NATIONAL OPEN UNIVERSITY OF NIGERIA

FACULTY OF HEALTH SCIENCES

DEPARTMENT OF PUBLIC HEALTH SCIENCE

COURSE CODE: PHS819

COURSE TITLE: HEALTH PROMOTION & EDUCATION & ITS ADVANCES

PHS815: HEALTH PROMOTION AND EDUCATION

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INTRODUCTION

The course PHS819 titled "*Health Promotion and Education and Its Advances*" is a two (2) Credit Units course that comprises of three (3) modules with nine (9) units. Health promotion and education is the process of enabling people to increase control over the determinants of health and thereby improve their health. It moves beyond a focus on individual behavior towards a wide range of social and environmental interventions. Health promotion is probably the most ethical, effective, efficient and sustainable approach to achieving good health. There is a global acceptance that health and social wellbeing are determined by many factors outside the health system which include socioeconomic conditions, patterns of consumption associated with food and communication, demographic patterns, learning environments, family patterns, the cultural and social fabric of societies; sociopolitical and economic changes, including commercialization and trade and global environmental change. In such a situation, health issues can be effectively addressed by adopting a holistic approach by empowering individuals and communities to take action for their health, fostering leadership for public health, promoting intersectoral action to build healthy public policies in all sectors and creating sustainable health systems.

WHAT YOU WILL LEARN IN THIS COURSE

The course PHS819 titled "*Health Promotion and Education and Its Advances*" has been designed into the course units and course guide. The course guide will tell you what the course is all about. It is general overview of the course materials you will be using and how to use those materials. It also helps you to allocate the appropriate time to each unit so that you can successfully complete the course within the stipulated time limit.

The course guide will help you to know how to go about your Tutor-Marked Assignments (TMAs) which will form part of your overall assessment at the end of the course. There will be regular tutorial classes that are related to this course, where you can

interact with your facilitator and other students. Please, I encourage you to attend these tutorial classes.

COURSE AIM

The aim of this course is to expose the students to the understanding of the health promotion and education in order to promote the wellbeing of individuals, families, and communities.

COURSE OBJECTIVES

At the end of this course, the student will be able to:

i. Define and explain the concept of health promotion and education
ii. Explain the contribution of WHO and international initiatives in health promotion and education
iii. Discuss the application of theory to guide changing individual behaviour communities and organizations
iv. Highlights the determinants of health
v. State the political and ethical considerations in health promotion and education
vi. Explain the concept of health standards and health indicators
vii. Define and explain healthy public policy
viii. Implement healthy public policy through partnerships
ix. Explain procedures for working with communities
x. Describe risk management, perception and communication in health care
xi. Discuss the application of models of behaviour change
xii. Discuss how you would carry out planning and evaluation of health promotion intervention

WORKING THROUGH THIS COURSE

This course has been carefully put together bearing in mind that you might be new to the field. However, efforts have been made to ensure that adequate explanation and illustrations were made to enhance better understanding of the course. For successful completion of the course, students are required to read each module and its unit, read the textbooks materials suggested for further study as provided by the National Open University of Nigeria. Reading the referenced materials can also be of great assistance. Each unit has self-assessment exercises which you are advised to do and at certain periods during the course you will be required to submit your assignments for the purpose of assessment.

At the end of the course, there will be final examination to assess students' knowledge and skills. The course should take you about 17 weeks to complete. This course guide will provide you with all the components of the course, how to go about studying and how you should allocate your time to each unit so as to finish on time and successfully.

COURSE MATERIAL

This course consists of three modules that are broken down into nine (9) units. The components of the course are:

- The study guide
- Study units
- Reference/further readings
- Assignments
- Presentation schedule

STUDY UNIT

This comprises of three modules that are broken down into nine units. They are listed below:

MODULE 1: INTRODUCTION TO HEALTH PROMOTION AND EDUCATION

Unit 1: Concept and Definition of Health Promotion and Education

Unit 2: WHO and International Initiatives

Unit 3: Using Theory to Guide Changing Individual Behaviour, Communities and Organizations

MODULE 2: PUBLIC HEALTH POLICY

Unit 1: Healthy Public Policy

Unit 2: Implementing healthy public policy through partnerships

Unit 3: Working with Communities

MODULE 3: HEALTH PROMOTION INTERVENTION

Unit 1: Risk management, Perception and Communication in Health Care

Unit 2: Application of Models of Behaviour Change

Unit 3: Planning and Evaluation of Health Promotion Intervention

PRESENTATION SCHEDULE

There is a time-table prepared for the early and timely completion and submissions of your TMAs as well as attending the tutorial classes. You are required to submit all your assignments by the stipulated time and date. Avoid falling behind the schedule time.

ASSIGNMENT FILE

There are two types of assessments in this course. First are the Tutor-Marked Assessments (TMAs); second is the written examination. In solving the questions in the assignments, you are expected to apply the information, knowledge and experience acquired during the course. The assignments must be submitted to your facilitator for

formal assessment in accordance with prescribed deadlines stated in the assignment file. The work you submit to your facilitator for assessment accounts for 30 percent of your total course mark. At the end of the course, you will be required to sit for a final examination of 1½ hours duration at your study center. This final examination will account for 70 % of your total course mark.

ASSESSMENT

There are three aspects to the assessment of this course. The first one is the self-assessment exercises. The second is the Tutor Marked Assignments and the third is the written examination to be taken at the end of the course.

Students are required to carry out the exercises or activities in the unit by applying the information and knowledge acquired during the course. The tutor-marked assignments must be submitted to your facilitator for formal assessment in accordance with the deadlines stated in the presentation schedule and the assignment file.

The work submitted to your tutor for assessment will count for 30% of your total course work. At the end of this course, you have to sit for a final or end of course examination of about a three-hour duration which will count for 70% of your total course work.

TUTOR-MARKED ASSIGNMENTS (TMAs)

This is the continuous assessment component of this course and it accounts for 30% of the total score. You will be given three (3) TMAs by your facilitator to answer. The three of which must be answered before you are allowed to sit for the end of course examination.

These answered assignments be returned to your facilitator. You are expected to complete the assignments by using the information and material in your readings references and study units. Reading and researching into your references will give you a

wider via point and give you a deeper understanding of the subject. Students should note the following:

1. Make sure that each assignment reaches your facilitator on or before the deadline given in the presentation schedule and assignment file. If for any reason you are not able to complete your assignment, make sure you contact your facilitator before the assignment is due to discuss the possibility of an extension. Request for extension will not be granted after the due date unless there in exceptional circumstances.

2. Make sure you revise the whole course content before the examination. The self-assessment activities and TMAs will be useful for this purposes and if you have any comment please do that before the examination. The end of course examination covers information from all parts of the course.

FINAL EXAMINATION AND GRADING

The final examination for PHS819: *Health Promotion and Education and Its Advances* will be of 1½ hours duration. This accounts for 70 % of the total course grade. The examination will consist of questions which reflect the theory, practice, exercises and the tutor-marked assignments. Note that all areas of the course will be assessed. To revise the entire course, you must start from Unit 1 of Module 1 to Unit 3 of Module 3 in order to effectively prepare for the examination. It may be useful to go over your TMAs and probably discuss with your course mates or group if need be. This will enable you to be more prepared, since the examination covers information from all aspects of the course.

COURSE MARKING SCHEME

Table 1: Course Marking Scheme

Assignment	**Grade**
Three (3) Tutor-Marked Assignments (TMAs)	Three TMAs count at 10% each, i.e. 30% of course grade
End of course examination	70% of overall course marks/grade
Total	**100% of the course**

Table 2: Course Organisation

Units	**Title of Work**	**Weeks Activity**	**Assessment (End of Unit)**
	Course Guide	**Week**	
1.	Concept and Definition of Health Promotion and Education	Week 1	Assignment 1
2.	WHO and International Initiatives	Week 2	Assignment 2
3.	Using Theory to Guide Changing Individual Behaviour, Communities and	Week 3	Assignment 3
4.	Healthy Public Policy	Week 4	Assignment 4
5.	Implementing healthy public policy through partnerships	Week 5	Assignment 5
6.	Working with Communities	Week 6	Assignment 6
7.	Risk management, Perception and Communication in Health Care	Week 7	Assignment 7
8.	Application of Models of Behaviour Change	Week 8	Assignment 8
9.	Planning and Evaluation of Health Promotion Intervention	Week 9	Assignment 9

HOW TO GET THE MOST OUT OF THIS COURSE

The National Open University of Nigeria employs open and distance learning mode of study, therefore, the study units replace the university lecturer in the conventional

university system. This is one of the advantages of distance learning mode; you can read and work through specially designed study materials at your own pace and at a time and place that suit you best. The study guide tells you what to read, when to read and the relevant texts to read for further information. You are provided with exercises at appropriate points, just as a lecturer might give you an in-class exercise.

Each of the study unit follows a common format. The first item is an introduction to the subject matter of the unit and how a particular unit is integrated with the other units and the course as a whole. Next to this is a set of learning objectives. These learning objectives are meant to guide your studies. The moment a unit is completed, you must go back and check whether you have achieved the objectives or not. If you make this your habit, then you will significantly improve your chances of passing the course examination.

The main body of the units also guides you through the required readings from other sources. This will usually be either from a textbook or from other sources. Self-assessment exercises are provided throughout the unit, to aid personal studies and answers are provided at the end of the unit. Working through these self-tests will help you to achieve the objectives of the unit and also prepare you for tutor marked assignments and examinations. You should attempt each self-test as you encounter them in the units.

FACILITATORS/TUTORS AND TUTORIALS

Sixteen (16) hours are provided for tutorials for PHS819: *Health Promotion and Education and Its Advances*. Students will be notified of the dates, times and location for the tutorial classes. As soon as you are allocated a tutorial group, the name and phone number of your facilitator will be given to you.

The duties of your facilitator are as follows: He or she will mark and comment on your assignment. He/she will monitor your progress and provide any necessary assistance you

need. He or she will mark your TMAs and return to you as soon as possible. You are expected to mail your tutored assignments to your facilitator at least two days before the scheduled date.

Do not delay to contact your facilitator by telephone or e-mail for necessary assistance if you do not understand any part of the study in the course material or you have difficulty with the self-assessment activities. Also if you have a problem or question with an assignment or with the grading of the assignment do not fail to contact your facilitator.

It is important and necessary you attend the tutorial classes because this is the only chance you have to attend face to face content with your facilitator and to ask questions which will be answered instantly. It is also period where you can state any problem encountered in the course of your study.

SUMMARY

This course PHS819: *Health Promotion and Education and Its Advances* consists of three modules with three units each. The course comprises of introduction to health promotion and education which discussed on the concepts and definitions of health promotion and education, World Health Organization and other international initiatives and using theory to guide changing individual behaviours, community and organizations. Module 2 highlights on health public policy, implementing healthy public policy through partnership and working with the communities. Moreover, module 3 dealt with health promotion intervention that comprises of risk management, perception and communication in health care, application of models of behaviour change and planning and evaluation of health promotion intervention.

PHS819 HEALTH PROMOTION AND EDUCATION AND ITS ADVANCES

MODULE 1: INTRODUCTION TO HEALTH PROMOTION AND EDUCATION

Unit 1: Concept and Definition of Health Promotion and Education

Unit 2: WHO and International Initiatives

Unit 3: Using Theory to Guide Changing Individual Behaviour, Communities and Organizations

MODULE 2: PUBLIC HEALTH POLICY

Unit 1: Healthy Public Policy

Unit 2: Implementing healthy public policy through partnerships

Unit 3: Working with Communities

MODULE 3: HEALTH PROMOTION INTERVENTION

Unit 1: Risk management, Perception and Communication in Health Care

Unit 2: Application of Models of Behaviour Change

Unit 3: Planning and Evaluation of Health Promotion Intervention

MODULE 1: INTRODUCTION TO HEALTH PROMOTION AND EDUCATION

Unit 1: Concept and Definition of Health Promotion and Education

Unit 2: WHO and International Initiatives

Unit 3: Using Theory to Guide Changing Individual Behaviour, Communities and Organizations

UNIT 1: CONCEPT AND DEFINITION OF HEALTH PROMOTION AND EDUCATION

MAIN CONTENTS

1.0 INTRODUCTION

Health promotion and education is probably the most ethical, effective, efficient and sustainable approach to achieving good health. It was defined initially by the World Health Organization in 1986, but the definition has since been refined to take account of

new health challenges and a better understanding of the economic, environmental and social determinants of health and disease. The most widely accepted and utilized definition of health promotion was given by WHO (1986) as: *'the process of enabling people to increase control over the determinants of health and thereby improve their health'*

2.0 OBJECTIVES

At the end of this unit, you will be able to:

i. define health education and promotion

ii. explain the emergence of public health

iii. distinguish between public health, health education and health promotion

iv. understand the origins and development of health education and promotion

3.0 MAIN CONTENT

3.1 THE EMERGENCE OF PUBLIC HEALTH

Terms in public health are used differently in different countries and are interpreted differently by politicians, depending upon their ideological perspectives. There is a multitude of terms, including health education, health improvement, health protection, disease prevention and health development. It is important to reflect upon the historical context and the professional and political interests and ideologies that underpin these different concepts. You will explore the origins of these terms and their application by reviewing the history of the development of health promotion.

The term 'health promotion' has a long and complex history. The basis for our current understanding of health promotion can be found in the public health movements of the nineteenth century in Europe and North America. These movements emerged partly in response to a series of major infectious disease epidemics in cities, which had a devastating impact on the population. Improvements in understanding of the mechanisms

for the transmission of infectious disease were matched by the actions of social reformers, such as Chadwick and Simon in the UK. and Shattuck in the USA, to influence public opinion and promote political action in the form of legislation and regulation to protect the public. These reforms led, in time, to improved housing, sanitation, food supply and working conditions for most of the population.

These advances were secured through political action, often in the face of opposition, and were intended to benefit the entire population, rather than the needs of individuals. Major improvements in the health and longevity of populations in high-income countries were achieved as a consequence of these early public health reforms (McKeown, 1979). This form of societal action has been the cornerstone of public health ever since. It forms the basis for an enduring definition of public health, developed in the 1920s by one of the most influential thinkers and writers on public health, C.E.A. Winslow, who described public health as: *"The science and art of promoting health, preventing disease, and prolonging life through the organized efforts of society"* (Winslow, 1923). Writing in 1923 on the topic of the modern public health campaign, Winslow provided a scholarly analysis of the origins of public health. Of particular significance, he emphasized the beginnings of a new phase in public health where 'education is the keynote of the modern campaign for public health'. He identified the new machinery through which such education could be accomplished *as "health bulletins, health news services, health lecture bureaus and institutes, health cinemas, health exhibits, and health radio programmes".*

He further stressed the goals of health education in the context of a public health campaign: These instruments are all of assistance in their two-fold object, of securing popular support for the community health programme, and for bringing into contact with health clinics various types of individuals who are in need of their services. Hygienic instruction, plus the organization of medical services for the detection and the early treatment of incipient disease, these are the twin motives of the modern public health

campaign. Thus, the stage was set for the emergence of health education, together with well-organized preventive health services, as the major tools for the promotion of public health in the twentieth century.

3.2 POST-WORLD WAR DEVELOPMENT AND THE EXPANSION OF MEDICINE

The lessons learnt in the latter half of the nineteenth century concerning the impact of the physical, social and economic environments became somewhat lost during the two decades following the Second World War. In most high-income countries during this period, a vast amount of investment was made in reconstruction and development. For example, in the UK the National Health Service was created to provide universal access to health care. In the USA, major government initiatives sought to greatly expand the availability of health care facilities and, through the creation of the National Institutes of Health, stimulate a huge expansion in bio-medical research. Further initiatives saw the introduction of Medicare and Medicaid to improve access to health care in the USA for the elderly and the poor.

Through these processes and similar developments in most high-income countries, the role of government in relation to the health of the population became increasingly defined in terms of the availability of and access to health care. Thus the public health perspective was lost. Health education, as it existed in the 1950s and 1960s, remained true to the goals advocated by Winslow, being defined primarily in terms of promoting optimal use of health services, particularly preventive services such as mass screening, ante-natal and child health services, and immunization programmes. Investment in health care, whether through private health insurance, publicly funded services or a combination of both, grew exponentially throughout the postwar period. Hence, governments in most high-income countries had to develop mechanisms to better regulate the costs of, and to control demands for health care – a role to which existing skills and programmes in health education could be adapted. A strengthened role emerged for health education, such as

encouraging the appropriate use of health services to reduce demand for services. This contrasted strongly with its established role of promoting use of preventive health services.

