PROMOTING HEALTH

The Primary Health Care Approach

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JANE TAYLOR
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Elsevier Australia. ACN 001 002 357
(a division of Reed International Books Australia Pty Ltd)
Tower 2, Level 1, 475 – 495 Victoria Avenue, Chatswood NSW 2067

ISBN: 978-0-7295-4471-9

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National Library of Australia Cataloguing-in-Publication Data

A catalogue record for this book is available from the National Library of Australia

Content Strategist: Melinda McEvoy
Content Project Manager: Shubham Dixit
Edited by Margaret Trudgeon
Proofread by Tim Learner
Copyrights Coordinator: Rupa Rai
Cover Designer: Gopalakrishnan Venkatraman
Index by Innodata
Typeset by GW Tech
Printed in TBA

Last digit is the print number: 9 8 7 6 5 4 3 2 1

CONTENTS

PREFACE

Health and wellbeing are resources that enable people to live, learn, play, work, flourish and thrive. However, physical, mental, social and spiritual health and wellbeing are experienced unequally, and most of those differences are unfair or inequitable. Addressing the factors that contribute to such health and wellbeing, and health 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 international change. There is increasing awareness of the positive and negative impacts of social, cultural, economic, commercial, political, built and natural environments on the health and wellbeing of people and the world. The United Nations' Sustainable Development Goals include 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 made 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.

Acting on the socio-ecological determinants of health to enhance health and wellbeing, 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 seven editions. The book is underpinned by key principles of critical health promotion and comprehensive primary health care, including equity, social justice and community empowerment. 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.

At the beginning of each chapter, the relevant International Union for Health Promotion and Education (IUHPE) Core Competencies for Health Promotion are identified. The chapters conclude with questions for the health practitioner to consider for each action area of the Ottawa Charter for Health Promotion. Each chapter also presents reflective questions that may prompt personal reflection or guide group exploration.

We hope that *Promoting Health: The Primary Health Care Approach* (8th 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

INTRODUCTION

This eighth edition of *Promoting Health: The Primary Health Care Approach* affirms the use of critical health promotion within a comprehensive primary health care context, to address health and wellbeing priorities in local through to the global settings. The philosophy underpinning comprehensive primary health care (CPHC) remains as relevant now as when it was first endorsed by the World Health Organization (WHO) in 1978, and expressed within the Declaration of Alma-Ata (WHO 1978).

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 health services. Central to CPHC are principles to guide all actions to create health and wellbeing. These principles include social justice, equity, community empowerment and ecological sustainability, and the need to work with people to enable them to make decisions about the health and wellbeing priorities that are most important to them. Addressing the socio-ecological determinants of health and wellbeing requires sound health promotion knowledge and skills to plan, implement and evaluate health promotion programs.

Different terms are used to describe the workforce involved in health promotion. The term "health workers" is used extensively in the women's health movement, because it implies a more equal relationship between professionals and those they work with. The term "health promotion practitioner" is used to describe those whose primary role is to enhance health and wellbeing. These specialist practitioners require a full range of health promotion competencies and can be professionally accredited. 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, but who are undertaking health promotion activities within a wider field of practice.

Given their position within the health sector, health practitioners from a broad range of disciplines are well placed to undertake health promotion action with communities, and advocate for the consideration of health and wellbeing in policies and programs outside the health sector. As such, health practitioners can take a leadership role in the enhancement of health and wellbeing for priority populations. *Promoting Health: The Primary Health Care Approach* provides detailed practical guidance for health professions, students and health practitioners new to health promotion to develop the competencies essential for critical health promotion practice within a CPHC context.

HOW TO USE THIS BOOK

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.

Chapter 1

Chapter 1 establishes the foundations for health promotion practice within a comprehensive primary health care (CPHC) context. The chapter begins with key concepts related to defining health and wellbeing, the human right to health and wellbeing, and health equity and equality. Indicators of health and wellbeing status, and inequalities within and between countries, are examined. The chapter then discusses the role that CPHC and health promotion have played in improving the health and wellbeing of populations, global health promotion actions to improve health and wellbeing, health equity and the health promotion competencies required for health promotion practice. A framework that health practitioners can use to guide their health promotion practice within a CPHC context is presented. The first row of this framework includes the action areas of the Ottawa Charter for Health Promotion (WHO 1986), which also provides the framework for chapters 5 to 9. Finally, the chapter includes a description of health promotion models, including the Red Lotus Critical Health Promotion Model developed by the authors of this book.

Chapter 2

Chapter 2 explores various socio-ecological health and wellbeing models that elucidate the broad range of interrelated socio-ecological determinants of health and wellbeing, and provides some examples of using the models to explore the determinants of specific health and wellbeing priorities. The chapter then describes individual-level socio-ecological determinants of health and wellbeing, including biological, socio-economic, cognitive and affective factors, and behaviours. Following this, the environmental-level socio-ecological determinants of health and wellbeing, including the social, cultural, political, economic, commercial, built and natural environments, are described.

Chapter 3

Building on the introduction to the natural environment in the previous chapter, Chapter 3 explores ecological sustainability as a process and outcome. Concepts such as climate change, extreme weather events, rising temperatures, water resources, air quality and food security are explored, and the planetary boundaries and global responses to ecological sustainability are discussed. The chapter then explores the impacts of ecological sustainability on health and wellbeing, and identifies opportunities for local-level health promotion action for ecological sustainability.

Chapter 4

Chapter 4 describes the health promotion practice cycle that consists of community assessment program planning, implementation and evaluation. Using the health promotion practice cycle facilitates a systematic, evidence-based approach to practice. The chapter describes the process required to plan a comprehensive health and wellbeing community assessment, and from this, identify health and wellbeing priority issues and their socio-ecological determinants. The chapter then explores the planning stage, in which health practitioners work with priority populations to develop an evidence-based health promotion program plan that includes SMART goals, objectives and sub-objectives, a portfolio of health promotion strategies to address the priority issues and a plan for evaluation. Processes for the implementation of the plan are then explored. Finally, the chapter describes the mechanisms for selecting and using appropriate data collection and analysis methods and tools to evaluate the short-term impact of the strategies on the determinants of the health

and wellbeing priority being addressed, and the long-term outcome(s) on the health and wellbeing priority.

Chapter 5

Chapter 5 examines the Ottawa Charter health promotion action areas of developing healthy public policy and creating environments and settings that support health and wellbeing. The chapter first describes healthy public policy, and the role of building healthy public policy to create environments and settings that support health and wellbeing. The chapter then describes the "Health in All Policies" approach to creating healthy public policy endorsed by the WHO through the many global health promotion charters and declarations. The policymaking process and levels of policy are described, with tobacco control presented as a case example of healthy public policy from global through to local levels. The skills and processes used to advocate for healthy public policy are then presented. The chapter then describes a range of health promoting settings to create supportive environments for health and wellbeing, including cities, municipalities, schools, workplaces, sporting organisations, universities and colleges. Finally, the chapter discusses the importance of intersectoral collaboration and partnerships to support health promotion action to address the socio-ecological determinants of health and wellbeing.

Chapter 6

Chapter 6 explores the Ottawa Charter action area of strengthening community action through the strategy of community development as part of health promotion programs. The chapter begins by describing the philosophy and core values of community development and then explains the role of community development strategies in a health promotion program. Models for community development practice are compared and contrasted, and community development roles, skills and attributes are described. The role of social entrepreneurship in community development is explored. The chapter then describes the evaluation of community development strategies, and finally discusses the challenges for community development practice.

Chapter 7

The Ottawa Charter action area of developing personal skills is explored in Chapters 7 and 8. In Chapter 7, the focus is on developing personal skills through the strategy of health education. The chapter describes the role of health literacy as a determinant of health and wellbeing, and the role of health education in the development of health literacy. Behaviour change theories and models are compared and contrasted, and learning and teaching theories and adult learning principles are described. The chapter then focuses on the development of appropriate teaching–learning activities for health education action, and the processes for working with different types of groups.

Chapter 8

Chapter 8 focuses on the Ottawa Charter action area of developing personal skills through the strategy of social marketing. The chapter describes the role of social marketing in comprehensive health promotion programs and explores the ethical issues associated with social marketing. The steps of social marketing and the strategies that can be used to engage mass and social media in a social marketing campaign are then explored. The

chapter then describes the key requirements of health communication materials to be used in a social marketing campaign.

Chapter 9

Chapter 9 is focused on the Ottawa Charter action area of reorienting health services. The chapter describes a health settings approach, including Health Promoting Hospitals and Global Green and Healthy Hospitals. Vaccination is then addressed as an example of a topic that most health services are involved with, and so can use as a vehicle to reorient their services. This section describes disparities in vaccination rates, vaccination policy, barriers to and enablers of vaccination, and local level vaccination program delivery. The chapter then describes the principles of population level screening, and strategies to maximise participation in screening programs. Individual risk factor assessment and its role in comprehensive health promotion programs are explored, followed by a risk assessment of local environments, including the different forms and processes of health impact assessment. Finally, the chapter describes the role of public health surveillance in informing health promotion action.

Critical reflection

Questions for critical reflection are included in each chapter of *Promoting Health: The Primary Health Care Approach*. These have been designed to encourage active and self-directed learning and to assist educators with class discussions. An answer guide to all reflective questions is available to educators on the Evolve website, which accompanies the book. Short quizzes for each chapter are also available to educators on the Evolve website.

Promoting Health assists students and health practitioners to develop an introductory-level understanding of core knowledge, values, attitudes and skills essential for health promotion practice. The International Union for Health Promotion and Education (IUHPE) health promotion competency statements included at the beginning of each chapter relate to the content of that chapter.

From Chapter 2 onwards, additional reflective questions related to the action areas of the Ottawa Charter appear after the conclusion of the chapter. The use of the Ottawa Charter assists the health practitioner in thinking broadly and strategically about practice challenges, and reflecting on and critiquing their professional role and the health promotion philosophy of their organisation.

We hope you find Promoting Health to be a valuable and practical resource for developing the knowledge and skills required to undertake critical health promotion action within a comprehensive primary health care context.

