EDITORIAL

Nursing, health education and health promotion: lessons learned, progress made and challenges ahead

The move towards health promotion in nursing

It is now approaching a decade ago that the WHO (1989) proposed in *Nursing Leadership for Health For All* that nurses have a key role to play in the health promotion movement. It therefore seems timely to reflect on the success or otherwise of changes in nurse education and practice that have been initiated in the intervening years in an attempt to respond to this challenge.

During the 1990s, nursing curricula for first level qualification have been designed with the aim of ensuring that nursing students are exposed to (some form of) health promotion theory and practice. The emphasis on continuing professional development in the post-qualification period has also ushered in opportunities for nurses to study health promotion. In the UK, for example, there has been a radical re-orientation of the pre-registration curricula towards a focus on health and health promotion in the wake of the Project 2000 (UKCC, 1986) recommendations, and a proliferation of opportunities for registered nurses to continue their professional development through post-registration courses at degree and post-graduate levels. Many of the latter do contain a discrete component of course content labelled as 'health promotion'.

Lessons to be learned

Looking back at these developments, we have—or should have—learnt a number of lessons from this experience. Firstly, many nurse educators were ill-prepared to teach nurses effectively, lacking both the theoretical and research base, as well as practical experience in health promotion. This was a finding to emerge from research into the implementation of a health-oriented curricula conducted by Lask *et al.* (1994) and also from Macleod Clark *et al.*'s (1996) study investigating changes in the philosophy and practice of nursing following the introduction of Project 2000 curricula in the UK. Related to the lack of preparation of nurse educators, within the nursing profession there was—and arguably this has now changed—a lack of reflection on and clarity about:

- The meaning of the concepts health promotion and health education.
- The different ideologies underlying the different approaches to health education and health promotion.
- What the role is for nurses in health promotion.

In relation to the first two of the issues outlined above, research (Latter, 1993) has demonstrated that nurses have been unclear about the meaning of the terms and hold perceptions of the concepts which are akin to a narrow, individual-oriented, lifestyle change model of health education with little recognition of the broad social and environmental aspects of health promotion. Perhaps the unwitting error in the rush to embrace the health promotion role has been a tendency for nurses and nurse educators uncritically to employ the prevailing political health promotion ideology as a framework for teaching and practice. In the UK, this has meant alignment with the reductionist, individual behaviour change perspective which underpins the *Health of the Nation* (1992) White Paper (for further discussion of this issue in the UK, see Brown and Piper, 1997). Rush (1997) also comments on how the ideology of individual responsibility has pervaded nursing curricula in the USA and argues that there has been an uncritical acceptance of this. Conversely, there has been less emphasis on social and economic determinants of health, and less support for community or collective action approaches to bring about social change (Benson and Latter, 1998).

Related to this, there has been a lack of discussion and clarity about the nursing role and its contribution to health promotion, and a subsidiary set of questions about different health promotion roles in different clinical settings and at different levels of experience and educational attainment also remain unanswered.

A review of health promotion literature can help in addressing these issues. In short, there is a consensus that health promotion comprised both
health education at the level of the individual and structural change at a more macro level including, for example, as the WHO (1986) put it, building healthy public policy and creating supportive environments for health. It is also clear that these twin elements can each be implemented according to different models or frameworks which are underpinned by contrasting ideological perspectives. For example, health education can be approached from either an empowerment or a medical model-derived, behaviour change perspective. Similarly, effecting change at the policy or environmental level can also be top down, or follow a more negotiated, empowerment-oriented approach.

The professional practice of nursing largely—but not exclusively— involves interactions with individuals, and therefore an ability to understand and practice an empowerment model of health education is central. It has also been argued (Macleod Clark, 1993) that nurses' roles in health promotion are not confined to interactions where there is an obvious 'education about health' component, but that any interaction can be more or less health promoting depending on the way in which it is carried out and the degree of control and empowerment offered to the patient, client or carer.

However, we also need to recognize that nurses need a clear understanding of the structural level at which health promotion operates. This will help to ensure that their interactions are sensitive to the broader context in which health choices by individuals are made. It will also challenge students to consider engaging in alternative forms of activity, e.g. lobbying or contributing to the development of healthy policies in hospitals and the local community, and will thus promote discussion about the opportunities and barriers they may face in attempting to achieve this more 'radical' goal.

In light of the above, perhaps we can begin to clarify the nursing contribution to health promotion. It is proposed here that what we might reasonably expect of nurses at initial qualification, at minimum, is an understanding of the principles of ethical and effective health promoting interactions and an ability to demonstrate a degree of competence in applying these in practice. The ability to adopt more innovative ways of working, such as the examples cited above, may well be dependent on greater autonomy and confidence which is often—although not always—a corollary of more senior and/or specialist positions. The goal of post-basic education in health promotion then becomes one of equipping nurses with the knowledge and skills to enable them to achieve this.

Returning to our retrospective view of health promotion in nursing over the past decade, it is pertinent to note that many of the practice situations in which nurses work have continued to be dominated by a bio-medical model approach to patient care and interactions. Robinson and Hill (1995) comment on this, arguing that this model is supported by both current health service audit mechanisms and by the interests of Western medicine. The underlying principles of the bio-medical model are in direct contradiction to a humanistic, empowering approach to health education. Thus, even when a critical awareness of current forms of health education and promotion practice has been fostered within some nurse education programmes, it is difficult for these students to swim against the tide.

