Masters in Public Health

Health Promotion II
Module Guide

2008

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School of Public Health
University of the Western Cape
& School of Health and Community Care
Leeds Metropolitan University
Vision Statement of the School of Public Health
University of the Western Cape

The Vision of the School of Public Health is to contribute to the optimal health of populations living in a healthy and sustainable environment in developing countries, particularly Africa, with access to an appropriate, high quality, comprehensive and equitable health system, based on a human rights approach.

The Purpose of the School is to contribute to developing policy-makers and implementers who are knowledgeable and skilled in the principles and practice of Public Health, whose practice is based on research, influenced by informed and active communities, and implemented with a commitment to equity, social justice and human dignity.
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I  MODULE INTRODUCTION

1  LETTER OF WELCOME

Dear colleague

Welcome to the Health Promotion II Module. This module was created to help prepare individuals in the fields of health and welfare to gain an understanding of the concepts and practice of Health Promotion. We hope that you will find the materials relevant to your work situation and useful in developing your skills as a health promoter.

Health Promotion is an important skill area for Public Health professionals. This module thus forms one of the core modules for the Postgraduate Diploma in Public Health. The module covers five main areas, aimed at providing you with an insight into the concepts, approaches, planning, implementation, and evaluation of Health Promotion programmes. It also builds on concepts developed in earlier modules, such as the concepts of health.

The first unit provides an introduction to what is meant by Health Promotion, highlighting the importance of addressing the determinants that impact on our health, and of addressing equity in Health Promotion programmes. The second unit focuses on theoretical considerations that inform Health Promotion practice, including a selection of models and approaches with ideas of how they can be applied. Unit 3 tackles dilemmas in Health Promotion planning and the basic programme planning cycle. This is followed by Unit 4 which covers the main methods of implementation, including policy development, health education and service reorientation. The module ends with Unit 5 which highlights some of the issues and complexities of evaluating Health Promotion programmes. The module uses a case study as a tool for learning, and whilst it may not match everybody’s experience, it serves as a common scenario for the assignment.

Finding your way around the Module Introduction

The introductory pages which follow provide you with an overview of the module, its outcomes, assignments as well as the sources from which you can expect support and assistance. Take the time to look through this section before you begin studying – taking particular note of the assignments and their requirements.

Contact Information

All the contact information that you may need is contained in the Programme Handbook. If your contact details have changed in any way, please send the Contact Details Update Form to the Student Administrator straight away.
Assessment

This module will be assessed through two assignments which test your understanding of the study materials and your ability to apply this understanding to a Health Promotion context.

We hope you enjoy your studies.

Best wishes,

Ruth Stern (Module Convenor: Semester 1)
Hazel Bradley (Module Convenor: Semester 2)

CONTACT DETAILS:

Dr Ruth Stern
E-mail: rstern@uwc.ac.za

Ms Hazel Bradley
Tel: 021 959 2630; Mobile: 072 297 9932
E-mail: hbradley@uwc.ac.za
2 INFORMATION ABOUT THIS MODULE

2.1 Acknowledgements

The writers wish to acknowledge the contribution of the following institutions and individuals for providing assistance in the initial development of the module: Nikki Schaay lecturer at the School for Public Health, UWC and Frank Tesoriero for their work in an earlier version of this module. We gratefully acknowledge the assistance of the School of Health and Community Care, Leeds Metropolitan University.

2.2 Module Aims and Rationale

This module was developed in recognition of the importance of promoting good health in its broadest interpretation, rather than just tackling ill health. Health Promotion is a relatively new field that draws on a number of disciplines. In particular it has drawn on the World Health Organisation's definition of health as a state of physical, social and emotional well-being, and not just the absence of disease or infirmity. The module therefore aims to provide students with an understanding of this evolution, and the different approaches and models that inform its practice. In so doing, it aims to enhance the health worker's ability to develop and manage Health Promotion initiatives at a district level.

The approach is practical, requiring students to relate information to their own context and reflect on their own experiences as they work through the module.

2.3 Module Outline

This module consists of five units divided into a number of study sessions. Most of the Study Sessions require you to read a number of texts from the Readers. You will be referred to them in the course of the study sessions.

In addition, you are expected to work through the Tasks which are integrated across the study sessions. Sessions vary in length and could take between three and five hours to complete.
The Units in this module are as follows:

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2.4 Learning Outcomes

Intended Health Promotion Learning Outcomes

By the end of this module, you should:

- Demonstrate critical awareness of the current debates and dilemmas in Health Promotion.
- Demonstrate familiarity with the main theoretical approaches used in Health Promotion and awareness of their strengths and limitations.
- Demonstrate the ability to plan, implement and evaluate a Health Promotion programme.
- Locate health determinants and intervention strategies within suitable models of and approaches to Health Promotion.
- Apply Health Promotion and planning knowledge to a comprehensive HIV/AIDS programme.
2.5 Readings

The module includes a number of readings. Some are more detailed than others, in order to cater for different levels of knowledge and interest. Some repeat themes, which is inevitable when using texts from a range of sources. We therefore advise that you use the readings selectively, judging what is useful for you. This, at times, will involve being selective about the depth at which you can complete the tasks. Please use your judgement for this too, but make sure that your reading prepares you for completing your assignments – it will not be enough to give only your opinions.

2.6 Module Evaluation

You will be asked by your lecturer to evaluate this module once you have completed it. Please let us know how you find it as this will help us to improve the module for future students.

3 ASSESSMENT

There is further information about assessment in the SOPH Programme Handbook 2009. Please refer to it before submitting your assignment.

3.1 Information about Assessment

There are TWO compulsory assignments in the module. You must submit both, on deadline. You will receive assignment deadlines from the SOPH Student Administrator; consider it your responsibility to ensure that you know the deadlines when the semester starts.

The modules are weighted as follows:

Assignment 1: 40%
Assignment 2: 60%

To pass the module:
- You are required to pass both assignments with a minimum of 50%.
- You must have a minimum aggregate of 50% for the module.
- You may repeat Assignment 1 once, if you get below 50%.
- If you do not pass one of the assignments, you must repeat the module.

3.2 Submitting Assignments

These guidelines must be followed exactly every time you submit an assignment. Getting this wrong wastes our time, and we WILL return the assignment to you to correct.
• You may send assignments by email, fax or post. (Email and fax save time). Keep a copy of everything you have sent. If you post, use fast mail or courier.

• Send assignments to the Student Administrators, not the lecturer.

• When you submit your assignment, you will receive acknowledgement that it has been received. If you don’t, check that it has been received.

• Type your assignment on A4 paper, in 1,5 line spacing, in 12 pt Times New Roman, and leave normal margins for the lecturer’s comments.

• Handwritten assignments will not be accepted.

• Keep to the recommended length. Excessively long assignments may be penalised.

• Number ALL pages.

• Include the Assignment Cover Sheet (completed fully) as the first page of the assignment, i.e. the cover sheet and the assignment must be one document.

• Always put your name on every file you send, and label the file correctly, using these instructions as a guideline if submitting by e-mail:
  • Your Name (Surname, Initial) e.g. Mambwe R
  • Module abbreviation (see Programme Handbook for Core module abbreviations). Use CAPITALS, e.g. PHC II
  • Assignment number, e.g. 1 or 2, and Draft or Final
  • The year, i.e. 2009
  e.g. Mambwe R, PHC II Asn 1 Final 2009; Mambwe R, PHC II Asn 1 Draft 2009.

SOPH Address to which assignments MUST be sent:

E-mail: soph-asn@uwc.ac.za

Fax: + 27 21 959 2872 (Att Student Admin, SOPH)

Post: The Student Administrator, SOPH, University of the Western Cape, Private Bag X17, Bellville 7535, South Africa.
3.3 Assignment Deadlines

- Assignments must be submitted by the due date, preferably by e-mail, but fax or post are accepted if dated on or before the due date.
- You will receive assignment deadlines from the Student Administrator once you have selected your modules.

PLEASE NOTE: Late submission of assignments will impact on the time you have available for the next assignment, disrupt your lecturers’ schedules and result in late submission of marks into the UWC marks administration system; should that happen, you will have to repeat the entire module. It’s therefore in your interests to manage your time as effectively as possible. Section 4 in this Module Introduction offers some general guidance and a blank work plan for you to work out your schedule for the semester. Should you require more guidance, try the SOPH Academic Handbook, 2008.

Assignment Extensions
Under special circumstances, extensions may be granted. Even so, the extension will not normally be longer than two weeks. To request an extension, contact the Student Administrator (not the lecturer or Module Convenor) as soon as a problem arises. No extensions will be given for Draft Assignments, and no late assignments will be accepted in Semester 2.

3.4 Draft Assignments: Please read this section carefully

Lecturers will give you valuable feedback on your assignment if you send a draft. However, Drafts will ONLY be reviewed if they are received TWO OR MORE weeks before the final submission date; no extensions will be given for drafts; assignments received less than two weeks before the final assignment submission date will be taken to be the final.

If you want to submit a draft, do not submit a complete assignment. Select sections with which you are having difficulty, or submit an outline of the whole, but not the whole assignment. Lecturers will make every effort to respond to submitted drafts timeously.

IMPORTANT:
The following section contains the assignments for the module. Please read questions and instructions carefully. There is important information about assessment in the SOPH Programme Handbook, be sure to refer it before submitting your assignment.
This first assignment tests your understanding of some of the theoretical approaches of Health Promotion. It is in three parts which must all be addressed. The same marking criteria will be applied to all sections.

a) Describe what is meant by a **Settings Approach** and discuss the value and limitations of the Health Promotion Settings concept, using examples to illustrate your answer.

b) According to Naidoo and Wills (2000), targeting has become a key concept in Health Promotion. This includes targeting risk conditions, at-risk groups and risky behaviours. They also caution us about the dangers of adopting a targeted approach.

Describe the **Targeting Approach** and discuss the advantages and limitations of this approach using examples from your own country.

c) Settings and targeting are not mutually exclusive:

Describe how you would integrate these approaches for enhanced benefit using an example.

**How you will be marked**

Use these assessment criteria to clarify how the assignment will be marked and where to lay the emphasis in your assignment.

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<tr>
<th>Assessment Criteria for Assignment 1</th>
<th>Marks</th>
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<tbody>
<tr>
<td>i) Understanding of the approach and relevant issues; with use of examples demonstrating understanding of the approach and its related issues</td>
<td>15</td>
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<td>ii) Integration of the two strategies</td>
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<tr>
<td>ii) Critical analysis (over all 3 questions)</td>
<td>10</td>
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<tr>
<td>iii) Academic rigour, including references (over all 3 questions)</td>
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<td><strong>TOTAL</strong></td>
<td><strong>40</strong></td>
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The second assignment looks at your ability to operationalise Health Promotion theory and concepts. It is based on the case study of Nomhle, Health Promotion Manager in Mfula District. It tests your ability to draw on the theory covered in the module, including but not exclusively the theories discussed in Assignment 1, and to apply your learning as well as your experience to conceptualise a Health Promotion intervention.

In the reading, School of Public Health (2002), and in the course of this module, you will be presented with a case study of Nomhle, who has been newly appointed to the position of Health Promotion Manager in the district of Mfula. Assignment 2 is based on this case study.

We urge you to prepare the assignment as you work through the sessions. The section Assignment Preparation advises you in how you may do this. The Instructions detail how you must produce the assignment task.

Assignment Preparation

Use the assignment preparation opportunities embedded throughout the Module Guide as “Assignment Preparation Tasks” (highlighted by the symbol A). These will help you prepare for this assignment as you work through your study sessions, and will form the building blocks for your Health Promotion plan.

The reason for keeping the notebook is that it will ensure that you engage with the Study Sessions and prepare for the assignment with the readings still fresh in your mind. Your notebook will probably not contain a lot of detail - it is for your use. You do not need to submit the Notebook and there are no marks for it.

Below is the assignment.

Instructions

Imagine you are Nomhle and you have been asked to develop a plan for a programme to address STI and HIV infections for Mfula District, which you will present to the District Manager and the heads of other sectors in the Mfula District. The plan will be a written document that explains the choices you have made in detail. You will also need to motivate for their value in combating the risks of further STI and HIV infections in this community. The plan will cover one year, but it should demonstrate that the programme will need to be sustainable if it is to be effective.

- Use the Ottawa Charter as the framework for the plan.
- Select one population group or setting.
In the proposal include information using the following sub-headings:

- **Context:**
  - Information about the context gained by undertaking a situational analysis and by your understanding of the determinants of health;
  - Evidence showing that you have researched and understood the issues of STI and HIV infections in communities like this one;

- **Mission Statement for the plan**;

- **Motivation:** for the choices you have made for the programme. This should include the determinants of health in the Mfula District, the complexity of stakeholders Nomhle will have to respond to (i.e. managers and communities), as well as the models you have studied.

- **Aims and Objectives** of your one year Health Promotion Plan;

- Theoretical underpinnings of your selected approach.

- **Programme:** A detailed description of the programme, including concrete activities that you propose. (This is probably best detailed in a table).

- **Advocacy Strategy:** Explanation of how you would advocate the Health Promotion Programme to different groups within the communities and their leadership;

- Briefly outline how you intend to evaluate the Plan

As you develop your plan, consider these issues:

- This is a Health Promotion plan not a care package, so keep to aspects that are about promoting health, and preventing HIV/AIDs and STIs.

- Remember also that the heads of the other sectors may resist the multifaceted approach of the plan, if they are more used to treatment, care or a Health Education approach. You would need to explain how you will include communities in your Health Promotion plan, and who advocate the plan to different groups within the communities.

- Although you may discuss the timing of the plan in the course of presenting it, you do not have to list resources, or develop a budget or a timeline.

**What kind of text must you write for the proposal?**

The proposal should be structured with sub-headings. You should cite references correctly using the Harvard Method. (See the *Academic Handbook* for relevant information on how to reference correctly).

**How you will be marked**

Use these assessment criteria to clarify how the assignment will be marked and where to lay the emphasis in your assignment. Your mission statement will be marked as part of criterion (ii), your motivation for the programme.

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<thead>
<tr>
<th>Marking criteria and mark allocation for Assignment 2</th>
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<tr>
<td>i) Introduction and situation analysis</td>
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<td>ii) SMART objectives, relevant for the particular population or setting</td>
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<td>iii) Realistic strategies and methods</td>
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<td>iv) Application of the Ottawa Charter throughout the proposal</td>
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<tr>
<td>v) General approach to the development of the Plan, ie, the structure, the level of argument made etc.</td>
<td>10</td>
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<tr>
<td>vi) Layout and referencing</td>
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<td><strong>TOTAL</strong></td>
<td><strong>60</strong></td>
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An Assignment Cover Sheet needs to be attached to every assignment. Please fill in all details clearly and staple this form to the front of your assignment. Alternatively, please fax it as the first page of your assignment, or develop a cover sheet like this one to e-mail with your assignment.

Full name: __________________________________________________________

Address: ____________________________________________________________________

Postal code: ____________________________________________________________________

Student number: ____________________________________________________________________

Module name: Health Promotion II

Module code: 881559

Module Convenor: Ruth Stern / Hazel Bradley

If faxed, state the total number of pages sent including this page: _________________

Assignment topic as stated in the Module Guide
_____________________________________________________________________

Student’s comments to tutor
_____________________________________________________________________

_____________________________________________________________________

Declaration by student

I understand what plagiarism is. This assignment is my own work, and all sources of information have been acknowledged. I have taken care to cite/reference all sources as set out in the SOPH Academic Handbook.

Signed by the student: _____________________________________________________

The tutor’s comments are on the reverse of this form
_____________________________________________________________________

Office Use

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<tr>
<th>Date received</th>
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SOPH, UWC: Health Promotion II - Module Introduction
4 DEVELOPING A WORK PLAN

It is estimated that a 20 credit module like this one requires approximately 200 hours of student work. This translates into at least 10 hours per week per module. This is a time-demanding module, and requires consistent work. We suggest that you set your own targets for completing the study sessions using the table below. Take into account that Draft Assignments must be submitted not less than two weeks before the final deadline. Guidelines for time management are provided in the SOPH Academic Handbook.

You are expected to work consistently and regularly through the sessions, but it is a good strategy to prepare for the assignment as you work through them.

The table presents a week-by-week work plan for the semester. Identify the period you have to complete Assignment 1, 2 and their drafts. You probably also have a second module running concurrently. One way to manage two modules at the same time is to study one module from Monday to Wednesday, and the other from Thursday to Saturday. Educationally this is positive because the two modules should complement each other.

Once you have worked out a plan, put a copy of it in an obvious place, e.g. above your work table, and refer to it daily, adjusting it if you slip behind or race ahead!
WORK PLAN FOR HEALTH PROMOTION II AND A SECOND MODULE

Insert the dates for drafts and finals of Assignments 1 and 2 as well as target dates for completing Study Sessions.

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<thead>
<tr>
<th>WEEK</th>
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5. STRATEGIES TO ASSIST YOU AS A DISTANCE LEARNING STUDENT

This module requires you to read all the papers and chapters provided, so try to do so actively. If you do not study them in depth as you proceed through the unit, you will end up feeling overwhelmed.

If you are not a confident reader, you may want to revise your active reading strategies: previewing and mind-mapping or making graphic representations. Both strategies aim to help you to read with understanding. We refer you to a paper on making graphic representations as you read. This can be a very helpful process in staying actively engaged while you read, and taking selective notes for revision purposes.

Two strategies for effective reading: previewing and making graphic representations

Here are two strategies that can be helpful making you a more effective reader.

Previewing

Previewing is a process that leads to what could be called intelligent or strategic reading. Preview your readings by following these steps. Try not to take more than ten minutes in the process.

- Explore the text for clues about what is covered and the author’s point of view. Look for the authors’ names, clues to the purpose of the chapter, the date of publication, the place where it was published. What do these features suggest to you? Remember that you should be critically aware that not everything you read is going to be helpful: it may be biased or confined to a specific perspective, irrelevant to your context or out of date. So previewing is also about being selective about what you read.
- Scan through the text looking closely at the advance organisers. These are the text features which structure the text. They include contents pages, headings, diagrams, sub-headings, bulleted lists, summaries, photos and captions.
- Skim-read the first and last paragraphs of the whole text, or of the different sections. This may seem strange to you, but it gives you an idea of the content because introductions and conclusions are written to orientate the reader.
- By getting an overview of the contents of the text, you create a mental picture of what lies ahead. Experts on reading tell us that this gives you confidence as a reader, enables you to speed up and therefore allows less distraction; it enables you to skip over difficult terminology or phrases as well as parts of the text which seem less important for your purpose.
- Now think of a few things that you already know about this topic. This is important – it creates hooks for you to hang new information on, and it
prepares your mind to be receptive to this topic. This is called creating a schema or mental picture to which you can add new information.

- Finally jot down two questions that you are going to bear in mind while you read the text. The questions may be suggested by the assignment or the text, or your own curiosity. The questions should serve your needs as a reader. At this stage, you may not be sure whether the text will answer the questions, but reading with questions in mind helps you to read actively. They give you purpose as you search for specific information; you can maybe jot down notes on these two topics too. Even if you have no desire to read the text, you need to create a purpose for yourself to read it.

Making graphic representations

Some of you will have read this paper before, and may be familiar with making graphic representations. The reading by Jones, Pierce, & Hunter (1989) introduces the method to you. It is a process of making a mind-map, but a more complex one, where you try to understand the structure of the reading in advance, and then select the most important points for your diagram. The advantage is that all the information is contained on a single page. Try it – it can be a very helpful academic skill.

READING

Keep the requirements of your assignment in mind as you work through the module and note any parts that will be relevant to it. Enjoy the module!
II STUDY SESSIONS

UNIT 1 A CONTEXT FOR HEALTH PROMOTION
Session 1 Determinants, Equity and Health
Session 2 Development of the Health Promotion Approach

UNIT 2 THEORETICAL PERSPECTIVES - MODELS AND APPROACHES
Session 1 An Overview of Health Promotion Theory
Session 2 How People Make Decisions about their Health
Session 3 Theories and Models of Behaviour Change

UNIT 3 PLANNING IN HEALTH PROMOTION
Session 1 Health Promotion in Practice
Session 2 Intervening Strategically

UNIT 4 STRATEGIES AND METHODS
Session 1 The Ottawa Charter Action Areas
Session 2 Approaches and Methods for implementing Health Promotion Interventions
Session 3 Case Study Examples

UNIT 5 EVIDENCE-BASED PRACTICE & EVALUATING HEALTH PROMOTION PROGRAMMES
Session 1 Evidence based Health Promotion
Session 2 Issues in Evaluation
Session 3 Planning Health Promotion evaluation
Session 4 Module Summary & The Challenges for Health Promotion
Introduction

Welcome to the first unit of the Health Promotion II module. We hope that the module will be stimulating and relevant to your practice.

Health Promotion includes a wide range of strategies aimed at improving people’s health. This is a departure from the earlier emphasis on disease prevention, and as such it has increasingly become part of the responsibility of a range of professionals. This focus on positive health and on prevention, has been recognised not only as a cost-effective approach, but also one which responds to the ethics and morality to which our society might aspire.

The process of planning and implementing a Health Promotion programme involves many stages. It also involves different ideological stances and practical approaches. This module guide will take you through a selection of approaches, highlighting the different interpretations at different stages of the development of Health Promotion, and the merits and problems of these interpretations.

This module is based on a case study about Nomhle, a newly appointed Health Promotion Manager, who has been given the task of developing a plan for a Health Promotion programme for the district to address the key issues of importance. The case study, School of Public Health (2002), which spells out the issue to be addressed, is in the accompanying Module Reader. Additional information will be provided as you progress through the Module Guide. The case study will also form the basis of your assignment. Detailed instructions on the Assignment are in Section 3.5 of the Module Introduction.

Unit 1 explores a number of concepts that are fundamental to Health Promotion, as well as some of the debates and dilemmas which have entered the discourse – debates that are inevitable in a growing field. They are also debates that you are likely to encounter in your professional practice. It is therefore important for you to understand them and to be able to interact with them and contribute to them.
The overall aim of this unit is therefore to introduce you to the current debates and challenges in Health Promotion, and its relationship with related disciplines.

**There are two Study Sessions in this unit.**

Study Session 1: Social Determinants, Equity and Health
Study Session 2: Developments in Health Promotion

In Session 1, we will take a look at the determinants of ill health, already explored in earlier modules, but this time with the focus on its relevance to Health Promotion. The session also focuses on the concept of equity (which is different to equality), and its importance in terms of fairness and social justice.

Session 2 provides a survey of recent developments in the international field of Health Promotion and presents some of the key debates.

**Learning Outcomes of Unit 1**

<table>
<thead>
<tr>
<th>By the end of this unit, you should be able to:</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Demonstrate awareness of health determinants and their influence on Health Promotion.</td>
</tr>
<tr>
<td>• Take equity into account in planning Health Promotion interventions.</td>
</tr>
<tr>
<td>• Demonstrate a critical understanding of the current debates around Health Promotion.</td>
</tr>
</tbody>
</table>

Because there is a substantial amount of reading in this module, we have included a small amount of academic support in the form of focus questions to help you to read actively and strategically.

In addition, you will remember that you are encouraged to develop your Assignment as you work through the module. This involves interacting with the case study as you work through each unit. Do this in an Assignment Notebook which can take any form e.g. an exercise book, a set of typed notes. Record your own thinking about Nomhle’s programme as you proceed through the units. This will enable you to study actively and with focus, as well as ensuring that you reach your Assignment deadline in good time.

We hope that you will find the unit stimulating and challenging and that it will enable you to situate your role more clearly within the field of Health Promotion, and thereby develop your practice as a health promoter.
Unit 1 - Session 1
Determinants, Equity and Health

Introduction

In this session, we introduce the case study of Nomhle, a newly recruited Health Promotion Manager. Her task is to develop a plan for an integrated Health Promotion programme for the community of her district. Like Nomhle, you are expected to review your understanding of the goals and vision of Health Promotion and there is a reading to assist you to do so. In addition, you will consider the complexity and levels of the determinants of health, think about how poverty affects health in both urban and rural settings and address the importance of equity or fairness in guiding Health Promotion programmes. In the process of exploring these issues, you will have the opportunity to reflect on and clarify your own values and beliefs in relation to Health Promotion.

There are two Assignment Preparation Tasks in this session, so start your Assignment Notebook now. Remember that this symbol [A] serves to remind you to include the task in your Assignment Notebook. As you work through the session, it may also be useful to list references to any relevant parts of the readings in your notebook, and to note down conclusions you reach in the course of the tasks. The topics in this session which may be relevant to your assignment are: debates about the determinants of health in a rural context, as well as equity issues in relation to women and HIV/AIDS.

