**CHAPTER 45**

**A Student Perspective on Learning and Doing Settings-Based Health Promotion in the era of TikTok**

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## Abstract

This chapter reflects on learning health promotion in the UK from a student perspective. Written during the COVID-19 pandemic, when health promotion education and practice operationalised online settings to comply with social distancing measures, it considers the roles of digital health literacies in promoting health. It also discusses how students of health promotion are introduced to the field and the impact these initial encounters have on framing students’ orientation to and thinking around health promotion, particularly settings-based health promotion.

**Keywords**:

Digital literacy; Hashtags; Health literacy; Infodemic; Social determinants; Social media

# Setting the Scene: Twenty-First Century Health Promotion in the UK

On 28 February 2020, under the hashtag #HealthForAll, the World Health Organization (WHO) launched its veriﬁed account on the video-sharing app TikTok to combat COVID-19 misinformation.

COVID-19 exacerbated the existing digital divide in the UK (Good Things Foundation 2020). Witnessing the impacts of this twenty-ﬁrst-century determinant of health in real-time, as the pandemic played out, has been instrumental to my learning and development as a student and early-career practitioner of health promotion and to my awareness of the work required if #HealthForAll – rather than just #ForYou, the TikTok users’ homepage tag (TikTok Cultures Research 2020) – is to be realised ‘IRL’ (in real life).

My approach to the study of health promotion is shaped by a background in information science and two years’ work experience as Health Literacy Project Manager within a National Health Service (NHS) library. Health literacy is deﬁned by the WHO as the social resources that enable individuals and communities to access, understand, and use information to make informed decisions about health (Nutbeam 1998). More than being able to read and understand a patient information leaﬂet, health literacy is an asset which can support people to improve the self-management of their health and navigate the settings of everyday life (including online settings). It is a distinct but compatible piece in the wider puzzle of health promotion (Nutbeam et al. 2018). Without health literacy, health promotion and #HealthForAll ‘cannot be meaningfully achieved’ (Nash et al. 2018, p. 1).

Low health literacy increases health inequities, leads to poorer health outcomes, and costs the NHS time and money (Berry 2016). It is a signiﬁcant problem in England: 61% of adults aged 16–65 struggle to understand health information when numbers are involved (Rowlands et al. 2015). The Health Literacy Project Manager role was created in November 2018 with the purpose of reducing the gap between health-related information complexity and the health literacy levels of the populations served by the NHS trust where I work. This remit includes the London borough of Waltham Forest where, at 76%, the prevalence of low health literacy exceeds the England average (GeoData Institute 2016).

The Health Literacy Project Manager role is aligned with and contributes to national eﬀorts by Health Education England (HEE) and the Royal Society for

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Public Health (RSPH) to improve individual and systemic health literacy holistically (NHS England n.d.). Social prescribing is one way to develop health literacy and help people to take control of their health (National Academy for Social Prescribing 2019), and I work closely with local public health teams to signpost to accessible, high-quality health information via social prescribing in partnership with public libraries, some of which are co-located with healthcare settings. I am currently drawing upon this experience to inform doctoral research into health literacy-promoting settings.

The health promotion work I undertake with public libraries takes a proportionate universalism approach to addressing the inverse information law (Rowlands and Nutbeam 2013) – whereby those members of society most in need of information, are also those least able to access such information – at each stage of the life-course. Activities range from early literacy programmes and death cafés to Making Every Contact Count (MECC) conversations and reminiscence sessions for people living with dementia.

UK public libraries are supported in these activities by the Universal Health Oﬀer (Libraries Connected 2018), which sets out how public libraries can develop their users’ health literacy and self-management through the provision of health information and the hosting of health promotion events. As part of this, evidence-based collections of books for mental and physical health curated by The Reading Agency under the ‘Reading Well: Books on Prescription’ scheme are available to borrow from UK public libraries for free in print (with selected titles also available in audio and eBook formats) via two pathways: self-directed social prescribing, or through general practitioner (GP) referral. As of April 2021, there are ﬁve book collections available:

* Reading Well for children (updated post-March 2020 to include corona-speciﬁc resources)
* Reading Well for young people (marketed as Shelf Help)
* Reading Well for mental health
* Reading Well for long-term conditions
* Reading Well for dementia (including reminiscence resources and children’s books that people living with dementia or their carers can read with younger relatives/friends).

