Values and principles evident in current health promotion practice

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Introduction
Health promotion finds itself in an increasingly complex world. Practitioners are expected to understand and respond to multiple interrelated determinants of health. This requires the ability to plan, implement and evaluate health promotion programs that are more complex and multifaceted than ever, and involves being able to work explicitly with the values and principles important to modern health promotion practice. A value is an idea or concept that is regarded as worthy, desirable or useful. A principle describes the code of conduct or a rule for action, and is generally regarded as action oriented. Although we recognise the important distinction between the terms, they are used interchangeably in much of the health promotion literature. As such, whichever term is used in an original source has been reproduced in this paper, whereas we have used the collective term 'values and principles' in our discussion.

There are four main challenges associated with working explicitly and proactively with values and principles. First, there is no consensus about the core values and principles of health promotion. Second, there is a lack of specific guidance on how to apply values and principles. Third, there are different interpretations about the use of values and principles in health promotion practice. Fourth, there is a gap between the espoused values and principles of modern health promotion and more conventional health promotion practice.

Challenge 1: Core values and principles of health promotion

Various attempts have been made to describe the central health promotion principles. The World Health Organization articulated the following concepts and principles for health promotion in a discussion paper in 1986:

1. Focuses on the population as a whole in their everyday life rather than people at risk of specific diseases.
2. Directed towards action on the determinants or causes of health.
3. Combines diverse but complementary methods or approaches.

Abstract

Issue addressed: Modern health promotion practice needs to respond to complex health issues that have multiple interrelated determinants. This requires an understanding of the values and principles of health promotion.

Method: A literature review was undertaken to explore the values and principles evident in current health promotion theory and practice.

Results: A broad range of values and principles are espoused as being integral to modern health promotion theory and practice. Although there are some commonalities across these lists, there is no recognised, authoritative set of values and principles accepted as fundamental and applicable to modern health promotion. There is a continuum of values and principles evident in health promotion practice from those associated with holistic, ecological, salutogenic health promotion to those more in keeping with conventional health promotion.

Conclusion: There is a need for a system of values and principles consistent with modern health promotion that enables practitioners to purposefully integrate these values and principles into their understanding of health, as well as their needs assessment, planning, implementation and evaluation practice.

Key words: Values, principles, health promotion practice.

So what?

A system of values and principles would assist practitioners to respond to complex health issues that have multiple interrelated determinants.
Table 1: The continuum of values and principles evident in current health promotion practice.