Session Contents

1. Intended outcomes of this session
2. Readings
3. An overview of the issues in Health Promotion
4. Determinants of health and Health Promotion
5. Equity and the right to health
6. Session summary
7. References and further reading
Timing of this session

This session contains five tasks and five readings. It could take about three hours to complete: a logical place to break the session would be after section 4.2.

1  LEARNING OUTCOMES OF THIS SESSION

By the end of this session, you should be able to:

- Give a broad overview of health promotion
- Analyse and discuss the implications of different health determinants.
- Distinguish between equity and equality.
- Reflect on your own values in terms of equity issues.
- Take the issues of equity into account when planning Health Promotion interventions.
- Analyse and compare Health Promotion interventions in rural and urban contexts.
- Identify strategies for Health Promotion intervention at different levels.

2  READINGS

The readings for this session are listed below. You will be directed to them in the course of the session.

<table>
<thead>
<tr>
<th>Reading</th>
<th>Publication details</th>
<th>Page in the Reader</th>
</tr>
</thead>
<tbody>
<tr>
<td>School of Public Health, UWC</td>
<td>(2002). Case Study of Nomhle, the District Health Promotion Manager in the Mfula District. Bellville: School of Public Health, UWC.</td>
<td>417 - 426</td>
</tr>
<tr>
<td>Solar O, Brown</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
3 AN OVERVIEW OF THE ISSUES IN HEALTH PROMOTION

In this section, we will introduce you briefly to the concept of health promotion, as a start to your exploration. We will also introduce you to Nomhle, a newly appointed District Health Promotion Manager and invite you to revise and clarify your understanding of a vision for Health Promotion in South Africa.

What is health promotion?

The term ‘Health Promotion’ is a generic term used to describe any activity that improves the health status of individuals, communities and the population as a whole. It can be described as a process where individuals are assisted to increase control over their health, and one in which communities, organisations and governments work together to improve the conditions in which people live, in order to enhance their health.

The term health promotion is used in many ways, often without much clarification about what it encompasses. There are inevitably different interpretations about what should be done to achieve this, ranging from providing information and encouraging individual lifestyle to legislation and changes in the socio-economic environment in which we live. In fact, it includes all these aspects. Health Promotion is a broad umbrella term covering all interventions that promote health.

Our capacity to maintain our health, or make the changes to improve our health, depends on the context in which we live and the opportunities we have. This session starts, therefore, with an exploration of the determinants of health and the importance of equity. Session 2 will then provide a more detailed discussion on Health Promotion, including the history, development of the concepts and different interpretations of health promotion.

To start the study, and to set the scene for your assignment, look at School of Public Health (2002), which will give you more background to Nomhle and her role as a health promoter in her new District.

READING

You will see that as District Health Promotion Manager, Nomhle has been set the challenge of developing a Health Promotion Vision Statement for the plan she is to develop. It will form the basis of building the district’s team understanding and ownership of the programme.

Now read the report of the XVIIth World Conference of Health Promotion and Health Education, (reading 2) by Wise and Jha. This will assist you in placing Nomhle’s challenge within the broad challenges for health promotion. Once you have read this, look at Task 1.

**READING**

**TASK 1 - Clarify your understanding of the aims and values of Health Promotion**
*(Please remember that this task should be done in your Assignment Notebook)*

a) From the readings, draft a Vision Statement for the District using Nomhle’s job description in the case study, and Reading 2. As you study these two readings, try to clarify what the District Integrated Programme aims to do in terms of Health Promotion. The purpose of doing this is to help you to actively review and question the aim of a Health Promotion programme. If you want to check how a Vision Statement is written, look at the School of Public Health’s Vision statement in the Introduction: yours can be longer.

Treat this as a draft and revise it when you have completed the unit. You are asked to include your Vision Statement in the Assignment Notebook and as part of your Assignment.

Remember that a Vision Statement is a succinct statement of the aims of the organisation, but that it also embodies the values of the organisation.

b) Describe the first step Nomhle should take to initiate the project.

**FEEDBACK**

a) Your vision statement will be useful to provide a shared perspective for the organisation. Vision statements are often developed as part of a team building exercise, as they can facilitate shared ownership.
b) The first thing that Nomhle will have to do is to persuade the people with whom that she is working on the scope of her role as the Health Promotion Manager. Whilst her colleagues are aware of, and accept that they all have a part to play in programme, they may not necessarily recognise the breadth of programme that Nomhle hopes to develop. Health Promotion, as Nomhle is aware, is generally considered to be an *umbrella term* that includes all the activities intended to prevent disease, improve health, and enhance well-being. However, she is aware that there is not always a shared view about the concept of Health Promotion, nor about its practice. This is inevitable in a field such as Health Promotion – as will be discussed later.

Now that you have begun to orientate yourself to what Health Promotion can do, we will explore some of the factors that feed into our understanding of the field and its issues. It is important to recognise that we, as health promoters, build our understanding of Health Promotion from our own perspectives and values. It is therefore critical to re-examine your own values in order to be conscious and maybe critical of what Health Promotion means for you at present.

Coming into a high responsibility role like Health Promotion Manager, Nomhle would have to reconsider her values; and she may also have to induct her colleagues into different ways of seeing Health Promotion. In the next section, we will introduce one of the factors which is critical to our understanding of Health Promotion – how we understand health and its determinants.

### 4 DETERMINANTS OF HEALTH AND HEALTH PROMOTION

It is important that Nomhle recognises the importance of the local context in which the programme will take place, as well as the need for her programme to address the wider determinants of health. In this section, we will look at these important issues.
4.1 Determinants of health at different levels

This diagram by Dahlgren and Whitehead illustrates the complexity and integration of factors which determine health in a community.

As you will see, the determinants near the centre reflect the concerns that are more personal and individual, whilst those on the outer circle are concerned with the broad determinants that are largely out of our personal control. These different levels of determinants have important implications for the way we develop Health Promotion programmes.

For example, what would be the implication for the Health Promotion programme if Nomhle did not consider the general social, economic and cultural conditions in her district, but rather concentrated on the individual or family level? Would her programme be effective? Would it be well-received by the local community? The answer to this question is complex and we will therefore address it in the course of the module.

4.2 Living conditions as determinants of health

Addressing the issue of context inevitably raises a range of health determinants arising from both rural and urban living conditions. Reading 3 provides an overview of the impact of poor living conditions, including inadequate water and sanitation.
READING


TASK 2 - Analyse the determinants in this study

From the Reading, list the factors that influence diarrhoea in young children. Then categorise them according to the diagram by Dahlgren & Whitehead above. Finally, consider these questions:

a) What is the range of determinants noted in this article?
b) What approaches do you think are required to remedy these problems?
c) Would you consider these approaches part of a Health Promotion programme?

FEEDBACK

a) Through this task, it will hopefully have become clear that in order to promote health, particularly among poor people, one needs to look broadly at the conditions in which people live. It also illustrates the unfairness of these situations i.e., the inequities.
b) You will probably have found that some of the determinants could be placed in several sections of the rainbow, depending on how you interpreted them. Many of the so called behavioural problems, such as poor food storage, are probably directly related to poverty, rather than individual 'lifestyle' choices. This will influence how to position them, and also, importantly, what you see as remedies.
c) In terms of remedying these situations, you will have noticed that medical approaches on their own are not sufficient. The example of the impact of immunisation on poor children is a good example.
d) If one looks at Health Promotion in its broadest sense, then these conditions are part of the responsibility of Health Promotion programmes. Poverty is one of the critical determinants of health, and for this reason, it has become recognised as a paramount concern of Health Promotion. In the next section, we will explore this issue further and in more detail later in this unit.
4.3 Tackling the determinants

To respond to the importance of tacking social determinants of health, the WHO established a Commission on Social Determinants of Health (CSDH). This was launched in March 2005 and it will operate till May 2008. Have a look at reading 6, which provides an overview of the Commission, its challenges and some examples of action.

READING


Now study the reading “Promoting equity in health promotion: health and poverty” by Naidoo and Wills. This reading is a chapter from a British Health Promotion book called Practising Health Promotion – Dilemmas and Challenges, and whilst it applies to a different context, it provides a good overview of the importance of recognising and addressing the root causes of poverty as a determinant. It also suggests that there are different levels at which health promoters can intervene in situations of poverty.

READING


TASK 3 - Tackling broad based issues as part of a Health Promotion programme

Whilst reading the chapter, make notes which answer the following questions:

a) What challenges face the health promoter in contexts where poverty prevails?
b) What approaches are possible at the different levels?

FEEDBACK

a) According to Naidoo and Wills, there are three main challenges which health promoters face: the ways in which poverty affects peoples’ physical, behavioural and psychological health (1994: 72). These factors, they say, arise from homelessness and inadequate housing e.g. cold and damp, poor resources in relation to food, fuel, transport, recreation and social facilities, social isolation and powerlessness. The authors also suggest a causal relationship between physical and psychological health effects and behavioural changes in poor people (see Figure 4.2 on page
These three sets of factors are the result of different levels of determinants and the challenge therefore lies in developing strategies which address the big picture including the sources of inequality in society.

Their model is based on research in developed rather than developing countries and you need to assess whether you believe it applies to our situation. To make this assessment, you may want to look back at your Health, Development and Primary Health Care I module, Unit 3, where the complexity of poverty in under-developed countries is discussed in more detail.

b) When addressing possible intervention approaches, notice how Naidoo and Wills have divided their intervention into three different levels. At the macro level, the response is an anti-poverty strategy, which draws on different sectors and has a strong policy component. As you will see, they have suggested drawing on a series of publications which provide measurements to demonstrate inequities in support of this approach e.g. the Black Report of 1980. The Global Equity Gauge Project which is currently being developed in South Africa by the Health Systems Trust at a national level is an example of how data can be gathered and collated to be used as a form of advocacy for policy change at the macro level. It has been designed to measure the distribution of public health resources according to need to different parts of the population.

The Global Equity Gauge has also included city based initiatives. One of these was coordinated by the School of Public Health, UWC in partnership with the Unicity and other organisations at a city-wide level in Cape Town. The Cape Town intervention showed the potential of an intervention at the meso-level in that it drew stakeholders from this range of organisations into consultations, discussions and processes related to establishing measures for equity, with the view to developing wider awareness and ownership of the issues.

Finally, the micro-level relies on the individual practitioner, where practitioners provide information, advice and support, while recognising and accommodating the constraints of one-to-one interventions. Empowerment of individuals occurs at this level, but with the potential for feeding into the other levels if, for example, those individuals become involved in advocating for meso- or macro-level change.

In fact, it is now well-recognised that health will not be achieved nor illness prevented and controlled unless existing health inequities between and within countries are removed, and as a result, these conditions have been recognised as a paramount concern of Health Promotion.
5 EQUITY AND THE RIGHT TO HEALTH

The issue of poverty and its effect on the health of a community or population raises the issues of inequity, and how a society can work towards social and economic justice. The right to health is also recognised as a human right by the WHO, and as such, people should have access to basic resources for health.

You will have already become familiar with the importance of tackling poverty and inequities to improve health. This is as important in Health Promotion as it is in all other areas of public health and primary health care – if it is not addressed as a positive strategy, the tendency is that those who have the greatest need, find the challenge of improving their health the most difficult.

5.1 Equity and equality

It is important, however, to recognise the difference between inequity and inequality, although the terms are used loosely and often interchangeably. Baum describes the difference as follows:

“All equality is concerned with sameness; equity with fairness. Policies are unlikely to be able to make people the same, but they can ensure fair treatment.” (Baum, 2002: 228).

Whitehead, who has been one of the main writers on the subject for the WHO, argues that:

“The term ‘inequity’ has a moral and ethical dimension. It refers to differences, which are unnecessary and avoidable but in addition are also considered to be unfair and unjust. So, in order to describe a certain situation as inequitable, the cause has to be examined and judged to be unfair in the context of what is going on in the rest of society.” (1990: 5)

To demonstrate this, Whitehead (1992) provides seven situations which, according to the definitions above, could be considered equitable or inequitable. For example, is it equitable that access to essential health care is restricted?
TASK 4 - Clarifying what you believe to be inequitable situations

Have a look at these health differentials, and answer which you think are inequitable. Indicate if you think this health situation is potentially avoidable or commonly viewed as unacceptable. The view of what is unacceptable indicates perceived inequity.

<table>
<thead>
<tr>
<th>Determinant of health differentials</th>
<th>Potentially avoidable</th>
<th>Commonly viewed as unacceptable</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Natural biological variation.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Health damaging behaviour, if freely chosen.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Transient health advantage of groups who take up health promoting behaviour first (if other groups can easily catch up).</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. Health damaging behaviour where choice of lifestyle is restricted by socio-economic factors.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. Exposure to excessive health hazards in physical and social environment.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>6. Restricted access to essential health care.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>7. Health related downward social mobility (sick people move down social scale).</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>


FEEDBACK
Whitehead’s view is noted below. Do you agree with her assessment? If not, explain why not?

Which health differentials are inequitable?

<table>
<thead>
<tr>
<th>Determinant of health differential</th>
<th>Potentially avoidable</th>
<th>Commonly viewed as unacceptable</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Natural biological variation.</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>2 Health damaging behaviour, if freely chosen.</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>3 Transient health advantage of groups who take up health promoting behaviour first (if other groups can easily catch up).</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>4 Health damaging behaviour where choice of lifestyle is restricted by socio-economic factors.</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>5 Exposure to excessive health hazards in physical and social environment.</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>6 Restricted access to essential health care.</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>7 Health related downward social mobility (sick people move down social scale).</td>
<td>Yes</td>
<td>Low income</td>
</tr>
</tbody>
</table>


The distinctions are often not that obvious until some thought is given to them. The task will alert you to some of the issues which Nomhle would have to
consider in planning her project, and which you should think about in relation to the Assignment. Do the last part of the task (b) in your Assignment Notebook.

**A** TASK 5 - Assess whether certain determinants of HIV/AIDS are the result of inequity

a) Below are some possible determinants of HIV/AIDS in relation to women, classified according to category. The idea of health determinants illustrates the complexity of the situation and the fact that many different factors contribute to this health problem.

For this task, we would like you to assess the factors which are potentially avoidable and those which are commonly viewed as unacceptable or inequitable.

b) In your Assignment Notebook, summarise the determinants of health in relation to HIV infection which you (and Nomhle) should be aware of when developing your programme plan. Comment on the issue of equity in relation to these determinants.

There will be no feedback on this task, as there are no right and wrong answers – only judgements, of which yours is one. However, it is interesting to note how the situations that are seen as unfair and potentially avoidable are within the outer circles of Dahlgren and Whitehead’s model of determinants of health.
Equity or inequity of determinants of the HIV/AIDS epidemic in relation to women in South Africa

<table>
<thead>
<tr>
<th>Determinants</th>
<th>Discussion of the interconnections between determinants</th>
<th>Potentially avoidable</th>
<th>Commonly viewed as unacceptable</th>
</tr>
</thead>
<tbody>
<tr>
<td>Genetic &amp; biological factors</td>
<td>Anatomically women are more at risk of HIV infection than men, as there is a larger exposed surface area of the vagina and labia, compared to the penis, through which HIV can enter. In addition, mucosal surfaces in the vagina are more susceptible or likely to be affected when compared to the hardened penile skin. (Abdool Karim, 1998)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Individual behavioural factors</td>
<td>Men and women who have many sexual partners and do not use condoms or practice safer sex, intravenous drug-users who share needles and syringes, and health workers who do not practise universal precautions place themselves and others at risk of HIV transmission. Alcohol is commonly associated with an increase in the level of violence, including sexual violence, which would then place women in a position of risk. Violent, rough and forced sex or rape results in a woman being forcibly placed in a position in which she is unable to say no to sex, or to protect herself by insisting that her male partner uses a condom.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Factors around work and living conditions</td>
<td>In some communities, particularly rural communities, women do not have equal access to on-going training and tend to be excluded from the formal economy. Where women have been able to access skills and training, they have not always had the power to negotiate equivalent work positions or conditions unlike their male colleagues. Having had less choice around what work they are able to do, women have often had to explore other work options, such as sex work, or in some cases, accepting gifts, favours, or a place to stay, in return for sex. In these situations, where women are economically dependant on their clients/men, they are likely to be placed in a situation where they accept money for sex without using a condom, or have to suffer abusive sexual situations.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Environmental factors</td>
<td>General degradation of the environment, for example, lack of street lighting creates an environment which is not safe for women to walk in, placing them at greater risk.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Broader political, social and economic factors

In general, women have less power in their intimate relationships and are therefore not in a position to talk about and negotiate safer sex practices. A woman is also more at risk of violence, abuse or rejection by her partner if she asks him to use a condom (either within or outside of his relationship with her), or if she says no to unprotected sex.

The apartheid legacy and the associated migrant labour system resulted in many families having to live apart from one another. Away from home, men often had multiple sexual partners, which placed their primary partner at risk of HIV infection when he returned home.

Women were left to work at home, often in rural areas, and suffered considerable hardship and poverty. In the case of men falling ill or dying, women were left in an even more vulnerable position. In many instances, women had no other choice but to have sex in exchange for food, shelter and support for their children.

(Adapted from Heywood, Schaay & Clifford, 2001: 13-16)

You have almost reached the end of this session. To consolidate and apply your understanding of the issue of poverty in Health Promotion and the resulting challenges, re-read the assignment instructions and make notes on relevant issues from this session as well as useful references from the readings. Make this a regular process and record your preparation in your Assignment Notebook.

6 SESSION SUMMARY

In this session, you have reviewed your vision of Health Promotion and used Whitehead and Dahlgren’s model to categorise determinants of health. You have also read two studies of the impact of poverty on health and explored the importance of equity or fairness in guiding Health Promotion programmes at different social levels.

Remember these issues as you progress through the module, bearing in mind the challenges, but also the potential of working for change at different levels i.e. as individuals, communities, local government and health districts, as well as at national government level and globally.
In the next session, we develop some of the debates which are relevant to Health Promotion by reviewing the historical development and changes in the Health Promotion movement.

7 REFERENCES AND FURTHER READING


Unit 1 - Session 2
Development of the health promotion approach

Introduction

In the first session, we looked at the importance of recognising and tackling the determinants of health as part of a Health Promotion programme, along with the need to address equity. In this session, we present an overview of recent developments in the discourse of Health Promotion internationally. In the process we raise some of the reasons for shifts in focus within the Health Promotion Movement. This session is, therefore, more than just an historical overview as it raises many of the issues and debates within the field today.

Session contents

1 Learning outcomes of this session
2 Readings
3 Health Promotion before and after the Ottawa Charter
4 Components of Health Promotion
5 Clarifying your own philosophy of Health Promotion
6 Session summary
7 References and further readings

Case study update

You will remember from the Case Study (School of Public Health (2002)) that Nomhle's job description implied a fairly narrow interpretation of what a Health Promotion programme would entail. Hopefully, through her proposal, she would be able to argue for a broader approach which takes into account the wider determinants of health discussed in Session 1, and propose strategies to address them. Before arranging any meetings, she therefore used the opportunity to remind herself of recent developments in the *discourse* of Health Promotion; by *discourse*, we mean the issues, thinking and debates within the field. To acquaint herself with these debates, she was able to use key documents contained in her Course Reader.

As well as strengthening the arguments she would use in her plan, she saw this as a useful way to place her recommendations within contemporary Health Promotion discourse. You are asked to do the same, taking note of any new information which would guide your thinking and help you to strengthen your arguments for your proposed programme.
Timing of this session

This session aims to give you a good grounding in the documents which have helped to shape current understandings of Health Promotion. There are five readings and four tasks. It could take you up to four hours spread over two or three sessions. Logical points to break the session are after Tasks 1 and 3.

1 LEARNING OUTCOMES OF THIS SESSION

By the end of this session, you should be able to:

- Place Health Promotion within a wider conceptual and global framework.
- Provide an overview of recent developments in the discourse of Health Promotion.
- Develop an overview of the debates which underpin changes in the field during the past three decades.

2 READINGS

The readings for this session are listed below. You will be directed to them in the course of the session.

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<th>Reading</th>
<th>Publication details</th>
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<tr>
<td>WHO</td>
<td>(Spring 1991). A Call for Action: Promoting Health in Developing Countries. Health Education Quarterly, 18(1)</td>
<td>513 - 526</td>
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3 HEALTH PROMOTION BEFORE AND AFTER THE OTTAWA CHARTER

In this section, we will provide a brief overview of the recent historical development of Health Promotion. Clearly there have always been cultural and religious traditions aimed at promoting health, although many of them are not documented. This description therefore builds on the practices that grew out of developed countries of the North, but which have relevance to, and have been adopted by countries of the South. It is interesting to note that many of the recent additions to the approaches were adopted by the North from the South, for example, community empowerment and development.

A convenient way to grasp the significant changes in Health Promotion that have taken place over the last three decades is to look at its interpretation and practice before and after the Ottawa Charter (1986). This was a landmark document which has had significant influence on Health Promotion and beyond it.

3.1 Health Promotion prior to the Ottawa Charter

Prior to the Ottawa Charter, emphasis was placed on Health Education. However, there have been many criticisms of the Health Education approach in recent years, chiefly because it was seen as focusing primarily on educating individuals. By implication, this was seen as overlooking the social, economic and environmental contexts in which people were living. An example of this is blaming people with heart disease for being overweight and smoking, whilst reasons such as the lack of affordable healthy food and high levels of stress are overlooked (Ewles & Simnett, 1999). This kind of criticism has therefore been referred to as the “victim blaming” approach, as it implies that if people are given information or advice and do not adhere to it, then their health problems are their own fault.

An often cited analogy of this failure to consider the broader environment is the “upstream/downstream” model described by Zola (1970). The analogy goes as follows: a practitioner, standing at the side of a river, is so busy pulling the drowning people out of the river, that s/he is unable to go upstream to find out why they have been pushed in. In other words, the model suggests that practitioners may overlook the reasons why people behave in the way they do, when giving health enhancing advice.
However, these arguments and criticisms may overlook the history of Health Education and its wider interpretations. Although a focus on behaviour change was characteristic of what is sometimes described as the traditional or preventive model of Health Education, it should be noted that there were co-existing approaches. Advocates of a humanistic educational model focused on knowledge development, values clarifications and enabling people to make health-related choices. Education informed by a radical or social model focused on developing peoples’ knowledge of the social and environmental determinants of health and developing skills which are needed to take action. The principles of Health Education were a component of the Alma Ata Declaration (1978), and are incorporated into the principles of the Ottawa Charter. They are an integral part of the overall concept of Health Promotion as a vehicle for developing the capacity of communities to participate in health promoting programmes.

3.2 The Ottawa Charter and beyond

The Ottawa Charter grew out of the New Public Health, which you have already encountered in your Core modules in the MPH. This period is marked by the Health for All by the Year 2000 campaign (now replaced by Health For All in the 21st Century), the Alma Ata Declaration, 1978 and the Ottawa Charter, 1986.

Since it was launched at the First International Conference on Health Promotion in Ottawa in 1986, the Ottawa Charter has become a focal point of recent Health Promotion theory and practice. There were two driving forces behind the development of the Ottawa Charter - the first being the failure of developed countries to adopt the Health for All (HFA) strategy, and the second, the limitations of the lifestyle change and behavioural approaches in Health Education, referred to above.
Since the Ottawa Charter, there have been 5 more important International Health Promotion Conferences, each using the Ottawa Charter as its foundation, and then focusing on, or developing specific aspects in response to the changes in the climate of health promotion.

These were:
- the Adelaide Conference in 1988, which focused on Healthy Public Policy,
- the Sundsvall Conference in 1991, which focused on Sustainable Environments,
- the Jakarta Conference in 1997, which had Investments in Health as its focus,
- the Mexico City Conference, in 2000, which focused on bridging the equity gap, and
- the Bangkok Conference in 2005, which launched the second Health Promotion Charter, the Bangkok Charter. The focus of this is tackling the determinants of ill health in a globalized world.

We are including the Ottawa and Bangkok Charters as readings. If you wish to, you can access the Conference Statements from Adelaide, Sundsvall, Jakarta and Mexico by logging on to the WHO website, http://www.who.int/en/ and searching for International Health Promotion Conferences.

### READINGS


See pp 1-6 in the Reader.


### TASK 1 - Analysis of the key Health Promotion documents

Read the Ottawa Charter, looking carefully at the five principles and the approaches.

Now read the Bangkok Charter,

Consider the following aspects of the above documents:
- Their inter-relationship.
- Their interpretation of health – that is, their values and approach.
FEEDBACK

The values adopted by the documents are in line with the view put forward in the first session of the module – that health is viewed holistically, and should include the broad socio-economic interpretation of health.

