

PART ONE

**FOUNDATIONS OF
HEALTH PROMOTION
PROGRAMS**

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CHAPTER ONE

WHAT ARE HEALTH PROMOTION PROGRAMS?

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LEARNING OBJECTIVES

- Define *health* and *health promotion*, and describe the role of health promotion in fostering good health and quality of life
- Summarize the key historical developments in health promotion over the last century
- Describe the national public-private initiative for health promotion
- Compare and contrast health education and health promotion
- Describe the nature and advantages of each health promotion program setting
- Identify health promotion program stakeholders, including the role each can play in fostering the development or continuation of health promotion programming

HEALTH PROMOTION PROGRAMS can improve physical, psychological, educational, and work outcomes for individuals and help control or reduce overall health care costs by emphasizing prevention of health problems, promoting healthy lifestyles, improving patient compliance, and facilitating access to health services and care. Health promotion programs play a role in creating healthier individuals, families, communities, workplaces, and organizations. They contribute to an environment that promotes and supports the health of individuals and the overall public. Health promotion programs take advantage of the pivotal position of their setting (for example, schools, workplaces, health care organizations, or communities) to reach children, teenagers, adults, and families with the knowledge and skills they need to make informed decisions about their health. This chapter sets the stage for discussing how to plan, implement, and evaluate health promotion programs.

HEALTH, HEALTH PROMOTION, AND HEALTH PROMOTION PROGRAMS

The World Health Organization (1947) defined health as “a state of complete physical, mental and social well-being, and not merely the absence of disease or infirmity.” While most of us can identify when we are sick or have some infirmity, identifying the characteristics of complete physical, mental, and social well-being is often a bit more difficult. What does complete physical, mental, and social well-being look like? How will we know when or if we arrive at that state? If it is achieved, does it mean that we will not succumb to any disease, from the common cold to cancer?

In 1986, the first International Conference of Health Promotion, held in Ottawa, Canada, issued the *Ottawa Charter for Health Promotion*, which defined health in a broader perspective: “health has been considered less as an abstract state and more as a means to an end which can be expressed in functional terms as a resource which permits people to lead an individually, socially, and economically productive life” (World Health Organization, 1986). Accordingly, health in this view is a resource for everyday life, not the object of living. It is a positive concept emphasizing social and personal resources as well as physical capabilities.

Arnold and Breen (2006) identified the characteristics of health not only as well-being but also as a balanced state, growth, functionality, wholeness, transcendence, and empowerment and as a resource. Perhaps the view of health as a balanced state between the individual (host), agents (such as bacteria, viruses, and toxins), and the environment is one of the most familiar. Most individuals can

readily understand that occasionally the host-agent interaction becomes unbalanced and the host (the individual) no longer is able to ward off the agent (for example, when bacteria overcome a person's natural defenses, making the individual sick). When needed, the interventions of a health specialist may restore balance (for example, by providing drugs to help the individual's natural defenses fight against the foreign agents or bacteria). But as will be explained before the end of this chapter, it is now the host-environment interactions that, we are learning through emerging research, are making us ill in ways that we previously were not aware of. Environmental factors are ascending as a focus of interest, and interventions to address host-environment interactions are increasingly being employed to address the prevention of chronic and infectious diseases as well as injuries and developmental disorders in order to ensure balance and prevent disease in specific populations.

Clearly, good health doesn't just happen; it's more than just luck. Although being born with good genes and having access to health care are important, they do not provide a guaranteed ticket to wellness. The food we eat, levels of physical activity, exposure to tobacco smoke, social interactions, the environment in which we live, and many other factors ultimately influence our health or lack thereof. The health of individuals as well as the health of our communities reflects the unique combination of biological, psychological, social, intellectual, and spiritual components as well as the cultural, economic, and political environment in which we live. Exploration of the interaction that occurs between individuals and their environment in regard to health has been a hallmark in the progress of nations in promoting and improving the health of individuals and the community at large. This ecological perspective on health emphasizes the interaction between and interdependence of factors within and across levels of a health problem. The ecological perspective highlights people's interaction with their physical and sociocultural environments. McLeroy, Bibeau, Steckler, and Glanz (1988) identified three levels of influence for health-related behaviors and conditions: (1) the intrapersonal or individual level, (2) the interpersonal level, and (3) the population level. The population level encompasses three types of factors: institutional or organizational factors, social capital factors, and public policy factors (see Table 1.1).

The ecological health perspective helps to locate intervention points for promoting health by identifying multiple levels of influence on individuals' behavior and recognizing that individual behavior both shapes and is shaped by the environment. Using the ecological perspective as a point of reference, health promotion is viewed as planned change of health-related lifestyles and life conditions through a variety of individual, interpersonal, and population-level changes.

TABLE 1.1 Ecological Health Perspective: Levels of Influence

Concept	Definition
Intrapersonal level	Individual characteristics that influence behavior, such as knowledge, attitudes, beliefs, and personality traits
Interpersonal level	Interpersonal processes and primary groups, including family, friends, and peers, that provide social identity, support, and role definition
Population level	
Institutional factors	Rules, regulations, policies, and informal structures that may constrain or promote recommended behaviors
Social capital factors	Social networks and norms or standards that may be formal or informal among individuals, groups, or organizations
Public policy factors	Local, state, and federal policies and laws that regulate or support healthy actions and practices for prevention, early detection, control, and management of disease

Source: Adapted from McLeroy, Bibeau, Steckler, and Glanz, 1988.

