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Being orientated towards social justice: Learning for health visitor practice

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ABSTRACT

Not applicable.

1. Introduction

It is hard to imagine health without social justice. Marmot et al. (2010) points out that health inequalities are a matter of life and death, with wide disparities between life expectancy within and between countries, depending on where people live and the different opportunities that society affords them. On page three, he defended an earlier international review of the social determinants of health against criticisms of ideology, saying: "*We do have an ideological position: health inequalities that could be avoided by reasonable means are unfair. Putting them right is a matter of social justice. But the evidence matters. Good intentions are not enough*". Marmot's 'ideological position' is highly relevant to the education and practice of health visiting.

Other countries with similar roles to the British health visitor include Denmark, Greece, Norway and Finland (also called health visitors), USA, Canada, Ireland (public health nurses), Australia (child and family health nurses), New Zealand (Plunket nurses), Belgium (social nurses), and Serbia, Kosovo, Kazakhstan (patronage nurses) (Malone et al., 2016). Health visitors provide a proportionately universal service, working in a preventive and social justice-focused role, mainly with expectant and new parents and their infants and young children. They use place-based approaches, which target an entire community and aim to address issues that exist at the neighbourhood level, to promote child and family health. Early child development has been called a social determinant of health (Irwin et al., 2007). Accordingly, this paper will highlight the central importance of the period from conception to age five (the first 2000 days of life) for health inequalities. Effective practice at this early stage of life is significant for social justice because it has the potential to improve the life chances and later outcomes of infants as they grow up, as discussed in later sections. The paper will describe how health visitors work with families, explaining how their practice can be significant in countering social injustice. It focuses on how health visitor practice can be creatively learned and taught, explaining skills used in education, which health visitors also use in their practice. We illustrate this, by applying Laurillard's (2012) learning modes and types (Table 1), developed from her conversational framework (which we refer to as 'relational').

Teaching based in the practice environment (by 'practice teachers') seeks to orientate student health visitors into a 'way of being' that embodies health visiting values. This co-creation of health visitor knowledge moves beyond the technical application of an intervention or skill. Student health visitors require grounding in a deep sense of purpose in their future role, through a particular 'orientation to practice' (Cowley et al., 2015). This orientation was identified through a programme of research that aimed to discover the 'how' of health visiting practice: focusing on what health visitors, specifically, bring to the table of early years provision. It included empirical studies and a review of health visiting research over 25 years, and provides detailed information that is not offered here, due to length restrictions.

The orientation to practice involves: 1) investing in health creation (salutogenesis), including the co-identification of unmet health needs with families, 2) valuing, including caring for, each person on their own terms and own strengths (human valuing), and 3) being aware of the dynamics and situation of the family/people they are working with (human ecology). These elements encompass a breadth of theoretical and practical knowledge, combined into a single approach to practice, which underpins the health visitors' whole professional identity (Cowley et al., 2015). To take a simple analogy: a skilled baker can combine knowledge, expertise and practical application to produce a delicious sponge cake from three separate ingredients (eggs, sugar and flour).[1] Similarly, a skilled health visitor blends learning about three distinct elements of the 'orientation to practice' (salutogenesis, human valuing and human ecology), with expertise about child public health and

[1] Acknowledgement: This analogy was partly inspired by Kemp's recipe for achieving adaptation and fidelity in population scale implementation of programmes. Prev Sci (2016) 17:429–438 DOI https://doi.org/10.1007/s11121-016-0642-7.

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proven interventions, to produce a form of effective practice that is personalised to each situation encountered. The separate ingredients cannot be removed from a baked cake, nor can the distinctive elements of health visiting practice be isolated from their application.

At the end of health visitor education, we expect students to be able to cogently identify, align and embody the values of health visiting through this orientation to practice. This educational expectation is achieved by clear illustration in creative learning design for mindful social justice to address health inequalities in health visitor practice.

2. Health inequalities and social justice

The period from conception to aged five years (the first 2000 days) is a key defining stage for infants' later health, development and wellbeing,

Table 1
Applying Laurillard's (2012) learning design to health visitor education.

