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Contemporary Issues in Health Promotion

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Introduction

Prior to 1986 the global community had realized the need for a new public health order capable of taking the world to next level in its quest for the achievement of health for all by the year 2000 and beyond. This felt need led to the convening of the first international conference on Health Promotion, by the World Health Organization (WHO) in Ottawa, Canada, 17th – 21st November, 1986. The conference produced what is known today as the Ottawa Charter on Health Promotion (HP).

The OttawaCharter defined Health Promotion (HP) as the process of enabling people to increase control over, and to improve their health (WHO, 1986). Implicit in this definition is the understanding that if individuals are helped to understand those factors that determine their health and are able to exercise control over those factors, they would not only prevent diseases, but also improve their health status.

The Ottawa Charter described HPas consisting of **five strategies** otherwise referred to as **five action areas**. The five strategies (action areas) are: development of healthy public policy;creation of supportive environment for health; strengthening of community action; development of personal action; development of personal skills; and reorientation of health services (WHO, 1986; FMOH, 2006).

The sixth global conference on HP held in 2005 in Bangkok, Thailand further amplified the definition of HP. According to the Bangkok Declaration, HP is the process of enabling people to increase control over their health and contributes to the work of tackling communicable and non communicable diseases and other threats to health (WHO, 2005). HP involves a multidisciplinary application of skills in psychology, anthropology, economics, political theory, consumer rights/law, communication, media design, epidemiology, management, community mobilization and the application of research, planning and evaluation skills (FMOH, 2006).

Basically, there are seven key principles guiding HP. The seven principles, paraphrased by Rootman (2001) are as follows:

1. **Empowerment.** Health Promotion initiatives should enableIndividuals and communities to assume more power over the personal socio-economic and environmental factors that affect their health.
2. **Participative**. Health promotion initiatives should involve thoseconcerned in all stages of planning, implementation and evaluation.
3. **Holistic.** Health promotion initiatives should foster physical mental, social and spiritual health.
4. **Intersectoral**. Health promotion initiatives should involve the collaboration of agencies from relevant sectors.
5. Equitable. Health promotion initiatives should be guided by a concern for equity and social justice.
6. Sustainable. Health promotion initiatives should bring aboutchanges that individuals and communities can maintain once initial funding has ended.
7. Multi-strategy. Health promotion initiatives should use a variety of approaches in combination with one another, including policy development, organizational change, community development, legislation, advocacy, education andcommunication (p.2).

The overall goal of HP is to enhance positive health and prevent ill health. (Rootman,2001). Specifically, HP aims to promote the wellbeing of individuals and encourage healthy lifestyles, prevent disease, illness and injury, enable environments that support health and wellbeing, and to reduce personal, economic and social harm (WHO, 1986).

The aim of HP is usually achieved through well packaged HP programmes. Such programmes whether aimed at initiating physical activities, nutritional intervention, or any given lifestyle change is expected to comprise health education and environmental actions. According toFertman and Allenworth (2010) the health education component focuses on improving health knowledge, health attitudes, health skills, health behaviours, health indicators and health status. Environmental actions should focus on the promotion of advocacy, environmental change, legislation, policy mandates and regulations, resource development, social support, financial support, community development, and organizational development. Beyond the above discourse on HP it must be appreciated that whether as a concept or programme HP has a number of contemporary issues worth examining.

Contemporary Issues in HP

The term "issue" has been conceptualized as "an important topic or problem of debate or discussion (Google, 2018). According to Hornby (2005), the term 'issue' means "an important topic that people are discussing or arguing about. Following from these, contemporary issues in HP are those issues associated with HP which currently attract and sustain public discussion. The issues include, but are not limited to, issues of conceptual mix-up, ethics, capacity building, use of technology, and community mobilization strategies. Others include culture and tradition, gender, role of physical activities in HP, healthy ageing, among others. **While all these listed issues are topical, the present paper focuses on the first five, namely: issues of conceptual mix-up, ethics, capacity building, use of technology, and communitymobilization strategies.**

Issue of conceptual mix-up

The concept of HP is relatively newer than such related concepts as public health and health education. This may partly explain the mix-up often observed among stakeholders and professionals expected to drive HP programmes (Snelling, 2014). This prevalent mix-up was succinctly captured by Ekenedo and Ezedum(2013).According to them even as awareness on the concept of HP gradually grows in Nigeria among health professionals one concern that persists is the divergent understanding of HP and its practice. This , according to Ekenedo and Ezedum (2013), poses problem not only in the training of HP training of HP personnel but also in health promotion practice since there is bound to be lack of uniformity occasioned by differences in the understanding of the concept.

