PROMOTING HEALTH
The Primary Health Care Approach
7E
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Health and wellbeing are resources that enable people to live, learn, play, work, flourish and thrive. Unfortunately, there are major disparities in people’s health status around the world. There is strong evidence that physical, mental, social and spiritual health and wellbeing are experienced unequally, and that most of those differences are unfair or inequitable. Addressing the factors that contribute to such inequities is the central challenge for health practitioners wanting to engage in critical health promotion in a comprehensive primary health care context.

This is a time of significant change internationally. Political instability and social uncertainty are the result of an erosion of ‘public goods’, persistent poverty, energy and food insecurity and, most recently, the global COVID-19 pandemic. It is a time of increasing awareness of the impact of globalised economic activities on the health and wellbeing of people and the social, cultural, economic, political and physical environments in which we live. There is deep concern about global climate change, ecological sustainability and the implications for human health and survival. The Sustainable Development Goals have set goals and targets in 17 areas, all of which impact on the health and wellbeing of people around the world, and while there has been good progress towards these, many are not on track to be achieved by 2030. As such, there has never been a greater need for critical health promotion.

Taking action on the socio-ecological determinants of health to enhance health and reduce health inequities is the basis for critical health promotion practice in a comprehensive primary health care context. The concepts and skills presented in this updated edition of Promoting Health: The Primary Health Care Approach provide an essential resource for such practice.

This edition builds on the sound philosophical approach of the previous six editions. The key principles of critical health promotion and comprehensive primary health care – equity, social justice and community empowerment – underpin both parts of the book. Part 1 addresses health promotion development and key concepts and introduces the Framework of health promotion practice in a comprehensive primary health care context. Each chapter in Part 2 of the book focuses on one part of the framework. Throughout the book, current policy and practice initiatives have been updated. The use of health promotion theories and models has been strengthened, and new examples from practice have been introduced in the book and on the Evolve website.

The Ottawa Charter for Health Promotion continues to provide a relevant and useful framework for improving health. At the start of Chapters 3 to 9, there are questions for the health practitioner to consider in relation to each action area of the Ottawa Charter. At the end of each chapter, the relevant International Union for Health Promotion and Education (IUHPE) Core Competencies for Health Promotion are identified. Each chapter also presents reflective questions that may be used to prompt personal reflection or to guide group exploration.

We hope that Promoting Health: The Primary Health Care Approach (7th ed.) engages health practitioners from a broad range of disciplines and supports them in their critical
health promotion practice in a comprehensive primary health care context to achieve better health and wellbeing outcomes for all.

Jane Taylor
Lily O'Hara
Lyn Talbot
Glenda Verrinder
This seventh edition of *Promoting Health* affirms the use of critical health promotion within a comprehensive primary health care context, to address health and wellbeing priorities in all settings from the local through to the global. The philosophy underpinning comprehensive primary health care (CPHC) remains as relevant now as it was when first endorsed by the World Health Organization in 1978 and expressed within the Declaration of Alma-Ata.

The term ‘comprehensive primary health care’ is used throughout this book to reflect a comprehensive approach to primary health care. It does not refer to primary-level services. Central to CPHC are principles to guide all action to create health and wellbeing. These principles tell us what is important and how we should do what we do. They include social justice, equity, community empowerment and ecological sustainability, and the need to work with people to enable them to make decisions about health and wellbeing priorities most important to them.

The socio-ecological determinants of health and wellbeing are well established and need to be the focus of effort both within and outside of the healthcare sector. Addressing the socio-ecological determinants of health and wellbeing requires sound health promotion knowledge and skills to plan, implement and evaluate health promotion policies and programs.

The Ottawa Charter for Health Promotion (WHO, 1986) operationalises CPHC principles set out in the Declaration of Alma-Ata (WHO, 1978) in a framework for health promotion practice. The Charter has been reaffirmed repeatedly by people working in health promotion worldwide, and continues to provide a relevant guide for professional practice in health promotion. Health promotion action to improve health and wellbeing must primarily work to change the environments that structure health and wellbeing opportunities, as well as to support individuals to address the determinants of health and wellbeing over which they have control. To undertake these actions, health practitioners need an extensive set of skills. This book focuses on assisting health practitioners from a broad range of disciplines to develop the competencies essential for critical health promotion practice within a CPHC context.

While health promotion is a discipline of its own that can lead to professional accreditation, health promotion is also everyone’s responsibility. Health promotion is a broad-ranging activity, which must be embraced by as many people as possible within and outside the health sector. Teachers, therapists, road safety workers, engineers, mediators, human rights investigators, community workers, local government workers and many more play a role in health promotion action. Active participation by members of the community in all aspects of health promotion action is also essential. Community members have a role to play in forming partnerships with practitioners and agencies to develop environments that are conducive to the health and wellbeing of the community.

Everyone has opportunities to promote health and wellbeing, whether it be to lobby for changes to improve the socio-ecological determinants of health and wellbeing, to work to
make community settings more health promoting, to assist individuals to learn about health-enhancing behaviour, or to engage people meaningfully in the decision-making processes that affect their health. There is a full range of health promotion practice roles, from policy advocacy and building health-enhancing settings, through to providing communities with support in making changes in their communities to improve health, conducting health education, providing health information, and conducting screening and surveillance activities on behalf of particular groups. Health practitioners in particular, have roles as advocates for communities and for consideration of the health perspective on priorities outside the health sector, which have an impact on health and wellbeing.

By virtue of these roles, health practitioners can take a leadership role in the creation of health and wellbeing. Professional associations such as the International Union for Health Promotion and Education (IUHPE), health promotion and public health associations, and the associations of other health-specific disciplines, play an important role in advocating for the health and wellbeing of the community and in modelling the effectiveness of a true multidisciplinary approach.

This book provides detailed practical guidance for students and practitioners new to health promotion, whether their role is specifically in health promotion or involves incorporating health promotion into their work in another health discipline or in wider fields of practice. In this book we encourage health practitioners to take up the challenge to work as health activists, and promote health and wellbeing in ways which enable communities and individuals to flourish and thrive.

If countries continue to support a burgeoning illness-management system, the costs to the health of the community will continue to rise. Inequalities in health status and lack of access to appropriate health services will become even worse. However, if a comprehensive primary health care challenge is taken up by all whose work impacts on health, as well as by community members who find their health jeopardised by the circumstances in which they live, then the positive effect could be quite profound.

Different terms are used to describe the workforce involved in promoting health and wellbeing. The term ‘health workers’ is used extensively in the women’s health movement, because it implies a more equal relationship between professionals and their patients or clients. The term ‘health promotion practitioner’ is used to describe the workforce role where the primary purpose is to enhance health and wellbeing. These specialist practitioners need to possess or develop a full range of health promotion competencies. The term ‘health practitioner’ is used throughout this book in recognition that many health promotion activities are undertaken by workers whose primary qualification may be from a different discipline, and who is undertaking health promotion activities within a wider field of practice.

In this book, the terms ‘low-income’, ‘middle-income’ and ‘high-income countries’ are used. Low-income countries are home to 9% of the world’s population. Alternative terms for low-income countries include ‘third world’ or ‘developing nations’ but these terms are not used in this book as they are perjorative. They suggest that the low-income nations are deficient, and reflect the parochialism of high-income countries. The majority of the world’s population now live in middle-income countries (76%). High-income countries are home to 16% of the world’s population but consume around 80% of its collective resources. High-income countries are often referred to as the ‘developed’ or ‘first’ world. For the same reason as described above, these terms are not used because they imply a hierarchy of countries based on levels of economic development.
Health promotion draws on many areas of expertise. In deciding which skills and topics to include in this book, we gave strong consideration to the International Union for Health Promotion and Education Health Promotion Competencies, and to topics commonly examined in university health science programs. In this book, we have used real-life examples from our own professional practice fields and often in our local geographic areas. This was a deliberate decision in order to illustrate the diversity and wisdom in health promotion. We encourage health practitioners to examine the health promotion practice around them and to draw on the wisdom and expertise of what is working locally. We hope that these examples will encourage health practitioners to become involved in showcasing their health promotion work, thus demonstrating that health promotion is a meaningful part of many health workers’ practice.

**HOW TO USE THIS BOOK**

The book is structured into two distinct but interrelated parts covering nine chapters.

- Part 1 comprises three chapters and addresses health promotion development and concepts. The chapters present an overview of the development of health promotion within a comprehensive primary health care (CPHC) context. Concepts fundamental to health promotion practice are discussed in some detail. The *Framework for health promotion practice within a CPHC context* is introduced and used throughout the remainder of the book.

- Part 2 provides guidance to health practitioners undertaking health promotion in a comprehensive primary health care context. Chapters in Part 2 are underpinned by principles and concepts fundamental to the health and wellbeing of people. They are based on and presented in reference to the *Framework of health promotion practice in a comprehensive primary health care context* introduced in Chapter 1.

Chapters are interrelated but also designed to stand alone. Readers can dip in and out of chapters and each chapter will direct them to the relevant theoretical concepts and content presented elsewhere in the book.

**Part 1: Health promotion development and concepts**

**Chapter 1**

Chapter 1 establishes the foundations for health promotion practice within a comprehensive primary health care (CPHC) context. The current state of health and wellbeing and health inequalities within and between countries are examined along with the socio-ecological determinants of the health and wellbeing of people. The World Health Organization’s (WHO) global responses to addressing health inequalities and creating health and wellbeing through a CPHC approach and health promotion are presented. We describe CPHC as a developmental process where the principles of equity, social justice and empowerment underpin the work for the socio-ecological changes necessary to improve health and wellbeing. The role that CPHC and health promotion have played in improving the health and wellbeing of populations is also discussed. The *Framework for health promotion practice within a CPHC context* is presented as a foundation for subsequent chapters. The purpose of this framework is to guide and support health practitioners undertaking health promotion work fulltime or as a component of their role.
Chapter 2
Chapter 2 presents a closer examination of the core concepts informing health promotion practice within a CPHC context. It commences with a discussion of the terms ‘health’, ‘wellbeing’, ‘quality of life’ and ‘salutogenesis’. Concepts related to the individual-level socio-ecological determinants of health and wellbeing, such as personal values, attitudes and beliefs, opportunities for education and individual responsibility for health and wellbeing are discussed. This is followed by a discussion of concepts related to the population-level socio-ecological determinants of health and wellbeing, including human capital and those particular to the social, cultural, economic, political and physical environments. The chapter concludes with important considerations relevant to health promotion practice in community settings.

Chapter 3
Chapter 3 builds on the ideas presented about the socio-ecological determinants of health and wellbeing and core health promotion concepts presented in previous chapters. It especially explores ecological sustainability and human health and wellbeing, focusing on the relationship between people and their social and natural environments. Links between the health and wellbeing of people, the health of the physical environment and the implications for health promotion within a CPHC context are made.

Part 2: Health promotion practice

Chapter 4
Chapter 4 describes the health promotion practice cycle that consists of community assessment, program planning, implementation and evaluation, and the underlying values and principles of critical health promotion. This content underpins the five broad strategy areas of health promotion action of the *Framework of health promotion practice in a comprehensive primary health care context* presented in Chapter 1. The health promotion practice cycle facilitates the development of a research base for health promotion action in a way that both strengthens the relevance of health promotion work and enables health practitioners to be accountable for their health promotion practice.

Chapter 5
Chapter 5 examines health promotion action that develops healthy public policy to create environments and settings that support health and wellbeing. The chapter unpacks the first broad strategy area of health promotion action in the *Framework of health promotion practice in a comprehensive primary health care context*. The meaning of healthy public policy, the policymaking process and the role of health practitioners in advocating for and creating healthy public policy are explored. Examples of healthy public policy at local, regional, national and international levels are provided. Frameworks for promoting health in various settings where people live, learn, work and play, such as cities, schools, health services and workplaces, are also explored.

Chapter 6
Chapter 6 discusses community development action to support social and environmental change, which is the second broad strategy area of health promotion action in the *Framework of health promotion practice in a comprehensive primary health care context*. Community
development is an essential component of the socio-ecological approach to health promotion, because it relates to making changes in the settings of people’s lives that improve their health and wellbeing. We examine community development as a way of working with communities on the health and wellbeing priorities they identify to achieve changes to the environment and to enable community empowerment. The chapter also examines the role of social enterprise and social entrepreneurship in community development, challenges for community development, and the evaluation of community development.

Chapter 7
Chapter 7 explores health education and health literacy to develop knowledge and skills for health and wellbeing, which is the third broad strategy area of health promotion action in the Framework of health promotion practice in a comprehensive primary health care context. The role of health literacy as a social determinant of health and wellbeing and an outcome of effective health education and empowerment of people is explored. Behaviour change theories and models, and learning and teaching theory as a basis for planning health education strategies are presented. Skills required for health practitioners to undertake effective education at group and community levels, including using adult learning principles and a range of teaching–learning activities, and theory, tips and skills for working with groups, are provided.

Chapter 8
Chapter 8 discusses health information and social marketing to address health and wellbeing priorities, which is the fourth broad strategy area of health promotion action in the Framework of health promotion practice in a comprehensive primary health care context. We explore how social marketing can be used to contribute to raising levels of knowledge in the community about particular health and wellbeing priorities, to support the implementation of a change to policy, or as a means of advocacy for a desired social change. Social marketing knowledge and skills required by health practitioners, as well as those required to prepare health communication materials are also presented. If the strategies in Chapters 7 and 8 are used alone, the approach is regarded as a behavioural approach, and is not consistent with CPHC. These strategies must be used in conjunction with all of the others in the Framework of health promotion practice in a comprehensive primary health care context, if the socio-ecological approach is to be used in a CPHC context.

Chapter 9
Chapter 9 focuses on vaccination, screening, risk assessment and surveillance for population health and wellbeing to monitor and reduce risk of disease conditions, which is the fifth and final broad strategy area of health promotion action in the Framework of health promotion practice in a comprehensive primary health care context. These four health enhancing strategies are mostly carried out in primary health care services and can make a significant contribution to the health status of the population. If the strategies in Chapter 9 are used alone, the approach is regarded as a biomedical approach which is not consistent with CPHC. If they are used in conjunction with those strategies in Chapters 7 and 8, but not the other chapters, then this approach is regarded as selective primary health care, and likewise, is not consistent with CPHC. These strategies must be used in conjunction with all of the others in the Framework of health promotion practice in a comprehensive primary health care context, if the socio-ecological approach is to be used in a CPHC context.
Critical reflection on health promotion study and professional practice

Questions for reflection are included in each chapter to encourage users to explore some of the important practice issues raised in the chapter.

These have been designed to encourage active and self-directed learning, and to assist educators with in-class discussions. An answer guide to all reflective questions is available to educators on the Evolve website accompanying the text. Short quizzes for each chapter are also available to educators on the Evolve website. In the practice-based Chapters 4 to 9, reflective questions framed in reference to the action areas of the Ottawa Charter appear at the commencement of the chapter. The use of the Ottawa Charter illustrates its direct applicability to health promotion practice, and assists the health practitioner to think broadly and strategically about practice challenges and to reflect on and critique their professional role and the health promotion philosophy of their organisation.

The purpose of Promoting Health is to set out the core principles that guide practitioners to engage in critical health promotion. In doing this, an ‘ideal’ set of circumstances and ways of working are described, which may be more difficult to put into practice than they seem. A more global perspective is taken in the early chapters, and content of specific relevance to health promotion in New Zealand and Australia is included. You are encouraged to read widely and examine the many other examples currently available, and to work with your colleagues to develop your own health promotion competence and ways of practising.

Health promotion competencies

Considerable work has been done since the 1990s to establish the core professional competencies for health promotion practice, which are described in detail in Chapter 1. This text enables health practitioners to develop an introductory-level understanding of core knowledge, values, attitudes and skills essential for health promotion professional accreditation. The IUHPE health promotion competency statements highlighted at the end of each chapter relate to the content of that chapter.

REFERENCES


In completing this seventh edition of *Promoting Health: The Primary Health Care Approach*, there are a number of people whose contributions must be acknowledged. Andrea Wass wrote the first and second editions and we pay tribute to her work and acknowledge the contribution of others to those two editions. Lyn Talbot and Glenda Verrinder assumed authorship for editions three through to six, and Jane Taylor and Lily O’Hara have joined the authorship team for this seventh edition.

We (Jane and Lily) thank and acknowledge the sustained contribution of Lyn and Glenda for editions three to six along with their colleagues and family that supported them along the way. We thank Lyn and Glenda also for inviting us to join them in co-writing this seventh edition.

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# Health promotion practice

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INTRODUCTION

This chapter describes the health promotion practice cycle of community assessment, planning, implementation and evaluation. Models and theories underpinning the health promotion practice cycle inform all action areas of the *Framework of health promotion practice in a comprehensive primary health care context* which was introduced in Chapter 1. Using the health promotion practice cycle facilitates the development of a research base for health promotion action in a way that both strengthens the relevance of health promotion work and enables practitioners to be accountable for their practice. Strengthening partnerships between communities, practitioners, governments and researchers is recommended to increase the likelihood of successful outcomes from health promotion programs (Jackson & Greenhalgh, 2015).

Health promotion programs are a coherent series of activities, which together contribute to improving quality of life. A health promotion program is usually developed in response to an identified health and wellbeing priority (Hawe et al., 1990). This chapter begins with health promotion models for practice, followed by the role of research in informing practice. This is followed by the four main sections of the health promotion practice cycle (see Fig. 4.1). The first section provides a rationale for and steps taken in community assessment to identify community health and wellbeing assets and needs. The second section describes the process of program planning in response to the findings of the community assessment. The implementation of a health promotion program plan is addressed in the third section. The fourth section describes the methods used to evaluate the process, impact and outcome of a health promotion program. Before starting the chapter, take some time to review *Putting the Ottawa Charter into Practice* on p. 168.
Critical health promotion values and principles

Assessing community assets and needs

Planning the program

Implementing the program and conducting process evaluation

Conducting impact and outcome evaluation

FIGURE 4.1 Health promotion practice cycle
The following questions, arranged in the Ottawa Charter action areas, are presented to guide health practitioners to reflect on and critically evaluate their professional role and practice and the health promotion philosophy of their organisation. Content of this chapter will assist practitioners to develop the necessary professional knowledge and skills to conduct community assessment and plan, implement and evaluate health promotion programs.

