5 HEALTH BEHAVIORS.

5.1 health promotion: Health promotion has been defined by the World Health Organization's (WHO) 2005 Bangkok Charter for Health Promotion in a Globalized World as "the process of enabling people to increase control over their health and its determinants, and thereby improve their health".The primary means of health promotion occur through developing healthy public policy that addresses the prerequisites of health such as income, housing, food security, employment, and quality working conditions. More recent work has used the term Health in All Policies to refer to the actions to incorporate health into all public policies. There is a tendency among public health officials and governments—and this is especially the case in neoliberal nations such as Canada and the USA—to reduce health promotion to health education and social marketing focused on changing behavioral risk factors.

Recent work in the UK (Delphi consultation exercise due to be published late 2009 by Royal Society of Public Health and the National Social Marketing Centre) on relationship between health promotion and social marketing has highlighted and reinforce the potential integrative nature of the approaches. While an independent review (NCC 'It's Our Health!' 2006) identified that some social marketing has in past adopted a narrow or limited approach, the UK has increasingly taken a lead in the discussion and developed a much more integrative and strategic approach which adopts a holistic approach, integrating the learning from effective health promotion approaches with relevant learning from social marketing and other disciplines.

A key finding from the Delphi consultation was the need to avoid unnecessary and arbitrary 'methods wars' and instead focus on the issue of 'utility' and harnessing the potential of learning from multiple disciplines and sources. Such an approach is arguably how health promotion has developed over the years pulling in learning from different sectors and disciplines to enhance and develop.

History

The "first and best known" definition of health promotion, promulgated by the American Journal of Health Promotion since at least year 1986, is "the science and art of helping people change their lifestyle to move toward a state of optimal health".

This definition was derived from the 1974 Lalonde report from the Government of Canada, which contained a health promotion strategy "aimed at informing, influencing and assisting both individuals and organizations so that they will accept more responsibility and be more active in matters affecting mental and physical health".

Another predecessor of the definition was the 1979 Healthy People report of the Surgeon General of the United States, which noted that health promotion "seeks the development of community and individual measures which can help... [people] to develop lifestyles that can maintain and enhance the state of well-being".

At least two publications led to a "broad empowerment/environmental" definition of health promotion in the mid-1980s:

- In year 1984 the World Health Organization (WHO) Regional Office for Europe defined health promotion as "the process of enabling people to increase control over, and to improve, their health". In addition to methods to change lifestyles, the WHO Regional Office advocated "legislation, fiscal measures, organizational change, community development and spontaneous local activities against health hazards" as health promotion methods.

- In 1986, Jake Epp, Canadian Minister of National Health and Welfare, released Achieving health for all: a framework for health promotion which also came to be known as the "Epp report".This report defined the three "mechanisms" of health promotion as "self-care"; "mutual aid, or the actions people take to help each other cope"; and "healthy environments".

The WHO, in collaboration with other organizations, has subsequently co-sponsored international conferences on health promotion as follows:

- 1st International Conference on Health Promotion, Ottawa, 1986, which resulted in the "Ottawa Charter for Health Promotion".According to the Ottawa Charter, health promotion:
- "is not just the responsibility of the health sector, but goes beyond healthy life-styles to well-being"

- "aims at making... [political, economic, social, cultural, environmental, behavioral and biological factors] favorable through advocacy for health"
- "focuses on achieving equity in health"
- "demands coordinated action by all concerned: by governments, by health and other social organizations.

Workplace health promotion

Work site health focus on the prevention and the intervention that reduce the health risks of the employee. The U.S. Public Health Service recently issued a report titled "Physical Activity and Health: A Report of the Surgeon General" which provides a comprehensive review of the available scientific evidence about the relationship between physical activity and an individual's health status. The report shows that over 60% of Americans are not regularly active and that 25% are not active at all.

There is very strong evidence linking physical activity to numerous health improvements. Health promotion can be performed in various locations. Among the settings that have received special attention are the community, health care facilities, schools, and worksites.Worksite health promotion, also known by terms such as "workplace health promotion," has been defined as "the combined efforts of employers, employees and society to improve the health and well-being of people at work".