REFERENCES

International Union for Health Promotion and Education (IUHPE) (2016). The IUHPE Health Promotion Accreditation System. Available at: www.iuhpe.org/index.php/en/the-accreditation-system

World Health Organization (WHO) (1986). The Ottawa Charter for health promotion. Available at: www.who.int/healthpromotion/conferences/previous/ottawa/en/

World Health Organization (WHO) (1978). Declaration of Alma-Ata. Available at: www.who.int/teams/social-determinants-of-health/declaration-of-alma-ata#:~:text=The%20Alma%2DAta%20Declaration%20of,goal%20of%20Health%20for%20All

ACKNOWLEDGEMENTS

We acknowledge First Nations peoples as the Traditional Custodians of the lands on which we were born, live and work, and recognise their ongoing connection to land, waters and culture. We celebrate Aboriginal, Torres Strait Islander and Māori peoples' strength, resilience and capacity, and pay our respects to Elders past and present.

In completing this eighth edition of *Promoting Health: The Primary Health Care Approach*, we would like to thank the following people. We acknowledge the work and contributions of previous author, Andrea Wass, who wrote the first and second editions, and Lyn Talbot and Glenda Verrinder, who assumed authorship for editions three through to six. We joined the authorship team with Lyn and Glenda for the seventh edition, and have authored this eighth edition.

We also extend our thanks to the students and practitioners who have contributed to the discussion and refinement of many ideas presented in this book, and participated in "field testing" some of the material. Thanks are also extended to colleagues and practitioners who have provided case examples drawn from their practice.

Finally, we would like to thank Melinda McEvoy from Elsevier and Shubham Dixit for their support throughout the process.

ABOUT THE AUTHORS

Jane Taylor is a public health academic at the University of the Sunshine Coast, Queensland. With over 30 years of experience as a health promotion professional and educator, she has worked in various capacities, including as a health promotion practitioner in community and government sectors. Her work has encompassed a range of community-based health promotion programs, focusing on areas such as women's health, Aboriginal and Torres Strait Islander health, school health promotion and public health service delivery in rural and remote Queensland, before joining the University of the Sunshine Coast in 2004, where she is the Public Health Discipline Lead in the School of Health. Jane leads a dynamic team of public health academics specialising in health promotion, environmental health, epidemiology, Aboriginal and Torres Strait Islander health and wellbeing and health economics. Her expertise in critical health promotion and public health education is reflected in her teaching of health promotion courses at both undergraduate and postgraduate levels, as well as her leadership in health professions education research. Jane's research focuses on strengthening the theoretical foundations of health promotion to support a critical (social justice and equity focused) practice approach. This involves using critical health promotion values and principles to design, implement, evaluate and critique health promotion policies and programs, and undertake research. She is also interested in the role of health promotion in reorienting health services to deliver comprehensive primary health care and health promotion workforce development.

Lily O'Hara is a public health academic at Griffith University in Queensland. Lily is a public health and health promotion educator and practitioner with over 30 years of experience in Australia, United Arab Emirates and Qatar. She has worked in health promotion practice roles with Queensland Health, Cancer Council Queensland, a multi-national pharmaceutical company, a small private health promotion company and the Department of Health in Abu Dhabi, UAE, on community, workplace, school and health service-based programs, addressing various health and wellbeing issues. She is a former national president and a Life Member of the Australian Health Promotion Association. Lily has worked in academic positions at the University of the Sunshine Coast, Queensland University of Technology, Emirates College for Advanced Education, Abu Dhabi University and Qatar University, teaching public health, health promotion and a wide range of other courses. Lily's research focuses on analysing public health approaches to body weight and their inequitable impact on people with larger bodies, and developing and evaluating ethical, evidence-based, salutogenic health promotion initiatives for body liberation using the social justice-based Health at Every Size approach. Lily's research also focuses on developing the ethical and technical competencies of the health promotion workforce. She is the co-author with Jane Taylor of the Red Lotus Critical Health Promotion Model and the Quality Assessment Tool for Critical Health Promotion Practice (QATCHEPP).

GLOSSARY

advocacy for health a combination of individual and social actions designed to gain political commitment, policy support, social acceptance and systems support for a particular health goal or program (Nutbeam & Muscat 2021).

capacity building the development of knowledge, skills, commitment, partnerships, structures, systems and leadership to enable effective health promotion actions (Nutbeam & Muscat 2021).

climate change the long-term shifts in temperatures and weather patterns (United Nations n.d.).

commercial determinants the strategies and approaches used by the private sector to promote products and services that have an impact on health (Nutbeam & Muscat 2021).

community social systems comprising people with shared characteristics or factors such as geography, age, culture, identity, sexuality, ethnicity, religion, occupation, workplace, social activism, sport or leisure interests.

community assessment the first stage in the health promotion practice cycle; involves gathering existing and new evidence to determine the health and wellbeing assets, needs and priorities of a community as a foundation for planning health promotion action.

community assets the combination of resources and capabilities that exist within communities including knowledge, skills, physical and service resources and infrastructure, social capital etc.

community development the process of facilitating the development of a community's skills and abilities to improve the conditions that affect their health and wellbeing. It often involves working with the community to identify priority issues and supporting actions to address these priority issues.

comprehensive primary health care (CPHC) a developmental process where the principles of equity, social justice and empowerment underpin the work for socio-ecological changes necessary to improve health and wellbeing.

contributing factor any aspect of behaviour, society or the environment, or anything that contributes to a risk or protective factor for a health issue (e.g. lack of access to condoms is a contributing factor for unprotected sex, which is a risk factor for contracting HIV). Contributing factors can be categorised as *predisposing*, *enabling* or *reinforcing* risk or protective factors.

critical health promotion a social justice approach to health promotion that is underpinned by a system of values and related principles that support the reflective process of explicitly identifying and challenging dominant social structures and discourses that privilege the interests of the powerful and contribute to health and wellbeing inequities (O'Hara & Taylor 2023).

critical health promotion values and principles a system of values and related principles that characterise critical health promotion practice. Critical health promotion values include priority population determined by structural inequity; the holistic health paradigm;

the salutogenic approach; systems science; the assumption that people are doing the best for their wellbeing; practitioners working with people as allies; empowering engagement processes; comprehensive use of theories, models and evidence; maximum beneficence; and non-maleficence as a priority consideration (O'Hara & Taylor 2023).

disease prevention includes actions to reduce the occurrence of risk factors for disease (primary prevention), detect the early presence of disease, often before it is symptomatic (secondary prevention), and reduce the consequences of disease once it is already established (tertiary prevention) (Nutbeam & Muscat 2021).

ecological science as applied in critical health promotion, is the application of systems theory and, therefore, recognition that people exist in multiple ecosystems, which are comprised of social, cultural, political, economic, commercial, built and natural environments; these ecosystems operate at all levels from the individual to the family, group, community, population, and planetary levels; all parts within these ecosystems impact on each other; and the whole of any ecosystem is greater than the sum of its parts (Gregg & O'Hara 2007).

ecological sustainability both a process and an outcome; a process of change that improves the long-term health of humans and ecological systems (Talbot & Verrinder 2018).

empowerment a social action process that promotes participation of people, organisations and communities towards the goal of increased individual and community control, political efficacy, improved quality of community life and social justice.

enabling taking action in partnership with individuals or communities to empower them through the mobilisation of community and material resources, to promote and protect health and wellbeing (Nutbeam & Muscat 2021).

epidemiology the study of the distribution, patterns and determinants of health and wellbeing in specified populations, and the application of epidemiological evidence to improving health outcomes.

equality the state of being equal in status, rights, opportunities, respect and consideration, regardless of differences in ethnicity, gender, age, religion, sexuality, body size, physical or intellectual ability, neurology, socioeconomic status, etc.

evaluation the process by which the worth or value of something is determined. In health promotion, this involves the systematic assessment of health promotion programs or policies to determine their effectiveness, efficiency, impact and outcome (Bauman & Nutbeam 2023).

global health achieving health equity at a global level by addressing the socio-ecological determinants of health and wellbeing, including those at a transnational level (Nutbeam & Muscat 2021).

health a state of physical, mental, social and spiritual wellbeing, and not merely the absence of disease or infirmity. Health is a resource for everyday life, not the object of living. It is a positive concept emphasising social and personal resources, as well as physical capabilities. Health is determined by the relationship between individuals and the environments in which they live, work and play (Nutbeam & Muscat 2021).

health communication use of interpersonal, digital and other media strategies to deliver credible and trusted information that is accessible, understandable and actionable for the intended audience to improve health and wellbeing (Nutbeam & Muscat 2021).

health education any combination of purposeful learning experiences to increase knowledge, health literacy and skills that enable action to address the determinants of health and wellbeing, and adapt to changing circumstances.

health equity everyone has fair opportunities to attain their full health and wellbeing potential, and no one is be disadvantaged from achieving this potential (Nutbeam & Muscat 2021).

health impact assessment a combination of procedures, methods and tools by which a policy, program, product or service is assessed for its impact on the health and wellbeing of the population, and distribution of impacts within a population.

health literacy the cognitive and social skills that enable people to access, understand and use information for health and wellbeing.

health outcome a change in the health status of an individual, group or population, which is attributable to a planned health promotion program.

health policy a formal statement or procedure within institutions or organisations that defines priorities and the parameters for action, in response to health priorities and available resources (Nutbeam & Muscat 2021).

health promotion competencies a combination of the essential knowledge, abilities, skills and values necessary for the practice of health promotion (adapted from Shilton et al 2001). Core competencies are defined as "the minimum set of competencies that constitute a common baseline for all health promotion roles"; that is, they are what all health promotion practitioners are expected to be capable of doing to work efficiently, effectively and appropriately in the field (Australian Health Promotion Association 2009).

health promotion practice work that reflects health promotion, as defined in the Ottawa Charter, and successive charters and declarations to promote health and wellbeing, and reduce health inequities.

health promotion practitioner a person who works to promote health and wellbeing, and reduce health inequities using the actions described by the Ottawa Charter, and successive charters and declarations to promote health and reduce health inequities.

health promotion setting the place or social context in which people engage in daily activities where environmental, organisational and personal factors interact to affect health and wellbeing (WHO 2024).