The titles in the child- and adolescent-speciﬁc collections are regularly reviewed by a panel of child and adolescent health professionals, including GPs, psychiatrists, Child and Adolescent Mental Health (CAMHS) workers, public and school librarians and young experts by experience. I contributed to the selection process for the Reading Well for children booklist, launched in February 2020. Many UK public library buildings closed physically shortly after the launch to mitigate the spread of COVID-19. The loss of the free WiFi provided by public libraries impacted outreach to digitally-excluded communities and necessitated a pivot in my learning and practice towards the literacies needed for pandemic-era health promotion: digital literacy, misinformation and disinformation literacy, and social media literacy.

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# The Pre-Literate Phase: An Interdisciplinary Journey Towards Professional Literacy in the Language of Health Promotion

My health promotion journey has followed an interdisciplinary trajectory: prior to developing professional literacy in the language of health promotion, I worked on an open access research publishing programme involving Wellcome Trust-funded medical humanities outputs. When I joined the NHS, I transferred my understanding of research management and dissemination to the health literacy role and from the outset viewed my partnership projects with public libraries – whether conducted in-person (ﬂoor-walking and drop-in ‘information prescription' sessions), or online through takeovers of public library social media accounts – as providing frontline public health services to meet the needs of under-served populations. Public libraries’ accessibility and reach make them ‘unique settings’ (Whitelaw et al. 2017, p. 897) accessible to all, including non-members of the library, for health-related learning, work and play (WHO 1986).

The focus on promoting health literacy on-the-ground through public libraries nurtured my interest in the academic research underpinning my career development. The result of being research-curious was two-fold: I began a PhD focusing on settings-based health literacy and joined the 2021 cohort preparing for UK Public Health Register (UKPHR) validation as an early-career health promotion practitioner. Both experiences have provided opportunities to reﬂect on how newcomers to health promotion are introduced to it through the canon of published studies most likely to appear on reading-lists in introductory textbooks: the key texts and models which carry conceptual currency in the ﬁeld, referred to in short-hand by those in-the-know (‘the Marmot Review’, ‘the Dahlgren-Whitehead rainbow’). The scholarly record inﬂuences the emphases that aspiring health promotion professionals are taught to place on aspects of their work and the process by which certain aspects come to be recognized by health promotion’s academic inﬂuencers as properly pertaining to health promotion, or as researchable within it. Where TikTok deploys creator notiﬁcations (to inform creators when they produce videos featuring eﬀects that could trigger photosensitive epilepsy, for example), health promotion deploys creator constrictions: my attempts to slot health literacy into the larger health promotion jigsaw are circumscribed by prevailing prescriptions of what is, and is not, deﬁned as health promotion within the disciplinary discourse.

COVID-19 injected new language into this discourse (Sørensen et al. 2021). Pre-pandemic, I had rated my personal ‘health promotion literacy’ based on how well I understood and could demonstrate application of the UKPHR Standards (Health Education England, 2021) for professional registration. The aspiration to become “literate” in health promotion led me to consider what this type of literacy might enable me to do, like identifying health-related fake news

and sharing this skillset with others. As someone with neither ‘health promotion’ nor ‘public health’ in their job title, I had previously despaired over preparing the evidence required for my professional portfolio; re-casting my experiences through a literacy lens helped me to see how I might match my knowledge to individual UKPHR Standards in new ways.

My concerns that I was ‘a bad health promoter’ – even an imposter health promoter – led to strategies to develop myself as a literate learner of health promotion by putting into practice Freebody and Luke’s (1990) ‘four resources’ model and adapting it to my purposes of code-breaking, making meaning from, participating in, and analysing health promotion’s texts and tenets. Applying this model taught me to critically ‘read’ health promotion as an institution, just as *How to read a paper: the basics of evidence-based medicine* (Greenhalgh 2014) taught me how to critically appraise research and David Spiegelhalter’s Tweetorials on risk taught me how to interpret data on vaccination safety (@d\_spiegel 2021). Developing critical health promotion literacy has brought me a step closer to ﬂuency in the ﬁeld. But there remains a need for health promotion itself to become more health-literate and digitally-literate, and more conducive to being understood as important for population health today by the audiences it seeks to serve.