The Ottawa Charter has, since its inception, been seen as a very significant document for health promoters. One of its main strengths is its ability to integrate so many of the different perspectives on Health Promotion: it was able to build on the foundations of the New Public Health, that is, that the pre-requisites of health are peace, shelter, education, food, income, a stable ecosystem, social justice and equity. At the same time, it kept its focus on behavioural and lifestyle approaches by placing emphasis on acquiring personal skills.

The Bangkok Charter builds on the values, principles and action strategies of the Ottawa Charter. In addition, new concepts and commitments have been added in response to the changes of globalisation. While the Ottawa Charter is generally viewed favourably, there has been an active debate on the merits of the Bangkok Charter. Comments in favour of it include the value of having a strong foundation in developing country issues. Against it, are comments about it representing a shift in discourse in health promotion from a democratic peoples approach to one concerned with technocratic law and policy work (Porter, 2006) and a description that calls in an inadequate and timid document that falls far short of what is required to tackle global health problems today (People’s Health Movement, 1005, cited in Mittelmark, 2007). For those interested, you can read more about the debate online by logging on to the Bangkok Global Conference on Health Promotion.

A developing country perspective

The origins of the Ottawa Charter, as noted, were in a developed country context, although you will have also seen the relevance to developing countries. The more recent International Conferences, as noted above, have had more of a developing country focus. However, before these later conferences, the WHO developed a Developing Country response, A Call to Action: Promoting Health in Developing Countries, which we have included as, despite being quite old, it raises important issues that remain relevant.
Read this document to consolidate the ideas so far.

**READING**


**TASK 2 - Applying these documents to your project**

This task should be done in your Assignment Notebook. It will help you to consider the needs in Mfula and to select relevant principles and strategies for your proposed plan for Mfula.

- Which of the proposals in “A Call to Action …” pose a particular challenge, or will be necessary, but difficult, to implement in your district and in the Mfula district? Why?
- What action areas from the Ottawa Charter will be relevant to your Mfula plan, and why? Just note these briefly now. You will be studying the Ottawa Charter in more detail in Unit 4.

**FEEDBACK**

No feedback is provided on question (a) as this reflects your own experiences.

You will probably have found that whilst the issues and priorities are different in developed and developing country contexts, the concepts and approaches are generally applicable to both contexts. The principles and approaches in the Ottawa Charter and those that followed encompass the important issues of development, and are clearly reflected in “A Call to Action”. These are therefore very useful documents to draw on in practice, and so will be useful to Nomhle in her endeavours to broaden her programme to include other sectors.

It is, however, also worth noting that the practical implications of the principles are not always possible to implement: for example, some centralised government policies make it difficult to work on policy issues at a local level. This may apply to you and you will have to bear this in mind when devising your programmes. Talk to people involved in policy development in your field to establish how you can best work within, but at the same time, try to influence your government’s policies.
4 COMPONENTS OF HEALTH PROMOTION

So far, we have looked at the broadening of Health Promotion to encompass a wider agenda. This has included exploring the determinants of health and the way in which they have influenced the global agenda. We have also begun to look at some of the levels at which health promoters can tackle this broad agenda. To consolidate this discussion, we will look in more detail at the different components of Health Promotion which have become part of our contemporary view of the field since Ottawa. This is in fact the sort of understanding that Nomhle would have to put across and be able to advocate to her District Manager when presenting her plan for a Health Promotion programme.

In this section, we will look at the concepts, terminology and scope of Health Promotion and its relationship with Health Education in more depth. As you will be fully aware by now, adopting a broad approach to Health Promotion means that one is inevitably building on a wide range of disciplines and theoretical foundations Health Promotion is also a dynamic, growing field in its own right.

In Session 1, we noted that there is general consensus that Health Promotion is an umbrella term to cover all interventions that promote health. These interventions include health education, healthy public policy, community participation, legislation and environmental changes.

(Ewles & Simnett, 1999: 25)
The extent to which the different components are developed, and the ways in which they are interpreted, varies according to the different theorists, different opportunities and different contexts. We will now examine these a bit further.

4.1 Contrasting interpretations of Health Promotion

The next two readings provide an overview of Health Promotion terminology and concepts used in the field of Health Promotion. The first is a glossary developed in 1998 (an update of the original glossary developed in 1986), and the second, a further update to include 10 new terms. Skim through these so that you know where to look should you need to clarify your understanding.

**READINGS**


The table below was developed by Tilford, Green and Tones and shows some of the shifts in the use of terminology between the original glossary in 1986 and the revised version in 1998. Identify those terms which are no longer used in the 1998 version of the glossary and question why this might have changed in relation to shifts in the aims and vision for Health Promotion e.g. “community action for health” only appears in the 1998 version. This suggests that the strategy of directing communities to address the determinants of health themselves is a recent development and recognises the importance of community participation in addressing their own health.

In the 1998 document, there appears to be greater emphasis on evaluation and related issues such as goals, outcomes and indicators. Strategies are more explicitly addressed, notably empowerment for health, settings, supportive environment, inter-sectoral collaboration, partnership, mediation, and sustainable development. There is concomitantly less emphasis on individual behaviour modification and mass media which perhaps signals the direction in which Health Promotion has evolved. New terms to emerge include health literacy, health development, investment for health, social responsibility for health and social capital. More detail is available in an article by Tilford, Green and Tones (2002), the details of which you will find in the References and Further Readings list.

Terms included in the Health Promotion Glossaries 1986 and 1998
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Now look at the additional terms in the 2006 article by Smith et al. This notes the impact on Health Promotion of globalisation and the need for political advocacy to address the determinants of ill health, the issues raised at the Bangkok Conference on Health Promotion noted in Session 1. However, despite this, you will notice that among the definitions are some that have a disease based, and a re-emphasis on individual or marketing focus, (burden of disease, self-efficacy, wellness and social marketing), which work against the principles of the Ottawa Charter and many of the trends noted in the Tilford, Green and Tones table. Others, however, tend towards more integrated approaches (capacity building and health impact assessment). Some of these terms will be picked up later in the module in more detail in Units 3, 4 and 5.

What then is health promotion?

This unit began by noting that Health Promotion is broad in its scope, and that there are different interpretations about its implementation. This is reflected in the lively discussion about the concept of Health Promotion in recent years. Inevitably, this is reflected in the way health promotion is defined. By their nature, definitions are summaries, so they will inevitably be unsatisfactory, and the subtleties of the objectives and processes are often missed or misrepresented.

Have a look at the range of descriptions of Health Promotion listed below to see whether you think they capture the ideas discussed so far.
TASK 3 - Analysing descriptions of Health Promotion

Read the definitions and descriptions below and then answer these questions.

a) What do you think are the common themes in these definitions or descriptions?
b) What are the differences between the definitions?

Definitions of Health Promotion

“Health promotion is a unifying concept for those who recognise the need for change in the ways and conditions of living in order to promote health. Health promotion represents a mediating strategy between people and their environment, synthesizing personal choice and social responsibility in health to create a healthier future.”
(WHO, 1984)

“Health promotion is the process of enabling people to increase control over, and to improve their health. To reach a state of complete physical, mental and social well-being an individual or group must be able to identify and to realise aspirations, to satisfy needs, and to change or cope with the environment.
…Therefore health promotion is not just the responsibility of the health sector, but goes beyond healthy lifestyles to well-being.”
( WHO, The Ottawa Charter, 1986)

“Health promotion incorporates all measures deliberately designed to promote health and handle disease. A major feature of health promotion is undoubtedly the importance of ‘healthy public policy’ with its potential for achieving social change via legislation, fiscal and economic and other forms of ‘environmental engineering’.”
(Tones, 1990)

More recent descriptions have added aspects such as:

Health Promotion being:
“a key investment [where] social responsibility for health is reflected by the actions of decision makers in both public and private sector to pursue policies and practices which promote and protect health.” (Jakarta Declaration, WHO, 1997)

And finally,

“Health Promotion is the process of enabling people to increase control over their health and its determinants, and thereby improve their health. It is a core function of public health and contributes to the work of tackling communicable and non-communicable diseases and other threats to health.”
FEEDBACK

There are clearly many overlaps in these descriptions as they all build on the themes of the Ottawa Charter and adopt a broad definition of health. However, there are also some differences in emphasis. For example, you will notice how the earlier definition (Tones) included a focus on education and disease prevention, whilst the more recent descriptions have developed more of a focus on investments for health (Jakarta Declaration) and a focus on tackling diseases (Bangkok Charter). This shift in focus was evident when comparing key terms included in the Health Promotion Glossaries referred to above.

4.2 The relationship between Health Promotion and Health Education

You will have noticed that we have used the term Health Education for the activities prior to the Ottawa Charter, and Health Promotion for the period after. This reflects the broadening out - from the individualistic focus of Health Education - towards the holistic process of Health Promotion which combines action on public policy for health and environmental action with Health Education. You will have noted that Ewles and Simnett (1999) include Health Education under the umbrella of Health Promotion.

Yet, there has been considerable criticism of what was seen as the limitations of Health Education’s individualistic approach, as was noted above. Tilford et al (2002) counter this criticism by pointing out that whilst the limitation of focusing on knowledge as a means of influencing behaviour is well-recognised, it is worth noting that knowledge still remains a pre-requisite for health.

Furthermore, they argue, education is often simply equated with the development of knowledge, with little acknowledgement of its contribution to the development of skills, values and motivations. Tilford et al (2002) point out that critics of Health Education often overlook the contribution of education to achieving social and political change. Tones and Tilford (2001) have argued for an expanded view of education in line with Paulo Freire, the Brazilian adult educator’s thinking and the concept of emancipatory education. This approach includes consciousness-raising and the development of a sense of community motivation and skills to take action to address health concerns.
We are nearing the end of the session, so to consolidate your understanding of Health Promotion, do this task which is taken from Ewles & Simnett (1999: 40).

**TASK 4 - Analysing your philosophy of Health Promotion**

"Clarify your view of Health Promotion by doing the following task. Consider the following statements A and B:

A. The key aim of health promotion is to inform people about the ways in which their behaviour and lifestyle can affect their health, to ensure that the information is understood, to help them explore their values and attitudes, and (where appropriate) to help them to change their behaviour.

B. The key aim of health promotion is to raise awareness of the many socio-economic policies at national and local level (e.g. employment, housing, food subsidies, advertising, transport and health service policies) which are not conducive to good health, and to work actively towards change in those policies.

a) Taking statement A:
   - List arguments in support of this view;
   - List any points about the limitations of this view, and any arguments against it.

b) Do the same with statement B.

c) Do you think that the views in A and B are complementary or incompatible? Why?

d) Imagine these two views at either end of spectrum.

A | .... | .... | .... | .... | .... | B

1 2 3 4 5

Indicate the two positions on the scale of 1 to 5 which most closely reflect (i) *what you actually do in practice* and (ii) *what you would like to do if you were free to work exactly as you would wish to.*" (Ewles & Simnett, 1999: 40)

**FEEDBACK**

a) The approach taken in statement A draws on an individualistic Health Education approach. The advantages of this approach are that it works with people to increase their awareness of situations that affect their health; it informs them of measures that they can adopt to reduce risk behaviours, such as smoking or to engage in health enhancing activities such as exercise. The disadvantage of the approach is that it does not look at the *bigger picture* that influences the behaviour of that person.
such as the socio-economic or environmental conditions that determine the choices they make. This can lead to *victim blaming* which was described earlier. Using the same two examples, people living in stressful situations often smoke to reduce their stress, and people living in unsafe areas are less likely to take exercise for fear of violence. This approach therefore works against equity – it is the people with the least personal resources that are the least able to “look after” themselves.

b) Statement B, by contrast, does focus on the wider determinants that affect people’s health. Tackling these determinants through policy can make a significant difference to whole populations. By improving the living conditions of individuals it makes them more likely to be able to make the healthier choices proposed in statement A. This approach therefore works to promote equity. However, these changes are more difficult to implement as they require the commitment and contribution of a host of stakeholders and departments. They are also slow. Finally, they overlook the possibility of people doing things for themselves.

c) The views in A and B form part of a continuum. Both are important, but have limitations. Many Health Promotion programmes have a focus on working with individuals whilst at the same time striving for policy change. In fact, many programmes include an “empowerment” or community development approach with individuals that leads to them becoming involved in the wider policy development activities.

d) Your views will probably have included some aspects from box A and some from box B, and you may find that you would like to do more from box B than you are able to in practice. Ewles and Simnett (1999) suggest that there is no right and wrong aim or approach for Health Promotion. This view is reflected in the definitions of Health Promotion, as is illustrated above.

6 SESSION SUMMARY

You have reached the end of Session 2. In it we looked at some of the key documents in the recent development of Health Promotion thinking and approaches to it. The session highlighted how the broad determinants of health which we discussed in Session 1 have become an integral part of Health Promotion thinking, and noted some of the criticisms of earlier practice. Finally, the concept of Health Promotion was “unpacked” into some of its component parts. The third and final session of this contextual unit is an overview of some theoretical contemporary challenges for health promoters.
7 REFERENCES AND FURTHER READINGS


- Tilford, S., Green, J. & Tones, B.K. (2002). *Values in Health Promotion and Public Health*. This article will appear on the UK Health Development Agency Website: [www.had.org.uk](http://www.had.org.uk)


Unit 2 - Introduction

Theoretical Perspectives – Models and Approaches

Introduction

The first unit introduced the concepts of Health Promotion and the contexts in which its activities take place. Whilst studying Unit 1, you will have noted the shifts that have taken place historically and ideologically, in thinking about health and Health Promotion over the past three decades.

This unit looks at theoretical perspectives on health promotion as an activity and some of the theories and models used to support Health Promotion activities. It is clearly beyond the scope of this unit to explore all the theories and models that have been developed. Instead, an overview of some main theories is given, and some of the more commonly used models and theories are described and debated. This is done largely through readings, and through short tasks to enable you to explore how theory is put into practice in the field of Health Promotion.

Unit 2 is divided into three sessions:

Session 1: An Overview of Health Promotion Theory
Session 2: How People Make Decisions about their Health
Session 3: Theories and Models of Behaviour Change.

The first session explores the nature of theories and models, identifies theories used in health promotion and considers in detail the different models and approaches that are used to distinguish different perspectives on health promotion practice. Session 2 introduces a selection of models which address the issue of health decision making in individuals and communities. Session 3 highlights theories and models which are relevant to individual and group behaviour change.

There are a number of activities for your Assignment Notebook which are marked with the symbol A.
Learning outcomes of Unit 2

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

- Discuss the importance of theory to practice.
- Provide an overview of Health Promotion theories, models and approaches.
- Describe selected models used in Health Promotion and apply to familiar health issues.
Unit 2 - Session 1
An Overview of Health Promotion Theory

Introduction
Theory is important in all stages of Health Promotion, including in the assessment of the importance of any intervention, in understanding the behaviours of individuals and groups, and in selecting the approaches that one may adopt for a programme. Given the history and broad base from which Health Promotion is drawn, it is not surprising that its theories and approaches are derived from a range of disciplines as diverse as sociology, psychology, education and epidemiology. This is considered by many commentators to be a strength of Health Promotion.

In this session, we will explore the importance of theory to practice in Health Promotion and provide an introduction to the theories used in practice.

Given the range of theories drawn on in health promotion we cannot consider all in detail. In this session we will focus specifically on models and approaches of health promotion practice considered as a whole, and sessions 2 and 3 will focus on models used for specific aspects of practice.

The emphasis of the session is on the readings but you will be asked to apply some of the theories and models to your own experience in Health Promotion.

Session contents
1 Learning outcomes of this session
2 Readings
3 The importance of theory
4 An overview of the theories used in health promotion
5 Models and approaches
6 Selecting a model or approach
7 Session summary
8 References
Timing of this session

This session is designed to orientate you to a range of theories, models and approaches. It could take you up to four hours to complete. There are two readings and three tasks.

1 LEARNING OUTCOMES OF THIS SESSION

By the end of this session, you should be able to:

- Explain the importance of theory to practice.
- Describe and categorise main Health Promotion theories.
- Compare two overviews of Health Promotion approaches.
- Apply models of Health Promotion to a familiar health issue.

2 READINGS

There are two readings in this session. You will be referred to them in the course of the session. Kindly note: in the text, when we refer to a page in a reading, we refer to the page number that appears in the original reading. So, for example, when we refer to “page 45” in Theory at a Glance, we don’t mean page 45 in the Reader, but page 45 within that reading.

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3 THE IMPORTANCE OF THEORY

What is theory and why do we need to study it as a basis for practising health promotion? Think about this and jot down some notes before reading further.

Now read pages 4-7 of Glanz (2005), ‘Theory at a Glance’. As you read, make sure that you are able to answer the 4 questions below. The questions are intended to help you ensure that you have grasped the key points.
READING

FOCUS QUESTIONS FOR READING
To focus your reading, try to answer these questions as you read:

- What are the key features of a theory?
- Why is theory important to Health Promotion practice?
- What do we mean by applying a theory to practice?
- What is the difference between a theory, a model and an approach?

FEEDBACK
Taking the four questions in order, if you noted some of the following points, then you understood the main points that the reading makes about theory:

What is a theory?
- A theory represents a systematic way of understanding events and situations.
- Theories are made up of concepts and propositions that explain or predict events.
- They are presented in abstract terms but can be applied to a range of concrete situations. For example, the Theory of Planned Behaviour which we will look at in this unit is presented in abstract terms but can be applied to understanding the determinants of a wide range of specific health decisions.
- The term ‘constructs’ is used to describe the concepts of any particular theory. For example, when we look later at the Health Belief Model we will note its constructs of ‘perceived threat of disease’, ‘perceived costs and benefits of action’, ‘perceived self efficacy’ and ‘cues to action’.

Why is theory important to health promotion?
- It provides a foundation for practice. It helps us at all stages of programme planning:
  i. analysing the factors influencing an issue we are to address and the relationships between the factors; and
  ii. designing, implementing and evaluating appropriate interventions.
• Theories support us in answering ‘why’ ‘what’ and ‘how’ questions in planning and implementing health promotion programmes.

• Theories take us beyond basing our work on intuition and hunches about what works.

• Theories can suggest innovative ways to approach analysing practice situations and planning interventions.

• Theory is important when we have to justify our decisions to others, such as managers and politicians. For example, if we want to encourage the adoption of a new practice in a community we will find it easier to get resources if we can show that we are basing our intervention on the elements of a theory rather than on a hunch about what might work. Theory will also be useful for Nomhle when justifying her choices and persuading her colleagues that, for example, a strategy broader than Health Education is needed in order to achieve her goals.

• Health promotion is a young discipline and like other disciplines needs to build its own individual theoretical base alongside a strong evidence base and a coherent set of values.

• According to Caplan (1993) (in Naidoo and Wills 2005) theory gives a common method and language through which to conduct a more thorough and informed debate about practice. Because many people involved in health promotion come from a range of disciplines they need to assimilate its theoretical base in order to work effectively with colleagues.

What do we mean by applying theory to practice?

• Using relevant theories in order to understand and explain health related issues and identify appropriate health promotion responses; and

• Using theories to aid the planning, implementation and evaluation of our activities.

Some theories help to explain how people make choices about their health – both individually and en masse (as a group). They can also define how social and environmental factors influence these decisions, and provide insight into the nature of both inter- and intrapersonal dynamics governing peoples’ behaviour. If we have a better understanding of the range of factors that influence decisions, we will be in a better position to devise strategies and formalise our Health Promotion goals, no matter what ideologies we subscribe to or models we choose to use.

What is the difference between a theory and a model?

Models are used to present a theory in a visual form. Models can integrate more than one theory. These various terms are not always used consistently as
you will see in your reading. In trying to differentiate between a theory and a model, Earp and Ennett (1991: 164) note that a model is often used to mean a visual representation of the elements of a theory. It is often informed by more than one theory, and allows the inclusion of processes and characteristics which are “… grounded in empirical findings”. (1991: 164). Theory at a Glance describes them as generalised hypothetical descriptions, often based on an analogy, used to analyse or explain something. While theories can be represented as models not all models are based on theory.

The Reading placed emphasis on theories which can be applied to a wide variety of situations, i.e. theories that are generalisable. Theories of this kind are typical of the natural sciences. They emerge from the thinking that there is an objective world than can be measured; one where relationships about cause and effect can be stated which can then be tested out in real life situations. These theories can be described as positivist ones. For example, the theories in Health Promotion which are used to understand health behaviours are of this type. However, there have been challenges to the idea that the social world can be understood objectively in a similar way to the natural world. There have also been questions about whether theories about the social world can be generalised as widely as those for the natural world. In addition, it is also important to remember that many theories used in health promotion were initially developed within specific parts of the world and their generalisability to very different situations was often assumed but not assessed. Many health promoters see it as important that we also take an alternative approach to the development of theory. They argue that we need to understand health and illness issues through the meanings held by individuals and communities. In other words we need subjective as well as objective information which can be obtained through interviews and focus groups, or by participating in the lives of communities. Theories can be drawn rigorously from the findings from these activities. It is not claimed that these theories are generalisable widely although they may be drawn on to help understanding of similar situations. They are described as interpretivist theories. Interpretivist theories are a systematic development of the understandings that practitioners develop through long experience or working in specific situations. An example of a study which sought to develop theoretical concepts in this way is Sifunda et al’s (2007) study of STI/HIV terminology among men in South African prisons in order to understand help seeking behaviours. Many would argue that we need to drawn on both positivist and interpretivist theories in our health promotion work.

It is important to emphasise that theory is often perceived by practitioners to be about book learning rather than of relevance to them in practice. It is not unusual to have practitioners talk with pride about how they have learned on the job rather than by theorising. This is particularly the case with fields of study such as Health Promotion, for two reasons: firstly this is because so much of what Health Promotion is about is seen as being common sense; and secondly, and importantly, because people involved in Health Promotion programmes come from a range of different disciplines, and therefore see the theories of those disciplines as their prime concern and do not recognise the importance of using health promotion theory. The implications of not having a theoretical
understanding is that whilst one might learn how to do something, one is less likely to think about why it is being done, or why it works or doesn’t work. Page 7 in Theory at a Glance provides some statements made about theory by practitioners. Listen out for comments about theory in your own work context and note whether they are similar, or different from the comments in the reading.

Finally it is important to remember that theories are tools. Like all tools their usefulness for specific tasks needs to be assessed. As knowledge develops theories may need to be changed. For example most of the main models of health related decision making have developed and changed over time.

You should now be able to start thinking about the challenges which Nomhle will encounter as she tries to develop her Health Promotion programme. By considering theories and models which have been derived from, or which have been successful in similar situations, she can plan with greater hope of success. She can also justify her proposal to colleagues who are sceptical, because her plan is based on tested theories. We will return to the issues raised in this session at the end of the Unit once you have been introduced to the range of theories, models and approaches used in health promotion.

In the next section, we provide an overview of Health Promotion theory with a reading to provide more background.

4 AN OVERVIEW OF THEORIES USED IN HEALTH PROMOTION

Health Promotion is a relatively young subject and, as we said in the Introduction to the unit it draws on a number of contributory disciplines for its theory, including psychology, epidemiology, sociology, education, anthropology, public and social policy and economics. What makes up Health Promotion theory is, therefore, a combination of concepts and theories derived from these contributory disciplines together with a growing body of theory developed within Health Promotion itself. Since Health Promotion is an evolving discipline, it is not possible to outline a fixed body of theory which everyone uses in analysing problems and planning appropriate interventions in this field. Although there is a broad measure of agreement about some central theoretical concepts and principles, there is continuing debate about the theoretical basis of Health Promotion as a whole, which is in itself a healthy situation.

The range of theoretical ideas that are commonly used in Health Promotion interventions apply to differing levels of analysis - individual, groups, community, or organisation or varying combinations of these levels. (see Table 1 on page 11 in “Theory at a Glance: A Guide to Health Promotion Practice” and Table 11 on Page 45 for specific example of theories at the first of the three levels.) Below is a range of theories, theoretical concepts and models which are applicable to Health Promotion:
• Models of health promotion as a complete activity and theoretical perspectives on its practice

- Individual theoretical concepts including self-concept; self-esteem; self-efficacy; locus of control; empowerment; values; attitudes; beliefs

- Theories of health decision making and behaviour change: Health Belief Model; Theory of Planned Behaviour; Health Action Model; Stages of Change.

- Communications theory: one-to-one and mass media. The theory addresses the nature of the communication process and its constituent elements

- Social marketing theory

- Sociological theory: culture; gender; ethnicity; social divisions and inequalities; social change.

- Education and learning theory: these theories inform the planning of Health Education activities.

- Social Learning/Social Cognitive theory: This is a combination of several theoretical concepts and principles. This theory has evolved over a long period and it has been widely used in Health Education programmes.

- Developmental psychology: cognitive, social, psycho-sexual, moral development. Such theory is drawn on in developing activities for client groups at differing points in the lifespan.