healthy public policy any form of legislation, standard of practice, code, bylaw or policy that contributes to health and wellbeing and health equity. The aim of building healthy public policy is to create supportive social, cultural, economic, commercial, political, natural and built environments that enable people to live well and thrive.

holistic health considers the complete person, addressing the interconnected social, spiritual, mental, physical and environmental aspects of wellbeing.

impact evaluation evaluates the immediate effects of the program, which corresponds to the measurement of program *objectives* and any unintended effects.

intersectoral action involves different sectors working together to take action on health and wellbeing priorities that is more effective, efficient and sustainable than can be achieved by the health sector acting alone (Nutbeam & Muscat 2021).

mediation a process through which the different interests (personal, social, economic) of individuals and communities, and different sectors (public and private) are reconciled in ways that promote and protect health (Nutbeam & Muscat 2021).

need *health needs* are those states, conditions or factors in the community which, if absent, prevent people from achieving optimum physical, mental, social and spiritual health and wellbeing, such as basic health services, information, a safe physical environment, good food, housing, productive work, and a network of emotionally supportive and stimulating relationships.

needs assessment part of the community assessment process.

neoliberalism an economic and political ideology advocating free-market capitalism, deregulation and liberalisation of trade and investment, reduction in government spending, privatisation of state enterprises, and the shift towards individual entrepreneurship and personal responsibility over collective welfare.

objective the desired measurable impact of a health promotion program on the determinants of health and wellbeing.

outcome evaluation assesses the extent to which a health promotion program has achieved its goal, and any unintended outcomes.

planetary boundaries quantified boundaries determined by scientists within which humanity can continue to develop and thrive for generations to come. Boundaries have been developed for climate change, biosphere integrity, land system change, freshwater change, biogeochemical flows (nitrogen and phosphorus cycles), atmospheric aerosol loading, ocean acidification, stratospheric ozone depletion and novel entities (Stockholm Resilience Centre 2023).

predisposing factor any characteristic of an individual, community or environment that increases the likelihood of a health outcome, but does not directly cause it, such as genetics, behaviours and socio-economic resources.

primary health care an approach to health care that includes health promotion, disease risk reduction, treatment, management, rehabilitation and palliative care, to meet the essential health and wellbeing needs of people across the life span.

process evaluation assesses the strategies and activities of the health promotion program, specifically program exposure, participant satisfaction, fidelity and implementation of program activities, quality of materials or other strategy components, and contextual factors.

program a coherent set of goals, objectives, strategies and related activities, carried out with a community for the purpose of improving their health and wellbeing. A health promotion program is planned in response to an identified health and wellbeing priority, and is based on scientific theory and evidence of effectiveness.

program evaluation assessment of health promotion program efficacy and effectiveness to determine the quality of a program and the degree to which it achieves its goal/s and objectives.

program goal the desired long-term outcome/s of a health promotion program that states the measurable improvements in health and wellbeing status and/or the determinants of health and wellbeing.

program planning the second step in the health promotion practice cycle, following community assessment. The process of articulating what you are trying to achieve with your program, why you are doing it and how you will go about it. Includes setting goals and objectives, selecting strategies, designing activities and developing the evaluation plan.

public health an organised activity of society to promote, protect, improve and, when necessary, restore the health of individuals, specified groups or the entire population. It is a combination of sciences, skills and values that function through collective societal activities and involve programs, services and institutions, aimed at protecting and improving the health of all the people (Nutbeam & Muscat 2021).

quality of life the perception of individuals of position in life in relation to their health, wellbeing, happiness and fulfillment.

reinforcing factor any factor that supports or reinforces an action that contributes to health and wellbeing.

salutogenic approach emphasises a focus on those factors that create and support holistic health and wellbeing, happiness and meaning in life (Gregg & O'Hara 2007).

social capital the networks, norms, relationships and trust that enable communication, cooperation, resilience and cohesiveness within communities.

social marketing the application of commercial marketing techniques to the analysis, planning, implementation and evaluation of health promotion programs.

socio-ecological determinants of health the individual and environmental factors which determine the health and wellbeing status of individuals or populations, and the dynamic interactions between them.

strategy portfolio the planned combination of actions to bring about desired changes in the determinants and contributing determinants of health and wellbeing. The action areas included in the Ottawa Charter used to develop a strategy portfolio include: building healthy public policy, creating supportive environments, strengthening community action, developing personal skills and reorienting health services (WHO 1986).

supportive environments for health social, cultural, economic, commercial, political, digital, natural and built environments where people live, learn, work and play that positively influence health and wellbeing.

sustainable development development that meets the needs of the present without compromising the ability of future generations to meet their own needs (United Nations 1987).

wellbeing a positive state experienced by individuals and societies which encompasses quality of life, sense of health, happiness and fulfillment, and the ability of people and societies to contribute to the world with meaning and purpose. Wellbeing at a community level includes the equitable distribution of resources, overall thriving and sustainability, resilience, capacity for action and preparedness to transcend challenges (Nutbeam & Muscat 2021).

Sources

Australian Health Promotion Association (2009). Core competencies for health promotion practitioners. Available at: healthpromotionscholarshipswa.org.au/wp-content/uploads/2014/05/core-competencies-for-hp-practitioners.pdf

Bauman, A., & Nutbeam, D. (2023). Evaluation in a nutshell (3rd ed.). McGraw-Hill Education Australia.

Gregg, J., & O'Hara, L. (2007). The Red Lotus Health Promotion Model: a new model for holistic, ecological, salutogenic health promotion practice. Health Promotion Journal of Australia, 18(1), 12–19.

Intergovernmental Panel on Climate Change (IPCC). (2007). Fourth assessment report. Available at: www.ipcc.ch/assessment-report/ar4/

Nutbeam, D. & Muscat, D.M. (2021). Health Promotion Glossary 2021. Health Promotion International, 36(6), 1578–1598.

O'Hara, L., & Taylor, J. (2023). QATCHEPP: A quality assessment tool for critical health promotion practice. Frontiers in Public Health, 11, doi.org/10.3389/fpubh.2023.1121932

Shilton, T., Howat, P., James, R. & Lower, T. (2001). Health promotion development and health promotion workforce competency in Australia: an historical overview. Health Promotion Journal of Australia 12 (2), 117–123.

Stockholm Resilience Centre (2023). Planetary boundaries—an update. Available at: www.stockholmresilience.org/research/planetary-boundaries.html

Talbot, L., & Verrinder, G. (2018). Promoting health: the primary health care approach (6th ed.). Sydney: Elsevier Australia.

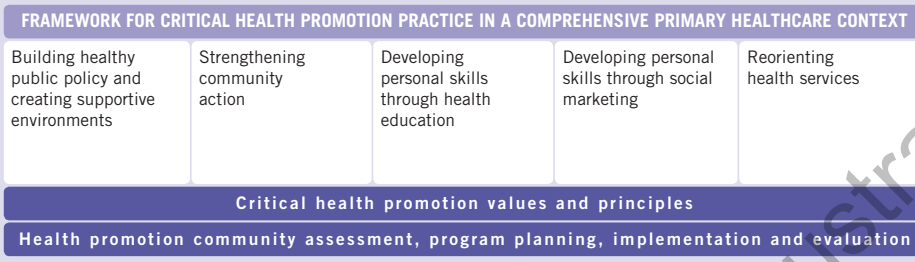
United Nations (1987). Report of the World Commission on Environment and Development: our common future. Available at: www.un-documents.net/wced-ocf.htm

United Nations (n.d.). Climate Action: What is climate change? Available at: www.un.org/en/climatechange/what-is-climate-change

World Health Organization (WHO) (2024). Healthy settings. Available at: www.who.int/healthy_settings/about/en/

World Health Organization (WHO) (1986). The Ottawa Charter for Health Promotion. Available at: www.who.int/healthpromotion/conferences/previous/ottawa/en/

4 Health promotion practice



LEARNING OUTCOMES

1. Describe the health promotion practice cycle, including community assessment, planning, implementation and evaluation, and the underlying critical health promotion values and principles.
2. Plan a comprehensive health and wellbeing community assessment.
3. Identify health and wellbeing priority issues and their socio-ecological determinants.
4. Develop an evidence-based health promotion program plan that includes SMART goals, objectives and sub-objectives and evaluation.
5. Select appropriate data collection and analysis methods and tools for health promotion programs.

IUHPE Core Competencies for Health Promotion

The IUHPE Core Competencies for Health Promotion Framework includes a set of ethical values and foundation knowledge, and nine domains of action (IUHPE 2016). This chapter addresses the following ethical values and foundation knowledge (Table 4.1), and nine domains of action (Table 4.2).

TABLE 4.1 Ethical values and knowledge base components of the IUHPE Core Competencies for Health Promotion

Ethical values underpinning Health Promotion	• Respect for the rights, dignity, confidentiality and worth of individuals and groups • Respect for all aspects of diversity, including gender, sexual orientation, age, religion, disability, ethnicity, race and cultural beliefs • Addressing health inequities, social justice and prioritising the needs of those experiencing poverty and social marginalisation • Addressing the political, economic, social, cultural, environmental, behavioural and biological determinants of health and wellbeing • Ensuring that Health Promotion action is beneficial and causes no harm • Being honest about what Health Promotion is, and what it can and cannot achieve • Seeking the best available information and evidence needed to implement effective policies and programs that influence health • The empowerment of an individual and groups to build autonomy and self-respect as the basis for Health Promotion action • Sustainable development and sustainable Health Promotion action • Being accountable for the quality of one's own practice and taking responsibility for maintaining and improving knowledge and skills
Knowledge underpinning Health Promotion	• The concepts, principles and ethical values of Health Promotion, as defined by the Ottawa Charter for Health Promotion (WHO 1986) and subsequent charters and declarations • The concepts of health equity, social justice and health as human rights as the basis for Health Promotion action • The determinants of health and their implications for Health Promotion action • Health Promotion models and approaches that support empowerment, participation, partnership and equity as the basis for Health Promotion action • The current theories and evidence that underpin effective leadership, advocacy and partnership building and their implications for Health Promotion action • The current models and approaches of effective project and programs management (including needs assessment, planning, implementation and evaluation), and their application to Health Promotion action • The evidence base and research methods, including qualitative and quantitative methods, required to inform and evaluate Health Promotion action

IUHPE 2016.

