Health promotion in sexual health 1: different theories and models of health promotion

Exploring the aims of health promotion and discussing the various theories and models that will empower clients and help them to improve their sexual health

AUTHOR Jayne Barnes, BSc, Diploma HE in Midwifery Studies, RGN, is contraceptive and sexual health nurse, contraceptive and sexual health service, Stockport PCT. ABSTRACT Barnes, J. (2009) Health promotion in sexual health 1: different theories and models of health promotion. Nursing Times; 105: 18, 20–21. This is the first in a two-part unit on health promotion in sexual health care. It discusses the aims of health promotion and various models and theories. It considers the importance of building empowerment, autonomy and self-efficacy.

LEARNING OBJECTIVES
1. Understand what health promotion is and its importance in sexual health care.
2. Know about the various theoretical perspectives in health promotion.

LEARNING OBJECTIVES

This indicates that health promotion focuses on the individual with an emphasis on the whole person. Health promotion delivered without people’s participation (a ‘top-down’ approach) is not seen as an ideal framework because recipients are not involved in the process (Jones et al, 1997). To achieve initial and sustainable success in health promotion, it is vital that work is driven from the bottom by including recipients (Naidoo and Wills, 2005). Health promotion in sexual health has three aims, outlined in Box 1.

CURRENT CONTEXT
Rising sexually transmitted infection rates (Health Protection Agency, 2008) and increasing termination rates (Department of Health, 2008) indicate that both issues need to be addressed through progressive work in sexual health care. Indeed, the Medical Foundation for AIDS and Sexual Health (2008) highlighted a clear need for people to be aware of how they can protect themselves from unplanned pregnancy and STIs, and the importance of sexual health promotion.

It is important, therefore, that practitioners not only seize the opportunity but also carry out health promotion to the highest levels of skill and expertise. The manner in which consultations are carried out affects the success of the health promotion opportunity.

DIFFERENT APPROACHES
It is worth considering the best way of delivering health promotion within sexual health care. The focus on preventing unwanted pregnancy and STIs suggests potential for a medical approach, as defined by Jones and Naidoo (1997). However, this could lead to a top-down approach. It is important to include clients in any health promotion intervention to ensure an individual focus.

An alternative approach to health promotion could focus on clients’ behaviour, for example on condom use. However, there is a danger that focusing purely on behaviour change could mean taking an approach centred on the professional agenda and therefore not engaging fully with clients. As discussed, health promotion is likely to be more successful if it involves clients. Jones and Naidoo (1997) suggested that health-promotion strategies intended to change behaviour may not sit comfortably with health promotion aimed at empowering clients and enabling them to make autonomous choices.

Empowerment is a concept that has become popular in health promotion and policy (DH, 2004; Tones, 1997). A definition of empowerment is ‘to give authority or power to’ or ‘give strength and confidence to’ (Pearseall, 2002). Empowerment also implies personal control, high self-esteem, having health and life skills, and the ability to value other people’s rights (Tones, 1997). It is also linked to self-efficacy and autonomy. Improving clients’ self-confidence and self-esteem enhances their ability to challenge...
and change their circumstances (Jones et al, 1997). This would sit comfortably with the individually focused approaches mentioned above (Naidoo and Wills, 2005).

Ultimately, empowerment is associated with having the ability to make free choices. An empowered and autonomous person who recognises that sexual encounters involve the risk of an unwanted pregnancy or STI will be more likely to avoid situations that are likely to lead to sexual encounters or use effective self-protection measures such as condoms, ideally with some additional contraception.

**HEALTH PROMOTION MODELS**

It is worth considering how this might be achieved in practice.

Three processes are suggested: the first is promoting individual empowerment and autonomy; the second is providing clients with enough information to stimulate and motivate them to use self-protection measures; and the third is encouraging clients to implement self-protection measures in practice, centring on real-life motivation.

This indicates an approach that empowers, educates and changes behaviour. The question is how to fit this in to health-promotion theory.

In addition to the simplistic models of health promotion identified above (medical and behaviour-change models), various models incorporate several variables with identified pathways.

One such model is the health belief model, which has been the subject of debate since the 1970s. It looks at how beliefs impact on behaviour (Conner and Norman, 2005; Janz and Becker, 1984).

This model implies that whether an individual puts protection (contraception and/or condoms) into practice depends on their thoughts about: their susceptibility to pregnancy or STI infection; the anticipated severity of that occurrence; the benefits of implementing self-protection; and the barriers to implementation. When certain health beliefs are held, ‘cues’ (such as health education or perceived symptoms) can stimulate health behaviour (Abraham and Sheeran, 2005).

The protection motivation theory (Norman et al, 2005) was developed during the 1970s. It is a more complex model that contains several components such as perceptions of severity, response costs, vulnerability, intrinsic rewards (pleasure) and extrinsic rewards (social approval). It also includes response efficacy (belief that the suggested behaviour will reduce the threat) and self-efficacy. Self-efficacy is a person’s belief that they can be successful in carrying out the suggested behaviour.

The theory of planned behaviour, is a complex theory. An individual’s perceived behavioural control is the expectation that behaviour is within their control, and therefore is linked to efficacy and autonomy. Within perceived behavioural control lie several factors, including information and skill (Conner and Norman, 2005).

Social cognitive theory focuses on individual motivation and action based on three types of expectancy. These are the situation outcome, action outcome and perceived self-efficacy.

These theories do not correlate directly with the processes identified above. However, they all incorporate at least one of the processes. The theories are complex and therefore need further study before they are put into practice. NICE (2007) recommended that healthcare professionals (trained in sexual health) put the theories into practice in one-to-one structured discussions with clients.

Conner and Norman (2005) identified that self-efficacy is a key predictor of health behaviour and this factor is not included in the health belief model. Because various theories overlap, Conner and Norman (2005) discussed combining some aspects of these theories.

**CONCLUSION**

Health promotion is an important aspect of service provision in sexual health care. An approach should be used that maximises impact with clients.

This could include encouraging clients’ participation – a bottom-up approach. Health promotion ultimately means stimulating clients to use measures to improve and sustain their health. It is vital to recognise the value of clients’ potential to do this.

There is potential for more work to produce a theory that combines all the best aspects of the current models. To achieve maximum effect, aspects such as building empowerment and autonomy should be included, with a focus on self-efficacy.

Part 2 of this unit, to be published next week, explores nurses’ role in sexual health promotion.

**REFERENCES**