- Policy making and implementation

- Theory related to understanding settings and organisations and their functioning and interrelationships including Communication of Innovations; intersectoral collaboration; Management of Change, Whole Systems theory etc.

- Programme planning and evaluation

You will all be familiar with one or more of these theoretical areas, based on your undergraduate education. It is not anticipated that you study them all.

You should skim read the whole of this reading to gain an impression of the variety of theories used in health promotion. You should note that not all areas of theory listed above are included in this reading. This reading should be used as an important resource as you work through later units in the module.

Theories can be grouped in a number of ways. *Theory at a Glance: A Guide to Health Promotion Practice*, p6 groups them into:

**Explanatory theory** – theory of the problem – theories which help us to analyse and understand the issues for which we want to plan health promotion interventions, e.g. Health Belief Model; Theory of Planned Behaviour etc

**Change theory** – theory of action – the theories we draw on in implementing and evaluating health promotion programmes. E.g. Stages of Change; Social Marketing Theory; Communication of Innovations

The relationship between these two types of theory is shown in Figure 1, page 6 in the reading. As you look at individual theories you can decide which of the two groups they belong to.

At this stage you will have thought in general terms about the nature of theory and its importance within health promotion practice and will have a sense of the variety of theories which can be drawn on. As you go through the rest of this Unit think critically about the theories, models and approaches to which you will be introduced and consider how you might use some, or all of them in your own practice.

## 5 MODELS AND APPROACHES

We have already looked at the difference between models and theories. We now move on to approaches to Health Promotion. As noted above, a model is often used as a visual representation of a theory, and it can incorporate one or several theories. On the other hand, we use the concept *approach* to describe the way in which we intervene or tackle Health Promotion issues. An approach can be informed by theories or a model or it can simply be descriptive.

It is not surprising that the diversity in concepts of health, the influences in health and ways of measuring health and the goals to be sought in health promotion, leads to a number of different approaches to Health Promotion. Each approach has its particular perspective and it is likely that two or more approaches may be included in any Health Promotion programme. It is also likely that health promoters will have strong preferences for a specific approach according to their values, professional backgrounds and the circumstances in which they work. These preferences will have implications for the way that practitioners interpret their roles. There are different ways of categorising these approaches to Health Promotion.
5.1 A categorisation of broad approaches to Health Promotion

To introduce you to the different approaches to Health Promotion, study pages 91 – 102 of the Reading by Naidoo and Wills which provides a useful overview of five different approaches and sets them out according to their aims, methods and evaluation. They categorise the approaches as:

- Medical or Preventive Approaches
- Behavioural Change Approaches
- Educational Approaches
- Empowerment Approaches
- Social Change Approaches

**READING**


**QUESTIONS TO FOCUS YOUR READING:**

For each approach, develop a table with five rows and three columns in which you make brief notes on the aims, methods and evaluation of each approach.

- As you read this chapter by Naidoo and Wills, consider the differences in how the approaches are described by the different people referred to in the chapter.

- As you read the chapter, think about issues in your country that could replace the UK examples e.g. The HIV/AIDS or TB policies and programmes.

**FEEDBACK**

Compare your points in the first two columns with those in the table on p102 and your third column with the points made at the end of the discussion of each approach

5.2 Another view of Health Promotion approaches

In Section 5.1, you read Naidoo and Wills’s (2000) categorisation of Health Promotion into five approaches. Tones and Tilford (2001) group the approaches into three, not five categories, which they refer to as ideological models (as compared to the technical models that will be described in Session 2). These are:
- The Educational Model
- The Preventive Model
- The Empowerment Model

Very roughly what Naidoo and Wills include in their ‘medical and preventive’ and ‘behaviour change’ approaches are included by Tilford and Tones in the preventive model. What Naidoo and Wills include in the Empowerment and ‘Social change’ models they include within the Empowerment model. There are some differences between the two categorisations in the way an educational model is described – more narrowly in Tones and Tilford than in Naidoo and Wills. You can read Tones and Tilford’s detailed analysis of these three approaches in the further reading recommended at the end of the session.

Although the examples given by Tones and Tilford, and also Naidoo and Wills in these particular readings are UK focused the models, or very similar ones, are used widely in countries of the North and also the South.

6 SELECTING A MODEL OR APPROACH

Selecting a model or approach is a challenging process. People coming from different professional disciplines have diverse views. Different circumstances also suggest approaches and models which may or may not be the first choice of the health promoter. Reflect on the models of Health Promotion developed by Tannahill and Beattie described below as an illustration of the differences between a descriptive and an ideological approach.

Tannahill’s model of Health Promotion

Study the following diagram of Tannahill’s model of Health Promotion.

Fig 5.3 Tannahill’s model of health promotion
(Naidoo & Wills, 2000: 107)
“Tannahill’s model describes Health Promotion as three intersecting circles of health education, prevention and health protection. Within these intersecting circles lie seven possible dimensions of Health Promotion:

- Preventive services for example, immunisation and cervical screening.
- Preventive health education, for example smoking advice.
- Preventive health protection, for example, the fluoridation of water.
- Health education for preventive health protection, for example seat belt legislation.
- Positive health education, for example, building lifeskills with groups.
- Positive health protection, for example, implementing a workplace smoking policy.
- Health education aimed at positive health protection, for example, campaigning for protective legislation.

Tannahill’s model highlights the importance of complementary activity in different areas. This model highlights the fact that practice does not conform to theoretical boundaries but overlaps and spans different theoretical paradigms simultaneously.” (Tannahill, 1985, in Naidoo and Wills, 2001: 293)

**TASK 1: Categorise your Health Promotion activities using Tannahill’s model**

Consider your own health promotion activities and fit them into the various segments of Tannahill’s model.
Beattie’s model of Health Promotion

According to (Naidoo & Wills, 2000: 106), “Beattie’s model of Health Promotion relates more directly to social theories and highlights how Health Promotion practice can never be value free, but is underpinned by values and moral principles. Beattie’s model uses two axes to generate four quadrants. The vertical axis runs from ‘authoritative expert-led interventions’, typically based on an objective knowledge of health risks, to ‘negotiated interventions’ that acknowledge and use people’s lay knowledge of health. Knowledge is therefore identified as being both expert-defined and defined by lay people themselves. Activities may be traditionally hierarchical in nature or more e.g. altruistic and negotiated. The horizontal axis runs from activities directed towards individuals...
to activities directed towards whole populations. The model thereby encompasses the more psychologically or medically-driven interventions directed towards individuals, as well as the more Public Health or sociologically-driven interventions directed towards groups and populations.

The four quadrants generated by the model encompass Health Promotion activity that reinforces the status quo (health persuasion): Health Promotion that is benevolent but forceful (legislation), Health Promotion that is communal and radical (community development), and Health Promotion that is aimed at empowering individuals (personal counselling). The right hand quadrants highlight the importance of social change, whereas the left hand quadrants emphasise the importance of social continuity and consensus. The model as a whole therefore embodies very different social philosophies and values, but demonstrates that each kind of activity has a role to play in promoting health.”


**TASK 2 - Reflect critically on the Tannahill and Beattie models of Health Promotion**

As you study these models, reflect on whether they have any limitations.

**FEEDBACK**

As you will see, the Tannahill model highlights the importance of complementary activity in different areas. It highlights the fact that practice does not conform to theoretical boundaries but overlaps and spans different theoretical paradigms simultaneously. Tannahill's approach is descriptive and makes no judgement about which kind of practice is preferable. It does not imply any value judgement or ideological position. This means that certain issues are not addressed including:

- A critique of the value of a top-down or bottom-up approach: A key issue in Health Promotion is the control and power held by professionals and clients. Issues include who decides the agenda. In other words, do the professionals decide on the priorities or are the people affected by health issues able to decide what is important to them?
- Compliance or freedom of choice: the model does not address people’s right to adopt unhealthy behaviour.
- Cultural or Western bias: the medical and preventive models are particularly relevant to countries where western medicine prevails, which may not be relevant or appropriate elsewhere.
- The potential for widening inequalities: there is a danger that Health Education activities only reach those who are economically better off.

Beattie's model by contrast highlights how Health Promotion practice can never be value free, but is underpinned by values and moral principles. Furthermore, it recognises and demonstrates that a variety of activities have a role to play in promoting health, and importantly, recognises that knowledge can be defined by
both experts and by lay people for themselves. In other words, Beattie’s model is an example of an analytical model. It draws more directly to social theories

**TASK 3 - Applying models of Health Promotion**

Here is an opportunity to practise applying Beattie’s model of Health Promotion to a number of issues with which you may be familiar. Choose at least two issues from the list below, although it would be beneficial to try three and to compare your results.

Examine these issues using Beattie’s model, described above.

**Issues:**
- Diarrhoeal disease in children under 5 years of age.
- Increased prevalence of smoking in teenagers.
- Workplace accidents.
- Rising TB levels.
- Poor growth rate in children after weaning.
- Road accident deaths.

**FEEDBACK**

*Let us use increase in smoking prevalence in teenagers as an example.*

In Beattie’s model, the intervention could be classified according to the four quadrants. At an individual level, health persuasion could be about giving information to the teenagers and expecting that their understanding of the problems associated with smoking would be adequate to encourage them to stop. The personal counselling approach could be about working with them to understand why they still smoke, e.g. the problems of peer pressure, and assisting them to become empowered to make more informed choices without losing their *street credibility*. At the collective level, legislative action could include the removal of tobacco advertising from sporting activities and restricting underage tobacco sales, whilst at the community development level, it could be working with children through a health promoting schools initiative, building on peer education schemes and promoting non-smoking role models.

In thinking about your own practice:
*Does your work fall more heavily within some quadrants than others? If so, what are the reasons for this? Are you happy with this situation?*

You will have become aware of the importance of empowerment as a core value of health promotion. The combination of the empowerment and social change approaches in the Naidoo and Wills typology, the empowerment model of Tones and Tilford or the bottom up elements complemented by some legislative action in Beattie’s model are the approaches which the module writers prefer. However, while we need to establish our own preferred approach to Health Promotion practice, we also have to acknowledge that there will be situations where the model drawn on is, to some extent, governed by constraints. For example:
• there may be health crises where, for the good of the community as a whole, we need to work to secure health behaviour changes as specified within the Preventive Model.

• (Bullet point needed) In very young children, where the full capacities for informed decision making are not yet developed, we may not feel able to adopt fully the Empowerment Model. In some contexts, professionals may be held accountable for the success of their work in terms of health behaviour changes. In such a situation it may again be more difficult to work using an Empowerment Model.

There are some aspects of Health Promotion practice where there is usually clear evidence of the preference for one or other of the models you have read about. In patient education, there has been frequent use of Preventive and Educational Models, although there is now more use of Empowerment Models. In community development work the strongly preferred model is an Empowerment one, but we should note that there are many occasions where such a model is only partially implemented.

You may find it helpful to consider the constraints which Nomhle will encounter in her work as they may suggest which model or approach may be helpful. Remember however that the next two sessions will provide more guidance in terms of appropriate models for application to this particular problem.

These issues will be developed further in Units 3 and 4, when planning of Health Promotion programmes, and methods of implementation are discussed.

7 SESSION SUMMARY

In this session, we have looked at the importance of theories, and at some of the different ideological models and approaches relevant to Health Promotion. Theories are drawn from a range of different disciplines as well as developed within health promotion itself. Models can draw on one or more theories, while approaches adopt different ideological positions. As such, alternative approaches tend to be used in different contexts by practitioners for different purposes. In the next session we will look at a particular class of theoretical models – those which explain health related decision making.

8 REFERENCES


**Further reading**

Unit 2 - Session 2
How people make decisions about their health

Introduction
In order to achieve health improvements, changes in individual behaviours may be desirable. Depending on our preferred approach to health promotion and the contexts in which we are working we may EITHER: adopt an empowerment model and enable individuals and groups to choose and carry out health behaviours OR we may adopt a preventive model and attempt to persuade people to adopt specific behaviours that are decided by professionals. In both cases, action must be based on a sound understanding of the many factors influencing health choices at the operational or micro-level. In other words, it is important to recognise and be able to explain why and how people make health-related decisions and to understand the factors that influence health choices e.g. knowledge, beliefs, skills, attitudes, social pressures and environmental constraints.

In this session we will explore three models of health decision-making – the Health Belief Model, the Theory of Planned Behaviour, and the Health Action Model. These models seek to understand the variety of factors which influence people when they take decisions relating to their own health. This is an important issue for health promoters in that their interventions are intended to influence decision-making. An effective model could therefore be of value in planning Health Promotion strategies and programmes.

The final task is a process of making notes on relevant models in your Assignment Notebook, to prepare for writing the assignment 2 A.

Session contents
1 Learning outcomes of this session
2 Readings
3 Models of health decision-making
4 The Health Belief Model
5 Theory of Planned Behaviour
6 Health Action Model
7 Session summary
8 References and Further Reading
Timing of this session

This session could take you up to three hours to complete. There are three readings and four tasks to complete. A logical place for a break is after Section 5.

1 LEARNING OUTCOMES OF THIS SESSION

By the end of this session, you should be able to:

- Describe the variables in the Health Belief Model and apply it to specific examples.
- Comment on the strengths and weaknesses of the Health Belief Model.
- Describe the variables in the Theory of Planned Behaviour and draw on studies which have used this theory.
- Describe the key components of the Health Action Model.
- Use the models as a framework for understanding health decisions in specific situations.

2 READINGS

You will be referred to the following readings in the course of this session.

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MODELS OF HEALTH DECISION-MAKING

As noted above, the three models we will be looking at are the Health Belief Model, the Theory of Planned Behaviour and the Health Action Model.

These models differ in the number of factors that they take into account. This is because they have slightly different purposes. The Health Belief Model and the Theory of Planned Behaviour include a small number of variables, which it is argued, can provide a good indication of the likelihood that health decisions will be adopted. In presenting the models it is recognised that other factors which are not included may also have an influence on health decision-making. However, those which are included are believed to be the key ones. When resources are often not available to explore all variables, it makes sense to examine what are believed to be key ones.

When we appraise these restricted models, we have to ask if they are sufficiently useful in developing understanding of health decision-making situations. In the critique of the Health Belief Model, in the further reading for example, you will see that the focus on a limited range of beliefs can be useful in understanding some health-related decisions, but is less useful in other cases.

The second type of model, of which the Health Action Model is a good example, sets out to provide a comprehensive mapping of all the factors which are believed to influence health-related decisions. This model includes the factors which are in the more restricted models together with additional ones.

Before we begin to look at any of the models we would like you to reflect on your own health decision making by completing Task 1

**TASK 1 - Reflecting on a health decision from your own life**

Select a health decision from your own life by identifying a recent occasion when you intended to adopt a new health-related behaviour or to modify an existing behaviour. Examples could be giving up smoking, adopting regular exercise, changing diet to reduce Coronary Heart Disease risk, breastfeeding exclusively for six months etc.

List all the factors that you think led to your intention to adopt the behaviour.

a) If your intention was translated into action and maintained, what factors helped this process?

b) If you did not put your intention into practice, why was this?

c) If you put your intention into practice but then gave up, why was this?

Spend a few minutes in grouping together the factors that you have listed. Don’t spend too long on this grouping process but we will return to it after you have studied the Health Action Model. For example if your decision was influenced by a number of other people, you can put these together in one group or if you had a number of beliefs that influenced your decision, you could group these together.
FEEDBACK

The factors that you have listed will relate to the particular health decision that you looked at as well as to you as an individual. In most cases however, in thinking about the factors that led to your behavioural intention you may have included: some, or all of the factors below. If thinking about ‘giving up smoking’ you might include:

- Beliefs about the links between a health behaviour and mortality and morbidity. e.g. I believe that if I give up smoking I will reduce my chances of getting lung cancer and heart disease.
- Beliefs about yourself, especially your capacity to make a health change e.g. If I am sufficiently determined I believe I can give up smoking.
- Beliefs about what others think about your health and the need for change i.e. family friends and health professionals; e.g. I believe my children worry about my health and want me to give up; My doctor thinks I should give up.
- Your attitudes towards the behaviour in question e.g. I want to give up for the sake of my health and to please my children.
- Your attitudes towards yourself e.g. I will feel better about myself and my self esteem will increase if I give up smoking.
- The pressures of other people on you to make a change e.g. friends, family, health professionals, etc.
- A local event or a mass media programme which made you think about changing your health behaviour, e.g. the setting up of a non-smoking policy in the place that you work; a recent Soul City programme.

When you looked at the factors that influenced you in translating the intention into action, you may have included:

- Support of friends, e.g. support from a friend who was quitting smoking at the same time as you.
- Environmental help, e.g. the existence of a no-smoking policy at work may have helped you.
- Information provided by friends, families, the media or health workers
- Other benefits e.g. money saved; feeling healthier.

If you put your decision into effect but then gave up this could be for a number of reasons. In the case of a decision to give up smoking, factors might have included:

- difficulties in coping with the craving to smoke;
- feelings of anxiety that could only be coped with by having a cigarette
- lack of support from smoking friends
- didn’t feel any health benefits – actually felt worse.

You may have listed many other factors. Later when we look at the Health Action Model which attempts to include the full range of factors that can influence health decision-making you should see that many of the factors you have listed fit into this particular model

We will now look at the first of our three models: The Health Belief Model.
4 THE HEALTH BELIEF MODEL

You have one reading that introduces you to the Health Belief model. The reading is Theory at a Glance pages 12-14

You will have seen from your reading that this theoretical model includes 6 constructs:

1. Perceived susceptibility

2. Perceived seriousness
These two interact to produce a Perceived Threat

3. Perceived benefits

4. Perceived barriers
Benefits might be greater than barriers or, alternatively, barriers might exceed benefits.

5. Cue to action e.g. mass media; communication from health service etc

6. Self efficacy

An example of an application of the model to a specific health issue is provided on page 14. Using this as a guide to complete Task 2

TASK 2 - Apply the Health Belief Model

Apply the Health Belief Model to your own decision in one of the following examples:

- The routine use of seat belts in cars.
- Adoption of routine condom use as HIV prevention.
- Taking children of 0-1 years for a recommended programme of immunization.

We can look at the use of seat belts for a young man who does not regularly use them.
Perceived susceptibility:
I am an excellent driver and won’t have an accident so I believe my susceptibility to injury or death is low.

Perceived seriousness:
If I did have an accident I could be badly hurt or might die.

i.e. Overall, the perceived threat is low.

Perceived benefits
If I was in an accident I believe I would not be hurt as much if I was wearing a seat belt.

Perceived barriers:
It’s too much trouble to do up a seat belt every time I drive;
If I was in an accident wearing a seat belt it could prevent me getting out of the car quickly;
It’s not macho to use a seat belt and my friends would laugh at me.

i.e. Barriers outweigh benefits.

Cue to action:
I have noticed lots of posters about wearing seatbelts and there was a TV campaign earlier this year about wearing belts.
There is a new law about wearing belts in those cars where they are already fitted.

Self efficacy:
I am able to use a seat belt if I want to when I am driving alone. If I am with friends they will laugh at me for being so cautious so I wouldn’t bother to use the seat belt. I’m mostly with friends when I am driving.

i.e. perceived self efficacy is quite low.

In order for this person to change behaviour and routinely use a seat belt which belief factors would we need to work on?

First we would need to work on ‘perceived threat’ He recognises that an accident could be serious to his health BUT because he believes he is not susceptible to having an accident the two beliefs interact and his perceived threat is low. We would need to provide educational activity to change his ideas about susceptibility. You can think about the methods you would use when you have completed the next session and also the later one on methods.

Second he believes that there are a number of barriers to wearing a seat belt and not much benefit. We would, therefore, have to change beliefs about the barriers and persuade him that there are benefits. His belief that it isn’t macho to use a belt probably reflects local culture and may be difficult to change in the short term but needs to be considered as it appears to be a key factor influencing the behaviour.

Third: there are cues to action so we may not need to do more unless we considered there could be more relevant ones for this young man.

Finally: his self-efficacy needs some attention. While he can carry out the behaviour if driving alone he feels less able to do so if with friends.
The model has proved useful in understanding some health behaviours, particularly use of preventive services, and in providing information on which we can base programmes to bring about change in these and other behaviours. There are other behaviours where the focus on this limited set of beliefs does not provide accurate prediction of what people will do. Alternative models can be used which include additional variables in the effort to enhance the accuracy of understanding.

5 THEORY OF PLANNED BEHAVIOUR

The reading for this model comes from Naidoo and Wills (2000), and describes the development of the Theory of Planned Behaviour from the earlier Theory of Reasoned Action.

**READING**


This model has been widely used in studies of the factors determining health behaviours. You will have noted that the model is built around the intention to take a specific action. This intention is the product of interaction between three variables:

i. Beliefs about a particular action and the evaluation of those beliefs which leads to an attitude towards the action.

ii. The beliefs about what significant others (or people whom you respect) think about the action and the motivation to comply with their beliefs. This leads to what is described as the subjective norm.

iii. Perceived behavioural control or the individual’s perception of whether the behaviour is easy or difficult to perform. This is similar to the concept of self-efficacy.

The model has been criticised for its lack of attention to the factors that influence the translation of a behavioural intention into behaviour. If you are interested in working with this model, a summary of studies which have used it and a critique of the model can be found in Conner and Norman (Chapter 5). The details can be found under Further Reading.
The Health Action Model is presented in a paper by Keith Tones who devised the model in the 1970s and has modified it over the years. Start off the reading by studying the diagram called Figure 3.6 which illustrates the model. We are not asking you to read in detail about this model but are introducing it because, as you will see, it is probably the one which fits most neatly with reflections on your own health decision making in Task 1.

**TASK 3 - Assess how well the model fits with your own health decision making**

To check that you have grasped the main components of the model, look back to Task 1:
- Decide how the factors you have listed fit into the boxes in the model.
- If you did not include all factors in the model, why was this?
- If you also listed factors that won’t fit into any of the boxes you might like to think about how this model could be expanded.

**FEEDBACK**

This model attempts to pay attention to all the variables that may be operating in particular health-related decisions. It is more complex than the earlier models and may require more time before you gain confidence in using it. You will have noticed in the reading that Tones explains why he separates out self concept and self esteem in the model. This may have puzzled you when you looked at the diagram of the model. Logically, self concept is one belief contained in the belief system, and self esteem is contained within the motivation system. He argues that if we want to adopt an empowerment model, self concept and self esteem are key factors to address and for this reason has visually highlighted them within the model. You may find it helpful to read the extended discussion about this model in Tones and Tilford (2001) which is included in the Further Readings.

The effort of becoming familiar with the model can pay off if it helps you to pinpoint the most important influences on health behaviours in specific situations. It ensures that limited resources are used most efficiently. The model can be used in quite a simple way. When asked to work on a specific health
behaviour with a defined client group, you could set up focus groups and, using appropriate open questions, you could gain information which fits into the main boxes of the model: i.e.

- Belief system: knowledge and beliefs in relation to the specific behaviour.
- Motivation system: attitudes, values and drives.
- Normative factors.
- Intentions.
- Enabling and inhibiting factors.

This should provide you with a basis for deciding on the nature of a planned programme.

If you had more resources available, you could develop an interview schedule to be carried out on a one-to-one basis which explores each of the Health Action Model components. If we review (even if very rapidly) all factors influencing health behaviours, we can identify those that may need to be changed in a future Health Promotion programme. For example if current beliefs are opposed to adopting a health action, they will need to be changed. In some instances you may find that people express intentions to adopt a specific behaviour, but that the enabling factors are not in place to translate intention into action. For example, young people may accept the importance of using condoms and say they intend to do so but if they cannot obtain them easily at a cost they can afford, or they lack the self efficacy to negotiate condom use with a partner the intention will not be put into practice In this case, health promotion actions will need to target enabling factors. Once you have gathered information in relation to each of the components of the model, you can then identify the main factors that need to be changed if the adoption of health behaviours is to be increased and sustained.

**TASK 4 - Applying the models to Nomhle’s situation**

How would you use the models to understand the health decisions which members of Nomhle’s community will be making?

Make notes in your Assignment Notebook for use when you write up your assignment programme plan.

**7 SESSION SUMMARY**

In this session, you have surveyed a selection of three models of health decision-making. You have applied them to specific health examples or to your own experience and considered how they would be used in developing Nomhle’s programme. In the next session, we introduce you to a selection of models and theories relevant to achieving behaviour change.
8 REFERENCES AND FURTHER READING


Unit 2 - Session 3
Theories and Models of Behaviour Change

Introduction

In the previous session, we looked at models which help us to understand the determinants of individual health behaviours and to identify priorities for action.

Those priorities could include the need to change:
- knowledge, beliefs and attitudes of individuals;
- beliefs and attitudes in families, communities and professional groups;
- policy and environmental actions to enable people to put health behavioural intentions into practice and to sustain the actions.