TABLE 4.2 Competency domains of the IUHPE Core Competencies for Health Promotion

Domain	Competencies
1. Enable change Enable individuals, groups, communities and organisations to build capacity for health promoting action to improve health and reduce health inequities	1.2 Use Health Promotion approaches which support empowerment, participation, partnership and equity to create environments and settings which promote health

Continued

TABLE 4.2 Competency domains of the IUHPE Core Competencies for Health Promotion—cont'd

Domain	Competencies
2. Advocate for health Advocate with, and on behalf of individuals, communities, and organisations to improve health and wellbeing and build capacity for Health Promotion action	2.2 Engage with and influence key stakeholders to develop and sustain Health Promotion action 2.5 Facilitate communities and groups to articulate their needs and advocate for the resources and capacities required for Health Promotion action
3. Mediate through partnership Work collaboratively across disciplines, sectors and partners to enhance the impact and sustainability of Health Promotion action	3.1 Engage partners from different sectors to actively contribute to Health Promotion action
4. Communication Communicate Health Promotion actions effectively using appropriate techniques and technologies for diverse audiences	4.1 Use effective communication skills including written, verbal, non-verbal, listening skills and information technology 4.2 Use electronic and other media to receive and disseminate Health Promotion information 4.3 Use culturally appropriate communication methods and techniques for specific groups and settings
5. Leadership Contribute to the development of a shared vision and strategic direction for Health Promotion action	5.1 Work with stakeholders to agree on a shared vision and strategic direction for Health Promotion action 5.3 Network with and motivate stakeholders in leading change to improve health and reduce inequities 5.4 Incorporate new knowledge and ideas to improve practice and respond to emerging challenges in Health Promotion 5.5 Contribute to mobilising and managing resources for Health Promotion action
6. Assessment Conduct assessment of needs and assets, in partnership with stakeholders, in the context of the political, economic, social, cultural, environmental, behavioural and biological determinants that promote or comprise health	6.1 Use participatory methods to engage stakeholders in the assessment process 6.2 Use a variety of assessment methods including quantitative and qualitative research methods 6.3 Collect, review and appraise relevant data, information and literature to inform Health Promotion action 6.4 Identify the determinants of health which impact on Health Promotion action 6.5 Identify the health needs, existing assets and resources relevant to Health Promotion action 6.6 Use culturally and ethically appropriate assessment approaches 6.7 Identify priorities for Health Promotion action in partnership with stakeholders based on the best available evidence and ethical values

TABLE 4.2 Competency domains of the IUHPE Core Competencies for Health Promotion—cont'd

Domain	Competencies
7. Planning Develop measurable Health Promotion goals and objectives based on assessment of needs and assets in partnership with stakeholders	7.1 Mobilise, support and engage the participation of stakeholders in planning Health Promotion action 7.2 Use current models and systematic approaches for planning Health Promotion action 7.3 Develop a feasible action plan within resource constraints and with reference to existing needs and assets 7.4 Develop and communicate appropriate, realistic and measurable goals and objectives for Health Promotion action 7.5 Identify appropriate Health Promotion strategies to achieve agreed goals and objectives
8. Implementation Implement effective and efficient, culturally sensitive and ethical Health Promotion action in partnership with stakeholders	8.1 Use ethical, empowering, culturally appropriate and participatory processes to implement Health Promotion action 8.2 Develop, pilot and use appropriate resources and materials 8.3 Manage the resources needed for effective implementation of planned action 8.4 Facilitate program sustainability and stakeholder ownership through ongoing consultation and collaboration 8.5 Monitor the quality of the implementation process in relation to agreed goals and objectives for Health Promotion action
9. Evaluation and Research Use appropriate evaluation and research methods, in partnership with stakeholders, to determine the reach, impact and effectiveness of Health Promotion action	9.1 Identify and use appropriate Health Promotion evaluation tools and research methods 9.2 Integrate evaluation into the planning and implementation of all Health Promotion action 9.3 Use evaluation findings to refine and improve Health Promotion action 9.4 Use research and evidence-based strategies to inform practice 9.5 Contribute to the development and dissemination of Health Promotion evaluation and research processes

IUHPE 2016.

INTRODUCTION

This chapter describes the health promotion practice cycle (see Fig. 4.1). Using the health promotion practice cycle facilitates a systematic, evidence-based approach to practice. The health promotion practice cycle is an ongoing iterative cycle of assessing community assets and needs, planning a health promotion initiative, implementing strategies for an initiative

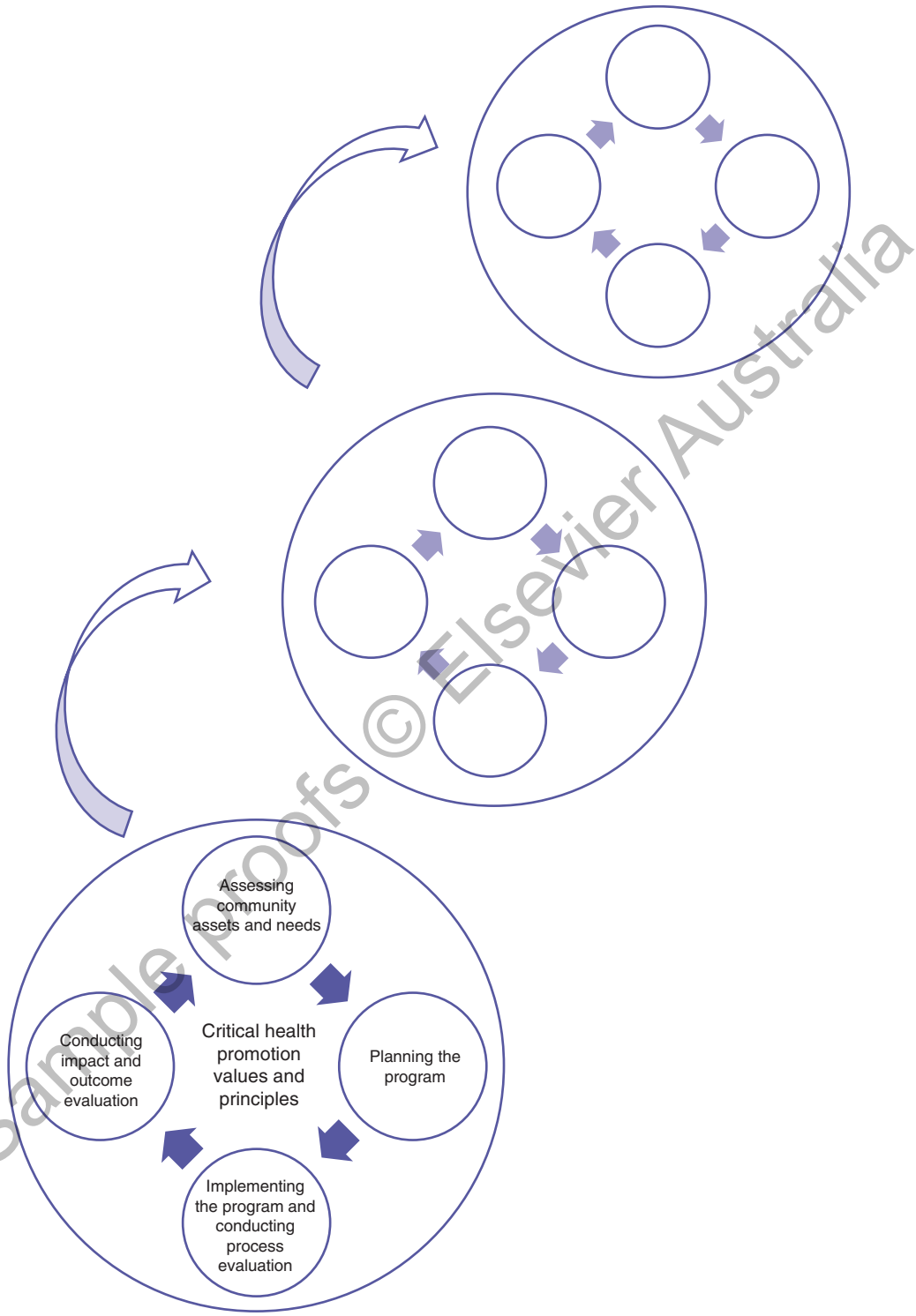


FIGURE 4.1 Health promotion practice cycle

and evaluating the implementation of strategies, short-term impacts and long-term outcomes. This is followed by re-assessing, re-planning, re-implementing and re-evaluating, in a continuous cycle of reflection and action. 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 underpin each stage.

Health promotion initiatives are ideally conducted in ways that meaningfully engage people in decisions about their health and wellbeing. Community participation in health promotion 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). As such, the emphasis must be on working with people as equal partners across all stages of the health promotion cycle. Health practitioners and community members can work together to undertake community assessment, planning, implementation and evaluation of health promotion initiatives. The steps within each stage of the cycle are outlined in Table 4.3.

In the community assessment stage, health practitioners work with priority populations to identify health and wellbeing priorities, and examine the range of interrelated socio-ecological determinants that contribute to the identified priorities. In the planning and implementation stages, they work with priority populations to develop health promotion strategies to address the socio-ecological determinants of the identified priorities, and then implement these strategies. In the evaluation stage, health practitioners work with priority populations to evaluate the short-term impact of the strategies on the determinants of the health and wellbeing priority being addressed, and the long-term outcome(s) on the health and wellbeing priority. A detailed description of each stage and the steps follows.

TABLE 4.3 Stages in the health promotion practice cycle

Stage 1 Assessing community assets and needs
• Identify the resources and activities required for community assessment.
• Examine the characteristics of the community, including identifying its strengths and assets.
• Gather primary and secondary data about health and wellbeing status from primary and secondary data sources.
• Analyse the primary and secondary data collected.
• Establish processes to actively engage all stakeholders in decision-making.
• Report the findings of the community assessment to the community.
• Work with communities to set health and wellbeing priorities for health promotion action.
• Analyse the individual and environmental level determinants of the health and wellbeing priorities.
Stage 2 Planning the health promotion program
• Determine the program goal, objectives and sub-objectives relevant to the health and wellbeing issue, determinants and contributing determinants respectively.
• Ensure the program goal, objectives and sub-objectives are specific, measurable, achievable, relevant and time bound (SMART).
• Select a portfolio of appropriate strategies to achieve the goal, objectives and sub-objectives.

