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Good human functioning, health and the promotion of health

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Good human functioning, health, and the promotion of health

Abstract

This paper extends a theory of health promoting schools (Author, 2003) that draws heavily upon Nussbaum's Aristotelian interpretation of good human functioning (Nussbaum, 1990).

This theory of health promoting schools proposed that health is grounded in the meeting of identified fundamental human needs and the realisation of identified essential human capacities (Author, 2003).

The extension of this theory is achieved through the application of influential social theories with practical tenets to Nussbaum's insights (Nussbaum, 1990). This extension includes additional essential human capacities, a description and definition of how good human functioning may be recognised, potential limitations of the capabilities approaches and a discussion of major factors inhibiting good human functioning.

The potential contribution of the outlined framework to discussions of health and health promotion is highlighted in two ways. First, this paper considers how the outlined framework may contribute to discussions of quality of life, morbidity/premature mortality and health-related behaviours. Second, this paper briefly considers how the outlined framework may contribute to discussions of 1) public health policy and 2) the planning, delivery and evaluation of health promotion initiatives. Basic exemplar pre- and post- questionnaires for a hypothetical health promoting community development programme are offered.

Good human functioning, health, and the promotion of health

Important theoretical frameworks propose that different interpretations of good human functioning are a precondition for health (e.g. Antonovsky, 1987; Marmot, 2004; Nordenfelt, 1995; Seedhouse, 1997). However, conceptual frameworks for understanding health that are based upon good human functioning are commonly overlooked in discussions of quality of life, morbidity/premature mortality and health-related behaviours. Moreover, there is an ongoing need to highlight the relevance of these frameworks for both public health policy and the planning, delivery and evaluation of health promotion programmes.

Nussbaum's Aristotelian interpretation of good human functioning (Nussbaum 1990; 2000) centres on identified essential human capacities the realisation of which varies from person to person and culture to culture. Nussbaum (1990) reasoned her interpretation is detailed, objective, flexible and universal and therefore potentially applicable to all people irrespective of situation and culture.

Author (2003, 2015) developed a conceptual framework for health promoting schools that was synthesised primarily from the application of Bernstein's influential theory of cultural transmission (Bernstein, 1975) to Nussbaum's conception of good human functioning (Nussbaum, 1990). However, Author (2003) separated some essential capacities (Nussbaum, 1990) from the others because they have a physiological dimension and consequently focus on issues to do with the body. These separated capacities were categorised as fundamental human needs (Author, 2003). Author (2003) went onto propose that 1) good human functioning is a prerequisite for maximising a person's health potential and 2) good human functioning is achieved through the meeting of the identified fundamental human needs and the realisation of the identified essential human capacities.

1 This paper broadens the health promoting school framework of Author (2003) through the
2 application of influential social theories that have practical tenets (Bernstein, 1975,
3 Bronfenbrenner, 1989, Freire, 1989, Hall, 1995, Freire, 1998) to Nussbaum's insights. This
4 broadening includes
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8

- 9 1) An extended list of fundamental needs and essential capacities.
 - 10 2) A discussion of how good human functioning may be recognised which includes a
11 definition of good human functioning.
 - 12 3) Potential limitations of the capabilities approaches.
 - 13 4) A discussion of major factors that inhibit good human functioning.
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24 This paper goes on to discuss the potential contribution of both Nussbaum's insights into good
25 human functioning (Nussbaum, 1990, 2000) and the extended theoretical position espoused in
26 this paper to discussions of health and the promotion of health in two ways.
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31
32 First, it considers how Nussbaum's insights (1990, 2000) and this paper's theoretical position
33 may potentially contribute to discussions of quality of life, morbidity/premature mortality and
34 health-related behaviours.
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42 Second, it briefly outlines how Nussbaum's insights (1990, 2000) and this paper's theoretical
43 position may potentially contribute to discussions of 1) public health policy and 2) the
44 planning, delivery and evaluation of health promotion initiatives. Basic exemplar pre- and
45 post- questionnaires for a hypothetical health promoting community development programme
46 are offered.
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56 **Good human functioning based upon an extended list of fundamental human needs and**
57 **essential human capacities (Table 1)**
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1 This paper proposes that the fundamental human needs and essential capacities identified by
2
3 Author (2003) may be extended in three ways.
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8 First, by drawing on Nussbaum's own list of essential capacities which she refined in 2000
9
10 (Nussbaum, 2000).
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14 INSERT TABLE 1 HERE PLEASE
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19 Second by drawing upon Wolff and de-Shalit (2007), who identified two other essential
20
21 capacities.
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26 'The capacity to live a materially decent life in a law-abiding fashion..... (This capacity
27 focuses on the possibility) of being able to live within the law: not being forced to break the
28 law, cheat, or to deceive people or institutions (in order to live)' (Wolff and de-Shalit, 2007,
29
30 p47).
31
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36
37 'The capacity to be able to be able to communicate including being able to speak the local
38 language, or being verbally independent' (Wolff and de-Shalit, 2007, p50).
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44 Third, by this paper's proposal that an additional capacity which is also essential and might
45
46 also separate humans from other animals and is therefore distinctive would be
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51 'The capacity to nurture and be nurtured throughout the life course and the subsequent
52 development of the ability to trust and be trusted'.
53
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58 The term nurturing is taken to include both the provision of succour and the facilitation of
59
60 another person's development throughout her/his life rather than the rearing of offspring until

1 they are able to live independent lives. This qualitative difference arises in humans because of
2
3 a respect for individuality.
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6
7

8 Nussbaum (1990) proposed that the essential capacities for practical reasoning and affiliation
9
10 are over-arching and plan and organise the other capacities because everything a person does is
11
12 planned and organised by her/his ability to reason and is done with or to other humans.
13
14
15
16

17 Thus, this paper proposes that good human functioning and autonomy, which are preconditions
18
19 for health, may be defined as:
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23

24 ‘Once the fundamental human needs for living such as food and shelter are met, good human
25 functioning, autonomy and thus, the ability to live a fully human life, are determined by
26 processes that facilitate the realisation of all the essential human capacities through the
27 realisation of the overarching capacities for practical reasoning and affiliation’.
28
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35 This, paper is therefore proposing that:
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39 The meeting of the identified fundamental human needs sustains the realisation of the essential
40
41 capacities and is necessary but not sufficient for good human functioning.
42
43

44 The partial realisation of all the identified essential capacities may occur alongside each other
45
46 but the realisation of the overarching essential capacities for practical reasoning and affiliation
47
48 is central to good human functioning. .
49
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51 Nussbaum (1990) maintains that the realisation of the essential capacities is influenced and
52
53 shaped both by time and the totality of a person’s environment and highlights the existence of
54
55 economic, social, familial and physical constraints and enablers that either prevent or promote
56
57 good human functioning. People therefore, need support from their environment in order to be
58
59 in a position to choose to function well and be healthy. Influential environmental constituents
60

1 include families/trans-generational factors, material resources, education, institutions, and
2
3 situational and cultural contexts (Nussbaum, 1990, 2000). Nussbaum's position therefore
4
5 resonates with other ecological frameworks that have been developed (e.g. Bronfenbrenner,
6
7 1989, Dahlgren and Whitehead, 2007). The existence of these environmental constraints and
8
9 enablers, Nussbaum posits, is confirmed by a focus on outputs and informed by a key question
10
11 'What is a person able to do and be?'. Moreover, these environmental constraints and
12
13 enablers, this paper proposes are the key to the promotion of health.
14
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19 Nussbaum (2000) also highlights the role of agency in functioning well. The application of
20
21 Bronfenbrenner's ecological systems theory (Bronfenbrenner, 1989) to Nussbaum's insights
22
23 highlights the transactional relationships between agency and structure and thus, between
24
25 people and their environments. This application therefore underlines how people may input
26
27 into their own ability to function well. Moreover, the transactional nature of the relationships
28
29 between people and their environments may help to explain why some personal characteristics
30
31 such as age, disability, ethnicity and gender have such a marked influence on human
32
33 development and human functioning and, hence, such a profound effect on people's lives and
34
35 thus, their health.
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42 The relationships between time, socio-political conditions, key environmental factors, the
43
44 meeting of the fundamental human needs, the realisation of the essential capacities, autonomy,
45
46 the ability to choose to function well and flourish and personal agency are summarised in
47
48 Figure I.
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52
53 (FIGURE 1 HERE PLEASE)
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58 **Potential limitations of the capabilities approaches**