# Theory into Practice: Adapting to Online Settings

Settings ‘represent the organizational base of the infrastructure required for health promotion’ (WHO 1997, p. 6). The long-standing association between health promotion and settings is reﬂected in health promotion’s milestone policies, which by convention are titled based on the conference locations where they were ratiﬁed (see WHO, 1991; 1997; 2016). Originally documented in the Ottawa Charter (WHO 1986), settings-based health promotion or ‘the settings approach’ underpins my work and research. Instead of relegating settings to the background

– as in, ‘health promotion in settings’ (Dooris 2006, p. 59) – the settings approach promotes settings to the starring role of interventions, focusing on how settings can actively create and contribute to health rather than ‘simply ensure we don’t experience poor health within them’ (Hodgins 2008, p. 17). Ilona Kickbusch pairs a settings approach ‘done right’ with action on the social determinants of health:

If a settings approach is done properly, then it does address the determinants of health – it changes people’s working environments, it changes the way work is organised, it empowers them as patients or as school children […] The big issues always reﬂect themselves in people’s everyday lives and unless you provide a political space for empowerment – which is essentially what the settings do – you’re not really doing health promotion.

(Kickbusch, interviewed in Dooris 2013, p. 45)

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Today, the settings approach has not kept pace with the new social determinants of health arising from the pandemic and the consequent hybridization of settings beyond the oﬃcial list of WHO-endorsed healthy settings (WHO n.d.). The absence of online settings from the WHO list has also impeded progress in settings-based interventions to develop health literacy, which historically have not strayed far from the same settings (cities; communities and neighborhoods; education; healthcare; prisons; workplaces). An updated settings approach for pandemic-era health promotion is urgently needed (IUHPE Global Working Group on Healthy Settings, 2021).

Newman et al.’s (2015) rapid review of settings for raising awareness of health inequities provides a blueprint for such an update: while building on the WHO’s list, the review provides evidence for the health-promoting potential of additional settings, including online, faith-based, sports, nightlife, green, and temporary or pop-up ones. Even before the ﬁrst UK wave of COVID-19 in early 2020 routinised online home-schooling for children of non-essential workers, Newman et al. (2015) ranked online settings second in terms of frequency in the literature reviewed (below physically-accessed education settings, and above healthcare settings).

Approaching the settings approach from alternative angles, as Newman et al. (2015) do via opening hours, ecological footprint and permanence, is important for ensuring the roster of settings for health promotion and health literacy development remains relevant. Combining Newman et al.’s (2015) ﬁndings with wider reading (Whitelaw et al. 2017) highlighted for me the potential of public libraries to be included as new entrants to the WHO list. In the UK, public library settings continued to oﬀer in-person support alongside online services throughout lockdown (for example, providing 3D-printing facilities for manufacturing Personal Protective Equipment (PPE), distributing food parcels for children during school closures, and reaching out to digitally-excluded local residents through wellbeing telephone calls).

The shift to online settings in my work with public libraries entailed re-tooling and re-training, from learning how to use Zoom to how to create memes and gifs championing health promotion (@VaccineSafetyNet 2021). My education also moved online: I continued compiling my evidence portfolio for UKPHR remotely and attended live and asynchronous health promotion lectures from home, using backchannels like Zoom’s chat function and WhatsApp to make connections with other practitioners and students in the absence of opportunities for in-person networking.

Social distancing became so normalized in my life that watching television series and ﬁlms made or set prior to 2020 and which featured large crowd-scenes and up-close interpersonal contact became surreally stressful. This was especially the case with the television series *It’s A Sin* (Channel 4 2021), about the onset of AIDS in the UK. A scene where one character requests another to bring back any pamphlets or zines they can ﬁnd relating to AIDS from a trip to New York, because of a lack of information available in the local public library, resonated with my memories of the early days of COVID-19 (when it was a news story reported from outside my ﬁlter bubble, and epidemiological terms had not yet become hashtags). Frerichs’s (2016) epidemiology primer and exposé of a United Nations-backed disinformation campaign around the source of a cholera outbreak also made for a discomﬁting re-reading experience in my new context.

The interruption by COVID-19 of established ways of doing health promotion and research aﬀorded me space to re-think learning models and epistemological and ontological commitments I had previously lived by. This reset extended to how best to translate the settings-based research I had planned back in 2019 to an online and remote context. The result approached a form of meta-research, as health promotion online became both the means of access to learning and the learning goal itself.

