. Health is … not something positive, it's simply not being ill. … Having a body (but)… it doesn't bother you in any way…*
> *2) **The reserve of health** expresses an organic-biological characteristic… one may build up one's reserve of health or break into it. This capital asset of vitality and deference may increase or dissipate…*
> *3) **Equilibrium**…, both in its presence and in its absence, represents an autonomous experience; one feels that one has equilibrium or that one has lost it… It comprises physical well-being, plenty of physical resources, absence of fatigue, psychological well-being, evenness of temper, freedom of movement,*

[84] d'Houtaud, A. & Field, M.G. The image of health: variations in perception by social class in a French population (*Sociology of health and illness,* 1984), 6(1): 30-60.
[85] Badura, B. & Kickbusch, I. (eds.) *Health Promotion Research* (WHO Regional Publications, European Series No. 37, 1991), pg. 86-87.

effectiveness in action, and good relations with other people… Nevertheless, there is no such thing as perfect health; it's much more a matter of being able to keep a balanced life… I am in good health when I am in equilibrium, when I feel capable of doing what I want.

Within this framework, health includes general well-being and functioning, along with social, psychological, and physical well-being. Another perspective is health as a *prerequisite* for social status and economic achievement, the capacity to perform social tasks and roles adequately within the family, at work and in the community. This concept also encompasses the notion of health as important to the sense of personal equilibrium and the capacity to satisfy one's own needs and those of others.[86]

Many authors have conceptualized the components of health. For example, J.E. Ware developed a set of scales that identify and measure personal *"health balance",* including four interrelated dimensions of health—*General health, Social health, Mental health, and Physical health*—along with subcategories and ways they are experienced personally.

Regardless of how one defines health, there is an inextricable two-way relationship between health and personal accomplishment. Health fuels the capacity to do and to be—to carry out roles and responsibilities at home, at work and in the community. Being able to accomplish these roles infuses the individual with a sense of satisfaction and well-being.

Because health is intertwined with our capacity to be and do and our sense of well-being, health is of primary importance in every one's life and in the economy of every nation. Whether one views health as a goal in and of itself or as a necessary prerequisite for accomplishment, health is the essential bedrock of individual and societal well-being.

6.2 Determinants of Health: Biological & Genetic, Psychological, Social, Lifestyle

From the perspective of the biopsychosocial paradigm, we recognise health as a multi-determined dynamic combination of biology and behaviour, a by-product of numerous personal and societal decisions over which each person potentially has considerable control. The biopsychosocial paradigm brings clarity about personal choice as an important determinant of health and longevity. (See Figure #4 for some of the most important factors which determine health.)

[86] John, K. et al. Assessment of psychosocial status: measures of subjective wellbeing, social adjustment and psychiatric symptoms, in: Abilene, T. et al., (ed.). *Measurement in Health Promotion and Protection.* (Copenhagen, WHO Regional Office for Europe, WHO Regional Publications, European Series, No. 22), pp. 133-150.

Factors Which Determine Health

1. **Individual Factors**:

   Biological factors—including genetic predispositions, age-related processes

   Lifestyle factors—including nutrition, smoking, alcohol consumption, substance abuse, exercise patterns, sexual practices, stress, sleep habits, leisure activities, and marital status

   Psychological factors—including coping abilities, self-efficacy, hardiness, self-esteem, communication skills, problem-solving skills

2. **Family Factors:**

   Including strength of family structure, amount of emotional support

3. **Socio-Economic Factors:**

   Including socio-economic status, education, access to and adequacy of health care services, working conditions, leisure activities, adequacy of housing, nutrition, exercise, availability of jobs, quality of social relationships and social support

4. **Cultural Factors:**

   Including health beliefs, health practices, eating customs, social activities, sexual practices, gender and role expectations

5. **Consumer Practices:**

   Including advertising, pricing, availability of goods and services

6. **Environmental Factors:**

   Including atmospheric pollutants, noise pollution, quality of water, chemical and nuclear waste, deforestation, industrial procedures

7. **Structure of Society:**

   Including laws, regulations, taxation, public health structure, school systems, industrial production, rule of government (whether democracy or not), availability of jobs, social equality, access to information

[Figure #4 – Factors Which Determine Health]

Social status is an interesting example of the relationship among biopsychosocial factor with data from numerous studies showing a "graded and continuous" relationship between income and mortality.[87] From these studies we realise that differences in health are not confined to "poor" segments of the population, and are not simply a function of absolute poverty. Rather, people who are poor, have low levels of education, or are socially isolated, are more likely to engage in risk-related behaviours and are less likely

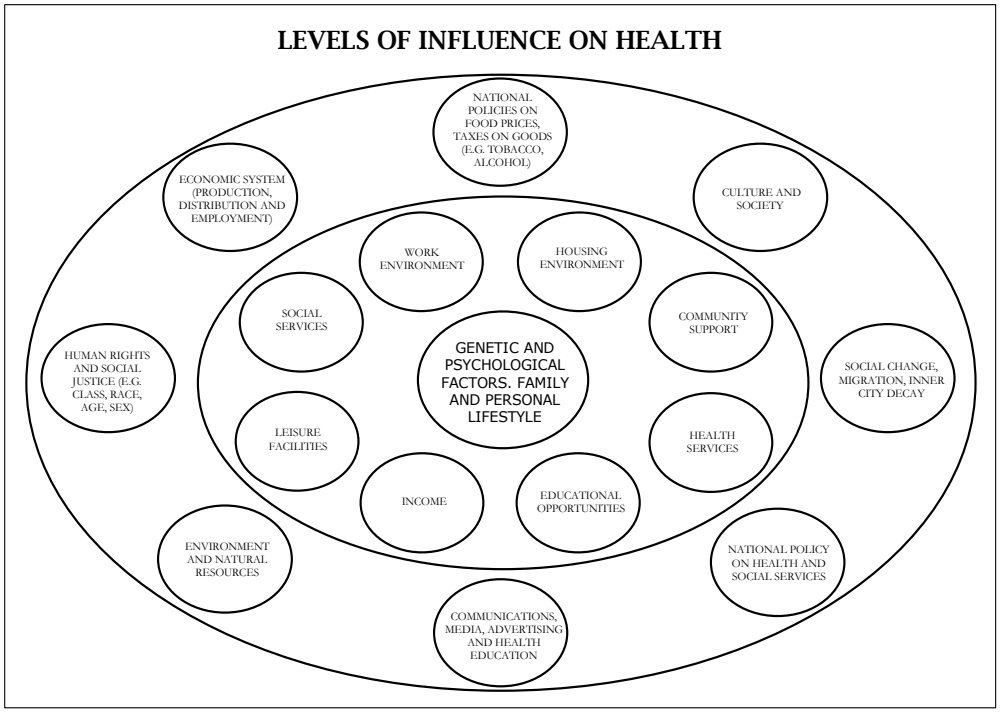
[87] DiClemente, et al., op. cit., pg. 332.

to engage in health-promoting behaviours. The social/cultural environments in which people live influence their behaviour by shaping norms, enforcing patterns of social control, providing or not providing opportunities to engage in particular behaviours, and reducing or producing stress, all of which impact health status.[88]

Social support and educational environments are also factors that influence health-related behaviour change, health status and survival. Family or group support and patient education increase adherence to prescribed medication regimens; psychological interventions help people adapt to and cope with many illnesses; family meetings help diabetic patients improve metabolic control; support groups, access to education and information, expression of emotions, and hypnosis all benefit people coping with health conditions, including irritable bowel syndrome, peptic ulcer disease, coronary heart disease, and cancer.[89]

A. Scott-Samuel has displayed Individual/Family, Community and Societal factors in a way that shows the varying levels of influence on health that are attributable to each of these factors, with the most dominant factors in the centre and those of decreasing influence in the two outer circles.[90] (See figure #10.)

[88] DiClemente, et al., op. cit., pg. 333.
[89] Ibid.
[90] Scott-Samuel, A., in: Zucconi, A., Perticaroli, S. & Chierichetti, F. *Health Promotion at the Workplace* (Rome: Istituto dell'Approccio Centrato sulla Persona, 2001), page 28.



[Figure #5 – Levels of Influence on Health]

While some research studies attempt to isolate individual health determinants and others look at the interrelationships between two or more factors, it is important to recognise that in many cases, a particular health-determining factor is inextricably linked with others as co-determinants of health.

In the following chapters in this section, we will focus on the various determinants of health. In Section V we will revisit these determinants and identify tools health professionals can use to empower their clients in these key dimensions.

Chapter 7 – Biological, Genetic & Psychological Determinants

"Health is a positive concept emphasizing social and personal resources, as well as physical capacities…. To reach a state of complete physical, mental and social well-being, an individual or group must be able to identify and to realize aspiration, to satisfy needs, and to change or cope with the environment."

WHO Ottawa Charter for Health Promotion

7.1 The Influence of Biological & Genetic Factors

It is widely understood that genetic inheritance, the way the body's systems function, and developmental/aging processes have significant impact on health. These health determinants have long been recognised by professionals and the lay public, with fuller understandings emerging continuously.

Genetic illnesses are caused by an alteration of the genetic code of an individual. Some genetic illness is present at birth as congenital anomaly; others develop in infancy or at adulthood. Some illnesses with genetic foundations are influenced by factors such as diet or lifestyle. With the term "genetic factors" we refer both to illnesses wholly inherited and to those affected by other factors. Genetic alterations that are not inherited, also called somatic mutation, can cause or contribute to the insurgency of serious illness like cancer.

It is important for people to be aware of the illnesses and diseases for which they have a genetic predisposition, such as diabetes or cardiovascular illness. Despite the fact that genetic risk factors cannot be modified, the adoption of healthy lifestyle can reduce, eliminate or exacerbate the insurgency of pathology (e.g., a person with a diabetic parent or sibling significantly increases his diabetes risk by becoming obese).

7.2 Influence of Psychological Factors

Mental and behavioural disorders are estimated to account for 12% of the global burden of disease,[91] yet less than 1% of the total spent on health by most countries is allocated for mental health expenditures. Moreover, there is no mental health *policy* in more than 40% of countries, over 30% have no mental health *program*, and more than 90% have no mental health policy for children and adolescents.[92]

Meanwhile, the impact of mental illness on society is escalating. In 1990, mental and neurological disorders accounted for 10% of the daily-adjusted life years (DALYs) lost due to all diseases and injuries. This increased to 12% by 2000 and is projected at 15% by 2020.[93]

Because most illnesses are influenced by a combination of biological, psychological and social factors, helping people gain psychological skills and competencies is an especially fertile arena for Health Promotion.

7.3 Key Psychological Factors

The ability to identify and choose healthy lifestyles and withstand the stresses of life depends to a great extent upon on the degree to which an individual possesses certain psychological and interpersonal strengths. Psychological factors most strongly correlated with health are Coping Abilities, Self-Efficacy, Hardiness, Self-Esteem, and effective Communication and Problem-Solving skills.

Hard data linking these factors to health are increasingly available and it is apparent that the connections are multi-dimensional. Therefore, an important component of the biopsychosocial paradigm is an intensified focus on the relationship between health and psychological factors. We will now examine the major determinants in this arena.

7.4 Coping Abilities

Lazarus and Folkman define coping as *a person's constantly changing cognitive and behaviour efforts to manage situations s/he has appraised as potentially harmful or stressful*.[94] Coping is what people do in response to what they perceive as problems. Coping efforts continuously change in response to new stressful or taxing situations and they include behavioural, emotional and cognitive responses.[95] People who cope well, that is, people who manage their problems effectively, have *flexibility* (being able to create and consider alternative plans); *far-sightedness* (anticipating long-range effects of

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[91] WHO. *Mental Health: New Understanding, New Hope*, op. cit., pg. 3.
[92] Ibid.
[93] Ibid.
[94] Goeppinger, J.& Lorig, K. What Do We Know About What Works? From: Muma, R.D. & Lyons, B.A. (eds.) *Patient Education: A Practical Approach.* (New York: McGraw-Hill Professional Publishing, 1996), chapter 7, pg. 117.
[95] Ibid.

coping responses); and *rationality* (making accurate appraisals.)[96] The box below describes how successful and unsuccessful people differ as they face challenges.[97]

People who cope Successfully vs. People who cannot cope

People who cope successfully respond to life challenges by taking responsibility for finding a solution to their problems. They approach problems with a sense of competence and mastery. Their goal is to assess the situation, get advice and support from others, and work out a plan that will be in their best interest. People who cope successfully use life challenges as an opportunity for personal growth, and they attempt to face these challenges with hope, patience, and a sense of humor.

People who cannot cope respond to life challenges with denial and avoidance. They either withdraw from problems or they react impulsively without taking the time and effort to seek the best solution. People who cannot cope are angry and aggressive or depressed and passive. They blame themselves or others for their problems and don't appreciate the value of approaching life challenges with a sense of hope, mastery and personal control.

[Figure #6 – Coping Successfully vs. Unsuccessfully

How a person sees a situation is key to how s/he reacts and copes with it, and this view of coping fits conceptually with Self-Efficacy theory, Hardiness and Self-Esteem, which we will discuss shortly. The development of coping abilities is a central to helping people change health habits or manage illness.

Lazarus and Folkman[98] identify two forms of coping: *problem-focused coping* and *emotion-focused coping*. Problem-focused coping involves the attempt to understand and define a problem and work out possible solutions, whether behavioural or mental. Emotion focused-coping is oriented toward managing emotional distress, and may include physical exercise, meditation, expressing feelings, seeking support. Successful coping with illness requires dealing both with the problem itself and the emotions associated with the problem.

Within the two forms of coping are fourteen common coping responses used in illness situations (with varying degrees of success). These include:

1. **Active Coping** (e.g., "I am doing everything that can be done to handle this problem")
2. **Planning** (e.g., "I have figured out what steps to take")
3. **Suppression of Competing Activities** ("I don't let myself get distracted by anything else but this")

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[96] Kleinke, C.L. *Coping with Life Challenges*. (Pacific Grove, CA: Brooks/Cole Publishing Company, 1991), pg. 11.
[97] Ibid.
[98] Lazarus, R.S. & Folkman, S. *Stress, Appraisal and Coping* (New York: Springer, 1984).

4. Restraint Coping (e.g., "I'm holding off on making changes until the time is right")
5. Seeking Social Support for Instrumental Reasons (e.g., "I am talking to others who have gone through this situation")
6. Seeking Emotional Support for Emotional Reasons (e.g., "I am able to talk with my spouse about what this situation is like for me")
7. Positive Reinterpretation and Growth (e.g., "I try to find something I can learn from this experience which will make me stronger as a person")
8. Acceptance (e.g., "I've come to terms with this in my life")
9. Turning to Religion ("I have asked for God's help in dealing with this")
10. Focus On and Venting of Emotions ("I'm very upset about this and can't stop talking about it")
11. Denial (e.g., "I refuse to believe that this has happened")
12. Behavioural Disengagement ("I've quit trying to make things different")
13. Mental Disengagement (e.g., "I watch a lot of movies so I don't have to think about this")
14. Alcohol and/or Drug Use (e.g., "I get through the day with some help from the bottle")

The specific choice of coping response is correlated with personality factors such as optimism/pessimism, confidence/low confidence, self-esteem/low self-esteem and low anxiety/anxiety.

Coping skills impact many components of health including: interpersonal relationships, especially family and social relations and the amount of support available from these relationships; a person's ability to handle stress, maintain disease resistance and recover from illness; the ability to learn from and gain support from others who have similar health problems; the ability to identify creative solutions for coping with pain and other health problems; relations with health care givers, which affect the kind and quality of treatment. Coping skills also affect a person's self-relationship, including the ability to face and deal with illness, the ability to make and persist in health-related behaviour change, and the ability to view health problems as opportunities for positive change and growth.

The importance of possessing or learning successful coping skills is highlighted by a comparison with those who view health and illness from the perspective of "learned helplessness." Learned helplessness is associated with the failure to engage in health-promoting behaviours. When such a failure is ascribed to a lack of will power and is viewed by the individual as a personality flaw resulting in inevitable failure, the "helpless" person feels excused from trying to change his behaviour.[99]

Another variant of learned helplessness is attributing failure to global factors, resulting in helplessness applied to other situations; e.g., "I cannot keep a good job, a happy marriage or lose weight, and therefore, there is no point in trying to lose weight." A third variant entails the confusion between short- and long-term factors, an example of

[99] Goeppinger & Lorig, op. cit. pg. 123.

which is the inability to lose weight over the Christmas holidays being viewed as proof of being unable to lose weight at any point in time.

These components of learned helplessness lead to an expectation of failure and lack of control which result in an unwillingness and inability to engage in behaviours that support health. Learned helplessness exacerbates problems in motivation, cognition and action, and often results in depression, which itself has negative health effects. Interventions that bolster coping ability decrease learned helplessness.

A study of hospital patients by Shelly Taylor[100]found that coping successfully with hospitalisation requires finding a balance between being assertive, getting proper treatment, and maintaining good relations with the overworked hospital staff. Activities that assist coping are rational thinking, self-relaxation, assertiveness, and talking yourself through the challenge.

Janis found that preparation for surgery through the coping skills of self-relaxation, humour and reliance on social support can be beneficial in reducing detrimentally high levels of fear.[101] Training patients to cope with impending surgery by *maintaining a feeling of control* over their hospitalisation (e.g., by enjoying the attention they would receive while hospitalised, using the time to take stock of their lives and enjoy a vacation from outside pressures, and practicing pain control strategies) has been found to increase levels of coping. Patients taught these coping skills recovered from surgery more quickly than others, were less anxious, more relaxed, and had less need for pain-relieving medication.[102] Coping by means of building a *strong support system* is important to physical and emotional well-being, as isolation exacerbates stress while a good support system can help moderate the effects of stressful life events.[103]

Coping skills that help women reduce anxiety about childbirth include *acquiring data that increases the accuracy of expectations, self-management skills, self-relaxation, use of distraction*, and *encouragement of social support*. These result in decreased anxiety and pain associated with childbirth and a more positive birthing experience.[104]

Information-seeking is one of the most effective health-related coping skills, whether for maintaining or recovering health. Actively seeking information is especially important when dealing with chronic illness as it reinforces the feeling of being in control and of doing something, rather than passively waiting for things to get better.[105] Information-seeking not only increases the person's data base, depth of understanding and range of options, it also has the important psychological benefit of increasing sense of control thus maintaining self-efficacy.

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[100] Taylor, S.E. Hospital patient behaviour; Reactance, helplessness, or control? (*Journal of Social Issues*, 1979) 35, 156-184.

[101] Janis, I.L. *Psychological stress: Psychoanalytic and behavioural studies of surgical patients.* (New York: Wiley, 1958).

[102] Langer, E.J., Janis, I.L. & Wolfer, J.A. Reduction of psychological stress in surgical patients (*Journal of Experimental Social Psychology*, 1975), 11, 155-165.

[103] Kleinke, op. cit., pg. 174.

[104] Leventhal, E.A., Leventhal, H., Shacham, S. & Easterling, D.V. Active coping reduces reports of pain from childbirth (*Journal of Consulting and Clinical Psychology*, 1989), 57, 365-371.

[105]Felton, B.J. & Revenson, T.A. Coping with chronic illness: A study of illness controllability and the influence of coping strategies on psychological adjustment (*Journal of Consulting and Clinical Psychology*, 1984), 52, 343-353.

Coping skills employed by women dealing with breast cancer include: *Searching for meaning*—to understand why we exist, to provide a reason for enjoying good times and tolerating bad ones, and re-evaluate and recognise what can be learned from the illness; *Maintaining self-efficacy*—by resolving to live with a positive attitude, not become helpless and passive, keeping busy, practicing self-relaxation, exercising, eating healthy foods, seeking information and knowledge about cancer; *Building self-esteem*—by engaging in thoughts and activities to bolster self-esteem, comparing self with those less fortunate, recognising cancer as a potentially valuable life experience and an impetus for making important changes in their lives.[106]

Coping skills found to be useful for AIDS patients are like those of cancer patients, with the addition of skills for coping with loss. It is also important that AIDS patients maintain their self-esteem and avoid self-blame.[107]

Coping skills and behaviours have a significant impact on the way people deal with illness, respond to treatment, initiate and maintain health-supportive behaviour change, and thus are important components of Health Promotion.

7.5 Self-Efficacy

Self-efficacy, a concept pioneered by Albert Bandura, refers to *the extent that a person believes in his capacities to regulate and control his own behaviour*. As lifestyle habits have a direct impact on health and are regulated by the individual, a high sense of self-efficacy is important in exerting control over lifestyle habits that damage health. Thus, self-efficacy beliefs impact health in significant ways.

People's beliefs about whether they can motivate themselves and regulate their behaviour play a crucial role in whether they will consider changing damaging health habits. People with high self-efficacy believe they can regulate their health behaviours and they learn how to influence and monitor their own behaviour—turning their beliefs into action. People with high self-efficacy set attainable sub-goals that motivate them, and enlist incentives and social support to sustain the effort needed to succeed.

Schwarzer and Fuchs reviewed a large body of evidence on how personal efficacy operates with other psychosocial factors to foster lifestyle changes that enhance health and alter behaviours that impair it.[108] The evidence showed self-efficacy is correlated with successful smoking cessation, maintaining regular exercise for an extended time, initiating and regulating diet and weight control, having regular cancer screening examinations, addiction recovery, negotiating safer sex practices,[109]coping with stress,

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[106] Taylor, S.E. Adjustment to threatening events: A theory of cognitive adaptation (*American Psychologist*, 1983) 38, 1161-1173; Taylor, S.E., Lichtman, R.R. & Wood, J.V. Attributions, beliefs about control, and adjustment to breast cancer (*Journal of Personality and Social Psychology*, 1984), 46, 489-502; Wood, J., Taylor, S.E. & Lichtman, R.R. Social comparison in adjustment to breast cancer (*Journal of Personality and Social Psychology*, 1985), 49, 1169-1183.

[107] McKusick, L. The impact of AIDS on practitioner and client: Notes for the therapeutic relationship (*American Psychologist*, 1988), 43, 935-940.

[108] Bandura, A. *Self-Efficacy in Changing Societies*. (Cambridge, UK: Cambridge University Press, 1995), pg. xii.

[109] Schwarzer & Fuchs in Bandura, op. cit., pg. 263-276.

controlling pain, success in controlled drinking programs, recovering cardiovascular function in post-coronary patients, and frequency of flossing teeth.[110]

A person's level of self-efficacy also affects nutritional habits, exercise practices, smoking, drinking, drug use, sexual habits, physical risks, educational attainment, job capacities, ability to cope with stress, and behavioural choices associated with these areas. Significant health outcomes affected include the level of risk for cardiovascular problems, cancer, respiratory disorders, sexually transmitted diseases, and accidents. As half of all deaths in the U.S. are estimated as determined by health habits over which people have some control, increasing self-efficacy is an important component of Health Promotion.[111]

Self efficacy is an important factor in stress control as it is not the amount or kind of stress per se but whether or not the person feels he can control a difficult situation that determines whether there are detrimental biological effects.[112] The biological mechanism seems to be that *exposure to stressors without efficacy to control them* activates potent stress-related hormones. When people's perceived coping efficacy is strengthened, they are able to deal with the same stressors without distress or visceral agitation from the stress-related hormones.[113] In fact, it has been shown that providing people with the means for managing acute and chronic stressors increases their immunological functioning.[114] Despite the stresses of modern life, several studies now support the view that with self-efficacy enhancement, stress can strengthen people's coping skills and create a physiological toughening as well.[115]

Altering lifestyle behaviours requires effective self-regulation which includes the capacity to motivate oneself, engage in self-monitoring, set attainable sub-goals, create incentives and enlist social support. This is especially true in the control of addictive habits and the social pressures that encourage them. The higher a person's sense of personal efficacy, the less vulnerable s/he is to slips and relapses; should setbacks occur, efficacy beliefs affect how they are viewed, managed, and whether or not the person is

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[110] Schwarzer, R. & Fuchs, R. Self-Efficacy and Health Behaviours, in: Conner, M. & Norman, P. *Predicting Health Behaviour*. (Buckingham, UK: Open University Press, 1995), pg. 166.

[111] McGinnis, J.M. & Foege, W.H. Actual causes of death in the United States (*Journal of the American Medical Association*, 1993), 270, 2207-2212.

[112] Bandura, A. Exercise of personal agency through the self-efficacy mechanism, in: Schwarzer, R. (ed.) *Self-efficacy: Thought Control of Action* (Washington, DC: Hemisphere, 1992b), pg. 3-38; Maier, S.F., Laudenslager, M.L. & Ryan, S.M. Stressor controllability, immune function, and endogenous opiates, in: Brush, F.R. & J.B. Overmier (eds.) *Affect, conditioning and cognition: Essays on the determinants of behaviour*. (Hillsdale, NJ: Erlbaum, 1985), pg. 183-201; Shavit, Y. & Martin, F.C. Opiates, stress, and immunity: Animal studies (*Annals of Behavioural Medicine*, 1987), 9, 11-20.

[113] Ibid.

[114] Antoni, M.H., Schneiderman, N., Fletcher, M.A., Goldstein, D.A., Ironson, G. & Laperriere, A. Psychoneuroimmunology and HIV-1 (*Journal of Consulting and Clinical Psychology*, 1990), 58, 38-49; Gruber, B., Hall, N.R., Hersh, S.P. & Dubois, P. Immune system and psychologic changes in metastatic cancer patients using relaxation and guided imagery: A pilot study (*Scandinavian Journal of Behaviour Therapy*, 1988), 17, 25-46; Kiecolt-Glaser, J.K., Glaser, R., Strain, E.C., Stout, J.C., Tarr, K.L., Holliday, J.E. & Speicher, C.E. Modulation of cellular immunity in medical students (*Journal of Behavioural Medicine*, 1986), 9, 5-21.

[115] Dienstbier, R.A. Arousal and physiological toughness: Implications for mental and physical health (*Psychological Review*, 1989), 96, 84-100.

able to reinstate control.[116] The transfer of information about sexuality without development of self-regulatory skills and the sense of efficacy to exercise personal control over sexual relationships have little impact on patterns of sexual behaviour.[117] Thus, programs for adolescents that help them master self-regulatory skills and enhance belief in their own self-efficacy help reduce risky sexual behaviour.[118]

Self-regulatory capabilities are also important in maintaining habit change and because of the personal mastery required, the process of achieving successful control over troublesome situations builds efficacy. Conversely, without confidence in their self-efficacy, people become easily discouraged when behaviour change doesn't bring quick results and a low sense of efficacy then increases vulnerability to relapse.[119]

Numerous well-intentioned health education programs have failed because participants lacked the efficacy needed to make changes in their behaviour. Health Promotion programs that foster skills in self-regulation have been shown to prevent or reduce health-risk, whereas those that rely mainly on providing health information are relatively ineffective.[120]

A wider perspective on Health Promotion requires that we also consider the notion of "collective efficacy" as a way of empowering health professionals as a group to persevere through the difficulties of mounting social and policy initiatives that affect human health. In order to become effective at instituting large-scale change in health practices, policy and structure, we must, as Albert Bandura says,

> *Develop the shared belief in the capacity to make health promotion a national (and international) priority, to forge divergent self-interests into a shared agenda, to enlist supporters and resources for collective action, to devise effective strategies and to execute them successfully, and to withstand forcible opposition and discouraging setbacks.*[121]

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[116] Bandura, A. *Self-efficacy: The Exercise of Control.* (New York: W.H. Freeman, 1997); DiClemente, C.C., Fairhurst, S.K. & Piotrowski, N.A. (in press). The role of self-efficacy in addictive behaviours, in: Maddux, J. (ed.) *Self-efficacy, adaptation and adjustment: Theory, research and application.* (New York: Plenum); Marlatt, G.A., Baer, J.S. & Quigley, L.A. Self-efficacy and alcohol and drug abuse, in: Bandura, A. (ed.), op. cit., pg. 289-315.

[117] Bandura, op. cit., pg. 32.

[118] Gilchrist, L.D. & Schinke, S.P. Coping with contraception: Cognitive and behavioural methods with adolescents (*Cognitive Therapy and Research*, 1983), 7, 379-388; Jemmott, J.B., III, Jemmott, L.S. & Fong, G.T. Reductions in HIV risk-associated sexual behaviours among black male adolescents: Effects of an AIDS prevention intervention (*American Journal of Public Health*, 1992), 82, 372-377; Jemmott, J.B., III, Jemmott, L.S., Spears, H., Hewitt, N. & Cruz-Collins, M. Self-efficacy, hedonistic expectancies, and condom-use intentions among inner-city black adolescent women: A social cognitive approach to AIDS risk behaviour (*Journal of Adolescent Health*, 1991), 13, 512-519.

[119] Bandura, A. Self-efficacy mechanism in psychobiologic functioning, in: Schwarzer, R. (ed.) *Self-efficacy: Thought control of action.* (Washington, D.C.: Hemisphere, 1992), pg. 3-38.

[120] Botvin, G.J. & Dusenbury, L. Substance abuse prevention: Implications for reducing risk of HIV infection (*Psychology of Addictive Behaviours*, 1992), 6, 70-80; Bruvold, W.H. A meta-analysis of adolescent smoking prevention programs (*American Journal of Public Health*, 1993), 83, 872-880; Jemmott, Jemmott, Spears, Hewitt, & Cruz-Collins, op. cit.

[121] Bandura, op. cit., pg. 33.

Besides helping strengthen clients' abilities to change their personal health habits, health professionals must find ways to develop the collective efficacy that empowers and sustains behaviour change on a social scale.

7.6 Hardiness

Hardiness, pioneered by Drs. Salvatore Maddi and Suzanne Kobasa, refers to "*a pattern of attitudes and skills that enhance performance, leadership, morale, stamina, and health, despite stressful circumstances*."[122] Hardy people, in this sense, are able to cope with changes rather than be overcome by them. Numerous studies by Maddi and others have found that people with high stress are protected from physical illness if they have a stress-hardy personality that exhibits three components of Hardiness:

> *Commitment*—an attitude of curiosity and involvement in what is happening; finding meaning in being involved with people and events;
> *Control*—the belief that one can influence events and a willingness to act on that belief rather than be a victim of circumstances—the opposite of helplessness;
> *Challenge*—the belief that life's challenges stimulate personal growth—that life is most fulfilling when you continue to learn from your experiences, whether positive or negative, rather than viewing change as threats to the status quo.[123]

These three components of Hardiness equip a person to react to stressful events by increasing his/her interaction with them—exploring, controlling and learning from them, rather than regressing into a passive, helpless posture.

The importance of Hardiness has been shown in hundreds of studies, making it one of the most scientifically researched concepts. One of the most important was a landmark 30-year study of Harvard graduates reported by Dr. George Vaillant which showed mental health as *the* most important predictor of physical health, and Hardiness as an important psychological factor. Men identified as having immature coping styles such as regressive coping (avoiding or denying problems rather than facing and dealing with them), became ill four times more often than those with hardier styles.[124]

Maddi's Hardiness Model (Figure #7) expresses graphically how various aspects of personality and genetics combine to influence how we handle stress, and how that stress affects performance and health. The upper right-hand box shows the undesirable results of Regressive Coping; the bottom four boxes show how stress and strain can be more effectively handled when channelled into Hardiness behaviours.

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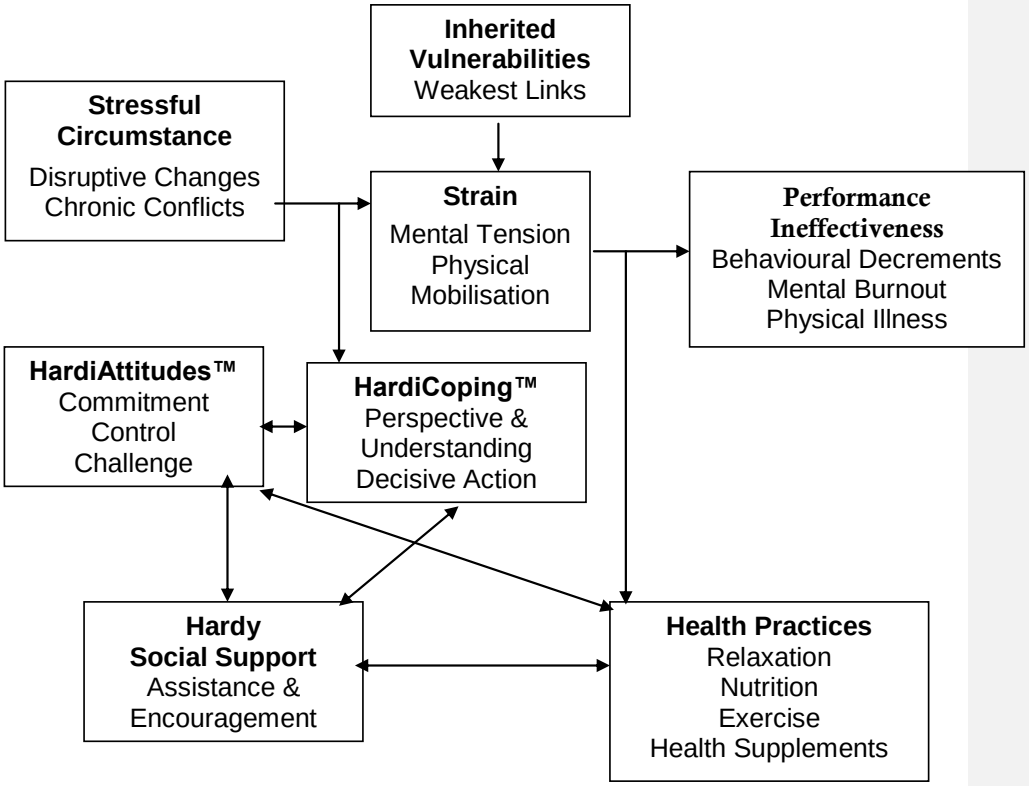
[122] Maddi, S. (Hardiness Institute, Irvine, CA, personal communication, August 16, 2001.)
[123] Ibid.
[124] Borysenko, op. cit., pg. 25.

Maddi's Hardiness® Model[125]



[Figure #7 – Maddi's Hardiness Model]

Here is a sampling from the many research findings that show a correlation between Hardiness and health: Psychological and physical symptoms of anxiety, psychosis, delusions and eating disorders in adolescent males were correlated with stress and low levels of the Hardiness components of commitment and control; Hardiness was inversely related to self-reported frequency of previous alcohol and drug use and to the degree of current drug use;[126] Hardiness buffered against psychological distress, negative feelings, attitudes, and behaviours among adult children of alcoholics;[127]

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[125] Maddi, S.R. The Hardiness model, from: *The Hardiness Enhancing Lifestyle Program (HELP) for Improving Physical, Mental, and Social Wellness* (Oakland, CA: Wellness Lecture Series, University of California/HealthNet, 1994), pg. 5, modified <<www.hardinessinstitute.com >> February 2002).

[126] Maddi, S.R., Wadhwa, P. & Haier, R.J. Relationship of Hardiness to alcohol and drug use in adolescents (*American Journal of Drug and Alcohol Abuse*, May, 1996), v22 (n2) :247-257.

[127] Kashubeck, S. & Christensen, S.A. "Differences in distress among adult children of alcoholics (*Journal of Counseling Psychology*, 1992), v39 (n3) : 356-362.

Hardiness reduced the impact of stress on symptoms felt, with hardy subjects experiencing less frequent stressors and perceiving the events as less stressful;[128] Hardiness moderated job stress and coronary risk in Type A individuals;[129] Hardiness was a buffer for discrimination-related stress;[130] Hardiness was a significant mediating variable in adjusting to childhood sexual abuse;[131] Hardy employees had higher levels of job satisfaction, fewer tensions at work, experienced a higher quality of life, had more positive affect, fewer somatic complaints and tended to be less depressed and anxious;[132] Hardiness and Locus of Control buffered the effects of stress on illness.[133]

Besides its value for the individual, Maddi's work on how to develop a hardy organisation shows the desirability of what can be called "Societal Hardiness," as a way for society to foster our collective abilities to function under the ever-present conditions of stress and continual change, and to develop the capacity to view change as an opportunity for society to grow in health-supportive ways.

7.7 Self-Esteem

Self-esteem has to do *with the way a person regards him/herself, in what kind of esteem s/he holds herself, and to what extent s/he views him/herself as capable and worthwhile.* Consequently, self-esteem affects attitudes, expectations, decisions and performance. High self-esteem enhances every facet of a person's life including family relationships, job performance, productivity, happiness, mental and physical health, lifestyle, and general feelings of well-being. Low self-esteem is correlated with depression, anxiety, personality disorders, and schizophrenic disorders.[134]

Because self-esteem affects attitudes and decisions, it is strongly intertwined with behavioural choices. Low self-esteem seems to be directly linked with disturbed body image, dropping out of physical activity, eating disorders, substance abuse, abusive relationships and interpersonal problems. Yellowleees sees low self-esteem operating as a predisposing and contributory factor in the development of depression, anxiety, eating

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[128] Banks, J. & Gannon, L.R. The influence of Hardiness on the relationship between stressors and psychosomatic symptomatology (*American Journal of Community Psychology*, Feb., 1988), v16 (n1) :25-37.

[129] Howard, J.H., Cunningham, D.A. & Rechnitzer, P.A. Personality Hardiness as a moderator of job stress and coronary risk in Type A individuals: A longitudinal study (*Journal of Behavioural Medicine*, 1989 June), v9 (n3) :229-244.

[130] Dion, K.L., Dion, K. & Pak, A.W. *Personality based Hardiness as a buzzer for discrimination related stress in members of Toronto's Chinese community* (1992, www.hardinessonline.com/Web%20Page%206.html)

[131] Feinauer, L. L., Mitchell, J., Harper, J.M. & Dane, S. The impact of hardiness and severity of childhood sexual abuse on adult adjustment (*American Journal of Family Therapy*, Fall, 1996), v24 (n3) :206-214.

[132] Manning, M.R., Williams, R.F. & Wolfe, D.M. Hardiness and the relationship between stressors and outcomes (*Work and Stress*, 1988), Jul-Sep, v2 (n3) :205-216.

[133] Lawler, K. & Schmied, L.A. A prospective study of women's health: The effects of stress, Hardiness, locus of control, Type A behaviour, and physiological reactivity (*Women & Health*, 1992), v19 (n1) :27-41.

[134] Ibid.

disorders, alcohol abuse and drug abuse.[135] It is also correlated with smoking, especially in adolescents. Since most smoking starts in adolescence and is high risk behaviour, it is evident that promoting adolescent self-esteem is an important component of Health Promotion.

Although our understanding of the impact of self-esteem on decision-making and behaviours is incomplete, over 30,000 research studies show the reach of self-esteem to be surprisingly large. A case in point is a study showing the correlation between mother's self-esteem and infant birth weight. The research team found that optimistic pregnant women with high levels of self-esteem are more likely to deliver healthy, normal birth weight infants than those who are pessimistic and have poor self-esteem. The pessimistic, low self-esteem mothers reported high levels of emotional stress which may have affected their ability to adapt to the changes and challenges of pregnancy, and the birth weights of their babies were substantially below normal. The researchers concluded that women with strong personal resources (i.e., high self-esteem) seek out health-related information and lead healthier lifestyles, such as refraining from smoking, alcohol and drug use during pregnancy.[136] As premature delivery and low birth weight are both linked with health problems for the infant, this study linking mother's self-esteem with infant birth weight provides a glimpse into the diverse ramifications of self-esteem on other components of health.

The extent to which people relate to themselves with trust and respect, and see themselves as capable and worthy, has a direct impact on their health. People with high self-esteem recognise the need and the right to do things that are good for their health, take time to obtain, prepare and eat foods that provide good nutrition, engage regularly in health care practices such as exercise and stress-reduction activities, and create relationships that are satisfying and support them emotionally.

People with good self-esteem take their health care needs seriously and seek skilled health professionals who offer caring and supportive relationships; people with good self-esteem recognise their needs and know that they have the right to get them met, in both social and work relationships, and in all matters that affect their lives and their health.

7.8 Communication and Problem Solving Skills

Communication skills and the ability to solve problems and resolve conflicts play important roles in determining the quality of interpersonal relationships, levels of stress and productivity. The capacity to communicate needs assertively, listen to others accurately and empathically, and find mutually acceptable solutions to problems influences the extent of social support people experience, including health care relationships. Because social support is an important determinant of health, communication and problem-solving skills are important factors in determining health.

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[135] Yellowlees. A. Low Self-Esteem and Eating Problems; Food for Thought, in: *Self-Esteem Solutions*. (Cambridge, UK: Daniels Publishing, 1996).
[136] Rini, C.K. Mother's self esteem influences birthweight *(Health Psychology*, July 1999), 18: 1-13.

Assertiveness is the ability to state your unmet needs and get them met without the use of aggression. The type of message considered the norm for assertive self-disclosure is called an *I-Message*, in which the sender describes his/her own needs and feelings without blaming or directing the listener to respond in a particular way. Communicating concerns and needs in congruent I-Messages has an impact on the extent to which those needs are likely to get met. Because I-Messages impose no demand upon the receiver of the message and reduce resistance and defensiveness, they increase the likelihood of a helpful response.

The skill of self-disclosure is especially needed at times of stress or emergency. In these situations, when the need is acute, it is important that people feel confident in their ability to assert their needs without fear of antagonising their caregiver. I-Messages also make it easier for the listener, whether health professional or other, to hear and respond to the sender's emotional needs rather than focus exclusively on technical details.

Empathic Listening is a second important communication skill, defined as the ability to listen acceptingly and non-judgmentally to another person and to feed back the gist of that person's communication accurately.

Skilled listeners are better able to understand information they receive from health professionals, comprehend their own health issues, understand probabilities and risks associated with medical decisions and follow recommendations successfully.

Empathic Listening is also a powerful relationship-builder in people's personal lives. It fosters intimacy that provides maximum emotional support, and it can also help the listener extract deeper meaning from a spouse or a friend's clumsy effort to help. For example, a typical message of concern about health risk might include a strong admonition to curtail saturated fats: A skilled listener is better able to catch the *underlying emotional content* of concern and caring, and is less likely to respond defensively to the content of the message. And, by hearing the underlying message of caring s/he is more likely to take action to change health-damaging behaviour.

Empathic Listening is also an important skill for medical professionals as it helps the patient/client explore concerns about medical issues, reduces resistance to treatment, and helps make interaction collaborative and cooperative.

Problem-Solving Skills enable people to generate mutually-acceptable solutions and eliminate resentment that comes from one person imposing a solution on another. They help improve family, social, and work relationships and increase closeness, cooperation and satisfaction. They also help people prioritise projects at work, manage complex tasks, reduce stress, and increase cooperation.

7.9 Summary

The field of Psychology has developed tremendously in the past century and the biopsychosocial paradigm brings its centrality to health clearly into focus. Recognition of the key psychological determinants of health—Coping, Hardiness, Self-Efficacy, Self-Esteem, Interpersonal Communication and Problem-Solving Skills—equip the health professional to empower their clients as responsible agents of their own health.

Chapter 8 – Social Determinants

> *"Political, economic, social, cultural, environmental, behavioural and biological factors can all favour health or be harmful to it. Health promotion action aims at making these conditions favourable through advocacy for health… Health promotion focuses on achieving equity in health. Health promotion action aims at reducing differences in current health status and ensuring equal opportunities and resources to enable all people to achieve their fullest health potential."*
>
> WHO Ottawa Charter for Health Promotion

Social factors are a prime illustration of the way health factors interrelate. For example, looking at social determinants of health, we see that someone with low socioeconomic status is likely also to have low educational attainment, less access to preventive care, and living conditions that include greater stressors. These social factors correlate with greater consumption of alcohol, a reduced inhibition system, lower frustration threshold when drunk, greater likelihood of violence toward spouse and children, and more household accidents. Drinking and smoking also correlate with more incidents of casual sex, increased STDs, immuno-deficiency and other negative effects on the body. Furthermore, higher stress levels put pressure on the immune system leading to greater susceptibility to colds and other infections. Thus it becomes apparent that all of these individual factors correlate with health and at the same time interact in a predictable, circular way with other health determinants, underscoring the importance of promoting health from a systemic perspective.

8.1 Socio-Economic Status

Socio-economic status is a powerful determinant of health, encompassing a wide range of factors including education, access to and adequacy of health care services, working conditions, and opportunities for leisure activities, adequacy of housing and nutrition, availability of jobs, and social support. Numerous studies in the past three decades show correlations among income/education/class and morbidity/mortality, with high economic status promoting higher levels of health and longevity, and low status and poverty being a formula for poorer health and shorter lives. The landmark Whitehall studies of the British civil service and the Multiple Risk Factor Intervention Trial in the United States show conventional risk factors such as smoking, obesity, inactivity and high blood pressure correlated with social status.[137]

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[137] McCally, M. *New England Journal of Medicine* (January 20, 2000) review of Kawachi, I., Kennedy, B., Wilkinson, R. (eds.). *The Society and Population Health Reader: Income Inequality and Health.* (New York: New Press, 1999).

Socio-economic status embeds people in a continuity of social circumstances that are not isolated factors, but a group of relatively small differences "which become linked into a chain of [either advantage or] disadvantage."[138] David Blane sees these as accumulating over a person's lifetime, with such enormous impact on morbidity and mortality that they can be viewed as "a social distribution of health and disease."[139] (See figure 8 on "Poor People's Views on Health Problems."[140])

Poor People's Views on Health Problems*

When questioned about their health, poor people mention a broad range of injuries and illnesses, including mental health problems, and difficulties associated with drug and alcohol abuse. Among problems mentioned are stress, anxiety, depression, lack of self-esteem and suicide, all of which are seen by them as the effects of poverty.