PUTTING THE OTTAWA CHARTER INTO PRACTICE

Build healthy public policy
- Can national, state and local policy priorities provide a rationale for a health promotion program?
- Are there agency protocols for funding community assessment, planning, implementation and evaluation?
- Are there existing international, national, state or local policies that address the health and wellbeing priorities of a community?
- What new policies, legislation, standards or codes of practice are required to address the health and wellbeing priorities of a community?

Create supportive environments
- Are there existing environmental structures or institutions that address the health and wellbeing priorities of a community? These may be in social, economic, built or natural environments.
- What new environmental structures or institutions are required to address the health and wellbeing priorities of a community?
- Are communities adequately supported so they are not set up to fail?

Strengthen community action
- Does the rationale for the program clearly state the importance of community engagement and capacity building?
- Is the process of engaging community members clearly documented?
- What methods are being used to engage people?
- Who is participating in the community assessment, planning, implementation and evaluation stages of the health promotion program?
- What roles do they have?
- What is their role in decision making?
- Who is not participating in the community assessment, planning, implementation and evaluation stages of the health promotion program?
- How could they be more engaged?
- Can the community showcase its skills to others?
- What community development strategies or actions are being used in the implementation of the health promotion program?

Continued
### Develop personal skills
- Are community members supported to develop their skills in community assessment, planning, implementation and evaluation?

### Reorient health services
- What role are health services playing in the community assessment, planning, implementation and evaluation of health promotion programs?
- What resources are health services contributing to health promotion programs?
- Do the health services have policies or strategic plans for working with communities on health promotion programs?
- Do the health services have health promotion responsibilities included in the job descriptions of health practitioners?
- To what degree do health services wish to have control or ‘ownership’ over health promotion programs? Are they willing to share or hand over governance to the community?
- Who are the influential people within a health service?
- Do the health services have a process of responding to the evaluation results of health promotion programs?

### HEALTH PROMOTION MODELS

A comprehensive primary health care (CPHC) approach ensures that the process and outcome of health promotion action are acceptable to the community and mindful of social justice, while ensuring the efficiency and effectiveness of the organisation or agency undertaking the action. The fundamental proposition of health promotion action is that health and wellbeing priorities are influenced by multiple interrelated socio-ecological determinants. As such, health promotion efforts must be multidimensional and multisectoral.

Conceptual health promotion models provide structure and organisation to a health promotion program. There are no perfect models and all have their strengths and weaknesses. However, all models address the components of the health promotion practice cycle. There are many useful resources to help practitioners in the health promotion practice cycle.

Models used by practitioners to guide their health promotion practice include: Ottawa Charter for Health Promotion (WHO, 1986); PRECEDE–PROCEED Model (Green, n.d.); Needs Assessment and Planning Model (Hawe et al., 1990); Program Management Guidelines for Health Promotion (New South Wales Department of Health, 1994); and Circle of Health, Health Promotion Framework (Prince Edward Island Health and Community Services System, 2003). There is considerable variation in the level of technical detail provided across the models. For example, both the PRECEDE–PROCEED Model and Needs Assessment and Planning Model provide more comprehensive detail about undertaking community assessment and evaluation. The Needs Assessment and Planning Model and Program Management Guidelines for Health Promotion provide moderate to comprehensive detail on planning and the latter provides a moderate level of detail on implementation. There is very limited detail across the models about implementation and sustainability.
Guidelines for Health Promotion is the only model that explicitly incorporates sustainability as a structural component, and the *PRECEDE–PROCEED Model* identifies it as an important tenet.

With respect to theoretical foundations, the only model that articulates the theoretical foundations upon which the model is based is the *PRECEDE–PROCEED Model*. Both *PRECEDE–PROCEED* and *Circle of Health* models indirectly identify the relevant health paradigm. The only model that refers to values and principles is the *Circle of Health Model*. Even though a list of values and principles is provided, there is no detail about how these values and principles might be applied in practice. Recognition of these gaps in existing models led to the development of the *Red Lotus Health Promotion Model* (Gregg & O’Hara, 2007).

The *Red Lotus Health Promotion Model* was published in 2007 by Jane Taylor (nee Gregg) and Lily O’Hara, two of the authors of this book, in response to the need for a model of health promotion practice that explicitly included the values and principles of critical health promotion and their application (Gregg & O’Hara, 2007). Since then it has been used in teaching, research and practice in Australia, the UK, USA, United Arab Emirates and Qatar. The model has recently been revised and is now known as the *Red Lotus Critical Health Promotion Model*. The model uses the image of a lotus plant to depict the essential components of critical health promotion. The pod of the flower represents holistic health and wellbeing, with the multiple seeds in the pod reflecting the various aspects of health and wellbeing, including physical, cognitive, emotional, social, cultural and spiritual aspects across the spectrum from illness and disability through to flourishing. Some seeds may be more robust than others, and will inevitably change over time. Likewise, health and wellbeing is not a set or complete state, but a complex and ever-changing set of states.

The stamens surrounding the pod and the first layer of petals represent the determinants of health and wellbeing, using a socio-ecological approach. The stamens represent the aspects of individual people that contribute to the various aspects of health and wellbeing, including: biological factors (age, sex, genetics and physiological status); socio-economic factors (education, employment, ethnicity, income, and marital status); cognitive factors (knowledge, attitudes, values and beliefs); affective factors (emotions, feelings and moods); and people’s behaviours (physical, mental, social, cultural and spiritual).

The first layer of petals represents the environmental determinants of health and wellbeing, including the social, cultural, economic, policy, natural and built environments, operating at multiple levels from the individual through to the family, group, community, population and global levels. The pod (health and wellbeing), stamens (individual-level determinants) and first layer of petals (environmental determinants) are organically interconnected and therefore multidirectional impacts are recognised. Changes to any of the individual or environmental determinants impact on health and wellbeing, but so, too, do changes in health and wellbeing influence or affect the determinants.

The other four petal layers of the lotus flower represent the health promotion practice cycle components of community assessment, planning, implementation and evaluation. Together, the whole lotus flower represents health and wellbeing, the determinants of health and wellbeing and the health promotion process required to enhance health and wellbeing. The pod cannot survive without the stamens and petals of the flower, and so enhanced health and wellbeing cannot be achieved without all of these components being considered.

In addition to flowers, the plant produces leaves which represent sustainability. The leaves are the permanent component of the plant and remind us to always consider
processes that will enhance the sustainable outcomes of health promotion action. The leaves and the flowers of the lotus plant are connected by stems to the plant’s roots. The roots and stems represent the values and principles of critical health promotion that must be present for the plant to produce leaves and flowers. All parts of the lotus plant impact on each other, and the whole of the plant is greater than the sum of its parts.

Values are regarded as the process or outcome that is valued, and principles are the action required to attain the value. The values and principles of the Red Lotus Critical Health Promotion Model are described in Table 4.1. They are contrasted with the values and principles of selective health promotion, which is the type of health promotion practice more consistent with selective primary health care. The Red Lotus Critical Health Promotion Model explicitly articulates the ethical and technical values and principles required for critical health promotion. In doing so, it encourages health practitioners to engage in critical reflection to determine the extent to which their current practice is reflective of these values and principles, and consider strategies that will enable them to move their health promotion practice towards a more critical approach.

HEALTH PROMOTION PRACTICE CYCLE

The health promotion practice cycle (see Fig. 4.1) is an ongoing iterative cycle of assessing community assets and needs, planning a health promotion program, implementing the program strategies, and evaluating the implementation process, short-term impacts and long-term outcomes of a program. This is followed by re-assessing, re-planning, re-implementing and re-evaluating, in a continuous cycle of reflection and action (Baum, 2016; Bauman & Nutbeam, 2014; Wadsworth, 1997). All health promotion models include these stages of the health promotion practice cycle; however, only the Red Lotus Critical Health Promotion Model explicitly identifies the critical health promotion values and principles that relate to each stage. The steps within each stage of the cycle are outlined in Table 4.2. A detailed description of each stage and the steps follows.

The stages of community assessment and evaluation are often framed as research processes, as they involve the collection of data to answer research questions about the community before a program, and then questions related to the process, impact and outcome of a health promotion program during and after the program. However, the whole health promotion practice cycle may be framed as a research process, as even the planning and implementation phases must involve critical reflection on practice-oriented questions. As such, before delving into each stage of the cycle, it is important to discuss issues related to health promotion as a research process.

RESEARCH AND PRACTICE

Systematically collecting and analysing information about communities is integral to the health promotion practice cycle. Evidence improves practice and limits wasting resources that are often scarce. When research is integral to practice, practice is strengthened in several ways. First, health promotion practice will be built around the assets and needs of the people for whom it is designed. It will be responsive to those assets and needs and based on recognition that priorities are dynamic rather than static and therefore change over time. Second, with grounding in community health and wellbeing priorities, health practitioners are less likely to implement programs that do not meet these priorities, thus
## TABLE 4.1 Health promotion values and principles

<table>
<thead>
<tr>
<th>Focus of Value and Principle</th>
<th>Red Lotus Critical Health Promotion Model</th>
<th>Selective Health Promotion Practice</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Related principle – action on the value in practice</td>
<td>Related principle – action on the value in practice</td>
</tr>
<tr>
<td>Health paradigm</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Holistic health paradigm</td>
<td>Seeing health as a complex concept that includes physical, mental, spiritual, social, and cultural aspects of wellbeing that relate to the whole person.</td>
<td>Biomedical-behavioural health paradigm</td>
</tr>
<tr>
<td>Program approach</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Salutogenic approach</td>
<td>Emphasising salutogenic factors that create and support health, wellbeing, sense of coherence, happiness and meaning in life.</td>
<td>Deficit approach</td>
</tr>
<tr>
<td>Scientific approach</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ecological science</td>
<td>Using the science of ecology, which recognises that: people exist in multiple ecosystems, from the individual, to the family, group, community and population levels; all parts within systems impact on each other, the whole of any system is greater than the sum of the parts.</td>
<td>Reductionist science</td>
</tr>
<tr>
<td>Who to work with</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Focus determined by equity</td>
<td>In recognition that access to health promoting conditions of living is a human right, prioritising work with people and communities that are most marginalised, vulnerable, and disadvantaged based on considerations of equity.</td>
<td>Focus on whole groups or populations</td>
</tr>
<tr>
<td>Professional role</td>
<td>Working with people as an ally</td>
<td>Working on people as an expert</td>
</tr>
<tr>
<td>Working with people as an ally</td>
<td>Working with people as a culturally competent ally and resource who is respectful of all aspects of diversity.</td>
<td>Working on people as an outside expert who assumes they know what is best for them.</td>
</tr>
</tbody>
</table>
### Assumptions about people

<table>
<thead>
<tr>
<th>Assumptions about people</th>
<th>Basis for practice</th>
<th>Strategy approach</th>
<th>Engagement processes</th>
<th>Personal autonomy</th>
<th>Benefit</th>
<th>Non-maleficence</th>
</tr>
</thead>
<tbody>
<tr>
<td>Assume people are not doing the best for their wellbeing</td>
<td>Limited or selective use of evidence and theory</td>
<td>Limited or selective use of evidence and theory</td>
<td>Disempowering engagement processes</td>
<td>Reducing personal autonomy</td>
<td>Limited beneficence</td>
<td>Scope of maleficence not fully considered</td>
</tr>
<tr>
<td>Assume people are doing the best for their wellbeing</td>
<td>Comprehensive use of evidence and theory</td>
<td>Portfolio of multiple strategies</td>
<td>Empowering engagement processes</td>
<td>Respect personal autonomy</td>
<td>Maximum beneficence</td>
<td>Non-maleficence is a priority consideration</td>
</tr>
<tr>
<td>Basing health promotion practice on evidence of community assets and needs, sound theoretical foundations, and evidence of effectiveness.</td>
<td>Using participatory strategic processes that empower and meaningfully engage communities, given their circumstances and available resources.</td>
<td>Using a portfolio of strategies incorporating all action areas of the Ottawa Charter.</td>
<td>Using participatory strategic processes that empower and meaningfully engage communities, given their circumstances and available resources.</td>
<td>Using participatory strategic processes that empower and meaningfully engage communities, given their circumstances and available resources.</td>
<td>Using participatory strategic processes that empower and meaningfully engage communities, given their circumstances and available resources.</td>
<td>Using participatory strategic processes that empower and meaningfully engage communities, given their circumstances and available resources.</td>
</tr>
</tbody>
</table>

### Basis for practice

- **Assumptions**
  - Assume people are doing the best for their wellbeing
  - Assume people are not doing the best for their wellbeing

### Strategy approach

- **Portfolio of multiple strategies**
  - Comprehensive use of evidence and theory

### Engagement processes

- **Empowering engagement processes**
  - Using participatory strategic processes that empower and meaningfully engage communities, given their circumstances and available resources.

### Personal autonomy

- **Respect personal autonomy**
  - Using participatory strategic processes that empower and meaningfully engage communities, given their circumstances and available resources.

### Beneficence

- **Maximum beneficence**
  - Using participatory strategic processes that empower and meaningfully engage communities, given their circumstances and available resources.

### Non-maleficence

- **Non-maleficence is a priority consideration**
  - Using participatory strategic processes that empower and meaningfully engage communities, given their circumstances and available resources.
PROMOTING HEALTH: THE PRIMARY HEALTH CARE APPROACH

preventing expensive mistakes. Third, when research is integral to practice, health promotion and other activities of health practitioners are routinely evaluated and the findings used to improve the quality of health promotion work. The principles underpinning The WHO Strategy on Research for Health (WHO, 2012) are that research is of high quality, designed to have the greatest impact, in a style of inclusiveness and collaboration.

A CPHC approach to research can be described by the following elements.

- Research is a dynamic cyclical process, inextricably intertwined with action. Its aim is to improve the conditions under which people live.
- The research process is guided by critical self-reflection on the part of the ‘researcher’ and the research participants. The values of researcher and research participants are acknowledged up front and are the subject of critical self-reflection as part of the research process.

**TABLE 4.2 Stages in the health promotion practice cycle**

<table>
<thead>
<tr>
<th>Stage 1 Assessing community assets and needs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Identify the resources and activities required for community assessment.</td>
</tr>
<tr>
<td>Examine the characteristics of the community, including identifying its strengths and assets.</td>
</tr>
<tr>
<td>Gather primary and secondary data about health and wellbeing status from primary and secondary data sources.</td>
</tr>
<tr>
<td>Analyse the primary and secondary data collected.</td>
</tr>
<tr>
<td>Work with the community to identify the health and wellbeing priorities.</td>
</tr>
<tr>
<td>Investigate the individual and environmental level determinants of the health and wellbeing priorities.</td>
</tr>
<tr>
<td>Ensure a participatory decision-making process.</td>
</tr>
<tr>
<td>Clarify what the stakeholders are attempting to achieve.</td>
</tr>
<tr>
<td>Investigate what types of health promotion actions are most acceptable and feasible for specific populations and circumstances.</td>
</tr>
<tr>
<td>Review existing practice to assess whether the health promotion action is meeting a justified health and wellbeing priority.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Stage 2 Planning the health promotion program</th>
</tr>
</thead>
<tbody>
<tr>
<td>Determine the program goal, objectives and sub-objectives relevant to the health and wellbeing issue, determinants and contributing determinants respectively.</td>
</tr>
<tr>
<td>Ensure the program goal, objectives and sub-objectives are specific, measurable, achievable, relevant, and time bound.</td>
</tr>
<tr>
<td>Select a portfolio of appropriate strategies to achieve the goal, objectives and sub-objectives.</td>
</tr>
<tr>
<td>Develop an action plan to implement the strategies using relevant theories or models.</td>
</tr>
<tr>
<td>Assign responsibility to specific stakeholders for each of the actions in the action plan.</td>
</tr>
<tr>
<td>Develop an evaluation plan to evaluate the implementation of strategy activities, and the short-term impact and long-term outcomes of the program.</td>
</tr>
<tr>
<td>Assign responsibility to specific stakeholders for each of the actions in the evaluation plan.</td>
</tr>
<tr>
<td>Ensure collaborative decision making in all aspects of planning.</td>
</tr>
</tbody>
</table>
The relationship between researcher and research participants is a partnership that itself acts to change the status quo by breaking down the traditionally ‘top-down’ approach of researchers. Thus, all people involved in the research process are best described as research partners.

**Working on, for and with others in research**

The health promotion practice cycle requires practitioners to collect various forms of data. It is important to distinguish between research arising from, being assigned to, or imposed on the community (O’Leary, 2005). Health promotion research is ideally conducted in ways that are ‘democratic, participatory, empowering and life-enhancing’ (Stringer & Genat, 2004, p. 28). The centrality of community participation in health promotion, discussed further in Chapter 6, is embedded in the Ottawa Charter definition of health promotion as ‘the process of enabling people to increase control over, and improve their health’ (WHO, 1986). The emphasis must be on working with people as equal partners, involving them in the research process and acknowledging their expertise. This will ensure that the research conducted is relevant to their priorities and therefore useful. This approach to research involves working collaboratively with community members while drawing on a wide range of research methods. Planning committees comprising researchers, health practitioners and community members can work together to undertake community assessment, planning,
implementation and evaluation of health promotion programs. Contributions of community members in defining the parameters of the research and reviewing priorities that arise, from their perspectives as community members, add much to the value of the research.

Some research methods have this participatory approach embedded in the research process. Of note here are participatory action research (PAR) and feminist research (Wadsworth, 1997). They are ideal approaches to working with community members, enabling them to reflect on their own experiences, plan how they can act to change their situation, act and then evaluate the impact of the changes in order to then re-plan, re-act and re-evaluate in a continuing cycle of change, development and learning. PAR also provides a framework for health practitioners to continually analyse and develop their own practice. That is, it provides a framework for good reflective practice (Baum, 2016).