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1 Concerns regarding the capabilities approaches developed by Nussbaum (1990, 2000) and Sen
2
3 (1999) may be divided into three broad categories.
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8 First, many commentators who draw upon the capabilities approaches focus primarily on
9
10 enabling or constraining generative mechanisms that occur within families, partnerships and
11
12 friendship groups i.e. close proximal relationships. Thus, the potential contribution to human
13
14 functioning of enabling or constraining generative mechanisms within distal relationships is
15
16 often overlooked (Taylor, 2011). Moreover, Carpenter (2009) reasoned that insufficient
17
18 attention is frequently paid to the influence of social movements. These movements have the
19
20 potential to greatly affect human functioning at both individual and group levels through their
21
22 influence on wider social policy and thus, resource acquisition and support. Carpenter (2009)
23
24 concluded however, that Nussbaum's approach could be usefully applied to the field of public
25
26 policy.
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33 Second, insufficient attention is commonly paid to the influences of generative mechanisms
34
35 within the wider context which again may be enabling or constraining. Thus, for example,
36
37 many interpretations of the capabilities approaches highlight participation in public arenas as a
38
39 fundamental aspect of good human functioning. However, as Dean (2009) maintains, people
40
41 would find it difficult to divorce themselves from external controls and external sources of
42
43 power which influence their potential to participate in public arenas. Additionally, people
44
45 cannot exorcise themselves from the direct and indirect consequences of exploitation through
46
47 human labour (Dean, 2009). The capabilities approaches have also been interpreted as failing
48
49 to highlight important societal barriers inhibiting good human functioning that many people
50
51 experience including people living with a disability. However, Burchardt (2004) reasoned that
52
53 the capabilities approaches resonate with the social model of disability which emphasises the
54
55 distinction between impairment and disability and views disability as a socially constructed
56
57 process.
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3 Third, commentators have reasoned that Nussbaum's insights are theoretical and their practical
4 application is consequently limited. Nussbaum herself asserts that it is not possible to be
5 prescriptive about how the identified essential capacities should be realised in order to flourish
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10 (Nussbaum, 1990).

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14 However, this paper proposes that the application of influential social theories with more
15 practical tenets (Bernstein, 1975, Bronfenbrenner, 1989, Freire, 1989, Hall, 1995, Freire, 1998)
16 to Nussbaum's insights helps to address some of the potential practical limitations of her
17 approach. This application also facilitates an understanding of how good human functioning
18 might be recognised and what factors inhibit good human functioning.
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28 **How might good human functioning be recognised?**

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30 The primary indicators of good human functioning are then, the sufficient realisation of the
31 overarching capacities for practical reasoning and affiliation.
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37 Drawing upon Bernstein (1975) and Freire (1989,1998), this paper proposes that:

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42 1. People who have sufficiently realised the capacity for practical reasoning through
43 informal and formal learning will have elaborate orientations to meaning rather than
44 restricted orientations to meaning that focus on lived and subjective experience. People
45 in this position are able to critically analyse the causes of problems and phenomena in
46 their lives from different perspectives, make moral judgements more justly, and make
47 proactive choices that are not restricted by external factors. These proactive choices
48 may also involve adapting or transforming reality through invention, creation or
49 recreation (Freire, 1989). Transforming reality is however, rarely achieved by the
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1 individual (Freire, 1989) and is more commonly achieved through the collective
2
3 (Freire, 1989) and social movements (Carpenter, 2009).
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- 8 2. People who have sufficiently realised the capacity for affiliation will have mutually
9
10 satisfying reciprocal interactions and attachments within proximal contexts with family
11
12 and friends and additionally within more distal contexts such as work and the wider
13
14 society. These reciprocal attachments will be based upon shared values and/or
15
16 empathetic orientations to meaning. People who have sufficiently realised the capacity
17
18 for affiliation will feel socially supported and will perceive they have a socially valued
19
20 role, a socially valued identity and are involved in socially valued decision making in
21
22 both proximal and distal contexts.
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28 Any factor which inhibits the realisation of any essential capacity will inhibit a person's ability
29
30 to function well (Wolff and de-Shalit, 2007). However, factors that inhibit the realisation of
31
32 the overarching essential capacities will have a profound influence on people's ability to
33
34 function well. Additional influential inhibitory factors inhibit the realisation of many essential
35
36 capacities and include insufficient material resources and weariness (Wolff and de-Shalit,
37
38 2007). The concept of weariness chimes with overload/underload balance which is a key
39
40 influence on Manageability - one of the three core concepts of the Sense of Coherence
41
42 construct (Antonovsky, 1987). How influential inhibitory factors inhibit good human
43
44 functioning requires consideration.
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51 **Influential factors that inhibit good human functioning**

52 Factors that inhibit the realisation of the capacity for practical reasoning

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54 This paper proposes that the sufficient realisation of the capacity for practical reasoning is
55
56 greatly impeded by confined imaginations and restricted orientations to meaning that focus on
57
58 lived experience. Confined imaginations and restricted orientations to meaning may arise as a
59
60

1 consequence of deprivation, injustice, impairment, unhelpful cultural norms and unhelpful
2 situational environments (Nussbaum, 1990). Under these circumstances, the ability to critically
3 perceive reality, make moral judgements more justly, make proactive choices and subsequently
4 choose to adapt or transform reality is commonly obstructed. People in this position will
5 consequently have a compromised ability to plan their own life and control their environment.
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14 Factors that inhibit the realisation of the capacity for affiliation

15 This paper proposes that the sufficient realisation of the capacity for affiliation is greatly
16 impeded by two factors:
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18

19 1) A constrained ability to create a socially valued role and identity through being involved in
20 socially valued decision making in both proximal contexts and more distal contexts such as
21 work and the political sphere. This constrained ability and resulting marginalisation may arise
22 because a person a) does not share others' values and/or is not empathetic to others'
23 orientations to meaning and/or b) is perceived as adding insufficient value via valued skills,
24 valued knowledge, a valued role, a valued emotional identity or a valued behavioural identity.
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38 2) A constrained ability to support and advance good human functioning in others. Thus,
39 people affiliated to groups seeking to unjustly oppress others may potentially have mutually
40 satisfying and reciprocal attachments within their proximal contexts. However, they cannot
41 sufficiently realise the capacity for affiliation because of the nature of their interactions with
42 people outside of their proximal attachments. That people in this position cannot sufficiently
43 realise the capacity for affiliation highlights the elevated importance of values over wants and
44 preferences.
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56 The inhibitory influence of insufficient material resources on good human functioning

57 This paper proposes that insufficient material resources may force or coerce people into
58 diverting their attention away from realising the essential capacities in order to meet their
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1 fundamental needs for food, warmth and shelter, pleasurable experiences and/or their need to
2
3 feel physically safe.
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8 Sufficient material resources are also required in order to sufficiently realise all the essential
9
10 capacities and live fully human lives. Importantly, material resources are commonly required
11
12 to overcome external sources of power and control in order to access groups that make socially
13
14 valued and/or prestigious decisions. Thus, insufficient material resources commonly obstruct
15
16 people's access to socially valued decision making outside of the contexts of proximal
17
18 relationships and negatively affect people's ability to develop a socially valued role and
19
20 identity. As a result, insufficient material resources commonly hinders the realisation of the
21
22 capacity for affiliation and negatively influences people's evaluation of themselves and the
23
24 positive development of characteristics such as self-esteem and self-worth. Moreover,
25
26 insufficient material resources will also negatively influence the realisation of the essential
27
28 capacities related to planning one's life, living life in one's own context and controlling one's
29
30 environment.
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40 The inhibitory influence of weariness on good human functioning