3.3 THE EMERGENCE OF HEALTH EDUCATION

Against this background of expansion in medical science and health care, the second half of the twentieth century was characterized by a growth in the importance of chronic, non-communicable diseases as a cause of premature mortality and morbidity, initially in high-income countries and more recently in middle- and low-income countries. Epidemiological studies of this phenomenon have identified individual behaviours or characteristics that are associated with an increased risk of disease. Smoking was the first to receive prominent public attention. Reports from the Royal College of Physicians (1963) in the UK and the Surgeon General in the USA during the 1960s brought this to public attention. Along with efforts to promote optimal use of health services, modification of such risky behaviour (often referred to as unhealthy lifestyles) increasingly became the focus of efforts to improve public health. Health education was one of the principal tools. So, too, were efforts to encourage people to use preventive health services. The individual and their personal behaviour were the focus for attention, rather than the population and the physical, social and economic environment, Since the 1960s, many examples can be found in the literature of health education programmes directed at achieving individual behaviour change. Need to define health education, goals and objectives

The objectives and target populations varied. These involved, for example, healthy people modifying existing behaviour to reduce present or future risks of disease and injury (for example, by using car seatbelts). In other cases, the target was individuals as patients, directed at promoting optimal use of available health services (for example, by reducing delay in seeking treatment). And in others, it was those who were sick, directed

at rehabilitation from illness or the effective management of chronic illness (for example, optimal management of diabetes).

Health education was thus seen not only as offering a solution to the problems of reducing demand for health care but also to a range of emerging threats to individual health. As a strategy health education was seen to be relatively cheap and as health educators mastered the rapidly evolving technologies of mass communication, a relatively high-profile activity.

3.4 HEALTH PROMOTION POLICY PLATFORM

A key turning point in the history of what is now referred to as health promotion was the publication in Canada, in 1974, of the Lalonde Report, *A New Perspective on the Health of Canadians*. The report, released by the then Minister for Health, Marc Lalonde, is widely acknowledged as a pioneering statement by a national government. It explicitly recognized that health was created by the complex interrelationships between biology, environment, lifestyle and the system of health care. Although not greeted with universal praise at the time (Labonte and Penfold, 1981; Labonte, 1994), by giving prominence to the role of lifestyle and the environment in an analysis of public health, the Lalonde Report opened the door to a significant debate in Canada and elsewhere about the role of government in improving health through its policy decisions and the limitations of personal healthcare. Although the Lalonde Report is recognized today for its influence on health policy development, at the time it generated little change in Canada. As Lavada Pinder (1994) succinctly put it, ‘there were no announcements, no new resources, and no implementation plan’.

It was not until a Health Promotion Directorate was established in the Canadian Federal Department of Health in 1978, under the gifted leadership of Ron Draper, that the ideas put forward in the Lalonde Report began to be considered more systematically. During this period, the Surgeon General’s Report on Health Promotion and Disease Prevention:

Healthy People (1979) was published in the USA. This provided an overview of the progress in public health in the USA and reviewed contemporary, preventable threats to health. It drew heavily on the growing scientific base of information on health promotion and disease prevention being developed through the National Institutes for Health and identified priority areas in which further gains could be expected over the following decade. In 1985, a mid-term review of progress in the USA showed that the objectives for the nation had helped establish a national health agenda. This was achieved by identifying specific health priorities, facilitating organized responses and supporting progress towards enhanced levels of health. Although the review found that almost half the objectives had been met, it also highlighted the need for further actions to achieve a reduction in some of the major inequalities in health status.

Self-Assessment

What social and political factors shaped the development of health education and health promotion in the world?

4.0 CONCLUSION

This unit discussed the concepts and definitions of health promotion and education. It highlighted that health promotion and education has a long and complex history. The emergency of public health is basis for our current understanding of health promotion can be found in the public health movements of the nineteenth century in Europe and North America. During the latter half of the nineteenth century concerning the impact of the physical, social and economic environments became somewhat lost during the two decades following the Second World War. In most high-income countries during this period, a vast amount of investment was made in reconstruction and development. Against this background of expansion in medical science and health care, the second half of the twentieth century was characterized by a growth in the importance of chronic non-

communicable diseases as a cause of premature mortality and morbidity, initially in high-income countries and more recently in middle- and low-income countries.

5.0 SUMMARY

You have learnt about the development of modern health promotion from its origins in the nineteenth-century public health measures through the widespread adaptation of health education during and after the Second World War to the emergence of a new paradigm since the 1980s. This has focused on empowerment of people encouraged by statutory services, non-governmental organizations and the self-help movement. However, the principal motivation for the development of health promotion has been the widespread realization of the limited ability of personal health care to solve all the health problems faced by populations.

6.0 TUTOR-MARKED ASSIGNMENTS

1. Why did health promotion become a key component of health policy?
2. Describe the emergence of public health in the eighteenth century?

7.0 REFERENCES/FURTHER READINGS

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UNIT 2: WORLD HEALTH ORGANIZATION AND INTERNATIONAL INITIATIVES

CONTENT

1.0 INTRODUCTION

You saw in Unit 1 how health promotion developed from the nineteenth century up until the 1970s and 1980s. In this unit, you will learn about the more recent history and, in particular, the key role that the World Health Organization has played through a series of declarations. First, however, you will learn contemporary models of health promotion that provide a framework for considering such international initiatives.

2.0 OBJECTIVES

After working through this unit, you will be able to:

i. Explain the nature of health promotion in the context of other public health domains and the main democratic political ideologies

ii. Highlight the need for a multi-sectoral, multi-method and multi-disciplinary approach to health promotion

iii. Discuss the two models of health promotion

iv. Explain the role of World Health Organization in health promotion

3.0 MAIN CONTENT

3.1 MODELS OF HEALTH PROMOTION

As you have learned in unit 1, changes took place in the conceptualization of health and health promotion during the 1980s and 1990s. These have resulted in the creation of several models of health promotion. These will be explored in relation to theory, and to implementation and evaluation of health promotion. Health promotion is a radical movement, which gathered momentum in the 1980s and which challenges the medicalization of health and stresses the social and economic aspects of health (Downie et al.,1990). Tannahill's model of health promotion sees it as comprising 'efforts to enhance positive health and prevent ill health, through the overlapping spheres of health education, prevention and health protection' (Downie et al., 1990). Tannahill neatly places health promotion within the framework of the broad range of traditional public health domains. The model can be depicted as a set of overlapping circles with seven domains which are united by the principles of health promotion, the nature of which is eclectic and multidisciplinary. The seven domains are:

i. preventive services
ii. preventive health education
iii. preventive health protection

iv. health education for preventive health protection
v. positive health education
vi. positive health protection
vii. health education aimed at positive health protection

There are three basic approaches (models) to improving health based on medical/ behavioural change, educational change or social change. In practice, these models overlap but can be described separately to show their differences. First, the medical model focuses on the prevention of disease (illness or negative health) and is combined with a philosophy of compliance with professionals' (usually the doctor's) diagnosis and prognosis. Second, the educational model is based on the view that the world consists of rational human beings and that to prevent disease and improve health you merely have to inform or educate people about remedies and healthy lifestyles because, as rational human beings, they will respond accordingly. And third, the social model is based on the view that health is determined by the social, cultural and physical environment. In this model, solutions are political and require protecting people from health-disabling environments. Like all models, these are simplifications of reality and as such are all incomplete. In practice, health promotion is a combination of these approaches.

3.2 THE ROLE OF THE WHO'S HEALTH FOR ALL

While the World Health Organization (WHO) has fostered and supported health education and disease prevention programmes around the world throughout its history, these efforts were largely uncoordinated and lacked a strategic reference point until the *Health for All* strategy adopted by WHO in 1978 declared:

The main social target of governments, international organisations and the world community in the coming decades should be the *attainment by all peoples of the world by the year 2000 of a level of health that will permit them to lead a socially and economically productive life*. This prompted a significant re-orientation of the work of

WHO and, for the first time, provided a comprehensive and coherent strategy for the organization and member states (WHO, 1981). *Health for All* has been important in making equity and social justice major social goals. It has also been credited with fostering a resurgence of interest in public health internationally, particularly by re focusing attention on social and economic determinants of health and their unequal impact on the health of populations.

3.2.1 Primary Health Care (1978)

The adoption of the *Health for All* strategy by WHO was followed by what has become recognized as a landmark meeting, jointly organized by the WHO and UNICEF, at Alma Ata, in Kazakhstan. This meeting resulted in the *Declaration of Alma Ata* on primary health care (WHO, 1978), which, like the *Ottawa Charter* that followed, has proved to be an inspirational statement, highlighting the need to reorient health systems in many countries towards the provision of primary healthcare. Primary health care was defined as: '*Essential health care based on practical, scientifically sound and socially acceptable methods and technology made universally accessible to individuals and families'.* The Declaration emphasized that such essential health care includes, at least education concerning prevailing health problems and the methods of preventing and controlling them that involves all related sectors which demand the coordinated efforts of all those sectors and requires and promotes maximum community and individual self-reliance and participation in the planning, organisation, operation and control of primary health care.

This focuses on primary health care, prevention, recognition of the role of other sectors in creating health and causing ill health, and of community participation and ownership of health programmes has been important to the work of WHO. It has been particularly influential in the evolution of health systems in many low-income countries but, disappointingly, national health policies that reflect the aspirations of *Health for All* and the *Declaration of Alma Ata* have been slow to materialize in high- and middle-income countries with established, medically oriented health care systems.

3.2.2 Targets for Health for All 2000

The European Region of WHO has sought to interpret the Health for All concept into one more meaningful for the countries of Europe. WHO has promoted a common approach to health policy in Europe by developing a series of targets for improved health status that reflect the Health for All strategy – Targets for Health for All 2000 (WHO, 1986a). This report provided a clear statement of the scope for improving health status within member countries and called for a fundamental reorientation of the health systems in individual countries towards the achievement of the targets. The report grouped targets into four major themes:

i. lifestyles and health

ii. risk factors affecting health and the environment

iii. reorientation of the health care system

iv. the infrastructure supports necessary to bring about the desired changes in these three areas.

The document recognized the importance of structural prerequisites for health by setting targets for resource allocation, public policy and workforce training. The report also emphasized the need to engage and reorient health systems towards the provision of appropriate care, in particular stressing primary health care as the basis for the health system. Altogether, 38 targets were specified, together with 65 ‘essential’ regional indicators (or groups of indicators) that could be used to measure progress. Progress reports in relation to the targets are submitted to the WHO every three years by the individual member states and the existence of the targets and reporting mechanisms has meant that these issues are regularly exposed in a public forum.

3.2.3 Ottawa Charter

Parallel with these developments, the European Office of WHO also sponsored a series of meetings to explore the concept and principles of health promotion, culminating in the organization of the Ottawa Conference on Health Promotion in Developed Countries. The *Ottawa Charter*, which emanated from this meeting, has defined health promotion action in many countries since this time (WHO, 1986). Since 1986, WHO has played a leading role in health promotion throughout the world, both by sponsoring international conferences to explore practical experience of the major strategies of the *Ottawa Charter* and by promoting a 'settings' based model for health promotion. Two WHO conferences that have extended our knowledge and understanding of the strategies defined in the *Ottawa Charter* were held in Adelaide, Australia to examine international experience in developing healthy public policy (WHO, 1988), and in Sundsvall, Sweden to explore ways and means of creating supportive environments for health (WHO, 1991). In the latter case, WHO has supported the development of the Healthy Cities Project, a network of health-promoting schools, and action to support the development of health promoting worksites and health promoting hospitals.

The *Ottawa Charter* define health promotion as *"the process of enabling people to increase control over the determinants of health and thereby improve their health"*. This salutogenic view implies strengthening people's health potential and that good health is a means to a productive and enjoyable life. Human rights are fundamental to health promotion and a concern for equity, empowerment and engagement. In addition, it has the following characteristics:

i. health promotion is a process – a means to an end

ii. health promotion is enabling – done by, with and for people, not imposed upon them
iii. health promotion is directed towards improving control over the determinants of health

These were updated in the *Jakarta Declaration* (WHO, 1997), which focused on creating partnerships between sectors, including private–public partnerships. The priorities for the twenty-first century were to:

i. promote social responsibility for health
ii. increase investment in health development
iii. consolidate and expand partnerships for health
iv. increase community capacity and empower the individual
v. secure an infrastructure for health promotion

The WHO, through the Bangkok Charter has reviewed the strategies for health promotion in a globalised world as the context for health promotion has changed markedly since the Ottawa Charter. In particular, increasing health inequalities, environmental degradation, new patterns of consumption and communication, and increasing urbanisation.

3.3 WORLD HEALTH ORGANIZATION'S PRIORITIES FOR HEALTH PROMOTION IN THE 21ST CENTURY

1. Promote social responsibility for health

Decision-makers must be firmly committed to social responsibility. Both the public and private sectors should promote health by pursuing policies and practices that: avoid harming the health of individuals; protect the environment and ensure sustainable use of resources; restrict production of and trade in inherently harmful goods and substances such as tobacco and armaments, as well as discourage unhealthy marketing practices; safeguard both the citizen in the market place and the individual in the workplace;

include equity-focused health impact assessments as an integral part of policy development.

2. Increase investment for health development

In many countries, current investment in health is inadequate and often ineffective. Increasing investment for health development requires a truly multi-sectoral approach including, for example, additional resources for education and housing as well as for the health sector. Greater investment for health and reorientation of existing investments, both within and among countries, has the potential to achieve significant advances in human development, health and quality of life. Investments for health should reflect the needs of particular groups such as women, children, older people, and indigenous, poor and marginalized populations.

3. Consolidate and expand partnerships for health

Health promotion requires partnerships for health and social development between the different sectors at all levels of governance and society. Existing partnerships need to be strengthened and the potential for new partnerships must be explored. Partnerships offer mutual benefit for health through the sharing of expertise, skills and resources. Each partnership must be transparent and accountable and be based on agreed ethical principles, mutual understanding and respect based on WHO guidelines.

4. Increase community capacity and empower the individual

Health promotion is carried out by and with people, not on or to people. It improves both the ability of individuals to take action, and the capacity of groups, organizations or communities influence the determinants of health. Improving the capacity of communities for health promotion requires practical education, leadership training, and access to resources. Empowering individuals demands more consistent, reliable access to the decision-making process and the skills and knowledge essential to effect change.

Both traditional communication and the new information media support this process. Social, cultural and spiritual resources need to be harnessed in innovative ways.

5. Secure an infrastructure for health promotion

To secure an infrastructure for health promotion, new mechanisms for funding it locally, nationally and globally must be found. Incentives should be developed to influence the actions of governments, nongovernmental organizations, educational institutions and the private sector to make sure that resource mobilization for health promotion is maximized. *'Settings for health'* represent the organizational base of the infrastructure required for health promotion. New health challenges mean that new and diverse networks need to be created to achieve inter-sectoral collaboration. Such networks should provide mutual assistance within and among countries and facilitate exchange of information on which strategies have proved effective and in which settings. Training in and practice of local leadership skills should be encouraged in order to support health promotion activities. Documentation of experiences in health promotion through research and project reporting should be enhanced to improve planning, implementation and evaluation. All countries should develop the appropriate political, legal, educational, social and economic environments required to support health promotion.

6. Call for action

The participants in the Jakarta Conference are committed to sharing the key messages of the Jakarta Declaration with their governments, institutions and communities, putting the actions proposed into practice, and reporting back to the Fifth International Conference on Health Promotion. In order to speed progress towards global health promotion, the participants endorse the formation of a global health promotion alliance. The goal is to advance the priorities for action in health promotion set out in this Declaration. Priorities for the alliance include: raising awareness of the changing determinants of health; supporting the development of collaboration and networks for health development;

mobilizing resources for health promotion; accumulating knowledge on best practice; enabling shared learning; promoting solidarity in action; fostering transparency and public accountability in health promotion.

National governments are called on to take the initiative in fostering and sponsoring networks for health promotion both within and among their countries. The participants call on WHO to take the lead in building such a global health promotion alliance and enabling its Member States to implement the outcomes of the Conference. A key part of this role is for WHO to engage governments, non-governmental organizations, development banks, organizations of the United Nations system, interregional bodies, bilateral agencies, the labour movement and cooperatives, as well as the private sector, in advancing the priorities for action in health promotion.

Self-assessment exercise

1. Review the history of health promotion you learnt about in Unit 1 from the point of view of the seven domains of the model
2. Can you track which elements were dominant in different phases of health promotion's history?
3. Considering the health system of your country, which domains are dominant now and where is health promotion practice situated?
4. The following extract from the Jakarta Declaration considers the influential themes of Health for All and the Ottawa Charter.
    a. Having read it, what needs to happen where you are?
    b. How might the perspectives from high, middle and low income countries differ?