Challenges to participatory research approaches

Developing participatory research in a way that is both rigorous and accepted by professional colleagues and funding bodies on the one hand, and meaningful and acceptable to community members participating in the process on the other, is a challenge. Involving community members as partners in the process means that the process may become unpredictable and uncontrollable. This may create difficulties for people if the framework in which they are working doesn’t allow for flexibility, or if the community members want to take the process in a direction that is against the principles of health promotion and CPHC. This is by no means a simple issue. How do practitioners balance the need to be flexible in their approach, ensure community members are true partners in the process and maintain the rigour of research at the same time? It is necessary to grapple with these challenges.

Baum (2016) highlights the issue of power in PAR and whose worldviews dominate the research (see More to Explore at the end of this chapter). She argues that ‘PAR is the only empirical method available to public health that will allow such wide-ranging assessments of complex realities and policy and political engagement’ (Baum, 2016, p. 407). Discussion of the worldviews or philosophies that underpin all research is beyond the scope of this chapter; however, the principles of health promotion and CPHC outlined in Chapter 1 and the values discussed in Chapter 2 are a starting point for the conduct of any research in communities. Further, it is important to reflect on the discussion about culture and cultural safety and competence in Chapter 2.

Research with Indigenous communities

The principle of working in partnership with people is central to health promotion, but unfortunately is not always evident. Arabena’s discussion (2010) of Indigenous knowledge across the world and research in Indigenous communities in Australia is instructive (Kendall et al., 2011; O’Donahoo & Ross, 2015). The way we conduct research has been traditionally based on ‘Western’ ways of doing research with ‘culturally insensitive research designs and methodologies that fail to match the needs, customs, and standards of Aboriginal communities’ (Kendall et al., 2011, p. 21). In New Zealand, research involving Māori or Pacific peoples is expected to be conducted or facilitated by people of the same ethnicity—in recognition of not researching ‘on’ but researching ‘with’ these population groups.

Research conducted within Indigenous communities, minority groups and other cultural groups requires specific knowledge of those groups that makes it imperative that they are
involved in every aspect of the research. Engagement with communities needs to start before a research proposal is put forward and continued throughout. It is also imperative that health practitioners are aware of ethical guidelines that provide clear procedures for the initiation, protocols, participation and ownership of the research process.

**Guidelines for ethical practice**

Health promotion research should be conducted with all the considerations and safeguards expected of all forms of research. There are international and national rules governing how research is conducted based on the core ethical values of merit and integrity, justice, respect and beneficence. In Australia, the Australian Health Ethics Committee advises the National Health and Medical Research Council (NHMRC) on ethical issues relating to health and the development of guidelines for the conduct of medical research involving humans. *Guidelines for Ethical Research in Australian Indigenous Studies 2012* (Australian Institute of Aboriginal and Torres Strait Islander Studies, 2012) guides research in Australian Indigenous communities so that researchers follow a process of meaningful engagement and reciprocity between the researcher and the individuals and/or communities involved in the research. Jamieson and colleagues (2012) have published ‘Ten principles relevant to health among Indigenous Australian populations’. The Health and Disability Ethics Committee (n.d.) provides guidance for New Zealand researchers. Human research ethics committees (HRECs) oversee research on behalf of many organisations. These committees are found in large organisations such as universities, education departments, health departments and large hospitals. It is not proposed that we deal comprehensively with ethical issues here. (Also see, for example, Bamberger et al., 2012, Chapter 9; Centers for Disease Control and Prevention, n.d.; Jamieson et al., 2012; Posavac, 2011, Chapter 5; Purtillo & Doherty, 2011 for a comprehensive discussion of codes of behaviour and ethics.)

**Approval for community assessments and evaluations**

There has been some debate about whether HREC approval is needed for health promotion practice, particularly community assessments and evaluations (Allen & Flack, 2015; Posavac, 2011). Some argue that much can be gained by seeking approval from HREC in any circumstance. Others argue that if the community is involved in identifying their own health and wellbeing priorities, and planning, implementing and evaluating appropriate health promotion initiatives to address these priorities, then seeking approval from an outside HREC is unnecessary. Allen and Flack (2015) argue that although the overall objective of research may be of public benefit and people may choose to participate in research for altruistic reasons, research activity may not necessarily have a direct individual benefit, and so great care must be taken. Awareness of power relationships is the most important consideration. Power imbalances may emerge in the research procedures in community assessments and evaluation. The values and principles of critical health promotion and CPHC provide a solid foundation for conducting community assessments and evaluation within the health promotion practice cycle. However, given Baum’s (2016) discussion of power and PAR, and the issues raised about culturally insensitive research above, further discussion is needed concerning some of the ethical issues for health practitioners to consider.

Five categories of ethical issues have been identified:

1. *Treating people ethically*
2. *Recognising role conflicts*
3. *Using valid methods*
4. Serving the needs of the program participants
5. Avoiding the negative effects of the research.

(Posavac & Carey, 2003, p. 97)

Treating people ethically

Health practitioners need to consider whether any harm will be done during the research process. Practitioners may need to take training in cultural awareness and there are four major principles to consider. First, treating people ethically means having an understanding of, and respect for, the culture and history of the community. Second, there needs to be clear and sustainable benefits to the community. Third, culturally sensitive methods need to be observed, and fourth, meaningful participation of the community in the entire research process is imperative (Kendall et al., 2011; O’Donahoo & Ross, 2015).

A core ethical value is respect and it is important to reflect on how this is demonstrated. Involving the community in the design and implementation of the research has been discussed. The quality of the data collection process is another and several aspects need to be considered including whether the people conducting the research have the necessary skills. For example, Allen and Flack (2015) argue that HRECs should not be asked to approve a survey written by someone with no expertise in survey design.

Obtaining informed consent prior to research is routine research practice. The emphasis here is on informed, which means that the information explaining the research and negotiating the participants’ role must be done in a way that can be understood, therefore enabling communities to truly make an informed decision about whether to participate or not. O’Donahoo and Ross stated that ‘permission without understanding is inherently exploitative’ (2015, p. 5305). Further, confidentiality agreements may need to be considered too. It is often not necessary to identify the participants or the community, because usually it is their opinion that is needed, not a record of their name and contact details. However, if it is necessary, utmost care must be taken to protect these, and, if confidentiality is promised, it must be preserved (Posavac, 2011).

Recognising role conflicts

Ethical dilemmas sometimes arise from the conflicting interests of the stakeholders. A conflict of interest may occur if someone has a personal interest in a particular outcome (Allen & Flack, 2015). How the stakeholders could be affected by the findings is a significant issue to be considered before the research takes place.

- Why is the research being done?
- Who is conducting the research?
- Who will have access to the findings?
- How will the findings be used?

These are important questions which, when addressed, prevent conflict and compromised research procedures (Posavac, 2011). A negotiated Indigenous research agreement may be needed (Allen & Flack, 2015; Kendall et al., 2011). O’Donahoo and Ross (2015) suggest story-telling in Indigenous communities enables a two-way transaction in communication. This ‘back and forth’ process may need to happen many times. Translating Western ideas into Indigenous narratives about the research and enabling researchers to see the research within the community worldview ensures genuine engagement and understanding. They advise that knowing who can speak on behalf of the community is imperative. In a fragmented community this can be a challenge, but this is not a reason to bypass ethical practice guidelines.
Using valid methods

When potential harms have been considered and minimised, and benefits to the community are clear, it is important to focus on the validity of the program. Research design must fit the needs of those who will utilise the information. Conducting research that is not suitable for the purposes for which it was commissioned is unethical. Interpersonal skills need to be highly developed. Experienced data collectors and analysts need to be involved in research. If quantitative methods are to be used, then a standardised test appropriate to the setting will minimise the risk of invalid results (Posavac, 2011). If interviews form part of the process, then experienced and culturally appropriate interviewers are required to avoid cultural insensitivity or wasting the interviewee’s time and research program funds through meaningless or inadequate interviewing. Good interviewing practice requires tremendous skill and sensitivity.

Serving the needs of the program participants

People will not benefit from the findings if they are not published (Posavac, 2011) and as we have said, working with participants in program development and evaluation maximises the chances of addressing the priorities of the participants. Collecting data that do not address the priorities of the participants, directly or indirectly, is unethical.

Avoiding the negative effects of the research

People can be hurt through a lack of due diligence leading to insensitive research and inaccurate findings. Disclosure of personal information carries risks for an individual, including embarrassment, loss of dignity, stigmatisation and discrimination in employment (Allen & Flack, 2015). The process and outcomes of research undertaken in Indigenous communities has largely been a negative experience for Indigenous community members (Kendall et al., 2011). O’Donahoo and Ross noted that ‘Indigenous communities are heartily sick of being told they are poorer, sicker and less functional than mainstream Australia’ (2015, p. 5307). Evidence-informed program design can minimise the negative effects of research.

Now that we have a sound ethical base for conducting health promotion research, we can move on to describing the stages in the health promotion practice cycle in more detail. We begin with Stage 1 Community assessment.

STAGE 1: COMMUNITY ASSESSMENT

Assessing community assets and needs is the first stage in the health promotion practice cycle (see Fig. 4.1 and Table 4.2) and the essential starting point for health promotion work. Community assessment can be defined as a process that results in:

… a comprehensive description of the (assets and) needs of a population that is defined, or defines itself, as a community, and the resources that exist within that community, carried out with the active involvement of the community itself, for the purpose of developing an action plan or other means of improving the quality of life in the community.

(Hawtin et al., 1994, p. 13)

This definition highlights considerations central to meaningful community assessment (adapted from Hawe et al., 1990).

- Community assessment is a process of determining both the assets and needs of a community. While considerable attention tends to be focused on the needs
of communities, and these certainly are important, a focus on needs alone tends to paint a ‘deficit’ picture of communities. This can be a negative, disempowering experience for communities and ignore the positive characteristics and resources of that community. Community assets can be a source of pride for the community and may hold a key to successfully addressing the needs that arise.

- Community assessment should be carried out with the active participation of community members. Community members have the right and ability to be meaningfully engaged in identifying what their assets and needs are. Good community assessment is a participatory process.
- Community assessments are carried out for the specific purpose of achieving change that improves the health and wellbeing and quality of life of those living as part of that community. A community assessment is not an end in itself, but a guide to action. Unless community assessments are acted on, they are a waste of time and resources. Community assessments that leave few resources for acting on what is found, or for which there is no real commitment to act on after their completion, are unethical. They do little to help those for whom the community assessment is purportedly being carried out, and are likely to result in significant community frustration.

In preparing to assess the assets and needs of any individual, group or community, it is vital to know why the assessment needs to be done. What needs to be known, and to what end? This will help determine how the assessment should be conducted. Adequate resources need to be available. As discussed, identifying needs, creating the expectation that something will be done about them, then not acting, is unlikely to develop confidence in those whose time has been wasted. Community assessment should reflect the socio-ecological perspective of health and wellbeing, and involve both formal and informal assessment of assets, needs and resources. It should be conducted in partnership between community members and practitioners.

Before expanding on the steps in a community assessment, we need to think about who or what the ‘community’ is and what is meant by community assets and needs. Community is defined in Chapter 2 and discussed further in Chapter 6. In the health promotion practice cycle, the essential initial questions are:

- Is the community local, state/territory or national?
- Is it a community of interest or a geographical community?
- How homogeneous or heterogeneous is the community?
- How will you engage as many people in the community as possible?

**Community assets and needs**

**Assets**

Kretzmann and McKnight (1995) have demonstrated that assessment of community assets, such as community members’ skills, is essential in program planning. To encourage and build healthy communities, the unique capabilities that communities offer in developing, nurturing and caring for their citizens must be identified (Cavaye, n.d.; McKnight, 2010). This approach does not imply that communities do not need additional resources from the outside. Rather, that outside resources will be much more effectively used if the local community is fully mobilised and engaged, and if members can define the
agendas for which additional resources must be obtained. The primary reason for incorporating this approach is that there is considerable evidence to suggest that community action is successful when local communities are committed to investing in themselves, including identifying and developing their own assets (McKnight & Kretzmann, 2005, p. 158).

Assets fall into three main categories: primary, secondary and potential building blocks (McKnight & Kretzmann, 2005). These assets are mapped alongside the needs of the community. Primary building blocks comprise assets in the community, largely under community control. These include the skills and connections within a community, as well as the community-controlled organisations such as citizens associations, business associations, and religious organisations. Secondary building blocks are assets in the community but controlled by outsiders. These can be divided into three main categories: private and non-profit organisations; public institutions; and resources such as hospitals, social service agencies, schools, police, libraries and parks. Partnerships between individuals and agencies can be formed to run these facilities. Potential building blocks are resources outside the community controlled by outsiders. These include major public assets such as public capital improvement expenditures, which empowered communities may begin to redirect to community building purposes (McKnight & Kretzmann, 2005). In Bajayo’s (2012) discussion of building resilience in the face of climate change, four sets of networked resources are proposed that individually and collectively build resilience in the face of natural disasters (see Chapter 3 on climate change and health system responses). The resources include economic development, social capital, information and communication, and community competence.

Needs
While comprehensive community assessment examines both the assets and needs of a community, the notion of needs has a central place in community assessment. This is especially so when there is a focus on social justice and working to achieve equity for those who are most marginalised. Arguably, any community assessment should start with an examination of what need is and a review of some of the issues surrounding the definition of something as a need. Need has been defined as ‘the condition marked by the lack of something requisite’ (Yallop, 2005). This definition highlights the fact that the very concept of need itself is value-based and socially constructed. Whether something is identified as a need will depend on the perspectives and values of those involved. In addition, the way in which health and wellbeing priorities are defined at a social and political level influences how individuals, groups and societies come to decide which issues are of concern to them and which things they need. Given the value-laden nature of need, it is important to be clear about which values are driving the needs-identification process.

There are several different ways in which needs can be classified. Bradshaw’s (1972) typology of felt need, expressed need, normative need and comparative need is useful. Which health and wellbeing priorities are constructed as needs depends on the particular values in place in the society or group. The categories of felt and expressed need include need determined by community people themselves, while the category of normative need represents need determined by experts, and comparative need by past responses to similar priorities or differences between one community and another. With an emphasis on equal partnership between practitioners and community members in a CPHC approach to health promotion, all these types of need have something useful to contribute to an assessment of need and an over-reliance on one type of data has its limitations. All these needs described below tell practitioners different things.
Felt need

Felt need is most easily described as what people say they need (Bradshaw, 1972). For example, if a local community is surveyed regarding its highest priorities for health promotion action, people may say that they want more intensive-care beds, safer streets in which their children can play or less youth unemployment in the local area. Felt need is important because it involves asking people themselves what their needs are. However, on its own it may not give a complete picture of need for several reasons.

First, people may limit what they tell practitioners they need to what they think they can have. If they believe that meeting some of their needs is beyond their reach, they may not ask for them. Second, people may only voice needs that they believe practitioners are interested in. For example, if a practitioner asks someone about their health and wellbeing needs, that person may interpret the question as referring to his or her illness problems alone and may not think of health in its broad context.

A third reason why felt needs should not be the sole source of information is that powerful groups in the community can have a strong influence in determining how people see their needs. Community members’ beliefs about what they need can be socially constructed by interest groups, opinion leaders and the mass media. Groups and communities may ‘adopt’ certain needs as their own because these have been sold to them through the mass media. In many instances, it is not the need alone but also one potential response to the need that is presented as the ‘solution’.

Finally, the perspective of a small group of community members may not reflect the perspective of the whole community. Careful consideration needs to be made of whom a group of community informants represents—a section of the community, a small subsection or only themselves. A useful consideration when conducting a community assessment is whose voices are not represented. This will provide some insight into the most marginalised people in the community. Effort will need to be made to connect with these people using culturally appropriate and ethical processes.

The principles of equity, empowerment and sustainability mean that health and wellbeing are promoted when health promotion programs are based on people’s own assessment of their felt needs. However, because of the forces that influence people’s perceptions of felt need, they may not have had a real opportunity to decide for themselves. In health promotion, as in any other area of health, practitioners need to ensure that people can make informed decisions and that they have access to the information they need to make those decisions. Of course, this process may require more than giving people information; it may require them to examine the forces that influence their decisions. That is, this process of helping people clarify their felt needs may involve the process of conscientisation (Freire, 1974). In Chapter 3, Insight 3.4 is an example of a process of local conscientisation in Australia on issues related to gas and coal.

Another important point to note is that the felt need is often expressed in the form of a solution, which can be very limiting. It is worth asking what is the health and wellbeing priority rather than what is the solution to the priority. There may be many creative solutions to identified priorities. Furthermore, health promotion funding is currently made available for specific programs, often aimed at particular diseases or risk factors. Frequently, funding may be granted and the program begun without any prior systematic assessment of the community’s felt needs. The program being funded may be a long way down the community’s list of priorities, and people may not be motivated to participate in the activities. It is imposed on the community, and, at best, the community is simply told about why they should want it. This approach to funding presents some very real dangers,
as it encourages practitioners and others to ignore a community’s own assessment of its needs, or regard them as a simple ‘add on’ rather than an integral part of the program.

The project focused on linking community participation and therapeutic landscapes to develop social prescriptions for health (Aitken et al., 2015) (Insight 4.1) is a good example of community-based research that explored the felt needs of a community. Community members were asked to identify places in their community that affected their health positively or negatively. Participants could focus on healthy places, develop strategies to deal with unhealthy places and change their therapeutic landscape by adding health to place.

The identification of felt need is important, but not sufficient to identify health and wellbeing priorities. What if a group or community wants something but there is no evidence to demonstrate the need for it? In such a situation, more information may be needed. Does the group or community know that it is comparatively well off in the area concerned? This may change the priorities that the group sets. Conversely, is it the case that there is a lack of formal evidence in this area because of the shortcomings of information

**INSIGHT 4.1 Linking community participation and therapeutic landscapes to develop social prescriptions for health**

Building social capital in rural communities encompasses the notion of ‘boundary crossing’ where:

> Boundary crossers understand the culture and language of community and health service domains and have the trust of both. Rural health professionals living within the communities they serve are ideally placed to harness community capacity so as to influence community-level determinants of health.