A recurring theme is the stress of not being able to provide for one's family. People associate many forms of sickness with stress, anguish, and being ill at ease, but often specifically mention HIV/AIDS, alcoholism and drugs.

Discussion groups in Zambia, Ghana, Jamaica, Thailand, Vietnam, and other countries have identified a causal relationship between poverty and prostitution, HIV/AIDS and death. .

People regard drug use and alcoholism as causes of violence, insecurity and theft, and regard the money spent on alcohol or other drugs, male drunkenness, and domestic violence as syndromes of poverty.

* Narayan D. et al. *Voices of the poor, crying out for change.* (New York: Oxford University Press for the World Bank, 2000).

[Figure #8 -- Poor People's Views on Health Problems]

One thread of this phenomenon starts with parents' social class which influences birth weight, with higher classes having higher birth weight babies.[141] Low birth weight babies are more likely to live in less affluent families, with poorer quality housing, poorer nutrition and disrupted sleep patterns.[142] These children experience delayed growth during childhood, resulting in their being, at age 7, shorter than children from more affluent families.[143] Height at age 7 is a powerful predictor of subsequent risk of unemployment. Those with slow childhood growth are likely to attain lower educational levels than cohorts of their social class and these educational disadvantages weaken their subsequent employment chances, exposing them to the health hazards of unemployment

[138] Blane, D. The life course, the social gradient, and health, in: Marmot, M. & Wilkinson, R.G. (eds.). *Social Determinants of Health*. (Oxford: Oxford University Press, 1999).
[139] Blane, op. cit.
[140] WHO. *The World Health Report 2001: Mental Health—New Understanding, New Hope* (Geneva, World Health Organization, 2001), pg. 41.
[141] Drever, F. & Whitehead, M. *Health inequalities: decennial supplement* (London: ONS, The Stationery Office, 1997).
[142] Montgomery, S., Bartley, M. & Wilkinson, R. Family conflict and slow growth (*Arch. Dis. Child*, 1997) 77, 326-30.
[143] Bartley, M., Power, C., Blane, D., Davey Smith, G. & Shipley, M. Birth weight and later socioeconomic disadvantage: evidence from the 1958 British cohort study. (*BMJ* 1994) 309, 1475-8.

and casual employment in the poorly regulated secondary labour market.[144] Several studies have shown poor growth during early childhood to be associated with increased risks to adult health.[145]

Studies in Great Britain show that the variation in life expectancy by social classes exists and is widening[146] (see table 9). Similar gradients are found in other European countries,[147] including former communist countries such as the Czech Republic and Hungary.[148]

Life Expectancy at Age 15, by Social Class

Classes I & II correspond to upper and upper middle classes, III to white-collar, IV to blue-collar, and IV &V to the lowest classes.)

	Men			Women		
	1977-81	1982-86	1987-91	1977-81	1982-86	1987-91
Life expectancy						
Classes I+II	58.8	59.9	60.5	64.1	64.3	65.8
Difference in years between I+II and:						
III Non-manual*	-1.9	-1.7	-0.7	0.0	0.0	-0.5
III Manual*	-2.2	-2.5	-2.4	-1.9	-1.4	-2.6
IV+V	-3.7	-4.0	-4.7	-2.1	-1.5	-3.4

[* Occupations]

[Figure #9—Life Expectancy after Age 15, by Social Class]

Similar evidence of socio-economic influence on health comes from the National Longitudinal Survey of Labour Market Experience of Mature Men in the U.S. which showed premature death to be influenced by length of schooling, family wealth, assets and type of occupation.[149]

A Norwegian longitudinal study of 180,000 deaths from 1960-1980 found that mortality risk among men was highest for those whose education ended at the primary level, worked in manual occupations, took early retirement from work, lived in poor

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[144] Blane, op. cit.

[145] Tanner, J.M. *Growth at Adolescence.* (Oxford: Blackwell, 1955); Douglas, J.W.B., Ross, J.M. & Simpson, H.R. *All Our Future.* (London: Peter Davies, 1968); M.A. Preece & Holder, A.T. The somatomedins: a family of serum growth factors, in: O'Riordan , J.L.H. (ed.). *Recent advances in endocrinology and metabolism*, Vol. 2 (Edinburgh: Churchill Livingstone, 1982); Preece, M.A. Prepubertal and pubertal endocrinolog., in: Falkner, J. & Tanner, J.M. (eds.) *Human Growth* (2nd edn.), Vol. 2. (London: Plenum Press, 1985).

[146] Drever & Whitehead, op. cit.

[147] Kunst, A.E. & Mackenbach, J.P. *An international comparison of socio-economic inequalities in mortality.* (Rotterdam: Erasmus University, 1992).

[148] Kunst, A. *Cross-national comparison of socio-economic differences in mortality.* (Rotterdam: Erasmus University, Ph.D. thesis, 1997).

[149] Mare, R.D. Socioeconomic careers and differential mortality among older men in the United States, in: Vallin, J., D'Souza, S. & Palloni, A. (eds.) *Measurement and Analysis of Mortality: New Approaches.* (Oxford: Clarendon Press, 1990), pg. 362-87

housing conditions in early life, and who remained poor through later life. Unfavourable life courses for women include poor early housing conditions, low education and low economic inactivity.[150]

The West of Scotland Collaborative Study of 5500 men found that deaths caused by cancers (other than stomach and lung), accidents, and violence were related to adult social class. Death from coronary heart disease, stroke, lung cancer, stomach cancer and respiratory disease were related both to childhood and adult social class.[151]

Socio-economic factors are in some cases further compounded by racial differences. A report by the U.S. Institute of Medicine of the National Academy of Sciences found that racial and ethnic minorities generally receive lower-quality health care and less intensive diagnostic services than white patients, even when their income, insurance and medical conditions are similar. Among the findings were that 74 blacks have coronary arterial surgery for every 100 whites, are 50% more likely to be denied coverage by their health plans, and have a 26% five-year survival rate as lung cancer patients compared with the white rate of 34%.[152]

Employment level is also an important socio-economic factor. It affects 1) income opportunities; 2) social identity as related to personal growth and development; 3) social standing, social esteem and approval, attitudes and behaviours in regard to leisure, family life, education and political activity; and 4) because work demands are the most pervasive and long-term ones in a person's life, adverse job conditions increase the risks of ill health, while positive occupational situations provide opportunities to experience financial reward, esteem, success and satisfaction.[153] (For an illustration of the cyclic relationship between Poverty, and Mental and Behavioural Disorders, see figure 10.[154])

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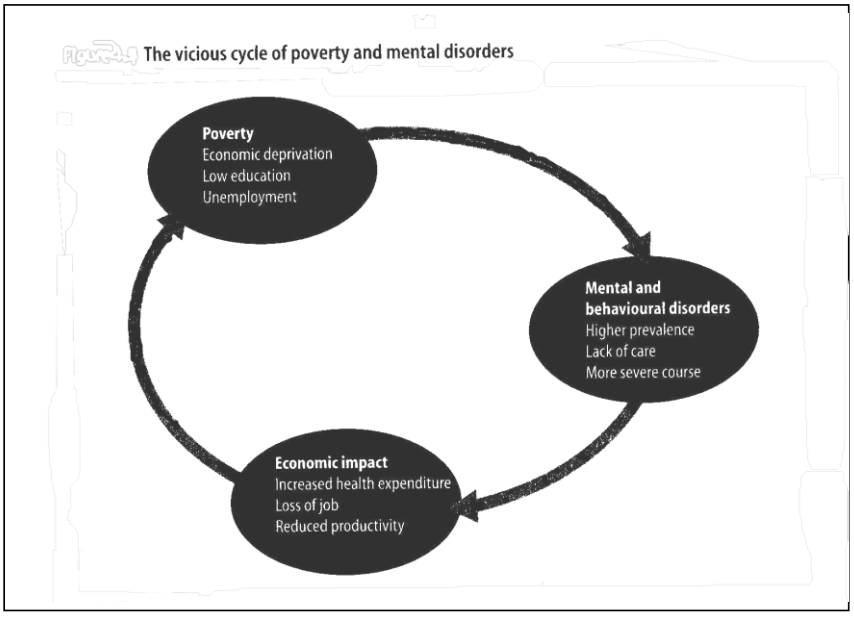
[150] Wunch, G., Duchene, J., Thiltges, E. & Salhi, M. Socioeconomic Differences in Mortality: A life course approach (*Eur. J. Popn* 1996), 12, 167-85.
[151] Smith, G. D., Hart, C., Blane, D. & Hole, D. Adverse socio-economic conditions in childhood and cause specific adult mortality: prospective observational study (*BMJ* 1998), 316, 1631-5,
[152] Pugh, T. Minority health care found lacking (*San Diego Union-Tribune*, March 21, 2002).
[153] Blane, op. cit.
[154] *The World Health Report 2001*, op. cit., pg. 14.



[Figure #10: The Vicious Cycle of Poverty and Mental Disorders]

The relationship between socio-economic factors and health is further illuminated by international comparative evidence showing that life expectancy is related more closely to *income distribution* within each society than to that society's overall wealth.[155] Where income differences are related to differences in social status, they are closely related to health; but where they do not affect social status, they are not. Thus, the key factor is between *health and relative income*, with health being less related to people's absolute material living standards than to their position in society as a function of income.[156]

Psychological, sociological and anthropological studies have shown racism and its resulting social marginalisation, to be related to the perpetuation of mental problems.[157] A review of 10 studies of diverse racial groups in North America established the correlation between racism and psychological distress[158] showing those affected by racism to have greater risk of developing mental problems and worsening existing ones, including depression.

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[155] Wilkinson, R.G. Income distribution and life expectancy (*BMJ*, 1992), 304, 165-8.

[156] Wilkinson, R. G. Putting the picture together: prosperity, redistribution, health, and welfare, in: Marmot & Wilkinson, op. cit.

[157] The World Health Report 2001, op. cit., pg. 15.

[158] Williams, D.R. & Williams-Morris, R. Racism and mental health: the African American experience (*Ethnicity and Health)*, 5(3/4): 243-268.

In more egalitarian societies where income and social status differences are smaller, average health standards improve,[159] with better health and increased longevity.[160] Also, people in more egalitarian areas *within* countries have better health than compatriots living elsewhere.[161]

Another characteristic of more egalitarian societies is heightened social cohesiveness which itself is a positive determinant of health. Putnam, in his study of Italian community life, found that income equality is an essential feature of the civic community.[162] In his numerous analyses of Britain during the two world wars, post-war Japan, Roseto, Pennsylvania, and parts of Eastern Europe during the 1970s-1980s, Wilkinson found evidence of a strong relationship between social egalitarianism, good health and cohesiveness.[163] Stansfeld and others have found death rates 2-3 times higher among people with low levels of social integration.[164] Ethnic minorities not fully integrated into society experience more problems gaining access to health services such as cancer screening and pre-natal care,[165] have lower cancer and AIDS survival rates than white counterparts,[166] and are more likely to experience stressors such as poverty, poor housing, unemployment, and poor working conditions. They also have fewer resources for responding to such stressors,[167] experience discrimination, racial harassment and reduced access to resources,[168]lack feelings of self-control, and experience discrimination and powerlessness.[169]

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[159] *The World Health Report 2001*, op. cit., pg. 15.

[160] Kawachi, I., Kennedy, B. & Wilkinson, R.G. (ed.). *The Society and Population Health Reader*: *Income inequality and health.* (New York: New Press, 1999).

[161] Kaplan, G.A., Pamuk, E., Lynch, J.W., Cohen, R.D. & Balfour, J.L. Inequality in income and mortality in the United States: analysis of mortality and potential pathways (*BMJ* 1996), 312, 999-1003.; Kennedy, B.P., Kawachi, I. & Prothrow-Stith, D. Income distribution and mortality: cross sectional ecological study of the Robin Hood index in the United States *(BMJ* 1996), 312, 1004-7; Lynch, J., Kaplan, G.A. & Pamuk, E.R., et al. Income inequality and mortality in metropolitan areas of the United States (*Am. J. Publ. Hlth* 1998), 88, 1074-80.

[162] Putnam, R.D., Leonardi, R. & Nanetti, R.Y. *Making Democracy Work: Civic traditions in modern Italy.* (Princeton, NJ: Princeton University Press, 1993).

[163] Wilkinson, op. cit.

[164] Stansfeld, op. cit.; House, J.S., Landis, K.R. & Umberson, D. Social relationships and health (*Science* 1988), 241, 540-5.; Berkman, L.F. The role of social relations in health promotion (*Psychosom. Res*. 1995), 57, 245-54.

[165] Doyle, Y. A survey of the cervical screening service in a London district, including reasons for non-attendance, ethnic responses and views on the quality of the service *(Social Science and Medicine*, 1991) 32: 953-7; Narang, I. & Murphy, S. "An assessment of ante-natal care for Asian women (*British Journal of Midwifery*, 1994), 2: 169-74.

[166] Haan, M.N. & Kaplan, G. The contribution of socio-economic position to minority health, in: *Report of the Secretary's Task Force on Black and Minority Health,* volume 2. (Washington, D.C.): US Department of Health and Human Services; Primm, B. AIDS: a special report, in: J. Dewart (ed). *The State of Black America* 1987. (New York: National Urban League, 1987).

[167] Brown, C. *Black and White Britain: The Third PSI Survey* (London: Heinemann); Robinson, J. Racial inequality and the probability of occupation-related injury or illness (*Milbank Memorial Fund Quarterly*, 1984), 62: 567-90.

[168] Kessler, R.C. & Neighbors, H.W. A new perspective on the relationships among race, social class, and psychological distress (*Journal of Health and Social Behaviour*, 1986), 27: 107-15.

[169] Sleutjes, M. Promoting safer sex among ethnic minority groups. Lifting the real barriers, in: Paalman, M. (ed.). *Promoting Safer Sex: Prevention of Sexual Transmission of AIDS and other STDs.* (Amsterdam: Swets & Zeitlinger, 1990).

Poverty is itself an important health determinant. People who work in low paid jobs are not only the most materially disadvantaged, they also have job and financial insecurity, experience more unemployment, work injury, lack of fate control, and other social and environmental stressors. Furthermore, they are more likely to have a cynical or fatalistic outlook and experience less social support.[170] In addition, poverty generally results in less access to medical care; even in countries with a national health service, increased risk of poor health is associated with greater degrees of poverty.[171]

The health effects of poverty are long-ranging, with British studies showing that those born to poverty in societies with a big discrepancy between the poor and wealthy carry into their adult life a high risk of premature illness and death.[172] The poorest in society have the poorest health, occupying the lowest step on "a gradient of ill health and mortality (spanning) all socio-economic strata" throughout the industrialized world.[173]

So powerful are socio-economic factors that material conditions have been described as "the underlying root of ill health"[174] with poverty imposing serious constraints on everyday life and limiting access to fundamental building blocks of health including adequate housing, good nutrition and opportunities for participation in society.[175] Resulting risk factors include overcrowded and inadequate housing, inability to maintain optimal hygiene practices, exposure to infections, damp, cold, and mould conditions, various respiratory diseases, fire, accidence, and conditions which impact mental health such as high noise levels, lack of privacy, and problems in child care.[176]

Poverty is also associated with inadequate diet, characterized by low fruit, vegetable and fish consumption and nutrient intakes, low dietary fibre, antioxidants and other vitamins, foliate, iron, and essential fatty acids.[177]

Poverty is strongly associated with unemployment, a factor which itself carries increased risk to physical and mental health.[178] In many parts of the world, status is defined by employment. The experience of unemployment leads not only to low income

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[170] Adler, N., Boyce, T., Chesney, M., Cohen, S., Folkman, S., Kahn, R. & Syme, L. Socioeconomic status and health: the challenge of the gradient. *(American Psychologist,* 1994), *49*, 15-24; Berkman, L. & Syme, S. (1979). Social networks, host resistance, and mortality: A nine-year follow up of Alameda County residents (*American Journal of Epidemiology), 109*, 186-204; Bosma, H., Marmot, M.G., Hemingway, H., Nicholson, A.C., Brunner, E. & Stansfeld, S.A. (1997). Low job control and risk of coronary heart disease (*American Journal of Public Health), 88*, 68-74; House, J.S., Landis, K.R. & Umberson, D. Social relationship and health (*Science, 1998), 241,* 540-545; Karasek, R. and Theorell, T. *Healthy Work.* (New York: Basic Books, 1990).

[171] Wadsworth, op, cit.

[172] Barker, D.J.P. *Mothers and babies and health in later life*. (2nd edn). (Edinburgh: Churchill Livingstone, 1998).

[173] Kunst, A.E., Buerts, J.J.M. & van der Berg, J. International variation in socioeconomic inequalities in self reported health (*J. Epidemiol. Commun. Hlth*, 1995), 49, 117-23.

[174] Davey Smith, G., Blane, D. & Bartley, M. Explanations for socio-economic differences in mortality: Evidence from Britain and elsewhere (*Eur J. Publ. Hlth,* 1994), 4 (2), 131-44.

[175] Black, D. & Laughlin, S. Poverty and health: The old alliance needs new partners (*Benefits*, Sept./Oct., 5-9, 1996).

[176] Ineichen, B. *Homes and Health: How housing and health interact* (London: Chapman and Hall, 1993).

[177] Dowler, E.A. & Dobson, B.M. Symposium on 'Nutrition and poverty in industrialized countries (*Proc. Nutr. Soc*., 1997), 56, 51-62.

[178] Montgomery, S.M., Bartley, M.J., Cook, D.G. & Wadsworth, M.E.J. Health and social precursors of unemployment in young men in Great Britain. (*J. Epidemiol. Commun. Hlth*, 1996), 50, 415-22.

but also to social isolation and reduced self-esteem. As Graham observed, looking at the other side of the coin, "employment remains the most effective guarantee against both poverty and the ill health with which it is associated."[179]

Despite advances in standards of living and the expansion of a world-wide economy, poverty is rising in Europe[180]and in other parts of the world as a result of mass unemployment, reductions in welfare systems, cuts in public services, aging populations, increasing divorce rates, increasing numbers of single parents, polarization of wealth and employment, and other socio-economic changes.[181]

The list of socio-economic determinants of health is lengthy and comprises one of the most influential systems in which the human organism is embedded. Viewing this vast array of economic and social influences on health from the perspective of the biopsychosocial model, it becomes evident that the work of Health Promotion is that of creating social change.

8.2 Social Support

Quality of social relationships is the single most important social determinant of health, with considerable evidence that social support is beneficial to health and social isolation leads to ill health.[182] Social support, defined by Cohen and Syme as "*resources provided by other persons,"*[183] refers to a network that may include marital partner, family, friends, neighbours, work, church, and club members that convey to a person the sense that s/he is valued, cared for and belongs to a social system of mutual connection and obligation.[184]

The Alameda County Study which measured participants' social network, found that those with the fewest social connections, regardless of lifestyle and prior ill health, had a 2-3 times greater mortality rate over a 9-year period than those with high social network scores.[185] This has been confirmed in subsequent investigations including the Tecumseh Study,[186] the Durham County Study,[187] Swedish studies,[188] and the North

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[179] Graham, H. *Women, health and the family*. (Brighton: Harvester Press, 1984).
[180] Oppenheim, C. & Harker, L. *Poverty: the facts.* (London: Child Poverty Action Group, 1996).
[181] Vogel, J. *Living conditions and inequality in the European Union 1997.* (Stockholm: Eurostat Working Papers, University of Umea, 1997).
[182] Stansfeld, S.A. Social support and social cohesion, in: Marmot and Wilkinson, op. cit.
[183] Cohen, S. & Syme, S.L. *Social support and health.* (London: Academic Press, 1985).
[184] Cobb, S. Social support as a moderator of life stress (*Psychosom. Med*. 1976), 38, 300-13.
[185] Berkman, L.F. & Syme, S.L. Social networks, host resistance, and mortality: a nine-year follow-up study of Alameda County residents (*Am. J. Epidemiol*., 1979), 109, 186-2-3.
[186] House, J.S., Robbins, C. & Metzner, H.L. The association of social relationships and activities with mortality: prospective evidence from the Tecumseh Community Health Study (*Am. J. Epidemiol*., 1982), 116, 123-40.
[187] Blazer, D.G. Social support and mortality in an elderly community population (*Am. J. Epidemiol*., 1982), 115, 684-94.
[188] Welin, L., Tibblin, G., Tibblin, B., et al. Prospective study of social influences on mortality: the study of men born in 1913 and 1923 (*Lancet*, 1985), 1, 915-18.; Orth-Gomer, K. & Johnson, J.V. Social network interaction and mortality: A six year follow-up study of a random sample of the Swedish population *(J. Chronic Dis*., 1987), 40, 949-57.

Karelia Study, which all found lack of social ties to be associated with elevated health risk.[189]

The 6-year Kuopio Study in Finland found that those at increased risk of death reported few persons to whom they gave or from whom they received support. Other factors were a low quality of social relationships, lack of participation in organisations, few friends, and not currently being married.[190] Kawachi et al. found social isolation was specifically related to increased cardiovascular disease mortality, deaths from accident and suicide, and stroke incidence.[191] A longitudinal Swedish[192] study found social integration to have a protective effect on the incidence of non-fatal myocardial infarction (heart attack), as did Vogt's 15-year evaluation of social ties and myocardial infarction.[193]

In addition to a health-protective effect, social support is also a factor in prognosis and recovery from chronic illness. Increasing the social support of socially isolated men has consistently been associated with recovery from myocardial infarction.[194] Social support has also been shown to help in dealing with chronically disabling and painful diseases, limiting disability and preventing the onset of secondary depression,[195]and protecting against short spells of illness for both men and women.[196]

Community involvement and the social support that comes from it can result in personal empowerment. Zimmerman found that people develop feelings of empowerment through involvement regardless of whether or not the organisation itself achieves its goals. The process of participation is beneficial in helping reduce feelings of hopelessness, and increase coping, problem-solving skills, and personal competence.[197] Several researchers, including Rappaport,[198]have noted the value of community

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[189] Kaplan, G.A., Salonen, J.T., Cohen, R.D., Brand, R.J., Syme, L. & Puska, P. Social connections and mortality from all causes and cardio-vascular disease: prospective evidence from eastern Finland (*Am. J. Epidemiol*., 1988), 128, 370-80.

[190] Kaplan, G.A., Wilson, T.W., Cohen, R.D., Kauhanen, J., Wu, M. & Salonen, J.T. Social functioning and overall mortality: prospective evidence from the Kuopio ischemic heart disease risk factor study (*Epidemiology*, 1994), 5, 495-500.

[191] Kawachi, I., Colditz, G.A., Ascherio, A., et al. A prospective study of social networks in relation to total mortality and cardiovascular disease in men in the USA (*J. Epidemiol. Commun. Hlth*, 1996), 50, 245-51.

[192] Welin, L., Tibblin, G., Tibblin, B., et al., op. cit.

[193] Vogt, T.M., Mullooly, J.P., Ernst, D., Pope, C.R. & Hollis, J.R. Social networks as predictors of ischemic heart disease, cancer, stroke and hypertension: incidence, survival and mortality (*J. Clin. Epidemiol*., 1992), 45, 659-66.

[194] Williams, R.B., Barefoot, J.C., Califf, R.M., et al. Prognostic importance of social and economic resources among medically treated patients with angiographically documented coronary artery disease (*JAMA*, 1992), 267, 520-4; Berkman, L.F., Leo-Summers, L. & Horwitz, R.I. Emotional support and survival after myocardial infarction: a prospective, population-based study of the elderly (*Ann. Int. Med*. 117, 1992), 1003-9.

[195] Fitzpatrick, R., Newman, S., Archer, R. & Shipley, M. Social support, disability and depression: a longitudinal study of rheumatoid arthritis *(Soc. Sci. Med*. , 1991), 33, 605-11.

[196] Stansfeld, S. A. Social support and social cohesion, in: Marmot. & Wilkinson, op. cit.

[197] Zimmerman, M.A. Taking aim on empowerment research: on the distinction between individual and psychological conceptions (*American Journal of Community Psychology*, 1990).18: 169-74.

[198] Rappaport, J. In praise of paradox: a social policy of empowerment over prevention (*American Journal of Community Psychology*, 1981), 9: 1-25.

participation, citing its importance in empowering individuals to help them gain control over their lives.[199]

On the other hand, not all social relationships are supportive. Living in crowded conditions, for example, may ignite interpersonal conflicts or other problems that have a negative health impact. Madelie and Goldbourt found that high levels of family problems were related to an increased risk of developing angina,[200] indicating the importance of looking at the quality of social relations in addition to quantity. For those with difficult close or family relationships, compensating support at work has been found to be protective, providing an apparent buffer that helps people cope with interpersonal stressors from home.[201]

8.3 Factors Influencing Consumer Behaviour

Advertising, pricing, taxation, government regulations and subsidies are practices that influence how reality is constructed socially, and thus influence consumer behaviour. Their impact on health can be both invisible and insidious.

Advertising practices influence the perceived desirability of goods and services, giving a positive cultural spin to eating, smoking, drinking and other lifestyle practices which impact health.

Advertising's impact is felt universally. Fast food has become a symbol of western civilization chic in remote outposts throughout the world; soft-drinks are the beverage of choice from the U.S. to the Amazon; "successful" people drive deluxe automobiles rather than walk or use public transport; teenagers smoke cigarettes to show their grown-up sophistication. As reality is socially construed and advertised, consumer opinion is determined by the trendy, elegant and persuasive images that skilled advertising agencies create. These images, linked to concepts of being popular, sophisticated, relaxed, sexy, and successful, are beamed by multi-media to consumers around the world, and often have detrimental effects on health.

The role of children as "opinion leaders" has become an important factor in determining which products families buy. Much food marketing is targeted for children, especially sweets, snack items, fast foods and convenience foods. In European countries, where there are less than half as many food advertisements than in Australia, advertising impact is enhanced by the use of promotional gifts, cartoon characters and other gimmicks directed at children.[202] Because children are even more susceptible to impulsive, poor food choices than adults, the impact of advertising bombardment is a subject of serious health concern.[203]

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[199] Tonnes, K. & Tilford. S. *Health Education: Effectiveness, Efficiency and Equity.* (2nd edn.) (London: Chapman and Hall, 1994).

[200] Medalie, J.H. & Goldbourt, U. Angina pectoris among 10,000 men: II. Psychosocial and other risk factors as evidenced by a multivariate analysis of a five-year incidence study (*Am. J. Med*., 1976), 60, 910-21.

[201] Stansfeld, op. cit.

[202] Consumers International. *A spoonful of sugar* (London*: Consumers International*, 1996).

[203] Robertson, Brunner & Sheiham, in: Marmot & Wilkinson, op. cit.

To counter a decline in the number of adolescents smoking in the early 1990s, American tobacco companies shifted some of the annual $5 billion spent on advertising toward the adolescent market. The infamous (and later banned) Joe Camel figure was introduced; an advertising symbol geared to getting young people to become smokers, and this was augmented by special promotional items. As a result, the all-time 10% low of adolescent smoking rose to 14%.[204]

Media images are undeniably persuasive. Marsh and Matheson[205] found that 44% of British smokers agreed with the statement that smoking could not be really dangerous or the government would have banned cigarette advertising. In addition to revealing a naive belief that government is always there to watch out for you, this study shows widespread failure to grasp the essential nature and purpose of advertising. Physician William Foege of Emery University's Carter Centre speaks against the pernicious impact of cigarette advertising in his JAMA article "*The Growing Brown Plague*" saying that "Executives in the tobacco industry… daily make the decision to kill for money, to become 'hit men' on a colossal scale." Foege dramatically predicts that *the annual global death toll of tobacco will equal the total death toll of the Holocaust* of Nazi Germany.[206]

Advertising also has a diffuse impact on behaviour; for example, a sample of 12-17-year olds with high levels of exposure to advertising were found more likely to approve of under-age drinking and even of drunkenness.[207] Aitken et al. found that beer commercials which were not targeted for youth aged 13-14 were nevertheless popular with this group and seen by them as conferring positive social attributes to the drinker and reinforcing under-age drinking.[208]

Associated with the recent introduction of advertising to the Countries of Central and Eastern Europe (CCEE) is an overall 112% increase in soft drink sales, with a 200% increase in Poland. The average consumption of soft drinks in CCEE is now higher than in EU countries.[209] Brand recognition as the result of advertising is so powerful that the name of a well-known U.S. soft drink is now recognised by 2/3 of the population of China and has become the second best-known brand name there.[210] The fact that advertising impact is strong in some countries where it is a relatively new phenomenon seems to be linked both to the novelty of advertising and to the widespread perception that advertised products are superior to those not advertised.

Marketing messages about products that do not support health may easily overwhelm health messages. The 1996-7 UK advertising budget for six soft drinks and three chocolate brands was found to be *sixty times greater* than the Health Education Authority budget promoting better diets. An unfortunate by-product is the rejection of produce such as fruits and vegetables that are not advertised. Marketing messages easily

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[204] DiClemente, et al., op. cit., pg. 341.
[205] Marsh, A. & Matheson, J. *Smoking Attitudes and Behaviour* (London: HMSO, 1983).
[206] Pelletier, op. cit. pg. 237.
[207] Aitkin, P.P., Leathar, D.S. & Scott, A.C. Ten to sixteen year olds' perceptions of advertisements for alcoholic drinks (*Alcohol and Alcoholism*, 1988), 23: 491-500.
[208] Aitken, et al., op. cit.
[209] Robertson, Brunner, and Sheiham, op cit.
[210] Ibid.

overwhelm health messages,[211] causing a significant percentage of the population to engage in a lifestyle of health-related decisions determined to a great extent by advertising. Because of the unique impact of advertising messages, it is important that Health Promotion messages gain a stronger footing in this important arena.

Pricing practices make goods and services available to some while unavailable to others, and lend an aura of desirability based on their cost rather than health impact. The availability of goods and services also determines who gains access and who is denied. Thus, in many instances, pricing becomes a factor affecting health.

Alcohol consumption in the UK, for example, has increased 60% in the past 25 years. During this period, the cost for wine and spirits has decreased while the cost for beer has increased. This has made wine and spirits relatively cheap ways of ingesting alcohol, increasing their consumption.[212]

Taxes and government subsidies affect which products are available, their market value and consumer behaviour. In the United States, raising the legal minimum drinking age to 21 and increasing the taxes on beer led to 7% and 34% reductions, respectively, in drinking-caused mortality among 18-20 year-olds; similarly, increasing taxes on beer was associated with a 52% reduction in drinking-caused mortality among 21-24 year olds.

Increasing tobacco taxation is considered one of the most effective ways to reduce consumption rates, with an estimated 4% reduction in consumption associated with every 10% price rise.[213] Considerable evidence shows that raising the price of cigarettes will cause some to stop smoking altogether and others to reduce consumption.[214]

New York City took action in 2002 to discourage smoking by increasing the city's cigarette sales tax by 1800%. This increase, along with an equivalent state tax already imposed on cigarettes, caused New York cigarettes to become the most expensive in the U.S. Despite some objections that this dramatic tax increase would cause a hardship on the poor, it can be said from a health perspective that the poor are most likely to benefit from the new tax. A fourteen-year analysis of health data by the Centres for Disease Control and Prevention found that a greater percentage of lower-income smokers quit when the price goes up; an estimated 25% of 18-24-year-old Hispanic smokers and 10% of same-aged blacks will quit smoking in response to a 10% price increase, whereas only about 1% of white smokers the same age will quit.[215]

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[211] Ibid.
[212] Badura & Kickbusch, op. cit. pg. 44.
[213] Peterson, D., Zeger, S., Remington, R. & Anderson, H. The effect of state cigarette tax increases on cigarette sales 1955 to 1988 (*American Journal of Public Health*, 1992), 82: 94-6.
[214] Chaloupa, F.J. & Grossman, M. *Price, tobacco control policies, and youth smoking: Working Paper No. 5740*. (Cambridge, MA: National Bureau of Economic Research, 1996); Hu, T.W., Sung, M.Y. & Keeler, T.E. Reducing cigarette consumption in California: Tobacco taxes vs. an anti-smoking campaign (*American Journal of Public Health*, 1995) 85, 1218-1222; Keeler, T.E., Barnett, P.G. & Manning, W.G. Taxation, regulation, and addiction: A demand function for cigarettes based on time-series estimates (*Journal of Health Economics, 1993)*, 12, 1-18; Lewit, E.M., Coate, D. & Grossman, M. The Effects of Government Regulations on Teenage Smoking (*Journal of Law and Economics*, 1981), 24, 545-569; Manning, W.G., Keeler, E.B., Newhouse, J.P., Sloss, E.M. & Wasserman J. *The Costs of Poor Health Habits*. (Cambridge, MA: Harvard University Press, 1991).
[215] Hertzberg, H. Comment: Bloomberg Butts In (*The New Yorker*, September 9, 2002), pg. 77-78.

Interestingly, the health impact of such a change is more dramatic over time. A simulation of the health benefits expected by a 4% decrease in smoking in response to a 10% price increase brings about an increase of 25,000 QALYs (life expectancy and quality of life estimation). This suggests that such taxation has a greater influence each year it is in effect, reaching a plateau at about 70 years in the future! The reason is that increased tobacco taxation has a strong impact on lower-income young people, keeping them from becoming smokers, and thus insulating them over a prolonged period of time from the various negative health consequences of smoking.[216]

Government subsidies affect cost and availability of goods and consequent consumer behaviour. For example, shifting subsidies from tobacco to beneficial crops not only causes tobacco products to become more expensive and less available, but also increases the availability of health-benefiting crops.

Laws themselves also affect consumer behaviour. When North Carolina raised its legal drinking age from 18 years to 21 years, fatal traffic accidents dropped 11%;[217] likewise, when some counties changed the law to allow the purchase of liquor at the place of consumption, alcohol consumption increased 250% at these places, along with an accompanying 16-24% increase in nearby traffic accidents.[218]

Consumer practices, in their variety and complexity, have a far-ranging impact on lifestyle behaviours and therefore on health. Unless and until consumer practices reflect greater consciousness about their impact on health, countless millions will be affected by these factors of which they are only partially aware.

8.4 Cultural Factors

The representation of reality is socially generated from different criteria in different parts of the world. Reality is not a universally agreed-upon experience but a social construction that varies from group to group, person to person. Because human beings are social creatures, health is *relational*—created through people's relationships with their family, friends, community, society, and both the man-made and natural environments. Because health is created as a function of the different social realities that humans create, it is important to understand the ever-variant social contexts through which health is determined around the world.

Cultural mores are customs handed down from one generation to another that influence people's attitudes and lifestyle choices. Beliefs, modes of behaviour and customs to which a person is exposed since the beginning of life, are interjected and become personal constructs, constituting how that person decodes his/her own experiences. Therefore, to promote change, it is necessary to facilitate the change of constructs.

Cultural factors affect food choices and nutritional status, exercise habits, sexual practices, educational attainment, choice of work, social activities, gender and role

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[216] DiClemente, et al., op. cit., pg. 343.
[217] Wagenaar, A.C. *Alcohol, Young Drivers and Traffic Accidents*. (Lexington, MA: Lexington Books, 1983).
[218] Holder, H.D. Control Issues in Alcohol Abuse Prevention: Strategies for States and Communities (Greenwich, CT: Jan., 1987, *Advances in Substances Abuse* Suppl 1).

expectations, relationships with various aspects of society, as well as general health practices. A person's culture and the extent to which s/he retains or departs from the practices of that culture affect health across the entire lifetime.

Differences in health-related behaviours vary within cultures along both race and gender lines. The relationship between ethnicity and health is illustrated by examining transmission of HIV. When the U.S. epidemic started in the early 1980's, it was predominantly a white, homosexual phenomenon. Since 1996, AIDS has become the number one killer of African-American men and women ages 25-44, with the largest proportion of new AIDS cases (41%) among African-Americans, although this group makes up only 13% of the U.S. population. Hispanics make up less than 10% of the U.S. population, yet they accounted for 19% of AIDS cases reported in 1996. Furthermore, 85% of children reported with AIDS in 1996 were African-American and Hispanic.[219]

A dramatic illustration of the influence of culture on health is the practice, in more than 25 countries, [220]of infibulations, the amputation of a girl's clitoris. This mutilation is done primarily to eliminate sexual pleasure, thus encouraging girls to remain virgins until they marry and true to their marriage vows thereafter. Additional reasons for the practice include religion, custom, hygiene, aesthetics, and ease of sexual relations. This practice may include sewing the labia together with vegetable fibres until the wedding night. These culturally supported procedures can result in infertility, anaemia, menstrual problems, inflection of other organs, obstetric complications, and life-threatening infections as well as a significantly impaired sexual life.

Another cultural practice with horrific implications is "son-preference" which occurs in some cultures in South Asia, the Middle East, Africa and South America. Preference for male children leads to induced abortions of female foetuses, girls being killed or abandoned at birth, and various levels of emotional and physical neglect. These practices sometimes deny girls life itself, and often limit their health, education and economic opportunities, while violating many articles of the Convention of the Rights of the Child.[221]

Custom and fashion also impact health. The long-abolished custom in China of binding women's feet produced a host of foot and skeletal problems with difficult consequences, among which were the curtailment of physical activity and social mobility. To a lesser, but still significant degree, contemporary high heel shoe fashions affect the way women walk, the extent of their mobility, condition of their feet, and bodily alignment. The female fashion for breast implants in order to increase sexual attractiveness carries numerous health risks; likewise, the fashion for tight clothes which can promote genital infection and reduce male fertility.

The burqa worn in public by women in some conservative Arab communities covers the entire body allowing the wearer only a small grid to see through. This cultural

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[219] National Institute of Allergy and Infections Diseases (NIAID). *Minorities and HIV Infection* (Washington, DC: National Institutes of Health, May 1997).
[220] Fact Sheet No. 23, *Harmful Traditional Practices Affecting the Health of Women and Children* (Convention on the Elimination of All Forms of Discrimination Against Women, art. 5a, adopted by General Assembly resolution, 18 December 1979).
[221] Ibid.

practice limits women's social mobility and field of vision, making them vulnerable to pedestrian accidents including being hit by undetected cars.

Body piercing, tattoos, and other fashion-dictated mutilations popular in many parts of the world increase vulnerability to infection and other health problems. Despite the possible health consequences, these choices are supported and even imposed by social custom and fashion.

Fashion and social desirability are also factors in smoking habits. Smoking first gained popularity in the U.S. in the 1920s when it was viewed as sophisticated for women to smoke, and reinforced by movies wherein popular stars were shown smoking. A 1988-1999 Dartmouth Medical School study of 5500 middle-school children shows this still to be the case: "Smoking is just one of the behaviours that kids are more likely to adopt from watching their favourite actors in movies. Kids look to the media to know what is cool. If they see actors smoking, that's all part of the package." [222] In the UK, smoking increased in the early 20th century when upper class women made it fashionable;[223] since then it has become more common among lower classes and among women with young children.[224]

Just as fashion can affect health negatively, it can also have a positive effect, such as the current fashion for exercise in America, Europe, and parts of Asia. Increasing numbers of people walk, jog, work out in gyms and participate in a variety of individual and team sports. The perceived desirability of these practices, their trendiness, along with an array of attractive sports shoes, warm-up outfits, and other equipment designed for consumer appeal as well as functionality, have combined to foster the notion of "being fit" as culturally desirable.

Gender and role expectations are also important determinants of health. A study by the National Institute of Health conducted at the University of Michigan found that when women work full time, the likelihood of their husbands being in good health declines by more than 25%. Working women have less time to engage in traditional roles—such as fostering social contacts—that reduce stress, promote health and manage illness.

Gender differences are heightened through the socialisation process that traditionally teaches girls to take care of themselves and encourages boys to ignore injuries and indications of danger.[225]

Customs that prohibit female education, inheritance, and land ownership undermine women's health through poverty, lack of civil rights and low self-esteem. Women in many countries work a "double day", and their health is undermined by cultural values and sense of responsibility which encourage them to sacrifice their own nutrition, exercise,[226]and sleeping requirements on behalf of the family.[227] Women's

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[222] Dalton, M. (*San Diego Union-Tribune*, Associated Press, November 11, 2000).
[223] Wadsworth, op. cit.
[224] Graham, H. *Women, health and the family*. (Brighton: Harvester Press, 1984); Flint, A.J. & Novotny, T.E. Poverty status and cigarette smoking prevalence and cessation in the United States 1983-1993: the independent risk of being poor (*Tobacco Control*, 1997), 6, 14-18.
[225] Peterson, K. S. Working wives have ill effect on husbands' health (*USA Today*, August 17, 2000).
[226] Green, E., Hebron, S. & Woodward, D. *Leisure and Gender. A Study of Sheffield Women's Experiences*. (London: Report to the Economic and Social Science Research Council/Sports Council Joint Panel on Leisure Research, 1986).

health is also compromised by the absence of labour laws protecting from discrimination at work and safeguarding jobs during illness and pregnancy.[228] Despite these problems women face, it is men who are more likely to be overweight, smoke, eat less healthily, drink more heavily, encounter more adverse working conditions, have more contact with carcinogens and work in jobs with higher risk of accidents.[229]

Sexual practices, determined to a great extent by cultural constructs, have a profound impact on health, and may entail sexually transmitted diseases (STDs), side-effects of contraception practices, and possible complications of pregnancy. Acceptable sexual behaviour varies by cultural groups and sexual practices carry implications ranging from the creation of life to the creation of death. The health consequences of pregnancy are most extreme for women whose culture discourages contraception and place a high social value on continuous pregnancies.

The amount of power societies accord women in regard to negotiations with their partners about sexual intercourse can have serious health implications. Thirty-eight percent of Australian young women reported having intercourse when they did not want it.[230] Similarly, British studies have shown that women's intentions to engage in safer sex practices may not translate into action; the choice of whether or not to use a condom or engage in other safer sex practices is frequently made by the male partner.[231] With the increasing spread of AIDS and other STDs, it is critical that women be empowered to negotiate successfully in regard to sexual choices and sexual practices.

Culture also determines eating habits, including caloric consumption and nutritional status. For example, American teenage girls—as well as women and girls from other cultures—place a high premium on being thin, and alter their eating practices in order to live up to this cultural norm. Besides the deleterious effects of vitamin and mineral deprivation, many of these young women fall victim to health problems from the twin curses of anorexia and bulimia.

Cultural practices throughout the world have health consequences of great importance. Therefore, Health Promotion must address these sometimes deeply embedded factors.

8.5 Structure of Society

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[227] Pearce, T.O. The health of working women in developing countries, in: Wallace, H.M., Giri, K. & Serrano, C.V. (eds.) *Health care of women and children in developing countries.* (2nd edn.) (Oakland: Third Party Publishing, 1995), pg. 218-224.
[228] Watkins, K. *The OXFAM Poverty Report.* (Oxford: OXFAM, 1995), p. 27.
[229] Reddy, D.M., Fleming, R. & Adesso, V.J. Gender and health, in: Maes, S., Leventhal, H. & Johnston, M. (eds.) *International Review of Health Psychology*, Volume 1 (Chichester: Wiley, 1992).
[230] Abbott, S. Talking about AIDS. Report for AIDS Action Council (Canberra: *National Bulletin,* August 1988), 24-7.
[231] Holland, J., Ramazanoglu, C., Scott, S., Sharpe, S. & Thomson, R. Sex, gender and power: young women's sexuality in the shadow of AIDS *(Sociology of Health and Illness*, 1990), 12: 336-50.; Abraham, C.S., Sherran, P., Abrams, D. & Spears, R. Health beliefs and teenage condom use: a prospective study (*Psychology and Health*, 1995), 11, 641-55.

Among the structural social factors that impact health, some have specific relevance: Law, legislation, and type of government, the structure and policy of public health, the structure, curriculum and quality of school systems, national food policies and distribution procedures, availability of jobs and economic productivity.

The **rule of law and structure of a government** determine to a significant extent whether the health of citizens is a priority and what health programs and services are available. Generally, governments founded upon the principals of democracy see each person as deserving of equal rights and privileges and hold the health of citizens as a high priority. They recognize that health is a matter not just of individual and familial concern, but one that ultimately affects the vitality of the country at large. Accordingly, countries founded upon these principals tend to develop programs and allocate funds to support health.

Unfortunately, millions of people live in countries where health is not a high national priority. An awareness of this helps us see how important it is to view Health Promotion as inextricably linked with strategies for promoting social change.

As we have discussed earlier, educational levels correlate with health outcomes and, as schools are regulated by state legislation, one means for impacting health on a national basis is through the school system and its curriculum. Educated people are healthier people and educated societies are healthier societies. Establishing education as a national priority is a powerful way to improve individual and societal health.

Education has both an indirect and a direct impact on health. Its indirect impact is exerted through the attainment of vocational competencies which increase socio-economic levels. Socio-economic levels can be seen as a series of situations and experiences through which a child develops his/her "personal social capital",[232] which becomes his/her pathway to health risk and/or health protective factors.

Health status also is affected directly by the extent to which people are educated about health, health determinants, and healthy choices, and are encouraged to grow as persons and empowered to make healthy choices in their lives. A significant amount of health education occurs within the family. Unfortunately, there are widespread knowledge gaps and unfortunate information associated with popular culture which health curricula do not address. Although hygiene courses are sometimes taught, much can be done to improve health curricula so young people receive a thorough grounding in how to maximise their own health. Because health has a profound impact on virtually every aspect of human life, it is hard to identify an educational subject of greater importance for young people and, ultimately, for the well-being of a nation.