41
42 This paper proposes that insufficient material resources and debt are additionally, major causes
43
44 of weariness which is also an important inhibitory influence on good human functioning
45
46 (Wolff and de-Shalit, 2007). Other major causes of weariness, this paper reasons, include
47
48 chronic ill health, long-term chronic pain, impairment and unmet fundamental human needs.
49
50 However, for many people weariness has its roots in exploitation and external sources of
51
52 power and control (Dean, 2009) and physically demanding jobs and insufficient rest (Wolff
53
54 and de-Shalit, 2007, Wolff, 2009). Extrapolating from Wolff and de-Shalit (2007), weariness
55
56 arises as a consequence of concern, fear, anxiety or, continuous worries associated with real
57
58 and perceived threats to securing the fundamental human needs and the realisation of the
59
60

1 essential capacities. Weariness, this paper proposes, inhibits the realisation of all the essential
2 capacities. However, the influence of weariness is likely to be felt most acutely by people
3 when they attempt to realise the essential capacity to live life in one's own context and control
4 one's environment (Wolff and de-Shalit, 2007). This proposal chimes with the findings of
5 Coast et al. (2008) whose investigations were also informed by Nussbaum's insights.
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16 To be of value, conceptual frames for understanding health that are based upon good human
17 functioning must contribute to our understanding of the various facets of health. This paper
18 goes on to consider how quality of life, morbidity/premature mortality and health-related
19 behaviour are all greatly affected by the influences of socio-political conditions on both the
20 meeting of the fundamental needs and the realisation of the essential capacities. These
21 considerations include exemplar hypotheses which may facilitate recognition and may be
22 potentially evaluated.
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35 **The application of this paper's outlined framework to quality of life,** 36 **morbidity/premature mortality and health-related behaviour** 37

38 **Quality of life** 39 40

41 Assessments of quality of life are commonly based upon people's preferences, desires or
42 satisfaction which Nussbaum (1990) reasons is not appropriate. This is because preferences,
43 desires or satisfaction;
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- 50 • are adaptive and formed from people's life experiences.
- 51 • will provide little insight into environmental constraints
- 52 • 'will frequently succeed only in shoring up the status quo' (Nussbaum, 1990: p213) .

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59 The shoring up of the status quo, this paper reasons, arises because people who experience
60 unhelpful situational/cultural norms and environmental constraints are likely to have a

1 strictured range of choice and may feel they have little influence over their destiny.
2
3 Nevertheless, people in this position may perceive their way of life is satisfactory. Others with
4
5 excessive wealth may believe their wealth and the opportunities their wealth affords them is
6
7 their right. People in this position may feel dissatisfied and aggrieved if their life
8
9 circumstances change even though these changes may not affect their potential ability to
10
11 sufficiently realise the essential capacities.
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18 Nussbaum (1990) maintains quality of life assessments should instead focus on the realisation
19
20 of the essential human capacities, what people are able to do and to be and what choices people
21
22 actually have. She is consequently supportive of the quality of life approaches adopted by
23
24 Allardt (1995) and Erikson (1995) which aim to ascertain if a person has reached minimum
25
26 thresholds of good human functioning. Other investigators, have also highlighted the
27
28 applicability of Nussbaum's insights to the study of quality of life (e.g. Coast et al., 2008;
29
30 Saccheto et al., 2016).
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38 This paper proposes, that the realisation of the overarching capacities for practical reasoning
39
40 and affiliation are especially important in relation to quality of life.
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46 The realisation of the capacity for practical reasoning and quality of life

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49 As described above, people who have not sufficiently realised the capacity for practical
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51 reasoning will have a limited range of choices which commonly arises because of external
52
53 constraints. People in this position are likely to be at increased risk of being overwhelmed by
54
55 external factors which promotes a fatalistic approach to life (Nussbaum, 1990). This would
56
57 compromise their ability to 1) formulate a conception of the good, 2) formulate and pursue a
58
59 life plan and therefore influence their destiny, 3) live their life in their own context and 4)
60

1 control their environment. As a consequence, restrictions would be placed on what they are
2
3 able to do and be which would negatively affect their quality of life.
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9 The realisation of the capacity for affiliation and quality of life

10
11 This paper proposed above that the realisation of the capacity for affiliation is commonly
12 inhibited when people have insufficient material resources and/or are marginalised. This
13 inhibition arises because people in this position are commonly excluded from socially valued
14 decision making within the distal contexts of their lives, which is likely to negatively affect
15 people's choices and what people are able to do and thus, their quality of life.
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27 **Morbidity/premature mortality in industrialised countries**

28
29 This paper proposes that a contributing factor to morbidity/premature mortality in
30 industrialised countries is the effects of socioeconomic position (SEP) on how well people are
31 functioning at the group level. SEP assessments attempt to group people based upon their
32 income, occupation or educational experiences. However, both Maslow (1970), who focused
33 of the concept of self-actualisation which is related to Nussbaum's conception of good human
34 functioning, and Nussbaum (1990) maintained that good human functioning is likely to be
35 extremely rare. Thus, even people enjoying the most favourable environmental conditions
36 such as those who have the highest SEP will rarely be functioning well. This paper
37 consequently reasons that the proposed associations between morbidity/premature mortality,
38 SEP and good human functioning will focus on how close people at the SEP group level are to
39 good human functioning rather than the proportion of people at the SEP group level who are
40 functioning well.
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1 Two pathways underpin the proposal that the negative gradient between SEP and
2 morbidity/premature mortality in industrialised countries is partially created because SEP
3 influences how close people at the SEP are to good human functioning at the group level:
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10 1) First, SEP influences the degree to which a person is required to focus on meeting the
11 fundamental human needs. The higher the SEP, the less likely a person will be required to
12 focus on meeting the fundamental needs at the potential expense of realising the essential
13 capacities. Supportive environments are required to facilitate the meeting of the fundamental
14 human needs (Table 1). For example, supportive food environments will positively influence
15 the meeting of the human need for food, food choices and dietary habits through improved
16 affordability, accessibility and availability.
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28 2) Second, SEP is an indicator of the environmental opportunities or constraints that facilitate
29 or prevent people from realising the essential capacities. The environmental opportunities and
30 constraints highlighted by Nussbaum (1990) are located within 1) situational and/or cultural
31 contexts 2) access to formal and informal learning, 3) income and material resources 4) types
32 of work and roles at work and 5) quality of affiliations with families and social networks.
33 Additional environmental opportunities and constraints are located within the degree of
34 exploitation through labour (Dean, 2009). This paper draws upon Nussbaum (1990),
35 Nussbaum (2000), and Wolff and de-Shalit (2007) to outline exemplars of how the
36 environmental opportunities and constraints that are related to SEP may influence
37 morbidity/premature mortality through the realisation of the essential capacities (Table 2).
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53 Drawing upon this perspective, it was hypothesised that the realisation of the capacity for
54 affiliation in proximal contexts would be the most variable influence on good human
55 functioning and thus, health amongst UK graduates. This is because graduates are afforded
56 relatively substantial formal and informal learning opportunities that facilitate the realisation of
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1 the capacity for practical reasoning and most are eventually afforded opportunities to be
2 involved in socially valued decision making in distal contexts through, for example, work.
3 Evidence partially supporting this hypothesis was obtained from a study of longstanding
4 limiting illness among UK students who graduated in 1985 and 1996 (Author, 2006)
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13 This paper also proposes that the framework outlined above may contribute in two ways to
14 explanations for the positive associations between country-level income inequality (as
15 measured by the Gini coefficient) in industrialised countries and morbidity/premature mortality
16 that were observed by Wilkinson and Pickett (2010). First, the greater the income inequality,
17 the greater the likelihood that people will have insufficient income and material resources to
18 sufficiently realise all the essential capacities. Second, the greater the country-level income
19 inequality, the more hierarchical the society. The greater the hierarchy, the greater the
20 minimum level of material resources that are required to overcome external sources of power
21 and control in order to access socially valued decision making in distal contexts. Thus, the
22 greater the inequality, the greater the proportion of people with equivalised disposable income
23 who are unable to access involvement in socially valued decision making in distal contexts.
24 This access is required to facilitate the sufficient realisation of the capacity for affiliation and
25 promote social cohesion and social reciprocity. These pathways, this paper proposes may
26 potentially act in tandem or even synergistically with the explanations of Wilkinson and
27 Pickett (2010) which focused on fracturing within society and psychological distress that is
28 grounded in comparisons people make regarding status.
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53 **Health-related behaviour**