There are various theoretical concepts and models that can be drawn on in an effort to bring about changes in individuals, communities or at policy level. There are many more which you may wish to explore in the course of your reading.

In this session we will look first at a model which has been widely used in efforts to bring about individual change – the Stages of Change Model. We will then look briefly at the communication process and model, the Yale-Hovland model for persuasive communication designed to change attitudes. We will also briefly introduce Social Learning/Social Cognitive Theory which aims to bring about behaviour change through modelling sensible health practices and finally, we will examine the Communication of Innovations Theory, a model for understanding the process of change within communities. In each case, you are asked to study the theory or model and to apply it to a familiar context. After each task, try to decide whether the theory or model will be useful to Nomhle’s programme. The last task in the session suggests that you write up your selection of relevant points in your Assignment Notebook.

Session contents

1. Learning outcomes of this session
2. Readings
3. The Stages of Change Model
4. Introduction to communication
6. Communication of Innovation
7. Session summary
8. References and further reading
Timing of this session

There are four short readings and six tasks in this session. It could take you up to three hours if you spend time applying the theories to your own experience.

1 LEARNING OUTCOMES OF THIS SESSION

By the end of this session, you should be able to:

- Describe the Stages of Change Model and consider its usefulness in HIV/AIDS programmes
- Describe the components of the Yale-Hovland model and apply it to developing persuasive communications on HIV/AIDS.
- Draw on the key concepts of the Social Learning Theory in outlining appropriate interventions designed to reduce HIV/AIDS.
- Explain to others the Communication of Innovations Theory and apply it to familiar situations.

2 READINGS

There are four readings for this session. You will be directed to them as they are needed in the text. One, Glanz, has been already been used in the previous session.

<table>
<thead>
<tr>
<th>Reading</th>
<th>Publication details</th>
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3. THE STAGES OF CHANGE MODEL

This model was developed by Prochaska and DiClemente and has become one of the most popular models used in health promotion programmes which are attempting to change behaviours. According to the model, when a person changes a behaviour they pass through a series of stages in a circular way. They may enter the cycle at different points and may enter and drop out of the cycle several times before finally sustaining a behaviour change. The model has been widely used as the theoretical framework for smoking cessation programmes in a number of countries. You can read about the model in Naidoo and Wills (2000) and also in Glanz (2005) on page 15.

READINGS


Naidoo and Wills explain the model and discuss how you would draw on it in practice. You may have wondered why this model was not included in the previous session. The models looked at in the previous session focussed on the factors which influence individuals in coming to a health decision. The Stages of Change model focuses on the actual change process. This model has been widely adopted by health promoters and used as a framework for many research studies on health behaviour change. Although easy to understand and to apply in research and practice there have been some criticisms of its value in understanding behaviour change. If you are interested in reading a critique, the paper by Adams and White in the Further Readings can be recommended. While there have been challenges to the model, it is important to consider its value in relation to the behaviours on which you are working. It may be very useful in helping to gain understanding of why behaviour changes are not sustained and why several attempts at a behaviour change may be needed before the change is sustained.

4 INTRODUCTION TO COMMUNICATION

Later in the module when you are considering Health Promotion programme planning, you will be asked to think in more detail about effective communication. In this session we will focus on one particular type of communication - that which is designed to persuade individuals and communities to change attitudes. As you saw in reading about the Theory of Planned Behaviour and the Health Action Model, attitudes are a key factor in
influencing health decisions. Both face to face methods and mass media communication can be used as strategies to achieve behaviour change.

You will notice in some of your readings about communication that they use technical language when discussing the process. You will see frequent use of the terms source, audience, channel and message to refer to the communicator, the people receiving the communication, the means used to communicate and the content of the communication. Not everyone is comfortable with the use of technical language. It is therefore important not to use it in situations where it may create barriers when your aim is to build relationships with individuals and communities.

Before looking at persuasive communication, we will focus on a few general points about the communication process. Very simply, we can define communication as an exchange of information which can be cognitive (about knowledge and beliefs), or affective (about feelings and attitudes) or about skills The process can be largely one-way, where mass media are used, or two-way, in face-to-face interaction.

TASK 1

Think back over the last 24 hours: List all the purposes of your communication during this period.

FEEDBACK

Communication has many purposes, including:

• to provide information,
• to convey feelings, to maintain relationships,
• to advocate for change,
• to change attitudes
• to develop skills

You will probably have listed other purposes.

In the case of two-way communication, in order to be successful we need to be aware of:

• any previous communication between those involved. If there is a history of poor communication this may continue to have an impact;
• people’s emotional state at the time of the communication e.g. anxiety and distress make communication more difficult;
• the power relationships between the two which can influence the communication process;
• linguistic and cultural barriers; and
• other situational factors e.g. noise and other distractions.
In two-way communication, there are verbal and non-verbal aspects to consider. The non-verbal elements are very powerful and may contradict the verbal ones. It may be that inappropriate language has been used or the non-verbal communication contradicts the verbal. For example, if a health worker’s words express concern for a patient but everything about the non-verbal language suggests a lack of interest and respect, the patient may ignore the verbal message.

Communications can combine words, pictures and actions according to what is appropriate to the purpose of a communication. People may perceive communications in the way that the communicator intended but very often this does not happen. Those involved in a communication process provide feedback to each other, a process which needs to be drawn on to make communication as effective as possible.

Although it is not a required reading for this session, you may find it useful to dip into John Hubley’s book on **Communicating Health** (1992) for a detailed discussion of the communication process. The details can be found under the Further Reading section.

**The Yale-Hovland Model and Persuasive Communication**

In some one-to-one communication and frequently in the mass media, communications are designed to persuade people to change attitudes. We will now look at this type of persuasive communication.

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You are asked to focus on pages 133-138 of this chapter. The earlier pages may provide a useful review of ideas discussed earlier. This brief reading discusses the aspects of the communication process that need to be addressed in developing a persuasive communication. The focus is on four elements: source, audience or recipient, message, and vehicle - although the writers use different terminology. Taken together, they are sometimes described as the Yale-Hovland model.

**TASK 2 - Identify key points about persuasive communication**

As you read, note the most important points which need to be addressed in relation to these four elements of a persuasive communication:

- Source (The communicator)
- Message (The communication)
- Recipient (The audience)
- Vehicle (The communication medium)
FEEDBACK

The following are some key points that need to be addressed in relation to the four communication elements. Add the points from the reading to this list.

Source of communication - the communicator
- Credibility - expertness and trustworthiness;
- Homophily (the source or communicator seen by recipients to be like them) or empathy;
- Attractiveness of the communicator to the audience e.g. football stars are attractive communicators to many young people;
- Perceived power, expert status and legitimacy of communicator.

Message
- One-sided versus two-sided arguments;
- Provision of conclusions when presenting arguments;
- Forcefulness;
- Rational versus emotional content;
- Careful consideration of fear levels.

Recipient/audience
- Coping style: problem-focused versus emotion-focused.

Vehicle
- Mass media versus interpersonal communication.

TASK 3 - Applying the persuasive communication model

Take this as your starting point: You have been asked to help Nomhle plan three short local radio slots designed to promote condom use. How would you advise her to draw on the elements of persuasive communication to maximise the communication?

FEEDBACK

We assume that you have given some thought to who might be selected to present the radio slots. There will be various alternatives depending on which of the characteristics of the communicator you choose to emphasise e.g. homophily or perceived power. You have also hopefully thought about the characteristics of the audience who will listen to the programmes, in order to decide which communicators are likely to appeal to them. For example, well-known local respected figures who are seen to be credible in relation to HIV/AIDS might be used. It is common to use well-known sports personalities, especially if programmes are directed towards young people for whom the sports personalities act as role models. You should expect to think carefully about the content of the messages in the radio slots, and how information is presented.

It is particularly important to consider carefully how fear appeal is used in communications. This has been debated for many years and there are various
theories about the use of fear. Some of these ideas are discussed in the next reading by Bennett and Murphy. As you will note, the effects of using fear are complex. You should probably advise Nomhle to examine the evidence relating to the use of fear very carefully before using it in her radio slots.

This chapter pulls together the literature on communication and attitude change. It is recommended that you read the chapter now, especially pages 98-106 as it will complement the earlier readings. It also provides references to the research literature which informs the Yale-Hovland model. Pages 103-105 focus on the issues in relation to fear messages.

If you refer back to Unit 2, Session 1 and the models of Health Promotion, you will realise that persuasive communication is a method adopted within a preventive model. It is widely used in mass media health communications. It clearly does not fit easily into an empowerment model.

5 SOCIAL LEARNING THEORY/SOCIAL COGNITIVE THEORY

This theory is most closely associated with the theorist Albert Bandura. It has developed over a number of years and has become more complex over time. It was initially called Social Learning Theory and later Social Cognitive Theory. The initial theory was developed around awareness of the ways that people learn many things by watching the behaviour of others. A process of *modelling* could be used to facilitate observational learning in which a model is provided from which observers can learn and with whom they may also identify. The theory has been used as a framework for planning many Health Education programmes although not all elements have always been used.

Pages 19-22 of the reading by Glanz provide an introduction to the key concepts of the model. You should note that the model explains behaviour as a result of a three-way interaction between personal factors, environmental factors and behaviour. Actions designed to influence behaviours therefore need to take into consideration both individual as well as environmental factors.
FEEDBACK

A brief illustration of actions directed towards the key concepts of the Social Cognitive Theory is provided here for a smoking cessation programme. You will probably have similar actions appropriate to your selected topic.

Environment: Implement no-smoking policies in public places; remove advertising of tobacco.

Observational learning: Use mass media role models who have stopped smoking and can model processes for coping with stress and getting support. Where support groups are used, leaders who have given up smoking themselves can act as powerful role models.

Expectations: Develop beliefs about potential for success and the benefits to be gained. In particular, develop understanding that several attempts may be needed before cessation is successful. (See Theory of Change Model in Session 2)

Self efficacy: Develop confidence in ability to give up smoking through group activities and other strategies.

Behavioural capability: Develop skills needed to stop smoking and to cope with stress, to resist pressures to resume smoking etc.

Reinforcers: Offer positive rewards from others for progress made; Develop awareness of financial gains, as money saved from tobacco purchase makes other things possible, especially for people with low incomes.

As you read Health Promotion studies, you will note that there are many that have used Social Learning Theory as a framework for planning interventions. Because the theory has evolved over time, the studies do not all include the full range of key concepts. You will find some examples of studies which have applied the theory in the Further Reading section.
COMMUNICATION OF INNOVATIONS THEORY

This theory offers an explanation of how numbers of people in a community or population group come to change their usual practices and behaviours. This model has been applied very widely to agricultural, educational and health related changes. It may also be referred to as the Diffusion of Innovations Theory. Diffusion of innovations is ‘the process by which an innovation is communicated through certain channels over time among the members of a social system’ (Rogers, 1971). There is a good summary in the reading by Glanz, on pages 27-29.

READINGS


TASK 5 - Apply the Communication of Innovations Theory

a) Identify a new idea that has been promoted in your own community or in your professional context and has been widely adopted. Drawing on the concepts of the Communication of Innovations model, explain why you think adoption happened.
b) Identify another idea that was promoted but was not adopted and explain why adoption did not occur.

In thinking about your specific example you will have looked at the Innovation, the Communication Channels used and the Social System into which the innovation was introduced.

The nature of the innovation. You will have thought about various aspects of the innovation:

Relative advantage: was your innovation better than what it replaced? For example if you were looking at adoption of dry pit latrines in households in an informal community the latrines could be seen as an advantage over visiting communal facilities after dark

Compatibility- was your innovation compatible with the existing values, past experiences and needs of the potential adopters. For example you may have thought about the adoption in schools of Child to Child health education teaching materials which need informal learning methods. Teachers trained in the use of informal methods and with some successful experiences of their use in the classroom would be more likely to adopt the new materials. Teachers who felt insecure with less formal methods, especially in large classes would be less likely to adopt.
Complexity – the degree to which an innovation is seen as difficult to understand and use. The female condom has not been widely adopted, in part because of its perceived complexity – as well as compatibility.

Trialability – could the innovation be tried out before making the decision to adopt. Using the dry latrine example: was there an option for opinion leaders in the community to try out their use?

Observability – the extent to which the results of the innovation were observable and easily measurable. For example: were adopters of the dry latrines expressing their satisfaction about convenience and greater sense of safety to their friends and neighbours?

Communication channels – you will have looked back at the ways information about the innovations was conveyed. Various mass media methods may have been used. The methods for achieving effective communication that you looked at earlier may have been used. For example the use of a communicator who was seen to be like the community (homophilous) or understanding of the community needs (empathic). There is good evidence to show that face to face methods are often the most effective, using opinion leaders. Mass media may have been used to reach the opinion leaders who then passed it on to communities through face to face approaches (the 2-step model).

The Social system
Communities and organisations, and the individuals in them differ in the extent to which they are responsive to new ideas ranging from innovators and early adopters through to late adopters and laggards. In a later unit you will be looking at the development of the settings approach to health promotion – where all aspects of the policy, environment and activities within a setting are focused on the promotion of health. If you were looking at the adoption of a health promoting hospital, for example, there could be enthusiasts for the development but opposition from various health occupational groups resistant to any change in their practices. In such a situation, developing a small demonstration project in one part of the hospital could be the way forward.

**TASK 6 - Identify theories and models that are applicable to Nomhle’s programme plan**

Before moving on, this would be a good time to identify which of the theories discussed above might apply to Nomhle’s intervention. Remember that practitioners might choose more than one theory on which to base their programmes. Do this task in your Assignment Notebook, so that when you come to writing your assignment 2, you have the information at your fingertips.
7 SESSION SUMMARY

In this session, you have been introduced to a very small sample of theoretical models that can be used in efforts to change behaviours at individual or community levels. Such models are particularly relevant to the Health Education component of Health Promotion. Theory at a Glance provides information on further theories which you can consider as you work through the rest of the module.

**Theory at a Glance**

This is the end of Unit 2. A few final comments on the use of theory in health promotion before we move on to the planning process for your programme in Unit 3.

- When planning tasks on the basis of theories, the theories which are being used need to be carefully assessed for their relevance to the task in question.

- Effective practice depends on good theory.

- ‘There is nothing as practical as a good theory’, (Lewin, 1951).

- The theories we are using need to be made explicit. It has been widely commented that practitioners do make use of theory but fail to make this explicit.

- We have been focusing on selected theories which have been developed and used widely in health promotion. When people are encouraged to develop theory-based practice it is these theories which are usually being referred to. However, we should not overlook the usefulness of what were labelled interpretivist theories in understanding health related situations and in planning some aspects of implementing interventions. In addition, we should remember that individuals and communities have their own ‘theories’ about their health and that these also need to be identified and understood.

**READINGS**

REFERENCES AND FURTHER READING


Papers which apply Social Learning Theory/ Social Cognitive Theory to aspects of sexual health:


Welcome to the third unit of this module. In Unit 1, you have explored some of the concepts and dilemmas in Health Promotion and you were introduced to some key points in the development of the Health Promotion approach. In Unit 2, you studied a number of theories, models and approaches used in Health Promotion.

In Unit 3, you will focus on the planning process. Amongst the issues to be discussed are the importance of community participation in the planning process and several approaches to enhancing the impact of your programme.

At the end of this introduction you will find a summary of your work on the assignment up to this point.

There are two Study Sessions in Unit 3:

Study Session 1: Health Promotion in Practice.

Study Session 2: Intervening Strategically.

In Session 1, you will review the three levels at which Health Promotion programmes can be implemented and consider some of the principles which guide an integrated approach. This session also covers the first step in the planning process – situational analysis.

In Session 2, you are introduced to two important considerations when planning a Health Promotion intervention – the strategy of targeting groups at risk, and the settings approach, whereby the planner targets an environment, like a school or organisation, as the site for implementation, and analyses its receptiveness to such an intervention.

Learning outcomes of Unit 3

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

- Demonstrate awareness of the values implicit in a selected Health Promotion model in a developing country.
- Describe an example of a Planning Cycle
- Explain the importance of participatory planning.
- Discuss and apply the processes of situational analysis and needs assessment.
In the course of this unit, you will engage in a number of tasks which feed directly into your assignment. Do them in your Assignment Notebook. This will enable you to compile your assignment from your notes at the end of the module.

We hope you will enjoy the unit and that it will enable you to take a step back from your practice and help you to build on your effectiveness as a health promoter.

Before you embark on Session 1, here is a quick overview of where you should be in the development of your assignment 2.

**Assignment update on Nomhle’s District case study**

Units 1 and 2 provided the context and theory that will inform Nomhle’s Health Promotion programme in her district, and therefore your assignment. This took the form of discussion in the study sessions, readings and tasks. Some of these tasks were kept deliberately general to enable you to develop an overview of Health Promotion issues and approaches. Others were specific to Nomhle’s role.

Before moving on to the practical details of how to plan and implement a Health Promotion programme in Units 3, 4 and 5, it is worth reflecting briefly on the specific tasks that we suggested would guide Nomhle in her challenge. Remember, these are included to help you think through issues relevant to the assignment.
Unit 1

Unit 1 provided the *broad sweep* overview of the socio-economic context of Health Promotion, and the global approaches and dilemmas.

- In Session 1, we set out the context of the broad determinants of health and the importance of equity. We suggested that Nomhle might have to work with people who were not familiar with this broad-based approach, and that she might experience resistance. We therefore suggested that you make a list of the issues which would help her argue the importance of the socio-economic and political aspects of health, and of gaining based ownership for Health Promotion programmes.
- We also had a look at the concept of equity as *fairness*, and at how health problems that are inequitable are potentially avoidable. We asked you to assess the determinants of health and to assess whether they were potentially avoidable and/or unacceptable. This assessment was designed to assist Nomhle in justifying some of her choices on the grounds of equity.
- In Session 2, we led you through the recent history of Health Promotion, showing how the above approaches have become global recommendations. Here again, we suggested that you use the literature, this time *A Call for Action*, to strengthen Nomhle’s arguments for a broad-based approach by placing it within a global context.

Unit 2

Unit 2 shifted the emphasis to theories, models and approaches at different levels. The intention is not for you to absorb or to use them all in your assignment, but to be aware of their existence and to select them as appropriate for your programme. In relation to Nomhle, however, we thought it might be worth considering the following:

- In Session 1, we again anticipated resistance from some of Nomhle’s colleagues, this time to theory rather than a socio-economic approach. We therefore suggested a task for self-reflection i.e. Task 1. If you choose to, this could be used as part of Nomhle’s endeavour to encourage her colleagues to be more analytical about their practice.
- In Sessions 1, 2, and 3, we outlined theories and models that related to ideological approaches, decision-making and behaviour change respectively. Here we suggested that you note the models, and decide which, if any, are applicable to Nomhle’s programme plan.

We hope this overview will help as you move on to the next stage. Units 3, 4 and 5 will assist you with planning the actual programme, the activities and the evaluation, within a participatory process.
Unit 3 - Session 1
Health Promotion in Practice

Introduction

This session will cover some of the critical dilemmas in planning Health Promotion interventions within a framework of equity in a developing country context. The session raises the issue that one cannot work in a value-free way – perspectives and processes ultimately influence the success of the Health Promotion programme or intervention. The main dilemmas covered are: How broadly should one view the health issue in question? How does one assess needs and resources? What role does community participation play in the programme?

Session contents

1 Learning outcomes of this session
2 Readings
3 Locating Health Promotion planning in a development framework
4 Planning and participation
5 Situational analysis and needs assessment
6 Session summary
7 References and further reading

Timing of this session

This session contains three readings and three tasks, including two assignment-related tasks. It should take you approximately three hours to complete. A logical point for a break is at the end of Section 3.
1 LEARNING OUTCOMES OF THIS SESSION

By the end of this session, you should be able to:

- Demonstrate awareness of the values implicit in working within a specific ideology, Health Promotion model and approach in the context of a developing country.
- Explain the importance of strategies for participatory planning.
- Use the Planning Cycle model.
- Discuss the processes of situational analysis and needs assessment.

2 READINGS

The readings for this session are listed below. You will be directed to them in the course of the session.

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As you plan Health Promotion interventions, it is useful to recognize, and take into account, that Health Promotion happens within the broad context of the promotion of development, and ultimately contributes towards the attainment of this goal.

The WHO Health for All policy serves as a useful orientation to some of the key strategies for working towards poverty alleviation and equity. The Health for All (HFA) policy concept was initiated in 1977, launched at the Alma Ata Conference in 1978 and reinforced by the Ottawa Charter in 1986. As you will remember, these declarations proclaimed Primary Health Care as the appropriate strategy to attain this goal. HFA remains fundamentally a call for social justice. You have already examined some of the guidelines of A Call for Action in Unit 1.

The following extracts of the HFA Policy have relevance for our Health Promotion planning process, and are from the section on ‘Making Health Central to Human Development’. The phrases in italics are to draw your attention to the key aspects that are relevant to understanding the background and approach being adopted towards Health Promotion in this module.

“Combating Poverty
37. The health sector has a vital role to play in targeting poor households and regions by focusing on problems that disproportionately affect the poor. As poverty is multidimensional, the combined efforts of many sectors will be required for the sustained alleviation of poverty. Collaboration between the health, agricultural, trade, financial, food and nutrition, education, and industry sectors is thus essential. In addition to broad-based approaches, people’s health and education must be protected during periods of temporary economic hardship. Ensuring food security is closely aligned to combating poverty.

Promoting Health in All Settings
39. Individuals, families and communities can act to improve their health given the opportunity and the ability to make choices for health. People therefore need knowledge, awareness and skills - as well as access to the possibilities offered by society - to cope with changing patterns of vulnerability and to keep themselves and their families healthy. The settings where people live, work, play and learn provide a host of opportunities for promoting health. Social action can help to protect the young from violence and substance abuse, ensure that working conditions are conducive to health, promote health foods and recreation, and create a school environment that is supportive of learning, health and personal growth.

40. Communications technology, including interactive methods, has become an important means of sharing images and messages for health promotion to support individuals and communities in improving the quality of their lives. Health information and entertainment that reach into every
community and home can allow even the most remote families to benefit from current knowledge. The media can play a greater role in advocating for health and health practices. They can help to raise the public profile of health and make it a topic of public debate.

**Operational principles for implementation**

83. Based on the HFA policy directions, *four operational principles* guide the implementation of the HFA policy. These are:

- Emphasizing health promotion and disease prevention by acting on the determinants of health
- Pursuing a human-centred approach to health development.
- Ensuring that strategies are sustainable.
- Devising policies and acting on the basis of the best available scientific evidence.

84. To act on the determinants of health requires recognition that health is attained in the context of human and social development and is a function of the social, physical, economic and cultural environment of the communities in which people live and grow. *Good health is both a resource for development and an aim of development in a mutually reinforcing cycle.* Consequently, it is possible to adopt a “healthy development policy”, whereby programming in all sectors is undertaken in such a way as to maximize the opportunity to improve health, whether directly or indirectly *Promoting the creation of an enabling environment for health is one of the most important strategies for the prevention of disease and disability.*" (WHO, HFA Policy, Online).

While there are many paragraphs in the HFA policy, it is these above that challenge us to view health as a resource for development as well as an aim of development. Tackling the causes of poor health inevitably requires a multi-sectoral approach. Mention is made of the need for health-related knowledge and resources, social action and the creation of an enabling environment – all key action areas of the Ottawa Charter. It also calls on health promoters to adopt an ideology of *empowerment*. All these strategies in Health Promotion will be covered in more detail in the following sessions.

Clearly, it is important to tackle the determinants of health from an equity perspective if lasting health improvements are to be achieved. However, this can be done on different levels and in various ways. Review the following reading, first encountered in Unit 1:


Consider what Naidoo and Wills suggested about taking action: you will be reminded of the levels at which they propose one should plan and take action – at the macro level (i.e. broad, inter-sectoral, with an emphasis on policy); at the meso level (i.e. organisational level) and at the micro level (i.e. personal level).

The challenge for any Health Promotion planner is to understand the determinants at all these levels in order to plan strategies that are appropriate to the level.
4 PLANNING AND PARTICIPATION

4.1 PLANNING

A successful programme requires thorough planning, and this applies as much in Health Promotion as it does in other fields.

There are several different approaches to planning, generally using one of the many variants of a ‘planning cycle’. All include some element of assessment of need, setting aims and objectives, determining what methods or strategies will achieve these objectives, and evaluating the outcome in order to make improvements in future. They are referred to as a ‘planning cycles’ as the lessons learnt, in particular through the evaluation process, serve to influence the future planning process. You will see two examples of planning cycles in your reading.

The setting of aims and objectives is particularly important in planning, so that the programmes achieve what they set out to do. Remember, your aim or goal is a broad statement that sets out what your programme hopes to achieve, while your objectives are the statements that outline the tasks needed to achieve the aim.