(Kilpatrick et al., 2009, p. 284)

As a rural pharmacist, I was interested in exploring the notion of community participation to improve rural health outcomes of the community in which I live and work. Part of my journey resulted in me enrolling in a PhD to become the researcher of the ‘Improving the health of communities through participation’ research project. The research included asking community members to locate on a map the places that affected their health and wellbeing. These places became a therapeutic landscape for participants, which could have a positive or negative effect on health. Community members wanted a place that promoted healthy living, got retired people ‘off the couch’ and encouraged socialisation and intergenerational dialogue. Adding health to places involved developing three community gardens in Warrocknabeal, Beulah and Hopetoun. Dietitians, physiotherapists and other allied and community health staff became involved in the program. Community participants reported greater socialisation, healthier eating habits and pride in the shared outcomes of the program.

One of the themes of this research is about capacity building for community stakeholders. The collaboration between the university and the health service has improved the academic focus of the health service staff, built research capacity within the organisation, and improved both health service and community sustainability. Even though I have lived and worked in one of these communities, as the researcher, I have learnt new skills, developed capacity and new relationships with university staff. I am treated as a peer by fellow academics and I have presented research findings at national conferences; outcomes that I would never have been able to achieve in the dispensary, behind a desk or ‘on the couch’.

Source: Aitken et al., 2015.
collection, rather than that there is no objective need? These questions demonstrate the importance of collecting information on other types of need.

**Expressed need**

Expressed need is need that is demonstrated by people’s use of services or demand for new or more services. That is, expressed need can be described as ‘felt need turned into action’ (Bradshaw, 1972). Examples of expressed need include waiting lists for services such as child care, housing or public dental services.

Expressed need has limitations, as people can only add their names to waiting lists for services that already exist or are about to come into existence. Indeed, waiting lists are limited to issues of service provision: for example, it is not possible to join a waiting list for a new public policy; however, the number of letters written to a politician on an issue may be regarded as another form of expressed need.

The constraints on people’s choices here are even greater than in felt need, since the specific service they are demanding must already be there. Moreover, expressed need can easily be misinterpreted. For example, a waiting list at the local dentist might be interpreted as the need for more dental treatment services, when in fact it could reflect inadequate oral health promotion or lack of awareness of school dental therapy services. Another problem with expressed need is that in many situations people may add their names to all available waiting lists for a particular service, although in reality they would accept only one place (e.g. a nursing home placement). In such a situation, adding up the numbers of names on waiting lists is likely to give an inaccurate impression. In other situations, people may refrain from placing their names on waiting lists if they believe the waiting lists are already long and their chances of success low. In addition, people’s beliefs about whether they have a right to particular services, or deserve to have access to them, will influence whether they act to formally express a need.

**Normative need**

Normative need is need determined by ‘experts’ on the basis of research and professional opinion. Examples of normative need include safe levels of air and water quality, recommended daily allowances of different food groups, and unsafe levels of lead ingestion. Normatively determined need is often regarded as objective and unbiased because it has been determined by experts. It often carries the assumption that it is value-free and beyond reproach, but this assumption needs to be called into question. Professional opinion often changes over time, leaving the public confused. Normative need may reflect some level of paternalism and it can provide conflicting information, depending on the values of the experts themselves (Bradshaw, 1972, p. 641).

One crucial issue that influences normative need and requires examination is that many professional groups act, often unconsciously, as gatekeepers in society. They may be unable or unwilling to acknowledge publicly that something is occurring at an unsafe level, such as lead levels in a mining town, if their judgement in this case has political implications. This then represents another possible limitation of normatively determined need.

**Comparative need**

Comparative need is determined by comparing the services or resources in one population or geographical area with those in another population or geographical area. Sometimes it is argued that a particular area requires a certain service because other areas with similar demographic characteristics have one. Comparative need can be useful in highlighting relative deficiencies in some communities. However, it can also be problematic because
it is based on the assumption that the service provided in the place of comparison was the most appropriate response to the problem (Bradshaw, 1972), and that the needs of the two areas are the same.

**Collecting community data using the socio-ecological determinants of health and wellbeing**

Health practitioners need to make themselves aware of what information is already known about a community. (Before we look at this in more detail, a note about the term ‘data’. Data is the plural of datum, and although data is used as a singular or plural in common language, it is generally used as a plural in scientific papers. We use it as a plural throughout the book.) There are a number of data sources and collation services to assist this process in the process of collecting community data. All sources of available information must be explored before committing resources to community assessments. Information about a community is only as good as the techniques used to collect it. Qualitative and quantitative methods used in the collection of community data are briefly discussed later. A lot of time and money can be wasted collecting data that are unuseable, or in planning and implementing activities based on data that do not reflect community priorities. Sources of data about a community fall into two main categories.

- **Secondary data sources** provide data from existing sources such as statistical and epidemiological data sources or peer-reviewed published literature. It is important to establish what is already known about the community before setting out to gather more information, and so the secondary sources of data should be explored first.

- **Primary data sources** provide new data directly from community members or by observation of the relationships between the system or subsystems within the community. Primary data can help to develop a deeper understanding of the secondary data, or to address gaps in the secondary data.

**Secondary data sources**

Secondary data are data that already exist and generally can be accessed relatively easily. These data contribute to the overall picture of a community and are essential to providing a strong rationale for a new program. Conducting a review of the peer-reviewed literature is usually the first task health practitioners take when looking for information about a community and its assets and needs. Furthermore, national databases such as the Australian Bureau of Statistics (ABS) or Statistics New Zealand (Stats NZ), national and regional ‘burden of disease’ reports, and local government databases that draw on databases such as .id (http://home.id.com.au/) with demographic information, are all rich sources of secondary data. These sources are often referred to as ‘grey literature’, and are equally as important for sourcing secondary data about communities as the ‘black literature’ published in peer-reviewed journals. This section deals first with the process of reviewing the black literature, followed by the numerous sources of grey literature.

**Peer-reviewed literature**

A literature review is defined as ‘... an extensive, exhaustive, systematic and critical examination of publications relevant to a chosen topic’ (Seaman & Verhonick, 1982 in LoBiondo-Wood & Haber, 2002, p. 78). It has two main purposes: first, to critically evaluate published research material; and second, to place current information and activities in the context of previous research. Literature reviews are applied to all parts of the health
promotion cycle, from identifying needs and assets, to analysing health and wellbeing priorities, and planning, implementing and evaluating programs. Conducting a literature review before commencing a program not only allows health practitioners to draw wisdom from the experts, but also prevents wasting time, or making the same mistakes that others have made. A later review of the literature may allow an extension of existing knowledge, identification of methods that could be used, or to guide modification of previously tried approaches in order to enhance their effectiveness locally. A literature review sets the current activity into the context of wider health promotion practice. Skills in accessing and reviewing literature are essential to informing different phases of a community assessment.

**Searching the literature:** There are different types of literature reviews such as systematic reviews, scoping or narrative reviews, and rapid reviews, each with strengths and weaknesses (Grant & Booth, 2009; Robinson & Lowe, 2015). For comprehensive guidance on the literature searching and reviewing process, consult a research methods text. University libraries also provide tutorials online (see More to Explore at the end of this chapter). However, basic principles of conducting a literature review apply. The following provides a brief overview of the main steps in the process and some practical guidelines.

- Primary research, reported in refereed journals, should be the key criteria used for selecting literature. Primary sources are first-hand accounts—research reports written by the researcher.
- Primary sources are preferred because anything interpreted by a second author has the potential to be biased by the views of the second author (LoBiondo-Wood & Haber, 2002, p. 83).
- A literature review requires good knowledge of data sources and skills in using them effectively. McKenzie and colleagues (2013, p. 94) provide a useful diagrammatic outline of a literature search strategy. Be wary of using the easily accessible, but completely non-validated writings and opinions contained in many internet addresses that turn up from a ‘keyword’ search.

There are many challenges for practitioners in accessing reliable evidence. Many organisations do not provide access to primary data through journal subscriptions or databases such as Proquest or CINAHL. There are some easily accessible websites that can be used to obtain reliable information. Google Scholar, the Cochrane Library and the Campbell Library are three good resources for students and health practitioners to start a literature review. Researchers sometimes post their articles on ResearchGate and similar websites that are free to access. Government websites sometimes provide primary data sources or reviews, and university libraries also provide access to databases and journals to individuals and organisations for a fee.

Secondary literature sources are at least once removed from the primary author. These could include summaries of research studies (e.g. an annotated bibliography). The Cochrane or Campbell libraries and databases of systematic reviews may be useful. Textbooks provide a foundation, particularly in historical, theoretical and conceptual areas, including definitions. However, they contain material assembled from other sources.

The process of searching the literature begins with a question and framing this question clearly helps with the next four steps of: searching the relevant bodies of literature; appraising that literature and managing the results; synthesising the literature; and writing an assessment. The process is iterative in that as you gain more understanding of the topic you will rethink, refine and rework your review (Harvard Graduate School of Education, n.d.). Following the development of the question, keywords are specified and ‘included’ or ‘excluded’ to begin a search strategy.
Critical evaluation of the literature: It is essential to critically evaluate published material in order to determine the quality of the research that is being reported and the trustworthiness of the information that is retrieved. The review must identify the strengths, weaknesses, conflicts and gaps in the literature. A literature review is not simply a matter of reading large amounts of literature and providing a narration. It should provide some critique to the reader as to the usefulness of the findings for the current purpose.

Use the following questions as a guide to reflect on each piece of literature.

- Is each piece relevant to the community/group/topic you are working with or does the paper report on a community/group very different from the one you are working with?
- Are the research processes and outcomes credible and sound?
- Are there flaws in the research design?
- Are reasonable conclusions drawn?
- Is the information vital to this review?

Be systematic in collecting the material (McKenzie et al., 2013). After deciding that an item is relevant and useful for the purpose, keep a copy of the article so it can be re-read, and quoted from if required. Be sure to have all the citation requirements at the time. How broad the review needs to be depends on its purpose. A review to inform data gathering for a major research process or higher degree will necessarily be very comprehensive. A short review for a small funding grant may be limited to literature that relates to the local context.

Two simple visual diagrams (Table 4.3 and Fig. 4.2), the literature review grid and the funnel, can be used to explain the techniques and phases in literature management to inform program planning. Concepts that are presented in diagrams or models provide valuable frameworks to assist when searching the literature and when structuring the review (Talbot & Verrinder, 2008).

Making a literature review grid: Making a grid in the reviewing process, before commencing writing, is a useful activity that will assist those who are less experienced with writing literature reviews to collate relevant material and to structure their review well (Talbot & Verrinder, 2008). Set up a grid/table in Microsoft Word or Excel. Some people

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find it easier to have a hard copy of key articles, so they can highlight main points, but
this can also be done within digital files like PDFs. Read all the materials the first time
without marking them, to get an idea of what the key themes are. In this way, new keywords
can be generated and specific subtopics identified and explored.

In the second reading, highlight aspects of the paper, according to the key themes
that are emerging, using the series of questions mentioned in the previous section to
evaluate each piece. During this review process, collate the grid—add new themes into
new columns as they arise. Use a new row for each article. In the cell, write very brief
prompts to enable easy identification of the section of the paper when writing the review
(see Table 4.3). (Different-coloured highlighters can also be used to highlight different
theme(s) in each paper—one colour per column.) As new themes emerge, the literature
searching is broadened to explore its significance in the original topic (Talbot & Verrinder,
2008).

When the literature reading, reviewing process and grid construction are complete,
the grid is used to help structure the writing of the literature review so it tells a logical
‘story’ to the reader, theme by theme.

A good review should answer the following questions.

- What is known about the topic?
- Why is it an important topic?

**FIGURE 4.2 Literature review structural funnel**
• What is not known about the topic?
• Why is it important that the knowledge gap is filled?
• What activities or processes might fill the existing knowledge gap?

The process is the same, irrespective of the size of the review. It is useful to conceptualise a literature review as a funnel, which takes the reader from the broad general topic or problem at the start and narrows through the exploration of key themes to the specific focus of the research or program that emerges at the end of the review.

This conceptual diagram (see Fig. 4.2) is useful and draws directly on the grid that was constructed during the reading phase. Commence with an introduction that sets out the purpose of the review and provides a rationale as to why it is a worthy topic. Introduce any key terms and definitions that are necessary for the reader. Outline any limitations in the breadth of the topic being explored or the search parameters. Next, provide a summary of current knowledge of the problem and introduce the key themes that the review will address (i.e. list off the column headings from the grid, in an order that will tell a logical ‘story’). The grid provides a ‘map’ for the review. The key point of advice when using the grid is that the grid rows are assembled horizontally as literature is read and analysed, but when using it to construct the written review, use the vertical columns, one theme at a time, integrating all the points and papers that are made in the cells in that column. This prevents the common problem of simply summarising individual papers sequentially.

Depending on the size of the review, a separate section is composed for each of the themes (or columns). Use a series of headings as ‘signposts’ to ensure that everything that is included in the section directly relates to that theme (the headings can be taken out at the end). Each theme becomes a ‘mini-essay’ in itself and so needs a strong introduction. This is followed by a discussion of the literature relating to that theme. Include the following in the discussion for each theme: the critique of what was useful, relevant, reliable about the research; what other research concurs or contradicts the findings; and the gaps in the knowledge related to the theme. After each theme is dealt with, the conclusion should highlight the purpose of the review. For instance, if it has a research purpose, the conclusion should highlight the topic that requires further exploration. If the purpose of the review was to inform health promotion planning or practice, the conclusion should highlight key action areas or wisdom from the field.

The literature review is usually the first step in compiling information about a community’s assets and needs. Once this is completed, the health practitioner needs to identify sources of information from the grey literature, including any epidemiological or local profiles that have been compiled about a community, and information about specific determinants at the individual and environmental levels relevant to the community.

**Epidemiological profile**

Epidemiology has been defined as dealing ‘with the incidence, distribution, and control of disease in a population’ (Merriam Webster Dictionary, n.d.). However, this definition is more consistent with a biomedical model of health. Holistic approaches to epidemiology frame it as the study of the incidence and geographic, demographic and temporal distribution of states of health and wellbeing and their determinants. Hence, traditional epidemiological data focus on levels of death (mortality) and disease (morbidity) and their distribution in the community according to such criteria as gender, age and place of residence. The holistic application of epidemiology also includes data about levels of physical, mental,
spiritual and social health and wellbeing. Epidemiological data come from a number of sources including:

- registries of births and deaths
- health surveys and studies; for example, those conducted by the Australian Institute of Health and Welfare (AIHW)
- social surveys and studies
- hospital discharge records
- reports of notifiable infectious diseases.

By providing information at a population level, epidemiology provides a useful tool to confirm or question the hunches of health practitioners and community members regarding health and wellbeing priorities. This can be valuable because assumptions about priorities in a community may not always be correct. The reports produced by the AIHW (2018), Organisation for Economic Co-operation and Development (OECD) (2019) or Stats NZ (Statistics New Zealand) (www.stats.govt.nz) for example, are of particular value in providing and analysing up-to-date epidemiological data. Also, local public health or health promotion units may prepare epidemiological data relevant to their own areas. Much of these data are available on the internet, especially in the validated reports of government agencies in areas such as women’s health, domestic violence, injury surveillance, and mental health and wellbeing.

It is important to note that epidemiological data are not equally available for all health and wellbeing priorities. Some health and wellbeing priorities have well-developed databases (e.g. cardiovascular disease) while others do not. Until relatively recently, the seriousness of Aboriginal and Torres Strait Islander health in Australia was ignored because data were not collected. Relying on pre-existing epidemiological data risks focusing further attention on conditions that are already well identified, at the expense of those that may be serious but that have been ignored in the past.

Morbidity and mortality data are useful when planning health promotion programs; however, used in isolation they are not sufficient to enable us to see all of the determinants of health and illness. Epidemiological data are of limited use in situations where no simple cause-and-effect relationship exists or where delayed onset of symptoms occurs. This may particularly be the case, for example, with environmental health issues where a relatively long timeframe is required before evidence of a problem emerges, by which time a number of people will have already experienced illness or even death. Epidemiology data usually express morbidity and mortality, not the extent of wellness of a community.

Local community profile

Community profiles are usually available on local government municipality websites. Most municipalities have a great deal of information about the community derived from national data repositories and other sources that are valid and updated at regular intervals. Every agency or service that has responsibility to a community will need to have access to a relatively up-to-date profile of that community. This is necessary to have a sense of what needs there may be and what demographic and social issues are likely to be shaping the lives of people in the community. Health practitioners may be part of the team that sets about preparing or updating a community profile.

It is worthwhile to examine what sort of information will be needed to include in a community profile and some of the general principles involved in preparing it. Data gathering in the community can be guided by a series of categories, which can be used
to document community assets and needs. Taken together, the information in these categories will provide a picture of the community. However, communities are dynamic and changing and so information will need to be added along the way. A community profile is not something that can be completed and then filed away. Explore all possible sources of secondary data first, but you may be required to collect additional information. It is important to note that community profile data obtained from governmental sources may not match the specific community that is being assessed. Further data may need to be collected, or the results of the existing profile should be used with caution when applying it to the community being assessed.

In addition to epidemiological and local community profiles, data about other individual and environmental-level factors impacting on a community need to be gathered in order to provide the most detailed picture of the community possible. Data about the individual people can include a range of social and economic factors.

Social and economic data about the people within a community help to construct a richer, more detailed picture of that community. Data may be gathered from national census data and broken down into regions, municipalities and suburbs. Data such as proportions of people in each age group, country of origin, cultural groups, religion, income, education, employment, housing status and use of public transport are examples of the information that is useful in helping to construct a picture of the community. State and local governments and community organisations may also have data about the community. For example, Community Indicators Victoria (CIV) measures wellbeing in the state of Victoria (Community Indicators Consortium, 2017). CIV provides a comprehensive framework of community wellbeing measured by local-level data. The wellbeing indicator data can be accessed through Wellbeing Reports, Live Reports or Data Maps. These reports are an example of the combination of secondary data from the ABS and Victorian State Government department sources and primary data from surveys conducted for this site. CIV enables municipalities to gauge the strengths and challenges facing their communities.