4.0 CONCLUSION

This unit comprises of two models of health promotion, the role of World Health Organization and the priorities of health promotion in the 21st century. Tannahill neatly

places health promotion within the framework of the broad range of traditional public health domains. The unit also discussed the WHO's strategies such as Health for All, Primary Health Care, and Ottawa Charter

5.0 SUMMARY

You have seen how the World Health Organization has developed the concept of health promotion since the 1970s through a series of international meetings or conference and declarations. These have helped provide support to individuals and organizations in nation-states to develop health promotion programme.

6.0 TUTOR-MARKED ASSIGNMENTS

i. Define primary health care according to WHO
ii. Explain the two models of health promotion
iii. Discuss the targets of Health for All
iv. Explain health priorities of the 21st century

7.0 REFERENCES FURTHER READINGS

Downie R.S., Fyfe C., and Tannahill A. (1990) *Health Promotion Models and Values.* Oxford: Oxford Medical Publications

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UNIT 3: USING THEORIES TO GUIDE CHANGING INDIVIDUAL BEHAVIOUR, COMMUNITIES AND ORGANIZATIONS

CONTENT

1.0 INTRODUCTION

In this Unit you will gain an overview of the use of theory to guide decision making in health promotion, drawing upon several of the most influential theories and models that have guided health promotion practice in the recent past and which remain influential. You will see how and when to used prudently, theories can greatly enhance the effectiveness and sustainability of health promotion programmes.

2.0 OBJECTIVES

At the end of this unit, you should be able to:

i. identify ways in which the use of theory can help you understand the nature of the health problem being addressed

ii. describe and explain the needs and motivations of the target population

iii. explain or make propositions concerning how to change health status, health-related behaviours and their determinants

iv. inform the methods and measures used to monitor and evaluate a health promotion intervention

v. describe the principles of administrative practice

3.0 MAIN CONTENT

3.1 USING THEORY IN PRACTICE

Most health promotion theories come from the behavioural and social sciences. They borrow from disciplines such as psychology and sociology and from activities such as management, consumer behaviour and marketing. Such diversity reflects the fact that health promotion practice is not only concerned with the behaviour of individuals but also with the ways in which society is organized and the policies and organizational

structures that underpin social organization. Many of the theories commonly used in health promotion are not highly developed in the way suggested in the definition above, nor have they been rigorously tested when compared, for example, with theory in the physical sciences. For these reasons, many of the theories referred to below are more accurately termed ‘models’. The potential of theory to guide the development of health promotion interventions is substantial. There are several different planning models that are used by health promotion practitioners. Internationally, the best known of these planning models is the PRECEDE/PROCEED model developed by Green and Kreuter (1999).

Several variations of this approach have also been produced (Nutbeam, 2001) as described by this and other planning models. In each case, these models and guidelines follow a structured sequence including planning, implementation and evaluation. Reference to different theories can guide and inform practitioners at each of these stages. A summary of the linkages between the five distinct phases in health promotion process, namely:

i. problem definition
ii. solution generation
iii. capacity building
iv. health promotion actions
v. outcome measurement

The use of theory in each of these stages is considered in turn.

i. Problem Definition

Identification of the parameters of the health problem to be addressed may involve drawing on a wide range of epidemiological and demographic information, as well as information from the behavioural and social sciences and knowledge of community needs

and priorities. Here, different theories can help identify *what* should be the focus for an intervention.

Specifically, theory can inform your choice for the focus for the intervention. This might be individual characteristics, beliefs and values that are associated with different health behaviours and that may be amenable to change. Alternatively, the focus might be organizational characteristics that may need to be changed.

ii. Solution Generation

The second step involves the analysis of potential solutions, leading to the development of a programme plan which specifies the objectives and strategies to be employed, as well as the sequence of activity. Theory is the most useful here in providing guidance on how and when change might be achieved in the target population, organization or policy. It may also generate ideas which might not otherwise have occurred to you.

iii. Capacity Building

Once a programme plan has been developed, the first phase in implementation is usually directed towards generating public and political interest in the programme, mobilizing resources for programme implementation, and building capacity in organizations through which the programme may operate (e.g. schools, worksites, local government). Models which indicate how to influence organizational policy and procedures are particularly useful, as too is *theory* which guides the development of media activities.

iv. Health Promotion Actions

The implementation of a programme may involve multiple strategies, such as education and advocacy. Here, the key elements of theory can provide a benchmark against which *actual* selection of methods and sequencing of an intervention can be considered in relation to the *theoretically* ideal implementation of programmes. In this way, the use of theory helps you to understand success or failure in different programmes, particularly by

highlighting the possible impact of differences between what was planned and what actually happened in the implementation of the programme. It can also assist in identifying the key elements of a programme that can form the basis for disseminating successful programmes.

v. Outcome Measurement

Health promotion interventions can be expected to have an impact initially on processes or activities such as participation and organizational practices. Theory can provide guidance on the appropriate measures that can be used to assess such activities. For example, where theory suggests that the target of interventions is to achieve change in knowledge or changes in social norms measurement of these changes becomes the first point of evaluation. Such impact measures are often referred to as *health promotion outcomes* (note, not outcomes in the sense of improvements in health).

Intermediate outcome assessment is the next level of evaluation. Theory can also be used to predict the *intermediate health outcomes* that are sought from an intervention. Usually these are modifications of people's behaviour or changes in social, economic and environmental conditions that determine health or influence behaviour. Theories can predict that health promotion outcomes will lead to such intermediate health outcomes. Health and social outcomes refer to the final outcomes of an intervention in terms of changes in physical or mental health status, in quality of life, or in improved equity in health within populations. Definition of final outcomes will be based on theoretically predicted relationships between changes in intermediate health outcomes and final health outcomes.

3.2 SELECTING AN APPROPRIATE THEORY

Theories are not static pronouncements that can be applied to all issues in all circumstances. In health promotion, some of the theories that have been used have been extensively refined and developed in the light of experience. The range and focus of

theories has also expanded over the past two decades from a focus on the modification of individual behaviour, to recognition of the need to influence and change a broad range of social, economic and environmental factors that influence health alongside individual behavioural choices. Thus, health promotion operates at several different levels:

i. Individual
ii. Community
iii. Organization
iv. Nation

Choosing the right approach is moderated by the nature of the problem, its determinants and the opportunities for action. Programmes that operate at multiple levels, such as those described in the Ottawa Charter for Health Promotion (WHO,1986), are more likely to address the full range of determinants of health problems in populations and, thereby, have the greatest effect.

Depending on the level of an intervention (individual, group, organization or nation), the type of change (simple, one-off behaviour, complex behaviour, organizational or policy change), different theories will have greater relevance and provide a better fit with the problem. Most often, you benefit by drawing upon more than one of the theories to match the multiple levels of the programme being contemplated. To be useful and relevant, the different models and theories have to be readily understood and capable of application in a wide variety of real-life conditions. Although you are constantly reminded that 'there is nothing so practical as a good theory', you may remain somewhat suspicious of the capacity of intervention theories to provide the guidance necessary to develop an effective intervention in a complex environment. Glanz et al. (2002) offer a common sense summary of how to judge a good fit between a theory (or combinations of theories) and the problem you are trying to address. These include the following question

i. Is it logical?
ii. Is it consistent with everyday observations?

iii. Is it similar to those used in successful programmes?

iv. Is it supported by past research?

Theories and models are simplified representations of reality – they can never include or explain all of the complexities of individual, social or organizational behaviour. However, while the use of theory alone does not guarantee effective programmes, the use of theory in the planning, execution and evaluation of programmes will enhance the chances of success. One of the greatest challenges for you is to identify how best to achieve a fit between the issues of interest and established theories or models which could improve the effectiveness of a programme or intervention.

3.2.1 Three Widely used Models

One of the major roots of health promotion can be found in the application of health psychology to health behaviour change. Evidence for this can be seen in the phenomenal growth in the discipline of health psychology and the evolution of the concept of behavioural medicine. This discipline has had a significant influence. For several decades, researchers have sought to explain, predict and change health behaviour by the development and application of theories and models evolving from psychology and, in particular, social psychology. Among the many theories and models that have been proposed, you will learn about three in the rest of this unit.

3.2.2 The Health Belief Model

This is one of the longest established theoretical models designed to explain health behaviour by understanding people's beliefs about health. It was originally articulated to explain why individuals participate in health screening and immunization programmes, and has been developed for application to other types of health behaviour. At its core, the model suggests that the likelihood of an individual taking action for a given health problem is based on the interaction between four types of belief. The model predicts that individuals will take action to protect or promote health if:

i. they perceive themselves to be susceptible to a condition or problem
ii. they believe it will have potentially serious consequences
iii. they believe a course of action is available which will reduce their susceptibility, or minimize the consequences
iv. they believe that the benefits of taking action will outweigh the costs or barriers.

Studies have shown how the use of a postcard to remind parents of immunizations that are due for their children are effective in raising immunization rates. Hawe and colleagues (1998) examined any difference in impact on immunization rates of using the health belief model to guide the content of a simple postcard message to encourage parents to bring their children for immunization with that of a standard card that provided only the time and place of the immunization clinic. This simple modification, guided by the health belief model, produced a significant improvement in the uptake of immunization in the community in which it was tested. The health belief model has been found to be most useful when applied to behaviours for which it was originally developed, particularly prevention strategies such as screening and immunization. It has been less useful in guiding interventions to address more long-term, complex and socially determined behaviours, such as alcohol and tobacco consumption. The model's advantage is the relatively simple way in which it illustrates the importance of individual beliefs about health and the relative costs and benefits of actions to protect or improve health. Three decades of research have indicated that promoting change in beliefs can lead to changes in health behaviour which contribute to improved health status. Changes in knowledge and beliefs will almost always form part of a health promotion programme and the health belief model provides a reference point in the development of messages to improve knowledge and change beliefs, especially messages designed for use by the mass media.

3.2.3 The Stages of Change (Trans-theoretical) Model

This model was developed to describe and explain the different stages in behaviour change (Prochaska and DiClemente, 1984). The model is based on the premise that behaviour change is a process, not an event, and that individuals have different levels of motivation or readiness to change. Five stages of change have been identified:

i. Pre-contemplation: this describes individuals who are not even considering changing behaviour or are consciously intending not to change
ii. Contemplation: the stage at which a person considers making a change to a specific behaviour
iii. Determination, or preparation: the stage at which a person makes a serious commitment to change
iv. Action: the stage at which behaviour change is initiated
v. Maintenance: sustaining the change, and achievement of predictable health gains. Relapse may also be the fifth stage

From a programme planning perspective, the model is particularly useful in indicating how different *processes of change* can influence how activities are staged. Several processes have been consistently useful in supporting movement between stages. These processes are more or less applicable at different stages of change. For example, awareness raising may be most useful among *pre-contemplators* who may not be aware of the threat to health that their behaviour poses, whereas communication of the benefits of change and illustration of the success of others in changing may be important for those contemplating change. Once change has been initiated at the action stage, social support and stimulus control (for example, by avoiding certain situations or having environmental supports in place) are more important. By matching stages of behavioural change with specific processes, the model specifies how interventions could be organized for different populations, with different needs and in different circumstances. The stages of change model stresses the need to research the characteristics of the target population, the importance of not assuming that all people are at the same stage, and the need to organize interventions sequentially to address the different stages that will be encountered.

The model has been used in workplace programmes to promote regular physical activity, which traditionally have met with limited success. Marcus and colleagues (1992) tested an intervention that used the stages of change model to classify workers according to their current level of activity and motivation to change. The intervention consisted of a mix of written materials and events that were targeted according to the different stage of change. The intervention produced promising short-term results by supporting many participants to move on through the different stages of change towards more regular activity.

The stages of change model have quickly become an important reference point in health promotion interventions because of its obvious advantage in focusing on the change process. The model is important in emphasizing the *range of needs* for an intervention in any given population, the *changing needs* of different populations, and the need for the *sequencing* of interventions to match different stages of change. It illustrates the importance of tailoring programmes to the real needs and circumstances of individuals, rather than assuming an intervention will be equally applicable to all.

3.2.4 Social Cognitive Theory

This is one of the most widely applied theories in health promotion because it addresses both the underlying determinants of health behaviour and the methods of promoting change. The theory was built on an understanding of the interaction that occurs between an individual and their environment (Bandura 1995). Early psycho-social research tended to focus on the way in which an environment shapes behaviour, by making it more or less rewarding to behave in particular ways. For example, if at work there is no regulation on where people are able to smoke cigarettes, it is easy to be a smoker. If regulations are in place, it is more difficult and, as a consequence, most smokers smoke less and find such an environment more supportive for quitting. Social cognitive theory indicates that the relationship between people and their environment is more subtle and complex. For example, in circumstances where a significant number of people are non-smokers and are

assertive about their desire to restrict smoking in a given environment, even without formal regulation, it becomes far less rewarding for the individual who smokes. They are then likely to modify their behaviour. In this case, the non-smokers have influenced the smoker's perception of the environment through social influence.

This is referred to as reciprocal determinism. It describes the way in which an individual, their environment and behaviour continuously interact and influence each other. An understanding of this interaction and the way in which (in the example) modification of social norms can impact on behaviour offers an important insight into how behaviour can be modified through health promotion interventions. For example, seeking to modify social norms regarding smoking is considered to be one of the most powerful ways of promoting cessation among adults.

For example, some young women may observe behaviour (such as smoking) by people whom they regard as sophisticated and attractive (*role models*).

If they observe and value the rewards that they associate with smoking, such as sexual attractiveness or a desirable self-image, then they are more likely to smoke themselves – their *expectancies* in relation to smoking are positive. Such an understanding further reinforces the importance of taking account of peer influences and social norms on health behaviour, and of the potential use of role models in influencing social norms.

Second, the capacity to anticipate and place value on the outcome of different behaviour patterns (referred to as *expectations*). For example, if you believe that smoking will help you lose weight and you place great value on losing weight, then you are more likely to take up or to continue smoking. This understanding emphasizes the importance of understanding personal beliefs and motivations underlying different behaviour, and the need to emphasize short-term and tangible benefits. For example, young people have been shown to respond far more to the short-term adverse effects of smoking (bad breath,

smelly clothes) than to any long-term threat posed to health by lung cancer or heart disease.

Finally, the theory emphasizes the importance of belief in your own ability to successfully perform a behaviour (referred to as *self-efficacy*). Self-efficacy is proposed as the most important prerequisite for behaviour change and will affect how much effort is put into a task and the outcome of that task.

3.3 THEORY OF INNOVATION DIFFUSION

The systematic study of the ways in which new ideas are adopted by communities led to the development of the *theory of innovation diffusion* (Rogers, 2002). It is based on the idea that there are five factors that influence the success and speed with which new ideas are adopted in communities. Understanding these factors is central to the application of diffusion theory to health promotion. The factors are:

- **i.** the characteristics of the potential adopters
- **ii.** the rate of adoption
- **iii.** the nature of the social system
- **iv.** the characteristics of the innovation
- **v.** the characteristics of change agents

A widely used system of categorizing adopters is based on the time it takes for adoption to occur. This identifies *innovators* as those 2–3 per cent of the population who are quickest to adopt new ideas, and *early adopters* as the 10–15 per cent of the population who may be more mainstream within the community but are the most amenable to change and have some of the personal, social or financial resources to adopt the innovation. The *early majority* are the 30–35 per cent of the population who are amenable to change, and have become persuaded of the benefits of adopting the innovation. The *late majority* are the 30–35 per cent of the population who are sceptics and are reluctant to adopt new ideas until such time as the benefits have been clearly

established. And, finally, the *laggards* are the 10–20 per cent of the population who are seen to be the most conservative and in many cases actively resistant to the introduction of new ideas. As indicated by the different percentages for each group, Rogers suggests that their distribution in a population matches the 'normal' probability distribution curve. From this simple classification it is possible to see how age, disposable income and exposure to the media, for example, are important variables which will define the different types of 'adopter' and influence the speed of uptake of innovations. Some innovations take much longer than others to introduce to the majority of the target population and, in some cases, will never reach the entire population. The increasing difficulty of influencing late adopters and the residual group of laggards translates into diminishing returns on effort in health promotion programmes and needs to be recognized in the planning and evaluation of such programmes. Analysis of programmes has led to the identification of *characteristics of innovations* that have been consistently associated with successful adoption. These include:

i. *Compatibility* with prevailing socio-economic and cultural values of the adopter. For example, if a change in diet is being advocated in a particular community, it is more likely to be adopted if the food is based on traditional food sources.
ii. Clarity of the *relative advantage* of the innovation compared with current practices, including *perceived cost-effectiveness*, as well as usefulness, convenience and prestige. For example, is the food (such as fresh fruit and vegetables) conveniently available at a price that people can afford.
iii. The *simplicity and flexibility* of the innovation. Those which require simple actions and which can be adapted to different circumstances are more likely to be successful. For example, is the food simple to prepare and consume, and are any new cooking methods required.
iv. The *reversibility and perceived risk* of adoption. Innovations perceived as high risk or involving an irreversible change in practice are less likely to be adopted. For example, no new cooking utensils need to be bought.

v. *Observability* of the results of adopting an innovation to others who may be contemplating change. For example, there are stories in local news media showing the impact of a changed diet on a person's life.