Modes of Learning	Learning Types in Health Visitor Education
Individual Learning Learning defined as allowing learners to hold an internal conversation whereby they begin to reflect and modulate their initial concepts and practice by thinking through what they have learnt, heard, read or received as feedback.	**Learning through Acquisition (Individual Learning)** • Predominantly a passive type of learning; typically student health visitors learn by listening to a lecture at university or observing a practice teacher working with parents. • Enables students to observe either articulations/explanations or model actions made by a lecturer in class or a practice teacher in clinical practice. • Learning through observations allows students to begin to construct and modulate concepts for their future clinical practice, without the need to generate any action or articulation. • For example: a student may make notes in a lecture on health needs assessments and begin to understand how these assessments are operationalised within the orientation to practice through observation. **Learning through Inquiry (Individual Learning)** • Requires a more active role by the student health visitor than Learning through acquisition. • Rather than simply 'taking in' information as presented by their lecturer or practice teacher, students can begin to take control of their own Learning through following their own line of inquiry. • Prompts students to reflect on concepts they have been taught and begin to learn; finding out by investigating and organising; generating new Learning through comparing what they already know with what they come across in their inquiries. • Includes making use of available resources, such as academic databases or clinical guidelines to learn about, for example, the evidence-base for managing faltering growth that they may have observed in a baby clinic, or exploring a physical location, such as conducting a public health walk of a local geographical caseload. **Learning through Practice (Individual Learning)** • Perhaps an obvious learning type in health visitor education, as working with practice teachers and parents in clinical placement is a dominant and mandated feature in their programme of study, but student health visitors may also learn by practice in clinical simulation at university. • Builds upon other types of learning (acquisition, inquiry, discussion); enables students to use their developing concepts to improve their clinical practice by putting 'theory into practice' by working toward an aim through pre-determined, purposive actions (as guided by the lecturer or practice teacher) and using feedback to modulate future practice. • For example, a practice teacher may ask a student to lead on the therapeutic activity of exploring infant feeding options with a parent in a new birth visit. To achieve this, the student will use previous learning on infant feeding (the concept) from university and clinical practice, then rehearse various approaches to stimulating therapeutic discussion with the new parent in the presence of the practice teacher. The student would then modulate their clinical practice based on feedback received from their practice teacher, engagement with the new parent and through individual reflection to determine improvements for future approaches. **Learning through Production (Individual Learning)** • This is another active type of learning whereby the lecturer or practice teacher motivates the student health visitor to pull together, consolidate and articulate their current learning and how they have used it in practice. • Provides the opportunity for the lecturer or practice teacher to respond with extrinsic feedback, guidance and further explanation to the student health visitor. • To take this learning type further, students should be encouraged to co-produce their learning with parents they work with. • For example, Learning through production may involve students being asked to produce an academic poster presentation on an aspect of the health visiting service for an assessment of a university module or to focus on ensuring the main focus of their output in their clinical practice is geared towards achieving completion of their practice assessment document.
Social Learning Learning defined as allowing conversation with other learners as they think through what they have collectively and comparatively learned, practiced, produced, with explicit focus on articulation and reasoning.	**Learning through Discussion (Social Learning)** • Involves student health visitors learning with others (e.g., students, clinical colleagues, lecturers, practice teachers), providing some kind of focus as a central point or stimulus for discussion. • The discussion begins with one generating ideas and questions around the focus, which results in others listening, modulating and responding with their own ideas and questions to generate further discussion. • For example, after being taught assessment considerations in child development in class, students may be asked to work in small groups to discuss what they have observed in assessments taking place in their clinical placements. • Another example may include a student health visitor and practice teacher reflecting in the car after a home visit on how they felt the overall parent engagement and satisfaction was established and developed. **Learning through Collaboration (Social Learning)** • This takes Learning through discussion to a greater depth and potentially is the most multi-layered type of learning student health visitors will encounter. It focuses on the joint process of knowledge building, by participation from students' previous Learning through inquiry and discussion with one another. • It is explicitly different from other learning types because students must participate as well as negotiate with their peers, attempting to produce a co-ordinated, shared conception to a problem or focus. The participation and negotiation involved not only requires student health visitors to modulate their actions but also provide reasons for them. • This type of social learning requires little in the way of involvement from the lecturer or practice teacher other than providing an aspiration for 'best practice' to a particular problem. • For example, a practice teacher may encourage a student to advocate for a parent, with whom they have developed a therapeutic relationship, within a child protection core group meeting through participation and negotiation with multi-agency colleagues. • Learning through collaboration is similar to co-production methods used in health visiting practice, approaches that students will need to become be familiar with, such as co-identifying unmet health needs with parents

Table 2
Framing the five components of the nurturing care framework through the Orientation to Practice (see Malone et al. 2016) when working with families experiencing poverty and potentially conflicting perspectives.