Education about breastfeeding is but one example. Seven out of 10 child deaths in the European Region are due to upper respiratory tract infections, diarrhoeal diseases, vaccine-preventable diseases such as tuberculosis, and nutritional deficiencies, all of which are correlated with knowledge about health practices and several of which are correlated with breast feeding. Only 1% of exclusively breast-fed infants experience

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[232]Wadsworth, M.E.J. Family and education as determinants of health, in: Blane, D., Brunner, E. & Wilkinson, R. (eds.). *Health and social organization.* (London: Routledge, 1996), pg. 152-170.; Kuh, D., Power, C., Blane, D. & Bartley, M. Social pathways between childhood and adult health, in: Kuh, D. & Shlomo, Y.B. (eds.) *A life course approach to chronic disease epidemiology.* (Oxford: Oxford University Press, 1997), pg. 169-98.

diarrhoea, a major cause of infant mortality, compared with 17% of those who are bottle-fed. [233] Not being breastfed is also associated with childhood health problems such as wheezing, vomiting, runny nose, colic and abdominal pain, asthma, constipation, eczema, and rashes.[234] Although there are strong social and commercial factors that mitigate against breast feeding, educational programs encouraging mothers to breastfeed equip newborns with numerous health-protective benefits.

Public health efforts have great impact, including the way a society produces and distributes food. An important component of this is government coordination between public health, agriculture, nutrition, and food safety specialists. For example, after World War II, the development of the Common Agricultural Policy (CAP) in Europe fostered production of animal food products such as meat and milk. This is an enormous program through which CAP spends almost half of the EU budget. Of this, 80% of farm subsidies have gone to 20% of the farmers, forcing a majority of small farmers out of business.[235] The immediate impact of CAP policies has been the production of surplus butter, meat and milk; the long-term impact is potentially much more serious. Health and agriculture officials now realise that food policies must be adjusted to ensure that cereal and potato production supply more than 50% of the union's energy requirements, and that other vegetables and fruits can supply more than 400g/day/person.

Government transportation policies that foster non-automotive transport can have beneficial effects on the health of the nation. Besides reducing air pollution and auto accidents, walking, cycling and public transportation is health promoting, have low health risk and fulfil sustainability objectives.

Policies for regulating business and industry affect the health of workers and also those who live near work sites. Governments, both national and local, establish policies regulating acceptable levels for industrial emissions, workplace safety, and conditions of employment, sick leave, insurance/health services and worker compensation programs. The extent to which government standards are established protecting the health of workers and others affected by workplace activities has a significant impact on the nation's health. Considering the magnitude of occupational injuries, diseases, and fatalities worldwide, it is clear that employment and health are profoundly intertwined, both for the individual and for the nation.

The role of government in **actions regulating the economy and the creation of new jobs** is another set of factors which affects national health. Since unemployment is in itself a major health risk, along with low socio-economic status, government policies that successfully support the creation of well-paying jobs and high economic activity promote health in many ways.

Policies are needed which work on reducing the overall burden of disadvantage—"tackling the structural sources of inequality" through **policies on employment, income,**

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[233] Popkin, B.M., Adair, L. Akin, J.S., Black, R., Briscoe, J. & Flieger, W. Breastfeeding and diarrheal morbidity *(Paediatrics,* 1990*)* 86, 874-82.
[234] Robertson, Brunner & Sheiham, et. al., op. cit.
[235] Ibid.

and education.[236] Economic policies pertaining to distribution of wealth, fostering greater economic equality and greater social cohesiveness, all reduce overall mortality.[237] Policies that combat health problems associated with social inequity include:

- Legislation to protect the rights and living conditions of minority and migrant groups, especially regarding citizenship, employment and anti-discrimination rights, access to the protection of asylum, access to education, health care and other services
- Programs to provide an adequate standard of living for the unemployed, and adequate minimum wages for those employed
- Policies which reduce the number of children born into poverty
- Progressive taxation and other policies which reduce wealth inequalities within populations
- Policies to ensure access to educational, training, and employment opportunities
- Policies which remove barriers to health and social services
- Housing policies which increase availability of affordable housing
- Employment policies which preserve and create jobs[238]

It is evident that how societies structure themselves and the extent to which they develop policies to foster health equalities are matters of profound importance. That health is created within a biopsychosocial context requires us to recognise that every level of decision-making within society will have a bearing upon health.

8.6 Environmental Factors

The environment we live in is inextricably linked to health and there is rising concern about the impact of environmental factors as our planet becomes increasingly crowded, forests are cut down, natural habitats are encroached upon and destroyed, the ozone layer becomes depleted, water supplies become contaminated, cities become polluted, nuclear waste is accumulated, along with numerous other trends that disrupt the Earth's ecological balance. WHO's global estimates in 2002 of the burden of disease caused by 25 risk factors identifies *seven of the top risk factors as environmental*— including ambient air, indoor air, water/sanitation/hygiene, and selected occupational risks such as carcinogens and selected airborne particulates.[239]

The cumulative impact of environmental factors on health is significant for people throughout the world, and especially damaging in some areas. Richard Poll of Oxford University compared life expectancy in the United States with post-industrial and

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[236] Wilkinson, R.G. Putting the picture together; prosperity, redistribution, health, and welfare, in: Marmot & Wilkinson, op. cit.
[237] Wilkinson, R.G. *Unhealthy Societies: The Afflictions of Inequality*. (London: Routledge, 1996).
[238] Shaw, M., Dorling, D. & Davey Smith, G. Poverty, social exclusion, and minorities, in: Marmot & Wilkinson, op. cit.
[239] WHO. Environmental Burden of Disease. (www.who.int/peh/burden/globalestim.htm, 10/6/02)

emerging Third World countries and concluded that environmental hazards in post-industrial and developing countries were more important influences on health than personal behaviour. He cited overpopulation and the production of greenhouse gases as two of the most dangerous factors.[240]

Increasing energy use affects the environment and health. The World Resources Institute and United Nations Development Program estimate worldwide oil usage will increase from 8,000 million metric tons in 1995 to 12,000 million metric tons in 2010. If not averted, this will be accompanied by increasing levels of air pollution as well as growing global warming due to emission of greenhouse gases and increased automobile use. Air pollution is a significant health factor in many nations, causing lung damage, exacerbation of heart disease symptoms, asthma inflammation, and related disorders. Murray and Lopez[241] reported that in 1996 five percent all deaths in the former socialist economies were attributable to air pollution.[242] The World Health Organization estimates that air pollution will cause about 8,000,000 deaths worldwide by the year 2020[243].

Air quality is degraded significantly by automobile emissions, an increasing factor. Black smoke emissions in the UK increased between 1970 and 1992 from 75,000 to 170,000 tons per year; 80% of black smoke in London is from vehicles.[244] Automobile use also increases noise pollution and decreases walking and bicycling as forms of exercise. Noise pollution increases stress levels and degrades housing quality and socio-economic status. Studies in the U.S. and Europe show that streets with less traffic have a better quality of life and are perceived as more friendly and free from danger.[245] Traffic intensities are also inversely related to social contacts, another important health determinant.[246]

There are three kinds of effects from automobile pollution: *directly poisonous emissions* such as benzene, a known carcinogen; *greenhouse gases*, especially carbon dioxide, which affect the global climate; and *small particulates* (black smoke), caused mainly by diesel vehicles. Their combined health impact is both long-term and acute.[247] Researcher Devra Lee Davis of Carnegie Mellon University estimates that by cutting greenhouse gases in just the four cities of Sao Paulo, Santiago, Mexico City, and New York City, 64,000 lives would be saved over the next 20 years.[248]

Automobile pollution has an increasingly significant impact on lung health. A study of children and teenagers in smoggy areas of Southern California where local mountains form a basin that concentrates auto emissions in the city of Los Angeles found

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[240] Poll, R. (*American Journal of Public Health*, July 1992).
[241] Murray, C. & Lopez, A. *The global burden of disease* (Cambridge, MA: Harvard University Press, 1996).
[242] Ibid.
[243] Recer, P. Pollution called deadlier than traffic crashes (*San Diego Union-Tribune*, August 17, 2001.)
[244] *Road Transport and Health*. British Medical Association (London: British Medical Association, 1997), pg. 32.
[245] Road transport, op. cit., pg. 38-43.
[246] Wanamethee, S.G., Shaper. A.G. & Walker, M. Changes in physical activity, mortality and incidence of coronary heart disease in older men (*Lancet*, 1998), 351, 1603-8.
[247] McMichael, A.J. Transport and health: assessing the risks, in: Fletcher. T. & McMichael, A.J. (eds.). *Health at the Crossroads: Transport policy and urban health.* (London: John Wiley and Sons, 1997), pg. 9-26.
[248] Recer, op. cit.

an association between moderate levels of air pollution and chronic deficits in lung function. Children in smoggy areas had lungs that developed up to 5% more slowly, and those who spent more time outdoors had greater problems related to vehicle emissions. Furthermore, because most children continue to live in the same general area, they are likely to accrue additional lung damage as they age, which the researchers believe may be irreversible.[249]

An air quality study in the 20 largest U.S. cities carried out by researchers at Johns Hopkins School of Public Health found that small particles—micrograms in diameter, both invisible and odourless—have a significant effect on health. These particles come from cars, power plants, construction sites, agriculture, brakes and tires, and they raise the death rate by ½% for every 10 micrograms of particles found per cubic meter of air.[250] An estimated 3 million people die each year because of air pollution, approximately 5% of all the deaths that occur annually in the world. About 30-40% of asthma and 20-30% of all respiratory diseases are linked to air pollution. Moreover, air pollution also damages plant and animal life and contaminates water sources, threatening economic and social welfare as well as health. [251]

In addition to the various detrimental ways that automobiles impact the environment and health, automobile accidents also kill a significant percentage of people. The World Disasters Report for 1998 reported that motor vehicle accidents kill more than half a million people a year and injure more than 15 million. Automobile accidents are predicted to be the third greatest cause of death and disability worldwide by the year 2020.[252]

On another front, deforestation is an environmental problem that threatens the bio-diversity of species, access to health-supporting medicines, the capacity for native peoples to heal themselves and earn a living, and the health of the ecosystem locally and throughout the world. The deforestation of tropical rain forests accomplished by cutting down and burning trees to make way for farms ("slash and burn agriculture") increases the amount of carbon dioxide (CO2) and other trace gases in the atmosphere and has a deep impact on the global carbon cycle. From 1850-1990, worldwide deforestation released 122 billion metric tons of carbon into the atmosphere; the current rate of release is about 1.6 billion metric tons per year. Deforestation adds an additional 25% to the carbon dioxide already released through the burning of fossil fuels, enhances the greenhouse effect, and contributes, it seems evident, to an increase in global warming.[253]

Over 55% of tropical rain forests have already been depleted, and at today's current rate of destruction will be reduced by half again in the next 45 years.[254] Because

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[249] Gauderman, J. There's trouble in the dirty air: Children's lungs may be impaired (*San Diego Union-Tribune*, November 15, 2000).
[250] McConnaughey, J. Tiny particles raise death rate, urban-pollution study confirms *(San Diego Union-Tribune*, December 14, 2000) on study published by Dr. Jonathan M. Samet (*New England Journal of Medicine).*
[251] WHO. *Air Pollution: Fact Sheet N. 187, 2000*. www.who.int/inf-fs/en/fact187.html
[252] International Federation of Red Cross and Red Crescent Societies. *World disasters report* (Geneva: International Federation of Red Cross and Red Crescent Societies, 1998).
[253] NASA, Earth Observatory. *Tropical Deforestation Fact Sheet* (<< http://earthobservatory.nasa.gov/Library/Deforestation>>)
[254] *Deforestation: Causes and Solutions*, www.davison.k12.mi.us/academic/global/deforest

these forests hold over half of all species, deforestation seriously threatens world-wide bio-diversity and the loss of species poses serious threat to the planet.

The disposal of chemical and nuclear waste is another critical area because in one sense, it is impossible to completely dispose of such contaminants anywhere on earth. This factor becomes more critical as population increases. Epidemiologists Michael Berry and Frank Bove found birth weight of infants born in areas near household and industrial landfills to be lower than average, for example, in the Love Canal area of New York state, a well-known site of industrial contamination.[255] The magnitude of the effect was about as great as the birth weight reduction associated with cigarette smoking during pregnancy. Increased survival risks and post-natal problems were attributed to contamination from chemicals such as benzene and xylene. Other studies have linked low birth weight offspring to the father working with automobile body solvents and the mother being exposed to workplace spray can propellants.

Chernobyl represents one of the most notable environmental disasters in recent history and its much-discussed, even controversial, impact on health illustrates the importance of viewing health from an integrated biopsychosocial approach. In addition to those who died immediately from the impact and those who suffered and will suffer from numerous related illnesses, the damage caused psychological and social damage, including increased distrust toward government officials.[256] Because of health concerns stemming from residual exposure to contamination, whole communities were evacuated or relocated, with ongoing widespread restrictions on daily life affecting schooling, work, diet, and recreation. This has caused disruption of social networks and traditional ways of life, and destruction of family and community networks. Those transferred to new areas were resented and even ostracized.

The Chernobyl disaster illustrates the shock wave that occurs when one part of the system is changed and helps us grasp the complex ways that health is embedded therein. The legacy of this disaster may be its vivid illustration of the ways that negative environmental impact cascades into negative health impact for human beings. Environmental pollution, water pollution, noise pollution, industrial pollution, chemical and nuclear wastes are all important determinants of health and must be focal points for those who work to improve human health.

8.7 War: Society's Ultimate Negative Health Determinate

> "The fundamental conditions and resources for health are: peace… ."
> WHO Ottawa Charter for Health Promotion

[255] Peterson, J. "*Low Birthweight, Early Births Found Among Infants Near Hazardous Landfill*, National Institute of Environmental Health Sciences (<<www.niehs.nih.gov/external/gaq/birth>> September 10, 1997).
[256] OECD: *Nuclear Energy Agency, Chernobyl: Health Impact*, chapter 5. (<< www.nea.fr/html/rp/chernobyl..)

Although not usually mentioned as a health concern, war in its many guises is one of the most vicious negative health determinants known. To suggest the immensity of its impact, there were 250 wars in the last century which killed close to 200,000,000 people, wounded and maimed hundreds of millions more, and killed huge numbers of domestic and wild animals. A continuing deadly aftermath is the remaining presence of estimated 60-70,000,000 landmines still buried in 68 different countries and killing some 26,000 people annually, half of them children. The toll in animals is estimated to be 10 to 20 times greater than for people,[257] bringing a concomitant horrific impact on the entire ecological balance.

The indirect assault on health caused by war's catastrophic damage to the environment, much of it permanent, might in the end be even more harmful than the direct killing. A few examples include the thousands of tons of toxic chemicals released into the atmosphere over Kosovo from the bombing of petrochemical plants; the 60 million or more gallons of oil spilled in the Kuwaiti desert in the Persian Gulf War from destroyed wells forming 300 lakes of black sludge over 19 square miles; the 100 million pounds of the defoliant and herbicide Agent Orange sprayed to destroy forests in Vietnam, causing ecological and health damage whose long-term effects scientists are still trying to assess.[258]

From these data, it is clear that armed conflict—which at this writing shows little signs of abating—remains a man-made health threat of the most severe nature.

[257] McFee, S. The Nature of War (*San Diego Union-Tribune*, March 13, 2002).
[258] Ibid.

Chapter 9 – Lifestyle Determinants

"Health Promotion… includes… access to information, life skills and opportunities for making healthy choices. People cannot achieve their fullest health potential unless they are able to take control of those things which determine their health."

WHO Ottawa Charter for Health Promotion

9.1 Lifestyle as Interplay of Many Factors

An individual's lifestyle is a combination of socialisation, choice and habit resulting from numerous biopsychosocial factors. Lifestyle is a powerful determinant of health and an important and fertile arena for Health Promotion.

Because lifestyle diseases in the western world account for such a large proportion of the annual mortality rate, and because the health care system is in economic crisis, there is a growing need for public policies that focus on the prevention of illness. Three kinds of prevention are identified, all of which include lifestyle factors, and all of which are important to Health Promotion:[259]

1) **Primary prevention**—which reduces the risks of illness for an entire population (e.g., a school program that encourages children not to smoke);
2) **Secondary prevention**—which reduces risk factors in high risk groups (e.g., programs to reduce AIDS among drug users)
3) **Tertiary prevention**—which reduces the duration of illness for those already afflicted (e.g., placing recovering heart patients on a low-fat, high-fibre diet and exercise program).

9.2 Key Lifestyle Factors

The Alameda County study,[260] surveying the health practices of 4,855 people in California over a period of nine years, yielded valuable data about the impact of personal behaviours—lifestyle—on morbidity and mortality. Researchers Berkman and Breslow found a consistent positive relationship between health and seven particular health practices:

1) Sleeping 7-8 hours daily

[259] Ibid.
[260] Berkman, L.F. & Breslow, L. *Health and Ways of Living.* (New York: Oxford University Press, 1983).

2) Eating breakfast almost every day
3) Never or rarely eating between meals
4) Currently being at or near prescribed height-adjusted weight
5) Regular physical activity
6) Never smoking cigarettes
7) Moderate or no use of alcohol

People who consistently followed 5 or more of these practices had a death and disability rate of about ½ of those who did not, and those who followed a few of the practices reduced their risk by about one-third. Follow-up studies revealed that people over age 75 who carried out all seven health practices had health comparable to those aged 35-44 who followed less than three.[261] People who adhered to the Seven Health Practices had "increased wellness characteristics such as sense of vitality, positive well-being and job attendance, decreased anxiety, depression and lack of self-control."[262] These data incontrovertibly link lifestyle with health.

We will now examine key lifestyle choices that affect health.

9.3 Smoking

Two of the health habits from the Alameda County study carry more importance than the others and are viewed by virtually all health professionals as essential: not smoking and getting regular physical exercise.

> "Cigarette smoking is the single most preventable cause of disease and death in the United States."
>
> *Healthy People 2010: Understanding and Improving Health.*
> U.S. Department of Health and Human Services, January 2000.

Data show that smoking is correlated with heart disease, emphysema and several forms of cancer including lung, larynx, mouth, oesophagus, pancreas and bladder.[263] Furthermore, there is evidence that the carbon monoxide gas inhaled and absorbed by smokers puts their brain in a toxic environment that causes brain damage.[264] On average, smokers reduce their life expectancy by five years[265] and have as much as 2-3 *decades* of reduced health capacity. In addition, smokers place their family, friends and co-workers in an environment of second-hand smoke, called "passive smoking", also known to be deleterious to health. For all of these reasons, tobacco use is seen as the leading cause of

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[261] Ogden, op. cit., pg. 15.
[262] Berkman & Breslow, op. cit.
[263] Smith, A. & Jacobson, B. *The Nation's Health. A Strategy for the 1990s.* (London: King's Fund, 1988).
[264] Howell, P. & Bruner, J. *Mental Aerobics*. (Unpublished manuscript, 1997), chp. 4, pg. 6-7.
[265] Bennett & Murphy, op. cit., pg. 8

preventable death in the United States.[266] Fortunately for those who smoke, disease risks are rolled back quickly once smoking is stopped.

Doll and Peto reported that when smoking is begun in childhood there is an increased chance of lung cancer compared with those who start smoking later in life.[267] As most adult smokers start in childhood, and nearly half of all school children have tried at least one cigarette,[268] smoking prevention measures should be instituted early.

Because smoking is strongly associated with health degradation and is an activity about which people can exercise personal choice, not smoking and smoking cessation are fundamental Health Promotion behaviours. Decrease in smoking in the U.S., from 42.4% in 1965, to 24.7% in 1997, is an encouraging and important trend.[269]

9.4 Exercise

Cicero observed centuries ago that "Exercise can preserve something of our early strength, even into old age" and modern media have jumped on the bandwagon with great enthusiasm, but most people in the Western world still do not get enough daily exercise. Modern life, in most societies, is not inherently entwined with exercise as it was for our ancestors, and most people have not found a way to reinstall exercise into their daily lives. The National Centre for Health Statistics reported in 2002 that seven out of ten Americans don't exercise regularly and 38% aren't physically active at all.[270] Despite the plethora of information on the importance of exercise, Americans have become alarmingly sedentary.

Studies have shown that many of the physical characteristics of aging can be reversed through exercise, and conversely, that the physiological characteristics of aging can be produced in young people by keeping them in bed for several weeks (see figure below).[271]

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[266] McGinnis, J.M. & Foege, W.H. Actual causes of death in the United States. *(Journal of the American Medical Association,* 1993), 270, 2207-2212.
[267] Doll, R. & Peto, R. *The Causes of Cancer* (New York: Oxford University Press, 1981).
[268] Murray, M., Swan, A.V., Bawled, B.R. & Johnson, M.R.D. The development of smoking during adolescence: The MRC/Derbyshire smoking study (*International Journal of Epidemiology*, 1984), 12, 185-92.
[269] Achievements in Public Health, United States, 1900-1999: Tobacco Use, Morbidity and Mortality (Atlanta: The Centers for Disease Control and Prevention, Weekly Report, Vol. 48, No. 43), pg. 986-993.
[270] McClam, E. 70% of American adults don't exercise regularly, study says (*San Diego Union-Tribune, April 4, 2002).*
[271] DeVries, H.A. Physiology of physical conditioning for the elderly, in: Harris, R. & Frankel, L.J. (eds.) *Guide to Fitness over Fifty.* (New York: Plenum Publishing Corp., 1977).

BENEFITS OF EXERCISE

Physiological and psychological benefits from regular exercise include:

increased strength and flexibility • weight regulation and control • improved cardio-respiratory fitness • increased bone density • lower cholesterol levels • lower diastolic blood pressure levels • regulation of sleep • increased brain blood flow and cognitive abilities • reduction of anxiety and depression • reduction in stress • increase in self-esteem and self-confidence • self-esteem and social benefits that come from looking better • protection against coronary heart disease and some cancers[126]

[Figure #11—Benefits of Exercise]

Besides the benefits noted above, Blumenthal found that an exercise program for older adults also improved family relations, the subjects' energy level and their sex lives.[272]

Morris et al. studied the relationship between leisure-time activity and coronary heart disease among sedentary middle-aged office workers and after 8½ years of study found that those who engaged in sport were less than half as likely to have suffered coronary heart disease as the other subjects.[273]

The Paffenberger study of Harvard graduates conducted over a period of 16 years found that those who consumed more than 2000 calories per week in active leisure activities lived, on average, 2½ years longer than those who were less active.[274] The probable reasons for these effects are reduction in blood pressure, weight and obesity, diabetes, coronary heart disease, and protection against osteoporosis.[275]

Because of its positive physiological and psychological effects, exercise is considered an important component of stress management. Brown and Siegel found that for adolescent girls stressful life events were associated with illness among those who exercised little, whereas stress and illness were not correlated in students with high activity levels.[276]

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[272] Blumenthal, J.A., Emery, C.F., Madden, D.J., George, L.K., Coleman, R.E., Riddle, M.W., McKee, D.C., Reasoner, J. & Williams, R.S. Cardiovascular and behavioural effects of aerobic exercise training in healthy older men and women (*Journal of Gerontology*, 1989), 44, M147-M157.

[273] Morris, J.N., Pollard,R., Everitt, M.G. & Chave, S.P.W. Vigorous exercise in leisure-time: Protection against coronary heart disease (*Lancet*, 1980) 2, 1207-10.

[274] Paffenberger, R.S., Hyde, R.T., Wing, A.L. & Hsiech, C.C. Physical activity, all cause mortality and longevity of college alumni (*New England Journal of Medicine*, 1986) 314: 605-13.

[275] Ogden, op. cit., pg. 141.

[276] Brown, J.D. & Siegel, J.M . Exercise as a buffer of life stress: A prospective study of adolescent health (*Health Psychology*, 1988), 7, 341-353.

Exercise produces a relaxation effect considered more powerful than a mild tranquilizer and more long lasting than quiet rest.[277] There is also evidence that depression can be prevented or treated with a program of exercise.[278] This may result from an increase of the neurotransmitter norepinephrine, or from the increased sense of mastery and self-control gained from exercise. Exercise also enhances body image and feelings of self-worth that may counteract depression.[279]

In addition to physiological benefits, exercise programs increase self-esteem in preschool children,[280]self-esteem and body concept in college students,[281]and personal perception of fitness and satisfaction with physical shape and weight in middle-aged adults.[282]

Though the media abound with stories about super athletes who train for many hours a day, the amount of exercise needed to obtain health benefits is moderate. A major reduction in mortality rates is associated with modest levels of physical fitness,[283]even where there is a history of elevated blood pressure, serum cholesterol levels, glucose level, poor health habits such as smoking, and a family history of coronary heart disease. Blair et al. believe that a beneficial level of fitness and health can be achieved through a 30-60 minute daily brisk walk.[284] Hagberg et al.[285]found a low-intensity exercise program resulted in greater lowering of systolic blood pressure in older adults with essential hypertension than a moderate-intensity exercise program. The Paffenberger study recommends a 20-minute walk, 3-5 days a week; others recommend one hour of exercise per day.

Nearly half of young people aged 12-21 are not vigorously active on a regular basis, more than 60% of adults do not have a moderate level of physical activity and 25% of adults are not active at all. Inactivity increases with age and is more common among women and those with lower income and less education.[286] Americans who make four times the amount of money than what is considered poverty level are twice as likely to

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[277] DeVries & Adams, op. cit.; Raglin, J.S. & Morgan, W.P. Influence of exercise and quiet rest of state anxiety and blood pressure (*Medicine and Science in Sports and Exercise*, 1987), 19, 456-463.
[278] Folkins, C.H. & Sime, W.E. Physical fitness training and health (*American Psychologist*, 1981), 36, 373-389.
[279] Sime, W.E. Psychological benefits of exercise training in the healthy individual, in: Matarazzo, J., Weiss, S., Herd, J., Miller, N. & Weiss, S.M. (eds.) *Behavioural health: A handbook of health enhancement and disease prevention*. (New York: John Wiley & Sons, 1984), pg. 488-508.
[280] Alpert, B., Field, T., Goldstein, S. & Perry, S. Aerobics enhances cardiovascular fitness and agility in preschoolers (*Health Psychology*, 1990) 9, 48-56.
[281] Johnson, M., Radmacher, S. & Terry, J. The effects of aerobic exercise on self-esteem (*Anali: dell'ISE*F, 1986), 5, 17-24.
[282] King, A.C., Taylor, C.B., Haskell, W.L. & DeBusk, R.F. Influence of regular aerobic exercise on psychological health: A randomized, controlled trial of healthy middle-aged adults (*Health Psychology*, 1989), 8, 305-324.
[283] Sheridan & Radmacher, op cit., pg.188.
[284] Blair, S.N., Kohl, H.W., Paffenberger, Jr., R.S., Clark, E.G., Cooper, K.H. & Gibbons, L.W.. Physical fitness and all-cause mortality. A prospective study of healthy men and women (*Journal of the American Medical Association*, 1989), 262, 2395-2401.
[285] Hagberg, J.M., Montain, S.J., Martin, W.H. & Ehsani, A.A. Effects of exercise training in 60- to 69-year-old persons with essential hypertension (*American Journal of Cardiology*, 1989), 64, 348-353.
[286] CDC/Centers for Disease Control and Prevention (<< www.cdc.gov/nccdphp/phyactiv.htm>> August 2000).

exercise as poor adults.[287] Inactivity is also correlated with smoking, seeing exercise as an effort, no history of past participation, low self-motivation, lack of spousal support, lack of available time, poor access to exercise facilities, and lack of belief in the value of good health.[288] All of these factors suggest important modes of intervention for increasing the percentage of people receiving the benefits of exercise.

Exercise holds a unique place in Health Promotion because of its documented role in fostering a broad spectrum of health benefits, both physical and psychological, and must be regarded as an essential ingredient of Health Promotion.

9.5 Nutrition

Nutrition is connected to three of the seven health practices identified in the Alameda County study: Eating breakfast daily, rare snacking between meals, and maintenance of a normal weight.

Diet plays a central role in obesity, an increasingly serious problem in modern society, for children as well as adults. American Surgeon General David Satcher reported in 2001 that 60% of Americans adults are overweight or obese, along with 13% of American children, and that 300,000 Americans die annually from illnesses caused or worsened by obesity, a toll that that is approaching tobacco as the chief cause of preventable deaths.[289]

Although diet is important to health, its direct relationship to specific kinds of ill health is not well understood by the general population. In an interesting analysis, Australian researchers Crowley et al. reviewed the literature in order to specify the proportionate contribution of diet to particular diseases and the total costs (direct and indirect) attributable to diet-related diseases. (Results are presented in figure 12.)[290]

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[287] McClam, op. cit.
[288] Ogden, op. cit., pg. 151.
[289] Neergaard, L. Surgeon general proposes fat fight (*San Diego Union-Tribune*, December 14, 2001).
[290] Crowley, et al. (www.dhs.vic.gov.au/phb/hprot/food/strategy/append1.htm 4/09/02).

Diet-Related Diseases and Total Costs Attributable to Them--Australia, 1989-90

	Range of Estimates			*Cost in Millions of $*	*Potential Years Lost*
Disease	**High %**	**Middle%**	**Low %**	**Middle est./costs**	**PYLL***
Coronary heart disease	60	40	20	$474 M	17,190/49,814
Hypertension	75	50	25	364	569/1579
Atherosclerosis	75	50	25	14	
Stroke	60	40	20	270	6168/16,126
Diabetes mellitus	75	50	25	166	3476/11,358
Cancers, overall	35				8433
--stomach		50	15	12	
--colon		35	15	16	
--rectum		35	15	12	
--breast		30	10	17	
--endometrium		25	10	3	
Osteoporosis	30	20	10	50	
Diverticular disease	75	50	25	23	
Hemorrhoids	75	50	25	27	
Dental caries	75	50	25	475	
Gallbladder disease	75	50	25	47	
Constipation	75	50	25	6	
Iron deficiency anemia	75	50	25	7	
Sub Total				**$1520M**	
Alcohol-related disease				470	
Total				**$1990 M**	**36,604/100,055***

*** PYYL = Potential Years of Life Lost—due to premature death from these diet-related diseases, to age 65/75**

[Figure #12—Diet-Related Diseases and Total Costs Attributable to Them]

Although the nutrition/health relationship is unquestioned, and Crowley's data make evident the great cost to society for poor nutritional practices, there is no health topic surrounded with more controversy and confusion. Nutritional adequacy is further complicated in various places throughout the world by droughts and other environmental conditions, political turmoil, crop failures, food shortages, poor food distribution, lack of food variety, and general famine, causing problems ranging from serious malnutrition to outright starvation.

Many studies link nutrition to various cancers. Some estimates attribute 25% of cancer-related deaths to dietary factors such as high fat, low fibre, and inadequate vitamin and mineral intake; other studies indicate 30-50% of cancers are preventable by dietary

means.[291] Foods considered to be protective against cancer are fruit, vegetables, fibre, anti-oxidants, fish oils and calcium.[292]

Consumption of fats, especially saturated fats and cholesterol, besides influencing obesity and cancer-risk, is strongly implicated in coronary artery disease and stroke: "Evidence from nearly half a million people attests to the role of blood cholesterol levels as a major risk factor for coronary heart disease."[293] The MRFIT study of more than 350,000 adults also found a strong correlation between blood cholesterol level and coronary heart disease and stroke: those in the top 1/3 of cholesterol levels had 3½ times more health risk than those in the bottom third.[294]

Iodine deficiency disorders (IDD) are viewed as the major cause of preventable mental retardation, affecting approximately 16% of Europeans,[295] and an even greater percentage of people in countries such as Albania, Tajikistan and Uzbekistan. Anaemia is also related to dietary deficiency, specifically micronutrients such as iron and foliates.

Malnutrition also exists in lands of plenty, stemming from dieting in order to conform to social and cultural norms, as well as confusion due to changing reports about what to eat for optimal health.

One abiding nutritional principle generally agreed upon is the importance of maintaining normal weight. While millions of people in the world are malnourished, and millions of others are overweight, both deviations have significant implications for health.

Obesity has been linked to cardiovascular disease, diabetes, joint trauma, breast and other cancers, hypertension, back pain, and mortality.[296] In addition, there are significant psychological problems associated with obesity including depression and low self-esteem. Obesity costs Europeans 8% of their total health budget, an amount equal to what is spent for cancer and AIDS.[297]

A second dietary target is reduction of sugar intake. Sugars contain calories and little else, except for the capacity to make people feel good. Sugar has social value as a "comfort food," and is ubiquitous in snacks and soft drinks that constitute an increasing percentage of calories consumed in industrialized countries. But, the comfort of these foods is short-lived. Simple sugars are digested quickly, necessitating replenishment and leading to high overall caloric intake. Acids from degenerating sugars demineralise teeth, leading to the formation of dental caries which are the most common disease in industrialized countries, and the fifth most expensive one to treat in the U.K.[298] Excessive intake of sugar has been linked to adult-onset diabetes, headaches, Alzheimer's Disease, in addition to obesity and its related diseases.

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[291] Ibid; Crowley et al., op. cit.
[292] Ibid.
[293] Law, M.R., Walk, N.J. & Thompson, S.G. By how much and how quickly does reduction in serum cholesterol lower risk of ischaemic heart disease? (*British Medical Journal*, 1994), 308: 367-72.
[294] Stamler, R., Stamler, J. Grimm, R., Gosch, F.C., Elmer, P. & Dyer, A. Nutritional therapy for high blood pressure: final report of a four-year randomized trial—the Hypertension Control Program (*Journal of the American Medical Association*, 1986), 7: 1484-91.
[295] Robertson, Brunner & Sheiham, op. cit.
[296] Ogden, op. cit., pg. 113.
[297] Robertson, A., Brunner, E. & Sheiham, A. Food is a political issue, in: Marmot & Wilkinson , op. cit.
[298] Robertson, Brunner & Sheiham, op. cit.

Philpott and Kalita see disease as a product of the body's cells not being provided with the optimum nutrients needed.[299] Cellular health, in their view, is not based on a minimum daily requirement of nutrients but upon an optimum daily need, determined by the biochemical uniqueness of each person. Though vitamins, minerals, trace elements, enzymes and hormones are not cure-alls, they believe "physical as well as mental illness will result when there is a deficiency of these chemicals in the human body."

In an effort to bring clarify to the complex and important field of human nutrition, the World Health Organization issued guidelines in 1999, "Twelve steps to healthy eating".[300] (See figure #13).

[299] Philpott, W.H. & Kalita, D.K. *Brain Allergies.* (New Canaan, CT: Keats Publishing, Inc., 1980), pg. 3-4.

[300] WHO. *CINDI Dietary Guidelines*., op. cit.

WHO—12 Steps to Healthy Eating

1. Eat a nutritionally healthy diet based on a variety of foods that come mainly from plants, rather than animals

2. Eat bread, grains, pasta, rice or potatoes several times per day at each meal

3. Eat a variety of vegetables and fruits, preferably locally produced, several times per day (more than 400g per day)

4. Maintain body weight between recommended limits (a Body Mass Index [BMI] between 18.5 and 24.9)

5. Eat a low fat diet (< 30% of daily calories). This includes all fats and oils—such as those found in meat, milk, other foods—and fats/oils used in cooking

6. Replace fatty meat and meat products with beans and legumes, plus fish, poultry, eggs or lean meat

7. Use low fat milk and low fat-low salt milk products (kefir, sour milk, cheese, and yogurt)

8. Select foods which are low in sugar and use refined sugar sparingly, limiting frequency of sugary drinks/sweets

9. Eat a low salt diet; this includes salt found in bread, processed, cured and preserved foods; total salt intake should not be more than one teaspoon (6 grams) per day; universal salt iodisation should be considered

10. Consume no more than 2 alcoholic drinks (each containing 10 grams of alcohol) a day

11. Prepare food in a safe and hygienic way; steam, bake, boil or microwave to reduce amount of added fats, oils, salt, and sugars

12. Promote *exclusive* breastfeeding for about the first 6 months with timely introduction of appropriate weaning foods

[Figure #13 -- WHO—12 Steps to Healthy Eating]

Each person is born with the responsibility for obtaining the nutrition needed to fuel his body, yet, as Philpott and Kalita warn, "the field of nutrition is no playground for amateurs." Nevertheless, most people eat and drink with limited awareness about human nutrition. What they eat is based upon preferences and custom, and they prefer to do this with minimal limitations imposed upon them. Nutritional guidance is, therefore, an enormous challenge—limited in part by our incomplete understanding about the relationships between nutrition and health, and by the reluctance of people to adjust their eating behaviours. Yet, the increasing clarity of our understanding about the linkage between nutrition and health urges health professionals to offer a perspective that can be helpful.

Beyond the WHO guidelines, three additional principles have apparent validity: Eating for nutrient density; becoming conscious about the relationship between what you eat and how your body feels and operates; and avoidance of fad dieting.

Nutrient density refers to the relationship between calories and the nutritional components in food. Nutrient-rich foods contain more nutritional ingredients than those characterised as having "empty calories"(e.g., comparing whole-wheat bread and a soft drink, both containing approximately 100 calories: The bread contains protein, carbohydrates, fat, riboflavin, thiamine, niacin, calcium, iron, and dietary fibre, whereas the soft drink contains only sugar).

Though "Listen to your body" is familiar folk wisdom, people overlook or disregard the nutrition-related signals their body gives them. People "overdose" on various foods—especially alcohol, sugars and fats, and don't focus on the connection between eating behaviours and health. The pressures of daily life also complicate nutritional practices—limiting the time available for families to eat together and causing food choices to be based upon ease of preparation rather than nutritional soundness.

9.6 Weight Management

Despite the estimation that between 60-90% of females attempt to restrain their food intake at some time in their life, with girls as young as 8-9 years old now dieting, data show most diets yield short-term effects that are reversed when the diet is abandoned. Moreover, severe caloric restriction can cause the body to believe it is being starved, whereupon it makes more efficient use of the calories provided, thus rendering the diet counterproductive. Repeated dieting failures also damage dieters' self-esteem, further compounding the self-defeating nature of the endeavour.

For legitimate needs to lose excess weight, the unglamorous but effective way is to eat fewer calories than you burn, and increase your exercise levels in order to increase the rate at which you burn calories. Weight management programs are widely available as components of Health Promotion programs.

9.7 Alcohol Consumption

The link between alcohol consumption and health is confirmed by a number of studies. Moderate or no use of alcohol is one of the health practices identified in the Alameda Health Study and moderation is advised by the World Health Organization.

A common opinion, also sustained by scientific information, is that moderate consumption of alcohol is preferable over complete abstinence because of alcohol's reported beneficial effects on health, such as reduction of LDL cholesterol associated with cardiac illness and blood pressure, in addition to being a useful short-term coping strategy.[301] However, the WHO warns of the possible dangers of campaigns that encourage a moderate use of alcohol and suggests substituting an explicit message that

[301] Odgen citation….

the less one drinks alcohol, the better.[302] The World Health Organization underlines how alcohol negatively impacts the life of drinkers, threatening their health, happiness, domestic life, friendship, work, academic studies, career opportunities and financial stability.[303] The European Charter on Alcohol produced by the European Conference on Health, Alcohol and Society, enunciates the ethical principals that should regulate national policy on alcohol. (See figure following).[304]

European Charter on Alcohol—Ethical Principles and Objectives

In furtherance of the European Alcohol Action Plan, the Paris Conference calls on all Member States to draw up comprehensive alcohol policies and implement programmes that give expression, as appropriate in their differing cultures and social, legal and economic environments, to the following ethical principles and goals, on the understanding that this document does not confer legal rights.

1. All people have the right to a family, community and working life protected from accidents, violence and other negative consequences of alcohol consumption.
2. All people have the right to valid impartial information and education, starting early in life, on the consequences of alcohol consumption on health, the family and society.
3. All children and adolescents have the right to grow up in an environment protected from the negative consequences of alcohol consumption and, to the extent possible, from the promotion of alcoholic beverages.
4. All people with hazardous or harmful alcohol consumption and members of their families have the right to accessible treatment and care.
5. All people who do not wish to consume alcohol, or who cannot do so for health or other reasons, have the right to be safeguarded from pressures to drink and be supported in their non-drinking behaviour.

[Figure #14 -- European Charter on Alcohol: Ethical Principles and Objectives]

Meanwhile, there is a large body of evidence linking health damage and excessive alcohol consumption including increased risk of liver cirrhosis, pancreatic and liver cancers, hypertension, nutritional deficits, memory deficits and self-harm through accidents.[305] As many as 40,000 people in the UK are believed to die each year from the consequences of excess alcohol intake,[306]including cirrhosis of the liver and several

[302] WHO—Press Release WHO/84 – November 1994 – Moderate Drinking: Serious Warning by WHO Specialists http://www.who.int/archives/inf-pr-1994/pr94-84.html.
[303] WHO—European Alcohol Action Plan, 2000-2005, European Health 21 Target 12 – Reducing Harm from Alcohol, Drugs and Tobacco.
[304] http://www.who.dk/AboutWHO/Policy/20010927_7. World Health Organization Regional Office for Europe. European Charter on Alcohol, 1995.
[305] Ogden, op. cit., pg. 81.
[306] Ibid.

forms of cancer. Oesophageal cancer rates are increased when those with high alcohol consumption also smoke.[307]

In addition to the physical effects of excess alcohol consumption, there are numerous associated psychosocial health problems, including: 20% of psychiatric admissions, 60% of suicide attempts, 30% of divorces, and 40% of incidences of domestic violence. Alcohol abuse in many cases impacts the drinker's relationships with family and friends. Added to these statistics are driving accidents, the majority of which are alcohol or drug-linked and many of which result in life-altering injury and death.

Examples in several countries demonstrate that significant health and economic benefits may be achieved if these 10 Health Promotion strategies for action on alcohol are implemented:[308]

1. Inform people of the consequences of alcohol consumption on health, family and society and of the effective measures that can be taken to prevent or minimise harm, including building broad educational programmes beginning in early childhood;

2. Promote public, private and working environments protected from accidents and violence and other negative consequences of alcohol consumption;

3. Establish and enforce laws that effectively discourage drink-driving;

4. Promote health by controlling availability (e.g., for young people) and influencing the price of alcoholic beverages (e.g., by taxation);

5. Implement strict controls, recognising existing limitations or bans in some countries, on direct and indirect advertising of alcoholic beverages and ensure that no form of advertising is specifically addressed to young people (e.g., through the linking of alcohol to sports);

6. Ensure the accessibility of effective treatment and rehabilitation services with trained personnel, for people with hazardous or harmful alcohol consumption, and members of their families;

7. Foster awareness of ethical and legal responsibility among those involved in the marketing or serving of alcoholic beverages, ensure strict control of product safety and implement appropriate measures against illicit production and sale;

8. Enhance the capacity of society to deal with alcohol through the training of professionals in different sectors, such as health, social welfare, education and the judiciary, along with the strengthening of community development and leadership;

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[307] Ibid.

[308] World Health Organization Regional Office for Europe. European Charter on Alcohol, 1995, op.cit..

9. Support non-governmental organisations and self-help movements that promote healthy lifestyles, specifically those aiming to prevent or reduce alcohol-related harm;

10. Formulate broad-based programmes in Member States, taking account of the present European Charter on Alcohol; specify clear targets for and indicators of outcome; monitor progress; and ensure periodic updating of programmes based on evaluation.[309]

9.8 Sexual Practices

Sexual practices are surrounded by moral/ethical opinions and values that can obscure their health impact. Possible health consequences of sexual behaviours include unplanned pregnancy, diseases such as Hepatitis B, cervical cancer, genital herpes, gonorrhoea, syphilis, and AIDS.

By the end of the past century, more than 3,000,000 people had died of AIDS worldwide and an additional 25,000,000 are known to be HIV positive.[310] AIDS has devastated many Sub-Saharan countries where it rages out of control; more than 30% of the population is affected in some countries, with innumerable deaths, and an increasing population of orphaned children, along with a tragic impact on African economies. Russia is also experiencing a great increase in cases of HIV/AIDS. In assessing the global burden of disease, the WHO reported that for the year 2000, HIV/AIDS was the leading cause of premature mortality in women of any age, and the third leading cause for men aged 15-44.[311] Every incidence of AIDS creates shattering effects on the patient, family, friends, workplace, the health care system, and society at large.

Adolescent heterosexuals are increasingly at-risk, currently accounting for 20% of all newly reported cases in the U.S.[312] AIDS has become the leading cause of death for American women between 25-34 and is the third leading cause of death for those aged 15-19. Ethnic minority adolescents, especially poor urban blacks, account for 53% of new U.S. AIDS cases.[313]

Today's social mores, with fewer restrictions on sexual behaviour, increase the number of people at risk for sexually transmitted diseases. Two factors are unplanned (and therefore, unprotected) intercourse and denial about the possibility of being at risk. Adolescents are especially susceptible to both. While the majority use some form of contraception, especially the pill, the least used contraceptive is the condom (24%), though it is the only effective protection against AIDS and other sexually transmitted

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[309] *European Conference on Health, Society and Alcohol.* (Paris, 1995).
[310] Bennett & Murphy, op. cit., pg. 11.
[311] WHO. The World Health Report 2001. *Mental Health: New Understanding, New Hope*. (Geneva: World Health Organization, 2001), pg. 27.
[312] Ibid.
[313] Ibid.

diseases. Denial of vulnerability coupled with unplanned, unprotected sex present health risks of great significance.

9.9 Stress Management

Hans Selye, a Canadian biologist considered the father of this concept, described stress as a reaction of the organism to external stimuli that subvert a momentary equilibrium. Stress occurs when the demands of a situation are greater than the resources the individual believes s/he has available to cope successfully with them. The experience of stress results from an interaction between a stressor (an environmental, social or personal factor that generates stress) and an individual's psychological and physiological processes.[314] When an individual experiences a stressor, either the objective event itself or his/her subjective response to it, results in his/her coping mechanisms being taxed beyond comfort level. The result is that the person experiences stress.