3.4 THE COMMUNICATION-BEHAVIOUR CHANGE MODEL

Effective health promotion strategies are best developed by engaging individuals and communities in the issue to be addressed. This involves understanding the beliefs and knowledge that people have about a problem and their skills in addressing it, as well as broader community understanding of why the issue is important and how it can most effectively be tackled. Clear communication between health promotion practitioners and those whom they are trying to influence is essential. The *communication-behaviour change model* was developed by McGuire (1989) to design and guide public education campaigns.

The five communication *inputs* described by McGuire are:

1. *Source:* the person, group or organization from whom a message is perceived to have come. The source can influence the credibility, clarity and relevance of a message. For example, the same message delivered from a government source, by a celebrity or from a non-governmental organization will have different credibility and relevance to different target audiences
2. *Message:* what is said and how it is said. The content and form of a message can influence audience response. For example, the use of fear or humour to communicate the same message may provoke different responses from different target audiences. Practical considerations such as the length of the message, form of language and tone of voice also need to be considered.
3. *Channel:* the medium through which a message is delivered. Mass media include television, radio and print media (e.g. newspapers, pamphlets, posters), as well as techniques such as direct mail. More recently, information technology has opened

up a range of new media for use in communicating health messages in high-income countries, including the internet and mobile phone text messages. Issues to be considered in selecting a channel for communication include the potential reach of different media, the cost of use, and differences in the complexity of message which can be communicated through different media.

4. *Receiver:* the intended target audience. Recognizing differences in audience segments and their media preferences are important in matching the right message to the right channel from the right source. Social and demographic variables such as gender, age, ethnicity, income and location, as well as current attitudes and behaviours, and media use can all be considered as a part of this element.
5. *Destination:* the desired outcome to the communication. This may include change in attitudes or beliefs, or, more likely, changes in behaviour. The communication-behaviour change model also provides a twelve-step sequence of events, representing *outputs* from a communication, which link initial exposure to a communication to long-term change in behaviour. This model illustrates that for a communication strategy to be effective, the message has to be carefully designed and delivered through an appropriate channel to reach the target audience. The population has to be exposed to the message, pay attention to it and understand it. Once understood by an individual, the message must create an inclination to change, reflected in attitude change which is stored and maintained until such time as the recipient is in a position to act on that attitude change. Once the decision to change a behaviour has been made and acted on, this new behaviour needs reinforcement to be maintained. These inputs and outputs can be put together as a matrix to illustrate the need to change the input mix depending on the targeted output. Different sources, messages and channels will be required to reach different people and achieve different outcomes.

3.5 MODEL OF ORGANIZATIONAL CHANGE

Health promotion practitioners are interested in influencing organizations for several reasons:

i. people are usually employed by organizations and have an interest in ensuring that their own organization is able to support the work that we are doing
ii. people are interested in influencing the activities or policies of other organizations who have an influence on the health of the population
iii. you have to find ways to enable organizations to work together to promote the health of the population. Goodman *et al.* (2002) have succinctly described the problems and potential rewards of facilitating change in organizations:

Organisations are layered. Their strata range from the surrounding environment at the broadest level, to the overall organisational structure, to the management within, to workgroups, to each individual member. Change may be influenced at each of these strata, and health promotion strategies that are directed at several layers simultaneously may be most durable in producing the desired results. The health professional who understands the ecology of organisations and who can apply appropriate strategies has a powerful tool for change. Unlike many of the theories and models described above, the application of theories of organizational change is far less developed and tested.

3.5.1 Four Stages of the Model

Goodman and colleagues (2002) propose a four-stage model for organizational change that is applicable to health promotion.

In the model, **Stage 1** is described as *awareness raising*. This stage is intended to stimulate interest and support for organizational change at a senior level by clarifying health problems in the organizational environment, and identifying potential solutions. for example, awareness raising may involve senior managers and administrators in the education system becoming concerned about tobacco control and recognizing the potential role to be played by the education system. These senior administrators are likely

to be the most influential in decisions to adopt new policies and programmes in an organization. If they are convinced of the importance of a problem and the need for a solution involving their organization, then the strategy moves to the next stage.

Stage 2 is described as *adoption* and involves planning for and adoption of a policy, programme or other innovation that addresses the problem identified in Stage 1. This includes the identification of resources necessary for implementation. In larger organizations, this stage will often involve a different level in the management structure – the gatekeepers –who are more closely associated with the day-to-day running of an organization. In the example, this could involve school principals and senior teachers responsible for school curricula and organization. Ideally, this stage will involve negotiation and adaptation of intervention ideas to make them compatible with the circumstances of individual organizations. This element of *adaptation* is often essential to the adoption of change in organizations, but is frequently missed by those attempting to disseminate new ideas through organizations.

Stage 3 is described as *implementation* and is concerned with technical aspects of programme delivery, including the provision of training and material support needed for the introduction of change. In the example, this could involve class- room teachers, as they will be most directly responsible for the introduction of change. This phase may involve training and the provision of resource support to foster the successful introduction of a programme. This *capacity building* is essential for the successful introduction and maintenance of change in organizations. Many policy initiatives fail at this point because too little attention is given to the detail of the implementation process and too little support is offered to the individuals at the level at which implementation takes place.

Stage 4 is described as *institutionalization* and is concerned with the long-term maintenance of an innovation, once it has been successfully introduced. Senior

administrators again become the leading players, by establishing systems for monitoring and quality control, including continued investment in resources and training.

3.5.2 The Importance of Focusing on Organizations

The model of organizational change provides useful guidance on the different steps required to introduce and sustain a programme in different organizational settings. In particular, it highlights:

i. the need to *understand the core business* of an organization, and it *organizational structure*, determine how a health promotion programme can fit within these parameters, and help to achieve the core business goals
ii. the need to work with individuals at *different levels* in an organization as well as between organizations
iii. the inherently political nature of the task of *influencing senior managers*
iv. the importance of *flexibility in negotiation* with 'gatekeepers' concerning the adoption of a programme
v. the need to support those individuals responsible for the delivery of a programme or innovation
vi. the need to establish a *system for longer term maintenance* and quality control.

One of the major reasons that the health sector is interested in working with organizations is to bring about systematic and lasting change that will address some of the basic determinants of health, such as safe workplaces, improved living conditions and the development of recreational facilities. Understanding how to do this most effectively has the potential to have profound impacts on health.

4.0 CONCLUSION

The promotion of self-efficacy is thus an important task in the achievement of behaviour change. It has been proposed that both *observational learning* and *participatory learning*

(e.g. by supervised practice and repetition) will lead to the development of the knowledge and skills necessary for behaviour change (*behavioural capability*). These are seen as powerful tools in building self-confidence and self-efficacy.

5.0 Summary

You have learnt about theories that explain health behaviour and health behaviour change. Theories that focus on the individual provide important guidance on major elements of health promotion programmes. Taken together, the theories and models described emphasize the importance of knowledge and beliefs about health, the importance of self-efficacy (the belief in one's competency to take action), the importance of perceived social norms and social influences related to the value an individual place on social approval or acceptance by different social groups, and the importance of recognizing that individuals in a population may be at different stages of change at any one time. There are limitations to psycho-social theories which do not adequately take account of socio-economic and environmental conditions and it is therefore important to change the environment or people's perception of the environment if health promotion is to be successful.

You have also seen how theories and models can help to conceive and plan health promotion programmes at the community and organizational levels. In particular, you have learnt about the theory of innovation diffusion, of communication behaviour change and of organizational change. In the next section, you will learn about some of the practical considerations that must be taken into account when applying these theories and models.

6.0 TUTOR-MARKED ASSIGNMENTS

i. You have been asked to develop a programme to promote condom use in your community. Use the characteristics of innovations from the diffusion of innovation

theory to help you to decide on factors that might be associated with a greater chance of success.

ii. What key messages and planning steps would you need if you were responsible for the implementation of a new immunization programme? Take account of the individual health behaviour change models, the diffusion of innovations through communities and the attention to communication. Think either of introducing a new immunization in high-income countries and bear in mind the concerns that have been brought to the fore with the issues over MMR (measles, mumps and rubella) vaccine, or introducing a previously unavailable vaccine in a low-income country.

iii. While you may have considered the roles of organizations in your plan, is there anything you would add now having considered the model of organizational change?

iv. How much more complex would it be if you were aiming to change long-term socially determined behaviours rather than some simple behaviour?

v. Consider a programme to improve the uptake of a childhood immunization. Suggest some interventions that could be implemented at the level of the individual, the community, the organization of services, and at the national level.

vi. If this model was used to shape a public education programme for HIV prevention, what beliefs would it be necessary for people to adopt so as to minimize their risk of infection?

vii. Identify three different forms of intervention that would assist individuals to move from their current stage in physical activity to the next stage.

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MODULE 2: PUBLIC HEALTH POLICY

Unit 1: Healthy Public Policy

Unit 2: Implementing Healthy Public Policy Through Partnerships

Unit 3: Working with Communities

UNIT 1: HEALTHY PUBLIC POLICY

CONTENTS

1.0 INTRODUCTION

In this unit, you will look at the development of healthy public policy which pays attention to how health is promoted through the actions of decision makers and communities outside the health care sector. You will also learn about the ongoing debates about the concept of healthy public policy.

2.0 OBJECTIVES

After working through this unit, you will be better able to:

i. explain the historical origins and modern development of the concept of healthy public policy

ii. describe the potential for advocating, developing and implementing healthy public policy

iii. identify constraints on healthy public policy and approaches to overcoming them

3.0 MAIN CONTENT

3.1 THE ORIGINS OF HEALTHY PUBLIC POLICY

Healthy public policy has its origins in the development of the 'new public health' and in the changing concepts and principles of health promotion over the last quarter of a century, which you learnt about in Units 1 and 2. As you will recall, understanding of what are the most significant influences on health has shifted with changes in the structure and organization of society and the knowledge of causes of disease. You also saw in unit 2 how the World Health Organization and some national initiatives have encouraged the development of healthy public policies over the past few decades. Their main objectives have been the promotion of lifestyles conducive to health, the prevention of disease, and the provision of rehabilitation and health services. These can be seen in the WHO Targets for *Health for All* published in 1985. There were thirty-eight targets grouped as follows:

i. Targets 1–12: Health for All; covering equity, increasing life expectancy and reducing disease

ii. Targets 13–17: Lifestyles Conducive to Health for All; including Target 13 'Developing Healthy Public Policies', which you will look at in more detail below.

iii. Targets 18–25: Producing Healthy Environments; including environment, housing and work-related risks

iv. Targets 26–31: Providing Appropriate Care; with a focus on primary care and the importance of improving the quality of services

v. Targets 32–38: Support for Health Development; covering research, information, education and training, and health technology assessment

As can be seen from this brief listing, the targets are a holistic approach to health improvement, with actions required in all sectors, and a prediction of a requirement for advanced technologies in terms of evidence, education and quality improvement.

Target 13 focused on the need to develop healthy public policies: By 1990, national policies in all Member States should ensure that legislative, administrative, and economic mechanisms provide broad intersectoral support and resources for the promotion of healthy lifestyles and ensure effective participation at all levels of such policy-making. The attainment of this target could be significantly supported by strategic health planning at cabinet level, to cover broad intersectoral issues that affect lifestyle and health, the periodic assessment of existing policies in their relationship to health, and the establishment of effective machinery for public involvement in policy planning and development.

Developments in the definition and understanding of health promotion, as one of the key vehicles to implement the *Health for All* 2000 (WHO, 1981) strategy, and healthy public policy were moving hand in hand. This is significant in that it underscores the principles and values of the practice of health promotion embedded in Health for All 2000. The WHO (1984) document on concepts and principles and the Ottawa Charter (WHO, 1986) provide the foundation stones for the approach to healthy public policy. The principles of health promotion were defined by the World Health Organization as:

i. involving the population as a whole in the context of their everyday life rather than focusing on people at risk for specific disease
ii. directed towards action on the determinants of health, requiring cooperation between sectors and government
iii. combining diverse but complementary approaches, including individual communication and education, legislation, fiscal measures, and organizational and community development
iv. effective community participation
v. involvement of health professionals, particularly in primary health care. Although directing action away from health care, health care professionals were not to be 'let off the hook' in terms of their responsibilities

3.2 CRITIQUES AND DEFENCE OF HEALTHY PUBLIC POLICY

There has been some debate about the meaning of 'healthy public policy' versus 'health promotion policy' – this really depends on whether the term 'health promotion' is being used as the goal of health improvement (in which case they are synonymous) or as the term for a field of endeavour (in which case health promotion policy is more limited to the practice and delivery of health promotion programmes).

Some of the dilemmas inherent in the whole approach to healthy public policy have been presciently stated and it is worth reflecting on the directions that have been taken since in the field of health promotion and whether these dilemmas are still relevant in current practice.

The political and moral dilemmas associated with health promotion, as stated by

WHO (1984), included:

i. the rise of 'healthism' – the ideology that health is the ultimate goal of all life, not the means to a fulfilled and quality life

ii. individual responsibility for health and the rise of 'victim blaming' rather than action on social and economic conditions

iii. increases in social and health inequalities as a result of health promotion initiatives being inaccessible to those very sections of the population most disadvantaged

iv. the professionalization of health promotion – making it a field of specialization to the exclusion of other professionals and lay people.

The extract from Targets for Health for All (WHO, 1985) that follows outlines many of the practical aspects that need to be taken into consideration in the implementation of healthy public policy. It is recognition of these techniques that characterizes the practice of health promotion. Although this is now 20 years old, the themes and issues are still pertinent today in the practice of multi-sectoral (partnership) working, which is the bedrock of healthy public policy.

3.3 PRIORITIES FOR THE DEVELOPMENT OF POLICIES IN HEALTH PROMOTION

Health promotion stands for the collective effort to attain health. Governments, through public policy, have a special responsibility to ensure basic conditions for a healthy life and for making the healthier choices the easier choices. At the same time supporters of health promotion within governments need to be aware of the role of spontaneous action for health, i.e. the role of social movements, self-help and self-care, and the need for continuous cooperation with the public on all health promotion issues.

1. The concept and meaning of 'health promotion' should be clarified at every level of planning, emphasising a social, economic and ecological, rather than purely physical and mental perspective on health. Policy development in health promotion can then be related and integrated with policy in other sectors such as work, housing, social services and primary health care.

2. Political commitment to health promotion can be expressed through the establishment of focal points for health promotion at all levels – local, regional and national. These would be organisational mechanisms for intersectoral co-ordinated planning in health promotion. They should provide leadership and accountability so that, when action is agreed, progress will be secured. Adequate funding and skilled personnel are essential to allow the development of systematic long-term programmes in health promotion.

3. In the development of health promotion policies there must be continuous consultation, dialogue and exchange of ideas between individuals and groups, both lay and professional. Policy mechanisms must be established to ensure opportunities for the expression and development of public interest in health.

4. When selecting priority areas for policy development a review should be made of: Indicators of health and their distribution in the population. Current knowledge, skills and health practices of the population. Current policies in government and other sectors. Further an assessment should be made of the following:

i. The expected impact on health of different policies and programmes

ii. The economic constraints and benefits

iii. The social and cultural acceptability

iv. The political feasibility of different options

5. Research support is essential for policy development and evaluation to provide an understanding. When selecting priority areas for policy development a review should be made of:

i. Indicators of health and their distribution in the population

ii. Current knowledge, skills and health practices of the population

iii. Current policies in government and other sectors

6. *Research support is essential for policy development and evaluation* to provide an understanding of influences on health and their development, as well as an assessment of the impact of different initiatives in health promotion. There is a need to develop methodologies for research and analysis, in particular, to devise more appropriate approaches to evaluation. The results of research should be disseminated widely and comparisons made within and between nations.

In developing integrated policy through partnerships, several skills are necessary: understanding of the balance of interests at play and high levels of negotiation and communication skills.

The Ottawa Charter (WHO, 1986) reinforced the view that health promoters should concern themselves with policy change, by placing the goal to build public policies which support health at the top of its list of actions to support the implementation of Health for All 2000. And the Adelaide Recommendations (WHO, 1988) consolidated the thinking of how to achieve changes in healthy public policy.

In addition to building on the principles and values already outlined, it highlighted four key action areas: supporting the health of women, food and nutrition, tobacco and alcohol, and creating supportive environments. It firmly reinforced the need for intersectoral working and introduced (somewhat tentatively), the term ‘partnerships’:

‘The most fundamental challenge for individual nations and international agencies in achieving healthy public policy is to encourage collaboration (or developing partnerships) in peace, human rights and social justice, ecology and sustainable development around the globe’.