Health promotion programs provide planned, organized, and structured activities and events over time that focus on helping individuals make informed decisions about their health. In addition, health promotion programs promote policy, environmental, regulatory, organizational, and legislative changes at various levels of government and organizations. These two complementary types of interventions are designed to achieve specific objectives that will improve the health of individuals as well as, potentially, all individuals at a site. Health promotion programs are now designed to take advantage of the pivotal position of their setting within schools, workplaces, health care organizations, or communities to reach children, adults, and families by combining interventions in an integrated, systemic manner.

This focus on planned change in health promotion can be applied among individuals in varied settings and at any stage in the natural history of an illness or health problem. Using a framework proposed by Leavell and Clark (1965), health promotion programs can help prevent new cases or incidents of a health problem (for example, preventing falls among the elderly, smoking and drug abuse among middle school and high school students, or risky drinking among college students).

These are programs that take action prior to the onset of a health problem to intercept its causation or to modify its course before people are involved. This level of health promotion is called *primary prevention*. Health promotion programs can interrupt problematic behaviors among those who are engaged in unhealthy decision making and perhaps showing early signs of disease or disability. This type of health promotion is called *secondary prevention*. Examples of this type of health promotion program include smoking cessation programs for tobacco users and physical activity and nutrition programs for overweight and sedentary individuals. Health promotion programs can improve the life of individuals with chronic illness (*tertiary prevention*). Examples are programs that work to improve the quality of life for cancer survivors or individuals with HIV/AIDS. Health promotion programs are a bridge between medicine and health and are part of an ongoing dialogue about how to improve the health and well-being of individuals across settings. Here are some examples of strategies for primary, secondary, and tertiary prevention applied in health promotion and disease prevention.

- Primary health promotion and disease prevention strategies include
 - Identifying and strengthening protective ecological conditions that are conducive to health
 - Identifying and reducing various health risks
- Secondary health promotion and disease prevention strategies address low-risk factors and high protective factors through
 - Identifying, adopting, and reinforcing specific protective behaviors
 - Early detection and reduction of existing health problems
- Tertiary health promotion and disease prevention strategies include
 - Improving the quality of life of individuals affected by health problems
 - Avoiding deterioration, reducing complications from specific disorders, and preventing relapse into risky behaviors

Health promotion programs are designed to work with a priority population (in the past called a target population)—a defined group of individuals who share some common characteristics related to the health concern being addressed. Programs are planned, implemented, and evaluated for their priority population. The foundation of any successful program lies in gathering information about a priority population's health concerns, needs, and desires. Also, engaging the schools, workplaces, health care organizations, and communities where people live and work as partners in the process of promoting health is most effective.

Finally, health promotion programs are also concerned with prevention of the root causes of poor health and lack of well-being resulting from discrimination, racism, or environmental assaults—in other words, the social determinants

of health. Addressing root causes of health problems is often linked to the concept of social justice. Social justice is the belief that every individual and group is entitled to fair and equal rights and equal participation in social, educational, and economic opportunities. Health promotion programs have a role in increasing understanding of oppression and inequality and taking action to overcome them and to improve the quality of life for everyone.

HISTORICAL CONTEXT FOR HEALTH PROMOTION

Kickbush and Payne (2003) identified three major revolutionary steps in the quest to promote healthy individuals and healthy communities. The first step, which focused on addressing sanitary conditions and infectious diseases, occurred in the mid-nineteenth century. The second step was a shift in community health practices that occurred in 1974 with the release of the Lalonde report, which identified evidence that an unhealthy lifestyle contributed more to premature illness and death than lack of health care access (Lalonde, 1974). This report set the stage for health promotion efforts. The third and current revolutionary step in promoting health for everyone challenges us to identify the various combinations of forces that influence the health of a population.

In the mid-nineteenth century, John Snow, a physician in London, traced the source of cholera in a community to the source of water for that community. By removing the pump handle on the community's water supply, he prevented the agent (cholera bacteria) from invading community members (hosts). This discovery not only led to the development of the modern science of epidemiology but also helped governments recognize the need to address infectious diseases. Initially, governmental efforts focused only on preventing the spread of infectious diseases across borders by implementing quarantine regulations (Fidler, 2003), but ultimately, additional ordinances and regulations governing sanitation and urban infrastructure were instituted at the community level. As an outgrowth of the New Deal in the United States, water and sewer systems were constructed across the nation. By the 1940s, the regulatory focus had expanded to include dairy and meat sanitation, control of venereal disease, and promotion of prenatal care and childhood vaccinations (Perdue, Gostin, & Stone, 2003).

As environmental supports for addressing infectious diseases were initiated (for example, potable water and vaccinations), deaths from infectious diseases were reduced. Compared with people who lived a century ago, most people in our nation and around the world are living longer and have a better quality of life—and better health. While new infectious diseases (HIV/AIDS, bird flu, MRSA) emerged at the end of the twentieth century and continue to demand

the attention of health workers, the emphasis of health promotion shifted in the last quarter of the twentieth century to focus on the prevention and treatment of chronic diseases and injury, which were the leading causes of illness and death. This change was stimulated, in part, by the Lalonde report, which observed in 1974 that health was determined more by lifestyle than by human biology or genetics, environmental toxins, or access to appropriate health care. It was estimated that one's lifestyle—specifically, those health risk behaviors chosen by individuals—could account for up to 50 percent of premature illness and death. Substituting healthy behaviors, such as avoiding tobacco use, choosing a diet that was not high in fat or calories, and engaging in regular physical activity, for high-risk behaviors (tobacco use, poor diet, and a sedentary lifestyle) could prevent the development of various chronic diseases, including heart disease, diabetes, and cancer (Breslow, 1999). By emphasizing the importance of one's lifestyle to the ultimate manifestations of disease, a shift in the understanding of disease causation occurred, making health status the responsibility not only of the physician, who ensures health with curative treatments, but also of the individual, whose choice of lifestyle plays an important role in preventing disease.