<table>
<thead>
<tr>
<th>Focus of value or principle</th>
<th>Holistic, ecological, salutogenic health promotion value or principle</th>
<th>Description of each end of the values and principles continuum</th>
<th>Conventional health promotion value or principle</th>
</tr>
</thead>
<tbody>
<tr>
<td>Worldview(^\text{17})</td>
<td>Organic</td>
<td>Seeing the world as a living, breathing, dynamic, whole as opposed to seeing the world as an unchanging, static machine.</td>
<td>Mechanistic</td>
</tr>
<tr>
<td>Epistemology(^\text{19})</td>
<td>Constructionist, Subjectivist</td>
<td>Acknowledging that all people are connected and that collectively they construct knowledge and understanding about their worlds, as distinct from believing that there is only one truth that is ascertained by an objective observer.</td>
<td>Objectivist</td>
</tr>
<tr>
<td>Science(^\text{2,5,11})</td>
<td>Ecological</td>
<td>Using the science of ecology, which recognises that people exist in multiple ecosystems, from the individual level, to the family, group, community and population level. All parts within the whole system affect each other, and the whole is greater than the sum of the parts. Ecological science incorporates the tenets of connectedness, complementarity, uncertainty and non-locality. This principle is distinct from reductionism or positivism, in which understanding about the whole comes from simply understanding each part.</td>
<td>Reductionist, Positivist</td>
</tr>
<tr>
<td>Health paradigm(^\text{11,17})</td>
<td>Holistic</td>
<td>Understanding that health is a complex concept that includes aspects of well-being that relate to the whole person, rather than seeing health as the absence of disease or ‘unhealthy’ behaviours, as reflected in the biomedical and behavioural health paradigms.</td>
<td>Biomedical, Behaviouralist</td>
</tr>
<tr>
<td>Emphasis(^\text{18,20})</td>
<td>Health and well-being</td>
<td>Emphasising factors that create and support health, well-being, happiness and meaning in life, as distinct from an emphasis on risk factors for disease.</td>
<td>Rates of disease and risk behaviours</td>
</tr>
<tr>
<td>Motivation for health(^\text{17})</td>
<td>Health as a resource for living, sense of purpose and enjoyment of life</td>
<td>Recognising that health provides a sense of purpose and enables greater enjoyment of life and is not an end in itself. This is distinct from believing that fear about the consequences of unhealthy behaviours are the primary motivators for people to develop long-term sustainable changes.</td>
<td>Fear about consequences of unhealthy behaviours</td>
</tr>
<tr>
<td>Assumptions about people(^\text{17})</td>
<td>People are naturally healthy</td>
<td>Assuming that when left to their own devices, people will do the best they can for themselves, their families and their communities, given their circumstances and available resources. This is distinct from assuming that left to their own devices, people will naturally adopt ‘unhealthy’ lifestyles.</td>
<td>People are naturally unhealthy</td>
</tr>
<tr>
<td>Health promotion strategies(^\text{1,9,11,17})</td>
<td>Participatory processes that enable and empower people</td>
<td>Using participatory processes that enable and empower people to connect with their inner wisdom and gain control over their lives and the determinants of their health. This is distinct from using disempowering interventions that target ‘at risk’ people and education about their ‘unhealthy’ behaviours.</td>
<td>Target ‘at risk’ people with behaviour change strategies</td>
</tr>
<tr>
<td>Population focus(^\text{1,10,21})</td>
<td>Determined by equity</td>
<td>Prioritising work with communities that are most marginalised, vulnerable, disadvantaged and often regarded as ‘hard to reach’ based on considerations of equity. This is distinct from working with more visible groups or whole populations, or the less vulnerable and more accessible populations.</td>
<td>Whole groups or populations</td>
</tr>
<tr>
<td>Power(^\text{1,9,11})</td>
<td>Participatory, egalitarian</td>
<td>Facilitating participatory and egalitarian processes that assist with the redistribution of power, rather than processes that have their foundations in patriarchy and domination.</td>
<td>Patriarchal, dominator</td>
</tr>
<tr>
<td>Change processes(^\text{17})</td>
<td>Active participation of people affected by the issue</td>
<td>Ensuring that the people most affected by an issue are an integral part of all components of a health promotion change process that addresses the issue, as distinct from being targeted as recipients of decisions made external to them.</td>
<td>Passive recipients of external decisions</td>
</tr>
<tr>
<td></td>
<td>Processes do not impinge on personal autonomy</td>
<td>Ensuring that all relevant parties consent to health promotion change processes and acknowledging and respecting that not all people will choose the same actions, rather than processes that expect all people to adopt the same actions, irrespective of their own preferences.</td>
<td>Universal processes that restrict personal autonomy</td>
</tr>
<tr>
<td></td>
<td>Maximum beneficence</td>
<td>Actively considering what the benefits of any health promotion change process may be to the full range of beneficiaries, as distinct from processes that only consider a limited range of beneficiaries.</td>
<td>Limited beneficence</td>
</tr>
</tbody>
</table>

continued next page
4. Aims at effective public participation.
5. Requires health professionals to have a role in enabling health promotion.

Ife outlines a comprehensive set of five principle categories that he posits as being integral to developmental approaches in community-based work, which includes health promotion. The principle categories and the nature of the principles within each category are:
1. Ecological principles – those principles associated with holism, sustainability, diversity and balanced development.
2. Social justice principles – those principles associated with addressing structural disadvantage, discourses of disadvantage, empowerment, need identification and human rights.
3. Valuing the local principles – those principles that value local knowledge, culture, resources, skills and processes.
4. Process principles – those principles associated with process, outcome and vision, process integrity, consciousness raising, participation, co-operation and consensus, pace of development, peace and non-violence, inclusiveness and community building.
5. Global and local principles – those principles that link the global and local, and anti-colonialist practice.