In addition to data about people, it is important to gather data about the various environments operating within the community, including the policy environment, physical (built and natural) environments, and social and cultural environments.

**Policy environment**

Policy documents often provide material from a combination of sources, particularly epidemiological data, social and economic indicators, and the views of professionals. They are developed with varying degrees of community consultation, depending on political will and timeframes. They are often used in rapid reviews and provide an overview or summary rather than systematically searching and critically analysing documents. It is important to note that policy documents are often reflective more of political priorities and processes than of the priorities of the community. The politically determined nature of these documents must be acknowledged. They need to be compared with local evidence of health and wellbeing priorities rather than be assumed to reflect the local picture. With recognition of these issues in mind, such documents can be useful sources of information and should be used wherever possible as one component of identifying needs. They are certainly useful for identifying funding priorities. It is worthwhile finding out about the process by which these documents were developed. Were they simply summarised from state and national documents, or were regional community assessments carried out? They may have been prepared without consulting the community members in the region. Their value may therefore be limited.
Built and natural environments

The physical environment in which people live strongly influences the way in which they can interact with each other. It also may be the source of some health problems for the community. A town that includes a number of dirty industries and is situated in a valley may face serious environmental pollution; a community may have little recreational space within its boundaries; or a suburb may be designed around the needs of cars, often resulting in lack of access to services for those who do not own cars. Evidence to support the importance of connection with nature is burgeoning (Cleary et al., 2017; Folke et al., 2016) and the potential for adverse environmental and ecosystem impacts on public health is increasing. An obvious example is the adverse socio-ecological impacts associated with extractive industries, which ‘range from environmental degradation to income inequality to structural violence and beyond’ (People’s Health Movement et al., 2014, p. 229). Another example, and to a lesser extent, is the provision of shade through the urban tree canopy which Cook and colleagues (2015, p. 7) argue is ‘critical to resilience, health, social equity, urban amenity and child-friendly cities in a warming world. Despite these benefits, tree cover remains uneven across metropolitan cities with those most vulnerable experiencing shade and cooling-deficits’. Community assessment processes can raise the issues for public concern and scrutiny, and prompt local action. Health impact assessments outlined in Chapters 3 and 9 are often used.

Social and cultural environments

The social environment of a community includes the social capital (the glue that binds people—see Chapter 2), social justice (see Chapter 2), social structures (organisations) operating within a community, the communication mechanisms used within the community, and the distribution of power and leadership within a community. The cultural environment includes the range of cultural groups and their respective cultural practices. It also includes the history of a community.

Organisations: Several organisations may operate and have influence in a community. Their presence and the role they play in the community could provide very useful information. Organisations can be classified under a number of categories, including local and state government bodies, industrial and commercial organisations, religious bodies, non-profit agencies and voluntary organisations. It is worthwhile finding out about the roles played by each of the organisations in the community and their relationships or partnerships. For example, is there a company that is the main employer? Is there a religious organisation that involves itself in a lot of community work?

Communication: Bajayo (2012) reports that communication is the most important resource for community resilience and further, that local and trusted communications systems best enable resilience. Knowing which mass communication methods are used in the community helps health practitioners understand the community in greater detail. For example, what radio and television stations are received in the area, and which stations seem to be listened to or viewed by which groups of people? Which newspapers are available locally? Is there a local newspaper? Several other effective communication options may also be operating. For example, are there community noticeboards that are well used? Do certain groups use blogs or Twitter? Are there community email networks or Facebook pages?

Power and leadership: Power and leadership can be both formal and informal, and an understanding of both is needed when health practitioners work with a community. Information of value here includes details about leaders of local political parties, local government and community groups as well as key influential people within those
organisations. It may also include information about people who seem to have a strong voice in influencing public debate or a particular organisation but who may not necessarily hold a current position of formal authority. All of these types of secondary data are important to gather in order to paint as detailed a picture of the community as possible, and to identify gaps where additional primary data may need to be gathered.

**Primary data sources**

As per the definition provided earlier, primary data provide new data directly from community members or by observation of the relationships between the system or subsystems within the community. Primary data can help to develop a deeper understanding of the secondary data, or to address gaps in the secondary data. However, it is vital that data gathering is purposeful and ethical.

A great deal of time and money has been spent and an enormous amount of information has been gathered from community members by researchers doing ‘data raids’; that is, gathering primary data without a clearly defined purpose in mind, and then making no use of the findings. Such processes are clearly unethical. Successful program outcomes and sustainability depend on community participation from the beginning. Participants in a potential program need to engage with the process and understand the outcomes. Community members may have many under-utilised and under-valued skills.

It is useful to use a conceptual framework such as the *Red Lotus Critical Health Promotion Model* to assist in the collection of primary data. There are qualitative and quantitative options for collecting primary data. It is important to have a basic understanding of each before conducting research to collect primary data in a community.

**Qualitative research approach**

A qualitative research approach is useful for exploring the ‘how?’ and ‘why?’ questions in the community, rather than the ‘how many?’ questions, which can often be answered from national and local census data and do not usually provide sufficient detail to be a basis for planning a community health promotion program. The aim of a qualitative research approach is to encapsulate the understandings, interpretations and experiences of community members in their everyday lives and environments (Denzin & Lincoln, 2011). A qualitative approach often involves face-to-face methods. There are a number of advantages and disadvantages of using a qualitative approach in community assessments. Some of the advantages include:

- People have a greater chance of defining and describing what is important to their health and wellbeing and why.
- It gives the researcher the opportunity to follow up on cues and explore priorities in detail.
- People are not forced to choose one way or the other—they are able to take a middle ground, or to put up options that have not been previously determined.
- People can begin to contribute to solutions and strategies.

Some of the disadvantages include:

- It is time-consuming and requires a skilled interviewer.
- Some people are unable or unwilling to share personal or private information with others.
- Anonymity cannot always be guaranteed.
The process may generate more questions than answers, or problems that cannot be managed by a proposed program, and therefore generate further community frustration.

Vocal participants can dominate.

It will not be practical to talk to all of the chosen community, so the aim is to canvass a broad range of opinion from all of the subgroups represented. Consider a data-gathering approach that will enable best access to as many people as possible, taking account of age, gender, ethnic or language background, employment status and area of residence. Informal networks as well as mass advertising may be the best way of recruiting participants from the various subgroups. Choose an acceptable and convenient location for the interviews or meetings. Prepare a broad interview protocol in advance, which will take only about half an hour. Keep the questions specific to the general theme of health, but be flexible enough to follow strong responses from participants. Use a planning model or theoretical framework (such as the Ottawa Charter) to develop the question framework. Pilot test the questions and then refine them. Have a research assistant or colleague ‘scribe’ the responses or record the session (with participants’ permission). Allow plenty of time to prepare the seating and facilities. Focus groups and public forums need skilled facilitators to ensure that all potential participants have the chance to be heard. Journal and record overall impressions and reflections after each session. Involve local community people as researchers, and ensure you provide them with the appropriate training and support.

**Preliminary consultations:** The first data-gathering process may be informal and its purpose is to determine the need for, and breadth of, a community assessment. The community may inform health practitioners of issues of concern to them, which may trigger informal information gathering to clarify the felt need. Conversations with other people such as concerned community members, police, teachers, medical practitioners, community workers, local government council staff and others may occur. These groups may contribute a great deal to the assessment of health and wellbeing priorities. In particular, other health practitioners may themselves have listened to community members or may have conducted formal community assessments in the past. Furthermore, several different practitioners may discuss a priority and each brings to it a slightly different perspective, based on individual experience and professional background. Similarly, they may each notice slightly different priorities in the same community. This can all be useful in gaining an understanding of the scope of health and wellbeing priorities facing the community.

**Community forum:** A community forum is a public meeting to which residents are invited to express their opinions about community priorities. It is important to have a semi-structured plan for the meeting, and to have strategies in place to enable participation from all people who attend, not just the most vocal.

**Focus groups:** A focus group is a group interview or discussion with a particular focus. The group is also focused because it has people or characteristics in common. These can be either face-to-face or via various online means such as Google Hangouts or Zoom. The group is encouraged to discuss issues of concern to them with a facilitator guiding the discussion to ensure all participants have an opportunity to express their views.

**Nominal group process:** This process is highly structured where five to seven representatives of a community (usually a subgroup) are asked to qualify and quantify specific priorities. Responses of the group are recorded for all participants to see without further discussion. The group is then asked to rank or order the responses by importance (McKenzie et al., 2013).

**Interviews:** Face-to-face or telephone interviews are conducted with members of the community. Participants may volunteer to take part or they may be identified because they
have some particular relevance to the future wellbeing of the community, its services and its people. Interviews may be conducted with subsections of the community, those who are affected by a particular issue, significant others, key informants or opinion leaders.

In the qualitative data-gathering options mentioned here, it is advisable to use a broad schedule of open questions and themes to guide discussion that prompts full responses, rather than narrow, closed questions that prompt monosyllabic responses (yes or no) and give no guidance for planning future strategies with the community. Consider using the WHO definition of health discussed in Chapter 1.

- What factors make it easier or more difficult for you to achieve good physical wellbeing in your community?
- What determinants make it easier or more difficult for you to achieve good emotional and mental wellbeing in your community?
- What factors make it easier or more difficult for you to achieve good social wellbeing in your community?

These three questions explored thoroughly and sensitively with a range of people in a community may be all that are needed to gain sufficient primary data to inform a health promotion program to build on their assets and address their health and wellbeing priorities.

**Observation:** Observation of the environment or people is another way of collecting data. These methods require the same attention to ethical standards as any other data collection method. Observations can be direct or indirect, obtrusive or unobtrusive. Individual or community behaviour can be observed. ‘Windshield tours or walk-throughs’ and photovoice can also be used to make assessments of the environment such as the types and condition of housing, recreational facilities, roads and the natural environment. Photovoice is a method of data collection where community members are provided with training and cameras to capture images of their community’s strengths and needs as they see them. The aim is to promote dialogue between community members, practitioners and policymakers about issues the community members have identified using images (Community Toolbox, n.d.; Minkler & Wallerstein, 2008; Wang, 1999).

**Analysing qualitative data:** Qualitative data are managed systematically using a four-step procedure.

1. Organising the data into a useable form, which may include collating notes and/or transcribing interviews.
2. Shaping the data, which means identifying key themes and categories. The interview schedule will be useful for this, but some data may fall outside what was anticipated by the questions.
3. Summarising the data by identifying the extremes of views or the range of opinion. All responses must be represented, but it is not appropriate to attempt to quantify the results.
4. Explaining what is meant by the data, consistent with the responses you have received.

In many approaches to qualitative research, researchers are advised to interrogate the data by exploring the transcripts line-by-line or paragraph-by-paragraph in a process of constant comparison with previously analysed text to draw out both similarities and disparities. The data are then explored further to establish whether or not there are relationships, patterns or interconnections between the concepts. Grbich (2007, p. 32) describes the process of managing the data as ‘block and file’ or ‘conceptual mapping or a combination of both’. Creswell (2003) describes a similar process of identifying specific segments of
information and labelling these to create categories. A process of reducing redundancy among the categories then occurs and a model is created that incorporates the most important categories. Computer software programs such as NVivo can be used to manage qualitative data. These programs are particularly useful in organising large sets of data.

This is a complex process requiring research expertise that is best obtained through practitioners gaining appropriate qualifications in research procedures or working with people who have expertise. Research skills are often limited in health promotion (Chambers et al., 2015). Wood and Leighton (2010, cited in Farmer et al., 2012) suggest that ‘third organisations’ in particular—that is, social enterprise organisations—are poorly equipped to conduct evaluation (which requires the same skill as community assessments), because there is a lack of skill, resources and time.

**Quantitative research approach**

A quantitative research approach is useful for exploring the ‘how many?’ and ‘amongst whom’ questions about a community. In epidemiology terms, these are referred to as the prevalence, incidence and distribution of issues. Examining distribution includes exploring how issues may differ across geographic areas, between different demographic groups, and over time. There are numerous methods used to collect quantitative data about communities, with the most common being the community survey.

**Survey:** Few communities are small enough for it to be possible to ask everyone to define their needs and assets. Therefore, often, a community survey will be conducted with a sample of people. Determining which people and how many to ask in order to obtain an appropriate sample is a key component of planning a survey, and requires the involvement of people with expertise in survey development.

Surveys are particularly useful to study ‘How often?’ or ‘How many?’ questions about assets and needs. A well-designed survey will enable the researcher to generate a large amount of data at the least cost. It is important to plan the survey process carefully to collect data that informs future planning. The terms survey and questionnaire are often used interchangeably; however, they are not the same thing. The survey is the overall method—to survey means to look over or across. Surveys can involve people surveys, environmental surveys, policy surveys, etc. The instrument used to collect data from people is most commonly a questionnaire. People may participate in a survey by completing a questionnaire. The questionnaire is often referred to as the survey instrument.

**Questionnaire design:** Designing a questionnaire requires a high level of planning and skill. Using a previously validated questionnaire whenever possible is therefore recommended. For instance, the SF-36™ Short Form Health Survey (Ware, 2000) is a 36-item questionnaire that provides a validated and very quick indicator of health status. It was developed to provide a general health survey that is ‘comprehensive and psychometrically sound, yet short enough to be for practical use in large scale studies’ (Stephenson, 1996). It covers themes such as physical, social and emotional functioning, role limitations due to health problems, vitality and general health perceptions. As a means of validating the instrument for use in Australia, standard norms for the Australian population have been derived from ABS census data.

If the questionnaire has not been previously validated, it is imperative to pilot test it to ensure the questions can be readily understood, that there is a logical sequence and questions do not lead the respondent into a certain response. As we have said, HRECs should not be asked to approve a questionnaire written by someone with no expertise in survey instrument design (Allen & Flack, 2015). Questionnaires can be distributed by mail, telephone, online tools or in person.
A multistep or Delphi technique may be used instead of a one-off questionnaire. In this approach participants are asked to make more than one contribution. The aim is to build consensus through a series of questionnaires. Broad questions are developed for the first questionnaire. The responses are analysed and the same participants are asked more specific questions in a second questionnaire, which are then analysed. This refinement of questions continues each round until consensus about priority issues is reached (McKenzie et al., 2013).

**Analysing quantitative data:** Quantitative data can be presented as frequencies of categorical data (such as what proportion of participants agree or strongly agree with a particular statement), or means and standard deviations of continuous data, such as the score on the SF-36™. These calculations can be made with readily accessible programs such as Microsoft Excel. Higher-level statistical analysis may be conducted to determine relationships between different factors. It may be necessary to recruit someone with higher-level skills in this area to assist with data analysis.

**Reporting the findings to the community**

Reporting the findings is an essential part of any community assessment, particularly to the people involved to ensure that the information obtained accurately reflects what people said. It will then enable community members to be involved in the priority-setting process discussed in the next section of this chapter. Responses should be presented in a succinct manner, with key findings in an Executive Summary. The report should be made available through a range of venues/forums, so that all people who took part in the data gathering have an opportunity to know of and discuss the results, and to take part in priority setting. Use the media options that will provide the best access, according to the characteristics of the community. Present the information in a format that makes the findings clear and which can be easily understood by all who participated—use tables, graphs, colours, quotes and plain language. Infographics are a common way to communicate research findings to a range of audiences. Unless appropriate probabilistic sampling techniques are used to recruit participants, the researcher must be cautious about making generalisations that apply to the whole community.

**Health practitioners’ relationships with community**

To conclude this stage, it is worthwhile examining the relationship between health practitioners and their communities. Sometimes practitioners suggest that, because they are a part of their community, there is little need to canvass community needs—what they themselves see as problems is an accurate reflection of community needs. However, although health practitioners may be members of a community, they cannot represent all groups in it, and in fact no one can. Because of their professional education and socialisation, health practitioners bring a particular perspective to health and wellbeing priorities. Certainly, this perspective is a valuable one that contributes much to the debate about health and wellbeing and health promotion. Nevertheless, it is only one perspective and cannot be substituted for the opinions of other community members. Therefore, while professional opinion offers a great deal, it cannot be assumed to reflect the views of the whole community or remove the need for listening to the community or checking external assessments of priorities.

Undertaking a comprehensive community assessment will enable the health practitioner to collect data from a broad range of primary and secondary sources about the community’s assets and needs. This is the foundation required for moving to the next stage of planning health promotion action.
STAGE 2: PLANNING THE HEALTH PROMOTION PROGRAM

The purpose of planning health promotion action is to devise a program that addresses the health and wellbeing priorities of a community identified in Stage 1 of the health promotion practice cycle (Fig. 4.1), within the available resources.

Separating priorities from solutions

Before designing the health promotion program, the community’s health and wellbeing priorities need to be separated from any prematurely proposed solutions. In presenting and analysing the findings of a community assessment, it is possible that the priorities will be expressed in terms of solutions to the priorities, rather than the priorities themselves. Often when this occurs, the assumption is that the solutions presented are the only mechanisms for addressing the priorities. The reason for this may stem from the way people interpret questions about their health and wellbeing assets and needs, which may lead them to think about a solution rather than the priority itself. You may need to ‘peel the onion’ to get to the deeper layer of understanding: ask what is the priority that leads them to this one solution?

It is very important to develop a vision of the priority as separate from any potential solutions, and so broaden the scope for addressing the priority by coming up with a range of possible solutions. This process is one in which community members and practitioners can think creatively together. It provides an excellent opportunity for consciousness-raising to occur. As people discuss the priorities in their community they may, layer-by-layer, be able to work their way through to alternative conceptualisations of them. This may broaden quite markedly the choices available in addressing those priorities.

Setting priorities for action

It is rarely the case that a community assessment identifies only one priority. Sometimes a number of priorities may be able to be dealt with together if they all share a similar root cause and you have recognised this in your analysis, but this will not always be the case. It will, therefore, be necessary to set some priorities, as it is rare to have the time or other resources to be able to deal with all the priorities at once.