The Lalonde report set the stage for the third and current revolution in promoting health by laying the groundwork for the World Health Organization meeting in which the *Ottawa Charter for Health Promotion* (World Health Organization, 1986) was developed. This pivotal report was a milestone in international recognition of the value of health promotion. The report outlined five specific strategies (actions) for health promotion:

- Develop healthy public policy.
- Develop personal skills.
- Strengthen community action.
- Create supportive environments.
- Reorient health services.

In the United States, the Lalonde report formed the foundation for *Healthy People: The Surgeon General's Report on Health Promotion and Disease Prevention* (U.S. Department of Health and Human Services, 1979), which set national goals for reducing premature deaths. *Healthy People* is discussed in the next chapter section.

In 1997, the *Jakarta Declaration on Leading Health Promotion into the 21st Century* (World Health Organization, 1997) added to and refined the strategies of the *Ottawa Charter* by articulating the following priorities:

- Promote social responsibility for health.
- Increase investment for health developments in all sectors.

- Consolidate and expand partnerships for health.
- Increase community capacity and empower individuals.
- Secure an infrastructure for health promotion.

The *Jakarta Declaration* gave new prominence to the concept of the health setting as the place or social context in which people engage in daily activities in which environmental, organizational, and personal factors interact to affect health and well-being. No longer were health programs the sole province of the community or school. Various settings were to be used to promote health by reaching people who work in them, by allowing people to gain access to health services, and through the interaction of different settings. Most prominently, workplaces and health care organizations as well as schools and communities were now seen as sites for action in health promotion (World Health Organization, 1998).

Much has happened as part of the current revolution in health promotion. Many of the topics and concepts that have been advanced are discussed in this text. These include partnerships for health, health outcomes, risk factors, advocacy, health indicators, health status and health communications, and poverty and equity. The breadth of the work is represented in the Canadian Centre for Health Promotion's quality of life model, which conceptualizes health promotion as aligned with a quality life (Table 1.2). Although the model has its roots in the developmental disability sector, its concepts are valid for other individuals and populations. The definition of *quality of life* is the degree to which an individual can enjoy his or her life. The model's definition of quality of life is based on nine life sectors that are grouped in three major themes: being, belonging, and becoming (Raeburn & Rootman, 2007).

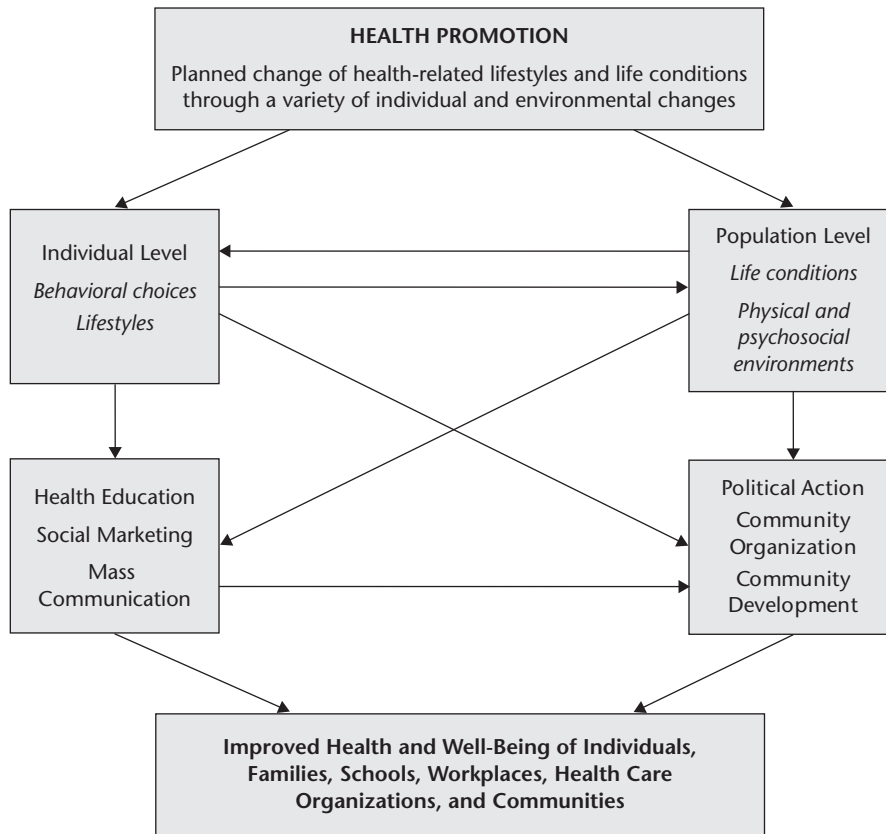
Today, health promotion is a specialized area in the health fields that involves the planned change of health-related lifestyles and life conditions through a variety of individual and environmental changes. Figure 1.1 illustrates the dynamic interaction between strategies aimed at the individual and strategies targeting the entire population. In actuality, the distinction is somewhat artificial in that individuals constitute the population. Nonetheless, certain health promotion strategies are needed to effect changes in knowledge and skill so that population-based or environmental strategies can be enacted. Although there is no question that regulatory and legislative actions generate the quickest behavioral changes within a population, these actions are the most difficult to enact and cannot be achieved without support from enough individuals who understand the value and health benefits of these actions and are willing to contact their legislators to urge support for the legislative actions under consideration.