Although HP, public health and health education overlap to some degree, each is a distinct field of study in and of itself (Snelling, 2014). It is therefore very important that the distinctions among these three concepts be clarified to make both HP programme development and capacity building easier.

According to the World Health Organization (WHO Centre for Health Development, 2004),health promotion "is the process of enabling people to increase control over, and to improve, their health. It moves beyond a focus on individual behavior towards a wide range of social and environmental interventions"(p.30).

Snelling (2014) defined HP as the process of helping people to move towards a state of optimal health through lifestyle changes. Centre for Health Promotion(2006) had earlier posited that HP is the process of empowering people to make healthy lifestyle choicse and motivating them to become better self-managers.

According to Hamza (2014), HP involves the individual and the community in decision making about their own health. It also takes into consideration the decision- making process by policy makers because the more people value health, the more willing they will be to make appropriate allocation and resources to promote and safeguard their own health.

O' Donnell (2002), comprehensively defined HP thus:

> *The art and science of helping people discover the synergies between their core passions and optimal health, enhancing their motivation to strive for optimal health,and supporting them in changing their lifestyle to move towards a state of optimal health. Optimal health is a dynamic balance of physical, emotional, social, spiritual, and intellectual health. Lifestyle change can be facilitated through a combination of learning experiences that enhance awareness, increase motivation and build skills and, most important, through the creation of opportunities that open access to environments that make positive health practice theeasiestchoice (p.xx).*

On the other hand, Health Education is defined by the World Health Organization (WHO centre for Health Development, 2004) as "any combination of learning experience designed to help individuals and communities improve their health, by increasing their knowledge or influencing their attitudes (p.29).

Public health, on the other hand, "is concerned with the health of the community as a whole. The three core public health functions are: the assessment and monitoring of the health of communities and populations at risk to identify health problems and priorities; and ensuring that all populations have access to appropriate and cost-effective care, including health promotion and disease prevention services, and evaluation of the effectiveness of that care (p.48).

According to Snelling (2014), the essence of HP is to actively promote healthy living by creating a society in which a "culture of health" is evident in places where people live, work, worship, and learn. HP balances individual health behavour choices with creating environments where healthier choices become easier choices. Following from this, Snelling (2014) concluded that HP is broader than Health Education, yet Health Education is an important component within the field of HP. Furthermore, the overlapping nature of HP and Public Health notwithstanding, each follows distinctly different approaches to address the health of the society. **While Public Health as seen from its definition above focuses on monitoring the health of the public, formulating policies, and ensuring all citizens have access to health care; HP focuses principally on chromic disease management.** HP does this by monitoring health conditions, helping individuals to make healthy choices, and creating healthy choices, and creating policies that create healthy environments (Snellings, 2014).

Ethical Issues in Promoting Health

Because of divergent positions as to the purpose of health promotion and the subsequent strategies to achieve its aims HP raises ethical dilemmas (Seedhouse, 2001). Ethics, for clarity sake, refers to the study of what is right or good and incorporates a variety of concepts such as duty, virtue and liberty (Cribb, Duncan, 2002;).

According to Bruide (2011), HP has three main ethical issues: (i) what are the ultimate goals for public health practice; that is what 'good' should be achieved? (ii) how should this good be distributed in the population?, and (iii) what means may be used in trying to achieve and distribute this good?

Regarding HP there exists at the moment little consensus on what constitutes its ethical foundation (Parker, Gould, & Fleming, 2007). The present paper does not intend to propose one either. The focus is to provoke academic reflection on the ethical issues involved in HP programming and practice.

Basically, ethical arguments may be classified into two main categories: rule-based or deontological, and consequence-based (Cribb & Duncan, 2002). Deontology is a philosophy that regards duty to be the foundation of morality, that is, some actions are obligatory regardless of their consequences (Cribb & Duncan, 2002). The other main paradigm in the ethical discourse, according to Cribb and Duncan (2002), is consequence-based ethics, that is the consequences of an action determines whether it is desirable. The ethical code for any HP programme is determined by which of the above two arguments is guiding the HP practitioner's decision.

Furthermore, in determining the ethical code for any HP programme one may be guided by the four principles of bioethics (Beauchamp& Childress, 1979). These principles are autonomy, beneficence, non-maleficence, and justice. Autonomy is the respect for persons and individual rights; beneficence is doing good and optimizing benefits over burdens; non-maleficence is refraining from doing harm, and justice is the requirement that benefits and burdens should be equally distributed (Beauchamp & Childress, 1979).