Murphy describes five guiding principles for health promotion action as:
1. A determinants approach.
2. Evidence-based health promotion.
3. Building collaborative partnerships.
4. Advocacy, engagement and empowerment.
5. Leadership in health promotion.

Raeburn and Rootman describe a set of broad principles for their ‘people-centred’ health promotion:
1. Health promotion is concerned with real living people.
2. Health promotion should focus on positive, life-enhancing matters rather than negative factors such as symptoms of disease or social problems.
3. Health promotion change is developmental and takes time.
4. Health promotion methods should focus on people’s strengths not weaknesses.
5. Health promotion should be systematic and well organised.

Table 1 continued: The continuum of values and principles evident in current health promotion practice.

<table>
<thead>
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<tbody>
<tr>
<td>Non-maleficence is a priority consideration</td>
<td>Actively considering what the potential harms of any health promotion change process may be; who may be harmed by the change processes and in what way; taking steps to minimise or avoid this harm; communicating risks involved in a truthful and open manner. This is distinct from change processes that do not assess the full range of potential harms due to a belief that health promotion processes will result in positive health outcomes.</td>
<td>Scope of maleficence not fully considered</td>
<td></td>
</tr>
<tr>
<td>Basis for practice</td>
<td>Practice based on evidence of need and effectiveness, and sound theoretical foundations</td>
<td>Ensuring that needs assessment processes incorporate the perspectives of all stakeholders, and that health promotion practice is based on sound evidence of need, evidence of effectiveness, and appropriate theoretical foundations. This is distinct from practice that is based on selective use of evidence and/or political imperatives.</td>
<td>Practice based on selective use of evidence, or on political imperatives</td>
</tr>
<tr>
<td>Strategy approach</td>
<td>Multiple strategies</td>
<td>Using multiple strategies incorporating all action areas of the Ottawa Charter, as opposed to reliance on one or two strategies, particularly legislation and regulation, and developing personal skills for behaviour change.</td>
<td>One or two strategies</td>
</tr>
<tr>
<td>Governance and decision making</td>
<td>Collaborative models of governance and decision making</td>
<td>Using models of governance and decision making that facilitate active and meaningful participation by all stakeholders, as distinct from non-democratic governance and decision making,</td>
<td>Health worker led and/or imposed from outside</td>
</tr>
<tr>
<td>Professional role</td>
<td>Ally</td>
<td>Working with a person as an ally and a resource, who is on tap for the community, as distinct from working on top of people as an outside expert who assumes they know what’s best for the community.</td>
<td>Expert</td>
</tr>
<tr>
<td>Evaluation objects of interest</td>
<td>Sustainable changes to determinants of health</td>
<td>Ensuring that evaluation focuses on assessing the sustainable changes in the range of factors that enable people to increase control over the determinants of their health, as distinct from evaluating changes in rates of ‘unhealthy’ behaviours and diseases.</td>
<td>Behaviour changes and disease rates</td>
</tr>
</tbody>
</table>
6. Philosophical values important to health promotion include empowerment, justice, equity, cultural appropriateness and spirituality.

7. Health promotion should be focused on health outcomes rather than other important social and justice endeavours. While there are some commonalities across these lists of principles, there is no recognised, authoritative set of values and principles accepted as fundamental and applicable to all health promotion activity.

**Challenge 2: Working with values and principles of health promotion**

The second challenge for practitioners wanting to work explicitly with values and principles is the lack of specific guidance on how to apply them. The Ottawa Charter for Health Promotion articulated the principles of equity, empowerment and participation as central to health promotion practice. Subsequent health promotion models, such as the Jakarta Declaration on Health Promotion in the 21st Century, and most recently the Bangkok Charter on Health Promotion in a Globalized World, reinforced these broad guiding principles. However, none of these key documents articulate how to mobilise these principles in practice.