TABLE 1.2 Quality of Life Model from the Centre for Health Promotion

<i>Being</i>	<i>Who one is</i>
Physical Being	<ul style="list-style-type: none"> • Physical health • Personal hygiene • Nutrition • Exercise • Grooming and clothing • General physical appearance
Psychological Being	<ul style="list-style-type: none"> • Psychological health and adjustment • Cognitions • Feelings • Self-esteem, self-concept, and self-control
Spiritual Being	<ul style="list-style-type: none"> • Personal values • Personal standard of conduct • Spiritual beliefs
<i>Belonging</i>	<i>Connections with one's environment</i>
Physical Belonging	<ul style="list-style-type: none"> • Home • Workplace • School
Social Belonging	<ul style="list-style-type: none"> • Neighborhood, community • Family • Friends • Co-workers
Community Belonging	<ul style="list-style-type: none"> • Neighborhood, community • Adequate income • Health and social services • Employment • Educational programs • Recreational programs • Community events and activities
<i>Becoming</i>	<i>Achieving personal goals, hopes, and aspirations</i>
Practical Becoming	<ul style="list-style-type: none"> • Domestic activities • Paid work • School or volunteer activities • Meeting health and social needs
Leisure Becoming	<ul style="list-style-type: none"> • Activities that promote recreation and stress reduction
Growth Becoming	<ul style="list-style-type: none"> • Activities that promote improvement of knowledge and skills • Adapting to change

Source: Adapted from University of Toronto, Centre for Health Promotion, Quality of Life Research Unit. (n.d.).

FIGURE 1.1 Health Promotion Interactions



Source: Adapted from O'Neill & Stirling, 2007.

HEALTHY PEOPLE: A NATIONAL PUBLIC-PRIVATE PARTNERSHIP TO PROMOTE HEALTH

In the United States, the Lalonde report formed the foundation for *Healthy People: The Surgeon General's Report on Health Promotion and Disease Prevention* (U.S. Department of Health and Human Services, 1979), which provided national goals for reducing premature deaths. This report was followed by *Promoting Health/Preventing Disease: Objectives for the Nation* in 1980 (U.S. Department of Health and Human Services, 1980), which set forth 226 targeted health objectives for the nation to achieve over the next ten years. At that time, this report was unique in that it was developed through a broad consultation process that included both public and private health

professionals—government scientists as well as health practitioners and academics—at the national, state, and local levels. This initiative asked states and local communities to use the report to focus and guide their health promotion efforts as well as to track and monitor their progress. Every decade since 1980, the U.S. Department of Health and Human Services has reinstated the same public-private process and released an updated version of *Healthy People* that provides the overarching goals and objectives that will guide and direct the health promotion actions of federal agencies; local and state health departments; and practitioners, academics, and health workers at all levels of government.

The mission of the 2020 Healthy People initiative (The Secretary’s Advisory Committee on National Health Promotion and Disease Prevention Objectives for 2020, 2009) is to

- Identify nationwide health improvement priorities.
- Increase public awareness and understanding of the determinants of health, disease, and disability and the opportunities for progress.
- Provide measurable objectives and goals that are applicable at the national, state, and local levels.
- Engage multiple sectors to take actions to strengthen policies and improve practices that are driven by the best available evidence and knowledge.
- Identify critical research, evaluation, and data collection needs.

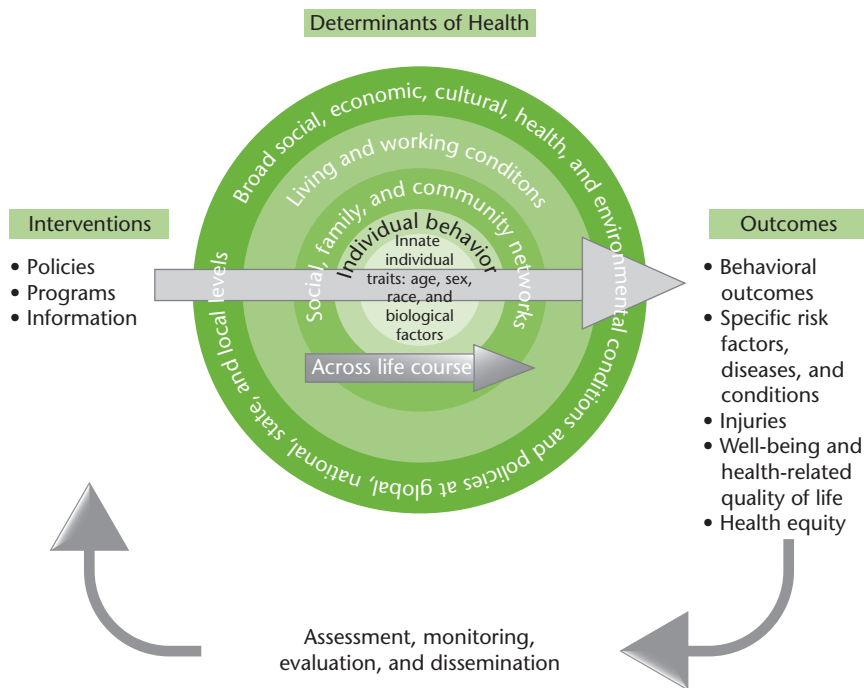
The vision for the 2020 initiative is a society in which all people live long, healthy lives. The specific goals for the decade leading up to 2020 are to

- Eliminate preventable disease, disability, injury, and premature death.
- Achieve health equity, eliminate disparities, and improve the health of all groups.
- Create social and physical environments that promote good health for all.
- Promote healthy development and healthy behaviors across every stage of life.