# Information Overload: Balancing Informed Practice with the Infodemic

The term ‘infodemic’ pre-dates the coronavirus pandemic: it was coined to describe the proliferation of unsubstantiated information intensifying public anxiety during the SARS epidemic of 2003 (OED Online 2021). With the shift of health promotion teaching to online settings, I was inundated with learning opportunities related to tackling the infodemic: London South Bank University (LSBU) ran a series of public health masterclasses, the International Union for Health Promotion and Education (IUHPE) convened webinars, the WHO initiated

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a regular Infodemic Management News Flash brieﬁng containing a plethora of links to yet more webinars, and my health-related podcast queue began to look as intimidating as the ‘to-read’ list in my reference management software. Sifting through the available educational sessions on oﬀer took time away from my health literacy role and research as I attempted to balance the consumption of new information with the consolidation of what I already knew, or needed to revisit: should I attend a webinar on the sophisticated scams designed to look like NHS vaccination invitations? Should I listen to an episode of Public Health Disrupted (UCL Health of the Public 2021) on how stand-up comedy could be integrated into health promotion? How could I manage – and, when hosting training myself, *compete with* – this information overload?

I am a regular user of social media for Continuing Professional Development (CPD) and horizon-scanning of trends and topics in health promotion and health literacy. Part of this usage includes practising social media literacy to ensure that I am in charge of my social media consumption – and not the other way round! – through initiatives like #PledgetoPause (taking time to reﬂect and fact-check before sharing information). The potential of health promotion for harnessing and taking control of the infodemic as a dataset from which to gather insights is demonstrated by Southerton’s (2020) analysis of TikTok as a health promotion tool: TikTok’s popular trend of lip-syncing can indeed save lives, Southerton argues, if health promotion professionals are the ones creating the trending videos.

Approaching health promotion obliquely, or with a disruptive mindset – not stand-up comedy in my case, but leveraging social media and maintaining a presence on the platforms where the audiences I would like to reach spend time – proved useful for helping me to overcome the ethical and practical challenges of doing research in a pandemic and including children and young people in ways that recognized their rights and met Patient and Public Involvement and Engagement (PPIE) best practices. In the same way that the ‘Ethical and Legal Values in Public Health’ lecture in LSBU’s series of public health masterclasses I attended was able to incorporate live reactions to vaccine hesitancy debates unfolding synchronously oﬄine, I was able to discuss with young research participants over Zoom the topics that mattered most to them right now, and to which they could make a diﬀerence by their own actions (for example, mask-wearing). Provision of refurbished digital devices with pre-loaded data to digitally-excluded households was essential for training these children as digital health champions who could then cascade their learning to older family members and friends (IHLA, 2021). With the help of youth-created memes like @VaccineSafetyNet’s curated GIPHY collection, shareable animated explainers (The Spinoﬀ, 2021), fact-checker social media accounts like Twitter’s @ViralFacts and inﬂuencers like the (medically-trained) Dr Ranj (@drranj), perhaps health promotion can do what an April 2021 TikTok on the need for two doses of a coronavirus vaccine (@hotvickkrishna 2021) did: cut through the noise, and go #viral.

# Looking Forward: Health Promo(tion) online and IRL

COVID-19 led to the disappearance of a once-common student job, conducted across offline and online settings: nightclub promoter. How can health promotion become as ubiquitous in our social media feeds and on our streets as nightclub promoters once were (and, when nightlife returns post-pandemic, may be again)? Discussions at a webinar to mark 70 years since the foundation of IUHPE (IUHPE 2021) provided food for thought on what the next 70 years of health promotion should look like, and what needs to happen to ensure that health promotion practice is itself health-promoting. As an example of the disconnect between the #HealthForAll goal and health promotion in reality, the pre-set fields of my university’s ethics application form did not list any ethics guideline specific to health promotion as an option, with the result that I ended up selecting the Social Research Association: Ethical Guidelines. The lack of a unified ethical framework for health promotion that is sufficiently recognized to be included on university ethics forms is an essential component towards the realisation of a health promotion practice that is authentically aligned (#nofilter) with health promotion values.