Continued

TABLE 4.3 Stages in the health promotion practice cycle—cont'd

• Develop an action plan to implement the strategies using relevant theories or models.
• Agree on the responsibility of each stakeholder for implementing actions.
• Develop an evaluation plan that includes formative, process, impact and outcome evaluation.
• Assign responsibility to specific stakeholders for each of the actions in the evaluation plan.
• Ensure collaborative decision-making in all aspects of planning.
Stage 3 Implementing the health promotion program
• Collect baseline data as required.
• Prepare program materials and resources, and conduct formative evaluation.
• Implement the strategy activities as planned.
• Conduct process evaluation.
• Make changes to the program in response to process evaluation findings.
Stage 4 Evaluating the health promotion program
• Collect impact and outcome evaluation data, and any data related to unanticipated impact and outcomes.
• Analyse impact and outcome evaluation data, and any data related to unanticipated impact and outcomes.
• Write the evaluation report.
• Distribute the evaluation report to all stakeholders.
• Use the evaluation report to advocate for continuing the health promotion program or redirecting energies to a different health and wellbeing priority.

CRITICAL HEALTH PROMOTION VALUES AND PRINCIPLES

As described in Chapter 1, critical health promotion values and principles characterise a critical health promotion approach. In the Red Lotus Critical Health Promotion Model, also described in Chapter 1, there are 10 values and associated principles (Table 4.4) that are applied across the four stages of the health promotion cycle. Practitioners need to proactively and critically reflect on the application of critical health promotion values and principles in practice. To facilitate this reflective process, we developed the Quality Assessment Tool for Critical Health Promotion Practice (QATCHEPP) (O'Hara & Taylor 2023).

STAGE 1: COMMUNITY ASSESSMENT

Community assessment is the first stage in the health promotion practice cycle (see Fig. 4.1 and Table 4.3), and the essential starting point for health promotion initiatives. 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.

Community assessment involves gathering different types of data about the health and wellbeing assets and needs of a community using a socio-ecological determinants framework (Ravaghi et al 2023). This forms the evidence base for identifying the community's health

TABLE 4.4 Critical health promotion values and principles

Focus of Value and Principle		Red Lotus Critical Health Promotion Model	
		Value	Related principle – action on the value in practice
1	Who to work with	Priority population determined by structural inequality	In recognition that the enjoyment of the highest attainable standard of health is a fundamental human right, prioritising working with people and communities that are most impacted by the inequitable distribution of structural and systemic privilege and power.
2	Health paradigm	Holistic health paradigm	Framing health as a complex concept that includes physical, mental, spiritual, social, cultural and environmental aspects of wellbeing.
3	Program approach	Salutogenic approach	Enhancing strengths and assets that create and support health, wellbeing, resilience, sense of coherence, happiness, self-respect and meaning in life, in addition to structural and systemic factors that create poor health and wellbeing.
4	Scientific approach	Systems science	Using systems science, which recognises that the determinants of health and wellbeing operate in multiple complex intersecting ecosystems (from the individual to the family, group, community, population and global level), which need to be addressed to achieve sustainable health and wellbeing outcomes.
5	Assumptions about people	Assume that people are doing the best for their wellbeing	Assuming that when left to their own devices, people will do the best for their wellbeing, including that of their families, communities and environment, given their circumstances and available resources.
6	Professional role	Practitioner works with people as an ally	Working with people transparently as a culturally and socially sensitive and reflexive ally and resource respectful of all aspects of diversity.
7	Engagement processes	Empowering engagement processes	Using participatory enabling processes that empower and meaningfully engage priority populations in collaborative governance and decision-making about health promotion programs designed with them.

Continued

TABLE 4.4 Critical health promotion values and principles—cont'd

Focus of Value and Principle		Red Lotus Critical Health Promotion Model	
		Value	Related principle – action on the value in practice
8	Basis for practice	Comprehensive use of theories, models and evidence	Basing health promotion practice on the comprehensive application of appropriate theories, models and evidence across community assessment, planning, implementation and evaluation components of a health promotion program to ensure sustainable health and wellbeing outcomes.
9	Beneficence	Maximum beneficence	Actively considering what the benefits of a health promotion program may be to the full range of beneficiaries, particularly those with less structural and systemic advantage.
10	Non-maleficence	Non-maleficence is a priority consideration	Actively considering who may be harmed by the health promotion program and in what way; taking steps to minimise or avoid this harm; and communicating the risk of harm involved in a truthful and open manner.

O'Hara & Taylor 2023.

and wellbeing priorities, and developing health promotion actions to address these. Community assessment is not an end, but an essential foundation for action. Unless community assessments are acted upon, they may be a waste of time and resources. Community assessments that leave few resources for acting upon what is found, or for which there is no real commitment to act on after their completion, are unethical. They do little to help the community and are likely to result in significant community frustration.

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. It is therefore essential that the full range of assets and needs in a community are assessed.

Prior to undertaking a community assessment, practitioners should reflect on their relationship with the community. Sometimes practitioners who are a part of their community may perceive that there is no need to assess community assets and needs as they already understand the community. However, although health practitioners may be members of a community, they cannot represent the diversity of the community, and in fact no one can. Because of their professional education and socialisation, health practitioners bring a particular perspective to health and wellbeing. While this perspective is valuable, it is only one perspective and does not represent the full range of perspectives within a community. 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. Prior to commencing a community assessment, it is important to define communities.

Defining community

Communities are social systems comprising people with shared characteristics or factors such as geography, age, culture, identity, sexuality, ethnicity, religion, occupation, workplace, social activism, sport or leisure interests. "Community" has been defined in various ways, but is usually characterised by either geographical communities, based on location, or functional communities, based on a common element that provides a sense of identity. Within the geographic or functional elements of community, multiple communities exist and individuals may belong to several different communities at the same time.

Two major characteristics of community are identified: social interactions that are dynamic and enable relationships to occur, and through these relationships, the identification of shared needs and concerns that occur (Laverack 2007). Tesoriero (2010) goes further and describes five interrelated characteristics of community as follows:

1. *Human scale*. This is where people know each other or can get to know each other relatively easily and as needed. Structures are small enough for people to be able to control them, facilitating genuine empowerment. There is no magic number, but it could mean several thousand.
2. *Identity and belonging*. This implies acceptance by others and allegiance or loyalty to the aims of the group. Belonging to a community gives one a sense of identity.
3. *Obligations*. The responsibility for survival lies with the members and so membership is supposedly an active experience. It carries both rights and responsibilities.
4. *"Gemeinschaft"*. People interact with a relatively small number of people, who they know well, in many different roles. Members develop and contribute a wide range of talents for the benefit of themselves and the wider community. This is different to "Gesellschaft", where we don't know the people we have contact with, except for the roles they have; for example, teacher, bus driver, shop assistant, and so on.
5. *Culture*. The valuing of locally-based culture rather than the mass culture of the wider society. Members are producers of the culture rather than consumers (pp. 96–98).

People form communities by virtue of facing common sets of issues in their daily lives that create interactive webs of ties among organisations, neighbourhoods, families and friends (DeFilippis & Saegert 2013). Communities are social systems bound together by geography, shared values or shared interests. Participation in the life of the community and identification as a member of the community are important and result in a sense of belonging. This sense of belonging may also be described as a "sense of community".

A community of interest or "community-of-common-purpose" (Falk & Kilpatrick 2000, p. 103) has been described as a group of people who share beliefs, values or interests on a particular issue. For example, communities of interest may include residents of a housing estate, groups of single parents or unemployed people, members of particular ethnic groups and global communities, such as religious groups that span nations, or social movements, such as the women's movement or the environmental movement. Defining a community of interest around a shared perspective on a particular issue recognises heterogeneity among people and the fact that those who share an interest in one issue may have few other shared interests or beliefs, and may even be divided

on other issues. Examples of the way the term "community" is currently used include the following:

- Global community with interdependent networks of trade, communication and travel, and with global commons, such as clean air and water and the protection of biodiversity. These are important issues facing the global community, given the health impacts of insufficient fresh water and climate change from greenhouse gas emissions.
- National community, where people identify with a range of potent symbols, such as Australia and the kangaroo, or Australia and the idea of giving people "a fair go".
- Loyal community, where people identify with a city or region, or identify themselves as other; for example, some people in Australia identify with "the bush". This is a mixture of geography and emotional attachment.
- Community of identity that binds people through beliefs such as culture and religion. A local community that shares a range of living and working conditions such as climate, access to services and morale. This is often a combination of geography and interest.
- Community of interest where people share attitudes, enthusiasm, need and activities around a particular issue.
- Virtual community where people communicate online. With recent rapid advances in internet communications, virtual communities can develop overnight as followers of an idea, issue or a person.
- Intimate community, comprising family and friends.

The term "community" is often romanticised, described in a way that assumes communities are made up of close-knit groups of people who care for one another and experience little conflict (DeFilippis & Saegert 2013). Such an impression is far from the truth. Communities are very often not characterised by harmony and shared values on all issues, and are likely to reflect elements of conflict and competing interests. Communities may be strongly divided by opposing values, and may even be built on attitudes that reflect racism, sexism or ageism, for example, rather than mutual care and concern (DeFilippis & Saegert 2013). In addition, the term "community" may often deliberately be used to take advantage of its romantic connotations, such as when governments use terms like "community care" or "community programs". Such programs may be seen positively because they are described in this way, yet such programs are often underfunded or reliant on volunteer labour that, in the case of community care, is usually provided by women, with negative impacts on their own health and wellbeing (Talbot & Walker 2007).