One value of the Healthy People initiative in the planning, implementation, and evaluation of health promotion programs is access to national data and resources. Because the initiative addresses such a broad range of health and disease topics, health promotion program staff can usually find objectives that are similar to those they are planning to address. Using Healthy People information allows program staff to compare their program data with national data and to use resources that have been generated nationally in order to achieve the national objectives.

Like its predecessors, Healthy People 2020 reflects continuing efforts on the part of national and various other health promotion program sites (see Figure 1.2). It will help set programming initiatives by federal public health agencies, as well as provide a framework for state and local public health departments to address risk factors, diseases, and disorders and also the determinants of health that affect the health of individuals across health settings. Furthermore, many other national nongovernmental health and educational organizations, philanthropies, and public and private universities will consult the Healthy People 2020 objectives when setting the direction for their respective health promotion programs. This decade's initiative also aims to engage nontraditional sectors such as businesses, faith-based organizations, state and local elected officials, policy organizations, health care organizations, and all others whose actions have significant health consequences. Health promotion is not just an activity for public health workers but an endeavor that requires the collaboration of traditional and nontraditional partners, particularly because understanding of the root factors of disease has

FIGURE 1.2 Action Model to Achieve the Overarching Goals of Healthy People 2020



expanded to include the social determinants of health (The Secretary's Advisory Committee on National Health Promotion and Disease Prevention Objectives for 2020, 2009).

HEALTH EDUCATION AND HEALTH PROMOTION

Health promotion has its roots in health education (Chen, 2001). In the United States, health education has been in existence for more than a century. The first academic programs trained health educators to work in schools, but the role of health educators working within communities became increasingly popular in the 1940s and 1950s. Health education promotes a variety of learning experiences to facilitate voluntary action that is conducive to health (Green, Kreuter, Deeds, & Partridge, 1980). These educational experiences facilitate gaining new knowledge, adjusting attitudes, and acquiring and practicing new skills and behaviors that could change health status. The educational strategies are delivered through individual (one-to-one) or group instruction or interactive electronic media in order to promote changes in individuals, groups of individuals, or the general population. Mass communication strategies that might be used include public service announcements, webinars, social marketing techniques, and other new strategies from text messaging to blogging.

Health education as a discipline has a distinct body of knowledge, a code of ethics, a skill-based set of competencies, a rigorous system of quality assurance, and a system for credentialing health education professionals (Livingood & Auld, 2001). Approximately 250 professional preparation programs offer degrees in health education at the baccalaureate, master's, or doctoral levels. Health education was one of the first disciplines to engage in rigorous, scientific role delineation, a process that resulted in verified competencies for health education practice. The distinct occupation of health educator is recognized and tracked by the U.S. Department of Labor, which estimated that there were some 62,000 health educators in the workforce in 2006 (U.S. Department of Labor, Bureau of Labor Statistics, 2008). When health educators working in schools and businesses are added, the number is even greater. According to the Bureau of Labor Statistics, employment of health educators is expected to grow by 26 percent between 2006 and 2016, which is greater than the average growth for all occupations. "Growth will result from the rising cost of health care and the increased recognition of the need for qualified health educators" (U.S. Department of Labor, Bureau of Labor Statistics, 2008).

Health promotion has been defined as the combination of two levels of action: (1) health education and (2) environmental actions to support the conditions for

healthy living (Green & Kreuter, 1999). Environmental actions target populations in organizations as well as in the larger community. Such environmental strategies and interventions include political, economic, social, organizational, regulatory, and legislative changes that can improve the health groups of individuals (see Table 1.3). As noted earlier, the priorities for health promotion programs identified by the World Health Organization (1997) were promoting social responsibility for health, the empowerment of individuals, and an increase in community capacity, which requires consolidating and expanding partnerships for health within the community, securing an infrastructure for health promotion, and increasing investments for health developments in all sectors. Health promotion uses complementary strategies at both personal and population levels (see Table 1.3). In the past, *health education* was used as a term to encompass the wider range of environmental actions. These methods are now encompassed in the term *health promotion*, and a narrower definition of health education is used to emphasize the distinction.

In 2008, the Galway Consensus Conference promoted global exchange and understanding in regard to domains of core competency in the professional preparation and practice of health promotion and health education specialists. The conference was designed to provide a forum for discussion among key leaders in order to identify the domains of core competency necessary to build capacity for health promotion, as well as systems that can ensure quality in education, training, and practice. Developing a shared vision for workforce capacity building and a set of standards is a critical foundation for subsequent strategic plans of action, which can be developed by many stakeholders and partners.