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It might be expected that the teaching and learning of health promotion during a public health emergency would automatically be conferred with importance and taken seriously. But health promotion’s fragmented representation as a discipline and profession in its own right (IUHPE 2021) has meant that too often in the present pandemic, the voice of health promotion has been effectively drowned out by algorithms that reward conspiracy theories over reliable health information (even after partnerships between social media companies and health organisations, like the one between TikTok and WHO). Re-writing these algorithms to establish social media as a health-promoting setting, buttressed by robust strategies for digital inclusion, offers an opportunity to advance the health promotion agenda.

To attain the solidarity, equity and transformation in health called for by IUHPE (IUHPE 2021), it is necessary to promote health promotion to students as a career that practises what it preaches in terms of transparency and the translation of learning into informed action (Guo et al. 2020). LSBU’s 2020–21 lunchtime talks by health promotion professionals from a variety of backgrounds and at different stages of their health promotion career life-course provided a model for transforming health promotion to #HealthPromotion – a community-generated hashtag for a shared endeavor that is well-prepared for what marketing calls a ‘phygital’ future of physical and digital engagement with health.

Table 1, after References, brings our reflection on the six triggering questions suggested by the Editors.

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**Table 1 –** Authors´ reflections on the six triggering questions suggested by the Editors

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| --- | --- |
| **Questions** | **Take-Home Messages** |
| What is our vision about HP?  | Health promotion should promote the health interests of individuals and communities. In combination with (increasingly digital) health literacy, health promotion should support people to determine the health determinants relevant to them and advocate for the co-creation of #HealthForAll in all policies and places. |
| What is the institutional and political context of your experience (participants, professions and courses involved, duration and frequency of activities)? | My experience as a student of health promotion spans professions (librarianship, public health), disciplines (health literacy, information science, open science) and participants (public library and medical library, staff, school staff, children and young people, expert patients, people living with dementia and their careers, homeless service-users, Recovery College graduates). I have been embedded in a library and knowledge services team within the National Health Service (NHS) as Health Literacy Project Manager from November 2018 to the time of writing (April 2021). I started a three-year PhD in children’s health literacy, informed by health promotion research and practice, in October 2019. I am currently participating in the 2021 cohort working towards professional registration with the UK Public Health Register (UKPHR) as an early-career health promotion practitioner. |
| Which theories and methodologies are used in the teaching-learning process? | The theories and methodologies that I have been exposed to through lectures, and which continue to frame my thinking in relation to health promotion, include the social determinants of health; the proportionate universalism approach; and the settings approach. As part of my PhD, I am applying institutional ethnography as a mode of inquiry for studyinghealthy settings. |
| What kind of forms of assessment are applied, results achieved, and challenges faced? | Health promotion lectures and masterclasses delivered over Zoom incorporate regular checks for understanding via interactive and participatory elements, including submitting comments and answers to questions in the chat-box; voting in online polls; and small-group discussion using the Breakout Rooms function. Continuing Professional Development (CPD) is challenging in a time of social distancing and reduced face-to-face support: the UKPHR validation scheme is being delivered remotely, and it is difficult to replicate online the serendipity of in-person networking that the pre-pandemic version of the scheme was able to facilitate. |
| Which principles, pillars, competencies or approaches to Health Promotion do you base your plan of teaching and learning? | My learning draws on several of the core competencies for health promotion, as outlined by the CompHP framework: a multidisciplinary knowledge base (including the significance of multiple literacies, e.g., digital literacy as well as health literacy), a commitment to enabling change and supporting self-advocacy (underpinned by critical pedagogies), partnerships with novel settings for health (e.g., public libraries), and the importance of embedding evaluation and research intopractice. |
| What others could learn with your experience? What is localized and what is “generalizable”? | My work on the health promotion remit of public libraries is UK-specific, but public libraries internationally are involved in health promotion work (e.g., staff at Philadelphia’s McPherson Square Library are trained to administer emergency naloxone to treat heroin overdoses, and Australian libraries employ Library Social Workers). Enabling engagement with populations on social media is more generalizable: e.g., the @viralfacts Twitter account, although focused on Africa, offers lessons in best practices for a national approach to challenging health misinformation in other countries. There is much to be learned from comparing the ways in which community-based settings, operating in different physical and online contexts, are supporting digitally-excluded populations to access health information and services during the pandemic. |

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