Self-assessment

i. While reading the extract, make notes as to which issues are still relevant or indeed are still underdeveloped in your country.
ii. From what you learnt in earlier chapters, suggest the four components of an effective policy to improve the health of the public.

4.0 CONCLUSION

In this unit you have learned about the development of healthy public policy which pays attention to how health is promoted through the actions of decision makers and communities outside the health care sector. You have also learned about the ongoing debates about the concept of healthy public policy and the priorities for the development of health promotion policies.

5.0 SUMMARY

You have revised the historical development of health promotion (previously discussed in Units 1 and 2) and the emergence of the concept of healthy public policy in the 1980s. You saw how national and international organizations, most notably WHO, have developed the concept of healthy public policy through a series of pronouncements and charters since 1977 and the ongoing discussions in the context of millennium developmental goals (MDGs) and Sustainable Developmental Goals (SDGs). In the next Unit, you will learn how healthy public policies can be implemented.

6.0 TUTORED-MARKED ASSIGNMENTS

Take a health issue such as tobacco, alcohol or obesity that is of interest to you and answer the following questions:

1. Which sectors in society and government (local or national) are involved?

2. Identify five or six main influences on your issue, and note for each whether they are a barrier to change or an enabler, and who is involved.

3. Are there conflicts of interest between different parties on your list?

4. Who would the key individuals be if you wanted to bring them together to explore the issue?

5. What would you like to see change and how could you present your goals as achievable and desirable?5

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UNIT 2: IMPLEMENTING HEALTHY PUBLIC POLICY THROUGH PARTNERSHIPS

CONTENTS

1.0 INTRODUCTION

In this unit, you will learn how people's needs do not fit neatly within a single agency's responsibilities. Needs are sometimes complex and partnerships are the best way of putting together new and better solutions. Such partnerships may be based around an issue (such as teenage pregnancy), a target group (such as young men), a locality (such as a housing estate), or a statutory authority (local council or health district).

2.0 OBJECTIVES

By the end of this chapter, you will be better able to:

i. describe how partnerships and inter-sectoral working can be implemented
ii. explain the constraints on inter-sectoral partnerships

3.0 MAIN CONTENT

3.1 INTER-SECTORAL PARTNERSHIPS

Partnerships do not just happen and they do not always run smoothly. Few workers at any level have had a great deal of experience in multi-sectoral working. This brings its own challenges of understanding others' points of view, compromise and conflict resolution. Experience of working in partnerships has demonstrated that there are key factors or characteristics that make a partnership effective. The following extract is taken from *The Working Partnership* (Markwell *et al.*, 2003) – an assessment and development tool produced after extensive European research and testing.

3.1.1 Effective Partnerships

Partnerships come in all shapes, sizes and structures. There are no unique models for successful partnerships. Different kinds of partnerships will be effective under different conditions, according to local needs and circumstances, but there are factors that are common to all successful partnerships.

A growing body of evidence from inter-agency and collaborative practice has led to improved understanding of the factors that make partnerships more effective. Analysis of effective partnership working (Audit Commission, 1998; Pratt et al., 1998) show that these factors are centred on the following elements:

i. Leadership and vision – the management and development of a shared, realistic vision for the partnership's work through the creation of common goals. Effective leadership is demonstrated by influencing, communicating with and motivating others, so that responsibility for decision-making is shared between partners.

ii. Organisation and involvement – the participation of all key local players and, particularly the involvement of communities as equal partners. Not everyone can make the same contribution. Most voluntary organisations are small and locally based, with few staff. They may need resources and time to enable them to become fully engaged.

iii. Strategy development and co-ordination – the development of a clear, community focussed strategy covering the full range of issues supported by relevant policies, plans, objectives, targets, delivery mechanisms and processes.

iv. Development of local priorities for action will rely on the assessment of local needs, sharing of data, and a continuing dialogue between partners.

v. Learning and development – effective partnerships will not only invest in shared objectives and joint outcomes, but will also add value through secondments and other opportunities to share learning and contribute to professional and organisational development in partner organisations. Willingness to listen and learn from each other builds trust.

vi. Resources – the contribution and shared utilisation of information, financial, human and technical resources. The new freedoms to pool budgets and to provide integrated services for example between primary care and social services, can remove some of the traditional barriers to joint working. Cooperation can start by resourcing what everyone wants, for example IT skills training.

vii. Evaluation and review – assessing the quality of the partnership process and measuring progress towards meeting objectives. Partnerships need to demonstrate that they are making a difference and that meetings are more than just talking

shops. They must also be able to show that they are making real improvements to services.

Central government has an important role in driving change but partnerships also need the flexibility to reflect local circumstances and resources. It is easy to underestimate the challenges of working together. Partnerships must establish legitimacy in the eyes of local people and enable voluntary sector, community and user groups to participate fully. They must also engage middle managers and frontline staff within statutory agencies. Partnerships must also devise effective cross-organisational arrangements that can cope with multiple lines of accountability to produce genuine collaborative working. They also need to generate meaningful yet realistic targets for change, and to demonstrate achievements and improvements.

These are formidable challenges that will require long-term commitment. There are a number of barriers to overcome in getting a range of agencies and groups with different responsibilities, structures, systems and cultures to collaborate. Some partnerships, particularly those with a history of working together, may find it easier than others to develop a sustained partnership capable of addressing some of these more complex, longer-term issues. Sustained partnerships take time and demand considerable skills from individuals and organisations. It is one thing to set up partnerships to join things up. It is another to develop the mix of skills, energy and commitment to make partnerships effective.

3.2 KEY ELEMENTS FOR SUCCESSFUL PARTNERSHIP

The following are the list of key elements for successful partnership. These are presented with a series of detailed questions for partnership teams to use to assess and improve their ways of working:

1. ***Leadership***

Effective leadership involves attention to:

- **i.** developing and communicating a shared *vision*
- **ii.** embodying and promoting ownership of and *commitment* to the partnership and its goals
- **iii.** being alert to factors and *relationships* in the external environment that might affect the partnership

2. ***Organization***

Clear and effective systems are need for:

- **i.** public *participation* in partnership processes and decision making
- **ii.** *flexibility* in working arrangements
- **iii.** transparent and effective *management* of the partnership
- **iv.** *communication* in ways and at times that can be easily understood, interpreted and acted upon

3. ***Strategy***

The partnership needs to implement its mission and vision via a clear strategy informed by local communities and other stakeholders which focuses on:

- **i.** *strategic development* to agree priorities and define outcome targets
- **ii.** sharing *information and evaluation* of progress and achievements
- **iii.** a continuous process of *action and review*

4. ***Learning***

Partner organizations need to attract, manage and develop people to release their full knowledge and potential by:

i. *valuing people* as a primary resource

ii. development and application of *knowledge and skills*

iii. supporting *innovation*

5. Resources

The contribution and shared utilization of resources, including

i. building and strengthening *social capital*

ii. managing and pooling *financial resources*

iii. making *information* work

iv. using information and communication *technology* appropriately

6. Programmes

Partners seek to develop coordinated programmes and integrated services that fit together well. This requires attention to:

i. realizing added value from joint *planning*

ii. focused *delivery*

iii. regular *monitoring* and review

3.3 HEALTHY PUBLIC POLICY IN THE TWENTY-FIRST CENTURY

While the enthusiastic advocates of health promotion in the 1980s seemed to have solutions to solve the world's problems, health promoters still need to convince others outside the field of health promotion. There has been substantial progress towards an understanding of healthy public policy in countries around the world, even if it is not fully implemented. To some extent, in some countries it has become almost the norm. Policies are to a large extent integrated or at least aligned and are focused on reducing inequity. The rising cost of health care coupled with the increased demands from an ageing society with increasing expectations has encouraged governments to see the necessity of focusing on health.

In the UK, for example, action on inequalities and inter-sectoral working has been placed centrally and partnerships, principally between health and local authorities, have become necessary parts of the public sector delivery system. Actions and indicators of progress across government departments focus on four areas: supporting families, mothers and children; engaging communities and individuals; preventing illness and providing effective treatment and care; and addressing the underlying determinants of health. A new target for a reduction in inequalities in health (which had been rising since the 1970s) was set to reduce inequalities in infant mortality and life expectancy at birth by 10 per cent by 2010. However, public health policy may yet put the emphasis back on individual responsibility and health care but at least there is greater cross-government understanding, some shifting of resources and significant changes throughout the health system.

In France, the High Committee on Public Health (2003) set out a detailed framework for action to control the increasing cost of health care. The Committee stated that health policy needs to cover three levels: (1) at the level of factors that determine health in order to promote good health; (2) to ensure top quality care is available when needed; and (3) rehabilitation. The authors state: 'Although this holistic idea is sometimes alluded to in an abstract fashion in France, rarely is anything concrete done about it. Resources and attention are massively concentrated at the second level of attention i.e. care and treatment. Ever since the end of the Second World War, policy has focussed on improving access to health care rather than improving health'. So while this system is at an early stage of developing healthy public policy, the understanding and evidence are growing. Sweden has taken it a stage further than most countries. The Swedish National Institute for Public Health announced aims to create the conditions for good health on equal terms for the entire population (Agren, 2003). The new Public Health Policy aims to create the conditions for good health on equal terms for the entire population, recognizing that politicians cannot prevent deaths and illness, but can influence what lies behind. In Nigeria, the National Health Policy of the year 2016 and National Health

Promotion Policy of 2006 by Federal Ministry of Health are part of successful public health policies.

4.0 CONCLUSION

The unit has described inter-sectoral partnerships, key elements for successful partnership and healthy public policy in the twenty-first century. Also, in this unit, you had learned how people's needs do not fit neatly within a single agency's responsibilities. Needs are sometimes complex and partnerships are the best way of putting together new and better solutions. Such partnerships may be based around an issue (such as teenage pregnancy), a target group (such as young men), a locality (such as a housing estate), or a statutory authority (local council or health district).

5.0 SUMMARY

You have learned about healthy public policy and how health promotion needs to be involved in the policy process both within and beyond the health sector. Healthy public policy is important for health promotion because so many of the factors that influence health lie outside the remit of the health sector or individuals' behaviour. Inter-sectoral (partnership) working is fundamental to achieving integrated healthy public policy.

6.0 TUTOR-MARKED ASSIGNMENT

i. What do you think might be the main obstacles to inter-sectoral partnerships?
ii. How would you organize a partnership to address the issue you described? Who would be on it and why? In the role of convenor, how would you organize the first few meetings? What would be the important things to do first?

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UNIT 3: WORKING WITH COMMUNITIES

CONTENTS

1.0 INTRODUCTION

As you will have already seen, community participation is a central tenet of the Health for All strategy and the Ottawa Charter, and a defining principle of health promotion. While health promotion can and does act on individuals, what distinguishes it from individual preventive care is a focus on creating the conditions for change in individuals and groups at the community level. In this chapter, you will explore the ways in which health promoters work with communities to improve their health. You will look at the definitions of the concepts of community, community participation, empowerment,

community development and social capital and briefly examine some of the methods and approaches to working successfully with communities.

2.0 OBJECTIVES

After working through this unit, you will be better able to:

i. understand key concepts, principles and the history of community development in health
ii. describe practical approaches to working with communities and issues of evaluating community development work
iii. appreciate the differing perspectives and constraints on working with communities, both from the view point of community members and professionals

3.0 MAIN CONTENT

3.1 CONCEPT OF A COMMUNITY

Although the meaning of community may appear self-evident, it is a concept that has defied simple definition. The most obvious type of community is one defined by geography, a district in a town, an estate or neighbourhood, or a school but such a community is not homogeneous. It consists of people of different ages, ethnicities, interests and aspirations. So, community can also be defined by interest group, health and social need, political views, and so on. Laverack (2004) identifies four key characteristics of community:

i. a spatial dimension, i.e. a place or locale
ii. non-spatial dimensions (interests, issues, identities) that involve people who otherwise make up heterogeneous and disparate groups

iii. social interactions that are dynamic and bind people into relationships with one another

iv. identification of shared needs and concerns that can be achieved through a process of collective action.

As you look more at the principles of working with communities, you will see that some of the key issues relate to notions of power and control in the relationship between community members and professionals planning and providing services for them. Thus in working with communities, an understanding of who the community comprises and why they have a common or shared need is essential. So too is the recognition that communities can only define themselves. So people 'belong' to a number of different communities at any one time and define their 'membership' themselves. A single community, although sharing many attributes, is not homogeneous.

3.2 COMMUNITY DEVELOPMENT

Community development seeks to bring about change locally, regionally and nationally. People differ on the definition of community development and the term is constantly under review. There are, however, some essential baselines. Community development is not just about what happens in neighbourhoods and interest groups: it is also concerned with how organisations and agencies respond to community issues and how they support local initiatives. One way of defining community development is to set out its goals. These are: to combat social exclusion; to promote participation; and to encourage people to acquire new skills.

The Standing Conference for Community Development's (SCCD 2001) framework for community development summarised some of the core values and commitments of community development and provides a useful basis to work from. The SCCD stated: 'Community development is about building active and sustainable communities based on

social justice and mutual respect. It is about changing power structures to remove the barriers that prevent people from participating in the issues that affect their lives. Community workers support individuals, groups and organisations in this process on the basis of the following values and commitments:

1. **Values**

i. Social justice: enabling people to claim their human rights, meet their needs and have greater control over the decision-making processes that affect their lives.

ii. Participation: facilitating democratic involvement by people in the issues which affect their lives based on full citizenship, autonomy and shared power, skills, knowledge and experience.

iii. Equality: challenging the attitudes of individuals and the practices of institutions and society, which discriminate against, and marginalise, people.

iv. Learning: recognising the skills, knowledge and expertise that people contribute and develop by taking action to tackle social, economic, political and environmental problems.

v. Cooperation: working together to identify and implement action, based on mutual respect of diverse cultures and contributions.

2. **Commitments**

i. Challenging discrimination and oppressive practices within organisations, institutions and communities.

ii. Developing practice and policy that protects the environment.

iii. Encouraging networking and connections between communities and organisations.

iv. Ensuring access and choice for all groups and individuals within society.

v. Influencing policy and programmes from the perspective of communities.

vi. Prioritising the issues of concern to people experiencing poverty and social exclusion.

vii. Promoting social change that is long-term and sustainable.

viii. Reversing inequality and the imbalance of power relationships in society.

ix. Supporting community-led collective action.

3.2.1 Principles for Involving the Public

These are described by Crowley (2000). They include:

i. The community is an asset and part of the solution, not the problem.

ii. Community representatives need support to link to the wider community and their input must be accountable to the local community.

iii. Any approach must involve marginalized minority groups – people with sensory or physical disability, gay men and lesbians, minority ethnic groups, etc.

iv. Financial support is necessary to ensure access – for a crèche, carer support, interpretation (including sign language, translation, audiotapes, etc.).

v. Community participation strategies are required where the community can setthe agenda and raise issues that are of concern to them.

vi. To involve the public, statutory bodies need to be developed so that they are responsive to the community's view.

vii. The process is important because if the community does not see some results from their voluntary involvement, they will lose interest.

viii. If meetings include local people they must be conducted in a way as to ensure their participation, such as by avoiding jargon.

3.3 EMPOWERMENT

The concept of empowerment is embodied in the Ottawa Charter in the phrase 'enabling people to take control over and to improve their health' (WHO, 1986). There are (at least) two rather differing perspectives on empowerment that influence health promotion practice today: the critical consciousness raising perspective of Freire (1972) and the psychological construct of self-efficacy (Bandura, 1977). Freire, working in Brazil in the

1950s and 1960s, sought through education to liberate people from the oppression of poverty and their associated helplessness to change the circumstances of their lives. The process of critical consciousness raising 'refers to learning to perceive social, political, and economic contradictions and to take action against the oppressive elements of reality' (Freire, 1972). It is inextricably related to notions of sharing power, as Freire puts it, carrying out transformations with the oppressed rather than *for* them. Freire's work has been influential in health education theory as it is centred around the acquisition of information and knowledge to bring about change and emphasizes the power of collective social action. Self-efficacy relates to individuals' self-perceptions of their competence at performing particular activities (Bandura, 1977). It differs from self-esteem, which is a rather more global concept of feelings of self-worth, in that self-efficacy is situation specific. Individuals can feel control or mastery over certain behaviours, while avoiding activities that they feel exceed their coping capacities.

Community development approaches have the potential to both empower through raising individuals' beliefs in their own capabilities either to make personal behaviour changes or to participate more fully in collective activities (such as having the confidence to speak up at meetings, for example) and through working with groups to achieve social change by advocacy and facilitating engagement with decision makers. The Building Blocks of Community Development (Barr and Hashagen,2000) include personal empowerment, community organizing and positive action as key elements of community empowerment. In the descriptions of workers' responsibilities, the roles of promoting confidence, skills, knowledge and consciousness in those who take part in group activities and action all result in individual and community empowerment.