54 Models exist for understanding people's uptake and rejection of health-related behaviours e.g.
55 Theory of Planned Behaviour (TPB) (Ajzen, 1991). However, this paper proposes that a
56 contributing factor that influences the uptake or rejection of a health-related behaviour will be
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1 people's critical assessments of the value, benefits and role of the health-related behaviour and
2
3 the value, benefits and role of alternatives to the behaviour. These critical assessments
4
5 may/may not be well developed. However, this paper goes on to propose that these critical
6
7 assessments will nonetheless be frequently rational and connected to people's attempts to meet
8
9 their fundamental needs or realise the essential capacities and additionally, people's concern
10
11 about their health.
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18 People who are functioning well may, for example, choose to indulge in behaviours that may
19
20 potentially harm their health such as eating sweet things in order to meet their fundamental
21
22 human need for pleasurable experiences.
23
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28 However, this paper proposed above that good human functioning is likely to be extremely
29
30 rare (Nussbaum, 1990; Maslow, 1970). Hence, most people will have unmet fundamental
31
32 needs and/or insufficiently realised essential capacities (Table 1) at some point in their lives.
33
34 People in this position are at increased risk of critically assessing that more harmful health-
35
36 related behaviours than eating sweet things may help them to meet their fundamental needs
37
38 and/or realise the essential capacities.
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46 People may, for example look towards harmful health-related behaviours such as illicit drug
47
48 use to meet their need for pleasurable experiences or to forget about their life circumstances if
49
50 their physical safety is constantly threatened.
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56 This paper also proposes that important critical assessments of the value, benefits and/or role
57
58 of the health-related behaviour in relation to the realisation of the essential capacities (Table 1)
59
60 will include the following three questions:

1
2
3
4 What critical assessments are made in relation to the realisation of the capacity for
5
6 affiliation?
7

8
9 How does the person assess the effects of taking up or refraining from a health-related
10
11 behaviour on her/his interactions with others and thus, her/his realisation of the
12
13 capacity for affiliation? Does, for example, adopting or refraining from the health-
14
15 related behaviour (such as smoking, drinking or illicit drug use) act as a vehicle for
16
17 assessing who is potentially similar and who is potentially different and/or, act as a
18
19 vehicle to either facilitate sharing and bonding or facilitate intended separation and/or
20
21 distance from others.
22
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24
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26
27
28 Are the situational/cultural norms such that they support a restricted range of valued
29
30 behavioural identities such as smoking or drinking cultures which encourage people to
31
32 adopt these health-related behaviours in order to conform to social expectations and
33
34 thereby potentially realise the capacity for affiliation?
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41 What critical assessments are made in relation to the realisation of the capacity for
42
43 laughter and play?
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45
46 How does the person assess the effects of taking up or refraining from a health-related
47
48 behaviour on her/his realisation of the capacity for laughter and play? People may, for
49
50 example, look towards health-related behaviours such as drinking alcohol, if they
51
52 critically assess that drinking alcohol will facilitate the realisation of the capacity for
53
54 laughter and play.
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1 What critical assessments are made in relation to the realisation of the capacity for
2
3 living one's own life in one's own context?
4

5
6 How does the person assess the effects of taking up or refraining from a health-related
7
8 behaviour on her/his ability to realise the capacity for living one's own life in one's
9
10 own context? Marginalised people, who do not share values of the dominant culture
11
12 and/or are not empathetic to the orientations to meaning of the dominant culture, for
13
14 example some adolescents, may determine that the expression of their right to
15
16 individuality is particularly important. They may consequently critically assess that the
17
18 realisation of the capacity for living one's own life in one's own context is of
19
20 considerable significance. Young people in this position may as a result, consider
21
22 adopting health-related behaviours such as smoking as an expression of their right to
23
24 individuality in an attempt to realise the capacity for living one's own life in one's own
25
26 context.
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35 These questions informed the analysis of a qualitative investigation into the reasons
36
37 Bangladeshi adolescents do and do not smoke (Author, 2001).
38
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43 Drawing upon this perspective, it was hypothesised that the generative context of schools,
44
45 which may be enabling or constraining in relation to the realisation of the capacities for
46
47 practical reasoning and affiliation, would influence the prevalence of smoking, illicit drug use
48
49 and violence through students' connectedness to school. Evidence supporting these hypotheses
50
51 was obtained from cross-sectional and longitudinal studies in the UK and US (Author, 2007,
52
53 Author 2008; Author, 2011)
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1 Conceptual frames for understanding health that are based on good human functioning also
2
3 need to be able to contribute to wider discussions regarding the promotion of health. Although
4
5 detailed comment is beyond the scope of this paper, brief discussions focussing on the
6
7 application of this paper's interpretation of good human functioning to both public health
8
9 policy and the planning, delivery and evaluation of health promotion initiatives are provided.
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16 **The application of this paper's interpretation of good human functioning to discussions** 17 18 **of public health policy** 19

20
21 This paper proposes that future public health policy should aim to ensure that everyone is able
22
23 to meet their fundamental needs and sufficiently realise their essential capacities. People who
24
25 achieve this can move towards functioning well, living fully human lives and maximising their
26
27 health potential.
28
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30
31
32 Nussbaum emphasises the economic, social and physical barriers and constraints which
33
34 prevent people from functioning well. Future public health policy would consequently focus
35
36 on social justice and the manipulation of economic, social and environmental circumstances so
37
38 that everybody is provided with enough resources and the training they need to take advantage
39
40 of these resources. These resources and training would be provided both in the short term and
41
42 long-term. Importantly, some people have greater needs and may require additional resources
43
44 and training (Nussbaum, 2000). Extrapolating from Nussbaum (2000), there is therefore a
45
46 requirement to focus on the needs of the deprived and disadvantaged while simultaneously
47
48 acknowledging that because good human functioning is rare, the vast majority of people would
49
50 also benefit from additional resources and/or training. This view echoes Marmot's notion of
51
52 proportionate universalism (Marmot, 2010). This type of strategy has the potential to amplify
53
54 gains in human functioning and health across all the social strata (Brennenstuhl et al., 2012).
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1 Many influences affect the meeting of the fundamental needs and the realisation of the
2
3 essential capacities and these influences consequently affect health through human
4
5 functioning. Notwithstanding the ubiquitous nature of these influences, this paper proposes,
6
7 that:
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9

10
11
12 The primary focus of future public health policy should be to promote health and
13
14 additionally physical, cognitive and social development in early childhood through a
15
16 combination of universal interventions and interventions targeted according to need
17
18 (Carey et al., 2015). Need would be based upon enforced disadvantage and deprivation
19
20 in relation to material resources, housing, social conditions including social exclusion,
21
22 environmental conditions, working conditions and educational conditions. The aim of
23
24 early childhood interventions would be to break the intergenerational transmission of
25
26 relatively poor physical and mental health and poor human functioning arising from
27
28 chronic illness, deprivation, injustice, impairment and unhelpful cultural/situational
29
30 environments.
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38 This proposal draws upon the emphasis of Nussbaum (1990) and Bronfenbrenner (1989)
39
40 regarding the potentially negative influences of families and trans-generational factors on
41
42 human development and functioning. It also resonates with views expressed by Irwin et al.
43
44 (2007), Marmot (2010), NHS Scotland (2013) and Melhuish (British Academy, 2014).
45
46
47
48