Health promotion practice will be influenced differently by geographic, demographic and social communities, and by the policy and political context (DeFilippis & Saegert 2013). Demographic or population communities, such as men, women or children, and geographic settings, such as neighbourhoods, schools or workplaces, have tended to focus on "top-down" approaches to health promotion, especially where there is national or state/regional government funding tied to the policy action or health promotion initiative. However, strategies supported for social communities have been more likely to provide opportunities for "bottom-up" approaches to health promotion; for example, through various "neighbourhood renewal" initiatives (DeFilippis & Saegert 2013; Labonté & Laverack 2008).

Community participation in health promotion

Community participation in all stages of planning, implementing and evaluating policies and services that impact on people's health and wellbeing is recognised in the Universal

Declaration of Human Rights (UN 1948), the Declaration of Alma-Ata (WHO 1978), the Ottawa Charter for Health Promotion (WHO 1986), and the other documents in the appendices of this book. Community participation has been increasingly reflected in the rhetoric of health policy documents, and health practitioners are urged to incorporate strategies to engage the participation of the communities that they work with into their practice. As the health and economic benefits of connected communities are increasingly recognised, more funding has been made available for these long-term approaches. Accompanying this has been the development of related evaluation indicators. As Farmer and colleagues (2012) have illustrated in their research, moving past the rhetoric to embedding community participation in agency strategic plans and best practice continues to be a challenge. Health practitioners provide an important conduit in ensuring ongoing and effective community participation. Discussion of the different approaches to participation is therefore valuable and presented in more detail in Chapter 6. Arnstein's (1971) Ladder of Citizen Participation (see Fig. 6.1) continues to be a relevant diagrammatic illustration of the different forms of participation.

In many respects, community members may not be adequately prepared to participate effectively in decision-making about their health and wellbeing. Even in democratic societies such as Australia and Aotearoa New Zealand, we do not necessarily learn how to participate. Therefore, if people are to be encouraged to participate, they need to be provided with an opportunity to develop the skills and resources to do so. Effective participation and decision-making processes need to be established so they can enable people to participate meaningfully in the decisions that affect their lives (Farmer et al 2012). Health practitioners are currently endeavouring to develop more innovative participation strategies. Using a diverse range of creative strategies to enhance community participation that meets the needs and characteristics of the community has the potential to create lasting positive changes in local communities.

Unless people feel that they are likely to have an impact, they may decide that it is not worth the effort of trying to participate. Organisations that decide they want to encourage participation must therefore decide to prevent manipulative tactics that exclude community members from effective decision-making, and instigate affirmative action techniques in meetings and decision-making so that all potential participants have a fair say. Otherwise, only those people who are most comfortable with meeting procedures, and are therefore the most dominant within the group, may have their voices heard and their ideas acted upon (Farmer et al 2012). As Arnstein (1971, p. 72) stated, "participation without redistribution of power is an empty and frustrating process for the powerless". Questions that need to be asked here include, who decides what is for the good of the community, and on what basis? Imposition of decisions by others can be problematic for community members, unless they are decisions related to policies that reverse disadvantage. However, it is not always practical or possible to involve the whole community in decision-making and assist them in developing all of the knowledge and skills to make informed decisions. When is it acceptable for decisions to be made on behalf of the community? Do health practitioners have the right to manipulate the environment "for the good of the community"? When different parts of the community have conflicts of interest on particular issues, whose interests should take precedence? These are just some of the ethical questions raised in health promotion practice.

If people are going to participate, then obviously the agendas of the organisations concerned must be relevant to them. This has an added advantage; if organisations adjust their agendas so that they are more relevant to the community, and people are therefore more willing to participate, it is likely that their activities will more effectively meet the

priorities of their community. Consequently, organisations are made increasingly accountable to the public, which goes hand in hand with the power sharing discussed above.

Types of community health and wellbeing assets and needs

Assets

Collecting data about the assets of a community is an essential component of the community assessment process (Sáinz-Ruiz et al 2021), and consistent with a salutogenic approach (Pérez-Wilson et al 2021). Community assets can be categorised as those within the community and controlled at the community level, and those within the community and controlled externally. Assets within and controlled at the community level can include formal and informal networks, local knowledge, skills, leadership, traditions, identity, sense of belonging, and community-controlled groups or organisations, such as neighbourhood and citizen associations, play groups, support groups, sport and leisure clubs, business associations, and cultural and religious organisations.

Assets within the community and controlled externally can include global, national, regional and local health and wellbeing-related policies and strategies. These include the UN Declaration on Human Rights, climate action agreements, national health priority programs, Healthy Cities initiatives, and local government social and community development strategies.

Community assets also include private, non-profit and public services, facilities, and resources such as community health centres, childcare services, aged care services, hospitals, social service agencies, schools, police, libraries and information and communication technologies. Blue and green spaces are also important community assets, including oceans, rivers, beaches, lakes, parks, forests and other natural environments.

Needs

Collecting data about the needs of a community is also a necessary component of community assessment. Need has been defined as "the condition marked by the lack of something requisite" (Yallop 2005). This definition highlights that needs are value-based and socially constructed, and dependent on the perspectives and values of those involved. Given the value-laden nature of health and wellbeing needs, it is important to be clear about the values that influence the community assessment process.

There are several ways that needs can be classified. Bradshaw's (1972) typology of *felt need*, *expressed need*, *normative need* and *comparative need* remains useful and is still applied in community assessment (Steiner-Lim et al 2023). The categories of felt and expressed need include needs determined by the community, while normative needs are determined by experts, and comparative needs are identified based on comparisons between communities. With an emphasis on equal partnership between practitioners and community members in a comprehensive primary health care (CPHC) approach to health promotion, all types of need are important to include in the community assessment process.

Felt needs

Felt needs are most easily described as what people say they need (Bradshaw 1972). For example, if a local community is surveyed regarding its health and wellbeing needs, people may say that want safer streets for children to play in, more support for new parents, and more secure employment opportunities for young people. Insight 4.1 describes how a community was engaged in the assessment of their felt needs whereby they were asked to identify places in their community that affected their health and wellbeing (Aitken et al 2015).

INSIGHT 4.1 Community participation in identifying felt needs and therapeutic landscapes to develop social prescriptions for health

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. 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***

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 Warracknabeal, 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.

When assessing the felt needs of a community, practitioners should keep in mind several factors. Community members may limit what they indicate they feel they need to what they think can be more easily addressed. If they believe that a specific need is beyond reach, they may not identify it in the community assessment process. Community members may only identify felt needs that those conducting the community assessment might be interested in or support.

Powerful groups in a community can have a strong influence in determining how community members perceive their needs. Community members' beliefs about what they need can be socially constructed by interest groups, opinion leaders and the mass media. The perspective of a small group of community members may not reflect the perspective of the whole community. It is important to consider whose voices are and are not represented. Culturally appropriate and ethical processes to connect with community members with the least access to power and privilege are required. The engagement of these community members in assessment of their felt needs enhances equity and empowerment in community assessment and sustainability of health promotion initiatives.

It is also important to note that felt needs are often expressed as health promotion actions rather than the health and wellbeing issue. For example, rather than identifying

the felt need for safer streets for children to play in, they propose that specific streets be more closely monitored by police. However, there may be many other sustainable, evidence-based health promotion actions to address felt needs that should be considered.

Health promotion funding is often allocated to programs to address specific diseases without consideration of the felt needs of the community. This may result in health promotion programs being imposed on the community that are incongruent with their felt needs, which are then not addressed. The assessment of felt needs is important, but not sufficient to identify the full range of health and wellbeing priorities of a community. It is also important to collect data on other types of needs.

Expressed needs

Expressed needs are evidenced by people's use of or demand for services or action to address felt needs. Expressed needs can be described as felt needs turned into action (Bradshaw 1972). For example, the community that identified the felt need for safer streets for children to play might initiate a petition to lobby their local government to incorporate traffic calming strategies, such as reduced speed limits, changes to road design and better street lighting. Other examples of expressed needs include community dialogue via social media, communications to politicians on specific health and wellbeing issues, and waiting lists for services such as parent support groups, childcare, housing, public dental services and employment skills development programs. When assessing the expressed needs in a community, practitioners need to consider several factors. The sole reliance on expressed needs has limitations as people can only add their names to waiting lists for services that already exist or are planned. 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. Waiting lists as evidence of expressed needs 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 access to school dental therapy services. Another issue of using waiting lists as evidence of expressed needs is that people may add their names to multiple waiting lists for a particular service, such as a positive parenting program, but only require one place. 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 are low. In addition, people's beliefs about whether they have a right to particular services or deserve to have access to them will also influence whether they act to formally express a need.

Normative needs

Normative needs are determined by health professionals based on routinely collected data, research and professional opinion (Bradshaw 1972). Examples of normative needs include current benchmarks for safe levels of air and water quality and lead ingestion, vaccination schedules, exclusive breastfeeding, daily consumption of food groups and alcohol and weekly levels of physical activity.

When assessing normative needs in a community, practitioners should keep in mind several factors. Normative needs are often regarded as objective and unbiased because they have been determined by health professionals and are assumed to be value-free and beyond reproach. Professional opinion changes over time based on new evidence, and differing and sometimes conflicting interpretations, which can be confusing for the public. Many professional groups or commercial entities act consciously or unconsciously as gatekeepers in society, and are unable or unwilling to publicly acknowledge the contravention of a normative need. For example, a mining company that collects data about lead levels

in the local water supply may be unwilling to publicly release data demonstrating unsafe levels. A health professional association may choose to refrain from criticising a government initiative that they regard as harmful to the health and wellbeing of communities with the least access to power and privilege due to fear of losing government funding for their association.

Comparative needs

Comparative needs are determined by comparing the services or resources in one community with another (Bradshaw 1972). For example, a community may argue that it requires a specific service on the basis that other communities with similar demographic characteristics have that service. Identification of comparative needs can highlight the inequitable distribution of services or resources between communities.

When assessing comparative needs in a community, practitioners should keep some factors in mind. Assuming the services or resources required in one community are the same as a comparison community can be problematic because such services or resources may be inappropriate or unnecessary. This leads to the inappropriate use of funding and/or other resources that may be better allocated to other health promotion initiatives.