3.4 COMMUNITY PARTICIPATION AND WAYS OF WORKING WITH COMMUNITIES

Community participation is used sometimes interchangeably with community development. In fact, it is a more general term and can be used to describe different forms

and degrees of involvement, which are usually considered to relate to different levels of sharing power between communities and decision makers.

While climbing up the ladder has been considered the goal of increasing degrees of empowerment and control, it must be remembered that not all communities, or individuals within a community, wish to have total control, or even significant responsibility. For some aspects of working with communities, simply provision of information may be appropriate, or working in mutually respectful partnerships of community members and professionals. At all times, the key issues are: What is the purpose of the work? To what extent do the community want to be involved? Are those who are engaged in activities actually representing the community, or engaging in their own personal desire for increased power, perhaps resulting in the further exclusion of marginalized groups? What are the goals of the health and social workers and is their style of working empowering?

Henderson *et al.* (2004) provide some practical details and exercises to enable workers to profile their community and understand its perceived needs and assets. They emphasize the importance of looking at its strengths and resources – that is, its social capital. A review of the research literature on participatory approaches in health promotion and health planning showed that the two most common methods used are participatory action research and rapid appraisals (Rifkin *et al.*,2000). Participatory action research, which has its origins in the work of Freire, involves all those concerned with the research outcomes (that is, researchers, professional and community members) participating equally at all stages in the planning, information collection and interpretation of results. Rapid appraisals have more recently become popular in the health and development fields. The features of both are similar but rapid appraisals are more usually done to inform planning and service issues.

3.5 GOOD PRACTICE GUIDELINES

Have a look at the good practice guidelines below about the best ways to involve the community in health. This comes from a review of over 200 community participation projects in England in the late 1990s, working with diverse communities on a wide range of health issues. This provides a clear and practical checklist of actions for working with communities that reflects all that has been learnt from work on empowerment, social action and community development.

The main good practice issues are grouped under five main headings (Hill et al., 2011)

1. ***Clear and realistic role and remit***

Good practice requires:

- **i.** projects to work within a wide definition of health and to establish health as an important community issue
- **ii.** clarity and consensus about participatory principles and values and their implications
- **iii.** community participation at all stages of a project's development and work
- **iv.** changes in the culture and ways of working of the statutory sector
- **v.** a realistic remit for community projects and initiatives based on the time and resources available and the needs and history of the community/users the project is working with
- **vi.** respect for, and acceptance of, minority/different needs and the need for mainstream as well as specific project work

2. ***Adequate and appropriate resources to meet the project remit***

Good practice requires:

- **i.** secure, adequate and long-term funding
- **ii.** accessible and appropriate premises

iii. an experienced, long-term team with community development skills

iv. reliable, committed and properly supported volunteers/activists

3. Adequate and appropriate management and evaluation to support the project

Good practice requires:

i. effective and supportive project management (be it through a management committee or line management model) by people with appropriate time, skills and experience

ii. clearly defined structural arrangements between projects and key agencies to avoid too much reliance on individuals and to ensure clear pathways for feeding in community needs and concerns

iii. community involvement in project management and decision making

iv. appropriate and adequate monitoring and evaluation to inform project planning and development in ongoing ways

4. Recognition of the importance of the wider environment within which projects operate

Good practice requires:

i. building on the past history and experience of communities and local agencies and developing new projects within that context

ii. harnessing the political support of local politicians and linking projects to new national policy openings endorsing community participation

iii. effective inter-agency/sector links and partnership working at both local and district/city-wide levels

5. Building in long-term sustainability

Good practice requires:

i. linking community health projects into the wide and variable agendas for change that are emerging in the health and social policy fields
ii. projects being able to show real changes/gains they have achieved and to promote these to communities, funders and agencies
iii. building community capacity in terms of skills, information access points, networks and groups
iv. organization development to ensure local agencies and professionals have the skills, knowledge and commitment to support the effectiveness of local community participation work, build community needs and views into their planning, policy and priority setting and to respond appropriately to community identified
v. seeing sustainability as an integral part of project work, not a final stage

4.0 CONCLUSION

This unit discussed the concept of community, community development, empowerment, community participation, ways of working with community and guidelines for good practice of health promotion and education. Community participation is a central tenet of the Health for All strategy and the Ottawa Charter, and a defining principle of health promotion. While health promotion can and does act on individuals, what distinguishes it from individual preventive care is a focus on creating the conditions for change in individuals and groups at the community level.

5.0 SUMMARY

You have learnt about different concepts of 'community' and of community development as an approach to promote public health. You then saw how three particular concepts

empowerment, community participation, and social capital have been proposed to explain the way communities may have an impact on people's health. Finally, you learnt about ways of working effectively with communities**.**

6.0 TUTOR-MARKED ASSIGNMENTS

While reading it, note the different perspectives from different sectors or professional groups as regards:

i. their ideas of power and control over people and life circumstances;
ii. the drive for social change; and
iii. the different types of participation that it encompasses.

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MODULE 3: HEALTH PROMOTION INTERVENTION

Unit 1: Risk Management, Perception and Communication in Health Care

Unit 2: Application of Models of Behaviour Change

Unit 3: Planning and Evaluation of Health Promotion Intervention

UNIT 1: RISK MANAGEMENT, PERCEPTION AND COMMUNICATION IN HEALTH CARE

CONTENTS

1.0 INTRODUCTION

In this unit, you will learn about a definition of risk followed by a framework for the management of risk, and an overview of risk perception and the cognitive pitfalls present when dealing with risk. It closes with a discussion of risk communication.

2.0 OBJECTIVES

By the end of this unit, you will be able to:

i. deconstruct risk into its main components
ii. apply management techniques to mitigate the risk
iii. plan how to prepare for risk situations
iv. design strategies on how to communicate in risk situations

3.0 MAIN CONTENT

3.1 RISK AND RISK MANAGEMENT

'*The real world isn't predictable. Should we consider everything that can happen?*' (McGilchrist, 2012).

Many situations in health promotion can be seen as an example of decision making in the presence of high risk, involving imperfect information as well as personal preferences, which, at times, can be regarded as inconsistent with rational behaviour.

While all of us talk about risk, few of us have a concise understanding of the concept. So, what is risk?

Risk consists of two parts: an undesirable outcome and the probability of its occurrence. Both have to be seen together, though often the focus is exclusively on outcome, while probability is ignored. The reason for this can be attributed to the generally low probabilities involved. People have cognitive problems in understanding low probabilities, due to a general lack of training in probability theory. For example, try to

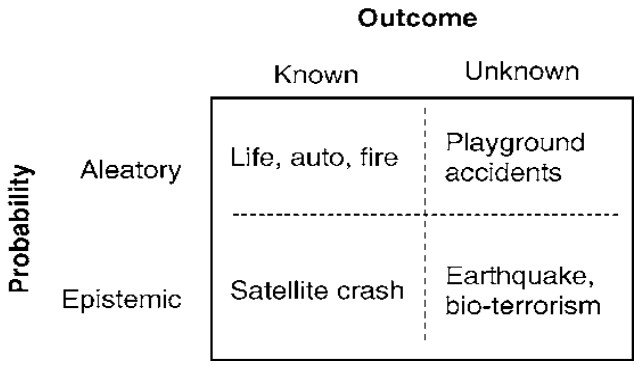
explain the difference between a probability of 0.01% and 0.001%. Furthermore, often the (unwanted) outcomes cannot be clearly identified.

This frequently results in highly uncomfortable situations, both for patients and health care professionals. What is the right course of action?

Let's take a closer look at the two ingredients of risk: undesirable outcomes and uncertainty. Outcomes can be known or unknown; for example, you know that the undesirable outcome of smoking can be lung cancer. On the other hand, in the case of new diseases (such as AIDS in the early 1980s), you may not know what the possible outcomes are.

Similarly, uncertainty can be classified as *aleatory* and *epistemic*. Aleatory uncertainty is the result of a known random process, meaning that you have a fairly good knowledge of the underlying probability distribution. This enables you to state, for instance, that the probability of the unwanted outcome follows a normal distribution. It also permits us to analyse the decision problem at a fairly detailed quantitative level. In the case of epistemic uncertainty, you are faced with a lack of knowledge. You don't know much about the probability distribution and thus it is difficult to perform a valid analysis of the situation.

Given these two dimensions of probability and outcome, you can distinguish between four cases, shown in the risk classification matrix (Figure 11.1). Depending on where you are located in the risk classification matrix, the risk analysis can be



The risk classification matrix

Source: Kunreuther (2002)

more or less challenging and call for different tools. In the case of a well-known aleatory risk, with known outcomes, you can use tools such as decision analysis to do a detailed evaluation of the decision problem at hand. For problems in other cells of the risk classification matrix, the analysis will generally be more complex and involve other analysis tools (Paté-Cornell and Murphy, 1996). Risk management can be thought of as going through five steps: identification, analysis, evaluation of actions, implementations and documentation. The first step in risk management is eliciting probable risks. If you were a health official in Toronto in 2003, when China was suffering the first cases of SARS, and you envisioned that some infected patients could travel from Lagos to Sokoto, you would have already completed the first important step in managing the corresponding risk and could proceed to Step 2, namely, analysing impact and probability.

When analysing risk, you have to make a clear distinction between good decisions and good outcomes. Unfortunately, the public often confounds the two, particularly in the area of public health. In the example above, a bad decision would be the choice of implementing programme A or programme B *without* previous analysis. A good decision would require a detailed analysis, followed by a value judgement and a choice of programme A or programme B. In the presence of uncertainty, the *outcome* of your

decision cannot be influenced by you that is, your decision to implement programme B does not change the probability of p=1/3 of saving 600 people.

But due to our previous analysis, you are able to make an *informed* decision, and thus a good decision. You also have to clearly distinguish between the risk analysis (which can be made by anybody with experience in the field) and the value judgement, which is reserved for the decision maker (e.g. patient, doctor, health official), based on the previous analysis and her set of preferences. It is very important to realize that different people have different risk profiles. That is, the same risk does not mean the same thing to different people; some are more risk-averse, others risk-prone. For example, participating in an experimental drug trial will not be acceptable to a healthy person, while patients with the particular illness to be treated by that drug might exhibit a different preference profile. A curious phenomenon is often present: individuals are risk-seeking when choosing between two losing options but risk-averse when choosing between winning options.

The example shown is a case in point. After having done a detailed risk analysis of the decision problem, the decision analyst and decision maker have come up with the decision tree shown. The analysis of the problem reveals that from the perspective of pure probability theory, alternatives A and B are equivalent in their expected outcomes, as both have an expected value of people saved equal to 200. This addresses the second point, the value judgement. The risk analysis should never be accepted at face value; it needs to be followed by the decision maker's value judgement.

Another important element of the risk assessment health that officials must be aware of is how the risk and the situation are being perceived by the public. There is ample scientific evidence that usually the mapping between actual risks and perceived risks is not congruent. This is primarily due to the cognitive inefficiencies of individuals and people's inability to judge (small) probabilities. Furthermore, a number of psychological effects are involved, leading to misperceptions of risk. Among them, you can list

voluntary vs. coerced (e.g. working in a nuclear plant vs. living in a nearby village), natural vs. industrial (e.g. sun radiation vs. telephone antennas), familiar vs. not familiar (car driving vs. canoeing), not dreaded vs. dreaded (high blood pressure vs. cancer), chronic vs. catastrophic (car accidents vs. airplane accidents), fair vs. unfair (riding a motorcycle at high speed vs. a pedestrian being hit by the same motorcycle), and so on. Perceived risk is also influenced by imaginability and memorability of hazard (terrorist threats).

Since the late 1970s, a number of publications in scientific journals have dealt with the topic of risk perception. Slovic *et al.* (1979) give comprehensive accounts of a series of studies. Based on the evidence presented, the authors drew the conclusion that there are statistically significant differences in the judgements of risk between experts and lay persons, while expert judgements are closer to the truth than those of the public. Additionally, they noted significant differences between perceived risks and actual risks, as can be seen in Figure 3. Here the public's estimates for causes of death are heavily influenced by current issues and less by rational thought.

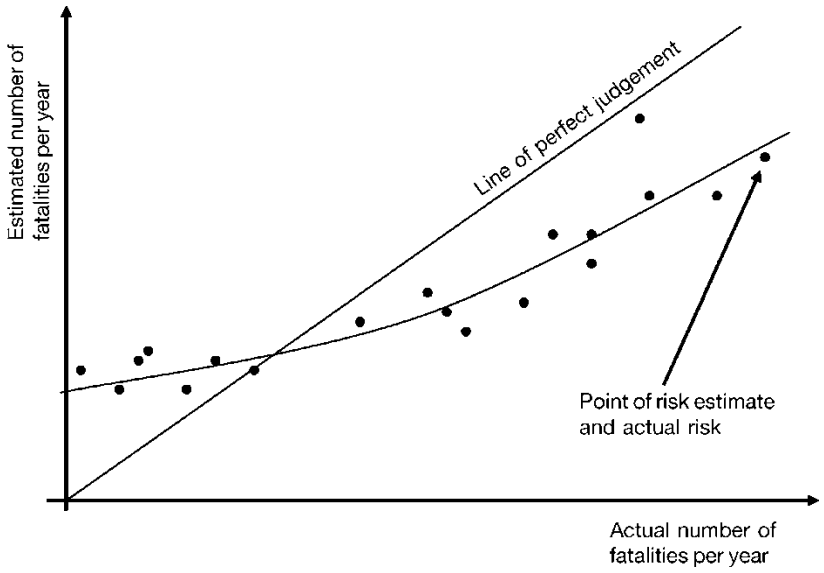


Figure 3 Risk perception of the public

Source: Slovic*et al.* (1979)

Research also showed that risks are put into a different order by different groups (e.g. students vs. experts). Perhaps more disturbing is the fact that disagreements about risks cannot be expected to evaporate in the presence of evidence (which often cannot be obtained). This different judgement of risk further complicates the efforts of health policy makers and professionals. Some guidance has been developed by the World Health Organization (Paté-Cornell, 1996).

Once a risk has been analysed, you can move to Step 3, defining risk mitigation measures: to lower the probability of unwanted outcomes or decrease their magnitude.

The Harvard Medical Practice Study concluded that 'Most medical errors are due to system errors and organizational deficits' (Leape*et al.*, 1991). This emphasizes the importance of organizational awareness in risk mitigation. Unlike the technical side, organizational mitigation often comes at a lower cost (but may encounter resistance from within the organization) and should therefore always be an option to be considered. Here, the health care sector has still a lot to learn from other sectors.

Now having determined what to do, you can progress to Step 4, which consists of implementing the activities, assigning responsibilities in the implementation and ensuring supervision of its evolution. Finally, Step 5 creates and maintains the proper documentation about the decision process, the assumptions made, and the outcomes achieved, and provides the primary source for learning and improving.

3.2 RISK COMMUNICATION

Besides risk assessment and development of control actions as described above, there is another area in risk management that becomes critical when a crisis has already occurred involving numerous stakeholders: communicating risk to them. Risk communication is very different from risk analysis in the sense that the public tend to focus on outrage and pay less attention to hazard. You will learn about two important issues related to risk

communication: the dilemmas involved in any communication decision and the use of message maps to convey the desired information to stakeholders.

3.2.1 Communication Dilemmas

When organizations face a crisis with a high degree of uncertainty, communication is difficult because how the situation may evolve and how the public will react to the messages are unknown. In this uncertainty, it is hard to decide what information to reveal or to withhold, whether to speculate or not, and so on. Every crisis is different but at the same time many crises are similar, and one of the similarities is that all crises pose pretty much the same dilemmas of communication policy. Crisis experts suggest that institutions should prepare for generic crises before they happen (Mitroff and Anagnos, 2000). These generic crises may include: economic (the sudden collapse of a currency), physical (destruction of a piece of equipment), those related to psychopathic behaviour (product alteration in the market), natural (earthquake), and so on.

Sandman (2002) lists ten communication dilemmas that managers must deal with when addressing communication with the general public and other stakeholders. Each dilemma can be considered in a continuum from candour, where you may decide to provide as much information as possible, to secrecy, where you may decide to hide as much information as possible. Both extremes have clear advantages. In favour of candour would be that people are at their best when collectively facing a difficult situation. The worst is when they find out that they have been misled – then things can get much more unstable, they are more likely to ignore instructions, develop paranoid hypotheses, etc. On the other hand, secrecy might be indicated if the information has not yet been checked. The fear is that people will misunderstand the right information or might panic if they know the whole truth. Another reason would be if opponents take advantage of what is said.