49 Interventions would include:

- 50
51 “Fortification of basic foods with key nutritional supplements” (NHS Scotland, 2013 p
52
53 72)
54
55 Vitamin supplement for pregnant mothers
56
57
58 Vaccination of toddlers
59
60
61 Free food supplements for babies and toddlers

1 Free nursery places

2
3 Childcare centres that provide opportunities for early learning

4
5 Interventions to facilitate language acquisition and pre-reading skills of toddlers

6
7 Free milk and fruit in nurseries

8
9 Parent and baby clubs (Wolff, 2011)

10
11 Child benefits

12
13 Parental support initiatives

14
15 Behavioural management interventions for parents

16
17 Community development programmes to ascertain what parents of young children feel
18 they need

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26 Some of these interventions resonate with some of the aims of the UK Sure Start initiative
27 which are area-based interventions aiming to promote the health and development of young
28 children (Roberts, 2000). However, the interventions outlined above are more extensive and
29 include a focus on the fundamental human needs such as the need for healthy food. This paper
30 proposes the combination of the interventions outlined above may improve the health of babies
31 and toddlers. This combination may also potentially reduce inequalities in health and
32 educational outcomes during childhood and therefore put people on pathways that facilitate
33 good human functioning and positive health in adulthood (Canning and Bowser, 2010). These
34 proposals are supported by lifecourse studies that highlight the influence of cumulative,
35 pathway and latent effects on adult health (Davey Smith, 2003) and the observed
36 intergenerational transmission of the epigenetic effects of social adversity (Cunliffe, 2016).
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54 Future public health policy should also have five key overarching themes that support the
55 primary focus and centre on the major factors inhibiting good human functioning outlined
56 above. These themes would focus on:

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59
60
1. The meeting of the fundamental human needs.

- 1 2. The facilitating of the realisation of the capacity for practical reasoning through
2 enhanced teaching and learning opportunities.
- 3
4
5 3. The facilitating of the realisation of the capacity for affiliation through
6 enhanced opportunities to be involved in socially valued decision making and
7 the creation of supportive social networks.
- 8
9
10
11
12 4. The provision of sufficient material resources.
- 13
14
15 5. Protection from weariness.
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19 These proposals chime with Wolff (2011) and Marmot (2010) who identified alleviating
20 poverty, improving living and working conditions and improving education particularly during
21 childhood and the early years as major social determinants that would improve health. The
22 relatedness to Wolff (2011) and Marmot (2010) is however, unsurprising given Wolff (2011)
23 was informed by Nussbaum's insights whereas Marmot (2010) drew upon Sen's 'thinner'
24 version of the capabilities approach.
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35 Marmot's strategy (2010) is the most comprehensive public health strategy in relation to the
36 promotion of good human functioning. However, the five core elements of the proposed future
37 public health policy outlined in this paper that are post-early childhood could be used to
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39
40

- 41 • highlight gaps in existing public health policy,
- 42 • develop supplementary public health policy
- 43 • provide justification for public health policy initiatives
- 44 • identify how existing education and welfare policy might contribute, perhaps
45 inadvertently to public health policy.
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56 These five core elements are drawn upon to assess the Scottish Health Inequalities Policy
57 Review.
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Scottish Health Inequalities Policy Review (NHS, Scotland, 2013) (Table 3)

(INSERT TABLE 3 HERE PLEASE)

Initiatives to ensure that people are able to meet their fundamental human needs

This policy has a number of initiatives that aim to facilitate the meeting of the fundamental human needs (Table 3). However, this policy could be augmented by a number of additional exemplar initiatives:

Provision of services to support vulnerable people including those who are homeless and/or have mental health problems (Smith and Eltanani, 2015). For example, the Finish initiative whereby homeless people are provided a self-contained apartment and support through a support worker. Importantly this initiative also facilitates the realisation of the capacity to live life in one's own context and control one's environment.

Enhanced building programmes including decent social housing (Smith and Eltanani, 2015)

Nutrition programmes including food co-operatives in order to increase the availability, accessibility and affordability of healthy food (Rankin et al., 2006). Other initiatives to promote healthy eating include those outlined in the Healthy Borough Programme in Tower Hamlets which is a disadvantaged inner city borough in London (Williams et al., 2011). These initiatives include Food for Health Awards for local catering businesses (including take aways and cafes) that improve the availability of healthy food choices. This initiative included healthy catering and healthy frying workshops and practical cooking lessons run by exemplar chefs from the local community and aimed to promote healthy changes to food preparation.

Community food growing projects which were developed in partnership with registered social housing providers. Healthy Families Project which aimed to promote increased knowledge and confidence in relation to making healthy food choices when shopping and preparing healthy lunchboxes. Work with convenience stores to encourage them to sell fresh fruit and

1 vegetables and improve their displays. Healthy canteens (and tuck shops when appropriate) in
2
3 early learning centres, schools and workplaces.
4
5

6
7 Implement 20 mph speed limits where 30mph ones have usually been in place (Dorling,
8
9 British Academy, 2014).
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11
12

13
14 Improve primary health care services serving very deprived areas (Smith and Eltanani, 2015).
15
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18
19 Moreover, existing Scottish initiatives that aim to facilitate the meeting of the fundamental
20
21 human needs could also be incorporated into the public health policy. These include
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23

24
25 Initiatives developed by Scotland's Violence Reduction Unit to reduce knife crime, violent
26
27 offending and homicides. These multifaceted interventions involve the police, the creation of
28
29 youth clubs, surgeons, schools, programmes for young people to challenge offensive behaviour
30
31 and develop their leadership and employment skills, adventure training and interventions to
32
33 reduce school exclusions.
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36
37 Initiatives that focus on reducing domestic abuse by improving multi-agency interventions to
38
39 protect victims at high risk of harm.
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43 44 Initiatives to facilitate the realisation of the capacity for practical reasoning

45
46 This policy highlights the importance of high quality education for children, youth and adults
47
48 including training on life skills that would facilitate the realisation of the capacity for practical
49
50 reasoning. Additional exemplar initiatives that might also facilitate the realisation of the
51
52 capacity for practical reasoning could include:
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57
58 The development of a curriculum for all high school students that is based on cross-curricular
59
60 themes which breach the boundaries between subjects. This type of curriculum facilitates an

1 understanding that there are different ways of knowing and that knowledge may be viewed as a
2 range of equally legitimate and sometimes inconsistent realities (Author, 2003). This in turn,
3 facilitates the realisation of the capacity for practical reasoning (Author, 2003).
4
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10 Pre-school and after-school clubs and extra-curricular activities, which in addition to
11 facilitating learning and the realisation of the capacity for practical reasoning, would promote
12 academic attainment through improved attachment to schools as organisations and improved
13 school attendance, and thereby promote students' life chances (Author, 2003; Author, 2015).
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21 Financial support for disadvantaged adults who left schools with no qualifications so that they
22 may enter into further and adult education (Chandola and Jenkins, British Academy, 2014).
23
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26 This type of initiative would increase the chances of people having sufficient material
27 resources through gainful employment and provide opportunities for social interaction and
28 participation which would facilitate the realisation of the capacity for affiliation.
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35 Initiatives to facilitate the realisation of the capacity for affiliation

36
37 The policy contains initiatives that would aim to promote the realisation of the capacity for
38 affiliation (Table 3). Other exemplar initiatives that might also facilitate the realisation of the
39 capacity for affiliation could include:
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46 Some of the initiatives in the Sure Start Programmes which were reported to promote positive
47 social behaviour among young children (Melhuish et al, 2008). Importantly these types of
48 initiative may also potentially promote language development and the development of verbal
49 reasoning skills among young children.
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1 Language classes for people whose first language is not English as this would facilitate the
2
3 realisation of ‘the capacity to be able to be able to communicate’ and potentially facilitate
4
5 increased social participation.
6
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10 Improvements in the work place environments including initiatives to reduce bureaucratic
11
12 obstacles so people may become actively involved in work-related decision making through
13
14 unions and co-operatives which would facilitate involvement in socially valued decision
15
16 making in distal contexts.
17
18
19

20
21 The creation of supportive social networks especially for people who are at increased risk of
22
23 isolation for example, social clubs for people who are retired.
24
25
26
27

28 The development and testing of participatory budgeting to engage communities in discussions
29
30 of public health priorities and the choosing of interventions (McKenzie, British Academy,
31
32 2014)
33
34
35
36

37 Optimisation of opportunities for supporting the health, participation and security of older
38
39 people by promoting the development of age-friendly cities. These cities would facilitate
40
41 social integration and the engagement of older people in identifying priorities. They would also
42
43 promote, through improved urban design, mobility and access to services and leisure (Kendig
44
45 and Phillipson, British Academy, 2014)
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47
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51 The provision of sufficient material resources

52 The policy embraces the need to provide sufficient material resources (Table 3). Other
53
54 exemplar initiatives that might also positively impact of the provision of sufficient material
55
56 resources could include:
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1 Benefits for the unemployed that are equal to the living wage which has been trialled in
2
3 Finland.