In the Galway Consensus Conference Statement, the terms *health promotion* and *health education* are often used interchangeably; however, depending on the

TABLE 1.3 Components of Health Promotion Programs

Health Education to Improve	Environmental Actions to Promote
Health knowledge	• Advocacy
Health attitudes	• Environmental change
Health skills	• Legislation
Health behaviors	• Policy mandates, regulations
Health indicators	• Resource development
Health status	• Social support
	• Financial support
	• Community development
	• Organizational development

country or context, these terms can have different meanings. In this text, the term *health promotion* is defined as it is in the *Ottawa Charter*: “the process of enabling people to increase control over their health and its determinants, and thereby improve their health” (World Health Organization, 1986). Thus, health promotion is considered vital in contributing to the public’s health. Health promotion and health education orchestrate a wide range of complementary actions at individual, community, and societal levels. The Galway Consensus Conference Statement underscores the idea that although health promotion is now established as a recognized field in many parts of the world, it is only emerging in others where the political will and resources to support capacity for health promotion are scarce and thus undermine its development. Health promotion occurs at many levels, is unique in the ways that it can contribute to society, and is characterized by a unique set of competencies and skills that involve integrating interdisciplinary theories and approaches (Allegrante et al., 2009).

Health promotion is guided by a set of core values and principles. These values and principles form the habits of mind that provide a common basis for the practice of health promotion and include the ecological perspective on health, which takes into account the cultural, economic, and social determinants of health; a commitment to equity, civil society, and social justice; a respect for cultural diversity and sensitivity; a dedication to sustainable development; and a participatory approach to engaging the population in identifying needs, setting priorities, and planning, implementing, and evaluating practical and feasible health promotion solutions to address needs.

The Galway Consensus Conference Statement focuses primarily on the domains of core competencies. The competencies required to engage in the practice of health promotion fall into the eight domains listed here. The domains represent key skill areas for effective health promotion program planning, implementation, and evaluation (Allegrante et al., 2009). All the areas are discussed in this text.

1. Catalyzing change—Enabling change and empowering individuals and communities to improve their health.
2. Leadership—Providing strategic direction for developing healthy public policy, mobilizing and managing resources for health promotion, and building capacity.
3. Assessment—Conducting assessment of needs and assets in communities and systems that leads to the identification and analysis of the behavioral, cultural, social, environmental, and organizational determinants that promote or compromise health.

4. Planning—Developing measurable goals and objectives in response to assessment of needs and assets, and identifying strategies that are based on knowledge derived from theory, evidence, and practice.
5. Implementation—Carrying out effective and efficient, culturally sensitive, and ethical strategies to ensure the greatest possible improvements in health, including management of human and material resources.
6. Evaluation—Determining the effectiveness of health promotion programs and policies. This includes utilizing appropriate evaluation and research methods to support program improvements, sustainability, and dissemination.
7. Advocacy—Advocating with and on behalf of individuals and communities to improve their health and well-being and building their capacity for undertaking actions that can both improve health and strengthen community assets.
8. Partnerships—Working collaboratively across disciplines, sectors, and partners to enhance the impact and sustainability of health promotion programs and policies.

SETTINGS FOR HEALTH PROMOTION PROGRAMS

Earlier in this chapter, we discussed the impact of the *Jakarta Declaration* in giving prominence to the concept of the health setting as the place or social context in which people engage in daily activities and in which environmental, organizational, and personal factors interact to affect health and well-being. Health is promoted through interactions with people who work in various settings, through people's use of settings to gain access to health services, and through the interaction of different settings. Most prominently, workplaces and health care organizations as well as schools and communities are now sites for health promotion (World Health Organization, 1998), and this text focuses on these four settings for health promotion programs. Health promotion programs are planned, implemented, and evaluated for specific sites, reflecting the unique characteristics of the environment as well as the individuals at the site.

Schools

Schools are pivotal to the growth and development of healthy children, adolescents, and young adults. School settings include child care; preschool; kindergarten; elementary, middle, and high schools; two-year and four-year colleges; universities; and vocational-technical programs. Young people spend large portions of their

lives in schools. Increasingly, postsecondary institutions are sites where one can find nontraditional students (for example, adults seeking a career change or retired individuals seeking enrichment). The correlation between learning and health has been documented. Graduation from high school is associated with an increase in average life span of six to nine years (Wong, Shapiro, Boscardin, & Ettner, 2002). It has been noted that as a nation, we could save an annual amount of more than \$17 billion in Medicaid and expenditures for health care for the uninsured if all students were to graduate (Alliance for Excellent Education, 2006).

Workplaces

Workplaces are anywhere that people are employed—business and industry (small, large, and multinational) as well as governmental offices (local, state, and federal). Employers have found that it makes financial sense to encourage and support employees' healthy practices. Employers, both on their own initiative and because of federal regulations administered by the Occupational Safety and Health Administration, have been active in creating safe and drug-free workplaces. As employers become aware that behaviors such as smoking, lack of physical activity, and poor nutritional habits adversely affect the health and productivity of their employees, they are providing their employees with a variety of work site–based health promotion programs. These programs have been shown to improve employee health, increase productivity, and yield a significant return on investment for employers (O'Donnell, 2002; National Institute for Occupational Safety and Health, 2009).