Sources of data on community health and wellbeing assets and needs

In community assessment, data on community health and wellbeing assets and needs are collected from secondary sources (existing data) and primary sources (new data). Before exploring these sources 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. Data is used as a plural throughout this textbook. It is important to use a conceptual framework such as the Red Lotus Critical Health Promotion Model to guide the collection of secondary and primary data on community health and wellbeing assets and needs. Community assessment is a research process; therefore, it is recommended that formal ethical approval be granted prior to collecting data. This can be sought from local health services or university human research ethics committees. Where possible, involve local community people as part of the data collection team and ensure they are provided with the appropriate training and support.

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 planning to collect more data. Secondary sources of data should therefore be explored as a first step. Primary data sources provide new data about community health and wellbeing assets and needs. 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 can generally be accessed relatively easily. These data contribute to the overall picture of a community and are essential for identifying health and wellbeing priorities and evidence for health promotion initiatives. Secondary data sources include the peer-reviewed literature, epidemiological data and local community profile data. Conducting a review of the peer-reviewed literature is usually the first task that health practitioners undertake when looking for data about a community and its assets and needs.

Peer-reviewed literature

A literature review is a systematic process of gathering, reviewing and synthesising relevant publications from peer-reviewed journals. 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 community needs and assets, to analysing health and wellbeing priorities and planning, implementing and evaluating programs. Conducting a literature review as part of community assessment enables health practitioners to draw on existing knowledge, and also prevents wasting time or making the same mistakes that others may have made. Skills in accessing and reviewing literature are essential to undertaking 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 their own strengths and weaknesses (Robinson & Lowe 2015). For comprehensive guidance on the literature searching and reviewing process it is advisable to consult a research methods text. University libraries also provide tutorials online and resources to support those undertaking a literature review.

A literature review requires good knowledge of data sources and skills in using them effectively. Many organisations do not provide access to primary data through journal subscriptions or databases such as Proquest or CINAHL. However, there are some easily accessible websites that can be used to obtain peer-reviewed literature. Google Scholar, the Cochrane Library and the Campbell Library are three good sources of literature. Researchers sometimes post their articles on pre-print servers such as medRxiv and SocArXiv, and personal repositories such as ResearchGate and Academia.edu, and similar websites that are free to access. Authors can also be contacted directly via email to request a copy of a publication. Government websites sometimes provide primary data and university libraries may also provide access to databases and journals to individuals and organisations for a fee.

Practitioners need to be wary of using easily accessible but non-peer reviewed literature from sources such as Google. Artificial intelligence programs such as ChatGPT will generate information complete with citations; however, in most instances these citations do not actually exist, have been artificially constructed and should not be used in community assessment.

Article information extraction: After sourcing relevant articles, it is useful to develop an extraction table using Word or Excel to document relevant information from each article prior to writing the literature review. The extraction table will include several columns that detail the scope of relevant information across the articles. For example, in community assessment the columns might include the author, date, title, aim or purpose, context or setting, participants, type of community assessment data, data collection methods, community involvement, ethical considerations, findings, conclusions, strengths, limitations, relevance and quality. The information extraction table is a dynamic tool that can change as needed to accommodate additional categories of information relevant to the purpose of the literature review.

Once articles are sourced, read them all to familiarise yourself with the content without thinking about what information to extract at this point, then re-read each article and highlight information to be extracted. Some people find it easier to use hard copies of articles and manually highlight relevant information as they read, but this can also be done digitally on files like PDFs. Use a new row for each article.

Summarising and evaluating the literature: When extraction is complete, the information is summarised to report what is known about the community from the peer-reviewed literature. Additionally, it is essential to evaluate the peer-reviewed literature critically to determine the quality of the research that is being reported and the trustworthiness of the information 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 critically evaluate the body of literature with respect to relevance to the community, quality of the research processes and credibility of the research outcomes and conclusions.

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 is the study of the incidence and geographic, demographic and temporal distribution of states of holistic health and wellbeing and their determinants. However, due to the dominance of the biomedical paradigm, epidemiological data predominantly focus on levels of death (mortality) and disease (morbidity), and their distribution in a community according to criteria such as gender, age and place of residence. The application of the holistic health paradigm to epidemiology requires the study of physical, mental, spiritual and social health and wellbeing.

Epidemiological data are available from several sources including registries of births and deaths, health and wellbeing surveys, health service data and other registries, surveillance and notification systems. National databases, such as the Australian Bureau of Statistics (ABS) (www.abs.gov.au/), Australian Institute of Health and Welfare (AIHW) (www.aihw.gov.au/) and Statistics New Zealand (Stats NZ) (www.stats.govt.nz) are all rich sources of epidemiological data. 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 aspects of holistic health and wellbeing. While there is a wealth of epidemiological data about some health and wellbeing issues, for example, cardiovascular disease, diabetes and cancer, there are less data about mental, social and spiritual health and wellbeing. Epidemiology data usually express morbidity and mortality, not the extent of wellness of a community. Likewise, epidemiological data are not equally available for all communities, particularly those with less access to systems of power and privilege. Relying on available epidemiological data may result in exacerbating inequities within and between communities.

Geographic community profile

Although there are many different types of communities, health practitioners in primary health care settings are likely to work with geographical communities. Geographic 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, 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 understand the demographic

and social issues shaping the lives of people in the community. Companies such as Informed Decisions (http://home.id.com.au/) provide online tools and consulting services to compile secondary data about geographic communities. Community profiles can include socio-economic data about people and the policy, social, cultural, built and natural environments.

Socio-economic data: Collecting socio-economic data about the people within a community helps 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 examples 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.

Policy environment: The policy environment of a community includes the political ideology, government policies, codes of practice, standards and regulations that impact on health and wellbeing. Government policies and strategies provide a statement about the government's position on an issue and intended actions to address. It is important to note that policy documents often reflect political rather than community priorities, and are only one part of a local community profile. They are developed with varying degrees of community consultation depending on political will. It is worthwhile investigating the process by which a policy or strategy was developed, and the extent of community engagement in the process. This may impact the extent of community support for a policy at the local level.

Social and cultural environments: The social environment of a community includes the social capital, social justice and social structures (organisations) operating 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 several 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? What are the communication mechanisms used within the community, and the distribution of power and leadership within a community?
- *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 X (formerly 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.

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 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.

Primary data sources

Primary data sources provide new data about community health and wellbeing assets and needs, and help to develop a deeper understanding or address gaps in the secondary data. It is important to distinguish between the community's health and wellbeing assets and needs, and any prematurely proposed solutions. When collecting primary data about health and wellbeing assets and needs, it is possible that they are expressed in terms of solutions rather than actual assets and needs. 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 asset or need itself. As such, you may need to "peel the onion" to get to the deeper layer of understanding by asking what the health and wellbeing asset or need is that leads them to this solution.

As with the collection of secondary data, it is important to use a conceptual framework such as the Red Lotus Critical Health Promotion Model to guide the collection of primary data. It is vital that primary data collection 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". Gathering primary data without a clearly defined purpose or not making use of the findings is unethical. Qualitative and quantitative approaches may be used to collect primary data.

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. The aim of qualitative research is to explore 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 and provides an opportunity for people to describe what is important to their health and wellbeing and why. Researchers can follow up on cues and explore the views of community members in detail. However, qualitative approaches can be time-consuming and resource intensive. Consider a data-gathering approach that will enable access to a diversity of community members using available resources. Community members include those with lived experience in the community and key stakeholders who have a professional role, such as teachers, health practitioners, community workers and local government council staff. There are several methods that can be used to collect qualitative data from community members.

Qualitative data collection methods

Individual interviews: Interviews are used to collect primary data from members of the community, stakeholders and decision makers about community assets and needs. They can be conducted face-to-face, online or via telephone, and can be structured, semi-structured or unstructured. Structured interviews use a standardised set of pre-determined questions with limited flexibility to introduce additional questions during the interview. Semi-structured interviews use a standardised set of pre-determined questions with flexibility to use probing questions to clarify or extend on participants' responses and introduce new lines of inquiry if relevant. Unstructured interviews do not use a standardised set of pre-determined questions and begin with a single broad question with follow-up questions arising from participant responses. Semi-structured interviews are the most used interview format in community assessment.

A socio-ecological determinants framework, such as the relevant components of the Red Lotus Critical Health Promotion Model, can also be used to guide the development of interview questions. Opening questions in a community assessment interview should explore the factors in the community that impact positively or negatively on emotional, mental, physical, social, spiritual and cultural health and wellbeing. It is important to explore all these aspects to ascertain a comprehensive and holistic view of the health and wellbeing of the community. Follow-up probing questions can then be used to explore in more depth the impact of environmental factors on health and wellbeing, including social, cultural, economic, commercial, political, built and natural environments. Interview questions should be pilot-tested with a small number of people from the community to ensure that they are appropriate for the community and will generate relevant data. Questions should be refined as necessary before use in the community assessment process.

Various methods can be used to recruit interview participants. For example, participants may be recruited through social media, community and professional networks, word of

mouth, community and workplace newsletters and other communication technologies. Consideration needs to be given to the most appropriate recruitment method for each community to ensure equitable opportunity for all community members to participate. An appropriate and convenient time and/or location to conduct an interview needs to be determined with participants. Seek permission from interviewees to record the interview. Make reflective notes immediately after each interview to capture any non-verbal and contextual observations relevant to the interview questions.

Focus group discussion/interview: A focus group is a facilitated interactive group discussion (also sometimes referred to as an interview) on a particular focus topic with people who have common characteristics. The purpose of a focus group is to gather exploratory or explanatory data from a group of people to ascertain their collective or shared perspective (Davidson et al 2017). For example, in community assessment, a focus group might be used to gather the perspective of young people living in rural and remote settings about employment and/or recreational opportunities in their local community. A focus group involves a highly structured process that requires careful planning by one or more facilitators to ensure the integrity of the data collection, and analysis and safety of participants. It is also important to note that the focus group method is used in two distinct ways in a research process. The first is as a single group interview. The second is to conduct group interviews with topic participants until the point of data saturation when no new perspectives or ideas are being identified through the discussions. It is advised that if planning a focus group method you use an appropriate focus group guide to ensure that you consider all the important steps in the process.