Research has generally focused on the relationship of stressful life *events* to disease, and overall results show modest correlations of about 9%.[315] Methodological problems may be one reason why the correlation hasn't been stronger. A less well-studied factor is *variability of response* to the same stressor. Cronkite and Moos found that the effectiveness of the coping process is a more important predictor of health and illness than either the frequency or level of stress.[316]

Because high levels of stress characterize life in today's society, coping with stress is a prime social and public health problem, with 50-80% of illness estimated to be stress-related.[317] (See figure on "Disorders Associated with Chronic Stress."[318])

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[314] Bennett & Murphy, op. cit., pg. 16.
[315] Ibid.
[316] Cronkite, R.C. & Moos, R.H. The role of predisposing and moderating factors in the stress-illness relationship (*Journal of Health and Social Behaviour*, 1984) 25: 372-93.
[317] Istituto dell'Approccio Centrato sulla Personna. *Stress Prevention and Management*. www.iacp.it., 2002.
[318] Ibid.

Disorders Associated with Chronic Stress

Subjective Effects:

Anxiety • Aggressiveness • Apathy, Boredom, Depression • Fatigue, Frustration • Sense of Guilt and Shame • Irritability, Mood Changes, Low Self-esteem • Tension, Nervousness • Solitude • Inability to Concentrate and Make Decisions • Impaired Memory • Hypersensitivity to Criticism • Mental Block

Health Effects:

Asthma • Chest and Back Pain • Cardiac Disorders, Coronary Disease • Diarrhea • Dyspepsia • Headache, Migraine • Loss of Menstrual Function • Neurosis, Psychosomatic Disorders • Nightmares, Insomnia • Psychosis • Diabetes Mellitus • Dermatological Disorders • Ulcer • Loss of Libido • Exhaustion

Behavioural Effects:
Frequent Accidents • Emotional Outbursts, Impulsive Behaviour • Compulsive Eating, Loss of Appetite • Tobacco, Alcohol, Recreational and Pharmaceutical Drug Abuse • Difficulty Concentrating • Nervousness • Tremors

Organisational Effects:
Absenteeism • Poor Relationships at Work • Low Productivity • High Accident Rate at Work • Conflict • Dissatisfaction • Increased Number of Sick Days

[Figure #15—Disorders Associated with Chronic Stress]

Since stress severity is defined by the individual and not by life events in general, factors which influence the response to stressful events include the personal experience of loss, the stressor's magnitude, unpredictability, time clustering, uncontrollability,[319] perceived lack of control, the individual's personality and coping style, cognitive ability, prior exposure to stressors, and the person's level of social support.

Several research studies have shown the importance of social support in mediating the effects of stress,[320]and impacting health in three ways:

1) by meeting basic human needs for affection, social contact, security;

2) reducing interpersonal conflict and tensions;

[319] Williams, D.R. & House, J.S. Social support and stress reduction, in: Cooper, C.L. & Smith, M. (ed.). *Job stress and blue collar work*. (London, Wiley, 1985), p. 207-224.
[320] Odgen, op. cit., pg. 212.

3) buffering, and thereby reducing, the health-damaging consequences of stress.[321]

Berkman and Syme found that people aged 30-69 with social support had lower death rates;[322] Oakley found that women with high levels of social support had fewer birth complications;[323] Arnetz et al.[324]found unemployed women with high psychosocial support had better immune functioning than those with less support; Vaillant found lonely men often became chronically ill by the time they reached their fifties;[325]and a study of Roseto, Pennsylvania, identified the buffering effect of social support as a protective factor against coronary heart disease, despite the prevalence of high risk health habits.[326]

Krause[327]found stress to have more adverse effects on women than on men and Kessler[328]found it had greater negative impact on people of lower socioeconomic status.

Seyle suggests an interesting insight into the complexity of individual responses to stress. He believed that stress can both damage and cure and those normative and expected life events (e.g., university exams) have the beneficial function of stimulating personal growth. Selye proposed that exposure to certain stressful experiences that are coped with successfully increases self-esteem and helps people develop skills that better equip them to handle similar difficult situations in the future.[329]

Numerous researchers have focused on the relationship between stress and decision-making latitude. Karasek et al.[330] found job demands to be positively associated with cardiovascular problems whereas greater *decision-making latitude* was negatively associated with cardiovascular problems, leading to the conclusion that "decision latitude can moderate or buffer the impact of job demands on health." Similarly, while men with highly demanding jobs had 30% greater morbidity,[331] those with low autonomy in their jobs suffered 40% higher rates for coronary heart disease than workers with high job control. A 14-year study of Swedish men by Johnson et al. found those in highly demanding jobs with low autonomy had double the risk of coronary heart disease than workers in non-stressful jobs. Additionally, workers with low support on the job had 2½

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[321] Badura & Kickbusch, op. cit., pg. 155.
[322] Berkman, L.F. & Syme, S.L. Social networks, lost resistance and mortality: A nine-year follow up study of Alameda County residents (*American Journal of Epidemiology*, 1979), 109, 186-204.
[323] Oakley, A. *Social Support and Motherhood* (Oxford: Basil Blackwell, 1992).
[324] Arnetz, B.B., Wasserman, J. & Petrini, B., et al. Immune function in unemployed women (*Psychosomatic Medicine*, 1987), 49, 3-12.
[325] Borysenko, op. cit., pg. 25.
[326] Borysenko, op. cit., pg. 25-26.
[327] Krause, N. Stress and sex differences in depressive symptoms among older adults (*Journal of gerontology*, 1986), 41: 727-731.
[328] Kessler, R.C. Stress, social status and psychological distress (*Journal of health and social behaviour*, 1979), 20: 259-272.
[329] Borysenko, op. cit., pg. 152.
[330] Karasek, R. et al. Job decision latitude, job demands, and cardiovascular disease: a prospective study of Swedish men (*American Journal of Public Health*, 1981), 71: 694-705.
[331] Bennett & Murphy, op. cit., pg. 20.

times the coronary risk of people in low stress jobs.[332] Brosschot et al. came to a similar conclusion; that it was the extent to which the person perceived stressors to be controllable that determined their impact on immune response, not the number of stressors that appeared.[333] Schneiderman, McCabe & Baum and Steptoe & Appels found that a lack of actual or perceived control over environmental demands "increases susceptibility to bacterial and viral infections, contributes to the development of physical disorders, and accelerates the rate of progression of disease."[334] These findings shed light on how job-related stress is created and the importance of participative decision-making as a way to reduce job stress, illness, and attrition. (See figure on "Situations Associated with Workplace Stress".)

Situations Associated with Workplace Stress

- Jobs where the employee does not have the opportunity to participate in the decision-making process about matters that affect him
- Jobs where the employee is caught in a crossfire (e.g., between supervisor and manager)
- Jobs requiring either higher or lower skills than those possessed
- Jobs where the employee is too tightly controlled, leaving little room for personal initiative
- Jobs where the employee is constantly underestimated due to lack of clear expectations and clear evaluation parameters
- Market fluctuations, re-engineering, and corporate take-over
- Jobs lacking career and growth opportunities
- Conflict with colleagues and superiors

[Figure #16—Situations Associated with Workplace Stress]

Finally, Bandura, Lazarus and Folkman and others suggest that self-efficacy is a powerful factor for mediating the stress response. Bandura observes that self-efficacy may have a role in mediating stress-induced immuno-suppression and physiological changes such as blood pressure, heart rate and stress hormones.[335]

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[332] Bennett & Murphy, op. cit., pg. 20.

[333] Brosschot, J.F., Benschop, R.J. & Godaert, G.L.R., et al. Effects of experimental psychological stress on distribution and function of peripheral blood cells (*Psychosom Med*, 1992), 54: 394-398; Brosschot et al. Influence of life stress on immunological reactivity to mild psychological stress (*Psychosom Med*, 1994), 56: 216-224.

[334] Bandura, A. (ed.). *Self-Efficacy in Changing Societies.* (Cambridge: Cambridge University Press, 1995), pg. 27.

[335] Bandura, A., Reese, L., Adams. N.E. Micro-analysis of action and fear arousal as a function of differential levels of perceived self efficacy. (*Journal of Personality and Social Psychology*, 1982), 55,

Because stress is a factor in almost everyone's life and plays a significant role both in objective measures of health as well as subjective measures of well-being, it is an important focus for Health Promotion.

9.10 Sleep

Sleep deprivation is a common occurrence that impacts health in a variety of ways. These range from simple sleepiness to psychiatric problems, reduced productivity and lethal accidents. Nearly half of all Americans have difficulty sleeping, 27% are negatively affected by poor sleep two or more days per week, and 70% are dissatisfied with their sleep.[336] The National Commission on Sleep Disorders estimates that sleep deprivation in the U.S. costs $150,000,000,000 a year in stress and reduced workplace productivity. Sleep deprivation can also lead to personal and public tragedy. Speculation exists that the Chernobyl nuclear reactor meltdown, the Exxon Valdez oil spill, and the Challenger aerospace disaster can be linked in part to people suffering from severe lack of sleep.[337]

A 1991 Gallup study[338]found that insomniacs report poor performance at work, memory difficulties, concentration problems, and fatigue-related auto accidents.[339] Blum et al.[340] reported 21% of poor sleeping pre-adolescents failed at school compared to 11% of good sleepers; Navy personnel found that poor sleepers earned fewer promotions and received lower pay.[341] Researcher Daniel J. Buysse concludes that "all persons with sleep problems (have) a significant degree of disability in their daily activities and social roles."[342]

Sleep disturbances are also linked to psychiatric disorders. Approximately 2/3 of patients with depression have some type of insomnia, and 35-50% of people with insomnia or hypersomnia also have mood or anxiety disorders, compared with 15-20% of those with no sleep complaint.[343] Evidence suggests that insomnia is a risk factor for the onset of depression.[344]

479-88; Wiedenfeld, S.A., O'Leary, A., Bandura, A., Brown, S., Levine, L. & Raska, K. Impact of perceived self-efficacy in coping with stressors on immune function (*Journal of Personality and Social Psychology*, 1990), 598, 1082-94.

[336] Walsh., J.K. Chronic Insomnia, Ability to Function and Quality of Life (*Worldwide Project on Sleep and Health).*

[337] CNN Interactive. *Lack of sleep America's top health problem, doctors say* (March 17, 1997).

[338] Gallup Organization. *Sleep in America.* (Princeton, NJ: The Gallup Organization, 1991).

[339] Ibid.

[340] Blum, D., Kahn, A., Mozin, M.J., Rebuffat, E., Sottiaus, M., Van de Merckt, C. Relations between chronic insomnia and school failure in preadolescents (*Sleep Research*, 1990), 19; 194.

[341] Johnson, L.C. & Spinweber, C.L. Quality of sleep and performance in the Navy: A longitudinal study of good and poor sleepers, in: Guillerminault, C. & Lugaresi E. (eds.). *Sleep/wake Disorders: Natural History, Epidemiology, and Long-term Evolution.* (New York: Raven Press, 1983), 13-28.

[342] Ustun, T. B. Diagnosis and Management of Sleep Problems in Primary Care: A Challenge for Public Health (*Worldwide Project on Sleep and Health*).

[343] Buysse, D. J. Psychiatric Disorders Associated with Disturbed Sleep and Circadian Rhythms, (*Worldwide Project on Sleep and Health*).

[344] Ford, D.E. & Kamerow, D.B. Epidemiologic study of sleep disturbances and psychiatric disorders. (*JAMA*, 1989), 262:1479-1484.

Sleep-Disordered Breathing, a condition defined as 15 or more apnoeas and hypopnoea per hour of sleep, estimated in 4% of women and 9% of men, is associated with elevated blood pressure, seven times greater risk of motor vehicle accidents, significant decrease in psychomotor function, and decreased quality of life.[345]

Walsh et al. estimated in 1990 that the apparent direct costs of insomnia worldwide were $10.9 billion, yet as only about 5% of insomniacs visit a physician for their sleep problem, actual costs are doubtlessly much higher.[346] Insomniacs report more medical problems than good sleepers, are hospitalised twice as often, consume more medication than good sleepers and are statistically linked to a worse health status.[347] It is not clear whether insomnia is the cause or the result of worse health status, but a leading explanation is that loss of sleep may reduce immune function.

9.11 Marital Status

Success or failure in your marriage relationship can have a significant impact on health, either for better or for worse. Researchers Lois Verbrugge and James House found that an unhappy marriage can increase chance of illness by 35% and shorten life by four years. They found that happily married people live longer, healthier lives than divorced or unhappily married couples. [348]

One benefit of marriage seems to be the support found for healthful behaviours such as exercise and proper eating. A.C. King of Stanford University evaluated 558 men and women over a 10-year period[349] and found a correlation between marital status and activity levels. King believes that people begin exercising after marriage because the relationship is a stabilizing factor and because married people normally receive spousal support for exercise. Furthermore, King found that married couples have reduced levels of stress and depression, due in part to the benefits of physical exercise and other positive benefits linked with the control of stress.

However, for couples in an unhappy marriage, the relationship can cause a great deal of stress along with negative health consequences—most frequently, chronic, diffuse physiological arousal, which puts added wear and tear on the body and manifests in a number of physical ailments, including high blood pressure, heart disease, anxiety, depression, suicide, violence, psychosis, homicide and substance abuse.[350]

Marriage relationships are so central to people's sense of well-being that a spouse's use of negative language and angry tone of voice can have a detrimental effect on the other's immune function. Kiecolt-Glaser and Glaser found that marital arguments cause changes in the endocrine and immune systems, with epinephrine and cortisol levels

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[345] Young, T. Primary Care: Epidemiologic Implications (*Worldwide Project on Sleep and Health*).
[346] Leger, D. & Paillard, M. *Economics*/Direct and Indirect Costs of Insomnia (*Worldwide Project on Sleep and Health*).
[347] Leger & Paillard, op. cit.
[348] Gottman,J.M. & Silver, N. *The Seven Principles for Making Marriage Work.* (New York: Crown Publishers, Inc., 1999), pg. 4.
[349] King, A.C. Marriage increases physical activity (Annals *of Behavioural Medicine*, October 27, 2000).
[350] Gottman, op. cit., pg. 5.

staying elevated for more than 22 hours afterward.[351] They also found blood pressure and heart rate to increase with relationship stress.

A 15-year study in Oregon found that having unequal decision-making power in marriage was associated with a higher risk of death for women. Studies consistently show that physiological effects of marital stress are stronger and last longer in women. Coyne, for example, studied congestive heart patients at the University of Pennsylvania and found that seven out of eight women with the poorest quality marriage died within two years. Coyne also found that the marital quality predicts recovery from congestive heart failure as well as measures of the heart's pumping ability: heart patients evaluated as "negative" with their spouses were found to be 1.8 times more likely to die within four years than those with more positive evaluations.[352]

A study of 50 married couples by John Gottman and colleagues at the University of Washington found evidence that a good marriage keeps you healthier by directly benefiting the immune system. Happily married men and women showed "greater proliferation of … white blood cells[353] They also found that happily married people had more effective natural killer cells that destroy damaged or altered body cells.[354]

Because the divorce statistics in many countries are very high, with more than 50% of all U.S. marriages currently ending in divorce,[355] with increasingly similar statistics developing in other western countries, success of marriage relationships is an important social issue—going beyond a matter of personal happiness to an area of concern for Health Promotion.

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[351] Lerner, S. Two words that will bring you a long life span: 'I do' (*New York Times News Service*, Nov. 23, 2002.)
[352] Ibid.
[353] Gottman, op. cit., pg. 5-6.
[354] Ibid., pg. 6.
[355] The National Marriage Project. *The State of Our Unions 2002: The social health of marriage in America.* (Rutgers: The State University of New Jersey, 2002).

Section IV
The Process of Promoting Health

Chapter 10 – The Person-Centred Approach

"Health promotion supports personal and social development through providing information, education for health, and enhancing life skills. By so doing, it increases the options available to people to exercise more control over their own health and over their environments, and to make choices conducive to health."

WHO Ottawa Charter for Health Promotion

10.1 The Tools of a Systemic Approach

As the preceding four chapters show, health is determined within the evolving context of interactions between people, their behaviours, their relationships and their internal and external environments. Accordingly, the systemic bio psychosocial paradigm of Health Promotion develops its strategies on the basis of those interactions. This comprehensive model has these components:

1) Concern for the whole person within the context of his/her human ecology: family and social relationships, recognizing the various cultural influences on health and emphasizing the importance of health, well-being, achievement of potentialities, and functioning in society;

2) Recognition for the importance of social factors that determine health and concern for health equity in society (e.g., income, gender, age, and education);

3) Understanding that health is socially created and/or undermined;

4) Understanding the personal and cultural meanings related to health and the importance of personal interpretations (constructs);

5) Recognising the impact of health and healthy behaviour change on people's daily lives;

6) Recognising the primacy of the individual in promoting and caring for his own health care, and the supportive role for professional health care;

7) Recognising the importance of self-care based upon its foundation in human dignity and personal development;

The systemic model recognises that health can be promoted in all settings, including primary health care facilities, hospitals, schools and other educational institutions, community parks, recreation facilities, worksites, and the home. In addition to traditional work with groups such as the elderly, the unemployed, parents, and ethnic minority groups, this model includes the promotion of health within the community at large and seeks to engage *everyone* in the process of Health Promotion.

Since we are moving towards a new paradigm that has empowerment of individuals as a central objective, the tools used in applying this paradigm must be congruent with the paradigm itself. One cannot, by definition, create a successful Health Promotion program while utilizing mechanistic and reductionist diagnostic or outcome measures; this has contributed to the downfall of numerous previous projects.

The promotion of health and well-being requires an understanding of human dynamics, the processes that help people grow, and the tools and competencies for fostering the growth of people and organisations. The assumptions that underlie this approach include a view of human nature that stresses the innate capacity for self-awareness and self-regulation. Thus, health promoting relationships are not ones of dependence but ones that facilitate the development of the potentialities—of the person, group and community.

To promote health means putting the person at the centre and this is achieved through a Person-Centred Approach wherein the roles of the principals change from that of expert/patient to that of *helper/client*. This change creates, from the outset, a different construction of reality. When a person sees people as capable and response-able, a relationship is created that promotes the development of the other person's potentialities, capacities for self-management, taking proactive steps toward bettering his health, and relating effectively with him/herself, others and the world.

This approach is essential to Health Promotion because:

1) it helps the client increase self-efficacy, making behavioural change more likely;
2) it helps the client relate to him/herself, grow in self-esteem, and relate effectively with others;
3) it increases the client's capacity to develop and maintain a support group that buffers stress and helps him deal with the world.

Central to the Person-Centred Approach are three conditions that foster the capacity to deal with problems: Acceptance, Empathy, and Genuineness. When a health professional provides these three conditions in a relationship with a client, countless research studies have identified them as both *necessary and sufficient* for promoting personal growth.[356]

Acceptance, Empathy, and Genuineness were first identified over fifty years ago by psychologist Carl Rogers and have since achieved widespread recognition and acceptance. Because of the potency of these conditions, the Person-Centred Approach provides an appropriate and vigorous model for those working to promote health.

Here are the three essential conditions for fostering growth:

Acceptance: A non-judgmental openness to another human being even when s/he is different from one's self and has different beliefs and values. Willingness for the client to have and express whatever thoughts and feelings are real in him/her at the moment.

Empathy: A delicate and sensitive understanding of the other person's thoughts and feelings. The capacity to communicate a sense of the other person's experience and convey that back to him/her in a way that enables the other to feel recognised and understood.

Genuineness: Being authentic, real, and congruent. Acting in ways that match what you are really feeling and thinking. Being what you are, without a front or façade.

[Figure #17 - Three Facilitative Conditions]

10.2 Brief History of the Person-Centred Approach

In the 1940's, Rogers made a revolutionary contribution to the helping professions by pointing out the inevitable consequences of the special relationship created between a helping professional and a client. In doing so, Rogers challenged professionals to ask themselves if they were aware of the social construction they were actively creating with each client. He did this by posing the question: As helping professionals, are we part of the solution or are we part of the problem?

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[356] Patterson, C.H. *Understanding Psychotherapy: Fifty years of client-centred theory and practice*. (Llangarron, UK: PCCS Books, 2000); Watson, J.C., Goldman, R.N. & Warner, M.S. (eds.) *Client-Centred and Experiential Psychotherapy in the 21st Century: Advances in theory, research and practice.* (Llangarron, UK: PCCS Books, 2002); Cain, D.J. (ed.) *Classics in the Person-Centred Approach*. (Llangarron, UK: PCCS Books, 2002).

He believed that labelling people asking for help as "patients" would contribute to their problems, not to the solution of their problems, since such a socially construed label would automatically put them in a passive, dependent role and disempower them. As a healthier alternative, he suggested the use of the word "client" as a non-limiting label.

Rogers also considered that if professionals focused on illness and dysfunction in a mechanistic way this would constitute part of the problem, not the solution. He believed it was more effective to focus on a systemic, holistic vision of health and well-being and to help people find healthy and effective ways of relating to themselves, others, and the world.

Rogers proposed a medicine based on *health* and centred on the *person* as being more effective than a disease-centred model. A Person-Centred Medicine was structured to enhance the collaborative relationship between health professionals and their clients and focus on achieving positive goals, not just reparative efforts.

Rogers' view of human nature is optimistic, and even more importantly, not mechanistic. His holistic-systemic approach views the human organism as a complex system of systems that has inborn in its genetic code the capacity for full development of its potentialities.

Although Rogers' vision was considered revolutionary by some, he proposed for human beings a vision that was already generally accepted in Western culture as being true for plants and animals. Nobody doubted that a plant's seed possessed within its nature the capacity to develop its full potentiality if the environmental conditions allowed the seed to become a mature plant and bear fruit; nor did anybody doubt that even the most "insignificant" animal had inscribed in its biological blueprint all the necessary conditions to fulfill the realisation of its animal-hood.

Rogers' vision of how a practitioner can best facilitate human beings in reaching their potential is based on three main concepts:

1) Awareness of the fact that when two or more people meet, one in the role of the professional helper, the other in the role of recipient of help, whether consciously aware of it or not, they create a specific, unique reality with as yet unrealized potential;

2) The need for the practitioner to be aware of and capitalise on this premise by welcoming the client into a world where the narrative offered is one of empowerment;

3) The practitioner must be skilled in presenting a respectful, non-judgmental attitude that lowers resistance and defensiveness; have the capacity to listen to and understand the client's feelings and concerns and be able to restate those cogently to the client; and finally, to be, and be perceived as, an authentic person worthy of trust. (See "Three Criteria of a Facilitative Climate" below.)

Three Criteria of a Facilitative Climate:

1) Facilitator's awareness of the potential of the reality being created in the helping situation

2) Welcoming client as capable and responsible

3) Respectful, non-judgmental attitude, Empathic Listening, and Authenticity

[Figure #18 – Three Criteria of a Facilitative Climate]

In addition, it is important for the health professional to recognise the extent to which the client is ready for change. Clients are not all at the same stage of readiness to change behaviour; indeed, Prochaska and DiClemente found that only about 20% are actually ready to take action and change their behaviour.[357] Health efforts easily fail if they are aimed at the "action" stage when the client himself is not there. Prochaska and DiClemente identify five Stages of Change:

1) **Pre-contemplation** - The stage at which a client is in denial about a problem associated with a lifestyle behaviour and is not thinking about changing in any way
2) **Contemplation** - The stage at which a client is reviewing his/her behaviour and the impact it has on his/her life and health
3) **Preparation** - When a client has decided that a change must be made in his behaviour and alternatives are being considered
4) **Action** - he point when a client is actively in the process of changing his/her behaviour
5) **Maintenance** - when behaviour change has been instituted and the client deals with issues relating to maintenance of those new behaviours over a long period of time.

Awareness of the client's stage of readiness, along with knowledge of the criteria of a facilitative climate, enables the health professional to respond sensitively to the client and customise a therapeutic approach that results in empowering the client. Whether the client is an individual or a group, this approach empowers the client to become an active agent for finding solutions to specific problems, develop the capacity to problem-solve effectively in the future, and make health-beneficial change. (See figure #19—"The Person-Centred Approach".)

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[357] Prochaska, J.O. & DiClemente, C.C. Stages and processes of self-change in smoking: Toward an integrative model of change *(Journal of Consulting and Clinical Psychology, 1983) 51(3)*: 390-395.

The Person-Centred Approach

The Person-Centred Approach is a systemic, holistic approach that focuses on health not illness, empowers rather than cures, and promotes development of potentialities of individuals, groups and organisations through the process of making people responsible for what they do rather than allowing dependency.

The Person-Centred Approach recognises the person as being in charge of his own life and problems, and as being the one with the most data about his personal situation. The Person-Centred Approach recognises that the role of the professional is that of a facilitator, providing an environment which fosters growth and empowerment, enabling the client to explore and find solutions to his/her own problems.

The central hypothesis of the Person-Centred Approach is that individuals have within themselves vast resources for self-understanding and for altering their self-concepts, basic attitudes and self-directed behaviour, and that these resources can be tapped if a definable climate of facilitative psychological conditions is provided.[401]

The Person-Centred Approach leaves the locus of responsibility for change with the client. It is important for both the client and the facilitator to recognise that the client—the person with the problem, must be the one entrusted to create change. Leaving the locus of responsibility and control with the client reduces the likelihood of passive, rebellious or victim-like behaviour, and sets up a process wherein the client develops an increasing sense of ownership of his/her problem, responsibility for the problem, ability to respond proactively, willingness to explore possible solutions to the problem, and willingness to initiate actions to solve the problem for him/herself.

[Figure # 19 – The Person-Centred Approach]

10.3 Applying the Person-Centred Approach to Health Promotion

The World Health Organisation (WHO) underlines the importance of empowerment in the promotion of health. To achieve this, it is necessary that health actions are people-centred and the tools used are effective. The Person-Centred Approach has as its objectives, and embodies in its processes, the empowerment of individuals and groups, and utilizes tools with demonstrated effectiveness.

The Person-Centred Model recognises the primacy of the client in the process. Central to this is helping the client move toward recognizing for him/herself how the health is created through a host of bio psychosocial determinants; expanding the understanding of health resources and healthy behaviours; and moving toward decisions and adopting behaviours which support health and vitality. (See figure #20 on "Ingredients of a Facilitative Relationship"). Information and advice is seen as less important than providing the conditions that foster the client's growth and facilitate exploration. Furthermore, when the three facilitative conditions are present in the relationship, the client is more likely to use the health professional as a consultant in personal health decisions.

Ingredients of a Facilitative Relationship:

- ✓ Listening to the client with empathy and without any judgment
- ✓ Understanding the experience of the client and giving clear, understandable feedback
- ✓ Being natural and sincere in the relationship
- ✓ Being respectful and sensitive to the client's different cultural/gender values, etc.
- ✓ Facilitating client responsibility
- ✓ Facilitating informed choices
- ✓ Giving information that is valid, clear and transparent
- ✓ Facilitating empowerment of the client
- ✓ Facilitating self-awareness
- ✓ Clarifying values
- ✓ Facilitating attitudinal change
- ✓ Facilitating decision-making and problem-solving
- ✓ Facilitating behavioural change
- ✓ Facilitating compliance
- ✓ Facilitating long-term gain

[Figure #20—Ingredients of a Facilitative Relationship]

The task of the Person-Centred practitioner is to help the client make certain decisions and it also has the more ambitious goal of enabling the client to develop the capacity to solve problems in the present and the future.

Once the practitioner has evaluated that a person-centred counselling is in the best interests of the client, s/he will clarify the contract they need for creating a working alliance together. This contract specifies that the practitioner will offer

information that is appropriate and scientifically sound in a clear and transparent way, that the practitioner's task is to empower and support the client to learn how to make responsible, informed choices, and take more control over his life, and does not include instructing a passive client to follow orders and prescriptions.

To be effective, the health professional must understand the differences between Disease-Centred and a Person-Centred Medicine, the old and new constructs contrasted in the box below.

Disease-Centred Medicine or Person-Centred Medicine?

When we assess the cost-benefit ratio of the traditional biomedical model, its limitations appear alongside its undoubted strong points. Development of *medicine centred on the disease*—defined in purely biological terms—has led in practice to a failure to consider the person except in relation to the disease, and has assigned the person the passive role of patient who is diagnosed and treated by a medical professional. Many writers have criticised this "disease-centred" model and suggested the importance of changing perspective to "person-centred medicine" or "medicine centred on the patient or client" (Rogers, 1942, 1951; Szasz, 1956; Balint, 1957; Jaspers, 1959; Illich, 1976; Byrne, Long, 1976; Brown et al., 1986; Levenstein et al., 1986; Stewart et al., 1986; Stewart, Roter, 1989).

At the root of the proposal for *person-centred medicine* is the concept of the *client* or *patient/customer* seen as partner or *active agent* who is involved in the process of recovering psycho-physical equilibrium and the development of his health potential. The feelings, cognitions and expectations of the patient/client thus become important subjects to be explored in the process of attaining his/her health or therapeutic objectives.

[Figure #21 – Disease-Centred Medicine or Person-Centred Medicine?]

10.4 The Impact of Person-Centred Communication Skills with Clients

Communication skills are central to a Person-Centred Medicine. Those who like their physician's communication skills are overwhelmingly likely to be satisfied with the treatment experience in general.[358] Moreover, Lester and Smith[359] found a

[358] Korsch, B. & Negrete, V. Doctor-patient communication (*Sci Amer*., 1971), 227, 66-74.
[359] Lester, G. & Smith, S. Listening and talking to patients—a remedy for malpractice suits? (*West. J. Med*., 1993), 158, 268-272.

correlation between malpractice lawsuits and the quality of communication between physicians and patients, concluding that good communication may prevent lawsuits even when physicians have made an error, and that physicians may reduce their risk of lawsuits by changing the way they relate to patients.

Studies by Comstock et al.[360]and Korsch and Negrete[361]found that patient dissatisfaction and non-compliance were correlated with poor transmission of information from patient to doctor, low comprehension of communications from doctor to patient and low levels of recall by the patient. High levels of patient satisfaction were related to the physician's expression of warmth and courtesy, empathic and encouraging questions about patients' concerns and expectations, clarifying information from patients, and giving information to patients in language understandable to them. Non-compliance with prescribed medication regimens has been a significant cause of hospital admissions, and studies show compliance typically falls to about 50% by the second office visit and 30% by the fifth visit.[362] Up to 50% of patients typically leave a medical care clinic or doctor's office with little or no idea of what to do to care for themselves.[363] Korsch and Negrete[364]found that 54% of mothers satisfied with their relationships with their child' pediatrician complied with instructions whereas only 17% of unsatisfied ones complied with the treatment plan.

These studies detail the importance of communication skills, and their centrality to person-centred medicine, the empowerment of clients, and treatment outcome. (See also Chapters 8 & 15.)

10.5 Using the Person-Centred Communication Skills with Clients

It is important to dismiss the common misperception that communication skills represent a *technique*. As authenticity is one of the essential conditions for fostering growth, it is important that the Person-Centred practitioner operate from attitudes--toward the self and others--which reflect *an authentic way of being.*

Upon this foundation, *Empathic Listening* is instrumental to the facilitative process as it provides both empathy and acceptance which facilitate a climate of trust and understanding and plays a central role in the client's ability to resolve problems. It fosters the development of rapport, facilitates accurate data collection, enlists the client's full participation in a collaborative relationship,[365]and plays an important role in helping clients process their health concerns. When a practitioner allows a client

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[360] Comstock, L., Hooper, E., Goodwin, J.W. & Goodwin, J.S. Physician behaviors that correlate with patient satisfaction *(J. Med. Educ*., 1982), 57, 105-112.
[361] Korsch & Negrete, op. cit.
[362] Phillips, E. *Patient Compliance: New Light on Health Delivery Systems in Medicine and Psychotherapy*. (Lewiston, N.Y.: Hans Huber, 1988).
[363] Svarstad, B. *The Doctor-Patient Encounter: An observational study of communication and outcome* (Madison, WI: University of Wisconsin, Ph.D. diss., 1976).
[364] Korsch, B. & Negrete, op, cit.
[365] Bird, J. & Cohen-Cole, S. The three function model of the medical interview in: Hale, M. (ed.) Methods in teaching consultation-liaison psychiatry (*Adv. Psychosom. Med.*, 1990) 20, 65-88.

to express health concerns and feeds those back to him with empathy, the client feels understood and accepted. This allows the client to experience his feelings fully, thus opening the door to emotional release and the resulting ability to deal more rationally with his problem.

The self-disclosing *I-Message* is the communication skill that most clearly communicates genuineness, the third facilitative condition, and fosters the client's capacity to identify with and assume ownership of treatment plans.

Below is an example of an interaction with a diabetic patient in which the doctor uses both Empathic Listening and I-Messages interchangeably:

Doctor: *I see that your last blood sugar test was done three months ago. I am concerned about this as we don't have current data on your blood sugar levels and confused also as I thought we'd agreed you would check them every day.*
Patient: *I've been very busy and just forgot to do it. Also, I don't like pricking my finger as it hurts.*
Doctor: *So there have been many distracting things that made you forget to take the tests, plus the pain is a barrier for you also.*
Patient: *Yes. But besides forgetting, I didn't do the exam because I'm afraid that my glycaemic level is too high.*
Doctor: *So your fear about discovering that your glycaemic level might be high is so strong that you wanted to avoid looking at it*.
Patient: *Yes, and I also have difficulty adhering to my diet… and, at the same time, I'm very worried about what's going to happen to me.*
Doctor: *So it looks like you have some real problems with the testing and the diet plan… and, I'm very eager that we have regular monitoring of your blood sugar levels so we can intervene effectively to lower the risks that provoke concern in both of us. As for your diet, we can go through it again together and explore some creative changes that would make a healthy regimen easier for you to follow.*
Patient: *That would be good because I can't face being stuck with a rigid diet for my whole life! You know I work and I am continuously dining out and at restaurants with colleagues it's a little embarrassing to have to make such a big deal about my diet, so I would like to find a plan that I could live with.*
Doctor: *Okay, so you're interested in a plan that is practical as well as healthy. That's great. Meanwhile, in order to reduce the complications that you are concerned about, I will need your collaboration in taking regular blood sugar tests so that you can avoid complications from the diabetes. Perhaps it would help to discuss some new products that reduce difficulties some patients have with this. Would you like to explore these?*
Patient: *Yes, that sounds very good. I'm sorry that I haven't taken the blood tests—I guess I've been kind of childish about that… I do want to get a handle on this whole problem and stay in touch with what's going on with my blood sugar every day, and have a plan I can live with that will reduce future complications.*

This interaction is a communication that is personal, caring, and precise and one that does not contain harsh requests or increase the patient's sense of threat. This kind of communication diminishes the likelihood that the patient will become resistant, and increases the probability of better compliance. Unlike classic doctor/patient communications (e.g., "It's important that you follow my prescription or you will have serious consequences!"), the Empathic attitude of the doctor fosters openness to collaboration.

Fear-arousing messages, like the example above, encourage resistance,[366] increase the patient's denial that he/she has a health problem,[367] and can even increase the behaviours they were attempting to extinguish.[314] Counter-productive results can be avoided when health practitioners listen empathically and share concerns genuinely, instead of giving orders, lecturing, or filling patients with grim thoughts of what could happen if they don't change.

10.6 Criteria for Effective Client-Centred Facilitation

When beginning Health Promotion work with a client, it is important that the health practitioner bring to the relationship a range of skills. Besides the communication skills discussed, this will include skills in assessing readiness, setting goals, identifying barriers to change, contracting, and problem-solving. Furthermore, the health professional must be aware of the assumptions s/he brings to the process as these can thwart or scuttle the process if they are not recognised. Following are some common assumptions health promoters should be alert to when working with the client:[368]

- The **assumption that the client OUGHT to change**
  Because health promoters place a high value on health, it is easy to assume that the client shares this value and is interested in changing. The health professional should be congruent and transparent in expressing his/her values about the importance of health habits (through I-Messages) and also make it safe (through Empathic Listening) for the client to express his/her own values in that regard, which may differ.
- The **assumption that the client WANTS to change**
  Motivation is not an all-or-nothing phenomenon, but always a question a degree. It is important that the health professional explore with the client his/her motivation for change as this is a critical factor in the success of the process.

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[366] Franzkowiak, P. Risk taking and adolescent development (*Health Promotion*, 1987), 2: 51-60
[367] Soames-Job, R.F. Effective and ineffective use of fear in health promotion campaigns *(American Journal of Public Health*, 1988), 78: 163-7.
[368] Rollnick, S., Mason, P. & Butler, C. *Health Behavior Change: A Guide for Practitioners*. (Edinburgh: Churchill Livingstone, 1999), pg. 34.
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• The **assumption that the client's health is the prime motivating factor for him/her**
Regardless of how much the health professional wants the client to make lifestyle changes; this may not be a high priority for the client. The facilitation process cannot succeed unless the practitioner accepts the client's as s/he is.
• **The assumption that if the client does not decide to change, the consultation has failed**
Deciding to change is a process that occurs over time, not a single event. Simply helping a client explore his/her readiness to change may be an important contribution to a long-term process.
• **The assumption that clients are either motivated to change or not**
Motivation is a matter of degree. Readiness changes over time and is facilitated by understanding and acceptance (through Empathic Listening).
• **The assumption that now is the right time for the client to consider change**
Many factors influence the client's sense of when to initiate change. It is the health practitioner's job to facilitate the client in determining when this seems appropriate.
• **The assumption that a tough approach is best**
While a tough, directive approach can seem attractive, this engenders defensiveness and resistance and can scuttle the client's exploration process and the relationship itself.
• **The assumption that the health promoter is the expert and the client should follow professional advice**
One of the most important goals for the health professional is to empower the client in the process of becoming increasingly expert about his/her own health. In consultations about healthy behaviour change, the client should be in control and the health professional in the role of resource person.

In working with a client, there are key signs which indicate that the facilitation is "on track" and appropriate (see figure #22, adapted from Rollnick, Mason & Butler.[369])

[369] Rollnick, Mason & Butler, op. cit., pg. 34-36.

Signs of an Effective Health Promotion Process

- The Health Promotion practitioner is speaking slowly
- The client is doing much more talking than the practitioner
- The client is actively talking about behaviour change
- The practitioner is listening carefully, gently directing the process at appropriate moments
- The client appears to be "working hard", often realising things for the first time
- The client is actively asking for information and advice
- It feels that the practitioner is holding up a canvas and the client is filling it with paint, in places sometimes selected by the practitioner, and sometimes selected by the client

[Figure #22 -- Signs of an Effective Health Promotion Process]

10.7 An Example of Facilitation with a Client for the Promotion of Health

While working with a client and engaging in a process that empowers the client and minimises resistance, the health promotion practitioner utilises I-Messages, Empathic Listening and the problem-solving process in a varying pattern, as appropriate to the interaction. The following is a condensed model of how these skills might be used in a case involving a client with typical heart disease risk factors of obesity, high stress, a sedentary life style, and high cholesterol levels:

Practitioner (expressing her concern with an I-Message): *I'm worried that if you go on as you are doing now, you will have a serious heart attack and die, or have a life that is severely curtailed. And I would feel very sad if that happened.*
Client (predictably resistant): *You can't be serious! I never felt better in my life!*
Practitioner (switching to Empathic Listening to feed back accurately her understanding of the client's message): *You feel that a heart attack is a really remote possibility for you.*
Client: *Yes, my parents both lived until their late eighties, so I don't think I have much to worry about.*
Practitioner (continuing to Empathically Listen): *So you feel your parents' track record indicates that you'll probably be able to live as long as they did.*

Client (sounding less defensive now): *That's right.*
Practitioner (returning to the I-Message, now that client feels understood and accepted): *I hear your disbelief that you are in any danger, but in my opinion your health habits and your laboratory reports point to a very high risk of heart attack, and that really worries me. I don't want that to happen to you.*
Client (now more open to hearing the Practitioner's inputs): *Why don't you think that I'm immune from this even though my parents never did anything special and they both lived to a ripe old age?*

[At this point, the Practitioner has been given permission by the client to share his/her expertise, health perspectives, test data, and whatever insights s/he has developed concerning her client's health. S/he has been "bought" as a consultant and can proceed to explain the client's medical risks in greater detail. After doing this…]

Practitioner (continuing): *What are your thoughts and feelings, now?*
Client: *That sounds awfully scary, and it's hard for me to believe. When I came in for this check-up, I certainly didn't expect to get hit with anything like this.*
Practitioner (with empathy and acceptance): *I certainly hear that my diagnosis and concern come as a very unpleasant shock to you, and you just wish it weren't really true.*
Client: *Absolutely! I can hardly cope with the idea.*
Practitioner: *You just wish it would all go away.*
Client (more resigned): *Yeah. But I guess I need to deal with it, don't I?*
Practitioner: *I'm afraid so... Would you be willing to engage in problem-solving with me to look for an approach to this problem that would meet your needs and work for you?*
Client: *I guess so. What would that look like?*
Practitioner: *Well, I'd like to suggest we use a six-step process for discovering our needs in this situation—both yours and mine—and looking for solutions that would best meet them, using both of our heads to accomplish this. Sound okay?*
Client: *O.K. What's the first step?*
Practitioner: *Discovering your real needs in relation to the health of your heart. Can you articulate them?*
Client: *Well, I would like to reduce my risk of a heart attack if there's anything I can do that wouldn't be too hard.*
Practitioner: (Empathic Listening) *You want to protect your heart as much as possible without making adjustments to your lifestyle that would be too unacceptable.*
Client: *That's right. And I want to stay healthy enough to be able to enjoy my kids as they grow up.*
Practitioner: *I hear three needs of yours: to reduce heart attack risk; not have to reduce the quality if your life too drastically; and to be alive to enjoy*

your kids as they grow up. And my need is to help you make the medical and lifestyle decisions that have the best chance of meeting your goals. Now let's go to Step 2 in the process and generate some solutions.
Client: *O.K. How do we do that?*
Practitioner: *We look for solutions that might meet both our needs. The goal of this phase is creativity and quantity, and it doesn't matter who comes up with the ideas. But it is important that neither of us turn down a brainstorm at this point because that puts a damper on the creativity. O.K.?*
Client: *O.K. I could start by going back to playing basketball again with my buddies.*
Practitioner: *Okay, another idea is for me to give you some help to quit smoking.*
Client: *I could take 15-minute breaks to breathe deeply, and maybe learn how to meditate.*
Practitioner: *Yes, and maybe take some healthy cooking classes so you'd be eating more healthily.*
Client: *Quit eating altogether! … or become a vegetarian … and maybe join a gym.*
Practitioner: *Yes, and we can consider trying a cholesterol-lowering drug to help bring down your present levels. (etc., etc.)*

When a long list of possible solutions has been generated, the practitioner moves the process to Step 3, Evaluation, (see Figure 23—"The 6-Step Problem-Solving Process") which involves eliminating any solutions not acceptable to either the client or the practitioner.

This is followed by Step 4, Choosing the set of solutions that best promises to meet both parties' needs, as defined in Step 1. As a combination of solutions emerges, the practitioner might probe its appropriateness by saying,

Practitioner: *This set of ideas meets my needs to protect your heart. Does it meet yours? And are you willing to make the changes we've outlined?*

To make the plan practical, Step 4 may need to include thinking through ways to incorporate new behaviours, ways to overcome obstacles that appear, use of models as inspirational support or as examples of how to implement new behaviours, skill training programs, systems for self-monitoring and plans for relapse prevention.

In this stage, the practitioner again uses Empathic Listening and I-Messages to hear the client's thoughts and feelings and to state his own, back and forth, until a plan for action is developed. Then, in Step 5, an agreement is made for both parties to carry out their parts of the plan, and an appointment is made for Step 6, a time to evaluate the plan's progress and level of success.

6-Step Problem-Solving Process

1. **Define** the problem in terms of the *needs of all parties*
2. **Brainstorm** creatively *(without evaluation)* a large list of solutions that might meet all parties' needs
3. **Evaluate** and reality-test the solutions generated against the list of identified needs
4. **Choose** a solution or combination of solutions
5. Discuss and decide on how to **implement** the chosen solution(s)
6. Provide opportunity for **evaluating** how well the solution works

[Figure #23 -- 6-Step Problem-Solving Process]

At evaluation time, the client talks subjectively about how well the plan is going for him, the practitioner arranges for medical tests to obtain objective measures of progress, and the effectiveness of the plan is measured against those criteria.

Should problems remain, or new ones surface, the practitioner and client again work through the six steps of the process to find new or additional plans to solve any remaining problems.

When the health practitioner uses this facilitation process, the client continually experiences the acceptance, empathy, and genuineness which lower resistance to change, foster self-responsibility and the implementation of beneficial solutions. Whenever resistance arises, the practitioner's empathic understanding and acceptance helps diminish barriers to change.

Using this approach, there is no need for the practitioner to become an enforcer because the solutions selected are *acceptable to both parties.* Should the client fail to carry out the treatment plan, the most likely assumption is that his needs have not been fully or accurately identified or that s/he promised more than he was able to deliver. In either case, rather than finger pointing, the procedure is to return to the Six Steps of Problem-Solving.

10.8 Results of Client-Centred Facilitation for the Promotion of Health

In a review of the medical literature, Gordon and Edwards[370] found communication and problem-solving skills to have many benefits for health professionals:

[370] Gordon, T. & Edwards, W.S. *Making the Patient Your Partner: Communication Skills for Doctors and Other Caregivers*. (Westport, CT: Auburn House, 1995), pg. 9-10.