How do you set priorities for action? Some people suggest that you deal with the easiest or most ‘winnable’ priorities first (e.g. Minkler, 1991), but there are some problems with this approach. The easiest priorities to deal with may not be the ones that make the biggest difference in people’s lives. The most difficult ones may well have the biggest impact if they are acted on successfully. Priority setting, done in partnership with community members and other organisations, is likely to be the most successful approach because of the community support for, and action on, any decisions made. Health practitioners need to be aware of complementary programs that already exist in the community, to avoid duplication, and at the same time they may ‘piggy-back’ strategies for added impact. Of course, there may be times when the health priorities are urgent and time for community involvement may be limited. Even then, maximum possible involvement by community members should be built into the decision making.

Priorities set by national health agencies or organisations can be taken up if they are identified as local health and wellbeing priorities. The advantage here is that if they are national priorities, it is more likely that funding will be available to support health promotion programs and health practitioners will be encouraged to take action in this area. Similarly, some areas may be included in the charter of the agency for which health practitioners
work, and so these may need to be addressed first. Furthermore, some priorities may be able to be dealt with first because the necessary expertise is available in the team with which you are working or because you have ready access to it. While it would be a mistake to build an agency’s work around the interests of the staff rather than the priorities of the community, acknowledging and working with the expertise of the staff and other available expertise is a valuable use of resources.

There are several questions worth asking about each identified priority in order to help to set priorities for action. The questions to consider could include the following.

- **Prevalence**: Is the priority widely experienced? How many people are affected?
- **Severity**: Does the priority cause major or minor problems? Is this a critical priority that should be addressed before other priorities? What will the consequences be if this priority is not addressed?
- **Selectivity**: Does the priority affect one group within the community more than another?
- **Amenability to health promotion action**: Are there known successful programs addressing this priority? How can this priority best be addressed? Is it likely to be affected by health promotion action? What programs are presently available to address the priority? Does the priority coincide with the organisation’s mission statement or policies? If not, why not? Can the organisation’s policies be influenced? What assets (funds, staff, connections, infrastructure, etc.) are available to address the priority? Which community members and other partners are most appropriate to work on these health and wellbeing priorities?

The answers to these questions will lead to the selection of one or more health and wellbeing priorities to address. For each priority, a comprehensive analysis must then be undertaken.

### Health and wellbeing priority determinants analysis

A health and wellbeing priority determinants analysis involves the identification of the range of socio-ecological health and wellbeing determinants that contribute to the health and wellbeing priority. One of the common frameworks used to categorise the determinants of a priority that are amendable to change involves identifying the predisposing, enabling and reinforcing determinants or factors (Green, 2005).

- **Predisposing factors**: a person’s or population’s knowledge, attitudes, beliefs, values and perceptions that facilitate (predispose towards) or hinder (predispose against) the capacity for change to people or environmental conditions.
- **Enabling factors**: people’s skills and resources and environmental conditions that facilitate (enable) or hinder (disable) the capacity for change. Facilities or community resources may be ample or inadequate; laws may be supportive or restrictive. Enabling factors thus include all the factors that make a change to people or environmental conditions possible.
- **Reinforcing factors**: the feedback received from others, the rewards, the punishments that result from a change to people or environmental conditions.

Knowing whether the factors are predisposing, enabling or reinforcing will guide the type of program that is ultimately developed. For example, will the program need to increase a community’s knowledge (predisposing factor) on a particular topic? Do policies (enabling factors) need to be developed in an organisation or municipality? Are there
community elders or other members who need to be engaged in the process of change (reinforcing factors)?

Fig. 4.3 provides an example of a health and wellbeing determinants analysis for the priority issue of exclusive breastfeeding until six months of age. The immediate determinants, and the contributing determinants—the factors that contribute to the immediate determinants—are identified across individual and environmental factors (see, for example, Rollins et al., 2016). Within this analysis, we can categorise factors as predisposing, enabling and reinforcing. For example, some of the factors in the analysis can be categorised as follows:

- **Predisposing**: mother’s intention to exclusively breastfeed, knowledge about the benefits, knowledge about good attachment, perception of adequate milk supply, confidence in feeding in public, knowledge of right to breastfeed in public
- **Enabling**: self-efficacy to breastfeed, antenatal information about normal sleeping and feeding patterns, access to lactation consultants, workplace policies for maternity leave and breastfeeding, limited exposure to advertising and promotion of infant formula through the media
- **Reinforcing**: infant issues well managed resulting in infant thriving, knowledge in the community about mothers’ rights to breastfeed in public.

The health and wellbeing priority issue analysis also identifies the priority populations for whom the health and wellbeing issue is a high priority, based on considerations of equity. In the breastfeeding example, the priority equity populations are Aboriginal and Torres Strait Islander women (Ogbo et al., 2016), women under 25 years of age (Baxter et al., 2009; Hauck et al., 2011; Meedya et al., 2010; Ogbo et al., 2016; Quinlivan et al., 2015), women living in rural areas (Hauck et al., 2011), women experiencing domestic violence (Ogbo et al., 2016).

**Developing the health promotion program plan**

The health promotion program plan includes goals, objectives, sub-objectives, strategies, activities and evaluation. (Use of the terms ‘goals’ and ‘aims’ varies across disciplines. In this book we use the term ‘goals’ for consistency.) The skills to develop all of these components for a health promotion program are an essential part of any health practitioner’s ‘toolkit’. Good goals, objectives and sub-objectives clearly define what changes the health promotion program aims to achieve. This provides the foundation on which the entire program is built. A solid foundation is essential to the development of appropriate strategies and activities that will be enacted in order to achieve the goals and objectives, and for developing the evaluation plan that will enable the health practitioner to evaluate if the program actually achieved what it set out to achieve. Fig. 4.4 (program logic) illustrates the relationship between goals, objectives, sub-objectives, strategies and evaluation. Program logic is underpinned by a theory of change. Fig. 4.5 provides a worked example of the development of a program goal, objectives and sub-objectives for the health priority of breastfeeding.

**Goals**

Goals express the changes in the health and wellbeing priority that the community wants to achieve. Sometimes these can be long term, depending on the nature of the priority. In the breastfeeding example, the priority issue is exclusive breastfeeding until six months
CHAPTER 4 HEALTH PROMOTION PRACTICE

Exclusive breastfeeding (BF) until 6 months

(Baxter et al., 2009; Hauck et al., 2011; Meedya et al., 2010; Ogbo et al., 2017; Quinlivan et al., 2015)

Immediate determinants

Individual: Mother’s intention to exclusively breastfeed
(Baxter et al., 2009; Meedya et al., 2010; Ogbo et al., 2017; Rollins et al., 2016)

Individual: High levels of knowledge about the benefits of breastfeeding
(Smith et al., 2018)

Environmental: Good quality antenatal information provided to mothers
(Rollins et al., 2016; Smith et al., 2018)

Environmental: Pain and discomfort experienced during BF is well managed
(Hauck et al., 2011)

Environmental: Mother’s perception of adequate milk supply
(Ogbo et al., 2017; Rollins et al., 2016)

Environmental: Mother returning to supportive work environment or capacity to delay returning to work
(Baxter et al., 2009; Rollins et al., 2016)

 Contributing determinants

Individual: High levels of knowledge about the benefits of breastfeeding
(Smith et al., 2018)

Environmental: Limited exposure to advertising and promotion of infant formula feeding through the media
(Atkins et al., 2009; Smith et al., 2018)

Environmental: Good quality postnatal support and information provided in hospital
Leaving hospital with adequate aftercare supports in place
Availability of human donor milk
(Rollins et al., 2016; Smith et al., 2018)

Environmental: Good quality antenatal education/provision of appropriate support provided e.g. routines, breastfeeding, expression, statement breastfeed policy (Baxter et al., 2009; Hauck et al., 2011; Ogbo et al., 2017; Quinlivan et al., 2015; Rollins et al., 2016)

Environmental: Easy and equitable access to lactation consultants or information on minimising pain/discomfort
(Hauck et al., 2011)

Environmental: High levels of knowledge in communities and among mothers of rights to BF in public
(Ogbo et al., 2017; Rollins et al., 2016)

Environmental: Supportive work environment (e.g. maternity leave, breastfeeding policy)
(Baxter et al., 2009; Rollins et al., 2016; Smith et al., 2018)

Environment: Mother returning to supportive work environment or capacity to delay returning to work
(Baxter et al., 2009)

Environmental: Supportive work environment (e.g. maternity leave, breastfeeding policy)
(Baxter et al., 2009; Rollins et al., 2016; Smith et al., 2018)

Equity populations: Aboriginal and Torres Strait Islander women (Ogbo et al., 2017), women under 25 years of age (Baxter et al., 2009, Hauck et al., 2011, Meedya et al., 2010, Ogbo et al., 2017, Quinlivan et al., 2015), women living in rural areas (Hauck et al., 2011), women experiencing domestic violence (Ogbo et al., 2017).

FIGURE 4.3 Health and wellbeing priority determinants analysis
of age. The goal developed to address this priority issue is to increase the rates of women exclusively breastfeeding for six months to 50% by 2025 (Smith et al., 2018).

Objectives and sub-objectives

Objectives state what must occur for the goal to be achieved. They address the determinants of the health and wellbeing priority identified in the analysis. Depending on the nature of the priority, they can also be expressed as learning objectives, action/behavioural objectives and environmental objectives. Objectives identify the type and degree of changes to the immediate determinants that are necessary to achieve the goal. Sub-objectives identify the type and degree of changes to the contributing determinants that are necessary to achieve the objectives. Writing goals, objectives and sub-objectives takes considerable time, research and practice to make them SMART, which means they should be:

- **Specific:** clearly state who is the focus, where the program will occur, and using terms that are able to be operationally defined
- **Measurable:** indicate what will change and the degree of change expected
- **Achievable:** ensure the degree of change is realistic and able to be achieved in the timeframe; refer to what other programs have managed to achieve as a reference
- **Relevant:** ensure that the goal is directly relevant to the health and wellbeing priority and the objectives are directly relevant to the determinants
- **Timescale:** state when the change is to be achieved.

In the breastfeeding example, one of the individual-level determinants that contributes to exclusive breastfeeding is the mother’s intention to exclusively breastfeed, which is influenced by her knowledge about the benefits of exclusive breastfeeding, and limited environmental exposure to advertising and media portraying infant formula as normal and easier than breastfeeding. The objective is therefore to increase to 60% the number of women who intend to exclusively breastfeed for six months by 2025. The sub-objectives to address the contributing determinants are to increase to 75% the number of women who can identify the major benefits of exclusive breastfeeding by 2020, and to decrease by 40% the number of advertisements for infant formula and media that portray formula feeding as normal and easier than breastfeeding by 2020. The program plan must identify what women it is referring to, where the program will be focused (e.g. local, regional, statewide or national), and the operational definitions of the constructs of exclusive breastfeeding, intention, knowledge and number of advertisements and media.
FIGURE 4.5 Goal objectives and sub-objectives

Timeframes and percentages are aspirational due to the lack of specified indicators in the Australian National Breastfeeding Strategy 2019 and Beyond.
It is important to note that one organisation’s goal can be another organisation’s objective. For example, the national government’s goal may be to reduce the incidence of suicide in young people and one of the objectives is to increase knowledge of the signs and symptoms of depression. There are many things that contribute to youth suicide, and in your town you may have identified a higher than normal incidence of depression and poor social support for marginalised youth. Rather than focusing your health promotion program goal on reducing suicide rates, your goal might be focused on reducing the incidence of depression in youth in your town. The program objective may be focused on increasing the social support networks for marginalised youth.

**Strategies and activities**

Once the program goal, objectives and sub-objectives have been established, a complementary mix of strategies to bring about the planned changes can be developed. This combination of strategies is referred to as a strategy portfolio. Strategies should be based on theories or models appropriate to the nature of the strategy. These will be explored further in the subsequent chapter on health promotion strategies. Health practitioners may be familiar with behaviour change theories, such as the social cognitive theory or the health belief model, but these are only applicable to developing personal skills. It is essential to seek out theories and models that can be used to build healthy public policy, create supportive environments, strengthen community action and reorient health services. In addition, a review of the literature is required to learn from the experience of others about what has worked in other similar programs. In this way, a portfolio of complementary theory-based and evidence-informed strategies and activities can be developed.

A useful framework for developing the strategy portfolio is the Ottawa Charter for Health Promotion (WHO, 1986). Achieving the goals, objectives and sub-objectives related to most health and wellbeing priorities will require building healthy public policy, creating supportive environments and strengthening community action. Some priorities will also require developing people’s personal skills and/or reorienting the health system towards a greater emphasis on health promotion. Activities may need to take place on different levels to address the health and wellbeing priority in the short term and longer term. For example, working for public policy change may take some time, but in the meantime people may need resources to strengthen the community capacity to address the priority. Each of these areas of health promotion action is underpinned by various theoretical frameworks and will be discussed in the following chapters.

In the youth suicide example above, where the goal is focused on reducing the incidence of depression in youth in your town, and one of the objectives is focused on increasing the social support networks for marginalised youth, you may decide that strengthening community action and creating supportive environments are the major strategies you will use to achieve this goal and objective. To strengthen community action, you may initiate an activity to develop a youth health Facebook page. Another activity may include engaging marginalised groups to develop this health page. To create a supportive social environment, your activities may include identifying potential youth facilitators from the marginalised group for the development of peer support programs in your town. All of these goals, objectives, strategies and activities contribute to addressing the nationally identified priority of reducing youth suicide rates, but at different levels to suit local conditions. Documenting the explicit logic of the program at the local level is just as important as at the national level.
Resources

An assessment of the resources available to implement the planned strategies and activities is required in the planning stage. Depending on the context of the health practitioner and the community, additional funding may be required to implement the program. Funding bodies usually provide very clear guidelines and it is important to read them carefully. Finding examples of successful applications from the funding body may be useful. Successful applications are the result of systematic program planning and careful budgeting. Part of the assessment is necessarily concerned with the organisational capabilities and resources for the development and implementation of the program. Limitations of resources, policies and abilities, and time constraints are investigated as part of the community assessment process. Resources for finding funding for community activities can be found at the end of this chapter. Funding proposals are generally expected to include the following sections.

Program summary

The program summary outlines very succinctly what will be done, why it will be done, how it will be done and who will be doing it; that is, the people for whom the program is designed. It outlines the health and wellbeing priority and the goal, objectives, sub-objectives, strategies, activities, evaluation and partners. This section is probably the most important part of the application. Busy reviewers will read the rest of the proposal if the summary provides a clear, organised overview.

Background

The background describes what the priority is and how that was determined. Evidence from the primary and secondary data sources is described.

Determinants of health and wellbeing

This describes the determinants of health and wellbeing for this particular priority.

Program goal, objectives and sub-objectives

This is a clear outline of the expected changes that will occur in the short and long term as a result of the program.

Implementation plan

The implementation plan outlines the program strategies and key activities, who will be involved, what resources will be needed and a tentative timetable.

Evaluation plan

The evaluation plan describes the process, impact and outcome evaluation. The plan should assess how effectively the program goal, objectives and sub-objectives have been met, and how process-related elements will be evaluated (refer back to the program logic diagram in Fig. 4.3). The section below on evaluation describes each of these in greater detail.

Program budget

The financial resources required to implement and evaluate the program are described in detail. Some funding agencies require applicants to also detail in-kind support that may be provided by the applicant’s own agencies and other collaborating organisations. This is the support that is not financial, but may include the allocation of human resources, space, time, communication technologies or any other type of support that contributes to
the program. Evidence of in-kind support from collaborating organisations is usually viewed very favourably by funding agencies.

**STAGE 3: IMPLEMENTING THE HEALTH PROMOTION PROGRAM**

Once the planning stage is complete, and resources are available, the health promotion program can begin. Implementation requires activation of the strategies and activities according to the plan, and keeping good documentation about what is being done. It is also important in the implementation stage to be aware of other opportunities that may arise related to the program, and to document any changes to the plan and the reasons why such changes may have occurred. Process evaluation (described in the next section) is undertaken in the implementation phase.

**STAGE 4: EVALUATING THE HEALTH PROMOTION PROGRAM**

Health promotion programs need to be fully evaluated. The theoretical frameworks used in community assessment, planning and implementation stages are also applied to health promotion program evaluation. Some of the important elements of evaluation applied to daily practice are described here and the importance of making evaluation itself a participatory, potentially empowering, experience for both health practitioners and community members is discussed in the following section.

**What is evaluation?**

Evaluation has been described as ‘the process by which we judge the value or worth of something’ (Suchman, 1967 in Hawe et al., 1990, p. 10). Evaluation is used to determine the strengths and weaknesses of an activity, program or system-wide plan. Evaluations can provide information about ‘what works, for whom, and under what circumstances’ (Baum et al., 2014, p. 1134). Evaluation may be as specific as determining the effectiveness of a particular learning aid or activity, or as general as gauging the effectiveness of a community-driven social activity. Evaluation allows us to identify inconsistencies that may exist between program goals or objectives and implementation processes.

**Why evaluate?**

Evaluation contributes to knowledge in a number of ways including: gaining a better understanding of the impact of health promotion action with individuals, communities or populations; improving an individual program; informing policy development; and being accountable to the funding body. Evaluation will almost always be a requirement of an organisation that funds the program and, quite reasonably, they want to know that their investment is making an improvement in the health of the particular population. Guba and Lincoln (1989) argue that evaluation is the process of sharing accountability, not assigning accountability. On one hand, health practitioners have a responsibility to the funding body to work in accordance with any reasonable demands made of them, while on the other hand, they have a responsibility to the individuals and communities they are working with.