To assist us in this process, the acronym SMART is used as a guide for setting objectives:

Objectives need to be:
- **Specific**
- **Measurable**
- **Achievable**
- **Realistic, and**
- **Time-limited.**
Aims and objectives – an example:

Please note the following, as an example of what could be the aim and objectives for a health promotion programme targeting obesity in a particular neighbourhood

**Aim:**
To reduce the level of obesity in the X community

**Objectives:**
- Within one month, an intersectoral ‘Food Watch Group’ comprising nutritionists, environmental health practitioners, retail outlet representatives, the local councillor for X ward and community members will have been established.
- A regular weekly self help eating discussion and exercise group will have been established by the intersectoral ‘Food Watch Group’ within three months.
- After 6 months of attendance, all participants of the self help group will report changes in their diet towards healthier eating.
- After six months of attendance, all participants of the self help group will report an increase in exercise, taken as part of their daily lives.
- Within one year all schools in community X will have established 3 sessions of 45 minutes of physical activity a week for all pupils as an integral part of the school curriculum.
- Within one year, an information pack for the community on healthy eating will have been developed by the Food Watch Group.
- Within a period of 3 months, the Food Watch Group will lobby all food retailers in the community to encourage the stocking of healthier food options.

Hopefully, the above example has helped you to think about what SMART objectives might look like, or reinforced what you already know. To assist you further, analyse the following objective to see how it meets the SMART criteria.

**TASK 1: Assess your understanding of SMART objectives**

Identify which elements of this objective are **specific**, **measurable**, **achievable**, **relevant** and what indicates the **timescale**.

**Objective:**
The community health worker will run 6, weekly, one hour discussion groups on mothers’ concerns about child health, with the mothers attending the immunisation clinics.

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\end{align*}
\]
FEEDBACK

You might have noted the following:

**Specific** – it says what the community health worker will do

**Measurable** – it states the number of sessions, when they will take place and the length of the sessions

**Achievable** - the CHW is based at the clinic, she knows the mothers and has the skills to work in a participatory style

**Relevant** – this ties into the CHW role and addresses mother’s defined concerns

**Timescale** – it gives a fixed period - which could be extended if required

Terms used in planning:

Naidoo and Wills (2000) describe planning as one of those terms that is used in many different ways by different people. They suggest that there are no hard and fast rules about the way terms are used. However, there does need to be some clarification to avoid confusion. We have included their suggested use of terms as they will be particularly useful in your planning of a Health Promotion Programme in Assignment 2:

- **A Plan**: how to get from your starting point to your end point and what you want to achieve
- **A Strategy**: a broad framework for action which indicates goals, methods and underlying principles
- **A Policy**: guidelines for practice which set broad goals and the framework for action.
- **A Programme**: overall outline of action. The collection of activities in a planned sequence leading to a defined goal or goals.
- **Priorities**: the first claims for consideration
- **An Aim or Goal**: broad statement of what is to be achieved
- **Objectives or targets**: specific goals to be achieved

(Naidoo and Wills, 2000: 347)

Now have a look at the Reading by Jone, Katz & Sidell (2000) which describes the reasons for planning; it also gives examples of Planning Cycles. Examples referred to are McCarthy’s Rational Health Planning Model and Ewles and Simnett’s Flowchart for planning and evaluating health promotion (1999).
Read pages 256 – 260 (15.1 – 15.2) at this stage. Look particularly at Ewles and Simnett’s flowchart on page 260. Note how they divide the process into seven stages, the first of which is “Identifying needs and priorities” and the second “Setting aims and objectives”. Take note of these two processes and return to them at the end of this session, where you are encouraged to plan Stages 1 and 2 on behalf of Nomhle, although you may decide to revise them later.

In Unit 2 you were introduced to a number of theories, models and approaches to Health Promotion. You noted the value of these as a basis for understanding real life health issues and also as a framework within which to plan and evaluate programmes. This is because they are based on researched experience and their impact has been found to recur with sufficient frequency to be regarded as valid. Think about how you will use these in your planning.

You will probably find that most of us have been in situations where we have carried out activities that could be called Health Promotion. But how often have you based your actions on theories? Have you ever considered the determinants of health, or worked out the relationship of the different determinants to the health problem? Have you spent time trying to understand the dynamics in the community in question before planning an intervention? These are all important parts of the planning process, and each level of planning is located within an ideological framework.

This diagram of the planning process from Tones and Tilford (2001) serves as a useful reminder of the necessity of approaching Health Promotion with a chosen ideology, theoretical understanding and a rational choice of interventions. It shows an outline of the planning process and, reading from the bottom up, illustrates the direction of the flow of your planning decisions.
Using theories, models and approaches in your planning is a little like making use of established wisdom rather than embarking on a plan and hoping it will succeed by trial and error.

### 4.2 PARTICIPATORY PLANNING

Finally in this section, we look at the challenges of planning for Health Promotion at an individual level and at the same time adopting a participatory community planning approach. In the next Reading, Laverack & Labonte (2000) offer a strategy to address this tension by encouraging us to take participatory planning seriously. Laverack and Labonte broaden our understanding of objectives in Health Promotion interventions. They suggest that empowerment or process objectives can be set alongside objectives that focus more specifically on behaviour change or health status improvement.

Although they do not go into detail on the Health Promotion methods, they provide some detail on the phases of planning an entire programme.

**READING**

You will now have a good sense of the different stages of planning, and so you will be aware of the importance of starting with a situational analysis or needs assessment. We have already emphasised the importance of understanding the determinants of health in order to ensure that Health Promotion strategies have a meaningful impact on people’s health. In order to understand these determinants, we need to understand the situation of the community in question in depth, and the priorities from their point of view.

The following Reading has been introduced here to assist you in thinking further about the importance of involving communities at all levels of your health promotion programme, starting with the planning process. Start by reading the descriptions of the key concepts which include “community organization”, ‘empowerment’ and ‘participation’. Then look at the 5-Stage process of community organizing on page 89. For this session, read the introductions and Stages 1 and 2, on ‘Community Analysis or Assessment’, and ‘Design and Initiation, i.e. up to page 99. (You will have a chance to read the rest of the chapter later).

**READING**


Having completed these readings, you should now be in a position to take your assignment development a stage further. Do these two tasks in your Assignment Notebook.

**TASK 2 - Plan your situational and needs analysis**

You have been provided with a certain amount of information about the District in which Nomhle is working in the case study (SOPH, 2002). There may, however, be some key pieces of information which are necessary for a more complete community analysis, but which are missing.

- If you find gaps in the information provided in the case study, make assumptions based on your general understanding of, and literature on, similar communities.
- When writing your final assignment, make it very clear where you have based your analysis and planning on assumptions from other communities or the literature.
- Use the readings in this session to make notes on how you or Nomhle would engage the local stakeholders and community members in the situational analysis/needs assessment and programme planning, and how to reflect the community’s needs more accurately.
TASK 3 - Identify determinants of health, levels of intervention, aims and objectives

In Task 5 of Unit 1 Session 1, you thought about the determinants of health in situations of poverty, and in relation to the priority issues identified for Nomhle to work on, and described in the Case Study.

- From the information provided in the case study, review these determinants.
- Consider how you might intervene at different levels, as well as whether the programme will be focused on individual prevention, organisational development and structures, or both.
- Identify a broad aim and objectives for the integrated health plan, bearing in mind that the objectives should also address different levels of intervention, including the need for broad community development.

On the basis of further readings and information provided in the sessions which follow, you may want to revise and improve on these aims and objectives.

6 SESSION SUMMARY

In this session, you have reviewed a specific Health Promotion vision, ideology and strategy which is appropriate to programme planning in the development context. You have also reviewed processes of community situational analysis. The issue of identifying aims and objectives in terms of the health determinants in Nomhle’s district has now become your challenge.

In the next session we will examine two strategic approaches to planning, the settings approach and the issue of targeting programmes at particular groups who appear to be at risk.

7 REFERENCES AND FURTHER READING


Unit 3 - Session 2
Intervening Strategically

Introduction

This session looks at how the impact of Health Promotion interventions can be enhanced according to the way in which they are targeted. The integration of health interventions into the settings where “… people live, love, learn, work and play” (Antonovsky, in Kickbush, 1997: 431) seems obvious, but recognising the importance of this integrated approach has had a profound effect on the way in which Health Promotion programmes are designed.

This is one of the factors which has fed into the development of the settings approach to health programmes which promotes the idea that interventions should be conducted within environments, such as schools or organisations, and that partnerships between such health-promoting environments are central to their success.

The other key strategy introduced in this session is the concept of targeted Health Promotion interventions: this involves identifying specific groups who are at risk or who are involved in risky behaviours or lifestyles and targeting programmes towards them.

These two approaches form the basis of Assignment 1 and, as you will have noted in the Assignment Instructions, will also benefit your plan in Assignment 2, used so take careful note of this session.

Session contents

1. Learning outcomes of this session
2. Readings
3. Targeting or not?
4. Using a settings approach
5. Session summary

Timing of this session

This session contains three readings and two tasks, one of which should be done in your Assignment Notebook. It should take you about three hours to complete. A logical point to take a break is at the end of Section 4.
1 LEARNING OUTCOMES OF THIS SESSION

By the end of this session, you should be able to:

- Locate health determinants and intervention strategies within suitable models of, and approaches to, Health Promotion.
- Describe the benefits and disadvantages of using a settings approach.
- Discern situations in which it is appropriate to target certain groups, ages or roles.

2 READINGS

The readings for this session are listed below. You will be directed to them in the course of the session.

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3. TARGETING OR NOT?

The next dilemma we face in understanding health and planning for health improvements is whether or not to deal with the problem “… in terms of populations” or “… in terms of organizations and systems” (Kickbush, 1997: 431). In this section, we explore one strategic approach to Health Promotion – targeting of particular at-risk groups within a health context, and the issues of who to target, as well as where and whether to target interventions.

Targeting is thoroughly explained in the following Reading and some interesting examples are described. However, the authors end the chapter with a strong caution against targeting. They warn that it can detract from tackling underlying causes of the health problem, and that it can easily lead to victim-blaming as well as negative cultural stereotyping.

READING


When you have completed this reading, consider whether targeting would be beneficial in Nomhle’s programme, or whether it could be construed as having a negative effect.

TASK 1– Consider targeting the programme in Mfula

After completing the Reading, map out what you know or can assume from the case study about the priority groups identified. Try to complete a diagram like the one on page 95 for the case study. This will provide a useful description of the local groups and risk factors.

A mapping of this sort also forms the background information to support your choice of strategies and interventions.
Defining one’s goals in terms of systems or organisations is called a settings approach and its value lies in the fact that it provides the framework for interventions at a macro or systems level, at an organisational or group level and at the micro or individual level.

The settings approach is promoted as a strategy for improving health, based on the premise that the health of an organisation or community is more than the aggregate health of its citizens’ individual health. There are ten or more years of well-documented evidence to demonstrate that better health outcomes can be achieved through healthy schools, healthy hospitals, healthy villages etc. You will read about examples which use the settings approach in the next unit.

In the following Reading, Kickbush gives an overview of the factors which led health promoters to develop the approach and discusses partnerships as central to this approach.

### READING


The Reading by Tones and Tilford (2001) provides an in-depth discussion of the settings approach. This includes the history of the settings approach and it provides examples from around the globe. As with most other Health Promotion approaches, there are advantages and disadvantages to its use.

### READING

TASK 2 - Applying the settings approach

Think of a school in your neighbourhood and identify some of the factors which threaten the well-being of the learners and teachers and the building of a positive learning culture.

If you were a local health promoter, you would first need to decide if this school would be a useful setting for improving the health of youth in the area. Try to answer the questions on page 200 of the reading which deal with:

- The question of access.
- The question of philosophy and purpose.
- The question of commitment.
- The question of credibility.
- The question of competence.” (Tones & Tilford, 2001: 200)

Also consider the disadvantages or problems with the settings approach as described on pages 209 & 210 of the Reading by Tones and Tilford (2001). They include stakeholder conflict, losing sight of marginal groups and the complexity of undertaking a settings analysis.

FEEDBACK

By way of example, let us focus on a high school in an area where gangsterism is rife, learners do not feel safe at school, and where there is a high drop-out rate from the school.

Deciding whether to use this school as a setting for improving learner security and encouraging them to stay at school to complete more grades will probably depend on:

- The extent to which the philosophy of the school is learner-centred or prepared to shift towards this philosophy.
- The level of involvement of parents with the school and the openness of the principal to embark on partnerships with other sectors such as Safety and Security and the Health Department.
- The competence and commitment of the teachers to adapt their teaching to create a more positive and creative learning culture.
- The number of youth who are already outside of the school system and will be missed or left out if we focus health education and environmental upliftment within the school context.

Obviously, the school you were thinking about will have different issues, but your points may be similar to this example. The point is to start thinking of a setting as the primary focus of a Health Promotion intervention, and to think of factors that may make one setting suitable to host a Health Promotion intervention, and those that would make such an intervention difficult to impossible.
Think about whether the settings approach would be an appropriate way of approaching the programme (in a given situation). Think about the uses of the Settings Approach, and how they further the goals of a Health Promotion goal, and the challenges of making this approach work.

As you have read, the settings approach relies heavily on partnerships. One of the key processes in applying the approach is inter-sectoral collaboration and inter-organisational learning and work. Currently, it is common in many sectors for a variety of partnerships to be formed between non-governmental organisations, between government and non-governmental organisations and/or with private enterprise.

It is useful to draw on Organisational Theory to understand how internal organisational changes and inter-organisational alliances can impact on health developments and policies. In addition, Naidoo and Wills (1998) suggest using Group Work Theory to establish and maintain successful partnerships or alliances.

5 SESSION SUMMARY

This session has looked at two approaches in Health Promotion – targeting and the settings approach. The differences between the two approaches has been examined, along with the advantages and disadvantages of both. Inevitably there is an overlap, with settings often targeting particular health concerns, and targeted approaches being developed within a setting. Note these issues as they form the basis of Assignment 1.

This unit targeted planning and while in the first session you explored some detailed planning approaches, in the second, you gained insight into two important approaches for developing a Health Promotion plan – targeting and the settings approach. These two sessions provide you with a holistic toolkit for making strategic interventions in planning Health promotion. In the next unit, you will learn about operationalising Health promotion plans; a range of strategies and methods for putting into effect Health Promotion goals will be discussed in detail.
Unit 4 - Introduction
Strategies and Methods

Welcome to the fourth unit in this module. In this unit, you will learn how to plan and implement Health Promotion activities; we will provide you with examples of different Health Promotion strategies and methods. Examples illustrate the range of interventions from a policy level down to individual awareness-raising. It is intended that you bear the case study in mind as you go along, and extract ideas that seem relevant to build into your programme plan, especially from the HIV/AIDS related Readings. We have included Assignment Tasks to assist you in the process.

There are three Study Sessions:
Study Session 1: The Ottawa Charter Action Areas
Study Session 2: Approaches and methods for Implementing Health Promotion interventions
Study Session 3: Case Study examples.

In Session 1, we will see how the Ottawa Charter action areas provide a useful framework for planning and implementing a health promotion programme. Session 2 focuses on specific approaches and methods used in implementing Health Promotion programmes. This includes approaches at organizational, population/community, and individual level. Session 3 provides case study examples, using two different issues, as examples of how the different approaches and methods can be used in practice.

Learning outcomes of Unit 4

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

- Describe the range of processes and activities which can be used to promote healthy public policy.
- Describe key issues facing developing communities regarding sustainable development.
- Explain the reasons for inter-sectoral work.
- Describe the processes and activities which promote organisational change.
- Plan a training programme to increase the capacity of workers.
- Explain the central place of communication in Health Promotion.
- Discuss issues relevant to mass communication and one-to-one communication.
- Make relevant choices of media channels and messages for different people and different settings.
- Discuss methods such as peer education and its application to HIV/AIDS programmes.
Unit 4 - Session 1
The Ottawa Charter Action Areas

Introduction

We introduced the Ottawa Charter in Unit 1; there, we saw how the Charter forms the focal point for Health Promotion. In this session, we focus on the Ottawa Charter action areas, demonstrating how their use as a framework for planning and implementing Health Promotion programmes. You will remember that the action areas are: healthy public policy; creating supportive environments; strengthening community action; developing personal skills, and reorientation of health services. Each topic will be supported by a Reading, and we will provide a task at the end in preparation for your assignment.

Session contents

1. Learning outcomes of this session
2. Readings
3. Public Health policy
4. Creating supportive environments
5. Strengthening community action
6. Developing personal skills
7. Reorientation of the Health Services
8. Session summary
9. References and further Reading

Timing of this session

There are six Readings and one task in this session. You will note two Readings that you have already studied. One is the Ottawa Charter, the topic of this session, and the other is Bracht (1999). They are included here once again so that you can look at them in the light of the Ottawa Charter. It should take you approximately two hours to complete.
1 LEARNING OUTCOMES OF THIS SESSION

By the end of this session, you should be able to:

- Describe the action areas of the Ottawa Charter.
- Provide examples of how each of these action areas can be addressed in Health Promotion.

2 READINGS

The Readings for this session are listed below. You will be directed to them in the course of the session.

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Before starting this session, we advise you to revisit the Ottawa Charter, in Unit 1, Session 2. Remind yourself of the overall principles and look again at
the five action areas. We are including Readings that relate to each of these areas.

**READING**


### 3 PUBLIC HEALTH POLICY

As you will realise when Reading the comprehensive chapter on Public Health policy in the Baum (1998) Reading, policy that addresses the determinants of health does not focus only on the health sector but on any policy or area that affects health status. Although many policies are developed and applied at a macro level, there are also many opportunities for developing local policies which have a positive impact on health.

**READING**


Note the role of advocacy in Baum’s description. Remember from your Reading of the Ottawa Charter that advocacy is one of the means of promoting health noted in the Charter. The other two are mediation and enabling. Note how these are used in the other Readings as you go through the rest of the session.
4 CREATING SUPPORTIVE ENVIRONMENTS

In Unit 1, we discussed the importance of context in health, and the need to address the social determinants of ill health and equity. As part of that Unit, you had a Reading that demonstrated the impact of the socio-economics on child health. Revisit this Reading to remind yourself of how these socio-economic conditions would need to be addressed as part of an overall package of health promotion if diarrhoea in young children is to be prevented. You will notice that the solutions mentioned in the article include situation analyses to determine the problems, food hygiene education, and the importance of socio-political and economic dimensions.

READING


Recently, there has been an emphasis on undertaking ‘health impact assessments’ as part of a process of policy development and programme development in Public Health. One example from Australia is noted below in the Further Readings section. If you would like to know more about these, there are many ‘health impact assessment guides’ available online.

5 SUPPORTING COMMUNITY ACTION

This Reading has already been studied as an example of how you can involve communities in planning. For this section, revisit the Reading, but this time, read from Stage 3, Implementation (page 99). This demonstrates how ways of working can provide the basis for encouraging community action around specific issues, advocating for policy changes and developing and disseminating appropriate health education.

READING


Note, however, how in his concluding remarks on page 103, Bracht points out that although community participation is common and expected, there are constraints to achieving this. They include fragmentation of the supportive capacities of communities, the fact that local problems are often
manifestations of global problems, the concentration of transnational power, the inaccessibility of information about power in society, the centralized domination of symbols of legitimacy, and the disempowering effects of the mass media. Bracht argues that each of these conditions “works against the ability to achieve social change.” (Bracht, 1999: 103)

6 DEVELOPING PERSONAL SKILLS

Enabling people to develop the resources to prepare themselves for all stages of life is another component of the Ottawa Charter. Remind yourselves of the discussion on ‘health education’ in Unit 1, session 2. Read the following article, (Reading …) which describes an action research project undertaken by the School of Public Health at UWC in partnership with the Medical Research Council, the Provincial Government of the Western Cape, the University of Cape Town and local communities.

READING

This project shows how a planning cycle, the Triple A cycle was used to assess the problem, analyse it, and then develop an action programme. The Action (implementation) phase shows how community health workers were empowered to organise and run health promotion sessions in their communities. (Note also how the researchers analysed the findings according to the social determinants rainbow described in Unit 1)

7 REORIENTATION OF THE HEALTH SERVICES

This would entail reorienting services more towards promotion of positive health and to the prevention of ill health and adopting a settings approach. In Unit 3 Session 2 we introduced the concept of Health Promoting Settings, showing these as a means of looking more broadly at organisations and at working collaboratively across organisations. There are many examples of how the settings approach can be adopted as part of a process of reorientation of services. Study the following Reading, which describes a Health Promoting Hospital.

READING
You will have noticed how organisations such as hospitals have the capacity to influence the community they serve and not just the patients and staff within the hospital. By focusing on the reorientation of some hospitals to becoming more health promoting, the authors of the Reading identify four sets of organisational arrangements to achieve this end. They also note that certain preconditions are conducive to reorienting an organisation like a hospital to a health promoting vision: “… an organizational commitment to change, supported at multiple levels of the organization, and reflected in policy and practice change.” (Johnson & Baum, 2001, 281)

**A TASK 1 - Consider interventions at macro level for your programme**

To end this session, return to your notes about Nomhle’s Action Plan, and add ways in which each action area in the Ottawa Charter might be addressed. Include these within your programme objectives and outline the processes you would follow in each case. Remember this is a key component of your Assignment 2, so it is worth spending time on this exercise.

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**8 SESSION SUMMARY**

In this session you have revisited the Ottawa Charter, but this time, you have looked at practical implications of each action area, using the Readings to illustrate the potential. You have also used the opportunity to reflect on how you would use the Ottawa Charter for Nomhle’s action plan.

**9 REFERENCES AND FURTHER READING**


Approaches and Methods for Implementing Health Promotion Interventions

Introduction

This session aims to give you an overview of some of the methods, processes and activities used health promotion. It starts with processes that aim at transforming organisations and developing networks through collaboration and community participation. Methods targeting population groups or individuals follow. The session ends with an example of a training approach to increase the capacity of health professionals and/or others to reorient their work and thereby their organisations. This is a long session, but it has three distinct sections, so it should be quite easy to give yourselves a break in the middle. A good time to do that is between 3, Working across Sectors and Organisations, and 4. Methods used in Health Promotion.

Session contents

1 Learning outcomes of this session
2 Readings
3 Working across sectors and organisations
4 Methods used in Health Promotion
5 Communication and mass media
6 Peer education
7 What works best?
8 Training as capacity building
9 Session Summary
10 References and further Reading

Timing of this session

There are eight Readings and three tasks included in this session. However, three of the Readings have already been studied and are included here for reference, or for you to scan quickly if you need to remind yourself of the issues.

It should take you approximately three hours to complete.
1 LEARNING OUTCOMES OF THIS SESSION

By the end of this session, you should be able to:

- Explain the reasons for, and ways of, working with other sectors on specific problems.
- Discuss issues relevant to mass communication and one-to-one communication.
- Make relevant choices of media channels and messages for different people and different settings.
- Discuss peer education and its applicability to HIV/AIDS programmes.
- Plan a training programme to increase the capacity of workers.

2 READINGS

There are five new Readings for this session, plus two that you have already seen. You will be directed to them in the course of the session.

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3 WORKING ACROSS SECTORS AND ORGANISATIONS

It has been emphasised before that intervention to improve health inevitably requires an intersectoral approach. But what are the principles and approaches for achieving this? Reading 39, although referring mainly to the Australian health care system, offers some useful points and a few relevant examples.

READING


Working across sectors and organisations also includes working with communities. We have already noted the importance of community participation, and included Readings in Units 3 and Unit 4 Session 1, so you will be clear that community participation applies at all levels – from needs assessment and planning through to evaluation of programmes. We are including the same Reading by Bracht (Reading…) for this session. Use it to remind yourself of the concepts and practical application if needed. We are including some other suggested Readings at the end of the session if you want to study further

READING


When reading about a collaborative approach to working across organisations and sectors, you will probably have thought about the description of health promoting settings you encountered in Unit 3, and referred to again in through the example of Health Promoting Hospitals by Johnson, A. & Baum, F. (2001)
in the previous session on the Ottawa Charter Action Areas. Scan the Readings to remind you of the main points if you feel you need to.

**READINGS**


Apply the concept of intersectoral approaches and community participation to the case study through this task.

**TASK 1 - Identifying intersectoral opportunities for your health programme**

a) Identify which government departments, NGO’s and community based organisations are key to the health programme. b) What are their respective roles?

c) What process would you follow in establishing a working relationship with each on the issues and roles identified?

d) Would a health promoting setting be a useful approach, and if so what setting would you use, and why?

**4 METHODS USED IN HEALTH PROMOTION**

We have just looked at the importance of working collaboratively across different sectors as a means of addressing the broad determinants of health, and some of the approaches and challenges in achieving this.