- Physicians gather much more accurate data and increase the number of correct diagnoses
- Patients/clients have more trust in the caregiver
- Clients' resistance to therapy and management is reduced
- Client catharsis and tension-release is facilitated
- Negative nonverbal communication with clients is reduced
- Client problem-solving is promoted
- Health professionals are more capable of helping patients cope in situations that exacerbate their disease
- Higher patient compliance with physicians' instructions
- Greater patient satisfaction with visits to physicians
- Physicians receive a higher assessment of their technical skills from patients
- Patients are less likely to become helpless, dependent, and depressed when hospitalised
- Patients change physicians less often and are more likely to return to the same practitioner
- Patients/clients are less resistant to treatment
- Patients are less likely to bring malpractice suits
- Patients are less likely to seek out quacks and faith healers
- Patients/clients are more likely to be optimistic and show a will to live

As we have seen, communication—good or bad—has a dramatic impact on the relationship between health practitioner and client, and to treatment outcome, and good communication skills are essential to creating the three criteria of a facilitative climate that are the foundation of a Person-Centred Medicine.

In addition to its appropriateness for working with individual clients, the Person-Centred Approach applies as well to the process of creating and implementing social changes inherent in any paradigm change. Although this application may be less obvious, it is in no way less crucial to the process of Health Promotion. The relative enormity of Health Promotion and the relatively small number of health professionals in the world make it essential to utilize the tools of facilitation and empowerment so that increasing numbers of people—in health delivery organisations, social organisations, business, and government—become empowered to empower others. To create meaningful progress toward the goals of the Ottawa Charter we must empower people throughout the world—both formally and informally—as health promoters.

Chapter 11—The Ethics of Health Promotion

> *"… if people in all walks of life… join forces in introducing strategies for health promotion, in line with the moral and social values that form the basis of this CHARTER, Health For All…. will become a reality."*
> WHO Ottawa Charter for Health Promotion

11.1 The Context of Professional Practice

The Ottawa Charter's definition of Health Promotion—as the process of empowering people to take more control over and improve their own health—circumvents some of the ethical dilemmas of the biomedical paradigm. Under that paradigm, ethical questions arise when, for example, the practitioner recognises the consequences of the client's lifestyle the client is unmotivated to change, when the practitioner intervenes against the patient's will, or when the practitioner attempts to generate motivation for behaviour change with a disinterested client. If the practitioner and client are at cross-purposes, ethical difficulties can arise.

Because the Person-Centred Approach works from the perspective that it is the client who determines his/her own agenda and readiness for change, and is an active decision-maker about courses of change, this orients the practitioner's work and clarifies some ethical dilemmas. Moreover, the health professional is not rendered inert when the client resists dealing with an important health issue as the confronting I-Message provides a potent, non-directive way of influencing the client to consider behaviour change while not crossing ethical barriers or trampling upon personal sensitive issues.

Within the context of this orientation, the work of empowering people and organisations must go hand in hand with ethical practice. To foster Health Promotion as a profession, we offer the following Code of Ethics.

11.2 International Health Promotion Association Code of Ethics[371]

PREAMBLE

The Health Promotion profession is dedicated to excellence in the practice of promoting individual, family, organisational, and community health and well-being. Guided by common ideals, Health Promoters are responsible for upholding the integrity and ethics of the profession as they face the daily challenges of decision-making. By acknowledging the value of diversity in society and embracing a cross-cultural approach, Health Promoters support the worth, dignity, potential, and uniqueness of all people.

The **Code of Ethics**[372] provides a framework of shared values within which Health Promotion is practiced. The Code of Ethics is grounded in fundamental ethical principles that underlie all health care services: respect for autonomy, promotion of social justice, active promotion of good, and avoidance of harm. The responsibility of each Health Promoter is to aspire to the highest possible standards of conduct and to encourage the ethical behaviour of all those with whom they work.

Regardless of job title, professional affiliation, work setting, or population

[371] Adapted from International Health Promotion Association Ethical Code, 1998.

served, *Health Promoters abide by these guidelines when making professional decisions*.

The Code of Ethics is intended to provide guidance for Health Promoters and standards of professional conduct that are applied by the INTERNATIONAL HEALTH PROMOTION ASSOCIATION (IHPA) and by other bodies that choose to adopt them.

The Code of Ethics is not intended to become a basis of civil liability. Violation of this Code of Ethics by a Health Promoter does not in and of itself determine whether the Health Promoter is liable in a court of law, whether a contract is enforceable, or whether or not other legal consequences should occur.

In the process of making decisions regarding their professional behaviour, Health Promoters must consider this Code of Ethics in addition to other applicable laws and state regulations. In applying the Code of Ethics to their professional work, Health Promoters may also consider other materials and guidelines that have been adopted or endorsed by scientific and professional organisations, the dictates of their own conscience, as well as consult with others within the field. If this Code of Ethics establishes a higher standard of conduct than is required by law, Health Promoters must meet the higher ethical standard. If Health Promoters' ethical responsibilities conflict with law, regulations, or other governing legal authorities, Health Promoters must make known their commitment to this Code of Ethics and take steps to resolve the conflict in a responsible manner. If the conflict is irresolvable through such means, Health Promoters may adhere to the requirements of the law, regulations, or other governing authority in keeping with basic principles of human rights.

ETHICAL STANDARDS

Article I: Resolving Ethical Issues

1.1 Misuse of Health Promoters' Work

If Health Promoters learn of any misuse or misrepresentation of their work, they take reasonable steps to correct or minimize the misuse or misrepresentation.

1.2 Conflicts Between Ethics and Law, Regulations, or Other Governing Legal Authority

If Health Promoters' ethical responsibilities conflicts with law, regulations, or other governing legal authority, Health Promoters make known their commitment to the Ethics Code and takes steps to resolve the conflict. If the conflict is irresolvable via such means, Health Promoters may adhere to the requirements of the law, regulations, or other governing legal authority.

1.3 Conflicts Between Ethics and Organisational Demands

If the demands of an organisation with which Health Promoters are affiliated or for whom they work, conflict with this Ethics Code, Health Promoters clarify the nature of the conflict, make known their commitment to the Code of Ethics, and to the extent feasible, resolve the conflict in a way that permits adherence to the Code of Ethics.

1.4 Informal Resolution of Ethical Violations

When Health Promoters believe that there may have been an ethical violation by another Health Promoter, they attempt to resolve the issue by bringing it to the attention of that individual, if an informal resolution appears appropriate and the intervention does not violate any confidentiality rights that may be involved.

1.5 Reporting Ethical Violations

If an apparent ethical violation has substantially harmed or is likely to substantially harm a person or organisation and is not appropriate for informal resolution under Standard 1.4, Health Promoters take further action appropriate to the situation. Such action might include referral to national committees on professional ethics, or to the appropriate institutional authorities.

1.6 Cooperating with Ethics Committees

Health Promoters cooperate in ethics investigations, proceedings, and resulting requirements of the INTERNATIONAL HEALTH PROMOTION

ASSOCIATION or any affiliated professional association to which they belong. In doing so, they address any confidentiality issues that are brought before them. Failure to co-operate is itself an ethics violation. However, making a request for deferment of adjudication of an ethics complaint pending the outcome of litigation does not alone constitute non cooperation.

1.7 Improper Complaints

Health Promoters do not file or encourage the filing of ethics complaints that are made with reckless disregard for or wilful ignorance of facts that would disprove the allegation.

Article II: Responsibility to the Public

A Health Promoter's ultimate responsibility is to educate people for the purpose of promoting, maintaining, and improving individual, family, and community health and well-being.

When a conflict arises among individuals, groups, organisations, agencies, or institutions, Health Promoters must consider all issues and give priority to those that promote wellness and quality of living through principles of self-determination and individual freedom of choice.

2.1 Health Promoters support the right of individuals to make informed decisions regarding health, as long as such decisions pose no threat to the health of others.

2.2 Health Promoters encourage actions and social policies that support and facilitate the best balance of benefits for all affected parties.

2.3 Health Promoters accurately communicate the potential benefits and consequences of the services and programs with which they are associated.

2.4 Health Promoters accept the responsibility to act on issues that can adversely affect the health of individuals, families, and communities.

2.5 Health Promoters are truthful about their qualifications and the limitations of their expertise and provide services consistent with their competencies.

2.6 Health Promoters protect the privacy and dignity of organisations, of institutions, and individuals and grant them privacy and confidentiality.

2.61 Maintaining Confidentiality

Health Promoters have a primary obligation and take reasonable precautions to protect confidential information obtained through or stored in any medium, recognizing that the extent and limits of confidentiality may be regulated by law or established by institutional rules or professional or scientific relationship.

2.62 Health Promoters discuss with clients and organisations with which they establish a scientific or professional relationship (1) the relevant limits of confidentiality and (2) the foreseeable uses of the information generated through their Health Promotion activities.

2.6.3 The discussion of confidentiality occurs at the outset of the relationship and thereafter as new circumstances may warrant.

2.6.4 Health Promoters who offer services, products, or information via electronic transmission inform clients of the risks to privacy and limits of confidentiality.

2.6.5 Health Promoters do everything possible to limit the risk of intrusion on privacy and specifically: 1) include in written and oral reports and consultations only information relevant to the purpose for which the communication is made. (2) Health Promoters discuss confidential information obtained in their work only for appropriate scientific or professional purposes and only with persons clearly concerned with such matters.

2.6.6 Health Promoters may disclose confidential information with the appropriate consent of the organisational client, the individual client, or another legally authorised person on behalf of the client, unless specifically prohibited by law.

2.6.7 Health Promoters disclose confidential information without the consent of the individual client only as mandated by law, or where permitted by law for a valid purpose such as to (1) provide needed professional

services; (2) obtain appropriate professional consultations; (3) protect the client or others from harm; or (4) obtain payment for services from a client, in which instance disclosure is limited to the minimum that is necessary to achieve the purpose.

2.6.8 When consulting with colleagues, (1) Health Promoters do not disclose confidential information that reasonably could lead to the identification of a client, research participant, or other person or organisation with whom they have a confidential relationship unless they have obtained the prior consent of the person or organisation or the disclosure cannot be avoided, and (2) they disclose information only to the extent necessary to achieve the purposes of the consultation.

2.6.9 Health Promoters do not disclose in their writings, lectures, or other public media, confidential, personally identifiable information concerning their clients, research participants, organisational clients, or other recipients of their services that they obtained during the course of their work, unless (1) they take reasonable steps to disguise the person or organisation, (2) the person or organisation has consented in writing, or (3) there is legal authorisation for doing so.

2.7 Health Promoters involve actively individuals, groups, and community in all the steps of the educational process in such a way that all the aspects of the process are understood clearly by everybody that can be impacted by them.

2.8 Health Promoters respect and recognise the right of others to hold different values, attitudes and opinions.

2.9 Health Promoters provide services with equality for all persons.

2.10 Health Promoters do not engage in sexual relationships with clients, students or supervisees.

Article III: Responsibility toward the Profession

Health Promoters are responsible for their professional behaviour, for the reputation of their profession, and for promoting ethical conduct among their colleagues.

3.1 Health Promoters maintain, improve, and expand their professional competence through continued study and education; membership, participation, and leadership in professional organisations; and involvement in issues related to the health of the public.

3.2 Health Promoters model and encourage non-discriminatory standards of behaviour in their interactions with others.

3.3 Health Promoters encourage and accept responsible critical discourse to protect and enhance the profession.

3.4 Health Promoters contribute to the development of the profession by sharing the processes and outcomes of their work.

3.5 Health Promoters are aware of possible professional conflicts of interest, exercise integrity in conflict situations, and do not manipulate or violate the rights of others.

3.6 Health Promoters give appropriate recognition to others for their professional contributions and achievements.

Article IV: Responsibility to Employers

Health Promoters recognises the boundaries of their professional competence and is accountable for their professional activities and actions.

4.1 Health Promoters accurately represent their qualifications and the qualifications of others whom they recommend.

4.2 Health Promoters use appropriate standards, theories, and guidelines as criteria when carrying out their professional responsibilities.

4.3 Health Promoters accurately represent potential service and program outcomes to employers.

4.4 Health Promoters anticipate and disclose competing commitments, conflicts of interest, and endorsement of products.

4.5 Health Promoters openly communicate to employers any expectations of job-related assignments that conflict with their professional ethics.

4.6 Health Promoters maintain competence in their areas of professional practice.

Article V: Responsibility in the Delivery of Health Promotion

Health Promoters endorse integrity in the delivery of Health Promotion. They respect the rights, dignity, confidentiality, and worth of all people by adapting strategies and methods to the needs of diverse populations and communities.

5.1 Health Promoters are sensitive to social and cultural diversity and are in accordance with the law when planning and implementing programs.

5.2 Health Promoters are informed of the latest advances in theory, research, and practice, and use strategies and methods that are grounded in and contribute to development of professional standards, theories, guidelines, statistics, and experience.

5.3 Health Promoters are committed to rigorous evaluation both of program effectiveness and the methods used to achieve results.

5.4 Health Promoters empower individuals to adopt healthy lifestyles through informed choice rather than by coercion or intimidation.

5.5 Health Promoters communicate the potential outcomes of proposed services, strategies, and pending decisions to all individuals who will be affected.

Article VI: Responsibility in Research and Evaluation

Health Promoters contribute to the health of the general population and to the advancement of their profession through research and evaluation activities. When planning and conducting research or evaluation, Health Promoters do so

in accordance with federal and state laws and regulations, organisational and institutional policies, and professional standards.

6.1 Health Promoters support principles and practices of research and evaluation that do no harm to individuals, groups, society, or the environment.

6.2 Health Promoters ensure that participation in research is voluntary and is based upon the informed consent of the participants.

6.3 Health Promoters respect the privacy, rights, and dignity of research participants, and honour commitments made to those participants.

6.4 Health Promoters treat all information obtained from participants as confidential unless otherwise required by law.

6.5 Health Promoters take credit, including authorship, only for work they have actually performed and give credit to the contributions of others.

6.6 Health Promoters who serve as research or evaluation consultants discuss their results only with those to whom they are providing service, unless maintaining such confidentiality would jeopardize the health or safety of others.

6.7 Health Promoters report the results of their research and evaluation objectively, accurately, and in a timely fashion.

Article VII: Responsibility in Professional Preparation

All professionals involved in the preparation and training of Health Promoters have an obligation to accord learners the same respect and treatment given other groups by providing quality education that benefits the profession and the public.

7.1 Health Promoters select students for professional preparation programs based upon equal opportunity for all, and the individual's academic performance, abilities, and potential contribution to the profession and the public's health.

7.2 Health Promoters strive to make the educational environment and culture conducive to the health of all involved, and free from sexual harassment and all forms of discrimination.

7.3 Health Promoters involved in professional training and l development engage in careful preparation; present material that is accurate, up-to-date, and timely; provide reasonable and timely feedback; state clear and reasonable expectations; and conduct fair assessments and evaluations of learners.

7.4 Health Promoters provide objective and accurate counselling to learners about career opportunities, development, and advancement, and assist learners in securing professional employment.

7.5 Health Promoters provide adequate supervision and meaningful opportunities for the professional development of learners.

Chapter 12 - Facilitating Change

> *"The prerequisites and prospects for health cannot be ensured by the health sector alone. More importantly, health promotion demands coordinated action by all concerned: by governments, by health and other social and economic sectors, by nongovernmental and voluntary organisation, by local authorities, by industry and by the media. People in all walks of life are involved as individuals, families and communities."*
>
> WHO Ottawa Charter for Health Promotion

Within the context of the Code of Ethics and its related values, skills and roles, health professionals must understand the process of change and the means of promoting it. In working with individual clients, this includes understanding how to help clients move beyond their personal barriers. In working with organisations and communities, this also includes knowing how to do force-field analyses, feasibility studies, skills in promoting health causes, using the media, lobbying, social marketing, project financing and promoting legislative changes.

12.1 Understanding Barriers to Change

Barriers to change occur at the personal, institutional and cultural levels and are manifest by resistance to new behaviours or policies. People are often reluctant to change their behaviours and frequently identify themselves with their values and lifestyles ("I never exercise—it's just not me"). Practitioners working in the biomedical health care system are understandably invested in that model and modes of practice. They have spent time, money and effort to gain certain expertise that is a precious component of who they are and wish to be as human beings. No one is eager to be separated from an investment of such magnitude unless s/he sees there is more to gain than lose in making a change.

Furthermore, the organisations biomedical practitioners work for hospitals, social service organisations, businesses, government agencies and are committed to the biomedical model through structure, policies, and ways of operating; their existence and financial viability as institutions are predicated upon that model. Anyone engaged in promoting change from the biomedical to the bio psychosocial paradigm can expect resistance both at individual and organisation levels.

12.2 Skills for Dealing with Resistance

The inevitability of client resistance during the process of exploring and instituting behaviour change calls for the skills and philosophy of the Person-Centred

Approach that provide a climate within which resistance is accepted, allowed full expression and nurtured into creative growth. When the practitioner supplies the conditions which enable the client to engage in genuine dialogue, the client experiences a safety that enables him to move beyond barriers to change, explore problems, and find appropriate and successful solutions to whatever problems are at hand, including the personal and institutional problems inherent in a paradigm shift. The skills that actualize Acceptance, Empathy, and Genuineness foster the creation of new realities, and facilitate the paradigm shift that brings reality to the health possibilities revealed by the bio psychosocial model.

12.3 The Facilitation Process

As the health promoter works with institutions and individuals, the logic and reach of the new paradigm will quickly convince some to move towards its adoption. But where it threatens others' interests or reveals conflicting needs, the health promoter must acknowledge the conflict, and use the conflict-resolution skills so that it can be resolved appropriately and successfully.

After identifying the existence of a conflict, the practitioners engages in problem exploration and identification through open-ended questions, Empathically Listening to the information and feelings revealed, and the self-disclosing I-Messages to make his/her needs and concerns clear. When the client understands that the goal of engagement is a *mutually acceptable solution*, not an imposed one, and experiences being accepted and understood, the intensity of resistance will decrease and the 6-Step Problem-Solving Process can begin. (See figure 23 in Chapter 10).

12.4 Community & Organisational Facilitation

Communities and organisations may have multiple needs and many persons who must be involved in the problem-solving process. The health professional must be aware of and comfortable with the fact that each player in a group has his/her own needs and concerns. This means that when the group is large and the constituency it represents is great, the up-front time needed to complete the problem-solving can represent a significant investment. This time is well spent in the long run, as when everyone's needs are identified and legitimized as important, there is much less resistance to implementing solutions chosen by the group. This saves considerable time at the back end and yields a far more successful result.

The temptation in any problem-solving situation is to rush to solutions, to jump ahead and argue persuasively on behalf of one's own favoured solutions, attempting to vanquish the arguments of others and sway them to one's perspective. Health professionals must resist the attractiveness of trying to impose their solutions—or anyone else's—on the client, and focus instead upon creating a process that maximizes the effectiveness of the group's wisdom and turns resistance into creativity.

The first step of problem definition is critical to successful outcome. For participants to be willing to implement solutions—to engage in behaviours which entail personal and organisational change—*they must be assured that the solutions they will eventually be involved in implementing will in fact meet their needs and those of their organisation*. Therefore, it is essential that all who will implement solutions be involved in the process so that their needs become part of the problem as defined, so each person identifies with and acknowledges the process, has confidence in the likelihood of a favourable outcome, and can willingly implement solutions chosen.

Meanwhile, it is critical that the group engaged in a problem-solving process contains the person or persons with sufficient authority to implement any solutions reached or that such a person be brought into the group when additional authority is needed.

By recognizing the inherent potential of individuals and groups and facilitating a process that enables growth to occur, the Person-Centred Approach empowers us to move beyond the limitations of the biomedical model and helps individuals, families, groups, and communities develop their full health potential.

Section VI
Applying the Person-Centred Model

Chapter 13 – Health Promotion & the Individual

> *"Health is created and lived by people within the settings of their everyday life; where they learn, work, play and love."*
>
> WHO Ottawa Charter for Health Promotion

13.1 Creating Health

The Ottawa Charter enshrined the idea of *health creation* as the cornerstone of Health Promotion and directs our efforts to *where health is created*—where people live their lives.[373] Health professionals should endeavour to establish relationships with all the persons and organisations throughout society which impact health. These include the individual, the family unit, the workplace, the community, the state and the international community. Each person in this system of relationships has unique opportunities to impact health in positive ways.

We will look again now at the key bio psychosocial determinants of health we discussed in chapters 7-10 and the tools Person-Centred health professionals can use to help their clients bring about behaviour changes that support health and well-being. In this chapter, we will look at work with the Individual.

13.2 The Individual

The Health Promoter who works with individuals will focus on ways to facilitate the development of the person's coping abilities, self-efficacy, self-esteem, hardiness, stress prevention and management, and the capacity to make informed decisions about nutrition, fitness and other lifestyle behaviours that compress morbidity and support health.

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[373] Ottawa Charter, op. cit.

13.3 Coping Skills

People who cope successfully have a battery of coping strategies and are able to gear their responses to the particular demands of the situation. They anticipate the long-range effects of their coping responses and make accurate, rational appraisals of stressful situations. Those who are do not cope, or cope ineffectively, have a paucity of coping responses, are irrational in their appraisals, and deny or avoid stressful situations. Successful coping does not result from the discovery of a single fool-proof response, but rather, from an attitude or philosophy of life. People who cope successfully teach themselves to use primary and secondary appraisal to ferret out the best coping responses for the life event they are facing.[374]

In assessing a potentially stressful situation, people make two types of coping appraisals—primary and secondary appraisal. *Primary appraisal* is a judgment about whether an event creates a sense of harm or loss. This is a product of the person's belief system and affects his emotional response. *Secondary appraisal* is the judgment as to whether or not the situation is changeable or controllable. Based upon how the client appraises the situation, s/he chooses one or more ways to cope with the perceived threat, ways that can either be functional or dysfunctional.

Functional coping responses include:

Seeking Social Support, Confronting, Distancing, Self-Control, Exercising, Self-Relaxation, Accepting Responsibility, Escape-Avoidance, Problem-Solving, Positive Reappraisal[375] (Also see figure 24.[376])

Dysfunctional responses include:

Demand for approval, High self-expectations, Blame-proneness, Emotional helplessness, anxious over concern, Problem avoidance, Dependency, Helplessness[377]

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[374] Kleinke, loc. cit.
[375] Goeppinger & Lorig, op. cit.
[376] Kleinke, op. cit., pg. 27-41.
[377] Kleinke, op. cit., pg. 17-18.

8 Basic Skills for Coping with Challenges

1. **Using Social Support Systems**
   e.g., "I had a good long cry about it with my best friend and somehow it seems easier to deal with now."

2. **Problem-Solving**
   e.g., "I figured out a plan that lets me tackle this one step at a time."

3. **Self-Relaxation**
   e.g., "Whenever it all gets to be too much, I go into my quiet place, take some deep breaths, and imagine a warm golden liquid washing all through my body."

4. **Maintaining Internal Control**
   e.g., "I don't let myself think about how bad it might get. I just focus on what I can do right now."

5. **Talking Yourself through Challenges**
   e.g., "I just tell myself: 'You've done it before; you can do it again'."

6. **Using a Sense of Humour**
   e.g., "Whenever I need a lift, I watch one particular TV show that always make me laugh."

7. **Exercising**
   e.g., "I notice that I always feel happier and emotionally stronger after I've had a good workout."

8. **Rewarding Yourself for Accomplishments**
   e.g., "For every 10 pounds I lose, I give myself a little shopping spree."

[Figure #24—8 Basic Skills for Coping]

Those who *seek social support* as a way to bolster their coping capacities surround themselves with supportive family and friends. Social support can bring benefits in direct aid, in emotional support, and caring, all of which are beneficial.

Confronting the reality of health risk or illness is not easy or pleasant for most people, yet it is a coping skill of enormous value and importance. By confronting a health problem directly, the individual empowers him/herself as being in charge of his life, gains fate control, and gains data about the problem and various ways of coping with it.

In *Distancing,* the client deals with his problem in a purely objective manner, not allowing it to engage his emotions or threaten his self-image. One way of doing this is to see others with the same disease as being completely different from oneself: "They may be suffering, but that has nothing to do with me—I'm not like them!"

Another coping mechanism is *self-control,* wherein the person determines to take control of and manage his illness, carrying out prescribed regimens, exercising, taking medications, etc. This strategy is favoured by health professionals, but, like all solutions to problems, must be embraced by the person with the problem and cannot

be successfully imposed no matter how much the health practitioner might like the client to employ this strategy.

Accepting responsibility for whatever contribution one's own behaviour makes towards prevention or recovery is another beneficial coping strategy (e.g., a heart patient giving up smoking and starting to exercise regularly). A counterproductive example is agonizing over the role smoking played in causing the disease—a form of victim (self-) blaming.

Problem-solving is a beneficial strategy where the health practitioner and client work together to define the problem and identify a wide-range of possible solutions to the problem, chose one or more solution which meet the client's needs (as well as the health practitioner's) and develop a plan for implementing the selected solution or solutions. (See discussions in Chapters 7 & 12.) Because this process entails the client being an active participant in the decision-making process, satisfaction with the chosen solutions is high, as is compliance.

Another successful means of coping with problems is *positive re-appraisal,* in which the client works on handling the situation and viewing the illness as a challenge or opportunity. In this process, the practitioner helps the client discover the *opportunity* inherent in his health situation, and to embrace the opportunity for growth, thus unleashing powers that would otherwise remain untapped.

Other functional coping strategies including *activity* and *distraction* as ways to cover pain, depression or difficulties in changing habits; *self-talk* as a means to engage self-fulfilling prophesy in a positive way; and *prayer* or *silent prayer* to engage other powers to help with problems the client feels are beyond his capacity.

A common characteristic of dysfunctional coping responses is that they tend to be rigid absolutes, containing "should", "must", and insistence on perfection. ("I must be number one or else I am not worthwhile"… "I shouldn't have to lean on anybody else"… "I should never give in to weakness"). Although it is not easy for clients to change maladaptive coping responses because thinking patterns are strongly ingrained habits, working to change and modify maladaptive constructs is an important focus of work between health practitioner and client.

Clients can change maladaptive responses by learning to make more reasonable primary appraisals which moderate negative emotions and reduce stress. Some strategies for overcoming maladaptive responses to primary appraisals include:[378]

Counters:

Self-statements to stop focusing on beliefs that are not functional or in the client's best interests, *e.g., "Nonsense!" "Stop!" "Get a grip!" "Just because I'm overweight doesn't mean I'm not loveable." "Don't put yourself down!"*

Alternative Interpretation:

Questioning your perception, or redefining your interpretation of a situation, especially when facing stress and challenge, *e.g., "Perhaps it wasn't that he didn't like me; maybe he was just in a bad mood." "I did very well. Coming in 5th out of 80*

[378] Kleinke, op. cit., pg. 21-23.

is actually a very high placement." "I can't expect myself to feel enthusiastic when I've been working non-stop for weeks."

Recognizing Worst-Case Scenarios:

Looking at the worst possible outcome of a situation and identifying what you could do to handle that, if it were to happen, as a means of putting into perspective your emotional responses to the current situation, *e.g., "So if it worked out that I did lose my job, that would give me the opportunity to re-evaluate what I'm doing with my life and I've been wanting to do that anyway." "If my husband died, I could go and live with my sister."*

Re-labelling:

Finding a different label that fits the situation and changes the emotional response to one that is easier to deal with, *e.g., Changing "fragile" to "sensitive" or "caring"; "compulsive" to "determined"; "hysterical" to exuberant"; "neurotic" to "normal"*

Making Rational Appraisals:

Altering an appraisal of a stressful situation for the sake of more liveable consequences, or practicing adaptive appraisals before being confronted with challenges, *e.g., "I don't know what I'm doing" to "I am a capable person who has faced many challenges and will continue to be able to do so"; "Life is just too overwhelming for me" to "I am sure I'll be able to find my path in life"; "I would never be able to handle it if I got breast cancer" to "My mother faced it and I can also."*

Another way to increase the quality of coping responses is to modify secondary appraisals. As secondary appraisals depend largely on the client's sense of self-esteem, competence and mastery,[379] this is discussed in section 13.6.

Coping strategies are of importance to clients with health issues including stress, depression, anger, loneliness, aging, grieving, pain, injury and trauma, surgery, chronic illness, as well as managing behaviour changes that maintain health. Like any other skills, coping skills are learned behaviours, social constructs that can be taught through a variety of means. Because of their significance to health, they deserve serious attention in any Health Promotion program.

13.4 Self-Efficacy

Self-efficacy is crucial to a person's capacity to change health-risk behaviours, and should be a focus of Health Promotion programs.

The likelihood that a client will adopt a healthy behaviour or give up a detrimental habit is connected to three sets of cognitions:

1) the perception that he/she is at risk

2) the expectancy that behavioural change will reduce the threat

[379] Kleinke, op. cit., pg. 23.

3) the belief that she is sufficiently capable of exercising control over the risky habit.[380]

The concept of Self-Efficacy is based upon the latter belief. In adopting a desired behaviour, individuals must first form an intention to act, and then make the actual behaviour change; self-efficacy is central to both. Ongoing maintenance of healthy change is also a function of outcome expectancies and personal efficacy beliefs.

There are four efficacy-enhancing mechanisms: 1) Skills mastery; 2) Modelling; 3) Re-interpretation of Physiological Signs and Symptoms; 4) Persuasion.

Skills mastery is considered the most powerful way of enhancing self-efficacy and can be accomplished by means of a contract between practitioner and client regarding specific behaviours to be mastered. In alignment with the Person-Centred Approach, such contracts should be client-driven, with the goals and action plan decided upon by the client with the support of the health professional. Consulting sessions are scheduled for the purpose of helping the client succeed with the contract s/he makes, for assessing successes and problems, identifying mid-course modifications to the program, and setting performance goals for the subsequent week.

Modelling is the process of identifying with another person and recognising that s/he has developed some skill(s) that would be of benefit to one's own life. Modelling is an effective way to enhance efficacy and change behaviour. Modelling can have a powerful impact, although the full extent of its influence may unfold slowly over a period of time. Practitioners who wish to foster modelling as a means of encouraging behaviour change in clients should match models for age, sex, ethnic origin, and socioeconomic status. Another approach to modelling is through group members who help each other—a formula used in medical self-help groups of all kinds. Experts caution against the use of "super achiever models" whose stories are inspirational but difficult for others to identify with.

It is important for health professionals to be sensitive to the importance of their personal impact as a model so that who they are as a person matches the practices they espouse for their clients, and so they speak authentically and work realistically in helping clients move toward healthy decisions and practices.

Re-interpretation of Physiological Signs and Symptoms involves identifying self-defeating beliefs which are based on the client's unduly pessimistic interpretations of his symptoms and then helping him/her re-interpret them more realistically and see behaviour change as a way to reduce the threat (e.g., helping a patient with mild angina stop interpreting every twinge as an incipient heart attack and recognise the potential benefits of lifestyle changes).

Persuasion is a familiar mode for enhancing efficacy and can be effective if the practitioner is aware of the risk of failure if the client's resistance is not allowed to be expressed. It is common to attempt to bolster a client's belief in his/she ability to make needed change ("I'm sure you'll be able to lose 30 pounds without much

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[380] Schwarzer, R. & Fuchs, R. Changing risk behaviors and adopting health behaviors: The role of self-efficacy beliefs, in: Bandura, A . *Self-Efficacy in Changing Societies*. (Cambridge: Cambridge University Press, 1995).

difficulty") but fail to recognise the client's subterranean resistance, not deal with it, and wrongly assume the client's self-efficacy is equal to the task. As with other kinds of advice or persuasion, it is essential to recognise that direct attempts to strengthen a client's belief in his own efficacy are beneficial only if welcomed.

Within a facilitative relationship where the client is free to explore options and express his response to them, the four means for enhancing self-efficacy are important to the promotion of health.

13.5 Hardiness

Hardiness recognises that people can be taught sensible, straightforward information about how to become stronger and more resourceful in dealing with stressful circumstances in their lives and be less likely to suffer illness as a result. Increasing Hardiness entails understanding the difference between what Maddi sees as non-hardy and hardy ways of handling stressful circumstances.

The non-hardy mode for handling stress is to allow mental and physical tension caused by the stressor to build without undertaking healthy countermeasures, along with ineffective coping measures (e.g., denial or avoidance), rather than tackling the problem directly. Persons exhibiting non-hardy characteristics in the face of disruptive changes in their lives or the presence of unresolved conflicts are shown by Maddi's research to be more vulnerable to wellness breakdown than those with hardier coping styles.

Maddi's prescription for a hardier response attacks the problem on four fronts:

1) Achieving better perspective and understanding, and undertaking decisive action (called HardiCoping™);

2) *Committing to cope effectively, taking control, and accepting the stressor as a challenge to be dealt with* (HardiAttitudes™);

3) *Actively seeking assistance and encouragement from others* (Hardy Social Support); and

4) *Taking effective measures to minimise the negative health and performance effects of the mental and physical strain involved*, such as relaxation skills, regular exercise, and healthy nutrition, including the use of appropriate vitamin and mineral supplements. (Note: Hardiness is also affected by genetic vulnerabilities that are not addressed by the Hardiness Model).

Maddi has found that wellness breakdown, either physical or mental, does not occur if the person has sufficient resistance to buffer the debilitating effects of stress and strain, and the hardiness prescription described above is designed to develop that resistance. Maddi reports that resistance factors "form an interlocking system in which hardy attitudes and hardy social support not only motivate hardy coping and hardy health practices but are, in turn, deepened by these practices."[381] (To review Maddi's construct, see Figure #13, Chapter 8.)

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[381] Maddi, S. Comments on Trends in Hardiness Research and Theorizing (*Consulting Psychology Journal: Practice and Research*, Spring 1999), pg. 68.

Health practitioners with a good understanding of Maddi's Hardiness® Model and who work with Person-Centred consulting skills can help clients become hardier copers. Because Hardiness mitigates stress-related illness and fosters the development of key health behaviours, this is an important focus for health practitioners. (For more information, including seminars offered by the Hardiness Institute, see index of resources at back of this book.)

13.6 Self-Esteem

Self-esteem affects a person's attitudes, expectations, decisions and performance. Self-esteem pioneer Nathaniel Branden believes that it has such impact on health and well-being that he refers to self-esteem as "the immune system of consciousness"[382] that helps to create resilience in the face of life's difficulties. Self-esteem also affects self-efficacy and the ability to undertake and persist in healthy behaviour changes. For all these reasons, health practitioners should work to foster their clients' self-esteem.

Carlock and Frey [383] present a model for the development of self-esteem that consists of four successive stages of intervention: *Identity, Strengths and Weaknesses, Nurturance, and Maintenance.*

Identity refers to an awareness and willingness to look at oneself honestly and in some depth. Fostered by Empathy and Acceptance, as well as the practitioner sharing honestly and congruently relevant data and observations, the client increases his self-awareness of salient health issues.

Once self-awareness is expanded, the next step is to explore the areas of *Strength and Weakness*. During this phase, it is beneficial for the client to see a *variegation* of strengths—an interplay of strengths and weaknesses, like the patterns of an interesting mosaic. Such a realistic view of the self enhances a stable self-esteem.

Tasks of the *Nurturance* phase are to internalize this new identity, with its more accurate view of personal strengths and weaknesses, and develop skills for nurturing oneself, including breaking down faulty logic, developing supportive relationships, and harnessing self-fulfilling prophecy as a means to support health and well-being.[384] A further focus is to encourage the client to nurture his or her newly found identity by using affirmations remembered from previous positive experiences for self-support in less positive environments.

During the *Maintenance* phase, it is important for the client to recognise that self-esteem is not a rigid, fixed concept but a process of evolution which changes as one matures, and to recognise the importance of regular self-esteem maintenance, just as with a house, car or interpersonal relationship. The process of maintenance must also embrace times of backsliding and *provide for oneself an internal climate of psychological comfort and safety* during times of threat to self-esteem. Maintenance also involves learning how to turn experiences into learning situations, practice beneficial

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[382] Branden, N. *Our Urgent Need for Self-Esteem* http://www.nathanielbranden.net, February 2,2002.
[383] Frey, D. & Carlock, C.J. *Enhancing Self Esteem* (Muncie, IN: Accelerated Development, Inc., 1989).
[384] Howell, P. *Management and Self-Esteem Workshop* (Encinitas, CA: Howell-Jones Trainings, 1995).

risk taking, set appropriate goals, forecast desired personal outcomes, and publicly affirm goals.

A common mistake for practitioners is to start interventions at the fourth-phase, examining beneficial risk taking and learning from experience. However, clients with low self-esteem generally risk too little or too much if they begin the process at this stage and are unable to set appropriate goals. Under these circumstances, predictable disappointments and failures are likely to lower the client's self-esteem and health goals are less likely to be achieved. By going through the first three steps of the model, the practitioner helps the client create within him/herself conditions in which risk taking, inherent in all processes of change, can realistically and beneficially be managed.

This developmental model for enhancing self-esteem, supported by the health practitioner's facilitation skills, enables the client to develop a realistic awareness of himself as a person with strengths and weaknesses, both physical and psychological, and as a person who needs to be self-nourished as s/he faces change and challenge. This process fosters the establishment of realistic health goals, and a resilient person who is able to move confidently along the path toward changes that enhance health.

While most work in self-esteem is done on a one-to-one basis or with small groups, the California Task Force to Promote Self-Esteem and Personal and Social Responsibility, initiated in 1988 by assemblyman John Vasconcellos, is a pioneering example of a broad-based public effort to improve health and cultivate healthy communities by enhancing self-esteem.[385]

13.7 Stress Management

Stress Management and Stress Prevention should be included in Health Promotion programs as stressors abound in modern life and how people deal with them has significant impact on health. Stress Management programs generally include several components: *Identification of Stressors and Stress Symptoms; Development of Relaxation Skills; Exercise; Nutrition; Reframing Thoughts; Communication Skills; Social Support; Self-Care*. In addition, health professionals may also work with clients to *reduce exposure to stressors, avoid burnout, enhance clients' ability to find pleasure in other activities, improve coping abilities, self-efficacy, hardiness, and self-esteem*. Each component contributes to stress reduction and thus, to increased health and vitality.

Identification of Stressors can be done through checklists in which the client assesses work stressors, stressors in his/her personal life, health concerns, specific physical, emotional and behavioural responses to stress, symptoms of depression and anxiety. Work stressors may include difficult work relationships, exclusion from the decision-making process, job conflicts with social/family obligations, unpleasant or unsafe work environment/commute to work, problems with workload,

[385] Mecca, A.M., Smelser, N.J. & Vasconcellos, J. (eds.) *The Social Importance of Self-Esteem*. (Berkeley, CA: University of California Press, 1989).

discrimination at work, lack of appreciation for work, lack of job security, change in job, inadequate pay, or inadequate intrinsic rewards from work.[386]

Stressors in personal life include problems with family relations, social isolation, difficulty getting needs met in key relationships, employment problems, financial problems, housing problems, lack of free time, and concern about family members.

Stress symptoms can manifest in a variety of ways and it is important for clients to develop the capacity to recognise personal responses to stress. Responses are categorised as physical, psychological, and behavioural.[387] The boxes below identify several common responses to stress.

SOME PHYSICAL RESPONSES TO STRESS:

C*ardiovascular*—rapid/shallow breathing, tightness in chest, heart pounding, high blood pressure

Vascular—migraine headache, tension headache, clammy hands/feet

Gastrointestinal: diarrhoea, constipation, burping, flatulence, colitis, indigestion, ulcers

Muscular—backache, neck pain, muscle tension, jaw pain/tension

Neurological—tics/tremors, dizziness, dry mouth

Dermatological-Immunological—frequent colds, increase in allergies

Other—increase in urge to urinate, menstrual distress/PMS, asthma, fatigue, sleeping difficulties

[Figure #25: Some Physiological Responses to Stress]

SOME PSYCHOLOGICAL RESPONSES TO STRESS:

Low Energy Responses—depression, hopelessness, powerlessness, feeling of little personal value, bored, fearful

[Figure #26 -- Some Psychological Responses to Stress]

[386] O'Hara, V. *Wellness 9 to 5*. (New York: MJF Books, 1995), pg. 28-30.
[387] O'Hara, op. cit., pg. 34-38.

SOME BEHAVIORAL RESPONSES TO STRESS:

Teeth grinding, procrastination, irregular eating habits, clenching fists, nail biting, rapid or loud talking, emotional overreaction, failure to complete projects, doing several things simultaneously

[Figure #27 -- Some Behavioural Responses to Stress]

After the client has identified his own stress reactions and developed a personal stress profile, the next step is to learn *relaxation techniques and other practices that reduce these symptoms of stress*.

Proper breathing is a key part of stress management. The Menninger Clinic states that "learning to be aware of your breathing and practicing healthier breathing techniques is an important step toward gaining optimal health and self-regulation over the physical and mental effects of the stress response.[388] Conscious breathing exercises bring people into the present moment and affect mood, increase oxygen flow, quiet the mind, reduce physical tension, and improve general physical health.[389]

A simple breathing exercise is to sit upright in a relaxed state and count to twelve with each inhale and each exhale. Time both actions so that each intake or exhalation is smoothly completed during the count from one to eight, followed by holding your breath during the count from nine to twelve. It takes concentration and practice to make the breath exchanges last exactly eight counts, and the four-count motionless periods have a calming effect. Repeated ten to twenty times, this is a quick and effective form of meditation. (See box below for other quick stress relief techniques.[390])

[388] Menninger Clinic, Center for Applied Psychophysiology. *Breathing and the Stress Response*. (Topeka, KS: The Menninger Clinic, Center for Applied Psychophysiology).
[389] O'Hara, op. cit., pg. 64.
[390] *The Health Promotion & Wellness Newsletter*. (Birmingham, AL: Oakstone Publishing, LLC, 1999).

For Quick Stress Relief

The Scalp Soother: Place thumbs behind your ears and spread fingers on top of your head. Move your scalp back and forth slightly by making circles with your fingertips for 15-20 seconds.

The Eye Easer: Close your eyes and place your ring fingers directly under your eyebrows, near the bridge of your nose. Slowly increase pressure for five seconds, then gently release. Repeat 2-3 times.

The Shoulder Saver: Place your left hand on the right side of your neck by your shoulder. Press fingers firmly into the muscle while tucking your chin in toward your chest. Exhale and hold for 10 seconds, release, then repeat on the left side.

The Palm Pleaser: Lace your fingers together, leaving thumbs free. Slowly knead your left thumb into the palm of your right hand for 20-30 seconds. Then repeat on your left hand.

[Figure #28—For Quick Stress Relief]

Relaxation Techniques are closely related to breathing techniques and are often built upon them. One of the best known is Jacobson's Progressive Muscle Relaxation (PMR), a process of progressively contracting and relaxing major muscle groups, depending upon specific therapeutic needs. Relaxation techniques and proper breathing, conducted in a quiet setting, with the mind focused progressively on specific body parts, is a brief, effective process that elicits the relaxation response and reduces symptoms of stress.

Stress Reduction techniques should focus on relaxing the mind as well as the body. The mind can be relaxed by playing soft music and engaging in the process of visualisation. *Visualization* consists of imagining one's self in a place of comfort, beauty and tranquillity, surrounded by a nurturing environment, experiencing a refreshing mini-vacation from the stresses of daily life. Visualisation is a powerful tool for replacing negative images and thoughts with ones that nurture and de-stress.

Meditation is another technique that calms the mind and relieves stress symptoms. Meditation is the practice of continually attempting to keep the attention on one designated thought, object or image. Meditation is also thought of as "mindfulness," a practice of anchoring attention in the breath and then passively observing thoughts, feelings, perceptions, and sensations without judgment.[391] People who meditate show increased productivity, reduced irritability and improved ability to cope with job pressures.[392] Others report more joy, increased peace of

[391] Borysenko, op. cit., pg. 90.
[392] Lowlier, J. Meditation 'takes the edge off' at Work (*USA Today*, 18 June 1993).

mind, clearer sense of purpose, and reduction of multiple stress symptoms through the elicitation of the relaxation response.[393]

Mindfulness can be practiced by choosing a routine daily activity and doing it mindfully—somewhat like a meditation. Another approach is cultivating awareness of where your mind is and then making a choice about where you want it to be, or focusing on breathing and your experience of being. Being *in the moment*, at one with your own breathing, holds the mind still as you open your attention to what is around you and experience the moment.[394]

Another form of meditation is *Quiet Time*—time spent walking, gardening, doing crossword puzzles, watching the sunset, any pleasant activity that allows the person to be "in the present" and not worried. *Creative Time* is an adaptation of meditation, a time for pleasurable hobbies or other forms of self-expression that release pent-up emotions and worries, and foster renewed energy. *Journaling* helps people clarify their thoughts and feelings and is beneficial as a release for stress.

It has been observed that "Stress begins between the ears," recognition that the way people perceive things affects their moods and the amount of stress they experience. Because perceptions are not based upon reality per se but upon personal beliefs, assumptions, values, and conditioning, stress can be reduced by a technique called *Reframing Thoughts*. Examples include *changing negative self-talk* ("I am not a loser; I did the best I could")*; replacing distorted thought patterns* (e.g., black and white thinking, tunnel vision, negative interpretation, exaggeration, personalising*); accepting what cannot be changed and learning to let go; regaining control of thoughts* (by taking scheduled "Worry Breaks"); *using affirmation to neutralise mind traps;* and *using creative imagination to release catastrophising* (exaggerated worrying) and the tension it creates.