Dual responsibility has implications for each health practitioner’s practice and the evaluation of the work of an agency. Whether working as a sole practitioner, in a team
within a larger institution or as part of a small agency or centre, a health practitioner will need to find out if their work addresses the health and wellbeing priorities of those to whom they are accountable. If health bureaucracies and employers uphold a CPHC approach, they are supportive of this primary responsibility and help health practitioners to respond to the priorities of the communities within which they work. Unfortunately, health bureaucracies in high-income countries are not often oriented to a CPHC approach (see Chapter 1), and health practitioners may often find themselves experiencing some difficulty as they attempt to grapple with their dual accountabilities to central planning agencies and communities. Evaluating against the values and principles of critical health promotion and the principles of CPHC on the one hand, and the sometimes-competing requirements of bureaucratic expectations on the other, may present some challenges. Some of the different and competing perspectives that may underpin a health practitioner’s decision about evaluation of a program include the following (Sarvela & McDermott, 2003):

Community’s perspective
- To learn about the value of planned change
- To increase community participation in a program
- To promote positive public relations
- To be accountable to the community

Health practitioner’s perspective
- To be clear whether program activities occurred as planned
- To determine whether the program achieved its objectives, and if not, why not
- To identify program elements that could be changed
- To inform planning of a new program or developing a comparable one
- To contribute to professional knowledge
- To identify areas for further research, or unmet community needs

Organisation’s perspective
- To decide if resources were well spent
- To be accountable, to meet accreditation requirements
- To inform future planning and allocation of resources
- To secure future funding by fulfilling funding body’s requirements

Funding body’s perspective
- To demonstrate program effects for political purposes
- To provide evidence for more program support
- To contribute to the evidence base

Evaluating practice can be a part of every working day. It can also be part of a more formal process in which health practitioners, either individually or as part of the team with which they are working, take time out every so often to formally review the activities with which they have been involved and the priorities they have been working towards. Building informal and formal evaluation into one’s practice will add greatly to the relevance and the power of health promotion work.

It is vital that health practitioners build knowledge and skills in both formal and informal evaluation, including critical reflection. This process involves developing a ‘culture of evaluation’ (Wadsworth, 1997, p. 57) and is an essential part of health promotion practice. Questions such as ‘What went well?’, ‘What would I do differently next time?’ and ‘What
else would I like to trial next time?’ are questions that can be asked as a matter of course at the end of each activity. Such questions can easily be asked by every health practitioner on a regular basis throughout their working day as well as at various stages throughout health promotion programs. Colin and Garrow (1996) describe this process as thinking, listening, looking, understanding and acting as you go along.

Who is the evaluation for?
Evaluation has been described as a ‘complex process of measurement and judgment which includes gathering and organising and interpreting information’ (Bedworth & Bedworth, 1992, p. 407). Judgements and interpretations can be based on different views of the world, by people or organisations holding contrasting values to those of the participants. The challenge is not to remove values from the evaluation process, but to ensure that the process reflects the values of the community as well as those of the health and/or funding agencies (Coombe in Minkler, 2012, Chapter 19) (see Insight 4.1). Community members or program participants are not the only people interested in the outcomes of health promotion evaluation. Funding bodies, managers and other practitioners may be keen to see a health promotion program evaluated, and their needs may be very different to those of community members participating in the program. So, despite the impression we are often given that evaluation is an objective process that will inform us of the ‘best’ way to proceed, it is clearly a process of judgement—and this judgement can never be value-free. We may describe evaluation by using such terms as ‘measurement’, ‘appraisal’, ‘assessment’ or ‘calculation’, but when we use terms such as these it is clear that the objects of interest are compared with some sort of standard or benchmark. Such baselines may be driven by competing values, such as cost control or prior political or organisational decisions to change services. Perceptions of successful outcomes can be time dependent, and influenced by political aspirations or perceptions (Farmer et al., 2012).

Evaluation is a value-driven process and in a CPHC approach it is the values of CPHC that drive the evaluation. That is, the needs of the people for whom the activity is carried out are foremost, as are issues of community control, social justice and equity.

Approaches to evaluation research
Evaluating any activity needs to be built around methods appropriate to health promotion action. A level of flexibility sufficient to respond to the needs of the people for whom it is being implemented needs to be maintained. Both qualitative and quantitative methods may be used, depending on the evaluation question. Each approach has strengths and limitations, although it seems that the primacy of the quantitative approach remains, particularly with many funding agencies. Certainly, quantitative approaches to evaluation can contribute significantly to evaluation processes when they are used appropriately and in balance with other approaches. However, they are often unable to provide the answers to questions regarded as important in health promotion, particularly to inform program refinement or redesign.

Planning for evaluation
An evaluation plan is integral to the health promotion practice cycle. Developing an evaluation plan ensures transparency, robustness, and clarity of purpose, which enable a program to be communicated to others (Farmer et al., 2012). Guiding principles include: having a clear process; being useful, relevant and practical; and using multiple and appropriate
data-collection methods. Evaluation findings need to be plausible; that is, they need to reflect the experience of all stakeholders, which means paying attention to power structures and politics. Leaving evaluation planning until after the program has been planned (or worse, after it has been implemented) means the impact or outcome of a program is difficult to demonstrate.

There are many perspectives that have to be incorporated at the planning stage. Health promotion programs are often complex with multiple components and expectations (Bauman & Nutbeam, 2014; Smith & Petticrew, 2010). Evaluations cannot be all things to all people and so evaluations conducted for different reasons can be conducted separately. Thinking through the implications of all these perspectives at the planning stage will mean that much of the information that is required by the different perspectives can be built into the implementation phase, making even formal evaluation for the managers or those funding a program easier than it might be if evaluation is regarded as an ‘add-on’ activity.

There are a number of steps that guide planning an evaluation:
- Identifying the purpose of the evaluation
- Formulating evaluation research questions related to the goals, objectives, sub-objectives, strategies and activities of the program
- Determining the most appropriate design for the evaluation including where and when the evaluation will take place
- Determining the most appropriate data-collection and analysis methods
- Considering the range of ethical issues related to evaluation research
- Clarifying the roles and responsibility of those involved in the evaluation
- Outlining how the results will be disseminated
- Costing the evaluation.

**Evaluation research ethics**

The four principles of ethical practice outlined in this chapter are integral to evaluation research: merit and integrity, justice, beneficence, and respect.

**Merit and integrity**

Applying the ethical principle of merit and integrity means that the evaluator must be competent and experienced, the evaluation study must be well designed and carefully planned, and the evaluation process, outcomes and benefits must be clear to all involved.

**Justice**

Enacting the ethical principle of justice means that the evaluation must be fair and inclusive, and no section of the population is excluded unfairly. This principle also means that it is unethical to expose one group of people to the risks of the evaluation solely for the benefit of another group, and provides special protections for vulnerable persons including children, pregnant women, prisoners, people with intellectual disability, people who are illiterate or have limited education and people with limited access to services.

**Beneficence**

The ethical principle of beneficence means that the evaluator is responsible for the physical, mental, social and spiritual wellbeing of participants, and all participants should receive
some benefit from the evaluation. It also means that the evaluation should do no harm to people participating in the evaluation, including harm to social standing or social relationships, psychological harm to mental or emotional wellbeing, financial harm, legal harm through exposure to legal proceedings, or physical harm to person or property. Harm may result from the data-collection process, or from a breach of privacy or confidentiality, which are described in the next section on respect.

Respect
Applying the ethical principle of respect in evaluation means treating people with dignity, respecting people’s rights to privacy and confidentiality, and ensuring fully informed and voluntary consent to participate in the evaluation study. Protecting privacy and ensuring confidentiality are key components of respecting the safety and dignity of evaluation participants. Privacy and confidentiality are similar concepts, and the terms are often used interchangeably, but they are different concepts and both need to be considered in any evaluation process.

Privacy relates to having control over the extent, timing and circumstances of sharing oneself with others. In other words, it relates to the methods used to gather information from participants. Evaluation methods that might pose concerns related to privacy include observational studies, focus groups, snowball sampling, intrusive or inappropriate questions in a questionnaire or interview, and knowledge about participation in a study on sensitive, stigmatising or illegal topics.

Confidentiality relates to the treatment of information that a participant has disclosed in a relationship of trust and with the expectation that it will not be divulged to others. It refers to the obligations of researchers and institutions to appropriately protect the information disclosed to them. Evaluation participants must be able to decide what measure of control over their personal information they are willing to relinquish to researchers. Protecting confidentiality does not mean that participants in an evaluation are not able to be identified or their information protected from disclosure. It means that the participant gets to decide that for themselves. Some participants want to be identified and quoted. Some agree to have their photographs, audio or video recordings published or otherwise made available to the public. The key consideration here is what participants provide informed consent for.

Ensuring confidentiality in the data-collection process is easiest if data are collected anonymously. However, if identity is required for follow-up purposes, then the evaluator should remove direct identifiers from the data set as soon as possible, use pseudonyms when reporting results, and/or only report aggregate results. After the data are collected, confidentiality must also be ensured through data protection. Decisions regarding where the data will be stored and for how long, what procedures will be in place to protect the data from inappropriate access, and who will have full access to the data all need to be carefully considered. Strategies for reducing breaches of confidentiality include encrypting the data, storing data on computers without an internet connection, ensuring computer and data files are password protected with different passwords, and data are stored in locked cabinets.

The final requirement of the ethical principle of respect is ensuring fully informed and voluntary consent to participate in the evaluation study. People must be provided with sufficient and understandable information about the evaluation to enable a fully informed decision about their participation. Information must be in the participants’ own language and at an appropriate comprehension level. The process of informed consent begins with recruitment and continues throughout the evaluation.
Evaluation challenges for health promotion

Health promotion work is often very difficult to evaluate because it can be long term, developmental and complex, and attributing the cause of changes to specific activities is often impossible. This is a serious challenge when funders interpret it as a problem of the work itself rather than the realities of evaluation research. Changes in systems and communities are non-linear and often unpredictable, and evaluation may not assess the wider ripple effects of a health promotion program.

Another challenge is that detailed evaluation of the effectiveness of programs is often beyond the scope of small organisations and more in the realm of special evaluation projects conducted by skilled research teams. Research shows that health promotion programs have not been well evaluated in Australia (Chambers et al., 2015; Jolley et al., 2007). Specific challenges in evaluating community-level health promotion programs include:

1. Methodological (choosing the appropriate and measurable unit of analysis)
2. Differentiating program effects from other trends
3. Identifying very small effects from community-level programs
4. The time it takes for any level of community penetration effect
5. The limitations of linking theory to the complexity of actions and levels of influence (Pommier, 2010 in Farmer et al., 2012, p. 146).

Evaluation of a health promotion program can also be influenced by influencers, fashion, dissemination routes and ‘tipping points’ (Farmer et al., 2012, p. 134). With increasing evaluation requirements placed on health practitioners, there is a great danger that short-term, simple (and potentially less useful) health promotion activities will be implemented because they are easier to evaluate and outcomes can be reported in a short timeframe, rather than more innovative, longer-term programs, which have the potential to make a much bigger difference to the socio-ecological determinants of health, but are more difficult to evaluate (Baum, 1999, p. 38). As a result, health practitioners may be so pressured to provide evaluation evidence that health promotion programs are developed to match the evaluation methods and short-term timeframes, rather than the other way around. ‘Too often the evaluation tail wags the program dog as health practitioners choose objectives amenable to evaluation’ (Freudenberg, 1984, p. 46). This may also have the effect of discouraging health practitioners from taking up innovative health promotion work because it may be difficult to evaluate. Underhill and colleagues (2016) provide insight into the learnings from the Healthy Together Mildura evaluation, and the difference made by applying systems thinking to their previous work. They support real-time feedback and adaptation, and evaluating with a focus on the whole rather than individual parts.

Evaluation in ‘high-risk’ and ‘low-risk’ programs

Health promotion is an investment package, balancing innovative but high-risk strategies (because definitive statements about outcome may not be possible) with more straightforward low-risk strategies on which evidence of effect is provided in the research literature (Hawe & Shiell, 1995). This portfolio approach is needed if health promotion is to address the range of socio-ecological determinants. For example, working to increase health equity and improve the health chances of poor or Indigenous people are the central goals of health promotion in Australia and New Zealand. Such goals require long-term commitment and resources. However, if outcome criteria revolve around whether or not a program is easily measurable, specific and achievable within a short funding cycle, a great deal of evaluation may occur, but it may do little in the long term to improve health.
Furthermore, evaluating programs beyond a reasonable level acts as a drain on the very limited resources available for health promotion. For those reasons, evaluation activities need to be critically reviewed and carefully considered so that inappropriate evaluation does not become part of the problem. The GoWell longitudinal research project in Glasgow, Scotland (Insight 4.2), and the Victorian Healthy Supermarket Trials (Insight 4.3), are examples of evaluations conducted by skilled researchers in collaboration with communities, with the aim of placing evaluation in a broad theoretical framework that links health determinants and program outcomes.

Cautions with evaluation

Failing to accurately indicate where the problems lie with a program can largely be avoided with thorough planning. After all, it is a significant waste of resources if health practitioners cannot be sure why a program works so well (or why it doesn’t). If a program is very successful, success should be shared with others, to save valuable resources and time, or to prevent them from making costly mistakes. There are two common pitfalls with evaluation.

**INSIGHT 4.2 GoWell**

The Glasgow Community Health and Wellbeing Research and Learning Program—GoWell—is a partnership between the Glasgow Centre for Population Health, the University of Glasgow’s Department of Urban Studies and the Medical Research Council and Chief Scientist Office (MRC/CSO) Social and Public Health Sciences Unit. GoWell is sponsored by the Glasgow Housing Association, the Scottish Government, NHS Health Scotland and NHS Greater Glasgow and Clyde.

GoWell investigates the impacts of investment in neighbourhood regeneration initiatives on the health and wellbeing of individuals, families and communities. Regeneration initiatives include:

- housing improvements
- transformational regeneration
- resident relocation
- the creation of mixed tenure communities
- changes in housing type (demolition of high-rise blocks and replacement with lower-rise flats and houses)
- community engagement and empowerment.

Launched in 2005, GoWell measures health and wellbeing before, during and after the implementation of these regeneration initiatives. The evaluation research includes a longitudinal community survey, qualitative research, ecological analysis and an economic evaluation. The evaluation findings are fed back into the planning and implementation process.

A range of outcomes has been reported across six themes:

- Communities
- Neighbourhoods
- Health and wellbeing
- Empowerment
- Housing
- Mixed tenure.

Source: https://www.gowellonline.com
1. Not sufficiently resourcing evaluation. It is better to do a thorough job of one form of evaluation, than to do a hasty, scant job of too many forms. Inadequate resourcing, in terms of time, personnel and funds, can mean either that the valuable aspects of a good program failed to be demonstrated, or you are unable to recognise where there may be issues of concern in a program.

2. Ignoring the results of the evaluation because of evaluation faults. A poorly planned evaluation may not identify the logical link between goal, objectives and strategies. Therefore, no matter how effective the activities or strategies are, the evaluation will never demonstrate achievement of an overly ambitious goal. Likewise, evaluation will fail to demonstrate that any form of activity has been effective if the program framework is based on an inadequate community assessment (Hawe et al., 1990).

**Types of evaluation**

There are various types of evaluation, and the choice of evaluation type depends on the purpose of the evaluation. Taking a systems approach to evaluation by integrating a range
of evaluation types should paint a relatively comprehensive picture of the health promotion action (Bauman & Nutbeam, 2014). Fig. 4.3 (program logic) earlier in the chapter shows the relationship between health and wellbeing priorities, their determinants and contributing determinants, the goals, objectives and sub-objectives of the program, and the types of evaluation linked to each. In addition to impact and outcome evaluation, there are a number of other types of evaluation for the health practitioner to consider.

**Organisational evaluation**

This evaluation occurs at the organisational level and assesses management practices; for example, quality assurance processes such as regular review of planning processes, accounting for the day-to-day use of funds or staff development processes. Evaluating the work of an agency or team is a vital process to prevent it wandering from its original goals or away from addressing the health and wellbeing priorities of the community. Informal evaluation can be incorporated into the normal work of the agency or team; for example, through discussion and reflection at weekly staff meetings. It will be necessary, however, for the agency or team to take time out to evaluate itself more formally and to involve the community in this process. This can be done by setting time aside specifically for evaluation and strategic planning. Although much of this can occur as a regular internal process, such as yearly evaluation and planning days, it can also be done by involving the agency or team in formal evaluation processes that include external evaluators. In these situations, however, care must be taken to ensure that the process is a supportive and useful one for the practitioners and community members concerned.

**Process evaluation**

Process evaluation is about evaluating the way in which health promotion strategies and activities are being implemented. Because of the centrality of process in the CPHC approach to health promotion, examination of the strategies and actions is particularly important. Furthermore, health promotion actions are often multifactorial and delivered in systems that are unpredictable so it is important to examine the progress, or the quality and quantity, of what was actually implemented in a program to understand what did or did not work and why. Hawe and colleagues (1990) recommend asking:

- Is the program or activity reaching the people for whom it was designed?
- What do the participants, staff and organisational partners think of the program or activity?
- Is the program or activity being implemented as planned?
- Are all aspects of the program of good quality?

The particular process elements important in a CPHC approach will also include the extent to which the direction of the program has changed in response to the needs of the participants, and evaluating the relationships between the organisational partnerships.

Evaluating how power was shared between health practitioners and participants—that is, what kind of participation occurred—may also be part of process evaluation. Process evaluation needs to show how populations facing the greatest inequality were engaged in a culturally and socially appropriate way.

**Impact evaluation**

In impact evaluation, the immediate effects of the program are assessed. The questions relate to whether the objectives and sub-objectives of the program have been achieved. The evaluation therefore relates to changes in the immediate and contributing determinants
of the health and wellbeing priority. In impact and outcome evaluation (discussed in the next section), quasi-experimental and non-experimental evaluation designs are often used as opposed to experimental designs. There are advantages and disadvantages of each evaluation design. Experimental designs use statistical methods, and randomisation of participants into control and program groups. The sample size is necessarily large to obtain statistical significance. There are strict protocols around the conduct of the research; the design therefore can be replicated. Experimental designs have traditionally been highly regarded but they are time-consuming and costly, and randomisation may discriminate against subgroups of the population. They are not necessarily the best design for participatory health promotion programs. In quasi-experimental designs, comparison groups are used rather than randomly assigned control groups. These evaluation designs can be rigorous and implemented relatively easily but they can also be costly. Pre-test/post-test designs are used in both quasi-experimental and non-experimental designs. Non-experimental designs do not use any comparison groups. They can be useful to obtain baseline data or data obtained at the end of a program. They are useful when the purpose is to understand the implementation process and are the least expensive option.