Health Care Organizations

Health care organizations provide services and treatment to reduce the impact and burden of illness, injury, and disability and to improve the health and functioning of individuals. Health care practitioners work with individuals in community hospitals, specialty hospitals, community health centers, physician offices, clinics, rehabilitation centers, skilled nursing and long-term care facilities, and home health and other health-related entities. Traditionally, these sites are thought of as being part of the health care industry, which is one of the largest industries in the United States and provides 13.5 million jobs. The U.S. Department of Labor reports that eight of the twenty occupations projected to grow the fastest are in health care. More new wage and salary jobs—about 27 percent, or 3.6 million—will be created between 2004 and 2014 in health care. The roughly 545,000 establishments that make up the health care industry vary greatly in size, staffing patterns, and organizational structures. About 76 percent of health care establishments

are offices of physicians, dentists, or other health practitioners. Although hospitals constitute only 2 percent of all health care establishments, they employ 40 percent of all health care workers. While health promotion programs might seem out of place in a treatment facility, in fact, much work is done in such facilities to reduce the negative consequences associated with disease.

Communities

Communities are usually defined as places where people live—for example, neighborhoods, towns, villages, cities, and suburbs. However, communities are more than physical settings. They are also groups of people who come together for a common purpose. The people do not need to live near each other. People are members of many different communities at the same time (families, cultural and racial groups, faith organizations, sports team fans, hobby enthusiasts, motorcycle riders, hunger awareness groups, environmental organizations, animal rights groups, and so on). These community groups often have their own physical locations (for example, community recreation centers; golf, swimming, and tennis clubs; temples, churches, and mosques; or parks). These affinity groups all exist within communities, as part of communities, and at the same time, they are their own community. Health promotion programs frequently seek out people both in the physical environment of the neighborhood where they live and within the affinity groups that they form and call their community.

Within a community, the local health department and community health organizations work to improve health, prolong life, and improve the quality of life among all populations within the community. Local and state health departments are part of the government's efforts to support healthy lifestyles and create supportive environments for health by addressing such issues as sanitation, disease surveillance, environmental risks (for example, lead or asbestos poisoning) and ecological risks (for example, destruction of the ozone layer or air and water pollution). The staff at a local health department includes a wide variety of professionals who are responsible for promoting health in the community: public health physicians, nurses, public health educators, community health workers, epidemiologists, sanitarians, and biostatisticians.

Community health organizations have their roots in local community members' health concerns, issues, and problems. These organizations work at the grassroots level, frequently operating a range of health promotion programs that target community members. In this text, the term *community health organization* is synonymous with the terms *community agency*, *program*, *initiative*, *human services*, and *project*. Some community health organizations do not choose to use these terms in their names, deciding to use a name that reflects whom they serve, the health issue they address, or

their mission—for example, the American Cancer Society, Caring Place, Compass Mark, Youth Center, Maximizing Adolescent Potentials, Bright Beginnings, Strength and Courage, Healthy Hearts, or Drug Free Youth. Regardless of their names, the common bond for community health organizations is their shared health focus.

STAKEHOLDERS IN HEALTH PROMOTION PROGRAMS

In beginning to plan, implement, and evaluate a health promotion program, the first step is to know who the stakeholders are in regard to the health issue under consideration. Stakeholders are the people and organizations that have an interest in the health of a specific group or population of people. Stakeholders are people or organizations that have a legitimate interest (a stake) in what kind of health promotion program is implemented. First and foremost are the program participants, also called the *priority population* (for example, students, employees, community members, patients). The program is for their benefit and works to address their health concerns and problems. Although the authors of this book believe that the audience of any health promotion initiative should be regarded as the primary stakeholders, the term *stakeholders* traditionally has referred to other stakeholder groups that also have an interest in a program—for example, top civic, business, or health leaders in the community. The term *stakeholders* may also be used to describe the sponsoring organization's executives, administrators, and supervisors; funding agencies; or government officials. In other words, stakeholders in a health promotion program are people who are directly or indirectly involved in the program.

In the case of a business implementing a health promotion program for employees, stakeholders would include the employees, supervisors, and owners. Other stakeholders might include funders, employees' family members, customers, or health care providers, including health insurance providers. Stakeholder groups often have similar interests in the program but may have different goals; for example, employees and supervisors both want employees to be healthy and productive. However, one group might want time off during the work day for physical activity and exercise, while the other might prefer that employees exercise before or after work.

Involving Stakeholders

Involving the stakeholders in a health promotion program is essential for its success. Involvement creates value and meaning for the stakeholders—for example,

enlisting stakeholders to assist in identifying a program's approaches and strategies in order to ensure congruence with stakeholders' values and beliefs will strengthen stakeholders' commitment to the program. Different stakeholders have different roles. Some stakeholders might help to define what is addressed in a program by sharing their personal health needs and concerns (a process called *needs assessment*, which is discussed in Chapter Four). Other stakeholders might offer services and activities in conjunction with the program (service collaborators). Stakeholders might serve as members of a program's advisory board or as program champions or advocates, roles that are often essential in creating successful health promotion programs.

Advisory Boards

Most health promotion programs form some type of advisory board or advisory group (also sometimes called a *team*, *task force*, *planning committee*, *coalition*, or *ad hoc committee*) to provide program support, guidance, and oversight. These groups look different across settings. Some are formal, with bylaws, regular meeting schedules, member responsibilities, and budgets. Others are informal, perhaps without any meetings but acting instead as a loose network of individuals who will offer advice and information when called upon by program staff.

Advisory boards play important roles at different points of planning, implementing, and evaluating a program. For example, during planning, advisory board members are involved with determining program priorities as part of the needs assessment, developing program goals and objectives, and selecting program interventions (Chapters Four and Five). During implementation, they might participate in the initial program offering, program participant recruitment, material development, advocacy, and grant writing (Chapters Six, Seven, Eight, and Nine). During evaluation they often review reports and give feedback on how best to disseminate and use the evaluation results and findings (Chapters Ten and Eleven).