**Recent progress in health promotion in nursing**

Despite these difficulties, some progress does appear to have been made. In the more recent past, an increased critical awareness of health promotion ideologies and the relevance of these to nurses appears to have developed in nursing. Although there is a lack of research evidence on which to base such a claim, the quantity and quality of publications on this issue in nursing journals acts as one indicator that this may be the case. Perhaps related to this, a second more recent development has been an increased awareness among nurses lately exposed to education of the principles which should characterize an effective and ethical approach to health education. In the UK, research by Macleod Clark *et al.* (1996) found that students who had followed a Project 2000 curriculum were very aware of central components of health education, such as empowerment and holism, although
they did not necessarily label these as health education. We have also commented recently on the increasing ability of students at one British nursing education institution to use their skills in a client-centred way and a reduction in the number who view health promotion as telling someone who has had diabetes for 30 years what to eat (Benson and Latter, 1998).

Other recent evidence suggests that some nurses are able to apply theory to practice and work in more innovative ways. For example, a research study by Daykin and Naidoo (1997) found that although primary health care team members rarely saw collective empowerment or community enablement strategies as part of their health promotion role, nevertheless initiatives were also identified which moved beyond traditional one-to-one approaches. For example, one primary health care team was working with a local sports centre to enable patients to benefit from low cost exercise opportunities.

**Challenges to further progress**

Whilst there is evidence to suggest that some progress has been made, nevertheless issues and challenges remain. A number of related features of the practice environment conspire to hinder the implementation of the health education and health promotion principles which we advocate. The lack of role models that nursing students see in practice has been suggested as an explanatory factor for students’ limited perceptions of health promotion in Lask et al.'s (1994) study and this was also confirmed by Macleod Clark et al.'s (1996) research. Conceptual nursing frameworks used in practice may also run counter to health education and health promotion principles—Robinson and Hill (1995), for example, suggest that nursing models impede humanistic and social action approaches to health promotion, due to their emphasis on the individual and on observable and measurable behaviour. Lindsey and Hattrick (1996) also comment on the reductionist and expert led focus of ‘the nursing process’ which continues to be widely used as a framework for practice. The organization of nursing work, and the manner in which it is audited, also acts as a constraint on the full development of nurses’ health promotion potential. In the UK, for example, the emphasis on numbers of patient or client contacts as a measure of primary health care nurses’ performance acts as a powerful inhibitor to engaging in forms of health promotion in which the ‘head count’ is not obvious or high.

Additionally, the issue of nurses as a disempowered group continues to represent a challenge to their ability to put health promotion into practice. Much has been written about nurses needed to be empowered both in order to empower others as part of their health education practice and also in order to take up broader health promotion roles which involve social and political action (e.g., see Latter, 1994). However, this issue is tied up with broader and established divisions within society such as those concerned with gender and class, and the continued dominance of science and medicine over nurses’ caring and emotional work. It is possible that the changes in nurse education, as well as changing boundaries between nursing and medical work, may help to create a more empowered and autonomous nursing profession, but inevitably changes of this magnitude will take time.

**The future**

Looking back allows us to identify some of the lessons learned and focus on the challenges which remain. It is also possible to consider some of the issues which are likely to shape health promotion in nursing in the future. For example, in both health promotion and nurse education, the debate about the balance between the acquisition of knowledge and of competencies will require us to ask whether it is possible to shift from education about principles and concepts (which has so far led to the increased knowledge and understanding described above) to assessment of competencies. These may be at the level of the individual encounter, but might also incorporate competencies in relation to, for example, group work or community development or, more radically, competencies which are involved in multi-sectoral collaboration...
or lobbying or effecting local policy change. Competency-based assessment will also force the issue of what we expect nurses at different levels to be able to do in relation to health education and health promotion.

A second issue concerns the fact that, as health promotion is a synergistic, multi-sectoral activity, shared learning and practice would seem to be the way forward. In the UK, the requirement for inter-sectoral collaboration is clearly outlined in the new Green Paper, Our Healthier Nation (1998). The document also emphasizes strengthening the expertise in public health in all sectors through education and training of the work force. As health care delivery generally is believed to be best approached from a position of multi-disciplinarity and as boundaries between roles have become more blurred, there is a move towards multi-professional learning in the health service professions, although to date it is still only patchy. Such a move is to be welcomed, although every effort does need to be made to ensure that there is shared learning as opposed to the dominance of one particular group.

A final example of future developments included here concerns the emphasis on evidence-based practice and the need for nurses to be aware of the importance of evaluating their health promotion work. An overview of the complex area of evaluation is beyond the scope of this paper (see Tones and Tilford, 1994, for a comprehensive analysis). It is the author’s personal experience that nurses can be overly optimistic about the selection of outcomes by which they will be able to evaluate their health promotion work, selecting indicators such as incidence of morbidity or hospital admission rates. Others focus on equally ambitious outcomes, but feel—rightly—too daunted by the magnitude and complexity of the task to begin. Whilst performance measurement indicators prescribed by health service management are sometimes ill-informed and crude (e.g. the ‘head counts’ in UK primary health care referred to above), nevertheless the emphasis on evaluation is likely to be here to stay. Therefore, nurses will need to have a realistic understanding of what is possible and to be cognisant of sufficiently sensitive measures of performance, including what Tones (1992) refers to as intermediate and indirect indicators of success.

In conclusion, perhaps it is possible to suggest that in nursing we have some reason to celebrate success in embracing the health promotion challenge, but work remains to be done if we are to realize the full potential envisaged by the WHO in 1989.

Sue Latter
Senior Research Fellow
Faculty of Health Studies
Buckinghamshire Chilterns University College
Buckinghamshire HP8 4AD

References