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7
8 Tax and benefit assessment exemptions for people in receipt of benefits (financial support
9
10 from the government) as this would allow people to earn extra income (Wolff, 2011).
11
12
13

14 In the UK, reversing welfare cuts and a halting of the escalating incomes of top earners
15
16 (Pickett, British Academy, 2014)
17
18
19

20
21 Improving employment conditions for public sector workers (which is a substantial employer
22
23 of staff particularly of ethnic minority groups) in relation to equitable distribution of salaries
24
25 across employment grades and developing and protecting pension rights to minimise
26
27 inequalities in income post-retirement (Nazroo, British Academy, 2014).
28
29
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31
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33 Initiatives to protect people from weariness

34
35 The policy incorporates initiatives that aim to protect people against weariness (Table 3). Other
36
37 exemplar initiatives that might also protect people against weariness could include:
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42 Debt is a major cause of weariness. Allmark and Machaczek (2015) proposed that in order to
43
44 increase people's chances of alleviating debt, initiatives aiming to promote people's financial
45
46 capability should take into account people's financial and social environments. These
47
48 initiatives would include 'making cheaper finance available through Credit Unions; working
49
50 with the Police to remove loan sharks, ...removing barriers to employment and ensuring
51
52 individuals take benefits and tax breaks they are due' (Allmark and Machaczek, 2015 p 4).
53
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58 Wolff (2011) proposed graded retirement ages. People who would receive their state pensions
59
60 at the earliest age would be those who had low paid physically demanding jobs throughout

1 their adult lives as these jobs promote weariness (Wolff, 2011) which inhibits the realisation of
2
3 all the essential capacities. Crucially, people in this position would be allowed to earn
4
5 additional income through part-time work. Part-time work, importantly, would also facilitate
6
7 people's realisation of the capacity for affiliation through social networks at work and
8
9 additionally, enable people to reap the mental health benefits that are potentially associated
10
11 with these social networks (Wolff, 2011).
12
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17 The provision of a wide range of health care including respite care and additionally places
18
19 where people can rest or recuperate such as the 'Kur' in Germany. The Kur is a health care
20
21 resort, often spa based, where the employed who are very stressed or who have a chronic
22
23 illness can receive revitalising therapies and typically stay for up to three weeks.
24
25
26
27

28 Increasing social protection for those on lowest income and provide more flexible income and
29
30 welfare support for those moving in and out of work (Smith and Eltanani, 2015).
31
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33
34

35 Improving employment conditions and practices for public sector workers (which is a
36
37 substantial employer of staff particularly of ethnic minority groups) in relation to holidays, sick
38
39 pay, parental leave and limiting unpaid overtime (Nazroo, British Academy, 2014).
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44 **The application of this paper's interpretation of good human functioning to discussions** 45 **regarding the planning, delivery and evaluation of health promotion initiatives** 46 47

48 If this paper's analysis of good human functioning is associated with health, then all
49
50 programmes and initiatives that promote the meeting of the fundamental human needs and/or
51
52 the realisation of the essential capacities may be judged as having positively influenced the
53
54 health of participants. This may help to raise the profile of health promotion.
55
56
57
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60

1 This paper also proposes that the fundamental human needs and the essential capacities (Table
2
3 1) could potentially become additional health promotion risk factors in the future and used as a
4
5 basis to support the evaluation of health promotion interventions. This view resonates with 1)
6
7 Marmot (2004) who reasoned that sources of psycho-social stress that negatively affect a
8
9 person's health include impaired autonomy and inadequate social networks and 2) Labonte
10
11 (1998) who maintained that community development programmes which aim to promote
12
13 health include those aiming to empower people, build self-esteem, and facilitate an increased
14
15 sense of belonging. Labonte's views (Labonte, 1998) are supported by Uphoff et al. (2013)
16
17 who reported in their systematic review that social capital might protect against the negative
18
19 influence of low SEP on people's health. Labonte's views also chime with this paper's
20
21 proposal that promoting people's involvement in socially valued decision making in distal
22
23 contexts promotes good human functioning through the realisation of the capacity for
24
25 affiliation and is therefore, a legitimate and key aim for health promotion.
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33 This paper offers pre- and post- questionnaires for a hypothetical health promoting community
34
35 development programme that could be administered to participants before and after the
36
37 programme has been implemented (Table 4). These questionnaires draw upon the conceptual
38
39 frame for understanding the preconditions for health outlined above and follow on from the
40
41 proposal of Labonte (1998) highlighted above concerning the relationships between
42
43 community development programmes and health. The aims of these questionnaires are 1) to
44
45 facilitate engagement of participants in the community development process and emphasise
46
47 that the interests and views of the participants are central to the programme and 2) to support
48
49 the evaluation of the programme. It is suggested that the pre-questionnaire would be used as
50
51 an introduction with participants to facilitate the formation of working partnerships and the
52
53 subsequent development of aims and objectives and outcome measures as agreed with
54
55 participants. The post-questionnaire would support the evaluation of the agreed outcome
56
57 measures and would be compared with the pre-questionnaire to highlight developments that
58
59
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1 occurred alongside the agreed outcomes. The questionnaires would then, support a
2
3 participatory research model (Chevalier and Buckles, 2013).
4
5

6
7 (INSERT TABLE 4 HERE PLEASE)
8
9

10 11 12 13 **Comparison between the outlined framework and Antonovsky's interpretation of good** 14 15 **human functioning and limitations of the outlined approach** 16 17

18 Nussbaum's insights and this paper's frameworks have some similarities to other
19 interpretations of good human functioning for example, the three key constructs of
20 Antonovsky's seminal Sense of Coherence (SOC) construct. *Comprehensibility*, is related to
21 the realisation of the capacity for practical reasoning. *Manageability*, underpinned by
22 underload-overload balance, is related to weariness which as discussed above is a major
23 negative influence on the realisation of all the essential capacities. *Meaningfulness* is related
24 to the realisation of the capacity for affiliation.
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37 However, there are clear differences between this paper's framework and the SOC construct.
38 A key question outlined in this paper is what is a person is able to do and be as a consequence
39 of meeting the fundamental human needs and realising the essential capacities which is a
40 crucial question for good human functioning and does not feature as prominently in
41 Antonovsky's account. Additionally, major contributors to *Meaningfulness* are
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48 consistent emotional bonds and connectedness to social/cultural groups to which a
49 person belongs,
50
51
52 commitment and cohesion to cultural roots
53
54
55 cultural stability
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1 However, this paper proposes that belonging to some social groups and some stable cultures
2 negatively influences good human functioning particularly when these groups/cultures
3 promote restricted orientations to meaning which inhibits the realisation of the
4
5 overarching capacity for practical reasoning and/or
6
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12 oppress other groups/cultures which inhibits the realisation of the overarching capacity
13
14 for affiliation which as discussed above emphasises the elevated importance of
15
16 peoples' values over wants and preferences.
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21 Following on from this point, high social capital may be better than low social capital in
22
23 relation to human functioning and health but it does not automatically follow that high levels
24
25 of social capital contribute to good human functioning and thus, health and high social capital
26
27 may even impede good human functioning and health. This is particularly the case when the
28
29 social capital is based on groups/cultures whose values hinder the realisation of the two
30
31 overarching capacities.
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38 Some of the limitations of the capabilities approaches are discussed above namely