Health promotion models commonly used provide guidance on the stages of health promotion activity from needs assessment through to evaluation. Although many health promotion models used to design, implement and evaluate health promotion programs place an emphasis on principles such as empowerment and participation, they do not overtly focus on the realisation of values and principles. There is little guidance within these models that would assist the practitioner to put the broad principles into practice. For example, well-used models such as the Hawe, Degeling and Hall Needs Assessment and Planning Model, PRECEDE/PROCEED, and the Program Management Guidelines from New South Wales Health are more technical in orientation and include useful descriptions of what to actually do, rather than the values and principles that underpin action.

**Challenge 3: Use of values and principles of health promotion in practice**

Although participation and empowerment are commonly named as broad, overarching, guiding principles for health promotion, the third challenge for health promotion practitioners wishing to work explicitly with values and principles relates to the different interpretations about their use in practice. They are sometimes described as a strategy (or a way of working), and other times described as outcomes (or what is hoped to be achieved). Despite the plethora of literature that describes the range of principles thought to underpin health promotion and various ways to practice health promotion, the authors could find no evidence of health promotion models that explicitly use values and principles in a systematic way. Many of the values and principles purported to be central to the science of health promotion practice are therefore limited to rhetoric.

**Challenge 4: Gap between modern and conventional health promotion values and principles**

The fourth challenge for health promotion practitioners wishing to work explicitly with values and principles is the divergence between the values and principles that reflect more conventional health promotion and those reflective of modern health promotion, which is holistic, ecological and salutogenic in nature. For example, a holistic model of health, which includes physical, mental, social and spiritual dimensions, is espoused as a value in modern health promotion texts. However, a significant proportion of present health promotion practice is underpinned by a conventional biomedical model of health that is concerned primarily with the physical body and its diseases. Modern health promotion also emphasises an ecological approach to health determinants, including the complex interactions, nested hierarchies and feedback loops between people and their physical, economic, social, cultural and political environments. However, many health promotion practitioners find themselves focusing primarily or exclusively on the conventional immediate or proximal behavioural risk factors for specific disease conditions, without the opportunity to address the distal or social determinants of health.

Salutogenic health promotion focuses on creating and supporting good health, well-being, happiness, and meaning in life through modern health promotion change processes that emphasise participation and empowerment. However, there is still significant investment in conventional health promotion activity that is exclusively concerned with limiting physical ill-health and/or that uses coercive or non-participatory processes.

**Continuum of health promotion values and principles**

The range of values and principles evident in health promotion practice have been organised into a continuum with values and principles associated with holistic, ecological, salutogenic health promotion placed at one end, and those associated with conventional health promotion placed at the other end (see Table 1). The table of values and principles evident in health promotion practice describes the focus of the value or principle, for example the health paradigm, emphasis, population focus, or change processes. The values consistent with each end of the continuum are listed, separated by a description of each value or principle. The first part of the description describes the
holistic, ecological, salutogenic health promotion value or principle, and the second part describes the conventional health promotion value or principle.

In reality, the values and principles of most health promotion practice are situated somewhere along the continuum and not concentrated exclusively at either end. Practitioners will recognise many of the values and principles that they either explicitly or implicitly work with on both sides of the continuum. Although some values and principles may be recognisable in theory to practitioners, the proactive utilisation of values and principles is difficult. Health promotion models in common use do not explicitly articulate the values and principles inherent within the model. The challenge for health promotion practitioners is how to proactively apply a connected set of values and principles across all phases of a health promotion program.

Conclusion

The exploration of the principles and values important to health promotion is not a new endeavour. Various attempts have been made to describe the central health promotion values and principles. Despite the existence of lists of principles or principle categories, this review has identified several challenges associated with using values and principles in health promotion practice. Values and principles evident in health promotion practice reflect the divergence between the values and principles of modern health promotion and those evident in conventional health promotion. There is a need for a system of values and principles consistent with modern health promotion that enables practitioners to purposefully integrate these values and principles into their understanding of health, as well as their needs assessment, planning, implementation and evaluation practice.

References


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