Orientation to Practice	Social Justice in Practice *(Individual components of the Nurturing Care Framework for Early Childhood Development (World Health Organization et al., 2018) are noted in italics)*	Independent learning types	Social learning types
Human ecology	• Seek to understand what it means to live in different parts of the community setting, making use of 'insider knowledge' through familiarity with local housing support groups, public transport systems, access to leisure facilities and identifying local citizen advocates *(security and safety, good health)*.	• *Acquiring* knowledge through joining lectures and seminars and engaging with peer review texts about differing family contexts and impact of home environments on child and family health.	• Use case studies to *discuss* and explore with peers, power, resource and positions of influence within families and communities.
		• *Inquire* upon social and public health policy that shapes the context impacting on family resources	• Engage in *collaborative exercises* to interrogate policy and local community resources to put in place actions that aid service accessibility in different family circumstances.
	• Recognise when the situation can undermine parent's efforts to practice positive parenting and intervene, seeking to counter adversity, e.g. offering positive praise, guided practice, to provide additional support and aid parenting self-efficacy *(responsive caregiving)*.	• Engage in the *practice* of providing home visits to families living in differing circumstances and critically reflect on factors impacting on family circumstances.	• Reflect on home visits completed and *discuss* with practice teachers the ways of being in the home setting. Reflect on how relationships can be a vehicle for demonstrating trustworthy help.
	• Consider the disempowering impact of poverty and financial insecurity on future planning and explore ways of enabling parents to plan safe play and learning experiences for their children (*responsive caregiving, opportunities for early learning)*.	• *Practice* in community settings to *acquire experience* (and expertise) in negotiating continued entry into different situations.	• Generate through *co-production* plans of action tailored to meeting the health needs of children and families at different time points and contexts
Salutogenesis	• Take action to actively support infant care in difficult circumstances (e.g. living in overcrowded accommodation), including by acknowledging the concerns of 'significant others' ambivalent about infants adapting to extrauterine life. For example, praise efforts made by the parents and reinforce messages about the power of breast feeding to impact on health of the mother and baby *(adequate nutrition, good health, safety and security)*.	• *Acquire* knowledge about factors that influence health and interventions effective in creating health.	• Engage in seminars and case study *discussion* with peers and stakeholders to examine the merits of evidence for what, how and when health interventions should be available.
		• *Inquire* about factors influencing health and disease through examining epidemiological data, identifying 'critical moments' for action.	• *Collaborate* with peers and stakeholders to debate and refine the design of service systems that are safe for all service users and providers.
	• Support efforts to ensure healthy diet and to optimise early opportunities for active play, especially where environmental resources are limited, such as overcrowded or unsafe housing, lack of cooking facilities, unsuitable green spaces/ play parks (*adequate nutrition, good health, safety and security*).	• Contribute to provision of interventions delivered in home and community settings and *practice* communication skills that enable growth of trusting relationships with families.	• Use trusting relationships to *co-produce* with families action plans for providing interventions suitable to address health and developmental needs.
	• Recognising and building on individual and family resources, understanding the need for cultural safety and suitability of proposed interventions *(opportunities for early learning, responsive caregiving)*.		
Human valuing	• Modify practice to ensure behaviours are culturally safe and appropriate, respecting the individual's belief system *(security and safety, responsive caregiving)*.	• Join learning events (lectures, webinars and film festivals) that explore human rights in different contexts to *acquire* knowledge about the human condition and intersectionality.	• *Collaborate* with peers to explore the concepts of 'hard to reach' and 'seldom heard', identifying behaviours that may limit equitable access to health and community services.
	• Support individuals living with disrupted lives by acknowledging a person's strengths and using this as a basis for achieving steps towards health goals *(security and safety, opportunities for early learning)*.	• Seek out citizen advocates to generate an understanding through *inquiry* about life in the local community.	• *Co-produce* with community citizens strategies for listening and understanding the needs of marginalised people in the community.
	• Tailoring interactions to meet the needs of individuals e.g. shift focus from a child developmental review to attending to the needs of a person experiencing perinatal mental health difficulties *(responsive caregiving, opportunities for early learning)*.	• *Practice* through role play the art of demonstrating positive regard for others different to ourselves.	• Explore through *reflective discussion* with practice teachers one's own unconscious bias and how this can be managed.

which makes a critical contribution to inequalities and inequities throughout life (Irwin et al., 2007). Evidence from neurological science illuminates the connection between the social and physical dimensions of life (Center on the Developing Child at Harvard University, 2010) and exposure to nurturing care (World Health Organization et al., 2018) at key moments of human development. In essence, positive parenting and early experiences can both protect children from risks and expose them to positive opportunities. In turn, these shape a child's capacity to form future relationships, benefit from future learning (development of language/communication and executive function) and manage responses to life stressors.