- 39 1) these insights are theoretical and lack practical application,
- 40
41 2) people's ability to meet their fundamental human needs and realise the essential capacities
42
43 will be greatly influenced by the social environment, elements of which are enabling or
44
45 constraining.
46
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48
49
- 50 3) people cannot exorcise themselves from the direct influences on human functioning of both
51
52 external sources of power and control and the direct and indirect consequences of exploitation.
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59 The application of social theories with more practical tenets to Nussbaum's insights in this
60 paper helps to address some of the potential practical limitations of her approach and identify

1 some elements of the social environment that have enabling or constraining effects on good
2 human functioning. However, exploitation and external sources of power and control continue
3 to have the greatest influence on people's ability to function well often via their influence on
4 weariness. Thus, the ability of public health policy to promote people's health through good
5 human functioning will continue to be undermined until issues related to exploitation, external
6 sources of power and control, resource acquisition and support are successfully challenged.
7 These challenges are likely to be led by the collective and social movements rather than by
8 individuals (Carpenter, 2009, Freire, 1989).
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23 **Conclusion**

24 The framework outlined in this paper may potentially contribute to discussions of quality of
25 life, morbidity and premature mortality and health-related behaviour. It may also potentially
26 contribute to debates regarding public health policy, and the planning, delivery and evaluation
27 of health promotion initiatives. However, hypotheses outlined in this paper within discussions
28 of quality of life, morbidity and premature mortality and health-related behaviour require
29 further research validation. Pre- and post- questionnaires for a health promoting community
30 development programme are also offered but their utility also requires investigation. Wider
31 debates are however, required to reach a broad consensus on the relationships between health
32 and human functioning and how enabling social and environmental circumstances promote
33 good human functioning.
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Table 1 The fundamental human needs and essential capacities (after Author, 2003, based upon Nussbaum (1990); subsequent extensions in parentheses are based upon Nussbaum (2000); additional capacities are based upon Nussbaum (2000), this paper and Wolff and de-Shalit, 2007).

<p>The fundamental human needs</p> <ul style="list-style-type: none"> • The need for a clean water supply, adequate food, warmth and shelter. • The need to address medical and human concerns that focus on years of life and to provide health care for the sick and/or injured. • The need to provide information about the body. • The need to have pleasurable experiences and opportunities for sexual satisfaction. • The need to be physically safe and able to avoid unnecessary and non-useful pain (<i>subsequently extended to include</i> to have one's own bodily boundaries treated as sovereign).
<p>The essential human capacities</p> <ul style="list-style-type: none"> • The capacity for practical reasoning, to imagine, think and reason and thus to be able to form a conception of the good and engage in critical reflection about the planning of one's own life. • The capacity for affiliation, to have concern for other humans, to live for others, to have familial and other interactions and attachments. • The capacity to love, grieve, feel longing for, and be grateful. • The capacity to laugh and play. • The capacity to be able to live one's own life in one's own context (<i>subsequently extended to include</i> to have control over one's environment and property rights on an equal basis with others). • The capacity to have concern for the world of nature. • The capacity to be aware of all the senses. • The capacity to be able to move freely from place to place.
<p>An additional essential capacity based upon Nussbaum (2000)</p> <ul style="list-style-type: none"> • The capacity to be able participate effectively in political choices that govern one's life, and to be protected by guarantees of freedom of expression with respect to both political and artistic speech and freedom of religious exercise.
<p>Possible additional essential capacities</p> <ul style="list-style-type: none"> • The capacity to nurture and be nurtured throughout the life course and the subsequent realisation of the ability to trust and be trusted (this paper). • The capacity to live a materially decent life in a law-abiding fashion (Wolff and de-Shalit, 2007). • The capacity to be able to be able to communicate including being able to speak the local language, or being verbally independent (Wolff and de-Shalit, 2007).

Table 2 Environmental opportunities and constraints that are related to SEP which respectively positively and negatively influence the realisation of the essential capacities and contribute to the creation of the stepwise relationship in industrialised countries between SEP and morbidity/premature mortality through human functioning (drawing upon Nussbaum, 1990; Nussbaum 2000; Wolff and de-Shalit, 2007)

Environmental influence	Environmental opportunities and constraints that influence the realisation of essential capacities	How is the realisation of essential capacities influenced?
Situational/Cultural	<p>A person is perceived within the situations she/he encounters and the cultures to which she/he belongs to have valued knowledge and/or valued skills and/or a valued emotional identity and/or a valued behavioural identity.</p> <p>A person shares the values, beliefs and orientations to meaning that are associated with the situations she/he encounters and the cultures to which she/he belongs</p> <p>Unhelpful situational/cultural norms that support a restricted range of valued knowledge, valued skills, valued emotional identities or valued behavioural identities.</p> <p>Unhelpful situational/cultural norms that support restrictive and/or oppressive values, beliefs and orientations to meaning.</p>	<p>Providing the situational/cultural norms are not unhelpful having valued knowledge and/or valued skills and/or a valued emotional identity and/or a valued behavioural identity will positively influence the realisation of the capacity for affiliation</p> <p>Providing the situational/cultural norms are not unhelpful, sharing the values, beliefs and orientations to meaning that are associated with the situations a person encounters will positively influence the realisation of the capacity for affiliation</p> <p>Unhelpful situational/cultural norms that support a restricted range of valued knowledge, valued skills, valued emotional identities or valued behavioural identities are commonly associated with relatively large proportions of people whose knowledge, skills, roles, emotional identities or behavioural identities are perceived to have limited value which negatively influences the realisation of all the essential capacities especially the capacity for affiliation</p> <p>Unhelpful situational/cultural norms that support restrictive and/or oppressive values, beliefs and orientations to meaning commonly promote the development of constrained imaginations which hinders the realisation of the capacity for practical reasoning.</p>

1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17	Injustice and deprivation Injustice and deprivation	Oppressive values also hinder the realisation of the capacity for affiliation Injustice and deprivation facilitate the development of restricted orientations to meaning which hinders the realisation of the capacity for practical reasoning. Injustice and deprivation restrict access to socially valued decision making in distal contexts which hinders the realisation the capacity for affiliation
18 19 20 21 22 23 24 25 26 27 28 29	Access to formal and informal learning	Formal education and training and informal learning through dialogue with others who have had extended educational opportunities Access to formal and informal learning may facilitate the development of more elaborate orientations to meaning that do not focus on lived experience and greater insights into the potential for multiple realities which may potentially positively influence the realisation of the capacity for practical reasoning
30 31 32 33 34 35 36 37 38 39 40 41 42 43 44 45 46 47 48 49 50 51 52 53 54 55 56 57 58	Access to material resources and income	Sufficient material resources Sufficient material resources may potentially positively influence the aspect of the capacity for practical reasoning that focuses on the planning and organising of one's own life Sufficient material resources may potentially positively influence the realisation of the capacity to live life in one's own context and control one's own environment Insufficient material resources including insecure contracts regarding mortgaging/renting of a house may force people to focus on their fundamental human needs Insufficient material resources negatively influence the realisation of all the essential capacities especially the capacity to live life in one's own context and control one's own environment Insufficient material resources may obstruct access to socially valued decision making outside of the contexts of proximal relationships Insufficient material resources negatively influence the realisation of the capacity for affiliation
59 60	Type of work and roles at work	Formal education and training at work and informal work-related learning Formal and informal work-related education may potentially positively influence the realisation of the capacity for practical reasoning