It is also beneficial to work with clients to develop their communication skills, starting with identification of feelings and recognition of bodily signs that reflect feelings. Once the client has developed a greater "feelings vocabulary" and success at identifying feelings while s/he is experiencing them, effective communication plays three important roles in stress reduction: (see Communication Skills in Chapters 7 & 14):

1) it enables a return to physiological and emotional stability, which occurs once the person has been able to ventilate honestly about something bothering him—in common parlance, "Getting it off your chest";
2) it increases the likelihood of another person responding sensitively, caringly and helpfully, and reduces the likelihood of problems escalating out of control;
3) it increases closeness and caring in personal relationships—important because social support is an important buffer against stress.[395]

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[393] O'Hara, op. cit., pg. 85.
[394] Borysenko, op. cit., pg. 93.
[395] Witmer, J.M. & Sweeney, T.J. A Holistic Model for Wellness and Prevention over the Life Span (*Journal of Counseling and Development,* 1992), 71:2.

Once clients learn these stress reduction skills, it is important that they make a commitment to following these practices in their daily lives so that they develop a more Stress-Hardy Personality. Stress Management programs should also include exercise and nutritional practices to help support the body's strength and resiliency.

13.8 Learned Helplessness Theory

Learned Helplessness, as identified by Seligman[396]and Maier, refers to a person's perception that his/her actions are powerless to alter the course of illness, leading to a sense of ineffectuality or helplessness. When this develops in a person, s/he ceases to focus on how to better the situation and remains the passive recipient of whatever takes place. As this has been shown to contribute to a worsened prognosis, an awareness of the dynamic of learned helplessness is important for health professionals seeking to empower their clients.

Learned helplessness is most likely to occur in illnesses where the relationship between client behaviour and clinical outcome is naturally weak. Examples include Multiple Sclerosis, which has an unpredictable course of exacerbations and remissions, and coronary artery disease and cancer, which develop over many years before symptoms occur.

While the Learned Helplessness notion does not directly suggest interventions or coping behaviours to handle the problem, it does explain a common human response to health problems, especially when the client believes there is nothing s/he can do to help the situation, which Lorig and Laurin[397]call "non-contingency".

The value of the Learned Helplessness model is that it allows the health practitioner to identify and label this type of self-defeating behaviour, and help the client work toward a healthier, more pro-active stance in managing illness.

13.9 Lifestyle Change

The process for helping clients make lifestyle changes is similar to the process described earlier for helping clients increase self-esteem. The essential ingredients are providing the three conditions that help clients grow and recognising that it is the client who is in charge of the process. The role of the practitioner is to provide a climate of psychological safety, accurate medical data and personal feedback when asked for by the client and appropriate to the process, and help the client explore alternatives that better meet his/her health goals. As with other aspects of Health Promotion, the practitioner is a resource for the client, not the person in charge of the process of change.

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[396] Seligman, M. *Helplessness: On Depression, Development, and Death* (San Francisco: W.H. Freeman, 1975.)

[397] Lorig, K. & Laurin, J. Some Notions about Assumptions Underlying Health Education (*Health Education Quarterly*, 1985), 12(3): 231-243.

Chapter 14 – Health Promotion & the Family

"Enabling people to learn, throughout life, to prepare themselves for all its stages and to cope with chronic illness and injuries is essential. This has to be facilitated in school, home, work and community settings."
WHO Ottawa Charter for Health Promotion

14.1 Health within the Family

The family is a powerful influence on the way individuals develop their health habits, dental and body hygiene practices, nutritional patterns, sleep habits, ways of relating to their body, self-medication, organisation of time, and beliefs about life, health, education, sexuality, relationships, and self-care. The family also influences its members' coping styles, self image, self-efficacy, self-esteem, as well as assertiveness and communication skills. A stable, caring and non-stressful family environment is an important support structure that helps children cope with the stresses of childhood and adolescence, and resist seeking immediate gratification in health-endangering habits such as smoking, junk food and high-risk sex.[398]

The family should be seen as a basic engine of each individual's construction of reality. In fact, the powerful impact of family explains how people within the same culture may have numerous differences due to learning and expectations in their family of origin. Important health-related subjects for families include habits regarding nutrition and eating, exercise, child rearing, sexuality, family planning and family communication.

14.2 Nutrition & Eating Habits

Food for the soul is whatever food people learn to love in their childhood. Its value lies not only in its good taste but also in the experience of having it prepared within the context of family love and caring. Nutritional preferences and habits are developed within family life and it is important that what becomes defined as "soul food" is nutritionally beneficial.

Most evidence suggests that nutritional education per se is not the most important parental influence on children's eating behaviour. Rather, it is the entirety of the *food-processing cycle* which includes selecting, shopping, storing, preparing, serving, interacting during meals, cleaning up, accompanied by companionship,

[398] Pratt, L. The social support functions of the family, in: Badura & Kickbusch, op. cit., pg. 244.

modelling and other modes of interaction—routines which provide "abundant and regular opportunities for family members to influence each other."[399]

Programs that focus on family nutrition have long been considered important and can become increasingly valuable if the health practitioner works by means of the Person-Centred Approach. One family member's good nutritional intentions can be scuttled by resistance from others in the family. When the practitioner works from this model, the family explores together their various dietary needs, desires, and complications, and decides upon and implements desired dietary changes. It is preferable to work with whole families as this enables each family member to specify his specific needs and come up with a nutrition plan that will work for everyone and with which every family member will be satisfied.

14.3 Exercise

The exercise habits of children are more dependent upon physical exercise being carried out within the family than on receiving encouragement or support to exercise. Behavioural modelling promotes physical exercise as a lifelong activity. Children whose parents are involved in sports are more likely to be athletically active as adults than those whose are not. Unfortunately, a child/youth fitness study in the U.S. found that a majority of mothers (58%) and fathers (62%) do not exercise with their child in a typical week, and less than one quarter exercise with their child two days a week for 20 minutes or more.[400] Millions of parents are not modelling patterns of healthy exercise.

Although well-intended exercise programs are notoriously plagued by drop-out, the Person-Centred Approach helps circumvent problems and empowers each family member take charge of his/her own life and develop beneficial health habits. Family consultations around exercise can explore ways for families to include exercise in the activities they enjoy together, and using the practitioner for data and help in developing programs they can follow. This approach enables the family to make exercise a family-based value that adds to their enjoyment as a family unit while at the same time benefiting the health of each member.

14.4 Child Rearing

Programs which help parents raise children with high self-esteem should be encouraged as early in the parenting relationship as possible, before destructive patterns are established. Parent Effectiveness Training (P.E.T.),[401] based upon the Person-Centred Model, is the best known and most widely available, and has been proven to help parents communicate better with their children, increase mutual

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[399] Pratt, op. cit., pg. 235.
[400] Pratt, op. cit., pg. 237.
[401] Gordon, T. *P.E.T., Parent Effectiveness Training: The Tested New Way to Raise Responsible Children*. (New York: Peter H. Wyden, Inc., 1970; 30th anniversary edition, 2000.)

cooperation and problem-solving, and foster a successful parent-child relationship (see Gordon Training information in appendix).

Health professionals can also play important roles in educating parents about healthy eating habits for children, family play time and exercise activities, and ways to foster children's educational attainment, coping skills, self-efficacy and hardiness. As more parenting mistakes are made from ignorance than malevolence, health professionals who establish a relationship of trust with the parents in their health practice can become a valuable resource for parents and families.

14.5 Sexuality

Sexual choices have important and far-reaching health impact and health practitioners have important roles to play in educating clients about healthy sexual practices and making conscious and informed decisions. However, there is perhaps no other human interaction about which people have so much discomfort, so it is essential for the health practitioner to develop a foundation of trust through Person-Centred facilitation skills. Traditional sex education programs have erred on the side of presenting data and advice rather than building relationships that clients can use to help them sort through the complex issues around dating and mate selection, sexual impulses and fears, sexual relations and relationships, sexual satisfactions and risks.

An aspect of sexuality and sexual relationships that should not be under-emphasised is the empowerment of young women about sexual decision-making and verbal communications about sex. Assertiveness is a skill many young women do not acquire and which can result in unwanted sexual experiences with numerous undesirable psychological and physical consequences. Sexual Assertiveness programs can be an important source of empowerment for young women and an important component of Health Promotion. (See box below for examples of HIV interventions.[402])

[402] Bennett & Murphy, op. cit., pg. 71-72.

Two Approaches for Preventing HIV Transmission

Behaviour Rehearsal

Weisse et al. (1995) worked with young adults in an AIDS prevention workshop aimed at reducing embarrassment while purchasing condoms, and encouraging their use. Half of the group practiced purchasing at nearby shops. All participants demonstrated greater knowledge about AIDS and more positive attitudes toward the use of condoms, but only the group who had practiced purchasing condoms during the workshop showed an effect that endured over time. The authors concluded that AIDS prevention workshops can lead to transient changes unless specific skills are both discussed *and* practiced.

Outreach Contact.

Blakey and Frankland (1995) studied prostitutes in Wales where a health worker informally met prostitutes on the street for a period of four years, giving information about the prevention of HIV infection, providing condoms, and discussing strategies for the women to encourage safer sex practices with clients. The prostitutes increased use of condoms and safer drug use through needle exchange. One third also passed along information to their clients about HIV prevention.

[Figure #29 – Two Approaches for Preventing HIV Transmission]

The health professional is also an important resource for couples seeking consultation about family planning. The delicate, complex subject of family planning benefits from the safety Person-Centred skills bring, helping couples explore family planning decisions that will work for them, reduce health risks and unwanted pregnancies, and increase the likelihood of desired ones.

Worldwide population growth increasingly becomes a major threat to health, with unwanted children placing a burden not only on the family but also upon the resources of society and the planet itself. Some epidemiologists now predict that in the twenty-first century, the effects of overpopulation will become one of the top three threats to global health (along with pollution and poverty). Worldwide population growth is predicted to result in a population of 10-12 billion people within the next century, placing even greater demand on the world's climate and resources, which along with pollution and poverty combine to create an increasingly negative impact on global health.[403] Thus, family planning is a focus of great importance for Health Promotion.

14.6 Communication

Communication training programs improve the strength of the family unit and the ability of family members to be of emotional support to each other. The widely known programs by Gordon Training International, including Parent Effectiveness Training (P.E.T.),[404] and Youth Effectiveness Training (Y.E.T.), are in many countries, and an English-language videotape *Family Effectiveness Training* is

[403] Turnock, B. J. *Public Health: What It Is and How It Works*. (Gaithersburg, MD: Aspen Publishers, Inc., 2001), pg. 61.
[404] Ibid.

also available. The more recent World Class Marriage™ book and training program by Howell-Jones Trainings,[405]also available internationally, focus on ways to increase long-term satisfaction in the spousal relationship.

These programs, both based upon the work of Carl Rogers, teach family members how to get their needs met in their relationships together, so the relationships are satisfying and health supporting. Benefits include enhanced communication, cooperation, closeness, reduced stress, increased self-esteem, self-efficacy, less rebellious and self-destructive behaviour by children and greater achievement at school, higher job satisfaction for the adults, more fun as a family, greater sense of emotional support and of having resources to go to in times of trouble, increased optimism, and increased capacities for self-regulation and empowerment—characteristics positively correlated with health. A beneficial by-product is that family members can use these same skills in their school, work, and social relations. (For more information, see index of resources at back of this book.)

[405] Howell, P. & Jones, R. *World Class Marriage: How to Create the Relationship You Always Wanted with the Partner You Already Have.* (Encinitas, CA: HJBooks, 2002).

Chapter 15 – Health Promotion in Schools

> "Action is required through educational, professional, commercial and voluntary bodies, and within the institutions themselves."
>
> WHO Ottawa Charter for Health Promotion

15.1 Key Role of Schools in Health Promotion

The school process is not limited to the learning of subject matter, and is a place where students learn a great deal about whom they are and how they should relate to themselves and others. The purpose of schooling is to promote learning that, in a global sense, involves the growth of the student's personality. In that sense, the school is a greenhouse of human relations, as well as a workplace for adults. Its mandate includes:

- Promoting professional preparation and facilitating the passage of students into the working world,
- Helping students understand their own personality, grow, and develop as people, and experience opportunities for creative self-expression
- Fostering the training of young citizens, enabling them to achieve active citizenship

The impact of the schooling process is that young citizens learn to construe reality. These learnings impact, for better or worse, their self-esteem, social behaviours and their lifestyle choices. In this sense, after the family of origin, the schooling process is of primary importance for the creation of consensual reality and as such, the entirety of the school experience becomes a powerful influence in the shaping of young citizens.

School experiences socialise, shape identity and help, or hinder, in developing innate potential. Schools are important venues for Health Promotion and health literary, and for modelling principles to young people at a time in their lives when life-long habits and beliefs are being formed. For all these reasons, schools have key roles in promoting health and should take seriously their unique opportunity to shape the future of society through empowering Health Promotion curricula and by becoming Healthy Schools. This sentiment was affirmed by the WHO Jakarta Conference: "Every child has the right and should have the opportunity to be educated in a health-promoting school."[406]

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[406] WHO. *Statement on Health Promoting Schools.* (Jakarta: 4th International Conference on Health Promotion, July 1997.)

Because of the important link between schools and societal health, the WHO's Global School Health Initiative was developed. (See box below.[407])

WHO's Global School Health Initiative:
Helping Schools to Become "Health-Promoting Schools"

"Health is directly linked to educational achievement, quality of life and economic productivity. Research in both developing and developed countries demonstrates that school health programmes can simultaneously reduce common health problems, increase the efficiency of the education system and advance public health, education and social and economic development in each nation."

15.2 The Healthy School

WHO defines "a Health Promoting School" as one that constantly strengthens its capacity as a healthy setting for learning and working. A healthy school:[408]

- Fosters health and learning with all the measures at its disposal;
- Strives to improve the health of school personnel, families and community members as well as students;
- Engages health and education officials, teachers, teachers' unions, students, parents, health providers and community leaders in efforts to make the school a healthy place;
- Strives to provide a healthy environment, school health education and school health services along with school/community projects and outreach, health promotion programs for students and staff, nutrition and food safety programs, opportunities for physical education and recreation, programs for counselling, social support and mental health promotion;
- Implements policies and practices that respect an individual's self-esteem, provide multiple opportunities for success, and acknowledge good efforts and intentions as well as personal achievements;
- Is centred not upon teaching per se but upon the facilitation of learning, with teachers who are effective in promoting the growth of their students.

The World Health Organisation's Healthy Schools project recognises the need to coordinate with local resources and organisations to train teachers,

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[407] WHO. *Global School Health Initiative, Fact Sheet No. 92, 1998.* (http://www.who.int/inf-fs/en/fact092.html)

[408] WHO. *School Health and Youth Health Promotion.* (http:// www5.who.int/school-youth-health/main.cfm?p=0000000642 October 2002).

encourage integrated health curricula, foster student health census-taking, and support the development of positive physical and psycho-social environments in schools.

Unfortunately, most schools do not teach Health Promotion and are not yet Healthy Schools. Reasons for this have included strong community demand (including from local employers) that schools concentrate on basic reading, writing, and computational skills, in addition to chronic budgetary constraints, reliance on the traditional biomedical paradigm, and the lack of a bio psychosocial vision. With the understanding now available about health's many determinants and its far-reaching impact throughout society, it is evident that health education and health empowerment should be included in the core educational curriculum. Health topics of special importance for school Health Promotion include nutrition, exercise teen smoking, alcohol/drug use, sexuality, sun protection, communication and problem-solving skills, self-esteem.

Some progressive schools have inaugurated programs based on the Person-Centred Approach. A broad-based study of students conducted by the National Consortium for Humanising Education found that students whose teachers were trained in Empathic Listening, I-Message and conflict resolution skills, made significant gains in math, verbal and reading scores on standardized tests, and had 30% fewer absences than for the preceding period.

From this and similar studies, it is apparent that Person-Centred skills can be taught to teachers, that these skills make positive contributions to mental health and to the academic success of students, and that there is a strong rationale for including the Person-Centred Approach as a component of a healthy school.

15.3 Summary

As the bio psychosocial paradigm expands the subject matter included in the "Health" curriculum, school health curricula must expand its focus. Schools have the unique capacity to reach children at a time when critical learning takes place, affecting health habits and health outcome throughout their lifetimes. The systematic inclusion in school curricula of knowledge and training in health literacy and Health Promotion is overdue and is an important component of empowering our youth to lead healthy lives and contribute to the social change upon which wide-spread Health Promotion efforts are dependent.

In order to do so, it is important to update the curriculum so that teachers and the curriculum itself become catalysts in this direction. Schools should become Healthy Schools because of the unique role they play in the health and well-being of the next generation of citizens.

Chapter 16 – Health Promotion in the Workplace

"Work ability and health promotion programmes at the workplace can be effective with little financial investment. The cost-benefits of such programmes are indisputable. This is why more enlightened companies have already understood that health promotion programmes are no longer a luxury but a necessity—a part of their basic strategy for improving productivity and efficiency."

World Health Organisation. *Guidelines on Improving the Physical Fitness of Employees,* 2000.

16.1 Return on Investment for Health Promotion in the Workplace

The workplace is an important arena for Health Promotion and its cost-effectiveness is now well established. In 2001, Aldana conducted a comprehensive review of Health Promotion in North American firms[409]and identified sixteen studies showing savings of $4-5 for every dollar spent on Health Promotion. Furthermore, 18 case studies demonstrated a significant decrease in absenteeism directly attributable to Health Promotion programs at the workplace.

The Health Management Resource Centre of the University of Michigan's database on health risk factors (of two million subjects from nine multinational firms)[410]shows a clear relationship between health risk factors and health care costs: They found a one unit increase of health risk costs $350 per worker while the equivalent decrease in risk saves $150 per worker. It is evident that it makes good financial sense to invest in Health Promotion programs, even for workers with few risk factors, as it is far more difficult and costly to cure health problems than it is to prevent them.[411]

Besides the fact that worksites expose workers to numerous risk factors that threaten their health, there are other reasons why the workplace is an important arena for Health Promotion work (see chart below[412]).

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[409] Aldana, S. Financial impact of health promotion programs; A comprehensive review of the literature. (*American Journal of Health Promotion* 2001 May/Jun).
[410] Edington, D.W. Emerging Research: A View from One Research Center. (*American Journal of Health Promotion* 2001 May/Jun).
[411] Ibid.
[412] Zucconi, A., Perticaroli, S. & Chierichetti, F. *Health Promotion at the Workplace.* (Rome: WHP in Europe, Health Promotion at the Workplace, 2001).

ADVANTAGES OF WORKPLACE HEALTH PROMOTION PROGRAMS

- MOST OF THE ADULT POPULATION SPENDS MUCH OF ITS TIME AT WORK
- THE WORKING POPULATION IS THE OPINION LEADER IN THE COMMUNITY
- LEVELS OF PARTICIPATION ARE HIGHER THAN IN OTHER SETTINGS
- WORK ENVIRONMENTS ARE REGULATED BY LAWS WHICH CAN BE EASILY MODIFIED TO INCLUDE PROVISIONS FOR HEALTH PROMOTION
- ALL SOCIAL CLASSES ARE PRESENT AND HAVE EQUAL OPPORTUNITIES FOR EMANCIPATION FROM THE LIMITATIONS OF ILLNESS
- MOST OF THE COST DOES NOT FALL UPON THE STATE
- WORKERS CAN ACHIEVE HEALTH OBJECTIVES TOGETHER THAT THEY MIGHT NOT ACHIEVE ALONE
- BUSINESSES EXPERIENCE A POSITIVE EFFECT BOTH ON PRODUCTIVITY AND IMAGE
- TRADE UNIONS GAIN CREDIBILITY AS WORKER HEALTH AND WELFARE ARE PRIMARY OBJECTIVES OF THEIR STRATEGIES
- COMMUNITIES WHERE THE WORKERS RESIDE BECOME HEALTHIER AND MORE PROSPEROUS

[Figure #30—Advantages of Workplace Health Promotion Programs]

16.2 Additional Motivations for Companies to Invest in Health

In the work environment, physical/environmental risk factors are well-known and well-documented, while fewer people recognise psychosocial factors that are correlated with health risks, including the corporate culture itself, the ways people interact on the job, how decisions are made, the flow of communication, employees' degree of fate control (self-regulatory power), respect for individuals, appropriateness of compensation, job security, training, and opportunities for career advancement. Creating an awareness of these psychosocial factors that impact employee health is an important first step in creating corporate change.

> "A 15% increase in morale has been found to result in a 40% increase in productivity."
> Koretz, J.G. "The vital role of self-esteem: It boosts productivity and earnings." (*Business Week* , Feb. 2, 1998).

[413] ILO "SafeWork" website: "Addressing psychological problems at work: SOLVE http://www.ilo.org/safeWork

Work-related psychosocial damage takes numerous forms, some of which are difficult to observe and quantify. Such damage can include job dissatisfaction, low morale, lack of motivation, mistakes, conflict among workers, strikes, disciplinary actions, sabotage and obstruction, tardiness, wasting time at work, missing deadlines, poor decision-making, complaints, high sick days including "mental health days", high turnover, bad communication, absenteeism, and low productivity.

Job stress is a common source of problems with numerous workplace manifestations: anxiety, aggression, apathy, boredom, depression, fatigue, frustration, guilt/shame, irritability, emotional shifts, low self-esteem, tension/nervousness, withdrawal, reduced concentration and decision-making ability, memory impairment, hypersensitivity to criticism, and mental blocks. Stress is also correlated with numerous physical problems from headaches to heart problems, fatigue, psychosomatic disorders, and back pains—all of which cause problems for employers and employees alike. As psychosocial problems are often interrelated, stress can also result in abuse of tobacco, alcohol, drugs, or violence. (See ILO SOLVE Program, chapter 17, figure 43.) The principal indicators of a company's low state of health are listed in the box below:[414]

Indicators of a Company's Low State of Health

- Job dissatisfaction, low morale, lack of motivation in employees
- Lower quality work performance
- Increase in mistakes
- Production slow down
- High levels of conflict among employees
- More days lost because of striking workers
- High turnover among employees
- High accident rate
- High amount of management and commercial mistakes in decision-making
- High level of sabotage and obstructionism among employees
- Low productivity
- High amounts of time wasted during working hours; failure to observe working hours
- Lack of compliance with deadlines and objectives
- Frequent complaints from employees
- High levels of absenteeism due to sickness
- Poor interpersonal communication
- Bad company relations

[Figure #31 -- Indicators of a Company's Low State of Health]

[414] Zucconi, et al., op. cit, pg. 41.

An important avenue for reducing psychosocial problems at work is training in communication skills and participative decision-making through programs such as Leader Effectiveness Training (L.E.T.).[415] Optimally, this training should occur at every level throughout the organisation. Besides the obvious benefits of clear communication devoid of hidden agendas, participative decision-making empowers each person to take a role in decisions that affect him or her, and brings better data to the process so higher quality decisions are generated. Further benefits are increased fate control for employees, greater emotional buy-in to company objectives, increased follow through on plans, development of employees' potential, reduced organisational stress, and enhanced employee well-being.[416] Participative decision-making reduces resentment and sabotage, makes better use of the company's resources including training and other educational programs, yields more satisfaction with compensation, and better communication flow throughout the organisation.

Because psychosocial health factors are under-recognised and are often interrelated with other risk factors, it is important that health professionals help workplaces recognise their presence and impact. Programs aimed at reducing individual risk factors should also focus on the organisational culture by instituting policies and procedures that support long-term behaviour change (e.g., through company-wide smoking-control policies, having healthy foods available at company lunchrooms, and enabling employees to take physical exercise while on the job). [417]

As benefits of Health Promotion become more widely known, more companies will seek the multi-level rewards of Health Promotion efforts. (See figure on the "Positive Results from an Effective HP Policy.)

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[415] Gordon, T. *L.E.T., Leader Effectiveness Training: The Foundation for Participative Management and Employee Involvement.* (New York: G.P. Putnam's Sons, 1977).
[416] Committee on Health & Behavior, op. cit., p. 243.
[417] Committee on Health and Behavior, op. cit., pg. 244.

Positive Results from Effective Health Promotion Policy

1. **Corporate strategy and financial responsibility**
   • Gives sense of direction • Sustainable development • Avoids accidents • Better planning • More stable and motivated workforce • Takes action • Increases productivity • Clear corporate culture • Better corporate image • More effective corporation • Transparency
2. **Human Resources**
   • Better health • Better motivation • Feeling of belonging • Better relation between employer and employee • Focuses care on most important asset in company: workers • Better recruitment and retention • Helps to plan and anticipate for needs • Knowldege of personnel needs and work loads-physical and psychological • Attention to job related and personal factors • Improved performance
3. **Finance**
   • Reduces legal costs • Influences increased production • Optimal allocation of financial resources • Minimizes lost time: indirect and direct • Allows application of cost-benefit analysis • Reduces cost of insurance • Decreases cost related to health problems • Reduces cost of training and retraining • Reduces costs due to product defect • Increases company image • Adds value to share prices
4. **Marketing**
   • Better company image • Better products • Customer satisfaction increases • Prevents bad publicity from legal action • Encourages employee ownership of products • Improves creativity • Increases quality and competitiveness
5. **Manufacturing and Operating Policy**
   • Customer satisfaction • Less absenteeism • Better delivery of services/production • Good working conditions • Allows tasks to be designed according to human abilities • Improvement in quality of product
6. **Information Management and Systems**
   • More efficient information • Earlier recognition of emerging problems • Stable structure to deal with emerging problems • Increased transparency • Avoids blind planning • Increases knowledge of problems and responses • Increases information dissemination • Improves worker participation because of increased awareness • Helps to gather baseline information and assessment • Job satisfaction • Clear goals • Encourages team building and work • Better communication about roles

[Figure #32—Positive Results from Effective HP Policy]

For all of these reasons, the World Health Organisation and the International Labour Organisation (ILO)—a tripartite UN agency formed by government, workers' unions and employers' unions in countries represented by the United Nations, strongly encourage Health Promotion in the Workplace and have developed a joint definition of Occupational Health (see below).

ILO and WHO Joint Definition of Occupational Health:

"Occupational health should aim at: the promotion and maintenance of the highest degree of physical, mental and social well-being of workers in all occupations…"

[Figure #33—ILO and WHO Joint Definition of Occupational Health]

To date, Health Promotion programs have been instituted in many large organisations and fewer small and medium-sized ones. As small-scale industries are particularly subject to workplace hazards and are less likely to have regular inspections or access to occupational health services,[418]special efforts should be made to create awareness of the benefits of Health Promotion for small and mid-sized companies.

Germany's BKK insurance company has created an innovative Health Promotion program that helps many other companies besides BKK itself. Along with the WHO, they developed the *European Information Centre on Company Health Promotion*, which includes a network of experts in the research and application of Health Promotion in the workplace. From this effort, BKK has reduced the rate of client claims for hospitalization and other medical services, and enhanced its image among clients as well as other corporations that utilise the information centre.

For companies wishing to begin Health Promotion efforts, the WHO identifies options at different levels of commitment. (See box below.[419])

Levels of Commitment for Workplace Health Programs

Levels of Intervention	***Examples of Program Content***	***Cost***
Communication & Awareness programs	Local physical activity events/clubs/facilities; Articles in company newsletter; Posters; Leaflets	Low cost
Screening and Assessment programs	Cardiovascular risk appraisal; Fitness testing; Cholesterol testing; Blood pressure screening	Mid-cost
Educational & Lifestyle Programs	Seminars; exercise prescription; Healthy back classes; Aerobics classes; Fitness contests	Mid-cost
Organisational, Cultural & Behavioural Change Support Systems	On-site fitness centre; Company sports teams	High cost

[Figure #34—Levels of Commitment for Workplace Health Programs]

[418] Protection of the Human Environment. *Occupational health: the workplace*. http://www.who.int/peh/Occupational-health.
[419] WHO. *Guidelines for Improving the Physical Fitness of Employees* (2002).

16.3 The Healthy Company

Comprehensive Workplace Health Promotion programs are multidisciplinary and cover four major areas:

1) occupational health and safety
2) workplace Health Promotion (including promotion of healthy lifestyles)
3) maintenance of work ability and employee assistance programs
4) environmental management and social capital management[420]

The degree to which businesses address workplace health risks and systematically incorporate health-supportive solutions affects their employees' health, job satisfaction, productivity and loyalty to the organisation. A firm can consider itself "healthy" if it promotes health and wellness of its workers and recognises that its greatest resources are the people who work for it. A "**Healthy Company**" *has a work culture which provides conditions and practices based on enlightened self-interest that benefit employees as well as the productivity and success of the business itself*.

As workplaces develop Health Promotion programs and work toward becoming a Healthy Company, it is important that the professionals involved not define their roles narrowly. (See figure on "Problems that Hinder the Development of Workplace Health Promotion."[421])

Problems that Hinder Workplace Health Promotion

1) Lack of awareness among key persons regarding the concept of Health Promotion, its possibilities, benefits, and what is entailed;
2) Inadequate skills of the professionals and company personnel, clinging to a narrow definition of their role, and inadequate skills or motivation to establish workplace Health Promotion;
3) Failure to market Workplace Health Promotion on the basis of its benefits—including adherence to new legislation and other health regulations, impact on morale problems, health problems, industrial relations problems.

[420] WHO. *About workplace health*. (World Health Organisation Regional Office for Europe: www.who.dk/healthyworkplaces), 2002.
[421] Wynne, R. & Clarkin, N. *Under Construction: Building for Health in the EC Workplace.* (Luxenbourg: Office for Official Publications of the European Communities, 1992), pg. 157.

[Figure #35 -- Problems that Hinder Workplace Health Promotion]

The World Health Organisation has developed five principles of Health Promotion, adapted for the workplace by Wynne, as follows:[422]

1) The approach can be applied across all groups in the workforce;
2) The approach is directed at the underlying causes of ill health;
3) The approach combines diverse methods;
4) The approach aims at effective worker participation;
5) The approach is not primarily a medical activity but is integrated into the work organisation and working conditions.

As the cost effectiveness of Health Promotion has been clearly shown, Sean Sullivan of the Institute of Health and Productivity Management believes a key is to help companies recognise health as a form of *human capital*—like knowledge and training.[423] When companies see Health Promotion as an investment rather than an expense, they will adopt it as a key corporate strategy. Furthermore, it is important for health promoters to address the practical considerations that typically are of concern. (See figure #36—"Countering Typical Arguments against Workplace Health Promotion".)

[422] Wynne, R. *Workplace Action for Health: A selective review and a framework for analysis.* (Dublin: Work Research Centre, 1989).
[423] Sullivan, S. *Wealthy and Wise Follow* < www.humancapitalmag.com> January 2001.

Countering Typical Arguments against Workplace Exercise Programs

• We can't afford it

Sooner or later, avoidable health problems will prematurely end the careers of valued employees. Can you afford not to invest in health promotion? Elaborate equipment is not essential. Inexpensive lockers and showers are often enough. Some activities (e.g., cycling, jogging) require no facilities; others (e.g., aerobic exercise to music) only require suitable floor space.

• Time off for physical activity will reduce productivity

Research studies indicate that in fact the reverse is true; healthy employees work harder and produce more. And, it may not be necessary for employees to take time off—some will exercise outside work, and others may come to work earlier or stay later to exercise.

• No other companies in the area have physical activity programs

Why not take the lead? Companies around the world are becoming more interested in the health of their employees as there are many advantages in doing so.

• Only fitness enthusiasts will participate

Yes, they will readily use the facilities and opportunities offered by the company. However, they will be outnumbered if the needs of all employees are taken into consideration in the planning. Good programming and positive word of mouth will stimulate others to get involved.

• We might be liable for injuries or a heart attack

Everything a company does involve liability. Encouraging employees to become more physically active in a well planned organised and staffed activity will minimise liability. Give quality advice to all employees and seek medical clearance for anyone who might be a potential risk.

• Let's just tell them to keep fit

The majority of adults exercise infrequently or not at all. Employers who provide the stimulus as well as the opportunity do themselves a favour in the process because sedentary living and its consequences cost a lot of money each year. Physical activity is a proven, inexpensive way to reduce those costs by improving the health of working people.

WHO. *Guidelines on Improving the Physical Fitness of Employees*, 2000.

[Figure #36 -- Countering Typical Arguments Against Workplace Exercise Programs]

Health promoters may wish to consider business incentives to encourage the adoption of Health Promotion programs. (See figure on "Some Possible Business Incentives").

Some Possible Business Incentives for Health Promotion

- A national prize awarded annually by a consortium of government authorities
- Favourable tax benefits
- Favourable treatment in public calls for tender
- Introduction of a *"Healthy Company"* certification, with public recognition and official listing on websites and other communiqués
- Creation of a database containing examples of excellence in Health Promotion
- Publication of bulletin/newsletter distributed to companies, describing innovative and beneficial Health Promotion programs
- Public television programs on companies showing Health Promotion excellence

[Figure #37 – Some Possible Business Incentives for Health Promotion]

16.4 Healthy Company Models

There are a variety of models of good practice in organisations large and small, each reflecting different corporate needs and differing approaches, and each with successes measured in employee health, increased productivity and a range of other benefits for the organisation. Herewith are some examples of successful company Health Promotion programs:

16.5 Du Pont de Nemours BV[424]

With 1500 employees in the Netherlands, this company aims to eliminate industrial accidents and work-related illnesses and ensure that employees are physically and mentally fit. Du Pont has developed a "Wellness Checkpoint" process to analyze the health and well-being of employees. Employees assess their personal health risks in their jobs and personal lifestyles and use this to develop strategies for change. A "Safety off-the-job-Commission" looks after the welfare of the staff outside of working hours.

All work materials and processes are examined in advance so that their safety can be guaranteed, and health experts are called in during the planning for new jobs and production processes. Employees suggest improvements and undergo training for a minimum of six days every year so they can cope with future job requirements.

[424] Ibid.

Health programs include medical examinations, assistance with drug and alcohol problems, and healthy food in workplace cafeterias, stop-smoking programs, stress management courses, sports and relaxation opportunities, and particular programs for groups with particular risks.

Du Pont's programs have improved job satisfaction and working atmosphere due to better working conditions and changes in leadership style; improved health and satisfaction by implementing employee suggestions; reduced absenteeism to 1/10 the industry average; generated financial savings of 1,000,000 Euros from increased productivity; enhanced corporate image; and lowered staff turnover.

Volkswagen's "Industrial Health Circle" Initiative

In two Volkswagen plants in Germany, health circles were formed with 15 foremen and assistants. Members of the circles were encouraged to participate in discussing any health-related problems or work-related stresses they experience. Medical examinations, interviews with circle participants and workplace visits were organised to build up a picture of the existing work situation. Information and education sessions were provided for circle members and also for managers and company doctors, so they would lend support to the experiment.

Once the circle had identified stressful areas of the work environment, a contact committee was created to stimulate more open discussion at the plant level about problems on the shop floor. Management, health circle members and contact committee members developed strategies to improve problems identified.

Interviews and questionnaires showed improvement in health-related conditions among circle members. It was concluded that health circles help employees reduce their stress level, improve their coping skills, and help them participate in creating a healthier working environment. Volkswagen introduced several improvements as a result of recommendations from the health circles initiative.

WHO. *Health promotion in the workplace*, op. cit., pg. 39.

[Figure #38—Volkswagen's "Industrial Health Circle" Initiative]

16.6 Caterpillar

Caterpillar, an old-line U.S. heavy equipment and engine manufacturer, faced a staggering billion-dollar-a-year health care projection for the turn of the century. To address this looming crisis, a task force produced a two-pronged approach: working with health care providers to lower costs, and reducing demand for health care services.

After successfully reducing its health care costs, Caterpillar's leadership recognised that additional and lasting reductions could be obtained by improving the health of Caterpillar's thousands of employees worldwide and their dependents as well. To achieve this, Caterpillar launched a comprehensive program called "Healthy Balance 2000". A core component of the program was "Healthtrac", a "need and demand reduction program" designed by Stanford University's Health

Project which focuses on improving major risk factors such as stress, physical activity, cigarette smoking, fat and fibre consumption.

Results include a 96% participation rate of eligible employees, plus 74% of eligible spouses, and a reduction of risk factors by 17% in the high risk group, as well as 6% for low risk employees. High risk participants reduced doctor visits by 17% and hospital days by 28%, for an overall decrease in direct costs of 23%.

In addition, over a three-year period, heart patients who participated averaged health claims $16,000 lower than those who didn't; more than 1,100 participants quit smoking cigarettes; and of the 60% of Caterpillar employees whose Body Mass Index was greater than 25 (the generally accepted threshold of moderate health risk), 4,700 had lost weight by the end of the study.

Healthtrac modified its program to incorporate many customized features requested by Caterpillar and sees these adjustments as a critical element of Healthy Balance 2000's success, along with the company's emphasis on continuous evaluation and improvement.

Based on independent analyses of the outcomes, Caterpillar anticipates long-term savings of more than $700,000,000 by 2015 as a result of their Health Promotion program.

16.7 Scandinavian Airlines System—SAS[425]

A multinational airline company, SAS has an active Health Promotion strategy with safe and healthy working conditions as a specific corporate objective, and Health Promotion integrated into the TQM (Total Quality Management) program of the company. Medical Director Jens Stokholm[426] reports that SAS's Health Management concept is based on a holistic approach: "The development of the company, its working environment and products, the prevention of injuries and damage and the support of individuals with health and social problems affecting their job—each of these factors demands that all aspects are involved if durable solutions and a continued development are to be achieved."

Health Promotion activities are controlled by means of target agreements and progress is reviewed every year. Specific Health Promotion projects have their own budgets while general improvements of the working conditions are integrated into production budgets.

Components of the TQM and Health Management program are:

1) Mapping of problem areas;
2) Implementation of training and attitude creation;
3) Implementation of quality improvements uncovered through the training sessions and analysis of injuries, damage and near-events;
4) System for identifying injuries, damage and risks/near-events, including cause analysis, action program and follow-up system;

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[425] Ibid.

[426] Stokholm, J. *Integration of TQM and Company Health Management*. (Denmark: Scandanavian Airlines, Health, Environment and Safety Department, 2000).

5) Quality follow-up and attitude impact through visible management;
6) Implementation of safety procedures beginning with top management down through the organisation;
7) Goal establishment and goal breakdown throughout the organisation.

Every department is responsible for identifying health targets and health action plans. SAS evaluates health-related data every three years, as well as staff surveys and job analysis, and from these data formulates corporate Health Promotion plans. Line managers with staff and finance responsibility are responsible for implementing Health Promotion strategies and performing the daily work safely. Employees are involved in the planning of health management work through safety committees and safety groups. The Human Resources division includes occupational health and airspace physicians, ergonomics experts and technicians, organisational psychologists, social counsellors and experts in the areas of external environment, working environment and health.[427]

All employees are given a 1-2 day course on motivation and attitude with a focus on safety; new managers take a 2-day course in environmental and health management; work managers are given a three-day training on organisational culture and management and a 4-day course on quality improvement techniques; instructors are coached in quality improvement projects. Rest and recuperation rooms have been created and SAS offers a wide range of sports and cultural programs.[428]

Since 1995, SAS has shown significant reductions across six measures of health and safety; reduced physical work, exposure to chemical substances, noise, and vibration; decrease in illness-related absenteeism rate from 5.7% to 4.9%; and decline in accident rate from 33.8% to 27.4%.[429]

[427] Ibid.
[428] Stokholm, op. cit.
[429] WHO. *Models of Good Practice*, pg. 18.

An Employer-led Initiative that Benefits the Community

Fruit of the Loom-McCarters in Ireland initiated an innovative three-part Health Promotion strategy to benefit employees and the community from which they are drawn:

1) Provision of wide-ranging occupational health promotion services for the workforce—including first aid, counselling (especially women's health issues) and referral to medical services, and a "Wellness at Work" program focused on the prevention of coronary heart disease. Simultaneously, "Health Awareness Evenings" were run in cooperation with the local health authority, and company smoking and healthy food policies were introduced.
2) Establishment of an education program for young and prospective workers from the nearby communities to provide information on the transition from school to work. Conducted onsite and in local schools, the program addressed topics such as income management, the nature of working life and effects of employment on family life.
3) Building an infrastructure and facilities available to the local community from which the workforce is drawn. The company helped to finance a local swimming pool and contributed toward the development of the town's water supply

WHO. *Health promotion in the workplace*, op. cit., pg. 39.

[Figure #39—An Employer-led Initiative that Benefits the Community]

16.8 Summary

Besides the substantial return on investment of Health Promotion programs, there are numerous intangible benefits that cost-benefit analysis per se does not take into account. These benefits are *indirectly* translated into increased profitability, yet they may ultimately be of even greater significance to the corporation. One measure of the extensive corporate benefits of Health Promotion is the Dow-Jones Sustainability Growth Index (see box below[430]).

The Dow-Jones Sustainability Growth Index (DJSGI)

The DJSGI takes into consideration, among the various parameters for the evaluation of firms quoted on the stock exchange, *the way a firm promotes the health of its workers, community health, environmental protection, and socially responsible policies.*

For example, in the year 2000, Dow Chemical was listed as first in its sector. Dow initiated a Health Promotion at the Workplace program in 1985 and now offers it to its 41,000 workers worldwide, plus many family members and retirees.

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[430] Baase, C. An Optimistic View from the Corporate Perspective. *(American Journal of Health Promotion,* May/Jun 2001).

[Figure #40—The Dow-Jones Sustainability Growth Index (DJSGI)]

Data abound making it clear that workplace Health Promotion programs are beneficial to employees and cost-effective to the organisation, and that their impact is beneficial on a multitude of levels. Consequently, workplace Health Promotion may have the greatest overall potential of all the areas we have considered.

Chapter 17 - Structuring Workplace Health Promotion

"The way society organises work should help create a healthy society. Health promotion generates … working conditions that are safe, stimulating, satisfying and enjoyable. Systematic assessment of the health impact of a rapidly changing environment, particularly in areas of technology, work, energy production and urbanisation, is essential and must be followed by action to ensure positive benefit to the health of the public."

WHO Ottawa Charter for Health Promotion

17.1 Design & Implementation of Workplace Health Promotion

Although the World Health Organisation adopted the Universal Declaration of Human Rights more than fifty years ago recognising the right of all people to "just and favourable conditions of work", UN Secretary-General Kofi Annan reported in 1998[431] that "hundreds of millions of people around the world are (still) employed in conditions that deprive them of dignity and value." The resulting shattered families and communities amass damage that Annan calls incalculable.

The world surely cannot afford to continue paying this price in human health, in addition to the draining impact on corporate productivity and competitiveness. The promotion of health at the workplace is our clear direction for the future.

"Promoting health at work is an integral part of the human resource development strategy."

3rd European Meeting of WHO Collaborating Centres in Occupational Health. *Good Practice in Occupational Health Services*. (Nancy, France, 30 September – 1 October 2002).

We will now address the task of transforming health-threatening jobs and procedures to safe ones, and health-damaging workplaces to environments that foster the health of workers.

"Occupational health is an important strategy not only to ensure the health of workers, but also to contribute positively to productivity, quality of products, work motivation, job satisfaction and thereby to the overall quality of life of individuals and society."

WHO *Global Strategy on Occupational Health for All*

[431] Annan, K. A. Occupational Health and Safety: A High Priority on the Global, International and National Agenda (*GOHNET Newsletter, The Global Occupational Health Network*), Issue. No. 1.

When we look at strategies and technologies for implementing Health Promotion in the workplace, Michael O'Donnell identifies five dimensions of "optimal" health that apply:[432]

1) *Physical Health*, including fitness, nutrition, medical self-care, control of substance abuse;
2) *Emotional Health,* including care during emotional crisis and stress management;
3) *Social Health,* including building of communities, families, friendships;
4) *Intellectual Health,* including education, achievement, career development;
6) *Spiritual Health*, including love, hope, charity, and having a sense of purpose.

These dimensions can help an organisation identify its specific health threats and enhancers. Ongoing health functions and activities must be considered and coordinated through an integrated management approach that will ensure durable results. Integrated management is best implemented by people at all levels of responsibility being given adequate information for considering the long- and short-term implications of their decisions.

Articulating a multi-faceted, dynamic and integrated view of Health Promotion, embracing it as a corporate value, incorporating it systematically into the workplace, and developing programs that encourage and support it may involve a multiplicity of activities. Some of the disciplines and specialties that can be called upon to help an organisation design and implement a program may not be apparent. O'Donnell has identified a partial list of these disciplines reproduced below as a reference and stimulus:[433]

[432] O'Donnell, M.P. Design of Workplace Health Promotion Programs.(*American Journal of Health Promotion*, 1988), pg. 2.
[433] O'Donnell, op. cit., pg. 3.

Disciplines Involved in a Systemic Approach to Health Promotion

exercise physiology	health education	nutrition
physical therapy	psychology	program mgmt
finance	computer technology	entrepreneurship
communication	marketing	ergonomics
biomechanics	social work	political action
family practice	chiropractic	podiatry
osteopathy	biochemistry	internal medicine
sports medicine	organisational development	nursing
psychiatry	cardiology	dentistry
occupational medicine	biostatistics	architecture
epidemiology	economics	recreation therapy
training	health care administration	patient education
occupational therapy	insurance	government policy

[Figure #41—Disciplines Involved in a Systemic Approach to Health Promotion]

It becomes evident that in working to achieve the goal of creating "just and favourable conditions of work" for all requires a transformation greater than the common, mechanistic, "Band-Aid" approach. It involves a redefinition of the nature of the workplace—not as a place where workers toil to meet corporate goals, but where *corporate goals are defined both in terms of product and process, and where the process is based upon the intention to create optimal productivity combined with optimal health for everyone in the organisation*. This creates organisations where "human beings are not servants of economies", but as Annan envisioned, where economic development and production serve human beings.[434]

Fortunately, we do not need to choose between corporate goals or the health of workers; they are mutually dependent. The task for health professionals is to educate about the essential interdependency of the organisation and its workers and to help organisations find effective means of promoting health within their place of business.