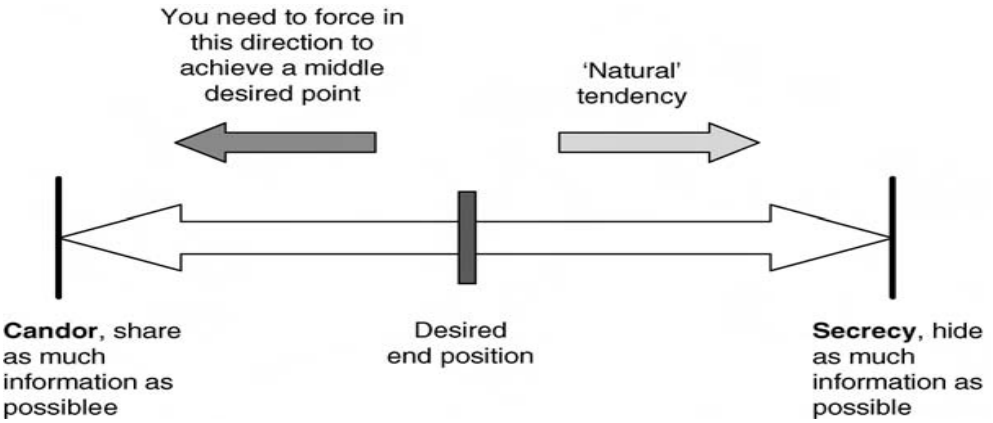


Figure 4 The dilemma continuum

Source: Scheme developed by Jaume Ribera based on Sandman (2002)

Probably the optimal approach is to strike a balance, providing enough information for the communication receiver to be able to act in a positive way, while not disclosing information that is not sufficiently checked and which could mislead the public. However, in all these dilemmas, you may have a natural tendency towards the right, so, if you wish to end up in a more moderate situation, you will probably have to pull towards the left. Becoming aware of these dilemmas is the first step towards handling them better.

3.2.2 Message Mapping

When a crisis appears, public perceptions and opinions may have as important a role in determining its resolution as executive actions do. If people do not understand the messages directed to them, they will feel irritated and will not follow further advice. On some occasions, people are outraged because they do not understand the risk, and educating the public may work, but in other cases, they do understand the risk and the irritation may be caused by the form of communication (e.g. feeling that the person in charge is withholding information, or receiving what they understand as contradictory versions from different people).

Message mapping is an important tool to assist crisis communication. It aims at achieving message clarity and conciseness and is based on developing a consensus message

platform, providing visual aids and road maps for displaying structurally organized responses to anticipated high concern issues, focused at specific stakeholder groups. These are based on widely used mind mapping tools and can be developed manually, or with computer support.

Covello (2002) proposes the following goals of message maps:

- **i.** identifying stakeholders early in the communication process
- **ii.** anticipating stakeholder questions and concerns before they are raised
- **iii.** organizing thinking and developing prepared messages in response to anticipated stakeholder questions and concerns
- **iv.** developing key messages and supporting information within a clear, concise, transparent and accessible framework
- **v.** promoting open dialogue about messages both inside and outside the organization
- **vi.** providing user-friendly guidance to spokespersons
- **vii.** ensuring that the organization has a central repository of consistent messages
- **viii.** encouraging the organization to speak with one voice

In any crisis it is very helpful to have message maps available (Figure 11.6), both because of the fact of having them and because of the learning and consensus building involved in producing them. A message map will be developed for a specific stakeholder group and for each main concern that affects this group. Therefore, the first stage in developing message maps involves the identification of stakeholder groups and eliciting or discovering their main concerns.

This process can be done in two directions, from the stakeholders to the concerns and vice versa. Some groups prefer a structured ‘top-down’ approach, first creating a list of stakeholders and then identifying the concerns that they might have.

Other groups prefer a ‘bottom-up’ approach, focusing first on the concerns brought up by the crisis and then identifying which stakeholders may be affected by them. In both cases,

what you obtain is a rather extensive list of specific stakeholders and specific concerns that need to be clustered around stakeholder groups and general concerns, in order to bring the list down to a manageable size. Possible stakeholders in a public health case may include the victims and their families, media, emergency response personnel, law enforcement agencies, hospitals and primary health centres and medical associations. The concerns of each group can be drawn from media reports, web pages of activist groups, meeting records, interviews with group representatives, reviews of complaints received, surveys and focus group meetings.

In the second stage, for each of the main stakeholders and their important concerns, you will need to develop the key messages. You can now concentrate on what they most need to know, what they most want to know and what they are most concerned with. Key messages are generally developed in brainstorming sessions with technical experts, communication specialists, legal advisors and possibly a facilitator. The objective of this phase is to create a set of key messages, addressing a concern of a stakeholder group. A key message may consist of a whole sentence or just two or three keywords, which will later be developed into full messages.

In the third stage, you will need to develop supporting facts and arguments as proof of the messages. Even though you will probably not include these in the primary message, they may be very handy if a particular message is challenged by someone in the audience. As a final stage, before the message is delivered, it is prudent to conduct some testing, presenting the messages to experts and surrogate target audiences, both internal and external.

Self-assessment

Consider a normal task that you perform often, like going from home to the video store to rent a movie. You want to watch a particular movie. Go through the first three stages of risk management. In particular:

i. Describe in detail what you plan to do to get the movie – that is, describe the different tasks, who will do them, how long do you expect them to take, etc.

ii. Identify the risks that exist in your previous plan. Try to imagine everything that could go wrong with the plan, everything that could prevent you from watching the movie tonight (focus on getting the videotape). Make a list of the risks you encountered.

iii. Evaluate the risks, by stating for each one of them its seriousness (i.e. how destructive it can be in terms of your achieving your objective) and its likelihood (i.e. how likely it is for the risk to happen). Now concentrate on the few important risks, in terms of seriousness and/or likelihood.

iv. For each of the identified risks, find possible actions that would either mitigate the impact or reduce the probability.

4.0 CONCLUSION

In this Unit, you had learned about a definition of risk followed by a framework for the management of risk, and an overview of risk perception and the cognitive pitfalls present when dealing with risk. It closes with a discussion of risk communication.

5.0 SUMMARY

You have seen how risk assessment is the process by which risks are identified and quantified and risk management is the process by which this information is used in making decisions to reduce or eliminate the risk. When there are fundamental uncertainties in a problem, there is often a tendency to resort to ‘conservative estimates’ – which then add up to a model that is far too conservative. Risk management in the public sector must address: economic efficiency and justice and equity. You have learnt how there is a lack of consistency in public decision making in the face of risk. An essential ingredient in any risk management programme is that of risk communication. When

addressing a crisis, health officials should not only consider the critical elements of risk (probability and impact) but also the outrage experienced by the population. Message mapping is an effective way to identify stakeholders early in the communication process, anticipate their questions and concerns before they are raised, and prepare key messages and supporting information within a clear, concise, transparent and accessible framework. It is also a great tool to open an internal dialogue among the professionals and to develop consensus on how to handle typical communication dilemmas.

6.0 TUTOR MARKED ASSIGNMENTS

i. Imagine that your government is preparing for the outbreak of an unusual disease which is expected to kill 600 people. Two alternative programmes to combat the disease have been proposed. Assume that the exact scientific estimate of the consequences of the programmes are as follows:

a) If programme A is adopted, 200 people will be saved.
b) If programme B is adopted, there is a 1/3 probability that 600 people will be saved, and a 2/3 probability that no people will be saved

Which programme would you choose?

ii. You have been exposed to a rare fatal disease and now face a chance of 0.001 of quick and painless death within two weeks. What percentage of the total amount you expect to earn during your lifetime would you be willing to pay to reduce this probability to 0 (e.g. by buying a new medicine)? Now assume that:

a) If programme A is adopted, 400 people will die.
b) If programme B is adopted, there is a 1/3 probability that nobody will die, and a 2/3 probability that 600 people will die.

Which programme would you choose?

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UNIT 2: APPLICATION OF MODELS OF BEHAVIOUR CHANGE

CONTENTS

1.0 INTRODUCTION

In this unit, you will consider the application of models of behaviour change as they apply to the promotion of health and the prevention of disease. You will learn about their principal strengths and weaknesses, see how to place these models and their implications within a societal framework, and learn how best to use the models in practice, in meaningful and useful ways.

2.0 OBJECTIVES

By the end of the unit, you will be able to:

i. understand the idea of applying models of behaviour change to appropriate situations in health promotion
ii. describe the strengths and weaknesses associated with modeling behaviour change
iii. consider the relationship between describing behaviour change using models and bringing about change on health behaviour in practice

iv. analyse a health promotion scenario involving health-related behavior Change

3.0 MAIN CONTENT

3.1 MODELS OF BEHAVIOUR CHANGE

There is a considerable amount of research about changing people's beliefs and attitudes about health and about changing health-damaging or promoting health-enhancing behaviours (Anderson, 1988; Kaplan *et al.*, 1993). A great deal of this research involves the use of models. As you learnt in Unit 3, a model is a schematic representation and simplification of some complex process.

There are a number of general points to make at the outset about models of behaviour change and their use in practice. Models tend to operate at fairly high levels of generality. This obviously aids simplification and understanding. On the other hand, it can make applying them to real-world situations a little tricky because real life tends to be complex and messy. As you saw earlier, models that are multi-level that is, which operate at the individual *and* social level and which take into account the needs and the characteristics of particular population groups work best. Unfortunately, the more particular the local characteristics and needs of the population, the more complex the models become and the advantages of simplicity can get lost. So in practical terms in real-life interventions, practitioners change and amend models to suit their needs. While this of course is an entirely sensible thing to do from a practical point of view, it often means that the models do not appear to work very well from a scientific point of view.

No single model or theory has been shown to be universally applicable, although many can accurately predict and describe some changes, particularly when they are focused on individual level factors.

There is a large amount of research dealing with these matters. It originally developed in the late 1940s in the USA when the first effective vaccines against poliomyelitis were

developed. In spite of the availability of an effective vaccine, the uptake was relatively low. In fact, there was an epidemic of cases in the USA after the development and availability of the vaccine. Two questions emerged from this.

What were the factors which led to this type of behaviour despite the availability of information? And, what could be done to change it? Models that have been designed to answer these questions have since been applied to all sorts of health behaviour such as the use of contraception, smoking cessation, oral health, taking exercise and alcohol misuse (Goel, Khanna, & Kishore, 2010).

3.2 EFFECTIVENESS OF MODELS

Recent reviews of the effectiveness of interventions have found that interventions using a theory-based approach – regardless of what theory they used tended to be more effective than those that did not, indicating perhaps that using a theory-based approach to plan interventions may make an intervention better planned and delivered. Models provide the basis for increased rigour in intervention design. Model-based interventions are necessarily more explicit. Exner *et al.* (1997) identify an important design component as 'having explicitly stated goals or hypotheses, with clearly operationalized outcomes'. Models require that the intervention articulates the determinants that influence behavioural and clinical outcomes and are explicit about which of these they propose to change; how they propose to change them; how they will demonstrate that change; and how, if at all, that change has contributed to a behavioural or clinical outcome.

Models also help you to know why, as well as whether, an intervention is effective, shedding light on the extent to which elements of interventions can be applied in different contexts with different populations. Different models work better in relation to some conditions or preventive actions rather than others. Approaches that can accommodate irrational behaviour and incorporate the function of wider determinants tend to cover a broader range of potential issues but to be less good when dealing with specifics and guiding interventions.

No single theory or model has universal applicability and the choice of a particular approach should depend on what the focus for change is. No single theory or model can universally predict behavioural intentions or outcomes for all populations, although many can accurately predict and describe some changes, particularly when they are focused on the individual. They tend to be less good at incorporating structural or socio-economic factors.

There are two limitations associated with these types of models: empirical and theoretical-ontological. The empirical problem is that where the models are used there is sometimes considerable variance in their predictive power. Unfortunately, it is unclear whether this is caused by poor design and method or underlying weakness in the models. Another problem is the propensity for practitioners to change components of the model to suit their needs. The reason for this is the need to ground the models in the real world and to operationalize the components in them to suit local circumstances.

It is also very important to acknowledge that notions like attitude, intention, belief and assessment of risk are much easier to talk about in the abstract than to apply to real settings and to real people.

The theoretical-ontological problem is more serious. This is about the explanatory focus on the individual to the exclusion of the social in these models and many like them. Where social factors are included in these models, they are invariably treated .as characteristics of individuals and hence as part of an individually driven explanation, rather than explanatory causes in their own right. Consequently, social structure is not dealt with adequately. It is treated as a set of individually expressed factors, not as a highly variegated pattern of social arrangements requiring their own level of analysis, irreducible to the individual. The population is not homogeneous. It is heterogeneous and its component parts respond to the same interventions in different ways. However, these models generally assume universal precepts about human behaviour or treat social differences as confounding factors in the analysis. In other words, the key differences

between social classes, men and women, ethnic groups, young and old, and residential circumstances are treated as background or contextual factors, rather than important determining factors in their own right. Different segments of the population respond in very different ways to the same intervention by virtue of their social differences and attempting to apply general principles across the whole population tend to under-emphasize the important role of social difference (Killoran and Kelly, 2004).

3.3 PRACTICAL STEPS TO INTERVENTIONS

The right direction indicated in the models needs to be given some practical substance. There are a number of aspects to this.

i. Choice of Theory or Model

The choice of theory or model to guide the intervention should be made on the basis of the problem being tackled. Multi-level approaches can be delivered by different mechanisms, so you need to think about mechanisms and media. For example, information from mass media campaigns can reach a large proportion of the population very quickly (although such campaigns may miss the very poor).

Tailored health information delivered via health professionals or others who work one to one with people, will take longer to filter through but may produce a stronger response because of its tailored and direct nature. Using mass media and professionals together may be highly synergistic and work better so long as it is integrated.

ii. Recognition of Context

Local circumstances and the engagement of local practitioners have a considerable effect on the success or otherwise of an intervention. So consideration must be given to the ways that the professionals who are to deliver it might respond. However, the prime basis for any intervention should be the group or population who are the focus of attention. An assessment of their needs and characteristics is the platform on which everything else

rests. It is therefore particularly important to develop an understanding of what the world feels like when viewed from the perspective of these people. It is important for the health professional *not* to assume that they know what the needs and characteristics of their target group are in advance. One of the most important things to do at this point is to try to discard prejudices and stereotypes of the type 'all white middle- class people are so and so, all Afro-Caribbean men are such and such, and men who have sex with men are thus and thus', and so on. It is of course never possible to know the way others truly think and feel, but it is important to try to get close to it.

iii. Technical Skills

These skills are about the technical hand skills, knowledge and confidence to do the new behaviour. For example, some smokers will need new ways to use their hands in the absence of the paraphernalia of cigarettes, lighters and matches. If you want people to start exercising, you need to help them to understand about proper warming up, how to start, how to pace themselves, how not to put themselves at risk and what clothes will be comfortable (as well as fashionable). If you want to talk about healthy eating, you have to think about healthy shopping, budgeting and cooking. These are considerable skills in their own right. The amount of information and sheer necessity of demonstrating them should not be underestimated.

iv. Interpersonal Skills

These are about teaching the person how to manage interactions with others as they engage in their new ways of behaving. So the smoker who wants to quit needs to learn how to refuse cigarettes from former fellow smokers who will undoubtedly sometimes try to make themselves feel better by trying to undermine the efforts of someone trying to quit. The giving-up smoker will need to know what to say in order to say 'no'. The person managing a sexual encounter may need to know the interpersonal skills of managing such encounters, and of learning the etiquette of sexual intercourse or refusal to

have sex. The busy mother trying to introduce a healthier diet onto the family tea table needs to anticipate the rejection that new menus might evoke from children and partners.

v. Intrapersonal Skills

This refers to the emotional and expressive feelings that people experience in any human behaviour and which they attach to human contact and encounters. These have a particular salience in the context of health behaviours and changes to health behaviours. So, there may be feelings of loss attached to the absence of previously valued behaviours and rewards from those behaviours like smoking.

People may genuinely miss it and yearn to be like they were before, even though they may recognize the benefits of giving up. The companionship, the intoxication, the sense of doing something with one's hands may all provide the props and parts of the script to everyday life for typical smokers. These things will be missed.