Who serves as a member of an advisory group? People with a genuine interest in the setting or program and who communicate well with others. Likewise, it is important to have a diverse group of individuals and organizations represented. Always consider the gender, ethnic, socioeconomic, language, and racial composition of the setting, organization, and community when selecting your membership. In addition, things like geographical boundaries, program representation, and community profile are key factors in the selection process.

For health promotion programs that are based at the site of an organization (for example, at a school or work site), advisory group members typically represent management, supervisors, and individuals involved with the work of the organization (for example, teachers, counselors, clerical staff, or production

workers) as well as human resource staff members, medical directors, board members, or representatives of groups such as unions. Some people participate as part of their job responsibilities (for example, a human resource director or a medical director), while others serve because of personal interest. Look for individuals with experience in serving on advisory boards. Avoid personal friends and individuals with a personal agenda. Finally, try to balance the committee with individuals who bring a wide range of interests, skills, and backgrounds to the group.

Frequently, groups in the community will join together to form coalitions that plan and support health promotion programs. Community coalitions might draw on the broad range of agencies and service providers in a community to address a health concern such as underage drinking, violence, teenage pregnancy, or tobacco use. The advisory team for such a community initiative would reflect the diverse groups of the coalition.

Bringing stakeholders together can sometimes be a frustrating task. Some stakeholders may be competitors for resources and attention in the community, so they may have difficulty with trusting one another. Such turf issues or professional or cultural differences may cause communication problems, unrealistic expectations of the committee, or concerns about loss of autonomy—all potential problems. A neutral person with group facilitation skills can often help forge a successful partnership, especially if the partners see a benefit in collaborative participation.

Champions and Advocates

Health promotion programs often have champions whose advocacy provides leadership and passion for the program. The champion typically knows the setting, the health problems, and the individuals, families, and communities affected by the health problem. In the process of planning, implementing, and evaluating a program, champions provide insight into how the organization operates, who will be supportive, and potential challenges to implementing a health promotion program. They know the history of the health problem and what has worked before in solving it as well as what has not worked. (Frequently, champions are also called *key informants* because they know this important or key information about an organization.) Champions are the people who have initiated the effort to start the program, identify the health problem, or try to solve the problem (often volunteering their time and energy). They fight for resources, funding, and space for the program's operations. Building a trusting and honest relationship with program champions, advocates, and key informants builds the foundation for the work of planning, implementing, and evaluating a health promotion program.

SUMMARY

Health promotion programs are the product of deliberate effort and work by many people and organizations to address a health concern in a community, school, health care organization, or workplace. And even though individuals across these sites may share broad categories of health concerns focused on diseases and human behavior, each setting is unique. Effective health promotion programs reflect the individual needs of a priority population as well as their political, social, ethnic, economic, religious, and cultural backgrounds.

Health promotion programs represent an evolution that has passed through three revolutionary steps in the quest to promote health. Today, health promotion programs use both health education and environmental actions to promote good health and quality of life for all. The Healthy People initiative is a public-private partnership that allows local health promotion programs to link their health promotion programming with national data and information.

The Galway Consensus Conference identified core competencies for planning, implementing, and evaluating health promotion programs. Health promotion programs involve stakeholders, advisory boards, champions, and advocates in program planning, implementation, and evaluation in order to ensure effective programming.

FOR PRACTICE AND DISCUSSION

1. What preliminary ideas did you have about the definition and role of health promotion programs prior to reading this chapter? How do these compare with what you have learned in this chapter?
2. The concepts of health and health promotion have evolved from a narrow focus on physical, mental, and social well-being to a broader conceptualization involving a person's quality of life: the degree to which an individual can enjoy his or her life. Use the Quality of Life Model from the Centre for Health Promotion presented in the chapter to discuss the quality of your, your parents' or guardians', and grandparents' quality of life. How are they similar and how do they differ?
3. Visit the Healthy People 2020 Web site (<http://www.healthypeople.gov/HP2020>). Pick a chapter and explore the objectives. As you explore the chapter think of your school and how you might use the Healthy People 2020 information for a specific objective to build a case for implementing a health

promotion program to address the identified health concern on your campus. Prepare a brief (250-word) statement to use to support your argument for a program.

4. Much of this text is about the eight core competencies defined in the Galway Consensus Statement. What more do you want to know about each competency? What questions do you have about the competencies? As you progress through this book, try to think of additional competencies you believe may be important and define why they are important.
5. What do you think it would be like to work in a health promotion program? This chapter talks about health promotion programs in four different settings—schools, workplaces, health care organizations, and communities. Which setting would be of most interest for you in regard to working in a health promotion program? What is attractive about this setting and the people in the setting? Who would be the stakeholders in this setting?

KEY TERMS

Advisory boards	Health status	Quality of life
Champion	Healthy People 2020	Schools
Communities	Interpersonal level	Secondary health promotion
Core competencies	Intrapersonal level	Secondary prevention
Ecological health perspective	<i>Jakarta Declaration</i>	Settings
Galway Consensus Conference Statement	Key informant	Stakeholders
Health	Lalonde report	Tertiary health promotion
Health care organizations	<i>Ottawa Charter</i>	Tertiary prevention
Health education	Population level	Workplaces
Health promotion	Primary health promotion	World Health Organization
Health promotion programs	Primary prevention	
	Priority population	

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