17.2 Characteristics of a Successful Workplace HP Program

[434] Annan, op. cit.

A successful Health Promotion program must incorporate effective approaches to three key elements: corporate management, program development, program delivery. The components of such a plan are presented below:[435]

Characteristics of a Successful Health Promotion Program

1. Program designed to achieve important organisational goals
2. Visible commitment from management, not only for initiating a program but also for following it through and ensuring it is fully implemented
3. Personal participation from top management
4. Worker participation in the design and maintenance of the program
5. A firm basis of trust so participants feel assured of confidentiality
6. Tackles issues identified as relevant and important by the workforce
7. Adequate resources to implement the program effectively
8. Flexibility so program can be modified and improved, if necessary, to suit needs of the workplace
9. Restrictions (e.g., smoking policies) or benefits (e.g., exercise facilities) apply to whole workforce
10. Capable program director/administrator
11. Physiologically and psychologically sound programs
12. Capable program staff
13. Appropriate knowledge of human health and behaviour
14. Stimulating educators and motivators
15. Warm, empathic human beings and credible personal role models
16. Easy access by program participants
17. Goal of long-term lifestyle changes
18. Attention to personal goals of the participant
19. Participant involvement in program operation and delivery
20. Program opportunities for participants with all different health status levels
21. Ways to develop health-supportive environments among co-workers, friends, and family

[Figure #42 -- Characteristics of a Successful Health Promotion Program]

It is important that employees individually choose to participate in workplace Health Promotion programs and commit to doing so. Good health programs will fail if they are not accepted by the workforce, lack management commitment,

[435] Adapted from O'Donnell, M.P. The Design Process, from: O'Donnell, M.P. & Ainsworth, T. *Health Promotion in the Workplace.* (New York: John Wylie & Sons, 1984) and: WHO. *Health Promotion in the Workplace: Strategy Options.* (Copenhagen: World Health Organisation, 1995).

appropriate funding, fail to meet the needs and interests of the workforce, or do not result in desired behaviour change.[436]

The ILO's SOLVE Programs

The International Labour Organisation has developed a package of training programs called SOLVE which focus on psychosocial problems due to stress, tobacco usage, alcohol and drug abuse, mobbing and violence at the workplace, HIV/AIDS. These problems concern all categories of workers in practically all countries and in all sectors. These interrelated health factors have been calculated by the ILO as accounting for a 3% erosion of the entire world's gross product.

SOLVE is designed to assist government institutions, firms and workers improve the psychosocial component of working conditions, reduce costs and increase productivity. SOLVE is a significant contribution to the development of solutions to health-related problems at the workplace.

[Figure #43—The ILO's SOLVE Programs]

17.3 Steps in Developing a Successful Health Promotion Program

Initiating a comprehensive Health Promotion program in a workplace can seem a daunting task. Fortunately, various authorities have analysed the steps that successful pioneers in the field—including the organisations described in the preceding chapter—have developed. There are five aspects that should be taken into consideration:[437]

1) **organisational issues**: including organisational goals, strategies for progressing toward them, organisational structure (division of labour, authority relationships, lines of communication), policies and procedures (formal rules that govern the organisation) and reward systems;
2) **social factors**: including management style, informal social networks, interaction processes (problem-solving, decision-making, conflict resolution);
3) **technology**: including job design factors, work flow design, technical systems;
4) **physical settings:** including spatial configuration, interior design, and physical ambiance—temperature, lighting and noise;
5) **Individual attributes**: including individual beliefs, attitudes and skills in health promotion.

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[436] Kelly, F. *Guidelines on Improving the Physical Fitness of Employees* (Bilthoven: WHO European Centre for Environment and Health, 2000), pg. 21.
[437] Committee on Health and Behavior, op. cit., pg. 242.

Attention also needs to be paid to the process of design and implementation so the program can sustain effective action. There are seven basic steps for in establishing a program:[438]

1) **Creating Awareness**—Regardless of whether the health initiative originates from management, workers, or occupational health services, the first step is to create awareness and educate others about the importance and potential benefits of Health Promotion to the organisation. This process is aided by collecting and presenting data on relevant health problems.
2) **Setting Up a Joint Working Group**—whether the group becomes a "health circle", "stress committee" or whatever its focus, representatives from all relevant groups should be involved.
3) **Reviewing Specific Needs and Problems of the Workplace—**the working group collects and reviews data on specific health concerns.
4) **Assessing the Possibilities for Action**—documenting what human and financial resources that can be made available.
5) **Choosing the Best Strategy**—examining the range of options for dealing with identified concerns, consulting throughout the workforce, and then selecting the most appropriate approach.
6) **Planning and Implementing the Program**—identifying clear objectives at the onset of the program, including training and education needs of staff, adequate funding for the duration of the intervention, specific senior personnel that will follow the program through.
7) **Monitoring and Feedback**—Devising monitoring procedures to evaluate progress and be a channel for feedback so the program can be modified, if necessary, as it moves forward.

Health professionals may also find it necessary to incorporate organisational change into Health Promotion programming. This involves training key personnel in methods for creating an organisational culture that supports the ongoing Health Promotion program. (See figure identifying "Core Competencies in Health Promotion"[439])

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[438] WHO. *Health promotion in the workplace*, op. cit., pg. 41-42.
[439] Ewles, L. & Simnett, I. *Promoting Health: A Practical Guide.* (2nd edn.) (London: Scutari Press, 1992), pgs. 27-29.

Core Competencies in Health Promotion

• Managing**, Planning & Evaluating**. Managing resources for Health Promotion, including money, materials, oneself and others, along with systematic planning and evaluation.

• Communicating. A high level of competence in one-to-one communication and in working with groups in various ways, both formal and informal.

• Educating**.** Educational competencies, both with lecturing and informal group work, and the capacity to select appropriate strategies for different educational goals.

• Marketing **and Publicity**. Competence in marketing, advertising, using local radio and TV, getting local press coverage of health issues.

• Facilitating **and Networking.** Helping others promote their own and others' health includes skill and information sharing, building confidence and trust.

• Influencing **Policy and Practice**. As health promoters are in the business of influencing policies and practices that affect health, this can be at any level, from national (e.g., policies set by government or political parties concerning housing, transport, future directions for national health academies, etc.) to the daily level of health promotion activities (e.g., determining what resources will be devoted to specific HP activities, etc.). It is important to understand how power is distributed and exercised between people at all levels and be able to use that knowledge to affect decisions with statutory, voluntary and commercial organisations. It includes working for health public policies and economic and regulatory changes requiring lobbying and taking political action,

[Figure #44—Core Competencies in Health Promotion]

Golaszewski and colleagues developed a useful curriculum for human resource managers.[440] Here are some additional guidelines[441] (see figure below):

[440] Turnock, op. cit., pg. 245.
[441] Zucconi, et al., op. cit., pg. 58-59.

A Methodology for Models of Good Practice

To be effective, Health Promotion projects need to incorporate the greatest number of variables known to be significant for the success and efficacy of such programs. The following are some of the most important parameters.

- Planning actions in recognition that Health Promotion is an action for social-cultural change in the individual, the organisation and the community. The actions must be consistent with the bio psychosocial model
- Taking account of the organisational structure and culture of the workplace, the culture and social reality of which the organisation is part, including the health care sector and the local environmental situation, as well as the common culture and beliefs, specifically those relating to the concepts of health and disease
- Carrying out a feasibility study for the program that takes into account all the factors cited above, along with an analysis of the forces acting in the field, indicating those that favour success for the action and those that could hinder it
- Assessing the willingness of the organisation to promote the program effectively. Ensuring support and commitment from top and middle management and trade union organisations
- Identifying objectives clearly and correctly
- Designing a program centred on the needs that emerge from an systematic analysis, and that provides benefits for ALL
- Planning the project properly
- Ensuring the participation of all parts of the organisation and involving the workers actively in both planning and implementation of the program
- Designing a monitoring and feedback procedure that enables the program to be modified if necessary
- Designing an appropriate evaluation system
- Designing a clear, long-term maintenance procedure that ensures follow-up and maintenance of the gains achieved

[Figure #45 -- A Methodology for Models of Good Practice]

As noted in the above methodology, a crucial step in the process is for the health promotion specialist to assess the readiness for Health Promotion. If the organisation is open to the concept but not fully aware of its value, it is important to educate management about the hidden costs of injury and illness and the cost-effectiveness of a healthy, satisfied workforce. This will help the organisation embrace Health Promotion as a corporate goal.

Because optimal health is a value with high face validity, it is not a hard sell to management once reliable data about cost-effectiveness are presented. Then, Health Promotion is not a hard to sell to workers once management has embraced the concept because workers are aware of the personal costs of injury and illness.

Once the decision has been made to incorporate health-supportive practices into all facets of the workplace and a working plan developed, an outline of the Health Promotion proposal and plan for implementation can be presented to the organisation for discussion and decision to implement. It is important during this process to get full "buy-in" from all levels of the organisation—upper and middle management, supervisors, and workers—so that the organisation is fully behind the endeavour.

In her book *Creating Health Behaviour Change*, Cheryl Perry presents a checklist of the steps required to build a Health Promotion program. We show in the figure below[442] its main points.

[442] Perry, C.L. *Creating Health Behavior Change.* (Thousand Oaks, CA: SAGE Publications, Inc., 1999), pg. 111.

Health Behaviour Change Checklist

1. Selecting health behaviours	Identify the health behaviours to be promoted or corrected within the organisation.
2. Providing a rationale	Discuss their causes and consequences and why they have been targeted in this plan.
3. Creating an intervention model	Describe how the model will work and specify the predict outcome behaviours and the reasons for their expected success.
4. Writing intervention objectives	Objectives should match the predicted outcomes and be both feasible and potent.
5. Applying intervention objective	Determine whether the objectives are consonant with organisational and community beliefs and values.
6. Reviewing types of programs	Research previously successful programs for applicable programs and interventions.
7. Creating program components	Develop a prioritized list of program elements to address each objective.
8. Constructing the program	Determine available resources, decide on an overall motif, then write and produce the package and do a pilot.
9. Implementing the program	Introduce the program to key people for support & implementation, train program staff, establish the components, conduct evaluations, and report to the community.
10. Maintaining the program	If the program is successful, assess the resources available for its continuation and identify a champion to spearhead its ongoing implementation.

[Figure #46 -- Health Behaviour Change Checklist]

Chapter 18 –Health Promotion in Hospitals & Health Care Settings

"The responsibility for health promotion in health services is shared among individuals, community groups, health professionals, health service institutions and governments. They must work together towards a health care system which contributes to the pursuit of health. The role of the health sector must move increasingly in a health promotion direction, beyond its responsibility for providing clinical and curative services."
WHO Ottawa Charter for Health Promotion

18.1 Hospitals & Health Care Organisations

By 1984, more than two-thirds of hospitals in the United States offered some type of community wellness program, [443]and hospitals are increasingly involved in Health Promotion and wellness services. Partially as a result of consumer demand for health information and preventive services, many hospitals now offer programs in wellness, nutrition, exercise, and stress management. These programs are sometimes organised through a comprehensive Education Centre, linking the public with classes, library facilities, health consultants, and Internet health information. Some hospitals also contract out their health services to workplaces, offering environmental assessment of health hazards, screening for health problems related to specific work tasks, and education about accident and injury prevention. Workplace health services provided by hospital professionals supplement those offered at hospitals and lead to more comprehensive workplace programs that support employee health and well-being.

Such programs expand hospitals' revenue base, offsetting losses incurred by declining inpatient populations, and burgeoning costs of technology and acute care. They also increase patient satisfaction, improve the hospital's relations with medical staff, burnish their image as concerned and helpful members of the community, and lead to improved public health. In addition, wellness programs help hospitals promote specific services, recruit physicians, market their services, and establish a presence within the community. Hospital-based Health Promotion programs save money and improve the overall quality of health care.[444] Another important by-product is that educated patients make more active and better informed partners with health practitioners, resulting in better diagnoses, care, treatment plans, and lifestyle

[443] Ross, C., et al. Health promotion programs flourishing: survey *(Hospitals*, 1985), 59(16)L 128-135.
[444] Speros, C. I. & Sol, N. Health promotion in hospital, in: Badura, B. & Kickbusch, I. (eds.). *Health Promotion Research: Towards a New Social Epidemiology.* (WHO Regional Publication, European Series, No. 37, 1991), pg. 279.

changes after discharge. In summary, Health Promotion programs in hospitals reduce costs and improve the quality of health care services.

Health insurance companies, Health Maintenance Organisations (HMO's) and Managed Care enterprises can also play important roles in encouraging Health Promotion by developing incentive programs, organising data about good health practices and disseminating this information through newsletters and other public relations vehicles. A heart-healthy lifestyle incentive program, for example, can benefit insurance companies and reduce health problems for many people. As a bypass surgery costs a minimum of thirty thousand dollars,[445] eliminating the need for just one of these represents a considerable amount of money that insurance companies can use for lifestyle-change programs that address the causes of heart disease and reduce the need for expensive medical treatments.

The hospital environment itself presents uniquely difficult health challenges as a workplace, including the pressures of coping with grief, stress and burnout, difficult working conditions, rotating shifts, frequent exposure to communicable diseases and on-the-job injury. Because hospitals are complex environments fraught with many factors that work against the health of employees, yet are places where ready Health Promotion expertise is available, they are opportune sites for Health Promotion efforts. Successful hospital programs can become valuable and inspirational models for other workplaces.

Expensive new technologies, the complications of Medicare and other managed care systems, a public that has become increasingly unhappy with the cost and quality of care, and the limits inherent in the biomedical paradigm, all call for restructuring of health care and health care delivery. Likewise, increasing technology, severity of illness and shorter hospital stays condense more activity into a shorter period of time, resulting in stresses for the hospital staff and dissatisfaction for the patient.[446] The transformation called for is a shift from managing illness through a bureaucratic, fragmented and compartmentalised structure to the process of creating and promoting health through an integrated, price-sensitive, Person-Centred Approach, oriented toward education, communication, and empowerment.

18.2 A New Orientation for Health Care Settings

The **WHO Health Promoting Hospitals Project**, initiated in 1988, has established guidelines for a process of strategic development to change a curative institutional culture into a health culture aimed at promoting the health of staff, patients and their relatives, and creating a supporting healthy environment. The

[445] Pelletier, op. cit., pg. 253.
[446] Parsons, M.L. & Murdaugh, C.L. *Patient-Centred Care: A Model for Restructuring*. (Gaithersburg, MD: Aspen Publishers Inc., 1994), pg. 6.

Ljubljana Charter for Health Care Reforms and Vienna Recommendations on Health Promoting Hospitals, define a **Health Promoting Hospital** as one that:[447]

1) Promotes human dignity, equality, solidarity, and professional ethics, acknowledging differences in needs, values and cultures of different population groups;
2) Is oriented toward quality improvement, the wellbeing of patients, relatives and staff, protection of the environment and realization of the potential to become a learning organisation;
3) Focuses on health with a holistic approach and not only on curative services;
4) Is centred on people providing health services in the best way possible to patients and their relatives, to facilitate the healing process and contribute to the empowerment of patients;
5) Uses resources efficiently and cost-effectively, and allocates resources on the basis on contribution to health improvement;
6) Forms as close links as possible with other levels of the health care system and the community.

18.3 A New Training for Health Personnel

Changing from a doctor-centred, biomedical approach to a Person-Centred bio psychosocial approach involves more than developing a systemic perspective on how health is created and illness can be treated. It involves changes in the way that doctors, nurses and other health professionals are trained to perceive their role, the way they are trained to relate to the patients they work with, and a transformation in the educational process itself.

Medical training has traditionally emphasized disease rather than health, and the process itself has tended to desensitise medical students to human suffering and undermine physicians' ability to communicate effectively and develop strong relationships with patients.[448] Because the bio psychosocial approach to Health Promotion represents a paradigm shift, this shift must be reflected in the training of health professionals. Training must emphasize ways to help patients' achieve their

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[447] WHO. (2002). *Health Promoting Hospitals: Working for Health*. http;//es.euro.who.int/

[448] Barbee, R.A. & Feldman, S.E.. A three-year longitudinal study of the medical interview and its relationshop to student performance in clinical medicine. (*Journal of Medical Education, 1970), 45,* 770-776; Cohen, S.J. An educational psychologist goes to medical school, in: Eisner, E.W. (ed.) *The educational imagination: On the design and evaluation of school programs.* (2nd ed. New York: Macmillan, 1985), pg. 324-338; Helfer, R.E. An objective comparison of pediatric interviewing skills on freshman and senior medical students (*Pediatrics,1970) 45,* 623; Preven, D.W., Kachur, E.K., Kupfer, R.B. & Waters, J.A. Interviewing skills of first-year medical students *(Journal of Medical Education, 1986), 61*, 842, 844.

health potential, the promotion of healing, and restoration of wholeness and connectedness after the disruption of illness.

Medical training should become a *student-centred* process that is congruent with and models the skills and values of a *Patient-Centred Medicine*. Medical students should be mentored in ways that nurture sensitivity and caring so they learn first-hand the empowering benefits of the Person-Centred Approach. Furthermore, the training of medical students must equip them to transfer to patients the skills of healing, so that patients see themselves as responsible for their own health and well-being, capable of healing themselves, and of changing aspects of their lives which don't support health.

Patient-Centred Medicine has its roots in the Socratic method in which both students and teachers are "inquirers" helping each other in the shared pursuit of truth. Training physicians and other health professionals in Patient-Centred Medicine is more than learning a set of knowledge, skills and attitudes, however comprehensive; it becomes, as well, a process of personal growth and empowerment which develops out of each medical student's personal experience of the Person-Centred Approach.[449]

18.4 The Emergence of a Person-Centred Medicine

The findings and recommendations of the National Academy of Sciences Committee on Health and Behaviour provide a framework for Person-Centred Medicine[450] (see following figure).

[449] Hendley, B. Martin Buber on the teacher-student relationship: A critical appraisal *(Journal of Philosophy of Education, 1978) 12,* 144, pg. 144.

[450] Committee on Health & Behavior, National Academy of Sciences, Institute of Medicine. *Health and Behavior: An Interplay of Biological, Behavioral and Societal Influences*. (Washington, DC: National Academy Press, 2001).

National Academy of Sciences Committee on Health and Behaviour: Findings and Recommendations (condensed)

Finding #1: Health and disease are determined by dynamic interactions among biological, psychological, behavioural, and social factors, which occur over time and throughout development. Cooperation and interaction of multiple disciplines are necessary for understanding and influencing health and behaviour. **Recommendation:** Funding agencies should direct resources toward interdisciplinary efforts for research and intervention studies that integrate biological, psychological, behavioural and social variables.

Finding #2: A fundamental finding is the importance of the interaction of psychosocial and biological processes in health and disease. Psychosocial factors influence health directly through biological mechanisms and indirectly through an array of behaviours. Social and psychological factors include socioeconomic status, social inequalities, social networks and support, work conditions, depression, anger, hostility. **Recommendation:** Research efforts to elucidate the mechanisms by which social and psychological factors influence health should be encouraged.

Finding #3: Behaviour can be changed: however, maintaining behaviour change over time is a greater challenge. Improved health outcomes will often require prolonged interventions and lengthy follow-up protocols.
Recommendation: Funding for health-related behavioural and psychosocial interventions should support realistically long-duration efforts.

Finding #4: Individual behaviour, family interactions, community and workplace relationships and resources, and public policy all contribute to health and influence behaviour change. Research suggests that interventions at multiple levels (individual, family, community, society) are most likely to sustain behavioural change. **Recommendation:** Concurrent interventions at multiple levels should be encouraged to promote healthy behaviours. Assessments of coordinated efforts across levels are needed.

Finding #5: Initiating and maintaining a behaviour change is difficult. Evidence indicates that it is easier to generalise a newly learned behaviour than to change existing behaviour. **Recommendation**: Resources should be allocated to the promotion of health-enhancing behaviour and primary prevention of disease. This should be a public health and health care priority.

Finding #6: The goals of public health and health care are to increase life expectancy and improve health-related quality of life. Many behavioural interventions document the capacity to modify risk factors, but few measure mortality and morbidity. **Recommendation:** Intervention research must include appropriate measures to determine whether the strategy has the desired health effects.

Finding #7: Changing unhealthy behaviour is not simply a matter of "willpower". Individual behaviour has biological underpinnings and consequences and is influenced by the social and psychological contexts in which it occurs. Changes in social factors, policies, and norms are necessary for improvement and maintenance of population health. **Recommendation:** Program planners and policy makers need to consider modifying social and societal conditions to enable health behaviour and social relationships. Longitudinal research designs, natural experiments, quasi-experimental methods, community-based participatory research, and development of new research methods are necessary to advance knowledge in these areas.

[Figure #47—National Academy of Sciences Committee on Health & Behaviour: Findings and Recommendations]

Patient-Centred Medicine must integrate conventional understanding of disease with the patient's experience of illness, the systemic determinants of health, and the skills for promoting health and human empowerment. The Patient-Centred Approach, as Stewart et al. observe, "allows the practitioner to find the methods of health promotion and preventive care that most appropriately match the patient's world… Knowledge of this world helps in making a judgment about which health promotion or disease prevention strategy provides the most appropriate fit."[451]

Levenstein et al. at the University of Western Ontario have identified six interconnecting components which serve as a useful model for a Patient-Centred Approach to Medicine.[452]

[451] Stewart, M., Brown, J.B., Weston, W.W., McWhinney, I.R., McWilliam, C.L. & Freeman, T.R. *Patient-Centred Medicine: Transforming the Clinical Method.* (Thousand Oaks, CA: Sage Publications, 1995), pg. 79.

[452] Levenstein, J.H., McCracken. E.C., McWhinney, I.R., Stewart, M.A. & Brown, J.B. The patient-centred clinical method: I. A model for the doctor-patient interaction in family medicine. *Family Practice,1986, 3*(1).

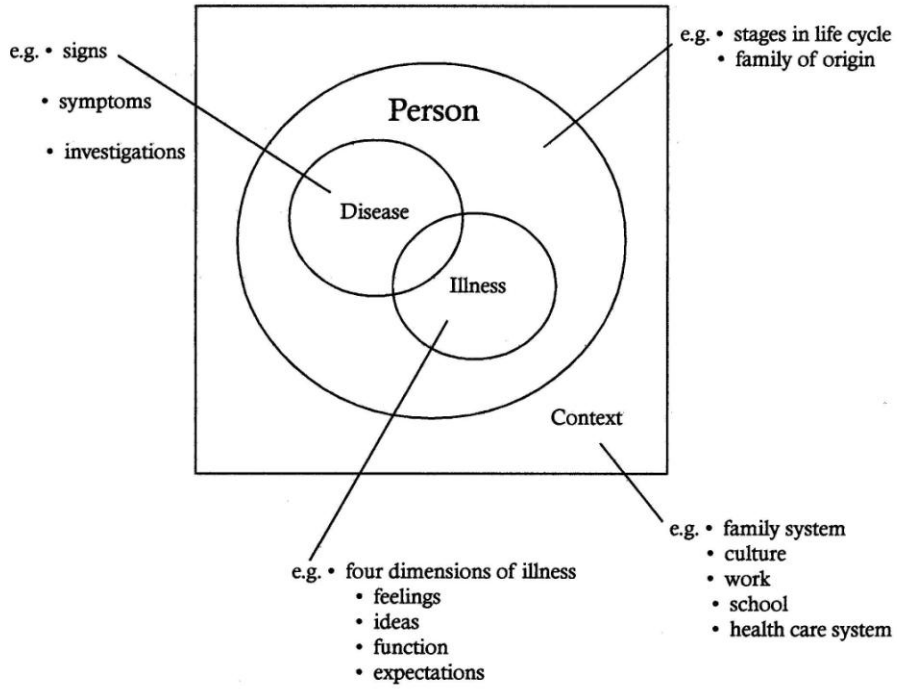
6 Interactive Components of the Patient-Centred Process

1. **Exploring both the disease and the illness experience**
   - A. Differential diagnosis
   - B. Dimensions of illness (ideas, feelings, expectations, and effects on function
2. **Understanding the whole person**
   - A. The "person" (life history, personal and developmental issues)
   - B. The context (the family and anyone else involved in or affected by the patient's illness; the physical environment)
3. **Finding common ground regarding management**
   - A. Problems and priorities
   - B. Goals of treatment
   - C. Roles of doctor and patient in management
4. **Incorporating prevention and health promotion**
   - A. Health enhancement
   - B. Risk reduction
   - C. Early detection of disease
   - D. Ameliorating effects of disease
5. **Enhancing the patient-doctor relationship**
   - A. Knowing and providing the characteristics of the therapeutic relationship
   - B. Sharing power
   - C. Developing a caring and healing relationship
   - D. Self-awareness
   - E. Handling transference and counter transference
6. **Being realistic**
   - A. Time
   - B. Resources
   - C. Teambuilding

[Figure #48—6 Interactive Components of the Patient-Centred Process]

In clinical practice, this model can be depicted as the figure below[453] (see "A Model of Person-Centred Medicine").

[453] Stewart, M., et al., op. cit., pg. 166.



[Figure #49 --- A Model of Person-Centred Medicine]

In behavioural terms, when a patient and physician meet, the patient presents cues about the nature of what is going on, and they begin together the process of exploring the problem and the patient's experience of it. This process may include a physical, history and lab testing, and also include the patient's ideas, expectations, feelings, and the impact of the problem on his daily functioning. As the doctor and patient work on the problem and develop a mutually-trusting and supportive relationship, they both grow in their understanding of the whole person involved (including family, work, beliefs, and struggles with various life crises), the interaction of illness and disease for the patient, and his/her problems, goals, and roles which provide the context for experiencing the problem. They consider ways to prevent future problems, and work together to develop a realistic, effective and mutually-agreed upon decision about the best course of action to improve the patient's health and well-being.

Patient-Centred Medicine requires attending as much to the patient's personal experience of the illnesses as to the disease itself. This requires the physician and

patient focus on the patient's ideas about what is wrong with him/her; his/her feelings (and especially the fears) about being ill; the impact on daily functioning; and the patient's expectations about what should be done. Being alert to the sense of powerlessness patients often experience is important as it enables the physician to support and encourage the patient's exercise of power and utilise the physician-patient relationship as a primary therapeutic tool.[454]

Selection of the best course of action requires that the physician understands the process of adult learning and be able to facilitate the learning process. This can be done by facilitating the patient's reflection upon health, helping the patient learn about potential threats to health inherent in his/her current lifestyle, and exploring the health impact of his behaviours, values, needs, motives, expectations and understandings. It is important that the physician understand the patient's world as a dynamic system that varies over time and across different health circumstances, and differs, in some ways, from other patients. The physician works with the patient to identify and select Health Promotion and health care strategies that best fit the patient's needs and the patient's world.[455]

Stewart et al. emphasise that the Patient-Centred Approach is applicable to ordinary patients, with the key being *"to follow patients' leads, to understand patients' experiences from their own points of view. This method improves patient satisfaction, compliance, and outcomes of both illness and disease."*

The Patient-Centred Approach can be used by health professionals from many disciplines and may be used in combination with more traditional interventions, depending upon, and tailored to, the particular client's needs.

The cooperative interaction that develops between the Patient-Centred health professional and the patient/client makes it relatively easy to design a customized Health Promotion program. Despite the time needed for customisation, such programs have been shown to be a more cost-effective in improving health than more intensive, multiple-approach interventions.[456]

Fundamental to Patient-Centred Medicine is a shift from traditional notions of patient compliance to a view of patients as autonomous individuals with the right to be involved in the process of deciding the courses of treatment and lifestyle changes. Implicit is that the health professional recognise the patient's autonomy and right to self-determination, and understand the social, psychological, and cultural issues that influence the way s/he relates to the health professional and the process of working on health.

Patient-Centred Medicine, a fundamental component of Health Promotion, is build upon the basis of shared power and control between physician and patient,[457] where both are seen as experts, both share a responsibility for acquiring knowledge,

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[454] Brody, H. *The Healer's Power*. (New Haven, CT: Yale University Press, 1992), pg. 65.
[455] Stewart, et al., op. cit., pg. 81.
[456] Cromwell, J., Bartosch, W.J., Fiore, M.C., Hasselblad, V. & Baker, T. Cost-effectiveness of the clinical practice recommendations in the AHCRP guideline for smoking cessation *(Journal of the American Medical Association,1997) 278,* 1759-1766.
[457] Brody, op. cit.

and together make decisions about the best course of action. As McWilliam succinctly puts it, "For optimal Health Promotion to occur, the physician must work collaboratively with patients to empower them to take an active role in planning and managing their own care."[458]

[458] McWilliam, C.L. Health promotion: Strategies for the family physicians (*Canadian Family Physician, 1993) 39,* 1079-1085.

Chapter 19 – Community & Legislative Health Promotion

"Health promotion goes beyond health care. It puts health on the agenda of policy makers in all sectors and at all levels, directing them to be aware of the health consequences of their decisions and to accept their responsibilities for health. Health promotion policy combines diverse but complementary approaches including legislation, fiscal measures, taxation and organisational change."

WHO Ottawa Charter for Health Promotion

19.1 Principles of Community-based Health Promotion

The traditional view has seen the work of health professionals as helping people "live ordinary lives in the community with whatever health conditions they happen to have."[459] Rather than responding to the health conditions people happen to have, the WHO strategy for Health Promotion works to minimize inequities and involve communities and individuals as active participants in the process of achieving health. The WHO strategy requires "a more thoroughgoing commitment by the general public than was ever thought necessary"[460]so that Health Promotion becomes *by* the people not just *for* the people.

Health Promotion calls for open discussion about the interests of individuals, groups and the public at large. Based upon the United Nations "Universal Declaration of Human Rights" and other international agreements, these practices foster "the deliberate nourishing of competence and confidence to understand society and take responsible decisions."[461] Ritsatakis has identified ten core values (see figure on "10 'S' Values of Health Promotion")[462] inherent in Health Promotion.

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[459] O'Keefe, E. & Newbury, J. *Divided London: Towards a European Public Health Approach* (London: University of North London Press, 1993).
[460] O'Keefe, E. Values and ethical issues, in: *An Individual and Community Focus for Health Promotion*, pg. 63.
[461] Ibid.
[462] Adapted from Ritsatakis, et al., op, cit., pg. 379.

10 "S" Values of Health Promotion

1) Socially acceptable—advocates and facilitates consensus on the value of Health for All

2) Sensitive—responds appropriately to differing needs (e.g., gender issues, needs of vulnerable groups) providing evidence to inform the discussion and ensuring that the voice of these groups is heard

3) Sustainable & feasible—promotes environmentally friendly solutions, tested to suit new patterns of living, working, and caring for family members

4) Seamless—an integrated approach to health, assessing the health impact of global, national, local policies, looking for threats to and opportunities for health across sectors and boundaries

5) Smarter—adapts quickly to technological advances, through flexibility in the face of rapid change while maintaining consistency of purpose

6) Simple not simplistic—avoids expert terminology, speaks the language of those with problems and those with the solutions, finds strategies and policy measures in line with felt needs

7) Scientific—provides sound evidence, utilizes quantified and qualitative data and the best available experience to match problems and opportunities to resources and solutions most likely to succeed

8) Selective—in the complex process of achieving Health for All, chooses priorities on the basis of clear criteria and a democratic process, sets a clear timetable, designates responsibilities and means of arbitrating conflicts of interest

9) Skilful—masters the new competencies (consulting, negotiating and advocating for health) needed to sustain a Health for All approach over time, works with new partners at the international, national, regional and local levels and with communities, groups and individuals; puts in place mechanisms that facilitate the development of such partnerships and counteract possible financial, structural and cultural obstacles

10) Steadfast—argues for equity, ethics, solidarity, participation and sustainability even in the teeth of opposition, and sticks by those principles even in hard times

[Figure #50—10 "S" Values of Health Promotion]

In concert with these values, the framework of the WHO strategy calls for:

> *widening the participation in decision-making of all sections of the population at large, as well as institutional stake-holders. The society is seen as needing to be more democratic and the population as requiring resources and opportunities to learn about and understand how health status is affected by the full spectrum of causation*.[463]

Since underlying causes of ill health include poverty and deprivation, Adams see *inequality* as an important factor and underscores the importance of social factors in Health Promotion:

> *A social model of health takes the view that social and economic factors exert the greatest influence in terms of health. The aim is to identify ways to change the social processes that make almost all the major causes of disease and death more common in poor people. This may be achieved by working with local people to meet health needs, aiming to reduce inequalities and improve the public health.*[464]

Such a model empowers individuals and communities to participate in determining their health and lifestyles, to achieve equity in power and resources, and a supportive relationship between people and their environment. (See following two examples from Sweden and the UK.)

[463] Op. cit., pg. 64.
[464] Adams, L. Health promotion in crisis (*Health Education Journal*, 1994), 53(3): 354-360.

Options for National Governments: Legal and Fiscal Measures in Sweden

In its Public Health Service Act of 1985, the Swedish Government formally acknowledged that the health of the population was determined predominantly by living and working conditions and lifestyles. The scientific evidence emerging in subsequent years persuaded the government that more health effort should be focused on the workplace. In 1988 the Swedish Commission on the Work Environment was appointed to look into problems and make policy recommendations. In particular, the Commission was charged with the task of proposing measures to eradicate the 400,000 most hazardous jobs on the labour market (Haglund et al. 1991). The Commission reported in 1990, recommending that legislation be amended to recognise the effects that modern work practices had on the health of workers, particularly psychosocial factors such as forced pace of work, lack of control over decisions, lack of social contact, piece-work and shift work.

Most of the recommendations were incorporated in 1991 into amendments to the 1077 Work Environment Act. This clearly specified the principles to be applied to the work environment, including:

- working conditions should be adapted to people's differing physical and psychological circumstances;
- employees should be able to participate in the arrangement of their own job situation and any proposed changes in the workplace that affect their jobs;
- technology, work organisation and job content (including remuneration and schedules) should be arranged so that the employee is not exposed to physical or mental pressures that may cause ill health or accidents;
- work should provide opportunities for variety, social contacts and cooperation, and continuity between individual tasks;
- working conditions should offer opportunities for personal and occupational development as well as for self-determination and occupational responsibility (Levi 1992).

The Act embodied recognition of psychosocial risk factors to a much greater extent than had been acknowledged in this or other countries before. It also acknowledged that work can be health promoting in its own right, for example, by offering opportunities for personal development.

European Occupational Health Series No. 10.
Health promotion in the workplace: Strategy options

[Figure #51—Options for National Governments: Legal and Fiscal Measures in Sweden]

Options for National and Local Governments: A UK Example

As part of the national health promotion strategy adopted in Wales in 1990 and the rest of the United Kingdom in 1992, targets were set for reducing various lifestyle-related risk factors. The workplace was identified as a key setting for interventions to help meet these targets.

One such intervention was the "Health at Work in the NHS" initiative. With over 800,000 employees, the National Health Service is the largest employer in Western Europe and recognised that it needed to set a good example if the government's exhortations to other employers in the country were to be taken seriously. The national Health Education Authority was commissioned to implement a plan to reach all employees in the NHS. In 1992 an action plan was sent to the general managers and chief executives in all parts of the service.

This was followed by workshops around the country to help formulate practical "Health at Work" strategies, which the health authorities in each region and district were required to incorporate into formal contracts. These contracts specify targets for the development and implementation of comprehensive policies on smoking, food and alcohol, and opportunities that will be provided by employees, ranging from physical activity programs to counselling and health checks.

The initiative is being used as a test-bed for the delivery and evaluation of different approaches to workplace health promotion, and pilot sites are being set up. In addition, a central database of projects is being established so that all employers can benefit from the experience around the country. (Department of Health, 1993).

Health promotion in the workplace: Strategy options, op. cit.

[Figure #52—Options for National and Local Governments: A UK Example]

An important component of large-scale Health Promotion is *Social Marketing*, in which new ideas and behaviours are encouraged through a process of marketing techniques applied to social issues and causes, rather than to products and services.[465] In the same way that commercial businesses research new markets in order to influence consumer need, health promoters can research the social, ethnic, and class profiles where they work, identify particular health needs and hazards, and promote the values of Health Promotion to the public, professional colleagues and policy makers.[466] Social marketing works to engage the public in a dialogue about common health concerns, help people see Health Promotion as a right, and create a demand for Health Promotion. The approach includes the use of mass media to diffuse health messages widely.

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[465] Lefebvre, C. Social marketing and health promotion, in: Bunton, R. & Macdonald, G. (eds.). *Health Promotion: Disciplines and Diversity.* (London: Routledge, 1992).

[466] Gott, M. & O'Brien, M. The role of the nurse in health promotion (*Health Promotion International*, 1990), 5(2): 137-143.

19.2 Facilitating Community Competence

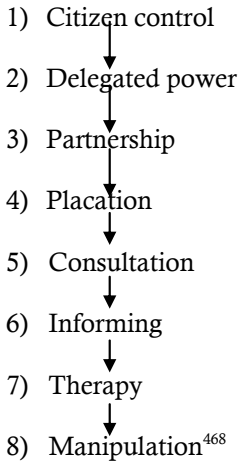
If we wish to empower communities to develop the full health potential of citizens, the Person-Centred Approach provides a solid base upon which health-supportive communities can be nourished. Facilitating community competence includes infusing organisations with the capacity for helping people make informed choices, take responsibility for their health, and developing the capacity for self-regulation. This must include the training of health promoters in these skills so that they can train others, creating a cascading beneficial impact throughout the community.

Studies of community organisations have found that during the early stages of community activation, orientation and information sessions are important for educating people about local health issues and the efficacy of cooperative action. Other important components are:

- The sponsoring group must operate in good faith;
- The authority of citizen groups must be clearly defined and adequate resources readily available;
- Project sponsors must commit to partnership and/or local ownership from the beginning of the project;
- Adequate knowledge is available about community history, organisational resources, influence structure, and inter-organisational networks;
- Participants have clearly stated roles and time commitments;
- Plans for reinforcement and recognition of citizen participation are built into the program;
- Forces resistant to change within the community are identified early and discussed openly;
- Conflict resolution strategies are used whenever appropriate.[467]

How much citizen involvement is achievable or optimal is unknown, and, in practice, the gamut ranges widely. Arnstein identified eight descending rungs on a ladder of citizen participation, ranging from true citizen power to tokenism, as shown below:

[467] Spergel, I. *Community Problem-solving.* (Chicago: University of Chicago Press, 1969); Carlaw, R.W., et al. Organisation for a community cardio-vascular health program: experiences from the Minnesota Health Program (*Health education quarterly*, 1984), 11: 243-252.



Generally, communities working at the higher levels form some kind of partnership between a core group of community leaders and knowledgeable health professionals, change agents, and political leaders. In the well-known Finnish project in North Karelia, for example, project organisers understood that change in the behaviour, values and norms of the community could occur only through the active participation of community residents and organisations. Citizen involvement was defined from the outset as a prerequisite for achieving the health goals of the project.

The community organisation may be developed as a coalition, a leadership board or council, lead agency, grassroots organisation, citizen panels, or a group of interlocking networks. Such structures are not static and may evolve into different forms as new needs emerge. Task groups support the work of the organisation, and plans are implemented in a variety of ways including working with the media, other organisations, policies, environment, adult and youth education, and health professionals. Once the program has been implemented, it is maintained by local involvement.[469]

Typical community Health Promotion projects have six stages that occur over a period of three years or more:

1) Community Analysis and Assessment

Typically taking about one year, this is a continuing process even after the initial assessment and identification of community needs is completed, as communities are dynamic entities whose needs continually evolve;

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[468] Arnstein, S. A Ladder of Citizen Participation (*American Institute of Planners Journal*, 1969), 5: 216-224.
[469] Op. cit., pg. 489-490.

2) Design and Initiation

Program design is generally begun during the first year while needs assessment is carried out, then refined and completed once the community's needs are fully identified;

3) Program Implementation

Program implementation begins after the HP program design has been ratified by the program sponsors and the community, personnel and funding are ready, and community awareness and support are achieved. Implementation generally begins in the second year and runs for two or more years;

4) Consolidation and Maturation

Once the Health Promotion program has been underway for about a year, it undergoes a natural process of refinement, with adjustments made to make the program more efficient and effective, based upon feedback from health professionals, program participants, community leaders, and the ongoing needs of the community. This refinement and consolidation runs through the length of the project;

5) Maintenance and Incorporation

After about two years of implementation, the program achieves a state of maturity and becomes accepted by the community as part of the status quo;

6) Dissemination and Reassessment[470]

After the initial project has run for the period planned, results are summarized and disseminated throughout the community and to the larger Health Promotion community. Based on results achieved, the project is reassessed and needed improvements, if any, are suggested and incorporated into future Health Promotion plans.

Chavis emphasises the importance of disseminating preliminary results of community-based projects:

> *It can enhance the quality and applicability of research, provide an opportunity for hypothesis generation and hypothesis testing and facilitate planning and problem-solving by citizens… (and) build a positive relationship between scientist and citizen.*

The town-and-gown balance between community and professionals is not always easily achieved, and lofty goals can run aground, especially if facilitation skills are not used at times of difficulty. Continual monitoring of the project is vital to achieving the desired results.

Outcome assessments of community-based Health Promotion activities should include the following variables:

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[470] Bracht, N. Citizen participation in community health: principles for effective partnerships, in: Badura & Kickbusch, op. cit., pg. 488.

- **Changes in health awareness**; how it is created, how it is supported
- **Behaviour change**; numbers of people engaged in various health-promoting behaviours, including immunizations, exercise, enrolment in community health programs, use of community exercise facilities
- **Policy changes**; implementation of health-supporting policies in schools, workplaces, community centres—including nutrition, exercise, stress reduction programs
- **Changes to physical environment**; changes in air pollution, noise levels, number of playgrounds and sports areas, traffic levels, walking paths, location and structure of new neighbourhoods including access to jobs and public facilities, availability of public transportation
- **Changes in health status**; analysis of trends in routine health statistics[471]

Interestingly, community involvement has an important by-product not readily apparent. Despite the evident benefits of citizen involvement in the development and implementation of Health Promotion programs, the greatest benefit may derive from *the processes of working together as a community*—the human interconnectedness which results from the process. Because human beings are social creatures and health is socially created, and because social isolation is a risk factor for illness, *the process of citizen involvement in Health Promotion may be one of the most important health factors for the individuals involved.* As Palmore found, there is clear evidence that those who are active in organisations derive better health, happiness and longevity from those activities.[472] In Cassel's words, "citizen participation can go far toward modifying those environmental factors which facilitate the occurrence of illness."[473]

19.3 Models of Successful Community Projects

[471] Adapted from Ewles, L. & Simnett, I. *Promoting Health: A Practical Guide*. 2nd edition (London: Scutari, 1992).
[472] Palmore, from: Walters, W.E., Heikkinen, E. & Dontas, A.S. (eds.). *Health, Llfestyles and Services for the Elderly* (Copenhagen: WHO Regional Office for Europe, 1989), pg. 40.
[473] Cassel, J. The contribution of the social environment to host resistance (*American Journal of Epidemiology*, 1976), 104(2): 107-123.

"Health promotion works through concrete and effective community actions in setting priorities, making decisions, planning strategies and implementing them to achieve better health. At the heart of this process is the empowerment of communities—their ownership and control of their own endeavours and destinies."

WHO Ottawa Charter for Health Promotion

Some cities have implemented healthy cities projects that are valuable models. Among the best known are projects in Finland, South Africa, Switzerland, and Australia. Projects in the U.S. include the Three-Community Study and the Five-City Projects in California, and the Minnesota Heart Health Project. Their health interventions included education programs focused on health risks such as smoking and cholesterol, community classes and contests, one-on-one-counselling, special programs for non-fluent English speakers, and school-based programs for particular grade levels. (Also see box for London's Collaborative Health Education Authority Plan.[474])

London's Collaborative Health Education Authority Plan

The Health Education Authority in London organised a plan called "Look After Your Employee" as a public and private workplace extension of a project on preventing heart disease. Employers were encouraged to join the program by signing in public a workplace charter committing their organisation to at least three of the following ten initiatives:

1) Providing information for all staff about the "Look after Your Heart" project and aspects of healthy living distributed through organisational newsletters and office settings.
2) Providing more smoke-free areas for employees and developing and implementing a comprehensive smoking policy.
3) Providing and promoting healthy food choices of food for staff; developing and implementing comprehensive food policy.
4) Introducing physical activity programs and encouraging staff to exercise.
5) Promoting sensible drinking; developing and implementing comprehensive alcohol policy.
6) Identification of sources of stress within organisation and ensuring employees are better supported in dealing with problems at work.
7) Providing opportunities for all staff to have health checks and appropriate follow-up.
8) Using "Look after Your Heart: Look after Yourself" workplace services, as appropriate, to disseminate and support health messages of the project.
9) Adopting practical management practices across the organisation that provides staff with an environment conducive to good health.
10) Exploring with the Health Education Authority various opportunities for working on the development and promotion of health, healthy products and services.

[474] WHO. *Health promotion in the workplace: Strategy options*. (Denmark: European Occupational Health Series, 1995).