Issue of capacity building in HP

Many countries lack capacity for HP practice (Mfrekemfon&Ugwulor, 2015). According to Mfrekemfon and Ugwulor (2015), this challenge manifests in the form of inadequate human and material resources.This lack also applies to Nigeria. This is not to say that Nigeria has not made some progress towards developing HP. The country through the support of the WHO has developed a National Health Promotion Policy in 2006 as well as produced implementation guidelines. The objective of the policy was to strengthen the HP capacity of the National Health System in improving health status of Nigerians and the achievement of health-related Millennium Development Goals -MDGs (Federal Ministry of Health - FMOH, 2006). WHO aided Nigeria in the training of 260 health educators after the launch of the policy (WHO, 2007). The aim was to reorient them in practice of HP as recommended in the policy. They were also expected to build the capacity of other staff in the Ministry whose duties were HP-oriented. This effort, according to Ekenedo and Ezedum (2013) has not in any substantial way addressed the HP capacity need of the country given the teeming population the HP practitioners are expected to serve.

Fundamentally, the issue of HP capacity building has to be understood from a broader perspective beyond manpower training. Capacity building occurs within systems and programmes, and is heavily dependent on collaboration and partnership working (Health Service Executive, 2011). Capacity building, according to Hawe, Noort, Kingand Jorden (1997), has three distinct dimensions. The dimensions are health infrastructure and service development, programme maintenance and sustainability, problem solving capability of organizations and communities.At the moment, there is nothing to suggest that Nigeria has fared well on these three dimensions.

Issue of technology use in HP interventions.

There is a body of evidence suggesting that technology-based health promotion initiatives are taking advantage of various technologies including computers, internet, mobile phones, tablets, notes, CD-ROMs, computer kiosks, among others (Bull & Mcfarlane, 2011). The notable advantage of these technologies range from such features as reach, standardized information, interactivity, privacy, autonomy, portability and potentially lower costs (Bull &Mcfarlane 201). Literature indicate that there are successful technology-based health promotion interventions to address a wide range of health issues, including those targeting smoking cessation (Rodgers, Corbelt, Bramley, Riddell, Wills, Lin, & Jones, 2005), sexual health (Lightfoot, Comulada, & Stover, 2007), physical activity (Hurling, Catt, Boni, Fairley, Hurst, Murray, &Sodhi, 2007), weight loss (Patrick, Raab, Adams, Dillon, Zabinski, Rock, & Norman, 2019), and alcohol use (Khadjesari, Murray, Hewitt, Hartley, & Godfrey, 2011). According to Cullen, Thompson, Boushey, Konzelmann, &Chen (2013), the use of technology-based HP approaches among youth has been particularly encouraging due tosuch technology's reach and popularity with this age group.The use of such technology is seen as a 'new channel'for behavior change (Cullen, Thompson, Boushey, Konzelmann, & Chen, 2013).Studies showed that especially among adolescents and young adults internet-based HP interventions such a self-guided websites, website-based programmes, online games, and social media were well received (Arps, 2014).

Furthermore, mobile phone-based HP interventions using text-messages were popular among young persons (Arps, 2014). Following from the above one can conclude that the prospects of technology-based HP interventions in Nigeria are enormous.

Conclusion

Following from the above discourse, it has been shown that the concept of HP ever since its inauguration in Ottawa, 1986 has presented a new and radical paradigm in global health care. HP has been shown to be related to but different from the concepts of health education and public health. Furthermore, a number of issues associated with HP have been highlighted in the course of the discourse. Among these are those of mix-up in the understanding of the concept of HP. This appears very fundamental since it more or less touches on the foundation of HP programming and practice.

It must be emphasized that the issues treated in the present paper are neither exhaustive nor selected in any special order. They were rather presented out of a plethora of related issues to help ginger deep reflections on them and other issues probably not highlighted. Some of such issues not highlighted which by all stretch of imagination remain very relevant include the issue of community mobilization for HP, use of physical activities and Physical Education for HP among others. These issues aremain as important as the ones herein discussed.

Finally, it must be noted that Nigeria has a serious capacity deficit with regard to HP. This needs urgent genuine attention from all stakeholders and policy makers. The promise held by HP regarding the facilitation of the attainment of all the Sustainable Development Goals in Nigeria can not be overemphasized hence the need for all hands to be on deck.

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