We will now look briefly at some of the methods that are used to promote health in face to face contact.
A TASK 2 - Methods that Nomhle may include as part of her health programme

- Group discussion
- Talks and lectures
- Pictures
- Role play and drama
- Songs and dance
- Puppets
- Posters and leaflets
- Counseling
- Communication through mass media – radio, TV, video, DVDs
- Internet
- Social marketing

Jot down briefly how these may be used in Nomhle’s programme. Note the advantages and constraints of each in relation to this specific programme. This will be useful when you select specific activities for your programme. Remember to ensure that they are suitable for the target audience and that the message is appropriate and understandable.

You may have listed advantages for all these methods, although you may also feel that some are likely to be interactive and therefore more effective than others. For example, lectures, posters and leaflets are more passive then group discussions, role play and drama, which tend to be good participatory methods. Furthermore, it is unlikely that you will be able to use them all in one programme, and decisions on which to use are often pragmatic, based on opportunities, the objectives that it is hoped to achieve, the availability of particular skills in your team, funds, and so on.

Rather then cover all, we will focus in some detail on communication and mass media, and peer education.

5 COMMUNICATION AND MASS MEDIA

Communication lies at the heart of health promotion encounters, at both an individual and groupwork level. You have already been introduced to communication in the session on Theories of Behaviour Change (Unit 2 Session 3) where you studied persuasive communication and the way in which innovations are most effectively implemented, a process which involves communication. In this session, we focus on the importance of communication using mass media.
Use of mass media

The use of the mass media is an extremely powerful tool in the hands of health campaigns: it carries the power to “… confer importance and legitimacy on issues …” (Finnegan & Viswanath, 1999: 120).

There are six main lessons described in this Reading:

- Planning is key to effective engagement of the mass media in public health campaigns. This point differentiates social marketing as seeking voluntary change in the behaviour of members of the public, while media advocacy focuses on advancing a public policy campaign.
- Mass media may be engaged in public health campaigns at different levels of involvement.
- Engaging the mass media in public health campaigns means in part establishing good working relationships with media “gatekeepers”, or those who control the media.
- The mass media can be highly effective in building the community agenda for public policy change on behalf of public health, but media attention alone is seldom sufficient without sustained efforts by empowered community groups and coalitions.
- The mass media’s impact as part of community-based campaigns to affect health behaviour or policy is considerable, but this impact is affected by the socio-economic structure of communities.
- Influencing entertainment programming to carry health messages is a promising, but as yet, not well-developed strategy for use of mass media in public health campaigns.

**READING**


In the South African context, there is a TV programme called *Soul City*; there are also health education materials related to this show. This is developed by a very successful multi-media “edutainment” organisation based in Johannesburg. They carry out detailed research in preparation for each *Soul City* series on TV. A few themes are integrated into each series e.g. HIV/AIDS, household fuel and water quality. Booklets are designed to match each theme and are distributed to clinics as well as through major newspapers. They have a website which is noted under Section 6, References and further Readings.
Peer education was used in education sector activities before it was adopted in health education. Turner and Shepherd (1999) suggest the following rationale for using peer education:

- It is more effective than other methods.
- Peers are a credible source of information and the education is likely to be more readily accepted.
- It utilises an already existing source of information for sharing.
- It is more successful than using professionals because people identify with their peers.
- Peer education has benefits for those providing it.
- It can be used where conventional methods cannot reach.
- Peers can reinforce learning through ongoing contact.

A well-known way of using peer education is the Child to Child programme. This was initiated in the International Year of the Child in 1979, and it has since developed many aspects and a range of materials. Four main principles inform this programme:

- The concept of PHC - developing the power of individuals and communities to take responsibility for the betterment of their own health.
- Faith in the power of children to spread the health messages and health practices.
- Belief that, at every level, health education learning must be accompanied by health action.
- Conviction of the need for joint action between education and health workers at all levels.

The following article describes the use of peer education and highlights some of the barriers to the effectiveness of the programme. This peer education programme uses the school as a setting. The article describes many of the constraints of this setting and the didactic patterns of teaching and learning. It also highlights the problem of adults being poor role models for youth when looking to develop healthy sexual relationships.

**READING**


It is critical to understand the issues described in this paper such as social identity, gender dynamics, social capital, empowerment, and critical consciousness, if one is to plan and implement appropriate interventions in communities living in a state of poverty.
The issues being raised and their suggestions for short, medium and long term planning are applicable to your assignment. “Summertown” could very well have been the district in which Nomhle is working.

7 WHAT WORKS BEST?

As noted above, health promoters have several choices to make in designing a programme. In Reading 45, an evaluation has been conducted in Uganda in relation to HIV/AIDS education, to establish which approaches seem to have the most impact. The methods used in this study were drama, video, community education and leaflets.

**READING**


The authors of this article conclude that multiple channels may be necessary to “overcome weaknesses inherent in individual channels.” (Mitchell et al, 2001: 411)

8 TRAINING AS CAPACITY BUILDING

Health Promotion programmes which aim to reorient services and increase the capacity of people to carry out more appropriate and high quality work rely heavily on training. The training may be designed for professional health workers or lay workers and volunteers. It may be on a large and formal scale, or on a smaller, informal level.

**READING**


While this Reading applies mainly to health care workers, it is still useful as many of the issues raised are about health promotion, and approach to determining training needs and implementing training programmes are very useful.
**9 SESSION SUMMARY**

In this session we have looked at different methods and strategies for implementing health promotion programmes. It included strategies for organisational level change which could be used to improve health in programmes generally and which could be applied in Nomhle’s district. They are: building partnerships through an intersectoral approach, involvement communities at all stages in the programme, and the value of using a health promoting settings for collaborative programmes.

We then looked at population or individual based approaches, which reflect a more targeted approach. These included communication and the use of media, and peer education.

The session concluded by noting the importance of capacity building through effective training programmes. 3 Tasks were included to assist with your assignment, providing the opportunity to explore how Nomhle could use these methods and approaches.

**10 REFERENCES AND FURTHER READING**


Unit 4 - Session 3
Case Study Examples

Introduction

The final session of Unit 4 will look at practical implications of health promotion programmes. We have selected two very different topics – one concerned with poor living conditions (inadequate water and sanitation) and the other an infectious disease (HIV/AIDS), so you can apply what you have learnt across a broad spectrum.

Session contents

1 Learning outcomes of this session
2 Readings
3 Sanitation and Health
4 HIV/AIDS
5 Session summary
6 References and Further Reading

Timing of this session

There are four Readings and two tasks in this session. We have used a mixture of new Readings and some that have been studied in earlier sessions. Those that you have already studied are now being included as specific case studies, to give an overview of specific health promotion interventions.

It should take you approximately three hours to complete.
1 LEARNING OUTCOMES OF THIS SESSION

By the end of this session, you should be able to:

- Relate the broad determinants of health to case studies.
- Describe interventions that have been undertaken to address the problems of inadequate water and sanitation and HIV/AIDS.
- Critically assess the successes and limitations of these interventions.
- Apply module lessons to the development of a Health promotion plan.

2 READINGS

There are 6 Readings for this session. Three of these have already been studied. You will be directed to them in the course of the session.

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In Unit 1, session 1, you looked at a Reading on the need to integrate environmental and social interventions in child health promotion programmes to prevent childhood diarrhoea, and you used this to identify the different determinants of diarrhoea in young children. You revisited these issues in exploring the action areas of the Ottawa Charter as an example of the need for the development of a supportive environment.

Have a quick look again at the article if you need to, as a reminder of the issues raised in it. You will apply what you have learnt by assessing Health Promotion interventions in two Case Studies.

**READING**


You will remember that the determinants included poverty, lack of access to sanitation and safe water, poor domestic hygiene, food contamination among others. Tackling the broad determinants of poverty and poor living conditions requires a broad intersectoral anti-poverty strategy. Reflect on the example from the UK in Naidoo and Wills (1994) [Ch 4 - Promoting equity in health promotion: health and poverty. *Practising Health Promotion*. London: Bailliere Tindall: 71 - 91] in Unit 1, Session 1. Programmes aiming to address behaviour change are clearly easier to tackle, but it is important to remember the reasons for some of the unhygienic practices, and consequently, the reasons for some of the failures of behaviour change strategies.

We have included two more Readings that relate to sanitation, hygiene and health, both examples of Health Promotion interventions. One is the development of community health clubs in rural Zimbabwe, which focuses on empowerment of communities, resulting in improved health and hygiene practices and an increase in the number of toilets built by the communities. The second is a comparative deworming programme in China in six schools. Two of these were control schools, which just practiced deworming, two had deworming and health education programmes, and the final two were integrated health promoting schools initiatives that included a focus on the school environment, school policies and relationships with the community and health services.
READINGS


TASK 1 - Evaluate a Health Promotion intervention using what you have learnt about constructing a successful intervention

- What aspects of the Community Health Clubs have been successful? Why have these strategies worked?
- What if anything do you think could have been done to strengthen them further?
- What aspects of the Health Promoting Schools made the difference? Why?
- What if anything do you think could have been done to strengthen them further?
- Which initiative do you think is more likely to be sustainable?

FEEDBACK

Both the above initiatives are innovative and have shown how well-planned, integrated health promotion programmes can make a difference. Both showed the benefits of working closely with communities. In the Community Health Club example, there was considerable focus on supporting the communities, strengthening their ability for them to change their behaviour and living patterns. This included infrastructure changes that led to a healthier environment for the club members. While there was clearly support for the environmental health technician, who in turn provided strong levels of support for the Clubs, less emphasis was placed on the wider policy and political environment: in terms of the Ottawa Charter action areas, healthy public policy and reorientation of the health services was not addressed.

The schools deworming study shows the value of an integrated health promotion programme that addresses at least some of the determinants of ill health, in this case the school environment. The strengths of the two health promoting schools is that they made infrastructure changes, as well as developing stronger networks with other groups and organisations, both
Both initiatives have the potential to be sustainable. The community health clubs have developed strong community and professional support: an important strength is that they are social as well as educational, and they are being used as a forum to raise a wide range of health issues. However, their survival will depend on the ongoing commitment of the club members and the environmental health technicians that support them. The health promoting schools, by emphasizing policy development and creating organizational structures including the project steering committees, should, ideally, be able to sustain the momentum, even with a turnover of staff and children.

4. HIV/AIDS

The second case study is on HIV/AIDS. This has been deliberately included to provide an opportunity for you to study examples that can be useful for your assignment. Two of these case studies have already been used in this Unit (Session 2) to illustrate specific methods. We have also added a Reading which is based on Tanzanian HIV/AIDS case studies. Even though these are not very recent, we have included them as they cover an extensive range of activities, which should be useful for your assignment.

As you read, keep in mind the questions you used to assess the Case Studies in Task 1. Note the key points that are relevant for the development of your own Health Promotion plan in Assignment 2.

READINGS


Finally, it is worth exploring some national HIV/AIDS policies and strategies to get an up to date indication of what is currently being proposed. As you have gathered from your studies in these past units, policy supplies a relevant broad framework for the development of Health Promotion interventions and
you should ideally find that it provides guidance for addressing the broad determinants of health, or health issues. Therefore, you may find the country-relevant policies useful in supplying ideas about some of the issues to be addressed in a well-developed and integrated strategic intervention.

Conduct a search online for policies relating to your own country. Key words that you might use are: HIV/AIDS + policy, plus the name of your country. You might also request relevant HIV/AIDS related policy documents from government offices in your country. NGOs could also be useful in providing relevant information.

**TASK 4 - Learning from practice**

This is the final task for your notebook for this Unit.

- Note down examples - strategies and recommendations - that you think would be useful in developing Nomhle’s plan.
- Remember to look at whether the examples are adopting the Ottawa Charter action areas, as we have done with the Sanitation example.
- Also refer back to your own notes about how the Ottawa Charter could be useful, to see if you want to now add or change anything.

We will not provide feedback for the HIV/AIDS case studies, as this task will be incorporated into your assignment.

5 **SESSION SUMMARY**

The final session of Unit 4 provided case studies on sanitation and health and HIV/AIDS. The purpose of this session was to provide an opportunity to focus on the interventions that have been adopted for these two health concerns, and to be able to critically analyse the successes and limitations of these interventions. In evaluating other case studies, you are further developing your competence in constructing a successful Health promotion intervention. The session ends with an opportunity to go back to your notes, using the lessons learnt during the Readings to inform your thinking.

6 **REFERENCES AND FURTHER READING**

- National, provincial and local Sanitation and HIV/AIDS policies and programmes from your own countries.
Unit 5 - Introduction

Evidence-Based Practice and Evaluating Health Promotion Programmes

Congratulations on reaching this final unit of the Health Promotion II Module! Evaluation is increasingly being recognised as a critical aspect of Health Promotion; there are also growing pressures to make practice evidence-based. Evaluation is not a separate aspect of Health Promotion practice, but ties in closely with other aspects of the practice, and so draws on issues already described earlier in the Module Guide. Aspects of evaluation are also covered in the Monitoring and Evaluation Module and Health Management II Module. In addition, research methodologies are covered in more detail in Quantitative Research Methods and Qualitative Research Methods Modules.

Unit 5 is divided into three sessions:

- Study Session 1: Evidence Based Health Promotion
- Study Session 2: Issues in Evaluation
- Study Session 3: Planning Health Promotion Evaluation

The first session will consider what is meant by evidence based practice and discuss some of the issues involved in its development.

The second session will look at some of the issues, debates and considerations when planning and conducting an evaluation.

The third will provide some guidance on the methodologies and practicalities of evaluating a Health Promotion Programme. All can be usefully applied in your assignment.
# Learning Outcomes of Unit 5

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

- Define evidence-based practice and comment on key issues in developing it.
- Discuss the benefits, as well as complexities of evaluating Health Promotion programmes.
- Discuss the methods and approaches to evaluating Health Promotion programmes.
- Select and demonstrate appropriate evaluation approaches for different interventions.
Unit 5 - Session 1
Evidence Based Health Promotion

Introduction

In earlier Readings, you may have noted references to the importance of adopting evidence based practice in Health Promotion. You will probably also have noticed comments on what we mean by evidence, and statements about how best to acquire the evidence we need in order to adopt evidence based practice. In this session we are going to look in more detail at the issue of evidence based practice before moving on to look at the principles and practice of evaluation in Sessions 2 and 3.

Session contents

1 Learning outcomes of this session
2 Readings
3 Introduction to Evidence Based Health Promotion
4 Barriers to Evidence Based Practice
5 The quality of evidence
6 Applying your understanding of Evidence Based Health Promotion
7 Session summary
8 Further reading

Timing of this session

This session contains three readings and five tasks. If you take the advice to skim read two of the papers for the session, those by McQueen and by Raphael, the session should take you about three hours. Two of the tasks should be done in your Assignment Notebook A. A logical place for a break would be after section 5.
1 LEARNING OUTCOMES OF THIS SESSION

By the end of this session, you should be able to:

- Define Evidence Based Practice.
- Describe and assess the types of evidence needed as a basis for Health Promotion practice.
- Be aware of the debate about appropriate ways to develop the Evidence Base in Health Promotion.
- Apply ideas about Evidence Based Practice to your own work and the case study.

2 READINGS

The readings for this session are listed below. You will be directed to reading them in the course of the session.

There are three readings for this session. The first, by Wiggers and Sanson-Fisher (1998), provides a useful overview of Evidence Based Health Promotion. The second, by McQueen (2001), also covers the general issues and asks about the global relevance of some of the debates. The paper by Raphael (2000) is particularly useful in thinking about the interplay of principles or values, ideas and evidence in Health Promotion decision making. The papers by McQueen and Raphael are quite detailed and you are advised to skim read them in order to pick out key points and to see them as a resource for further reading in the future.

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INTRODUCTION TO EVIDENCE BASED HEALTH PROMOTION

What is your current understanding of the concept of Evidence Based Health Promotion practice? Jot down what you know in the margin before you begin.

Now study the following Reading which provides a useful overview of Evidence Based Health Promotion and offers important input for the intended outcomes of this session.

READING

TASK 1 - Develop an understanding of the rationale for a strong Evidence Base in Health Promotion

- What is meant by Evidence Based Health Promotion?
- List reasons for promoting Evidence Based Practice from your own perspective.
- Outline the main points in the Reading by Wiggers and Sanson-Fisher: How is Evidence Based Practice described in the Reading? What reasons are given for Evidence Based Practice? To what extent do the reasons in the Reading match up to the ones you listed yourself?

FEEDBACK

While definitions of Evidence Based practice vary, we are essentially talking about what Wiggers and Sanson-Fisher describe as the “explicit application of quality research evidence to planning and conducting health promotion initiatives”. They state that this evidence can be obtained from the appraisal of the research literature or, where feasible, from research data which has been collected by the Health Promotion practitioner. They stress that the application of quality research evidence to Health Promotion interventions needs to be combined with the use of practitioners’ professional skills and knowledge. This expertise includes the capacity to select health issues, target groups, interventions and evaluation designs. It also includes identifying and responding to the expressed needs of communities, interest groups and governments. They conclude:

“... evidence based health promotion therefore comprises a decision making process whereby quality research evidence is applied in a manner consistent
with the circumstances of a community, their expressed need for interventions, the priorities of government and funding authorities and the availability of resources. Neither quality research evidence nor professional expertise alone is a sufficient basis for appropriate and effective health promotion”. (Wiggers & Sanson-Fisher, 1998).

We should note, at this point, the debates about what should count as ‘quality’ evidence. Different kinds of evidence can be drawn on. Evidence can be drawn from earlier practitioner evaluations. However, when people refer to adopting evidence based practice they are often referring to the use of published evidence from research and evaluation studies and systematic reviews of this evidence.

There is frequently a strong emphasis in the literature on the importance of evidence of the effectiveness of interventions in achieving Health Promotion outcomes. Such evidence can include:

- Development of health promoting schools, health centres, workplaces or other health promoting settings
- Development of policies designed to addressed underlying determinants of health
- Reduction of health inequities
- Changes in health in terms of mortality or morbidity. e.g. Reduction of children absent from school with diarrhoeal disease following improvements to water supply in schools and an education programme.
- Positive health measures e.g. the percentage (%) of children of 0-5 years meeting developmental targets
- Health-related behaviours
- Knowledge, beliefs, attitudes
- Empowerment of individuals or communities
- Skills: decision making; advocacy; partnership working; communication
- Measures of intersectoral working.

People will differ in the extent to which they see all of these indicators as relevant measures of health promotion success. Those which relate to the application of a preventive model may be rejected as inappropriate measures by some people in contrast to those indicators which, for example, assess the development of empowerment of individuals and communities or assess achievements in developing complex programmes.

Evidence on the way that programmes work – referred to as process evaluation in the following sessions – is also important. Such evidence helps us to know why an intervention has worked, or in those cases where it has not, why it has not worked. It also helps us to see whether a programme has had harmful effects on participants. Process evidence is collected during the course of an intervention. You will read more about the importance of process evaluation in the Springett (2001) paper in Session 3.
As you will see, process evaluation can include:

- Information on whether the activities intended to achieve effective outcomes have been incorporated and carried out correctly.
- Satisfaction of the participants with a programme.
- Indications of whether an intervention has fit with Health Promotion principles and values. For example if the importance of community participation in design and implementation of an evaluation is valued, has this been adequately addressed?

In completing Task 1, you will have listed a variety of reasons for Evidence Based Practice. These include:

1. Evidence of what has been shown to work in previous evaluations can help us identify the ways that our current practice should be changed in order to become more effective. Eg evidence on changing eating behaviours may indicate that effective programmes need to be holistic and focus on individual issues such as knowledge beliefs attitudes and skills together with changes in the access to appropriate foods and other enabling factors. Our programmes may have been focused narrowly on individual knowledge and beliefs and ignored the other important factors.

2. Basing practice on evidence, if it is available, can make better use of scarce resources. It is not always possible to get sufficient resources for thorough evaluation of all programmes, so basing them on existing evidence of what works and monitoring outcomes can be recommended. Activities which, on the basis of the evidence base, have been shown not to work might be discontinued. In some cases, however, the evidence may point to the need for more complex activities than we have previously used, so additional resources may actually be needed. For example, evidence from an evaluation of health promoting schools may reveal that a lack of success resulted from teachers not being given the time or appropriate training to develop their understanding of the idea of the health promoting school and the way to promote its development. Resources would be needed to provide the time and necessary training.

3. Making sure that practice is evidence based can make health promotion more credible with other professionals. You will recall that we also made this point about credibility when discussing theory in Unit 2
4 BARRIERS TO EVIDENCE BASED PRACTICE

Although evidence based practice is strongly advocated, it is difficult to implement. The next two Readings and task explore some of the barriers to evidence-base practice. Use the task to help you construct a summary of some of the key barriers. “Barrier” does not mean the task is impossible, but alerts you to what you should be aware of, and take into account when developing evidence-based practices in your Health Promotion practice. Skim read the two Readings - there is some overlap between these two readings, which will reduce your reading time, and also draw on the Reading by Wiggers and Sanson-Fisher in completing the task that follows.

READINGS


TASK 2 - Exploring the barriers to Evidence Based Practice

What are some of the barriers to evidence based practice? Take particular note of McQueen’s discussion of the cultural and geographical bias of much evidence.

FEEDBACK

The Reading by Wiggers and Sanson-Fisher lists the following barriers:

- **A lack of quality research evidence.** In making this point we need to consider how they define quality evidence. [Raphael (2000) comments on this and suggests that Wiggers and Sanson-Fisher are conforming to ideas of a hierarchy of evidence that defines quality of evidence in a specific way used widely in medicine. You will examine this point further in the next task and in the following sessions. Note what is said on this in the reading by Springett (2001).]

- **A lack of funding for Health Promotion research and evaluation affects Health Promotion in some countries more than others.** This is also a problem for some health topics. As a result, the evidence base is uneven.
There is a lack of training and consequently of practitioner skills in conducting evaluations and in critical appraisal of published evidence. There are major difficulties in conducting Health Promotion research in accordance with bio-medical models of research. Many would add to this that these are also not appropriate models for evaluating health promotion programmes. There is a lack of acceptance of the relevance of Evidence Based Practice to Health Promotion. A lot has changed since this book was written and there is now a much wider acceptance of the need for evidence based practice.

McQueen (2001) makes the important point that much of the research-based literature where evidence is reported does not fully reflect the breadth of activity that is taking place. Evaluations which have been conducted using specific designs are more likely to be published. Also, although there is an evidence base on activities in developing countries, this has not been widely published or adequately disseminated. This situation is now beginning to improve. McQueen (2001) also raises concerns about the geographical and cultural bias of discussions about evidence and Evidence Based Practice. He poses some questions on page 262 which arose from the Mexico Conference which you should consider. He reviews the issues further on page 267.

5 THE QUALITY OF EVIDENCE

Effectiveness of evidence is often described as differing in strength. This is illustrated by the hierarchy of evidence which you will have seen discussed on page 130 of the Reading by Wiggers and Sanson-Fisher and on page 358 of the Reading by Raphael.

**READINGS**


**TASK 3 - Critically analyse the hierarchy of evidence**

- From the hierarchy of evidence described in these readings, what methods are used to generate the strongest evidence?
- What reservations are expressed about such methods in Health Promotion?
- What is presented as the recommended approach to developing evidence for Health Promotion?
Evaluation studies based on experimental designs are claimed to generate the strongest evidence. The design of such studies and also those which are defined as weaker are described in the Reading by Wiggers and Sanson-Fisher. This hierarchy of evidence and the quantitative approach to research which it reflects, while used in Evidence Based Medicine, has been widely debated and challenged in Health Promotion. Raphael summarises these reservations on page 358 as follows:

The hierarchy of evidence is questioned because of its:
- Emphasis on the quantitative approach.
- Emphasis on linear cause-effect relationships.
- Tendency towards an individualistic focus to the detriment of contextual factors.
- The level of importance attached to objective measurement

Raphael (2000), in common with many other commentators, proposes that Health Promotion theory, principles and practice provide a direct challenge to the above. He suggests that much of the criticism concerns the inappropriateness of traditional quantitative data analysis approaches for understanding human experience, an essential component of Health Promotion activities. The importance of using qualitative research methods to evaluate complex Health Promotion interventions is stressed.

There are those who argue that experimental studies have no place at all in Health Promotion evaluation. Others would argue that although they may have only a limited contribution to make, they can be useful in evaluating some types of Health Promotion activity especially limited health education activities. As you read notice the different positions that writers take on this issue and think about your own views.

The reading by McQueen picks up on the point that experimental design evaluations are insufficient for assessing health promotion and refers to the WHO (1998) recommendation to:

“… adopt an evidence based approach in health promotion policy and practice, using the full range of quantitative and qualitative methodologies.” (McQueen, 2001)

The reading by Springett (2001) in Session 3 considers these issues about appropriate evaluation for health promotion.