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<p>34</p> <p>35</p> <p>36</p> <p>37</p> <p>38</p> <p>39</p> <p>40</p> <p>41</p> <p>42</p> <p>43</p> <p>44</p> <p>45</p> <p>46</p> <p>47</p> <p>48</p> <p>49</p> <p>50</p> <p>51</p> <p>52</p> <p>53</p> <p>54</p> <p>55</p> <p>56</p> <p>57</p> <p>58</p> <p>59</p> <p>60</p>	<p>Affiliations with families and social networks</p> <p>Proximal affiliations with family and friends and distal affiliations with people outside of family and friends contain people who have elaborate orientations</p> <p>Families and social networks contain people who have sufficient material resources and are in a position to offer practical, financial and emotional support</p> <p>Poorly developed familial relationships and social networks</p> <p>Families and social networks contain people who have restricted orientations to meaning</p> <p>Families and social networks are dominated by people who are unable to provide practical</p>	<p>Connectedness to people with elaborate orientations to meaning may potentially positively influence the realisation of the capacity for practical reasoning</p> <p>Being able to access practical, financial and emotional support may potentially positively influence all the essential capacities especially the capacity for affiliation</p> <p>Poorly developed familial and social networks may hinder the realisation of the capacity for affiliation</p> <p>Connectedness to people with restricted orientations to meaning may potentially hinder the realisation of the capacity for practical reasoning</p> <p>Being unable to access sufficient practical and financial support may potentially hinder the realisation of</p>

<p>1</p> <p>2</p> <p>3</p> <p>4</p> <p>5</p> <p>6</p> <p>7</p> <p>8</p> <p>9</p> <p>10</p> <p>11</p> <p>12</p>	<p>support and/or have relatively limited access to material resources</p> <p>Families and social networks are dominated by people who are unable to provide emotional support</p>	<p>the capacity to live life in one's own context and control over one's environment</p> <p>Being unable to access sufficient emotional support may potentially hinder the realisation of the capacity for affiliation</p>
<p>13</p> <p>14 Exploitation through human labour</p> <p>15</p> <p>16</p> <p>17</p> <p>18</p> <p>19</p> <p>20</p> <p>21</p> <p>22</p> <p>23</p> <p>24</p> <p>25</p> <p>26</p> <p>27</p> <p>28</p> <p>29</p> <p>30</p> <p>31</p> <p>32</p> <p>33</p> <p>34</p> <p>35</p> <p>36</p> <p>37</p> <p>38</p> <p>39</p> <p>40</p> <p>41</p> <p>42</p> <p>43</p> <p>44</p> <p>45</p> <p>46</p> <p>47</p> <p>48</p> <p>49</p> <p>50</p> <p>51</p> <p>52</p> <p>53</p> <p>54</p> <p>55</p> <p>56</p> <p>57</p> <p>58</p> <p>59</p> <p>60</p>	<p>Promotes weariness and prevents people from obtaining sufficient rest</p> <p>Increased vulnerability arising from poor working conditions, insecure work contracts and lack of advancement opportunities</p>	<p>Weariness and insufficient rest negatively influences the realisation of all the essential capacities especially the capacity to live life in one's own context and control one's own environment and the capacity for affiliation</p> <p>Increased vulnerability negatively influences the realisation of all the essential capacities especially the capacity to live life in one's own context and control one's own environment and the capacity for affiliation</p>

Table 3 Assessment of the Scottish Health Inequalities Policy Review based upon this paper's outlined framework

	Health Inequalities Policy Review for the Scottish Ministerial Task Force on Health Inequalities (NHS, Scotland, 2013)
Meeting the fundamental human needs	<p>Improved housing; set standards for housing</p> <p>Water fluoridation</p> <p>Reduce exposure to cheap unhealthy foods</p> <p>Free smoking cessation, eye tests, school meals and fruit and milk in schools</p> <p>Promotion of safety for pedestrians</p> <p>Lower speed limits</p> <p>Loan schemes for child restraints</p> <p>Install hard wired smoke alarms</p> <p>Controls for outdoor and indoor air pollution including reducing exposure to second hand smoke</p> <p>Changes in physical environment to meet a new Neighbourhood Quality Standard.</p>
Facilitating the realisation of the capacity for practical reasoning	<p>High quality education for children, youth and adults including training on life skills</p>
Facilitating the realisation of the capacity for affiliation	<p>Creation of a vibrant democracy, greater and more equitable participation in election and decision making,</p> <p>Training to ensure public sector and services workforces are sensitive to all social and cultural groups to build on personal assets of service users</p> <p>Specialist outreach and targeted services for high risk individuals (e.g. looked after children and homeless)</p> <p>Participation in workplace decision making</p>
Provision of sufficient material resources	<p>Minimum income for healthy living</p> <p>Progressive individual and corporation taxation</p> <p>Active labour market policies to create good jobs</p>

	<p>Increased job security</p> <p>Support for returners to work and enhanced job retention</p> <p>Welfare rights advice (including in health care settings) to maximise income of low-income families</p>
Protection from weariness	<p>Enhanced job control and in-work development</p> <p>Protection from adverse work conditions in relation to health and safety</p> <p>Increased job security</p> <p>Support for returners to work and enhanced job retention</p>

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Table 4 Basic exemplar pre- and post- questionnaires for a hypothetical health promoting community development programme

	Questions at baseline	Questions at end of the programme
Fundamental needs		
Provide health care	Is there any aspect of caring for your health or the health of others that you would like to find out more about while you are on this programme?	Were you given any information either about caring for your health or caring for the health of others while you were on the programme? This information could have been given by the people running the programme or other participants? If so will you tell us about, please? With regards to accessing health care, is there anything you would do differently now that you have been on the programme? If so will you tell us about, please?
Information about the body	What if any aspects of mental or physical health are you hoping to find out more about while you are on the programme?	What, if any, aspects of mental and/or physical health were discussed formally or informally while you were on the programme? If mental or physical health were discussed as part of the programme how did you find these discussions? Please tell us more about this in terms of how interesting and/or useful these discussions were?
Essential capacities		
The capacity for practical reasoning	What, information are you hoping that this programme will provide? Apart from getting information, what are your main reasons for coming on the programme?	What if anything, have you learned from participating on the programme? Is there anything that you would do differently as a consequence of coming on this programme? If so will you tell us about this, please? Are you planning to do anything as a consequence of coming on the programme? If so will you tell us about this, please? What for you was the most important aspect of the programme and why?

		What aspects of the programme would you change? Please feel free to say why you think this.
The capacity for affiliation	<p>How many people do you know on the programme?</p> <p>How many of the people on the programme would you describe as your friends?</p> <p>What do the most important people in your life feel about you coming onto this programme?</p>	<p>Has being a participant on the programme helped you in any way in terms of your personal relationships with people on the programme and/or outside of the programme? For example, have you made new or stronger connections with people as a consequence of coming onto this programme? If the programme has helped you in any way in terms of your personal relationships with people will you tell us about this, please?</p> <p>Has being a participant on the programme been unhelpful for you in any way in terms of your personal relationships with people on the programme and/or outside of the programme? If it has will you tell us about this, please.</p> <p>Now that you have completed the programme, what do the most important people in your life think about you having participated on the programme? Do any of these important people think, for example, that you have benefited in any way? Would you mind telling us about this please?</p> <p>Do any of these important people think that participating on the programme has had some negative effects? Would you mind telling us about this please?</p>
The capacity to live one's own life in one's own context and control one's environment		Has attending the programme changed any aspect of the way you live your life? If it has would you mind telling us about this, please.

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The capacity to laugh and play		<p>What aspects of the programme, if any, did you enjoy? Would you mind telling us about this, please?</p> <p>What aspects of the programme, if any, did you not enjoy? Would you mind telling us about this, please?</p>
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Health Education

Figure I

The relationships between time, socio-political and cultural conditions, influential environmental elements, the fundamental human needs, the essential human capacities, the ability to function well and agency (after Nussbaum, 1990)