[Figure #53—London's Collaborative Health Education Authority Plan]

"Natural helper" programs have been beneficial where communities don't have access to large amounts of funding. In rural Mississippi which has a high rate of sexually transmitted diseases (STD), natural helpers—those members of a community that others naturally turn to for advice—serve as health advisors after a brief training in a program known as "Respect and Protect". They provide health information and advice, emotional support and tangible aid, including instruction in the proper use of condoms and encouragement to seek health screening.[475] Natural helpers demystify the local health agency and function as contact persons helping young African-American women become comfortable interacting with the predominantly white agency staff. Evaluation after 18 months showed a 60% increase in the number seeking STD care within three days of symptoms among those reporting symptoms, and a 26% increase for those without symptoms.[476] Data from two health centres using natural helper interventions with migrant farm worker families showed that 50-82% of maternal and child health care visits resulted from interaction with trained natural helpers.[477] In North Carolina, natural helpers trained as part of the Save Our Sisters program, created links with older African-American women who had avoided annual breast cancer screenings because of memories of the previously segregated health care system and stigma associated with cancer. The natural helpers produced an educational video and raised funds from churches to cover the cost of bringing a mobile mammography unit to housing projects. In the first 2½ years, mammography use increased by 42%.[478] Natural helpers counsel and assist individuals to improve their health practices, and help the community to build partnerships with the formal health delivery system, bringing structural changes to the health system and social change to the communities.[479]

"The cost of such national programs is moderate, but the cost of *not* launching such programs is to accept the notion that the energies of communities cannot be harnessed for planned social change for health benefit."

Dr. John W. Farquhar, Stanford Centre for Research in Disease Prevention, Stanford Three-Community Study and Stanford Five-City Project.

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[475] DiClemente, et al., op. cit., pg. 127.

[476] Thomas, J.C., Earp. J.A. & Eng, E. Evaluation and lessons learned from a lay health adviser programme to prevent sexually transmitted diseases (*International Journal of STD & AIDS,* 2000) *11,* 812-818.

[477] Watkins, E.L., Harlan, C., Eng, E., Gansky, S.A., Gehan, D. & Larson, K. Assessing the effectiveness of lay health advisers with migrant farmworkers *(Family and Community Health,* 1994) *16,* 72-87.

[478] Eng, E. & Smith, J. Natural helping functions of lay health advisers in breast cancer education (*Breast Cancer Research Treatment,* 1995*) 35,* 23-29; Earp, J.A., Rauscher, G. & O'Malley, M.S. *Closing the black-white gap in mammography use* (Paper presented at the 128th Annual Meeting of the American Public Health Association, Boston, November 2000).

[479] DiClemente, et al., op. cit., pg. 143.

Munich in Germany, developed the Munich Health Park as a preventive institution to "close a gap in the overall health care system between verbal health information and active curative treatment."[480] Its tasks are related to primary and secondary prevention, outpatient rehabilitation of heart patients, and treatment of psychosomatic diseases. The park operates on the principle that behavioural changes are more lasting if the person actively engages information, emotions, and his/her own creative potential in a learning process focused on concrete experiences. The "Learning by Doing"[481] process has five specific learning goals:

1. Restore and preserve physical abilities
2. Systematically relax and recover
3. Revive hidden emotional and sensory potential and develop creativity, spontaneity and sensitivity
4. Establish satisfactory social relationships through improved self-confidence and increased initiative, social contacts, and ability to face conflict
5. Understand health interrelationships through information and consultation[482]

Forty percent of the participants are referred to the Health Park by physicians, 60% attend at their own initiative; 14% have had cardiovascular problems. The 500 participants are supported by a team of 30 full-time staff and 140 associated free-lance professionals, including 20 physicians, 70 psychologists, 50 sports instructors, arts teachers, therapists, physiotherapists, motional therapists, etc. Participants may enrol either in"training" or a "practice" group and the program is permanently open with new admissions possible at any time. The staff of the Health Park works closely with family doctors in all aspects of the outpatient rehabilitation process.[483]

Despite the fact that some participants have to travel long distances to reach the Health Park, and others have limited physical strength, physicians are astonished at the long periods participants spend at the park actively engaged in activities of all kinds. This level of engagement is attributable to the emotional support, the satisfaction of behavioural learning, and the pleasure of the activities themselves.

19.4 Importance of Intersectoral Collaboration

If healthier choices become the easier choices, and organisations throughout society are infused with a vision about the value of realising citizens' full health potential, health transformation can become a reality. With vision, leadership and co-ordination, we can set into motion multidimensional elements of Health

[480] Op. cit., pg. 268.
[481] Ibid.
[482] Op. cit., pg. 269.
[483] Ibid.

Promotion, including: an awareness of the importance of developing policies, goods, and services which support health; educational opportunities, social policies and work opportunities that foster social equity; community structures that support family and social cohesion; safe living and working conditions; a healthy eco-system.

To realise society's full health potential will take coordination and collaboration between all sectors of society: government, schools, social services, workplaces, planning offices, public facilities, health services, community organisations, the media. Such collaboration is not unprecedented. Sweden's Intersectoral Health Council brought together several ministries to evaluate the health effects and implications of their respective policies; the Worker Protection and Working Environment Act in Norway set standards for physical and psychosocial aspects of working environments; and the United Kingdom's National Health Service exports its "Health at Work" initiative to the private sector through workshops and the establishment of a national database.

Links need to be established between mental health services and various community agencies at the local level so that housing, income support, disability benefits, employment, and other social service supports exist for the prevention of illness and the rehabilitation of those being treated.[484] Examples of this type of intersectoral collaboration include university-organised, community-based programs in Zimbabwe, in which public service and local community primary care personnel detect, counsel, and treat women suffering from depression; and in the United Republic of Tanzania where an intersectoral group developed an agricultural program to rehabilitate people suffering from mental and behavioural disorders.[485]

Intersectoral coordination is motivated by recognising the exorbitant costs we pay throughout every layer of society for the unrealized health potential of millions, and seeing the benefits that will come from achieving society's health potential. We must define this as an achievable goal—perhaps in the way that the first human moon landing was articulated; somewhat incomprehensible and somewhat overwhelming, but something we intend to accomplish. We must recognise the importance of intersectoral collaboration in creating the widespread social change that will make this important goal of human empowerment a reality.

19.5 Legislative and Regulatory Action

Health Promotion puts health on the agenda of policy makers at all levels of government—local, state/provincial, national, international—directing them to recognise the far-reaching health consequences of their work and establish policies that make health an achievable goal for all. (See figure 54 on Challenges for Health Policy Development.[486]) One example is the California Tobacco Control Program,

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[484] WHO. *The World Health Report 2001*, op. cit., pg. 92.
[485] Ibid.
[486] Ritsatakis, A., et al. *Exploring Health Policy Development in Europe*. (Copenhagen: WHO, 2002), pg. 375.

which includes media campaigns, laws restricting advertising by the industry, laws restricting sales to minors, laws restricting environmental tobacco smoke exposure in public buildings, and promotion of clinical services for smoking cessation. This became the largest anti-tobacco education program ever developed, advocating policy and legislative restrictions, and taxation increases amounting to millions of dollars which fund a variety of anti-tobacco education activities including school programs, state wide media initiatives, and programs to promote smoking cessation in pregnant mothers.[487]

Challenges for Health Policy Development

• Continued domination of the main causes of death
Assuming no new illnesses arise, the pattern of disease will be broadly as we know it now, requiring action in many sectors to tackle the underlying causes of morbidity and mortality.

• Unequal chances
Large numbers of people will continue to be excluded due to their lack of employment, income, education or health, unless measures are taken to enhance their capacities to cope and provide them with the necessary skills and opportunities to use their full potential. A sense of solidarity will need to be maintained.

• Increasing demands and limited resources
The demand for goods and services will surpass sustainable production processes. Consequently, there will be a need to make critical choices and set priorities in order to use available resources more effectively. This will require a transparent and broad participatory approach to decision-making.

• Conflicts of interests and a pluralism of partners
Certain actors, such as some multinational corporations, those with access to the means of mass communication, even small vociferous lobbying groups, may wield more power than is desirable in a healthy civic society. The state will need to play a strong role in orchestrating an open discussion, enforcing standards and protecting the vulnerable.

• Societies in a state of flux
Societies where institutions and relationships had previously seemed stable will be constantly shifting: relationships between national and local authorities, public services and amenities, employers, employees and workmates, and family members. Therefore, the need will be for a readiness for *change* rather than a readiness to fill a predefined role.

• Information explosion
Seemingly boundless information will be available for some, improving their chance for informed participation, but leaving at a disadvantage those who cannot access this wealth of knowledge. There will be a strong need to access and utilise available information and to employ democratic systems to deter its misuse.

• Technological and scientific advances
We will inevitably be surprised by unexpected technological and scientific breakthroughs, bringing either a positive or negative impact on health and health services. The health sector will need to be vigilant in uncovering and dealing with the opportunities and threats to health.

• New skills and ways of working
Intersectoral action, building and maintaining new partnerships for health and development, requires new skills and approaches. There is an urgent need for training and capacity-building in ways to achieve consensus and managing change.

[Figure #54-- Challenges for Health Policy Development]

[487] DiClemente, et al., op. cit., pg. 370-371.

As governments move to implement approaches to health-for-all, the World Health Organisation identifies four important strategic considerations:[488]

1) Countries will need to make a strong shift towards intersectoral action for health so that health is seen as integral to overall socioeconomic development;
2) Much action should take place in tackling the underlying determinants of health;
3) It is no longer sufficient to put health on the agenda of other sectors; there must also be an attempt from the health sector to contribute to the achievement of objectives in other sectors by looking for common or converging objectives;
4) New alliances must be made and new skills developed, including those required for presenting a convincing health argument; creating awareness of health issues; reaching consensus and dealing with conflicts; assessing the health impact of social and economic policies; evaluating strategies and interventions; monitoring progress; and adapting to change.

One task for legislators is to spread the understanding that the health of citizens is inextricably linked to success and prosperity, and that the laws of the land affect health in profound ways, both positively and negatively. Grounded in this recognition, health impact becomes an important criterion of meaningful legislation. One measure of our progress toward becoming a healthier society will be when the public routinely asks politicians about their Health Promotion legislative record.

Health legislation must be grounded in an understanding of the social determinants of health as previously discussed, especially the following:[489]

- *Equity in the distribution of social resources:* For example, despite the high level of technological advancement of medical care in the U.S., its infant mortality rate is higher than Sweden's where medical technology is less advanced but there is more equitable distribution of education, employment, and income.
- *Education:* As educational attainment is the single most determining factor in mortality rates between various socio-economic classes, increasing educational attainment becomes vitally important for achieving the Health Promotion agenda.
- *Unemployment:* Unemployment levels correlate with mortality, suicide, homicide and imprisonment rates, and thus affect the health of many citizens.

[488] Ritsatakis, op. cit., pg. 378.
[489] International Conference on Health Promotion, Ottawa, 1986.

- *Income, housing, and safe working condition:* These social factors correlate with levels of health, as identified in earlier chapters.

As health is central to national success, and health is socially created, it is important to make *health impact an important criterion for cost-benefit analyses of proposed legislation.* Legislative areas that have significant wide-spread health impact include public health, the economy, labour and industry, commerce, agriculture, energy and transportation, public services, research and technology, and education. Legislation that has a positive impact on Health Promotion will promote these values:

- *Public health legislation* that is oriented towards Health Promotion and health education rather than just maintenance and treatment;
- *Employment legislation* that works toward achieving full employment;
- *Energy legislation* that fosters equitable distribution of energy supplies, lower pollution of the environment, low pollution sources, minimal accident rates, and energy conservation;
- *Transport legislation* that promotes public transportation, close access to jobs and other methods for alleviating commuting; safety measures; non-polluting forms of transportation, ride sharing; community cohesion, walking paths and bicycle routes;
- *Commercial legislation* that limits advertising and sale of health-damaging products like tobacco and excessive alcohol consumption; insurance legislation that reimburses practitioners for healthy lifestyle education programs;
- *Agricultural legislation* that encourages cultivation of healthy foods, health and safety in the production of foods, cultivation and availability of pesticide-free products; discouragement of food subsidies for health-damaging agricultural products such as tobacco;
- *Research and technology policies* that support research on the health impact of government policies; models and measures to assess intersectoral collaboration; tools for measurement of Health Promotion, standards for assessing health impact of new technology and applications;
- *Defence legislation* that promotes peace as an important prerequisite of health; healthy work environments in the defence industry as models of Health Promotion; training of armed services personnel in Health Promotion; voluntary service in non-profit Health Promotion organisations for conscientious objectors;
- *Education policies* that increase school attendance, access, achievement, and whole-person learning; promote health literacy and Health Education in school curricula and health literacy as a national educational goal; mandate healthier school meal programs; promote in-service, post-graduate training, and life-long learning; support training of Health

> Promotion professionals; institute Health Promotion as a required standard for certification of schools.[490]

19.6 Allocation of Funds and Other Resources

Government funds are legitimately and wisely used for Health Promotion because the promotion of health is in the best interest of a country. Government funds can be used to support public and private Health Promotion efforts, and to establish government offices as models of Health Promotion in the Workplace.

Because government is one of the largest employers and contractors, it can institute policies for awarding contracts to businesses that promote the health of workers. This will provide incentives to private businesses and serve as a high profile model of good practice.

Within the private sector, governments can institute fiscal measures including awards, incentives and tax benefits to businesses that promote health in the workplace, produce goods and services in a healthy way, identify, invent and produce products and services that foster health.

Governments can offer prizes and incentives to develop beneficial projects, and higher taxation and other disincentives to businesses that produce health-damaging products.

Government funds can support Health Promotion in the public sector. A portion of government money now used for health remediation can be re-directed to Health Promotion programs. Government money can be used for scholarships for Health Promotion students and for establishing internships bringing Health Promotion education to rural settings.

Government money can support research on Health Promotion, especially for obtaining objective data in areas of public concern such as optimal nutrition, assessment of personal health risk, and highest priority lifestyle changes.

Tax benefits can be given citizens to purchase Health Promotion services such as stress reduction classes, communication skills programs, nutrition and exercise programs, and for achieving specified health-related goals such as reduction in blood pressure, smoking cessation and obesity reduction.

Since government, at local and national levels, is the major funding source for schools, universities and adult education, it possesses a tremendous unrealized potential for promoting health through the curricula of elementary, high school, vocational, undergraduate, graduate and postgraduate educational programs; additionally, professional training programs including medicine, psychology, sociology, business administration, public administration, city planning, engineering, environmental studies and architecture.

Government money can be spent effectively in mass communication about Health Promotion. Besides government's ready access to the news media, some

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[490] Ibid.

countries have government-owned television stations and other media outlets that can produce programs on topics of public concern. Such campaigns will reach a national, even an international audience, and are important ways to increase health awareness and institute widespread behaviour change. (See figure below on WHO Perspective on Essential Components of Health Promotion.[491])

WHO Perspective on Essential Components of Health Promotion:

• **Intersectoral Cooperation**, both governmental and non- government, in innovative actions.

• **Local communities becoming the crucial hub for Health Promotion**, establishing priorities, strategies, and practical actions to achieve their own aspirations for improving health and wellness.

• **Training and education programs** to help citizens increase their capabilities throughout their lifetime, and making these available at school, home and work. Continuing education must be practiced in daily life in every context and at all levels.

• **Health and other sectors becoming restructured consolidated and refocused** on the objective of promoting health and providing effective systems of treatment. Specific health policies must be implemented to:
1) finance research on Health Promotion, disseminate this new culture, address the risks created by ignorance and prejudice; and
2) re-orient health institutions and their personnel in the new awareness and instruments appropriate for treating not just the illness but the whole person.

[Figure #55 – WHO Perspective on Essential Components of Health Promotion]

[491] Zucconi, et al., op. cit., pg. 74-75.

Chapter 20 – Health Promotion in Other Institutions

> *"Our societies are complex and interrelated. Health cannot be separated from other goals… The overall guiding principle for the world, nations, regions and communities alike, is the need to encourage reciprocal maintenance—to take care of each other, our communities and our natural environment*."
>
> WHO Ottawa Charter for Health Promotion

20.1 Social Service Organisations

Social service organisations—whether private (e.g., Red Cross/Red Crescent), religious (e.g., Salvation Army, Catholic Charities) or governmental (e.g., Public Assistance) offer a broad and respected base for Health Promotion activities. Their mandate is to aid and support the well-being of their client populations, they are well organised, staffed by conscientious people dedicated to making a difference and are well-known in the community. Furthermore, their orientation has traditionally included attention to psychosocial factors, even though the approach to medical issues has mainly been reparatory.

The needs addressed by these organisations illustrate their involvement with health: family planning and birth control; family and child counselling; aid to seniors; drug and alcohol addiction; disaster relief; support groups for victims and families of catastrophic illnesses; aid to the homeless, handicapped, destitute, victims of domestic violence; psychological counselling; youth exercise; job training centres, and many more. The bio psychosocial paradigm will refocus these agencies in a valuable way, empowering their capacities to help the needy and poverty-stricken segments of society whose very neediness is a deleterious health determinant and one of the most difficult to address. Social workers who expand their expertise in the bio psychosocial approach to Health Promotion, with a caseload of people already at hand, will be at the front line of Health Promotion.

Since the lives of the population served by social service agencies are prone to crises which social workers have traditionally been expected to resolve, burnout has been a troubling by-product for many social service practitioners. Health Promotion efforts that emphasize client empowerment can improve clients' lives while having the added benefit of helping social workers deal more effectively with their workload.

20.2 Professional Associations and Guilds

Health is promoted or inadvertently damaged by the work of many professions—including obvious ones like medicine, psychology, counselling, nursing, social work, and less obvious ones like management, teaching, transportation and environmental engineering, city planning, architecture, city management. These professionals organise themselves into guilds and associations to enhance their image and influence, set standards and criteria for professional competency, keep practitioners in touch with each other and up to date in their technical expertise. Such organisations are national and even international in scope, and many require members engage in continuing education to keep their certification in good standing. Since Health Promotion is or can be shown to be relevant and important to all these fields of practice, professional associations have the potential for positive impact if Health Promotion competencies are included as criteria for certification and re-certification.

Members of these groups are reachable and teachable candidates for empowerment as health promoters. The bio psychosocial approach offers a curriculum that will expand the awareness of many professions, bring new skills and competencies, encourage communication and collaboration across professional boundaries, and expand professional effectiveness.

20.3 Education, Training & Adult Education

We have spoken of the important roles government can play in support of Health Promotion through its involvement with educational institutions. Educational institutions themselves have an important role in designing and offering Health Promotion curricula at all levels from pre-school to university and trade school. In the public sector, consulting and training organisations design Health Promotion programs as out-sourced options for business, government and community organisations, and Adult Education programs for schools and community colleges. Organisational Development consultants, professional trainers and other educators are important forces for change in this process of enabling society to realise its health potential.

Adult Education, with its access to the adult learning population, has untapped potential for carrying the message of Health Promotion to its consumers. Not only is Health Promotion an interesting interdisciplinary subject for intellectual pursuit, it is an important way to empower mature adults and enhance the well-being of communities, benefits which make Health Promotion a valuable addition to Adult Education programs.

20.4 The Media

The impact of mass media as opinion makers and "reality builders" throughout society is well known. The influence of television, radio, newspapers, magazines, books, videotapes, CD's and more recently the Internet and the World

Wide Web, is enormous—for good or ill. Whether dispensing news, offering entertainment, or advertising products, the media educate and persuade, divert and inform, claim large pieces of people's time, and influence the way people interpret the world. For all these reasons, Health Promotion needs media support to achieve the social change required for widespread success.

Today's media culture is complicated by corporate consolidation, pressure to improve profitability and stock prices, and a drive toward sensationalism to acquire and retain viewers and readers. The interjection of Health Promotion can be a valuable counterbalance for these forces.

Health concerns have always had a place in the media, including "health adverts" on television news programs, articles in newspapers, magazines and the Internet. While these may be seen as good signs, they are typically brief, too often characterised by sensationalism rather than accuracy, and grounded in a mechanistic approach to health.

The task of Health Promotion through the media is to wean the viewing and reading public away from the biomedical model on to a systemic bio psychosocial paradigm while using the media's unique abilities to entertain. Media experts can make a genuine contribution to Health Promotion by working with health experts to "package" Health Promotion in ways that present valid information, involve readers and viewers, engage their curiosity and intellect, and spur personal action. Young people, who spend long hours watching television and surfing the Internet, constitute an especially important consumer group to which vigorous Health Promotion efforts should be directed through their favourite media.

Besides the numerous public benefits of this, media managers can enhance their own and their company's images—an important value in the industry—by making and implementing a long-range commitment to Health Promotion.

20.5 Research Institutions

Research institutions are essential to Health Promotion. From the science departments of large universities, to non-profit foundations that fund the search for cures of specific diseases, and giant pharmaceutical laboratories probing for new drugs to sell, research institutions have made stunning curative advances operating within the biomedical model. However, their dramatic successes accelerate the demand for newer and better, and consequently, more expensive, cures, and drive research efforts and public interest towards increasingly unsustainable health costs. Furthermore, their primary focus has not been the promotion of health per se.

A major task is to foster a shift within the research community—reducing concentration on cures, and emphasising the development of a fuller knowledge about the systemic nature of health. Research should address at a more complete level the psychosocial determinants of health so the average citizen will gain deeper understandings about lifestyle, personal choice and health. Research is also needed on how to save our increasingly-threatened environment upon which the health of every creature on earth is dependent. Some eco-system health subjects deserving

greater investigation are over-population; clean and renewable energy sources; alternatives to fossil fuels and nuclear energy; air, water and soil pollution; ozone layer depletion; and global warming. Challenges for social scientists will include finding ways to make needed changes both politically and economically viable.

20.6 International Cooperation

Because health is created in a social context that exists without national borders, because modern society is extremely mobile, and because the world increasingly becomes one neighbourhood, international cooperation for Health Promotion is essential.

Countries like Canada with innovative Health Promotion programs, data, and expertise can provide assistance to other nations. Official linkages between governments open the door to international cooperation that benefit all—through data sharing, sharing of methodology and other forms of expertise, professional exchanges, cooperative ventures and joint funding possibilities.

Just as Quality Assurance certifications and Total Quality Management programs have the same parameters all over the world, Health Promotion criteria should likewise be included as measures of quality in international certification programs. Productivity and quality are advanced when workplaces promote the health and well-being of workers, yet this correlation is not yet visible enough to propel some organisations to action. When it becomes mandatory for businesses to promote health in order to gain certain certifications, Health Promotion will become fully embedded in the culture of the workplace.

Health Promotion, a subject inherently systemic, will benefit from networks of linkages, joined to empower each other in working to create the full health potential of all of Earth's citizens.

Chapter 21 — Conclusions

Those of us living now have more opportunity than any human beings who have lived before us to create *Health* for ourselves and those we love. Not just the treatments of disease, symptom relief, and prevention—but vitality, wholeness, well-being— are all available like never before. Building upon the breakthrough revelations developing out of the biomedical model, the systemic paradigm which views health as embedded within a multiplicity of bio psychosocial determinants enlarges our field of investigation and empowers us with new tools. The Person-Centred Approach provides a context for creating growth-producing relationships and skills that facilitate the empowerment of professionals and the clients they serve. In combination, these innovations enable people to make changes in their personal behaviour, changes in the culture of the workplace, and changes in social systems that bring the promise of the Ottawa Charter to life. As a result, we are now at a place in history where health is a right and a need whose time has come. The task of Health Promotion is to bring that promise into welcome reality.

Health Promotion will require bold and widespread initiatives throughout society. To achieve health for all will require a transformed set of understandings and priorities-—from individuals, to families, social organisations, workplaces, government at all levels, and international partnerships. It will ask individuals to grow, it will ask organisations to change, and societies to view their human and financial resources in different ways. It will ask for a complex, systemic change throughout society. Part of the change will be for Health Promotion to be viewed not as a cost to society but as a sound and essential investment by which the well-being of individuals, the success of businesses, and the prosperity of nations can and will be increased. (See the HP Challenge of the New Millennium, below.)

The Health Promotion Challenge of the New Millennium: Where and How Is It Carried Out?

- At all levels and in all sectors of society;
- Concentrated in projects and areas that guarantees an optimal cost-benefit ratio;
- Conceived as a vast effort to promote change in the ideas, habits and laws that governs our society;
- Must include communicating clearly about benefits to the public;
- Must include training and retraining of professionals involved in various aspects of health protection and human resources management;
- Important to create a new professional role—that of Health Promoting Spoecialist;
- Important to restructure training curricula and continuing education courses for doctors, psychologists, teachers, social assistants, social workers in general;
- Important to restructure training and continuing education programs for other professions including engineers, economists, architects, magistrates, managers, trade unionists, politicians at both national and local levels.

[Figure #56—The HP Challenge of the New Millennium—Where & How Is It Carried Out?]

Health Promotion, in all its ramifications, promises incalculable benefits for our lives and for our world. We have opportunities to improve our own health, which we should and must, and opportunities to empower others in similar ways. Centuries of knowledge combine with new understandings to give us a precious opportunity to create personal and societal change that will better peoples' lives and reverberate positively throughout the world. Working together, we can usher in an exciting new era of Health Promotion.

APPENDIX

FOR MORE INFORMATION & RESOURCES

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GORDON TRAINING INTERNATIONAL/Effectiveness Training Programs
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www.gordontraining.com Email: info@gordontraining.com

HARDINESS INSTITUTE, INC.
Dr. Salvatore Maddi/4425 Jamboree, Suite 140, Newport Beach, CA 92660 USA
TEL: 1-949-252-0580; FAX: 1-949-252-8087;
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HEALTH EDUCATION: ***Health Education Research*** **(journal)**
Oxford University Press, Journals Subscription Department, Great Clarendon Street
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www.her.oupjournals.org E-mail: jnl.info@oup.co.uk

HOWELL-JONES TRAININGS/World Class Marriage™
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IACP—ISTITUTO DELL'APPROCCIO CENTRATO SULLA PERSONA
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TEL: 1-360-437-0300; FAX: 1-360-437-0300
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INTERNATIONAL LABOUR ORGANISATION (ILO)
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www.ilo.org Email: ilo@ilo.org

SELF-EFFICACY
Dr. Albert Bandura/Jordan Professor of Psychology, Stanford University, Palo Alto, CA 94305 USA
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Additional info at: www.emory.edu/EDUCATION/mfp/efficacy.html

WORLD HEALTH ORGANISATION (WHO)
20, Avenue Appia, CH-1211 Geneva 27, Switzerland
TEL: (41) 22 791 22 11; FAX: (41) 22 791 31 11
http://www.who.int Email: info@who.int
- Healthy Workplaces: www.who.dk/healthyworkplaces
- Healthy Schools Program: www.who.int/inf-fs/en/fact092.html
- Health, Environment & Safety Management in Enterprises (HESME) website: www.epaw.co.uk/HESME

GLOSSARY

Acceptance: A non-judgmental openness to other human beings even when they are different from one's self and have different beliefs and values. Willingness for the client to have and express whatever thoughts and feelings are real in him/her at the moment. Acceptance is one of the three most powerful facilitation skills.

Assertiveness: The ability to state your unmet needs and get them met without the use of aggression. The type of message considered the norm for assertive communication is called an I-Message.

Biomedical Model: Also, Medical Model. The traditional approach of western medicine for the past 150 years. A disease-based paradigm, founded upon a mechanistic, reductionist viewpoint of biological systems. Illness is seen as arising from biological changes beyond individual control, either from outside the body, or as internal involuntary physical changes caused by factors such as chemical imbalances, bacteria, viruses, genetic predisposition. Treatments involve medication, surgery, chemotherapy, vaccination and other interventions that aim to change the physical state of the body. The mind and body are viewed as functioning independently from each other, with the mind incapable of influencing physical matters. Responsibility for treatment is seen as lying with the medical profession.

Bio psychosocial Model: A systems-based paradigm which recognises that health is determined by a multiplicity of biological, psychological and social factors all of which mutually interact. Health is promoted by empowering individuals as responsible for and capable of taking steps that support their own health. The mind and body are viewed as one, each strongly influencing the other. Illness is seen as the result of a combination of biological, psychological, social, lifestyle and environmental factors, over many of which each person has significant control. Individuals are seen as largely responsible for their own health, with health professionals as valuable resource people. Treatment is given to the whole person, not just the physical symptoms associated with the illness. Treatment may include fostering behaviour and lifestyle changes, coping strategies, social and emotional support, and better compliance with medical recommendations.

Community: A group of people who have common characteristics. Communities can be defined by location, race, ethnicity, age, occupation or other common bonds.

Community Needs Assessment: An approach to identifying health needs and health problems in the community. A variety of tools can be used. The essential focus is community engagement and collaborative participation.

Confrontation: A primary way to deal with a client's unacceptable behaviour. Most effective when done non-blamefully and if practitioner deals sensitively with whatever resistance is generated. (See I-Message.)

Construct: An interpretation of reality, frame of reference, perception, belief system developed by people to give order and meaning to experience. What is construed as "reality" is always a co-construction between the individual and the people and cultural institutions that influence him/her.

Coping: A person's constantly changing cognitive and behavioural efforts to manage a situation s/he has appraised as potentially harmful or stressful.
Coping Skills: A variety of techniques used to deal with difficult situations. Common skills for coping with illness include: confronting, distancing, self-control, seeking social support, accepting responsibility, escape-avoidance, problem-solving, positive reappraisal, activity, distraction, self-talk, prayer.
Empathy: A delicate and sensitive understanding of the other person's thoughts and feelings. Empathy entails the capacity to communicate your sense of the other person's experience and convey that back him/her in a way that enables the other to feel recognised and understood.
Empathy is communicated through feedback by means of the skill called Empathic Listening.
Empathic Listening: Feeding back to the other person your understanding of his/her thoughts and feelings, without changing or placing judgment on them in any way. The single most powerful facilitation skill; also called Active Listening, Reflective Listening, Power Listening.
Facilitation Process: Engaging with the client in a process which moves from problem exploration, to goal setting, to the facilitation of action.
Genuineness: Being authentic, real, and congruent. Acting in ways that match what you are really feeling and thinking. Being what you are, without a front or façade. One of the three most powerful facilitation skills.
Hardiness: A pattern of attitudes and skills that enhance performance, leadership, morale, stamina, and health, despite stressful circumstances.
Health: The state of complete physical, mental and social well-being, and not merely an absence of disease or infirmity. Health has many dimensions: physical, mental and social, and is largely culturally defined. The relative importance of various disabilities will differ depending on the cultural milieu and the role of the affected individual in that culture. Usually is measured in terms of morbidity and mortality.
Health Promotion (or HP): The philosophy and actions of working for the acceptance and adoption of the bio psychosocial model for understanding the systemic nature of health, and for empowering individuals, workplaces, schools, civic groups, social and governmental organisations with the skills for promoting health.
Healthy Policy: Social policy concerned with the process by which public health agencies evaluate and determine health needs and the best way to address them, including the identification of the resources and funding mechanisms.
Health Promotion Specialist/Practitioner/Professional: Any professional from a variety of related disciplines who works for the empowerment of individuals and institutions in achieving their full health potential. Also, informally, any person who works to promote his/her own health as an individual.
Iatrogenic Effect: Unfavourable responses to medical treatment which are induced by the treatment itself—when the cure becomes part of the problem.
I-Message: A message in which the sender communicates openly and genuinely about what is going on in him/her, rather than focusing on what the other person is doing or trying to get the other to change. Developed by Thomas Gordon, this form of self-revelation is considered the most effective means of assertive confrontation.

Integrative Management: A management approach that aims to resolve multiple and conflicting goals, deliver actions and implement strategies that ensure durable long-term solutions meeting the needs of all stakeholders.
International Labour Organisation: The specialized UN agency which seeks the promotion of social justice and internationally recognised human and labour rights. The ILO has a unique tripartite structure with workers and employers participating as equal partners with governments in the work of its governing organs.
ISO 9000: Standard measuring procedure established by International Organisation for Standardisation for certifying the quality of services and products in businesses and organisations.
Locus Of Control: A concept first developed by Rotter which proposed that people have a generalised expectancy relating to the relationship they perceive between their actions and outcomes. Persons considered to have an internal locus of control ("internals") believe that events are a consequence of their own actions and are under personal control, whereas those with an external locus of control ("externals") believe that events are unrelated to their actions and are determined by factors beyond their personal control. Locus of Control Theory predicts that "internals" are likely to take more responsibility for their health and engage in health-promoting activities.
Modelling: A means of facilitating the learning of adaptive behaviours, wherein one person recognises in another certain desired skills and uses that person's behaviour as a model for enhancing his/her own self-efficacy. Can be accomplished either through direct observation (in vivo), film or covert techniques. An important method for teaching skills for coping with illness and reducing anxiety, communication skills and healthy behaviours.
Person-Centred Approach: A systemic, holistic approach that focuses on health not illness, empowers rather than cures, and promotes development of potentialities of individuals, groups and organisations through the process of making people responsible for what they do rather than allowing dependency. The role of the practitioner is defined as that of creating an environment which enables the client to express concerns, explore options and make decisions in the interest of his own health and well-being.
Personal Social Capital: A composite factor related to educational access and achievement; comprised of one's inherited biological capacities and limitations, parents' socio-economic status, education, and self-esteem, the degree of family accord, area of residence, and personal characteristics including self-esteem, coping strategies, cognitive and social skills.
Problem-Solving: A system for resolving conflicts in which both parties get their needs met. A 6-step system helping people move beyond win/lose approaches and seek mutually-acceptable solutions to problems or conflicts.
Psychoneuroimmunology: A multi-disciplinary approach that investigates the relationship between psychological factors, mental functioning and the immune system.
Psychosocial Factors: The personal interpretations or understandings of social relationships, events, or status that reflect a combination of psychological and social variables which are internalized and, along with biological factors, affect health.
Reinterpretation: A technique in which the health professional identifies self-defeating beliefs that the client holds, reinterprets them in a more effective light and helps the client

develop different understandings which better support his health. In Health Promotion, reinterpretation is often done concerning physiological signs and symptoms.

Self-Efficacy: The belief in one's capabilities to organise and execute the sources of action required to manage prospective situations. Self-efficacy is related to better health, higher achievement, more social integration and other behaviours associated with health.

Self-Esteem: The way a person regards him/herself, in what kind of esteem s/he holds herself, and to what extent s/he views him/herself as capable and worthwhile.

Skills Mastery: A powerful way of enhancing self-efficacy, often accomplished through a contract specifying a plan of action for the client to take in order to develop desired health-related skills.

Social Construction of Reality: The process by which people learn to attach meaning in society. Important influences on people's construction of reality are the family, school, workplace and other cultural institutions. However, how an individual construes "reality" is always a co-construction between the person and the other social influences in his/her life.

Social Support: Resources provided by other persons; refers to a network consisting of marital partner, family, friends, neighbours, work, church, and others which convey to a person the sense that s/he is valued, cared for and belongs to a network of mutual connection and obligation.

Stressor: Environmental, social or personal factors that can generate stress.

System Theory: A view of human ecology and human interaction which sees individuals as embedded in a network of systems—within the body, within social interactions, within the total ecology of the universe—and which recognises that each of these systems constantly interacts with, affects and is affected by all other systems.

Ottawa Charter for Health Promotion

FIRST INTERNATIONAL CONFERENCE ON HEALTH PROMOTION
OTTAWA, 21 NOVEMBER 1986

The first International Conference on Health Promotion, meeting in Ottawa this 21st day of November 1986, hereby presents this CHARTER for action to achieve Health for All by the year 2000 and beyond. This conference was primarily a response to growing expectations for a new public health movement around the world. Discussions focused on the needs in industrialized countries, but took into account similar concerns in all other regions. It built on the progress made through the Declaration on Primary Health Care at Alma-Ata, the World Health Organisation's Targets for Health for All documents, and the recent debate at the World Health Assembly on intersectoral action for health.

HEALTH PROMOTION

Health promotion is the process of enabling people to increase control over, and to improve their health. To reach a state of complete physical, mental and social well-being, an individual or group must be able to identify and to realize aspirations, to satisfy needs, and to change or cope with the environment. Health is, therefore, seen as a resource for everyday life, not the objective of living. Health is a positive concept emphasizing social and personal resources, as well as physical capacities. Therefore, health promotion is not just the responsibility of the health sector, but goes beyond healthy life-styles to well-being.

PREREQUISITES FOR HEALTH

The fundamental conditions and resources for health are:

- peace,
- shelter,
- education,
- food,
- income,
- a stable eco-system,
- sustainable resources,
- social justice, and equity.

Improvement in health requires a secure foundation in these basic prerequisites.

ADVOCATE

Good health is a major resource for social, economic and personal development and an important dimension of quality of life. Political, economic, social, cultural, environmental, behavioural and biological factors can all favour health or be harmful to it. Health promotion action aims at making these conditions favourable through advocacy for health.

ENABLE

Health promotion focuses on achieving equity in health. Health promotion action aims at reducing differences in current health status and ensuring equal opportunities and resources to enable all people to achieve their fullest health potential. This includes a secure foundation in a supportive environment, access to information, life skills and opportunities for making healthy choices. People cannot achieve their fullest health potential unless they are able to take control of those things which determine their health. This must apply equally to women and men.

MEDIATE

The prerequisites and prospects for health cannot be ensured by the health sector alone. More importantly, health promotion demands coordinated action by all concerned: by governments, by health and other social and economic sectors, by non-governmental and voluntary organisation, by local authorities, by industry and by the media. People in all walks of life are involved as individuals, families and communities. Professional and social groups and health personnel have a major responsibility to mediate between differing interests in society for the pursuit of health

Health promotion strategies and programmes should be adapted to the local needs and possibilities of individual countries and regions to take into account differing social, cultural and economic systems.

HEALTH PROMOTION ACTION MEANS:

Build Healthy Public Policy

Health promotion goes beyond health care. It puts health on the agenda of policy makers in all sectors and at all levels, directing them to be aware of the health consequences of their decisions and to accept their responsibilities for health.

Health promotion policy combines diverse but complementary approaches including legislation, fiscal measures, taxation and organisational change. It is coordinated action that leads to health, income and social policies that foster greater equity. Joint action contributes to ensuring safer and healthier goods and services, healthier public services, and cleaner, more enjoyable environments.

Health promotion policy requires the identification of obstacles to the adoption of healthy public policies in non-health sectors, and ways of removing them. The aim must be to make the healthier choice the easier choice for policy makers as well.

Create Supportive Environments

Our societies are complex and interrelated. Health cannot be separated from other goals. The inextricable links between people and their environment constitutes the basis for a socio-ecological approach to health. The overall guiding principle for the world, nations, regions and communities alike, is the need to encourage reciprocal maintenance - to take care of each other, our communities and our natural environment. The conservation of natural resources throughout the world should be emphasized as a global responsibility.

Changing patterns of life, work and leisure have a significant impact on health. Work and leisure should be a source of health for people. The way society organizes work should help create a healthy society. Health promotion generates living and working conditions that are safe, stimulating, satisfying and enjoyable.

Systematic assessment of the health impact of a rapidly changing environment - particularly in areas of technology, work, energy production and urbanization - is essential and must be followed by action to ensure positive benefit to the health of the public. The protection of the natural and built environments and the conservation of natural resources must be addressed in any health promotion strategy.

Strengthen Community Actions

Health promotion works through concrete and effective community action in setting priorities, making decisions, planning strategies and implementing them to achieve better health. At the heart of this process is the empowerment of communities - their ownership and control of their own endeavours and destinies.

Community development draws on existing human and material resources in the community to enhance self-help and social support, and to develop flexible systems for strengthening public participation in and direction of health matters. This requires full and continuous access to information, learning opportunities for health, as well as funding support.

Develop Personal Skills

Health promotion supports personal and social development through providing information, education for health, and enhancing life skills. By so doing, it increases the options available to people to exercise more control over their own health and over their environments, and to make choices conducive to health.

Enabling people to learn, throughout life, to prepare themselves for all of its stages and to cope with chronic illness and injuries is essential. This has to be facilitated in school, home,

work and community settings. Action is required through educational, professional, commercial and voluntary bodies, and within the institutions themselves.

Reorient Health Services

The responsibility for health promotion in health services is shared among individuals, community groups, health professionals, health service institutions and governments. They must work together towards a health care system which contributes to the pursuit of health.

The role of the health sector must move increasingly in a health promotion direction, beyond its responsibility for providing clinical and curative services. Health services need to embrace an expanded mandate which is sensitive and respects cultural needs. This mandate should support the needs of individuals and communities for a healthier life, and open channels between the health sector and broader social, political, economic and physical environmental components.

Reorienting health services also requires stronger attention to health research as well as changes in professional education and training. This must lead to a change of attitude and organisation of health services which refocuses on the total needs of the individual as a whole person.

Moving into the Future

Health is created and lived by people within the settings of their everyday life; where they learn, work, play and love. Health is created by caring for oneself and others, by being able to take decisions and have control over one's life circumstances, and by ensuring that the society one lives in creates conditions that allow the attainment of health by all its members.

Caring, holism and ecology are essential issues in developing strategies for health promotion. Therefore, those involved should take as a guiding principle that, in each phase of planning, implementation and evaluation of health promotion activities, women and men should become equal partners.

Commitment to Health Promotion

The participants in this Conference pledge:

- to move into the arena of healthy public policy, and to advocate a clear political commitment to health and equity in all sectors;
- to counteract the pressures towards harmful products, resource depletion, unhealthy living conditions and environments, and bad nutrition; and to focus attention on public health issues such as pollution, occupational hazards, housing and settlements;
- to respond to the health gap within and between societies, and to tackle the inequities in health produced by the rules and practices of these societies;
- to acknowledge people as the main health resource; to support and enable them to keep themselves, their families and friends healthy through financial

and other means, and to accept the community as the essential voice in matters of its health, living conditions and well-being;

- to reorient health services and their resources towards the promotion of health; and to share power with other sectors, other disciplines and, most importantly, with people themselves;
- to recognise health and its maintenance as a major social investment and challenge; and to address the overall ecological issue of our ways of living.

The Conference urges all concerned to join them in their commitment to a strong public health alliance.

Call for International Action

The Conference calls on the World Health Organisation and other international organisations to advocate the promotion of health in all appropriate forums and to support countries in setting up strategies and programmes for health promotion.

The Conference is firmly convinced that if people in all walks of life, nongovernmental and voluntary organisations, governments, the World Health Organisation and all other bodies concerned join forces in introducing strategies for health promotion, in line with the moral and social values that form the basis of this CHARTER, Health For All by the year 2000 will become a reality.

Cardiff Memorandum

The Network for Health Promotion at the Workplace (WHP - Work Health Promotion) considers it of primary importance to focus its action on small and medium enterprises, a strategic sector, but one difficult to involve in Health Promotion in the workplace. Member countries therefore reaffirmed their interest in that sector in a meeting held in Cardiff and signed a document known as the ***Cardiff Memorandum.***

WORKPLACE HEALTH PROMOTION IN SMALL AND MEDIUM SIZED ENTERPRISES[492]

APRIL 1998

INTRODUCTION

"Workplace Health Promotion (WHP) is the combined efforts of employers, employees and society to improve the health and well-being of people at work.

This can be achieved through a combination of: improving the work organisation and the working environment promoting active participation encouraging personal development"

(Luxembourg Declaration on Workplace Health Promotion in the European Union)

WHP plays a significant role in developing healthy organisations: future economic success and well-being is strongly dependent on well-qualified, motivated and healthy employees. In the past, WHP activities have mainly targeted larger organisations, which have an appropriate infrastructure for WHP to be successful. Yet throughout Europe more than 50% of the total workforce is employed in SMEs with a staff of less than 100, with the numbers of people working in small organisations still increasing. SMEs have limited resources and have to avoid heavy administrative, financial and legal procedures that could jeopardise their development.

The state of health of employees in SMEs is of prime importance to them, to the organisations in which they work, their families, the communities they live in and the economic well-being of the Member States. This memorandum launches new initiatives of the European Network for WHP to bridge the gap of finding an appropriate infrastructure for SMEs to implement WHP activities in small organisations.

Characteristics of small and medium enterprises (SMEs)

[492] SMEs = Small to Medium-sized Enterprises

SMEs differ from larger organisations in many respects:

- Less division of labour and standardisation of jobs and working conditions
- direct relationships between employers and employees
- higher degree of flexibility
- less benefits from occupational health and safety services
- limited time and resources for promoting employee well-being and health
- higher dependency on employees' attendance at work

CHALLENGES FACING WHP IN SMEs

Considering the limited resources in small organisations, it is especially difficult for SMEs to carry out health promotion activities. In addition, the available knowledge in WHP is based on experience in larger organisations which must be adapted and modified to the needs of SMEs.

WHP in SMEs needs to respond to a wide range of challenges:

- to increase the awareness of WHP and in benefits among stakeholders in SMEs
- to develop appropriate models for WHP in SMEs
- to implement specific strategies involving the different stakeholders concerned
- to adapt WHP activities to an appropriate scale and connect them to the actual problems and needs of the SME
- to highlight how the implementation and development of WHP in SMEs could be supported by external resources
- to continue action at branch, local and regional level

Priorities of the European Network for WHP

The members of the European Network for WHP regard SMEs as a priority for action.

In order to meet the challenges listed above, the Network proposes the following initiatives to promote WHP in SMEs:

1. To increase awareness of the current priorities, health concerns and health actions undertaken in SMEs.
2. To identify and disseminate good practice in WHP in SMEs.
3. To promote the benefits of WHP in SMEs to all stakeholders.
4. To build alliances and partnerships with the small business sector and key representative organisations
5. To support the development of appropriate WHP models and methods for increasing health and well-being in SMEs.

This memorandum was adopted by all members of the European Network for WHP at the network meeting held in Cardiff on April 24-25, 1998.

EUROPEAN NETWORK FOR HEALTH PROMOTION IN THE WORKPLACE

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