There may also be intense feelings of frustration and anger, as the giving-up smoker experiences withdrawal symptoms. There may be similar feelings of loss if people stop eating large amounts of sweet and fatty foods. Chocolate and cakes may become objects of fixation or of loss. Using condoms may lead to feelings of lack of intimacy sexual relationships. At a more general level, the whole approach to leading a healthier life may be seen either as something to be valued or regarded by the people whose behaviour is being changed as an intense interference to individual freedom. You have to help clients both work through and prepare for these feelings in advance. It is very important not to underestimate the intensity of feelings, positive and negative, linked to so much of what we might wish to change, and not to undersell these to clients.

vi. Subjective Skills

Subjective skills are to do with helping the client make sense of it all. The issues you are dealing with here, the things which are the targets of the health promoter's attempts to

change, are central to the ways people live their lives and are integral to their sense of whom and what they think they are. Their sense of self and their sense of identity, indeed the very ways they make sense of the world and their place in the world, are deeply embedded in what they eat, drink, their sex lives, their smoking, and so on. When you ask someone to change, in varying degrees you are asking them to be a different person to the one that they habitually think of themselves as being and to break emotional bonds with significant others in important ways. So deciding to stop smoking is not a simple choice like deciding that you prefer one cheese to another. The decisions you are asking of people are not to make a choice between living a healthy life or an unhealthy one. Rather, you are asking them to take actions that will essentially change the nature of the person that they are. So obviously you must not just dump down in front of them the options to smoke or not to smoke, or to eat a low-fat or a high-fat diet. It is about much more fundamental processes of helping the target population come to terms with the changes they may genuinely want to make, and working through the processes of change. It is about understanding the barriers to change, most of which while structurally determined exist in the micro world, the life world, of the individuals you hope to influence. Those barriers are generated in the mind and everyday interactions of the individuals themselves, as well as the social structure they inhabit. So at the heart of any attempt to change behaviour, there must be ways of helping the people who you want to do things differently make sense of it. That is why you need to understand the world from their point of view before you start. That is why simply telling someone it is for their own good, or that it is a simple choice, is inadequate.

Self-assessment

1. Explain health behaviour and health behaviour change at an individual level (the health belief model, the stages of change or trans-theoretical model, and social cognitive theory).
2. What are the main features of these models?

3. Write down some examples of models of human behaviour change drawn from your own experience. These need not necessarily be from the field of health promotion.
4. What sorts and ranges of behaviour are health promoters aiming to change to improve health? Think about all the different sorts of people and organizations that are interested in behaviour change, including schools, prisons, retailers and governments.
5. Draw on your understanding of the range of impacts health promotion aims to have on different sectors and different communities, as well as individuals.

4.0 CONCLUSION

The unit had discussed the models of behaviour change, effectiveness of models and practical steps to interventions in health promotion and education. It had considered the application of models of behaviour change as they apply to the promotion of health and the prevention of disease. You had learned about their principal strengths and weaknesses, working mechanisms of these models and their implications within a societal framework, and how best to use the models in practice, in meaningful and useful ways.

5.0 SUMMARY

You have seen how behaviour change operates at different levels. Organizational features set the context within which decisions are made at the individual level. As the models of behaviour change show, there are complex human calculations in operation as people work through the decision they make. There is a process which the decision-making path follows and there will be a variety of potential cues to action. There is also a range of practical things that can be done which depend on four types of skill – technical, interpersonal, intrapersonal and inter-subjective.

These have to be applied with an understanding of the life worlds of those you want to help. The models are your starting point. They provide you with a set of signposts about

the direction in which you can go. However, the practical problems that reside within people's everyday life worlds have to be solved, and using the schema here, it is perfectly possible to tease out the critical issues and work them through.

6.0 TUTORED-MARKED ASSESSMENT

Imagine you are a health promoter and you have been asked to organize a health promotion intervention in hospital and community settings in your capital city, to increase the number of new mothers who both start and continue to breastfeed for at least nine months. Think first about how you would construct a list of objectives for such an intervention. You may need to look back over the theories of organizational change and planning steps in Unit 4. Many different aspects of services may need to be involved, and a variety of professionals too. And do not forget the mothers! Then identify some of the specifics of the intervention that might be applied. Consider how much involves behaviour change and how much organizational change. In behavioural terms, what are the key intervention points? Finally, list the practical problems that might be encountered and describe the kinds of solutions you might apply to overcome those problems.

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UNIT 3: PLANNING AND EVALUATION OF HEALTH PROMOTION INTERVENTION

CONTENTS

1.0 INTRODUCTION

In this unit, you will examine the planning process for a health promotion intervention. In previous chapters, you have dealt with specific issues in developing a health promotion programme and have highlighted a range of methodologies available for use. In units 3 and 4, you looked at theories underpinning health promotion and were introduced to

some of the models that will be considered in this unit. This unit presents you with information about areas to think about in planning an intervention from start to finish and provides you with an overview of some of the planning tools currently available that can help you to ensure quality in your intervention. It is a practically oriented chapter that will help you apply your learning about health promotion to the systematic planning of health promotion activities.

2.0 OBJECTIVES

After you have worked through this chapter, you will better be able to:

i. understand the basic stages required to plan a health promotion intervention
ii. methodically plan a health promotion intervention
iii. draw upon available planning tools to help ensure the creation of a quality health promotion intervention
iv. explain the process of evaluation of health promotion intervention

3.0 MAIN CONTENT

3.1 PLANNING A HEALTH PROMOTION INTERVENTION

Assess need; this may require you to use a range of sources, such as:

i. epidemiological data
ii. demographic and socio-economic information
iii. the felt need of the target audience
iv. the perceived need of professionals who work with the target audience
v. assets which the target group may possess that you will be able to build upon

From this information you should be able to identify clearly the target group for your intervention, understand the nature of the problem and be aware of any assets currently in existence. At the assessment stage, you should also consider the political climate and whether your intervention will garner the necessary support from those in key decision

making roles. For instance, will you receive permission to carry out the work from those who need to give it or approval from those who will be required to fund it? Try to balance those aspects which you think will help your intervention and those that will hinder it. Examples might include the presence of lots of human capital but a lack of access to services, or the availability of funds, but only for the period when weather would limit the ability to work in the target geographical area.

The following are the steps for planning health promotion intervention:

1. **Interrogate the Evidence Based**

Once you have defined the problem, or the assets you wish to enhance, you will need to look to local and international literature sources to determine what interventions have been shown to work in this situation You may also draw upon learning from similar pieces of work that you know have taken place in a comparable cultural setting but which have not appeared in the literature. Care should be taken to examine the evaluation of any intervention that you intend to emulate, to ensure that you are learning from good practice and will not repeat the mistakes of others.

2. **Identify Resources**

Resources may be equipment, financial or human. Consider those which will help with the intervention practically on the implementation level and those which will give political support as a resource.

Inevitably, you will have finite resources, so you will need to plan an intervention that is realistically achievable within those confines. However, you may wish to develop a proposal for additional resources. In this case, it is best to leave this stage until the other stages of the plan have been completed.

3. **Aims**

Identify what you hope the intervention will achieve. For example, you may be working towards a health improvement or behaviour change. Identifying your aims at the outset will help to orient you during the planning process and will ultimately assist in evaluating the programme.

4. **Targets**

Sometimes the most effective way to demonstrate success is by using a numerical target. An example of a numerical target would be: to reduce the rate of smoking in 11–14-year-old girls in Riga by 10 per cent by the year 2015. However, to set this type of target, you need accurate baseline data. In this instance, you would need accurate data about the smoking rate at the outset of your intervention. You will also need to take care when designing the evaluation, so that your methodology will produce the right sort of data to demonstrate progress against the target

5. **Objectives**

Objectives are the specific actions you will take to achieve the aim.

6. **Methodology**

These are the techniques you will employ to operationalize your objectives to meet your overall aims.

7. **Evaluation**

It is important that health promotion interventions are evaluated, not only so that you can be sure that your intervention is achieving the desired outcome, but also to add to the evidence base for health promotion. Unit 14 will deal with appropriate evaluation methodologies.

3.2 RESOURCE ALLOCATION AND BUDGET SETTING

It is important at this stage to identify what resources will be required for your intervention to be successful. This should include a budget that details the costs over the duration of the intervention. If the budget exceeds what is available, you may need to prioritize areas of your work.

Examples might be reducing the number of participants, or omitting one of the inputs. However, it may be that a reduction in funding will compromise the proposed intervention to a point where it is no longer viable. In this case, it is better to accept than to start an intervention that has little chance of success. Implementation of the intervention should not commence until all of these stages have been adequately addressed.

3.3 EVALUATION OF HEALTH PROMOTION INTERVENTION

There is no standard definition of evaluation. Generally, the term can be interpreted as a planned set of activities to help people see the value of their project, programme or policy. As Suchman (1967) put it, 'the process by which we judge the worth or value of something'. Evaluation tells us what is the right thing to do.

In general, evaluations should aim to:

i. ensure that activities are having the intended effects (effectiveness)
ii. determine whether activities are cost-effective (efficiency)
iii. establish whether activities are acceptable to the target population (humanity)

Criteria to assess the quality of evaluations will be discussed in more detail later. However, two are crucial to the success of a good evaluation. They are the:

i. *Purpose of the work*: a clear set of aims and objectives should be defined during the planning stage of the evaluation.
ii. *Stakeholders' perspectives*: stakeholder analysis should be carried out to understand what questions are being asked and for what purpose.

Wimbush and Watson (2000) have proposed a framework for evaluation which allows you to make explicit the specific needs (and questions being asked) and perspectives of a full range of stakeholders involved in health promotion development, implementation and practice. In doing so, they frame the types of question being asked of evaluations and the methods appropriate to producing credible evidence about the best approaches to health promotion.

3.3.1 What Sorts of Evaluations Are Needed and Valued?

The overall aim of evaluation is to assist people and organizations to improve their plans, policies and practices on behalf of citizens. While it is relatively easy to build consensus around evaluation for learning and improvement, there are important differences, in perspective and in emphasis, among stakeholder groups around what forms of evaluation are needed and valued. This can be illustrated with reference to the field of health promotion.

3.3.2 Professional Evaluators

Professional evaluators (including academic researchers) tend to engage with evaluation as a knowledge-building exercise, seeking to improve knowledge and understanding of the relationship between an intervention and its effects. They are also concerned to maintain quality standards for research, in particular with regard to research design, methodological rigour, reliability and validity. However, evaluators employed within health promotion practice settings are often frustrated by being expected to ‘evaluate everything’ on a small budget and not having the resources to conduct what they regard as ‘quality’ research. Academic researchers are often highly critical of the quality of evaluation research carried out in practice settings, but are sometimes all too ready themselves to conduct resource-intensive evaluations of effectiveness with little attention to assuring the quality of the intervention being tested. This situation contributes to findings from large-scale evaluations which demonstrate the failure of community health

interventions (e.g. Stanford, Pawtucket, Minnesota, Heartbeat Wales), the failure being attributed to the quality of programme implementation and delivery. Inevitably, there is likely to be some overlap between the interests of the different stakeholder groups.

In advocating the need for evaluation evidence that is relevant to their own particular priorities, the different stakeholder groups can disregard the necessity and contributions of other forms of evaluation. This suggests a need for more 'joined-up' thinking and partnership working on evaluation across the different stakeholder groups policy makers and strategic planners, programme managers and practitioners, user/consumer groups – as well as those commissioning and doing evaluation work.

3.3.3 HEBS Evaluation Framework for Health Promotion

The evaluation framework developed by HEBS (1999) uses the key stages of programme development as the basis for differentiating between the types of evaluation used and useful in health promotion practice. The HEBS framework identifies the different purposes of evaluation and the associated evaluation questions that are characteristic of each of these stages, acknowledging the importance of assessing effectiveness, as well as assuring quality and making explicit the mechanisms of change implicit in a programme's theory.

i. Planning stage: Systematic Reviews of Effectiveness

In the planning stage, once a health-related problem and the population group at risk have been identified, a second phase in the needs assessment process involves an option appraisal process which takes into account: (a) learning from other evaluation research about the most effective ways of addressing the problem with a particular group and/or within a particular setting (systematic reviews of effectiveness); (b) how the health-related need/problem is currently addressed by current policies and service provision (review of current provision/policy); (c) what professional 'experts' regard as the best ways of addressing these needs/problems (consultation interviews or seminar)...

ii. Design and Pilot Stage: Developmental Evaluation

The effectiveness of interventions is increased if an initial pilot stage is undertaken before the proposed programme is fully implemented. A programme plan can be designed which is based on the initial assessment of need and appraisal of what is likely to be the most effective or 'best' intervention, given the evidence and resources available, and what can be achieved within a particular setting and set of partner agencies. Against this backdrop, the design stage involves defining the long-term goal of the programme, setting programme objectives, defining the range of activities required to meet these objectives, identifying staffing and training requirements, setting up administration, publicity and monitoring procedures.

Developmental evaluation is an essential part of this design stage. Formative evaluation is likely to be the most appropriate approach since the prime purpose of the evaluation is developmental and the process is iterative, providing continuing feedback from key stakeholders and the target group/project users in order to adjust, refine and optimize the programme's focus, design and ultimate effectiveness. If the programme is found at this stage to be unfeasible or impracticable without major revisions, then the project should be abandoned and a new approach devised.

iii. Implementation Stage (Early Start-up): Monitoring and Review

For evaluation purposes, it is helpful to distinguish between different phases of implementation: early start-up, establishment and a fully operational phase. Overall, the implementation stage is characterized by the operation of the full programme across all sites in its revised post-pilot form.

The main tasks here are project management, quality assurance and evaluation. At the start of a project, the project manager is concerned with defining appropriate milestones for the project, reviewing cycles and agreeing with key stakeholders' appropriate performance indicators and quality standards for the project. Monitoring and review

systems should be set up to continue throughout the duration of the project's life for both evaluation and quality assurance purposes. These systems include:

i. monitoring systems for routinely recording data about inputs, outputs, project activities and any agreed quality standards;
ii. evaluation work should begin by looking at management issues around the delivery of the project and quality assurance. If the impacts and outcomes of the project are to be assessed over time, it may be appropriate to collect baseline information at this early stage.

iv. Implementation Stage (Establishment): Impact Evaluation

This phase of implementation is when the project has become stable, project staff have gained experience and confidence and early problems have been addressed. At this stage, 'impact evaluation' is appropriate and the evaluation focus turns to examining the implementation process: the extent to which the project is working as planned; how far the project has reached the target population; and the immediate effects of the project (i.e. its impacts or results) on the target population and others. If monitoring data on costs is available, simple economic evaluation measures such as cost effectiveness and/or cost-benefit ratio might also be produced.

v. Implementation Stage (Fully Operational): Outcome Evaluation

Once the project is well established, the evaluation can focus on effectiveness whether the end results, or intermediate outcomes, are being achieved and thus the extent to which the project has been effective in contributing to longer-term health and social policy goals. Outcome evaluation should be conducted when an impact evaluation has already demonstrated a programme's short-term effectiveness, ideally in several settings/populations, but long-term effectiveness is still unknown. To allow long-term follow-up over time, this type of evaluation requires dedicated and substantial research

resources and those with specialist evaluation expertise who can advise on appropriate research designs and methods, implement these and conduct the appropriate analysis.

One of the biggest problems with this form of evaluation is providing evidence of a causal link between the project being evaluated and the outcome measures. Experimental and quasi-experimental research designs go some way towards addressing this problem, although these designs are regarded by many as a research design that is neither feasible nor desirable for community-based interventions...

vi. Dissemination Stage: Transfer Evaluation

The dissemination stage begins when there is information available for dissemination beyond the immediate audience of project staff, funders and stakeholders, about the 'results' of, or learning from, the impact and outcome evaluation research. Typically, this is when the initial project funding period comes to an end. Programmes that have proven to be effective will only have significant impact if they are disseminated and taken up more widely. This is the purpose of 'demonstration projects'.

The focus of evaluation at this stage is on the transferability of the programme and the replicability and sustainability of its outcomes when transferred to a wider range of settings and/or populations.

Self-assessment

As you read the following extracts from the WHO Working Group report, make notes on the main differences between health promotion interventions and biomedical interventions. You will need to consider: the time frame; the end points; the nature of the intervention; who instigates the intervention; the health of the target audience; the likely size of any benefit; and the aim of the intervention.

4.0 CONCLUSION

This unit highlights the process of planning a health promotion intervention programme and the necessary tools that are employed to conduct successful planning health promotion. The process of evaluation of health promotion programme were discussed in this unit.

5.0 SUMMARY

In this unit, you have learnt how to plan a health promotion programme or intervention. You were introduced to the basic steps in the planning process and to several tools available to assist with planning. It is hoped that you will have developed a basic understanding of the tools presented and are able to determine tools most appropriate for your particular purposes. Different tools have different strengths and limitations. Your familiarization with each tool should allow you to make an educated decision about which tool best fits your planning style or your proposed intervention.

6.0 TUTOR-MARKED ASSIGNMENTS

To understand properly the steps outlined above, it is useful to plan a sample intervention utilizing them. Take some time now to plan a smoking intervention using these key planning stages. When planning your intervention, make certain you are clear about your specific aim; perhaps you are planning a programme to prevent young children from smoking later in life or maybe you wish to design an intervention aimed at helping elderly smokers to quit. Think critically about each stage in the planning process and be very specific with your target group, aims and objectives. Be sure you are considering each step carefully. Record all the information

7.0 REFERENCES/FURTHER READINGS

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