Outcome evaluation

Outcome evaluation assesses the long-term effects of the program. The questions relate to whether the goals of the program have been achieved. The evaluation therefore relates to changes in the health and wellbeing priority, and so it is often the type of evaluation conducted beyond the organisational level. Health departments usually measure health and wellbeing indicators. Evaluation designs for outcome evaluation are discussed in the previous section on impact evaluation.

Goal-free evaluation

Evaluation carried out by comparing results with goals and objectives is not a complete evaluation of a program’s outcomes because it does not provide an opportunity to note any outcomes that do not relate directly to the goals and objectives. These outcomes may either add greater benefit to the activity or undermine some of its other benefits. In either case, these unpredicted consequences are an important part of the program, and reliance solely on evaluation against goals and objectives would have caused them to be missed. For these reasons, some evaluation not directly linked to the goals and objectives is useful. This type of open-ended inquiry can be described as ‘goal-free evaluation’ (Wadsworth, 1997, p. 39). Wadsworth (1997) highlights the importance of conducting this type of evaluation before impact and outcome evaluation. This is because the process of measurement against goals and objectives is by definition constrained to the short- and long-term changes desired, and does not encourage creativity. Undertaking impact and outcome evaluations first may make it very difficult for people to think broadly and creatively. However, conducting open-ended inquiry first will not make it difficult to undertake impact and outcome evaluation, and in fact may help health practitioners evaluate goals and objectives themselves. Wadsworth (1997, pp. 48–49) suggests that the philosophical values that guide the development of an organisation may provide better guidance for an evaluation than the specific goals and objectives. This is because goals and objectives may not reflect the value base and long-term goals of the organisation, and the extent to which this has been implemented may in fact be the most important thing to evaluate.

The quality and appropriateness of the goals and objectives is critically important. The complexities of capturing what is happening in a community program also highlights the importance of writing SMART objectives which describe the quantitative impacts of
a program, as well as the more qualitative social impacts. Relying solely on goals and objectives that may not have been drawn up under optimum conditions severely limits the potential value of any evaluation. Further, sometimes the length of time it takes to realise outcomes, the cost of conducting robust evaluation and the changes in policies, structures and the community and unforeseen impacts make assessment of the process elements all the more important.

**Economic evaluation**

This type of evaluation is based on a cost–benefit analysis. Value for money is assessed and is assigned to the funding body. In this evaluation the resources consumed, such as time and money, are assessed as being efficient relative to the population served and outcomes achieved. For example, social return on investment (SROI) has been used internationally to evaluate the impact of programs, organisations, businesses or policies (Millar & Hall, 2013). The methodology assists to identify the benefits generated in the social, economic and physical environment and place a value on this impact. This value can then be compared to the investment required to generate the benefits. These evaluations are relatively complex and resource intensive (Farmer et al., 2012) but the same questions are asked, and similar processes occur, as for any other evaluation.

**Evaluating community participation and empowerment**

One of the key features of working with a CPHC approach is that the evaluation process actively involves the people for whom the program is running, building on their active involvement in the community assessment, planning and implementation of health promotion action. It is for this reason that participatory evaluation fits most comfortably with a CPHC approach—because it is built on the active involvement of community members in the evaluation process. There are four overarching dimensions of community participation that need to be examined in participatory evaluation (Baum, 2016; Coombe in Minkler, 2012, Chapter 19; Jolley et al., 2008; Wadsworth, 1997):

- the extent and scope of community participation
- the processes of working together
- the capacity and support for practitioners and community participants
- the impacts of participation.

Wadsworth points out that while non-participatory research may come up with useful outcomes, ‘a non-participatory, non-democratic process of evaluation cannot ensure a user-appropriate outcome’ (Wadsworth, 1997, p. 16). In addition to what is done to promote health, how it is done is very important and can have a positive or negative impact on the people as discussed previously. It is recognition of this, along with recognition of the expertise community members have about local factors that concern them, that is behind support for participatory evaluation. Drawing conclusions about a health promotion activity in a way that is disempowering will be of limited value for community members (Coombe in Minkler, 2012, Chapter 19).

In Chapter 6, the discussion centres on using community development approaches to support citizens increasing their abilities to control decisions that affect their community. A number of principles presented in that chapter can be used as the basis for formulating an evaluation plan. For example:

- the six principles of community development processes can be used to formulate objectives, and as the basis for impact evaluation discussions or in a community survey
the DARE criteria for reflecting on community empowerment through goal setting are a useful evaluation benchmark

the two principles of community development outcomes can be used to formulate a program goal, and as the basis for outcome evaluation.

As one of the essential characteristics of community development, community members would decide on the evaluation criteria or what they see as measures of success.

Community participation and empowerment are also indicators of individual and community wellbeing. Rifkin and colleagues (1988) suggested a means of evaluating the quality of community participation. The community identifies the various concepts or domains that they consider would be indicators of participation in their community. Rifkin and colleagues suggest these domains could be:

- the level of involvement in community assessments
- the degree to which community is heard and their opinions are valued in decision outcomes
- whether there is a reference group with a majority of community members, guiding the program
- whether existing organisations are included in new community processes; or
- whether program money is used to employ, increase the capacity of and improve the health of community members.

The domains can be imagined, for example, as a five-item Likert scale with a higher score being allocated to the most desirable or successful end of the scale. To improve the visual clarity and impact of the scoring process, the findings can be represented diagrammatically in the form of a spider’s web. Each domain forms an arm of the web. Lines are drawn between the average scores for each domain. The domains can be used for evaluation in different ways:

- members of a community or reference group can score each domain and the results can be compared between members
- reference group and management can score the domains and compare perspectives as a basis for discussion
- the scores from each group can be compared over time as a basis for tracking improvements in the effectiveness of participation
- the extent of participation and the different perceptions of the stakeholders about the degree of the participation can be mapped over time by overlaying the webs.

Laverack (2007) has drawn on the work of Rifkin and colleagues (1988) in his work describing community empowerment. He identifies that the spider’s web configuration can be created using readily available spreadsheet packages, such as Chart Wizard (see Fig. 4.6 as an example).

Evaluating partnerships

Health promotion is everyone’s business. Community health and wellbeing priorities are complex and require the perspectives and resources of many, particularly when we are applying systems thinking. Forming organisational partnerships to work towards common goals becomes essential and whether partnerships are working well can be evaluated. The extent of collaboration, whether there is genuine collaboration or whether there is a dominant person or organisation, are central questions. Other elements for consideration in
evaluating partnerships might be whether there is a common vision, whether trust is valued and given time to develop and whether the partners think the relationship is productive and enjoyable (Jolley et al., 2008). The outcomes of a successful partnership could be evaluated by considering whether there are more equitable, effective and accessible services or whether the population is experiencing an improvement in health status, wellbeing and quality of life (Jolley et al., 2008). Partnership logic models guides are available (see, for example, the Centers for Disease Control and Prevention (2011), the National Collaborating Centre for Methods and Tools (n.d.) and the VicHealth Partnership Tool (VicHealth, 2011)).

**Evaluation reports**

Having done the evaluation, it is then necessary to write the evaluation report. This helps health practitioners, organisations and funding bodies make decisions about the changes that need to be made to the program (if any). The evaluation report brings the community health and wellbeing priorities to the attention of others and promotes greater understanding. Individual, community or policy changes may take place as a result of disseminating the evaluation report. All stakeholders need to have access to the information, particularly those who designed the program or for whom the program was designed. In order that the evaluation report meets the needs of the widest possible audience, health practitioners must consider who the report is for and the most appropriate format. Different audiences have different expectations and you may need to develop more than one report. Research reports for funding agencies may have a template to follow. If not, there are numerous resources available to help you with different styles of report writing. In preparing the report you will need to think about the most appropriate length, language and visual presentation of results. In a written report, the executive summary is extremely important. It is often the only component of the report that the majority of the people will read; therefore it must summarise each section of the report. It is useful to think about the executive summary as a document in its own right. You will need to report on what has been done, why it was done, how it was done, what the outcomes were and how it contributes to best practice.

Finally you will need to consider how the report should be disseminated. You could conduct face-to-face presentations, provide printed materials, make a video, a series of social media posts, or develop a web page.
CONCLUSION

This chapter has described the health promotion practice cycle of community assessment, program planning, implementation and evaluation. Research evidence and skills form the basis of the ongoing cyclical process, which must be underpinned by the values and principles of critical health promotion. Models and theories underpinning the health promotion practice cycle inform all action areas of the Framework of health promotion practice in a comprehensive primary health care context. Community assessment incorporates assessment of both assets and needs and results in the identification of health and wellbeing priorities. Community assessment may be both a formal and an informal process, but it is only the first step to improving the health and wellbeing of community members; it is never an end in itself. Planning involves developing the goal, objectives, strategies, activities and evaluation plan, together with identifying the required resources to deliver the plan. Implementation involves implementing the strategies and activities and documenting the process. Evaluation involves putting the evaluation plan into place and is an integral component of good health promotion practice. All stages of the health promotion practice cycle should be transparent, and detailed documentation of processes and dissemination of evaluation findings are important to maintaining the credibility of health promotion.

MORE TO EXPLORE

PARTICIPATORY ACTION RESEARCH
- Power and glory: Applying participatory action research in public health (Baum, 2016)

COMMUNITY ASSESSMENT, PLANNING, IMPLEMENTATION AND EVALUATION TOOLS
- Community Health Assessment and Group Evaluation (CHANGE) action guide: building a foundation of knowledge to prioritise community needs (Centers for Disease Control and Prevention, 2010)
- Conducting a community needs assessment (Our Community, n.d.)
- Planning and Evaluation Wizard (PEW) (Flinders University, 2019)
- The Health Equity Assessment Tool: A user’s guide (Signal et al., 2008)
- Community Sustainability Engagement Evaluation Toolbox (Evaluation Toolbox, n.d.)

LITERATURE REVIEWS AND SECONDARY DATA SOURCES
- A typology of reviews: an analysis of 14 review types and associated methodologies. Review Article (Grant & Booth, 2009)
- The literature review: a research journey (Harvard Graduate School of Education, n.d.)
- PHIDU (Public Health Information Development Unit), Torrens University Australia (Torrens University Australia, n.d.)

PLANNING MODELS IN HEALTH PROMOTION
- The PRECEDE–PROCEED Model of health program planning and evaluation (Green, n.d.)
• Planning, implementing, and evaluating health promotion programs: a primer (McKenzie et al., 2013)
• Health promotion planning: planning and strategies (Tones & Green, 2010)

**EVALUATION (SEE REFERENCE LIST)**
• Bamberger et al. (2012)
• Bauman and Nutbeam (2014)
• Evaluation Toolbox (n.d.)
• Hawe et al. (1990)
• Patton (2011)
• Posavac (2011)
• Tones and Green (2010)
• Wadsworth (2010)

**ETHICS IN RESEARCH AND EVALUATION**
• National Statement on Ethical Conduct in Human Research, Preamble, Ethical background: National Health and Medical Research Council (2007, updated 2018a)
• National Statement on Ethical Conduct in Human Research, Section 1: Values and principles of ethical conduct (National Health and Medical Research Council, 2007, updated 2018b)

**RESOURCES FOR FINDING FUNDING FOR COMMUNITY ACTIVITIES**
Funding is available from local, state and national government and philanthropic sources. A number of resources are available to assist health practitioners to find funding, including the following.

• Our Community Pty Ltd (https://www.ourcommunity.com.au/community/) is a useful website that includes a publishing house and several knowledge and service hubs. It contains some good resources that can help community groups, individuals and businesses to find funding and write effective applications. Each organisation tends to use its own application proforma; small grants offered by local government and local service clubs are a good place to start.
• Philanthropy Australia (https://www.philanthropy.org.au/) provides a primary resource to identify the priorities of trusts and foundations and provide information about corporate funding available in Australia. Health organisations and public libraries often subscribe to this service. The application process and reporting expectations are often less daunting than public health agencies and services.

**IUHPE Core Competencies for Health Promotion**
The IUHPE Core Competencies for Health Promotion (International Union for Health Promotion and Education, 2016) comprises nine domains of action. Each domain has a series of core competency statements and a detailed outline of the knowledge and skills that contribute to competency in that domain.
The content of this chapter relates especially to the achievement of competency in the health promotion domains outlined below.

<table>
<thead>
<tr>
<th>1. Enable change</th>
<th>1. Use health promotion approaches which support empowerment, participation, partnership and equity to create environments and settings which promote health</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>Determinants of health and health inequities</td>
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<tr>
<td></td>
<td>Theory and practice of collaborative working including facilitation, negotiation, conflict resolution, mediation and teamwork</td>
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<tr>
<td></td>
<td>1.4 Facilitate the development of personal skills that will maintain and improve health</td>
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<tr>
<td></td>
<td>Health promotion models</td>
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<tr>
<td></td>
<td>1.5 Work in collaboration with key stakeholders to reorient health and other services to promote health and reduce health inequities</td>
</tr>
<tr>
<td></td>
<td>Knowledge of strategy and policy development and how legislation impacts on health</td>
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<tr>
<td></td>
<td>Partnership building and collaborative working</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>2. Advocate for health</th>
<th>2.5 Facilitate communities and groups to articulate their needs and advocate for the resources and capacities required for health promotion action</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>Methods of stakeholder engagement</td>
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<tr>
<td></td>
<td>Knowledge of strategy and policy development</td>
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<tr>
<th>3. Mediate through partnership</th>
<th>3.1 Engage partners from different sectors to actively contribute to health promotion action</th>
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<tbody>
<tr>
<td></td>
<td>Systems, structures and functions of different sectors, organisations and agencies</td>
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<tr>
<td></td>
<td>3.2 Facilitate effective partnership working which reflects health promotion values and principles</td>
</tr>
<tr>
<td></td>
<td>Principles of effective intersectoral partnership working</td>
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<td></td>
<td>Networking</td>
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<tr>
<th>4. Communication</th>
<th>4.1 Use effective communication skills including written, verbal, non-verbal, listening skills and information technology</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>Communication skills including written, verbal, non-verbal, listening skills and information technology</td>
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<tr>
<td></td>
<td>Working with individuals and groups</td>
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<td></td>
<td>Use of electronic media and information technology</td>
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<td></td>
<td>4.4 Use interpersonal communication and groupwork skills to facilitate individuals, groups, communities and organisations to improve health and reduce health inequities</td>
</tr>
<tr>
<td></td>
<td>Ability to work with individuals, groups, communities and organisations in diverse settings</td>
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</table>
| 5. Leadership                                                                 | 5.1 *Work with stakeholders to agree a shared vision and strategic direction for health promotion action*  
Principles of effective intersectoral partnership working |
| 5.5 *Contribute to mobilising and managing resources for health promotion action*  
Principles of effective human and financial resource management and mobilisation |
| 6. Assessment                                                                 | 6.1 *Use participatory methods to engage stakeholders in the assessment process*  
Ability to work with stakeholders from community groups/organisations |
| 6.2 *Use a variety of assessment methods including quantitative and qualitative research methods*  
Range of assessment methods/processes using both qualitative and quantitative methods |
| 6.3 *Collect, review and appraise relevant data, information and literature to inform health promotion action*  
How to obtain, review and interpret data or information  
Qualitative research methods including participatory and action research  
Quantitative research methods including statistical analysis  
Critical appraisal skills |
| 6.5 *Identify the health needs, existing assets and resources relevant to health promotion action*  
Evidence base for health promotion action and priority setting |
| 6.6 *Use culturally and ethically appropriate assessment approaches*  
Understanding social and cultural diversity |
| 6.7 *Identify priorities for health promotion action in partnership with stakeholders based on best available evidence and ethical values*  
How to obtain, review and interpret data or information |
| 7. Planning                                                                  | 7.1 *Mobilise, support and engage the participation of stakeholders in planning health promotion action*  
Use and effectiveness of current health promotion planning models and theories |
### 7.2 Use current models and systematic approaches for planning health promotion action
Principles of project/program management
Principles of resource management and risk management

### 7.3 Develop a feasible action plan within resource constraints and with reference to existing needs and assets
Use of health promotion planning models

### 7.4 Develop and communicate appropriate, realistic and measurable goals and objectives for health promotion action
Analysis and application of information about needs and assets
Use of project/program planning and management tools

### 8. Implementation

#### 8.1 Use ethical, empowering, culturally appropriate and participatory processes to implement health promotion action
Use of participatory implementation processes

#### 8.2 Develop, pilot and use appropriate resources and materials
Theory and practice of program implementation

#### 8.3 Manage the resources needed for effective implementation of planned action
Use of project/program management tools
Collaborative working

#### 8.4 Facilitate program sustainability and stakeholder ownership through ongoing consultation and collaboration
Use of participatory implementation processes

#### 8.5 Monitor the quality of the implementation process in relation to agreed goals and objectives for health promotion action
Quality assurance, monitoring and process evaluation

### 9. Evaluation and research

#### 9.1 Identify and use appropriate health promotion evaluation tools and research methods
Knowledge of different models of evaluation and research
Critical appraisal and review of literature
Write research reports and communicate research findings effectively and appropriately

#### 9.2 Integrate evaluation into the planning and implementation of all health promotion action
Formative and summative evaluation approaches
Qualitative and quantitative research methods
**Reflective Questions**

1. You have been assigned the task of leading a community assessment to identify the assets and needs of your local geographical community. Develop a plan for undertaking this task including the range of assets and needs you will need to collect data about, the sources for the different types of secondary and primary data needed, and your approach to working with the local community and stakeholders.

2. Using Fig. 4.5 ‘Goals, objectives and sub-objectives’, develop an outcome and impact evaluation plan to evaluate the goal and related objectives and sub-objectives.

3. Reflect on the *Red Critical Health Promotion Model* values and principles in Table 4.1. Identify which values and principles are most relevant to each stage of the health promotion practice cycle. Discuss the extent to which these values and principles are evident in health promotion initiatives that you are aware of.

**REFERENCES**


/PROMOTING HEALTH: THE PRIMARY HEALTH CARE APPROACH