WHO states that the workplace "has been established as one of the priority settings for health promotion into the 21st century" because it influences "physical, mental, economic and social well-being" and "offers an ideal setting and infrastructure to support the promotion of health of a large audience". Worksite health promotion programs (also called "workplace health promotion programs," "worksite wellness programs," or "workplace wellness programs") include exercise, nutrition, smoking cessation and stress management. Reviews and meta-analyses published between 2005 and 2008 that examined the scientific literature on worksite health promotion programs include the following:

- A review of 13 studies published through January 2004 showed "strong evidence... for an effect on dietary intake, inconclusive evidence for an effect on

physical activity, and no evidence for an effect on health risk indicators".

- In the most recent of a series of updates to a review of "comprehensive health promotion and disease management programs at the worksite," Pelletier (2005) noted "positive clinical and cost outcomes" but also found declines in the number of relevant studies and their quality.

- A "meta-evaluation" of 56 studies published 1982–2005 found that worksite health promotion produced on average a decrease of 26.8% in sick leave absenteeism, a decrease of 26.1% in health costs, a decrease of 32% in workers' compensation costs and disability management claims costs, and a cost-benefit ratio of 5.81.

- A meta-analysis of 46 studies published in 1970–2005 found moderate, statistically significant effects of work health promotion, especially exercise, on "work ability" and "overall well-being"; furthermore, "sickness absences seem to be reduced by activities promoting healthy lifestyle".

- A meta-analysis of 22 studies published 1997–2007 determined that workplace health promotion interventions led to "small" reductions in depression and anxiety.

- A review of 119 studies suggested that successful work site health-promotion programs have attributes such as: assessing employees' health needs and tailoring programs to meet those needs; attaining high participation rates; promoting self care; targeting several health issues simultaneously; and offering different types of activities (e.g., group sessions as well as print materials).

5.2 PREVENTION OF HEALTH: Scientists are always looking for new and better ways to prevent disease and injury — both to avert human suffering and to control the tremendous economic costs of ill health. But when researchers and health experts talk about "prevention," what do they mean?
Going upstream: Imagine you're standing beside a river and see someone drowning as he floats by. You jump in and pull him ashore. A moment later, another person floats past you going downstream, and then another and another. Soon you're so exhausted, you know you won't be able to save even one more victim. So you decide to travel upstream to see what the problem is. You find that people are falling into the river because they are stepping through a hole in a bridge. Once this

is fixed, people stop falling into the water. When it comes to health, prevention means “going upstream” and fixing a problem at the source instead of saving victims one by one.

In general, prevention includes a wide range of activities — known as “interventions” — aimed at reducing risks or threats to health. These are usually grouped into three categories.

Primary prevention
Here the goal is to protect healthy people from developing a disease or experiencing an injury in the first place.

For example:
- education about good nutrition, the importance of regular exercise, and the dangers of tobacco, alcohol and other drugs
- education and legislation about proper seatbelt and helmet use
- regular exams and screening tests to monitor risk factors for illness
- immunization against infectious disease
- controlling potential hazards at home and in the workplace

Secondary prevention
These interventions happen after an illness or serious risk factors have already been diagnosed. The goal is to halt or slow the progress of disease (if possible) in its earliest stages; in the case of injury, goals include limiting long-term disability and preventing re-injury.

For example:
- telling people to take daily, low-dose aspirin to prevent a first or second heart attack or stroke
- recommending regular exams and screening tests in people with known risk factors for illness
- providing suitably modified work for injured workers

Tertiary prevention

This focuses on helping people manage complicated, long-term health problems such as diabetes, heart disease, cancer and chronic musculoskeletal pain.

The goals include preventing further physical deterioration and maximizing quality of life. For example:

- cardiac or stroke rehabilitation programs
- chronic pain management programs
- patient support groups

What works best?

For many health problems, a combination of primary, secondary and tertiary interventions are needed to achieve a meaningful degree of prevention and protection. However, prevention experts say that the further upstream one is from a negative health outcome, the likelier it is that any intervention will be effective — think about fixing the hole in the bridge so people stop falling through and drowning downstream.

Unfortunately, this isn't always possible, especially when there's limited knowledge about what causes a particular illness or injury. For example, when it comes to low-back pain, there are few proven primary prevention measures. But researchers are learning more about secondary prevention — i.e. how to reduce disability and promote recovery in workers who have already experienced problems.

While primary and secondary prevention interventions are clear in areas like cancer or heart disease, such distinctions may be less useful in talking about musculoskeletal disorders. That's because episodes of back pain and other symptoms tend to come and go, blurring the lines between primary, secondary and tertiary prevention. So when it comes to musculoskeletal disorders, some researchers prefer to talk about “prevention, period.”