In general, there is broad agreement that combining methods which generate quantitative data with those which generate qualitative data provide the fullest picture in evaluating Health Promotion. On pages 358-360, the Raphael (2000) Reading makes a number of key points in support of such a pluralist approach to methodology.
6 APPLYING YOUR UNDERSTANDING OF EVIDENCE BASED HEALTH PROMOTION

In this section, you are asked to record your tasks in your Assignment Notebook. The tasks provide preparation in applying Evidence Based Health Promotion concepts to the case study. They should also be useful as a preliminary to Sessions 2 and 3.

**TASK 4 - Identifying appropriate evidence**

- What kinds of evidence should Nomhle aim to gather in order to demonstrate the effectiveness of her programme?

**FEEDBACK**

Nomhle will probably have developed her own views about what she sees as the most appropriate evidence to demonstrate the effectiveness of her Health Promotion activities. For example, she may wish to demonstrate evidence of community participation in the design and implementation of interventions, evidence of community satisfaction and evidence of empowerment of individuals and communities. In these cases, she would prioritise qualitative evidence.

She will, however, also be accountable to others who may put pressure on her to produce evidence of health behaviour change and improvements in morbidity data evidenced by quantitative data. If this is the case, it will be necessary to have discussions about these differing demands before finalising an evaluation strategy.

In practice, most stakeholders may support the idea of generating both quantitative and qualitative evidence. For example, if Nomhle was supporting schools in evaluating their sexual health education programme, she might encourage them to carry out the following:

- A self completed questionnaire before and after a programme from which *quantitative* data would be derived on knowledge, attitudes and reported behaviours.

- Focus groups generating *qualitative* in depth evidence on young people’s views about the sexual health education programme.

These considerations should help you select the most appropriate kinds of evidence that can demonstrate the effectiveness of Nomhle’s plan.
As you read through evaluations of Health Promotion programmes, note the types of evidence that are being collected and the justifications that are provided for the approach that has been adopted.

**A TASK 5 - The challenges of getting evidence into practice**

- What factors need to be considered in getting evidence into practice in Nomhle's district?

Recently, there has been growing attention to the effective dissemination of evidence and ways in which Evidence Based Practice can be facilitated.

Nomhle will need to think about:

- Identifying appropriate evidence and getting it to those who need to use it.
- The capacity of practitioners and their motivation to draw on the evidence and use it in planning activities.
- Development of practitioner knowledge and skills to carry out Evidence Based Practice.
- Addressing the evidence needs of policy makers and budget managers and finding ways to bring evidence to their attention when it is needed.

**7 SESSION SUMMARY**

This session has introduced a key contemporary challenge in Health Promotion: the development of Health Promotion as an evidence-based discipline, or practice. You have seen that there is a considerable amount of debate on Evidence Based Practice – what it is, how it should be done and how to deal with the barriers to this sort of practice. You will therefore probably need to read further in order to become fully familiar with the discussions that are taking place. It is important to emphasise that in planning evidence based Health Promotion interventions we need to ask:

- What existing evidence do we need in order to judge what kind of intervention may work with this client group and in this setting?
- How strong is the evidence that exists and how was it collected?
- If there is no published evidence available, can we evaluate the proposed intervention so that we generate evidence that is useful to ourselves and to others? And what methods will we use to do this? (The next two sessions are designed to develop your understanding of planning and carrying out evaluations.)
- How can we disseminate evidence of effectiveness to others who may benefit from the knowledge?
8 FURTHER READING


Unit 5 - Session 2
Issues in Evaluation

Introduction

The growth in Health Promotion has been accompanied by an increased emphasis on the importance of evaluating Health Promotion Programmes. However, as has become apparent as you studied this module, Health Promotion is a complex field, drawing on many disciplines. It often involves different kinds of activities, some of which are difficult to evaluate, and this is particularly true in the case of longer term actions. In addition, the evaluation of Health Promotion programmes may be required by different stakeholders and for different reasons. The purpose of this session is to provide you with a general overview of some of the key issues in evaluating Health Promotion Programmes, before putting it into practice.

Session contents

1 Learning outcomes of this session
2 Readings
3 Defining evaluation in Health Promotion
4 Issues in Health Promotion evaluation
5 Dilemmas in evaluating Health Promotion initiatives
6 Session summary
7 References and further readings

Timing of this session

There is one Reading and one task in this session. It should take you approximately one and half hours to complete.
1 LEARNING OUTCOMES OF THIS SESSION

By the end of this session, you should be able to:

- Understand the role of evaluation in Health Promotion
- Identify key issues in evaluating Health promotion initiatives
- Describe the dilemmas in Health Promotion evaluation.

2 READINGS

The readings for this session are listed below. You will be directed to them in the course of the session.

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3 DEFINING EVALUATION IN HEALTH PROMOTION

Health Promotion is often thought of as a vague activity where it is difficult to demonstrate success. Furthermore, as a relatively new field, Health Promotion has been expected to prove itself – to show that it is worthwhile and of value. This sort of expectation often comes from people who assume that approaches such as randomized controlled trials are of the greatest importance, and should be used to assess the validity of Health Promotion programmes. As discussed in the previous session, these are not, however, suitable for most of the issues and programmes that we deal with. Yet, despite the doubts and conditions, there is an overwhelming weight of evidence that suggests that Health Promotion does work if we adopt a broader approach to evaluation. (Naidoo and Wills, 2000).

This session will start the discussion on evaluation by looking at issues concerned with evaluation, given the complexities outlined so far.
3.1 What is different about evaluation in Health Promotion?

As we have discussed in the module so far, Health Promotion (very often) by definition involves complex activities, multiple approaches, multisectoral inputs including community participation and it operates at several levels, often over long periods of time. How does one assess the impact of all this?

Have a look at the descriptions of evaluation below. Do they account for these complexities?

“As a process, evaluation is concerned with assessing an activity against values and goals in such a way that results can contribute to future decision making and/or policy”. (Tones & Tilford 1994: 49)

“Good quality evaluation depends on a balance between the rigor demanded by good quality research, an appreciation and understanding of the values for stakeholders, a commitment to the principles of health promotion and the resources available’. (Springett, 1998:27)

“At its core, evaluation concerns assessment of the extent to which an action achieves a valued outcome. In most cases there is also value placed on the process by which these outcomes are achieved. (Nutbeam, 1998)

What is clear from these statements is that Health Promotion evaluation is essentially:

- Making a judgement about the value of a Health Promotion activity
- Recognising that Health Promotion is a process, directed towards enabling people to take action.
- Combining a actions of assessing:
  - WHAT has been achieved (Outcomes), and
  - HOW it has been achieved (Process)

The Process includes all the implementation stages that happen between the input and outcome. Such as, did the activities happen as planned, did they include the range of people as intended, did they happen on time, were the methods used appropriate for the audience?

The Outcome is the end product of the Health Promotion activity or programme expressed in appropriate terms (e.g. changes in people’s attitudes or knowledge, or change in uptake of services). Basically it relates back to achieving the Health Promotion Programme goals.

These aspects are described in the Reading. Look at the Reading now.
The report of the WHO European Working Group provides an accessible overview of the principles for evaluating Health Promotion activities, and a set of clear recommendations for us to follow. This is from a European perspective, but the recommendations apply equally to other regions, including African countries.

3.2 Applying the principles in practice

Now that you have familiarised yourself with some of the issues in evaluating Health Promotion initiatives, tackle the following task.

A TASK 1 - Preparing to evaluate the intervention Nomhle is proposing

Jot down answers to the following questions in relation to your proposal.

- Who is likely to have requested the evaluation?
- Why would they want it?
- Who is likely to pay for it?
- Who will use it?
- What will be its purpose?
- Who will do the evaluation – will it be Nomhle or her colleagues, or an outside evaluator?
- How will the team know if they have achieved their objectives?

FEEDBACK

Hopefully, the readings will have assisted you to answer these questions. However, you may find that your answers raise more questions. This is predictable, given the complexities described above. We shall explore some of these issues in more detail in the next section.

4 ISSUES IN HEALTH PROMOTION EVALUATION

The points below illustrate some of the issues that should be considered in planning Health Promotion evaluation.
4.1 When and what to evaluate

When beginning an evaluation, it is useful to think through exactly why you are doing the evaluation. One reason is to keep track of your progress as you implement and develop the programme further. This is sometimes referred to as monitoring your programme, and sometimes as process evaluation. However, evaluation is wider than monitoring as it involves judgements about values. Monitoring asks if we are doing things right, while evaluation asks if we are doing the right thing.

The other reason for programme evaluation is to reflect on whether your programme has met its objectives - that is, whether it has done what it set out to do. This is generally undertaken at the end of a programme, but also often as a mid-term evaluation. These issues will be dealt with in more detail in the readings in Unit 5 Session 2. It is also important that the findings of the evaluation are used to inform future plans for the programme and also that the information is shared with others so that they can learn from your experience.

4.2 Who is the evaluation for?

As you have seen, the reasons for doing the evaluation and how you do it will also depend on who requested it. Evaluations are often done because the funders of the programme require it. Their interest will probably be in the cost-effectiveness of the intervention, with questions including how many sessions were held, how many people attended. The evaluation could also be requested by managers, who are interested in the effectiveness of their staff. Finally, the evaluation could be initiated by those involved in the programme itself, and their interest is more likely to be about what their intervention is achieving - and is therefore more likely to be a process evaluation. They may also be interested in using the evaluation as a source of fundraising, in which case they are more likely to want an evaluation that is positive and constructive, and that minimises the problems.

Generally, regardless of who initiates the evaluation, those involved in the programme will want to make the most use of it. This is sensible, given how costly and time-consuming evaluations are. However, remember that there are different motivations and expectations of different interest groups and they will influence the depth and detail of information required. You will also need to remember that different groups may require different presentation formats and feedback, such as a structured report format for a national or international funder and an oral presentation to a local community group.
4.3 Who will do it: insider or outsider evaluation?

Another important consideration is who does the evaluation. Should it be carried out by a practitioner involved in the programme, or an outside researcher?

There are advantages to both. The insider evaluator is more familiar with the context and what is needed, and insiders are also cheaper. The outside evaluator, however, is regarded as more *objective* and brings a fresh perspective to the programme. The table below, adapted from Naidoo and Wills (2000: 372), illustrates some of the advantages and disadvantages of both kinds of evaluator. It is also possible to combine insider and outsider evaluation, drawing on the advantages of both.

**Advantages and disadvantages of insider and outside evaluators for Health Promotion Projects**

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<thead>
<tr>
<th></th>
<th>Insider evaluators</th>
<th>Outside evaluators</th>
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<tbody>
<tr>
<td><strong>Advantages</strong></td>
<td>Know background</td>
<td>Unbiased attitude</td>
</tr>
<tr>
<td></td>
<td>Acceptable to all</td>
<td>Research expertise</td>
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<tr>
<td></td>
<td>Cheaper</td>
<td>Fresh perspective</td>
</tr>
<tr>
<td><strong>Disadvantages</strong></td>
<td>Too involved in project</td>
<td>Unfamiliar with project</td>
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<tr>
<td></td>
<td>May not have research expertise</td>
<td>May be threatening</td>
</tr>
<tr>
<td></td>
<td>Biased towards proving success</td>
<td>Expensive</td>
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</table>
5 DILEMMAS IN EVALUATING HEALTH PROMOTION INITIATIVES

Two key dilemmas posed by Health Promotion Programmes are:

- Knowing what constitutes success, and
- How do we know that the change can be attributed to the intervention

5.1 Knowing what constitutes success

In many areas of Health Promotion, there is not enough base-line or pre-programme information to make an informed judgement about what has changed. Whenever possible efforts to gather some baseline data are advised. It is also difficult to gauge the degree of change that is possible. So if specific objectives are set for a programme, they are often a shot in the dark. They may be too modest, in which case the achievement can occur without much input, resulting in an unhelpful evaluation; or they may be too ambitious, in which case the objectives may not be met, resulting in an evaluation that could be overly discouraging. This dilemma will be explored further in Session 2.

5.2 How do you know that the results are due to a Health Promotion input?

Because Health Promotion is a long-term process, and because any situation is constantly changing, it can be difficult to ensure that the changes detected are the result of the Health Promotion input and not to any other factors. Health-related knowledge, attitudes and behaviour are constantly changing, regardless of Health Promotion activities. Societies and environments are also changing. Think, for example, of the knowledge about the dangers of smoking and the attitude towards smokers in public places, or the knowledge of the risks of HIV infection and the importance of the use of condoms. How can you say that attitude and behavioural changes are the result of your intervention?

It is obviously difficult to establish what has led to any individual or community becoming more aware of the risks of a particular behaviour. However, what is clear is that the classic scientific measurement-based research for establishing cause and effect is frequently not feasible or appropriate: this is because it relies on controlling all factors other than the one being studied, and the use of control groups who are not exposed to the programme. Short of removing people from all sources of public information, setting up a control group is clearly not feasible. In some cases it may be possible to compare the effects of the public information activities with a similar (matched) community which has not been reached by the programme. Alternatively, the
information on knowledge about risks can be compared before and after the programme. Process evaluations are also useful in this respect, as they measure the actual activity that has taken place. This will be explored in the first reading in Session 2

5.3 Evaluation of partnership programmes

The complexities become even greater when the programme you are evaluating is a partnership programme, such as programmes working in health promoting settings. The assumption in partnerships is often that, faced with shared problems, people will agree on shared goals and targets to be measured. However, that is not necessarily the case. There may be different vested interests, different interpretations and different priorities within the groups that determine their objectives. This dilemma is illustrated in the diagram below. The importance of spending time clarifying these objectives is particularly important in partnership situations as is evident in this cartoon.

![Diagram](image)

(Feuerstein, 1986:13)

Baum (2002), noting these tensions, reminds us that all partners need to be involved in conceiving and planning the evaluations, so that their values, aspirations and concerns can guide the evaluation. She suggests the following pointers as a guide to a good evaluation, which are applicable to both community and professional evaluation partners.
• Develop a realistic, feasible and adequately resourced evaluation plan so that it is possible to deliver on promises about what will happen and when it will happen.
• Allow for adequate release time from normal duties to cover the time needed for the evaluation. Remember the time required is usually underestimated.
• Avoid really problematic settings (e.g. where organisation is under severe strain).
• Work hard on utilisation as frustration will occur if there is no action taken on the findings of an evaluation.

Baum (2002:187)

Before you finish this session, return to the list of preparatory questions you put together for your evaluation in Task 1, and add to or amend any of your points in the light of this discussion on the dilemmas of evaluation.

6 SESSION SUMMARY

In this session, we have noted the increasing importance placed on evaluating Health Promotion initiatives. The session has also highlighted some of the issues and complexities of evaluating programmes. The next session will show how some of these dilemmas are tackled in practice.

7 REFERENCES AND FURTHER READING


Unit 5 - Session 3
Planning Health Promotion Evaluation

Introduction

The second session of this unit explores the practical process of evaluation. Some of the debates and issues referred to in Session 1 are further explored and step by step approaches are presented as well as a set of guiding questions for Health Promotion programmes implemented within settings. Lastly, you are encouraged to finalise your evaluation plan for Mfula.

Session contents

1. Learning outcomes of this session
2. Readings
3. Appropriate methods for HP evaluation
4. Planning your evaluation
5. Session summary

Timing of this session

There are three Readings in this session and one task. It should take you approximately two and a half hours to complete.

1. LEARNING OUTCOMES OF THIS SESSION

By the end of this session, you should be able to:

- Demonstrate an awareness of the methods and approaches to evaluating Health Promotion programmes.
- Plan an evaluation for a Health Promotion Programme.
2 READINGS

The readings for this session are listed below. You will be directed to them in the course of the session.

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3 APROPRIATE METHODS FOR HEALTH PROMOTION EVALUATION

As we have already noted in the previous session, there are many ways in which the success of a health promotion programme can be gauged. What is clear is that health promotion invariably does not involve a single act followed by a defined outcome, but in most situations involves complex interventions that take place in a specific social context, and often over a long period of time, with sometimes hard to define direct outcomes. This means that simply quantifying a particular indicator before and after the intervention will not usually provide a very clear picture of the value of the health promotion intervention. Consequently, considerable weight is given to evaluating the process of the intervention, as well as the actual outcome. Additional factors that influence health promotion evaluation are the underpinning values of health promotion, such as empowerment and equity. As a result, health promotion evaluation places considerable emphasis on the perspective of the population for whom the intervention is planned to benefit and thus often employs participatory research in which qualitative methodologies predominate. Read the article by Springett (2001), where you will find some of these issues debated. We have referred earlier to the debates about evaluation. Think about Springett’s stance as you read the paper.
You will notice that Springett (2001) focuses on the appropriateness of evaluation in Health Promotion. The Springett article is particularly useful in its questioning of appropriate for whom, and appropriate for what. Among the issues she raises are: the difference between Health Promotion activities which have, as their focus, encouraging something to happen, unlike traditional disease based evaluations which focus on something not happening; the different ‘truths’ in any situation, and therefore the importance of values in Health Promotion; and the issue of control, as Health Promotion is about people having control on the factors that influence their health.

In her discussion on appropriate for what, Springett explores the importance of establishing the purpose of the evaluation for determining the evaluation design, as well as the value of getting people on board to be part of the evaluation process, which she considers to be even more important then the design itself. This is more likely to ensure the usefulness of the evaluation for those involved in the programme. Note also her analysis of the tension between Health Promotion evaluation and the more traditional medical style evaluations, also discussed earlier, and the differences between using qualitative and quantitative approaches. Finally note her emphasis on participatory evaluation, with the emphasis on learning and improving rather then proving.

4 PLANNING YOUR EVALUATION

Having explored some of the issues in evaluation design in Springett’s paper, review the preparation you did for evaluating your programme in Session 1. Now, have a look at the practical aspects of evaluation in the Australian Territorial Health Services Reading.

This article takes you step by step through doing an evaluation. The Australian article starts with questions about why evaluation should be done, and then proceeds through the process of planning and implementing an evaluation. It uses Australian situations as examples, but these are easily adaptable to other situations. This article adds guidelines for involving stakeholders and provides Macpherson’s useful Eight Stage Model for evaluation planning in Figure 4 on page 4-45. This Reading also provides an outline for process evaluation and impact or outcomes evaluation.
In the final session of Unit 4, you looked at a number of readings describing health promotion programmes: Ehiri & Prowse, Waterkeyn et al, Xu et al, and Mitchell et al. If you have time you may find it useful to go back to these projects and note what they said about the approaches to evaluation, methods and indicators used. These may also give you ideas of evaluation activities to include in your own programme.

To draw the unit and module to a close, look at the table in the Reading adapted by Baum and Brown (1989). This table provides a useful framework of the key evaluation questions for partnership evaluations. It also serves as a reminder of the issues for Health Promotion initiatives involving partnerships. Whilst this particular framework refers to Healthy Cities initiatives, the principles and approach are shared by all settings.

**TASK 1- Finalising your evaluation plan**

Finally, turn your attention to how you are going to recommend that Nomhle, and the stakeholders in the Mfula district, evaluate their programme, using the above readings in particular to inform your decisions. Remember that the reasons for doing the evaluation will determine your approach, as will the range of people involved in the programme.
5 SESSION SUMMARY

This final session on Evaluation has provided tools to help you reflect on the programme you are developing in the form of an evaluation. Hopefully, it has also helped you to reflect on the whole module: by drawing together the threads and themes that Nomhle should include in her evaluation, you will have had a chance to reflect on the issues and approaches that represent Health Promotion.

6 REFERENCES AND FURTHER READING


Module Summary and the challenges for health promotion practice.

We have now reached the end of the module and need to stand back and think broadly about the challenges which exist for health promotion practice. Throughout the Module Guide and the readings you will have come across suggestions of what is useful in Health Promotion, as well as some of the challenges that face us.

In Unit 1, we placed Health Promotion in its broader context, looking at equity, the right to health and the social and economic determinants of health. This led to an overview of the development of Health Promotion, showing how it has shifted from a fairly narrow focus of health education to a broad based approach, exemplified by the Ottawa Charter. We also noted the shift in recent years towards investment in health and technocratic approaches.

Unit 2 explored theories in Health Promotion, examining models and approaches. Included in this unit are some examples of different types of models, such as models of decision making and models of behaviour change.

Units 3 and 4 shifted emphasis towards practical application for HP programmes. Unit 3 discussed the planning process as it applies to HP, and then looked at two main approaches, the settings approach and targeting. Unit 4 returned to the Ottawa Charter discussed in Unit 1, this time showing how all the action areas relate to planning in health promotion programmes. This was followed by methods used in Health Promotion interventions, such as collaboration across sectors, communication and mass media and peer education. The unit ended with case study examples, where readings gave examples of how these approaches are used in practice.

Having an evidence base for health and health care programmes is increasingly important in pursuing Heath Promotion practice. Unit 5 therefore examines the issues and challenges in developing an evidence base for Health Promotion. This was followed by two sessions on Evaluation, the last two of the module. Session 2 explores issues in evaluation for Health Promotion, and Session 3 looks at practical examples of evaluation.

We hope you have enjoyed the module and found it useful for your work. Before finishing, we suggest you embark on a short quiz, to consolidate your learning, and to guide you with your assignments.
TASK

- Write down a list of what you see as the major challenges facing you in your own practice OR the challenges which face Nomhle.

When you have done this, compare your list with the points we have raised in the feedback. This exercise provides a useful opportunity for you to reflect on your own practice; so it would be best for you to first think about your own challenges before looking at the feedback. The feedback can only help you consider aspects of your own practice that you hadn’t previously considered.

FEEDBACK

There are inevitably many challenges you could have noted. We’ve listed some challenges which are often raised in discussions with practitioners. If there are any which aren’t on your list, decide which it would be useful to add.

- How to deal with demands to use behaviour change approaches when your own value position is to work collaboratively towards empowerment;
- How to persuade others that health promotion needs to work on the social determinants of health alongside work on individual determinants;
- How to get resources to work on what communities themselves define as their health problems rather than those issues which are defined and funded by others;
- How to build partnerships with others in order to build a settings approach in schools, workplaces etc;
- How to persuade others that effective health promotion requires complex interventions and not simply the provision of knowledge which people may already have;
- How to engage ‘hard to reach’ groups in the community in health promotion programmes;
- How to persuade colleagues that because we have always done things in a particular way there can be alternative, and better ways;
- How to persuade generous donors that the programmes they want to support have been shown to be ineffective;
- How to be a successful advocate for health;
- How to influence policies for health;
- How to adopt evidence based practice when it is very difficult to find evidence which applies to the programmes we are planning;
- How to use theory to improve practice;
- How to find out what other people are doing in health promotion in my region or country.

Wise and Jha (2001), in their paper which you read in Unit 1, also reflect on challenges in health promotion. They are concerned to focus on very broad issues and offer a vision for the future. If you have the time, look again at this short reading. They noted these points, amongst others:
There are shared concerns across the globe. Improving health requires us to think and act globally, as well as regionally and locally;

There is a need to refocus on the social determinants of health rather than the development and implementation of programmes;

The need to influence global and national decisions that affect the distribution of world’s resources and which impact on health;

The importance of ongoing attention to the ethics (and values) of our work;

The need for new evidence to guide policy and practices to achieve equity and social justice for all and the need for health promotion practitioners to become better at using evidence to influence policy and practice across sectors;

The need for those engaged in health promotion to become effective advocates for health;

The need to strengthen the capacity of communities to control and make decisions that affect their lives and environments;

To ensure that work is based on rigorously derived evidence.

You will notice some similarities between the two lists.

You may feel that some of these issues are remote from everyday practice. For example, working on the details of a specific health education programme for a particular group of people can seem easier to handle than addressing the wider determinants of their health or influencing policymakers in their decision making. We should remember that the widely accepted values of health promotion do require us to address healthy public policy as well as health education. Reflect again on the exercise in Unit 1, Session 2 (Task 4) that looked at statements about Health Promotion at the opposite ends of the spectrum.

Remember these challenges and the others that you have identified in your assignments and in your practice. On the basis of your work for this module and previous experience you will have some knowledge and skills to draw on in meeting the challenges identified. More help will come from further study of the module readings but also from sharing ideas and experience with others working on similar issues. This can happen through meetings, texting, contributing to newsletters and conferences. Making links with existing networks (e.g. Health Promoting Schools, a regional Health Promotion network if you have one,) is also a good way to share experience. Or you may decide to start up a new network. If you have internet access there are many sources of useful information e.g. emailing health promoters in your own and other countries, accessing websites associated with some health promotion textbooks and journal articles, to which there is a growing free access. Health
promotion is continuing to develop and all involved can make contributions to this development. We look forward to reading about your contributions in the years ahead.