Providing a safe and secure environment when living in economically harsh conditions is challenging, and the mental stress of poverty can constrain any caregiver's capacity to provide nurturing care. Thus, poverty and the inequitable distribution of opportunities for employment, housing and restorative leisure activities create a social injustice with ramifications for health. In addition, it has negative consequences for parenting capacity and optimising the 'key moments' for infant growth and development (Center on the Developing Child at Harvard University, 2016). Addressing this requires proactive steps to intervene in redressing the causes of health inequalities and also provide social interventions that can aid positive parenting practices. The latter includes service provision in the home and community by health visitors, who are specifically educated to attune to the needs of parents and infants, taking account of their circumstances to provide person-centred guidance in parenting and infant care.

People facing endemic stigma, violence or other environmental constraints that lead to social injustice may, like those living in poverty, experience greater challenges as new parents and also need sensitive and informed health visiting support (World Health Organization et al., 2018). Table 2 provides examples of how the orientation to practice can be applied to learning for social justice. It uses the example of working with families experiencing poverty and potentially conflicting perspectives, focusing on the five components of nurturing care (good health, adequate nutrition, security and safety, responsive caregiving and opportunities for early learning), identified as essential for infants to reach their full potential (World Health Organization et al., 2018), and thus ameliorate social injustice. There is not enough space to detail every possible challenge in this paper, but a newly qualified health visitor needs to be able to practice confidently in all such situations.

3. Health visitor practice

There is a wealth of strong evidence about the trajectory from early health and development needs and later disadvantage. Harron et al.'s (2021) review provides one good example for the UK. Also, there are sound, research-based interventions directed at the earliest years, aimed at improving their life chances (Center on the Developing Child at Harvard University, 2016). Descriptors used to explain these interventions vary across countries and districts. For clarity, we distinguish three groups, following the typology used by the World Health Organization (WHO): universal, indicated and selective prevention (WHO, 2004).

Health visitors are in contact with every expectant and new parent, visiting shortly after they are discharged from the midwife's care, until the infant reaches school age. This provides a golden opportunity for broad-based universal prevention (Institute of Health Visiting, 2019), directed at enabling parents to provide the nurturing care required for optimum development (World Health Organization et al., 2018). Nurturing care is an overarching concept incorporating a stable environment that is sensitive to a child's development and it is supported by a large array of social contexts with which health visitors need to be familiar, including different family forms, economic pressures and diverse groups and communities within a given population. The five components of nurturing care provide a focus for the orientation to practice when working with families in different social contexts, which is illustrated in Table 2.

The next group of interventions aim to improve outcomes amongst infants or young children who are already showing signs of disadvantage ('indicated prevention'). Examples include feeding concerns or excessive weight gain that predicts possible later obesity and health problems; or behavioural issues, which may be linked to impaired early learning or development of executive function, leading to later problems at school and in employment.

Finally, interventions may be targeted before any signs of difficulties appear, by identifying individuals from groups known to have a higher risk of adverse outcomes ('selective prevention'). Examples include the infants of incarcerated parents, those who have experienced violence or forced migration, young and/or unsupported parents and those who have previously experienced severe mental health problems or lost a baby to sudden unexplained death in infancy.

Reviewing the wealth of evidence about suitable interventions, programmes and support schemes for each level of prevention, particularly in relation to social disadvantage, lies beyond the remit of this paper. However, determining "the appropriate mix of strategies to capitalize on existing strengths and address specific needs" is not only a challenge for scientists working in the early years field (Center on the Developing Child at Harvard University, 2016, page 29), but also one that health visitors face each day in practice. Crucially, practice depends upon the ability to integrate multiple strands of evidence, knowledge, skills, capabilities and values to develop the particular form of expertise and practical wisdom that characterises the health visiting profession.

In turn, educators preparing student health visitors, need an understanding that extends beyond the application of specific programmes or interventions, to encompass a breadth of knowledge about the multiple interacting aspects of the families' lives. Attitudes and insights about the social determinants of health in early life, and how these interact to create disadvantage and social injustice, provide a key foundation from which students can learn how to practice.

4. Learning design for the orientation to practice

Health visitor education has long been embedded within higher education and clinical practice. The current post-graduate level of preparation demonstrates investment in the knowledge-base and level of critical thinking required. This education is concerned with enabling health visitors to practice in a range of situations, particularly focusing on families with infants in the first 2000 days. Good child health outcomes can be achieved when health visitor practice is fully optimised, even when daily living realities are immersed in great social injustice, with indicated poor health trajectories (Institute of Health Visiting, 2019). Since the origins of health visiting, their professional practice naturally operates within this complexity, through a human ecological model of health. New insights have been added to this foundation with the orientation to practice described above. On qualification, health visitors ultimately practice through co-producing health solutions with people, groups and communities, contextualised within and by their complex social realities. Student health visitors can be enabled to reach this professional destination through learning design, and explicit teaching that embodies the orientation to practice, by university educators and practice teachers.

To maximise student health visitors' recognition, interpretation and transition to embodying the orientation to practice, it may be necessary to balance the teaching and learning design of this new type of practice as a 'whole' model as well as in separate elements or fragments. To support this balance, we identified a helpful conceptualisation of different modes and types of learning (Laurillard, 2012) that can be applied to health visitor education. It offers student health visitors varied opportunities to 'learn' their new way of 'being' in practice. Detailed examples of how this happens are incorporated in Table 1.

Arguably, health visiting practice is only fully realised, by both the individual professional and families, when it is carried out contextually,

sensitively and knowingly by the health visitor. Teaching for this type of expertise is potentially challenging. From an ecological perspective, Cianciolo and Sternberg (2018) suggest that, whilst expertise is knowledge-domain-specific, key attributes of expertise within a specific time and place (context) heighten the performance. These attributes are tacit knowledge and practical intelligence.

Cianciolo and Sternberg define tacit knowledge as '…an adaptive intellectual resource that can be applied to novel situations because it stems from multimodal and reciprocal interaction between people and their environment' (Cianciolo and Sternberg, 2018: 773). Practical intelligence is defined as '…the ability to acquire tacit knowledge from experience and to apply this knowledge to handling practical problems in which the information necessary to determine a solution strategy is often incomplete' (Cianciolo and Sternberg, 2018: 774). Cianciolo and Sternberg affirm that developing these attributes are not mysterious. Learning methods such as 'communities of practice' are effective at the explication of tacit knowledge and the practical intelligence. This affirmation affords substantial emphasis for social learning in health visitor education, such as a university classroom, a health visitors' office space, or even whilst travelling with a practice teacher between scheduled (observed) visits.

The ecological view of expert performance helpfully provides an educational apparatus for demonstrating to student health visitors how the orientation to practice is 'to be' and done; for example, achieving positive outcomes from the application of an evidence-based intervention or assessment/identification, or a novel response to individual queries. Thus, 'being' and 'doing' merge into a practical appreciation of practice, through the explicit teaching of social values, non-judgemental approaches, confidence and 'knowing' the evidence. This merge requires a metacognitive awareness about why they want to become a health visitor, including political ideology. With the increased need for truly developing one's social competence and effectiveness, student health visitors finally arrive at the point of realising that people's attitudes and capacities depend greatly upon their prior experiences and environment. All people have an inherent value and are deserving of a service, especially bearing in mind the needs of children and the potential to break generational disadvantage or anti-social attitudes. This is where Cianciolo and Sternberg's points become heavily involved in professional responses.

Laurillard's (2012) relational framework involves independent and social learning, which parallels the individual (child and family) and community focus of health visiting practice (human ecology). Recognising the value of learning design allows each student health visitor to flourish, as they develop the ability to provide an individual, non-judgemental and person-centred service (human valuing). Co-production and collaboration, which are embedded within this approach to learning, is essentially salutogenic and used in health visiting practice to enable parents to discover their own strengths and ways of parenting effectively.

5. Conclusion

In conclusion, this paper emphasises that the practical wisdom developed through health visitor education is fundamentally orientated and destined to be pro-social justice, with logical, intellectual and practical concepts designed to optimise the first 2000 days of a child's life. By focusing on the contextual attributes of expert performance (tacit knowledge and practical intelligence), student health visitors not only 'operate as' but 'become' valuable professionals, through the embodiment of the orientation to practice (Malone et al., 2016).

This paper has illustrated how independent and social learning types (Laurillard, 2012) can offer educators imagination of embedding social justice learning within the orientation to practice. Ultimately, health visitor practice is unique from other professions by the identification, co-production and response to social injustices through health activities in universal, indicated and selective prevention. Whilst there is fundamental need for integration of research-informed, evidence-based practice in the co-production of nurturing care within the first 2000 days, this paper emphasises the importance of learning about social justice for health visiting practice.

Declaration of competing interest

None.

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