Focus groups generally comprise 8–12 participants, take about one hour, and can be carried out either face-to-face or via various online means such as Google Hangouts, Zoom or Teams. When deciding on the means to conduct a focus group it is important to consider what setting is most appropriate for and accessible to the group. A focus group protocol comprising any ethical information, such as participant consent and the interview questions, needs to be developed and then piloted before being implemented with participants. Focus group questions follow a route from introductory, transitional and concluding questions (Davidson et al 2017). Introductory questions are designed to engage the participants in sharing their experience of the focus group topic. Transition questions are then used to probe deeper into more specific elements of the topic and take most of the focus group time. Concluding questions are then used to sum up participants' views about the group discussion and additional comments not covered in the discussion. It is very common for transition questions to be guided by relevant theory or frameworks. For example, if exploring young mothers' perspectives about the factors that impact on their wellbeing in their local community a socio-ecological health and wellbeing determinants framework could be used to develop questions that ensure all individual and environmental level determinants are considered.

It is the facilitator's role to guide the discussion and ensure all participants have an opportunity to express their views. In most instances a focus group facilitator is supported by a second facilitator, who takes notes, manages the time, and may ask additional emergent probing questions not identified by the lead facilitator. When all the data is collected and collated, thematic analysis is generally used to do the analysis, and findings are reported back to participants for their verification, with an opportunity to add any further relevant information missed at the interview.

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.

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. 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 (photovoice.org/). The aim is to promote dialogue between community members, practitioners and policymakers about issues the community members have identified using images.

Analysing qualitative data: Qualitative data are managed systematically and there are numerous approaches that can be used. Computer software programs such as NVivo can be used to manage the analysis of qualitative data. It is important to use an established qualitative analysis approach to ensure rigour and trustworthiness of the process and findings. One such approach is Ritchie and Spencer's (1994) five-step framework process.

1. Familiarisation involves immersion in the data via reading and rereading, and viewing and listening to data collected, along with any researcher notes to develop familiarity with the data, and making notes about key ideas and emergent concepts.
2. Development of a thematic framework that is based on concepts emerging from key ideas in the familiarisation stage. A thematic framework may also draw on an a priori framework or theory.
3. Indexing involves applying the thematic framework to code the data. This can be done line-by-line or paragraph-by-paragraph in a process of constant comparison with previously analysed text to draw out similarities and differences.
4. Charting involves grouping coded data according to each component of the thematic framework. The data are explored to identify relationships, patterns and interconnections between concepts.
5. Mapping and interpretation involve in-depth analysis of charted data to finalise themes and provide an interpretation of the findings as a whole.

Quantitative research approach

A quantitative research approach is useful for exploring the "how many?" and "among whom" questions about a community. In epidemiology terms, these are referred to as the prevalence, incidence and distribution of health and wellbeing status, and the socio-ecological determinants. 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 surveys being the most common.

Quantitative data collection method

Survey: Few communities are small enough for it to be possible to ask everyone to define their assets and needs. A community survey will usually be conducted with a sample of people. Determining which people and how many to ask 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 community 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 and means to look over or across. Surveys can involve people surveys, environmental surveys, policy surveys, and so on. 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. Questionnaires can be distributed by mail, telephone, text messaging, online or in person.

Questionnaire design: Designing a questionnaire requires a high level of planning and skill. Using a previously validated questionnaire whenever possible is therefore recommended. For example, 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. Norms for the SF-36v2 and SF-12v2 have been estimated using national health survey data (Frieling et al 2013).

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 that they do not lead the respondent into a certain response. A Human Research Ethics Committee should not be asked to approve a questionnaire written by someone with no expertise in survey instrument design (Allen & Flack 2015).

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 findings to the community

Reporting the findings is an essential part of any community assessment, particularly to those from whom data are collected. Findings should be presented in formats appropriate for the community and made available through a range of venues/forums, so that all people who took part in the data gathering have an opportunity to review the results. 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 probabilistic sampling techniques have been used to recruit participants, practitioners must be cautious about making generalisations that apply to the whole community.

Setting priorities for health promotion action

The next step in the community assessment stage is to use the community assessment findings to determine the community health and wellbeing priorities and priority populations most impacted. Communities will usually identify multiple health and wellbeing issues that they perceive to be priorities. It will be necessary to use processes and criteria to establish priorities, as it is rare to have the time or other resources to be able to deal with all the priorities at once.

The process of priority setting should be carried out in partnership with community members and stakeholders. 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. There are several processes that can be used to engage communities in priority setting such as community forums, weighted voting, consensus panels, the Delphi technique and values clarification (Salihu et al 2015). One commonly used process is the nominal group process, which is highly structured and involves five to seven representatives of a community identifying specific priorities, which are recorded for all participants to see without further discussion. The group is then asked to rank or order the responses by importance.

One criterion could be that the health and wellbeing priorities are determined based on how easy they are to address. Health and wellbeing issues that are perceived to be the easiest or most "winnable" are prioritised with more difficult and complex issues given lower priority. However, there are some problems with this approach whereby the easiest issues to address may not be the ones that make the biggest difference to the health and wellbeing of the community. The most difficult issues to address may well have the biggest impact on the health and wellbeing of the community and health equity within the community.

Another criterion could be whether an issue is a national, state, district or organisational level priority. The advantage of using higher level priorities is that they are more likely to have funding available to support health promotion programs, and health practitioners will be encouraged to take action to address them. Similarly, some priorities 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 issues 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.

Other criteria that can be used to identify community health and wellbeing priorities include prevalence and incidence, severity, selectivity and amenability to action.

- *Prevalence and incidence:* Is the health and wellbeing issue widely experienced? How many people are affected? Who are the people that are most impacted? What is the geographical distribution of the issue? What are the patterns and trends in the prevalence and incidence of the issue over time?
- *Severity:* Does the health and wellbeing issue have major or minor implications? Is this a critical issue that should be addressed before others? What will the consequences be if this issue is not addressed?
- *Selectivity:* Does the issue affect one group within the community more than another? Are there any disparities between groups of people impacted? Are those most impacted from priority communities or populations, for example, Aboriginal, Torres Strait Islander or migrant communities?

- *Amenability to health promotion action:* Are there evidence-based health promotion programs that have successfully addressed this health and wellbeing issue? Are there resources (funds, staff, connections, infrastructure, etc.) available to implement health promotion programs to address the issue? Does the issue align with the organisation's mission statement or policies? If not, why not? Can the organisation's policies be influenced? Which community members and other stakeholders are most appropriate to work on these health and wellbeing issues?

Using a community-based decision-making process to answer these questions will inform the selection of health and wellbeing issues as priorities to address. For each priority issue, a comprehensive health and wellbeing analysis must then be undertaken.

Health and wellbeing priority issue analysis

A health and wellbeing priority issue analysis involves the identification of the range of socio-ecological health and wellbeing determinants that contribute to the priority issue. One of the common frameworks used to categorise the determinants of a priority issue 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 or may not be adequate and laws may be supportive or restrictive. Enabling factors include all the factors that can make a change to people or environmental conditions possible.
- *Reinforcing factors:* the feedback received from others, the rewards, the deterrents such as fines or incarceration 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 issue? 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. 4.2 provides an example of a health and wellbeing 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

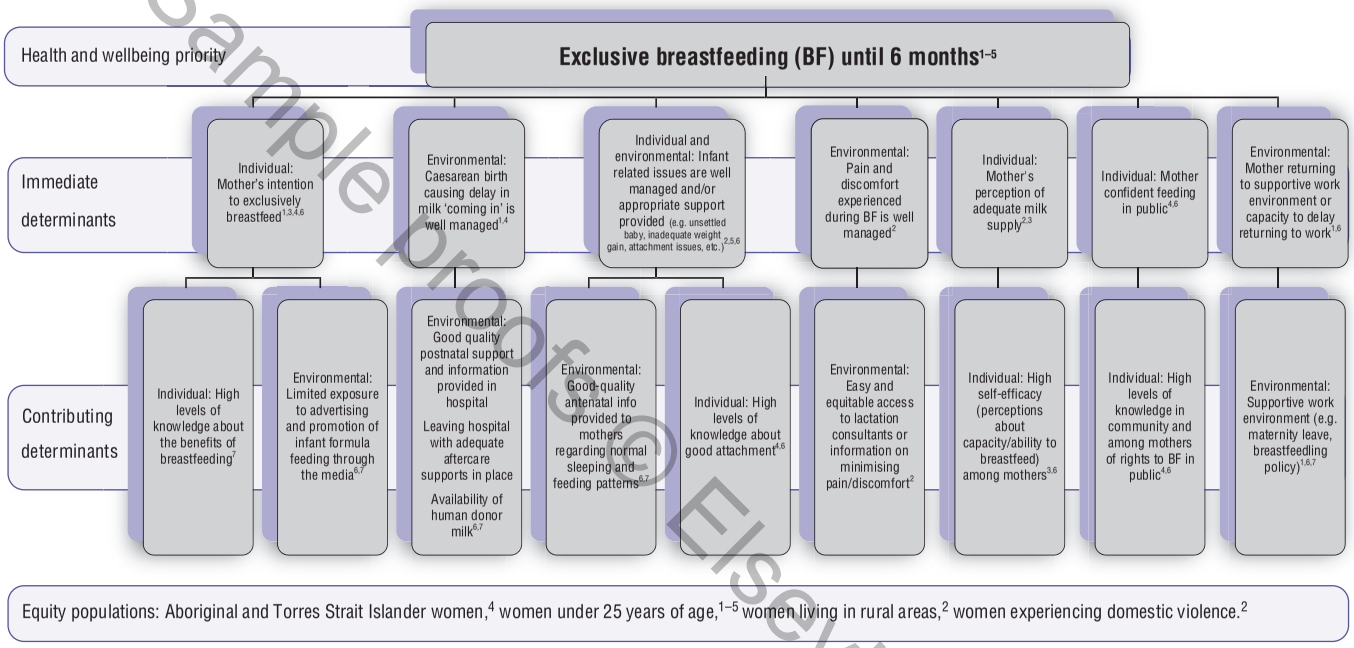


FIGURE 4.2 Health and wellbeing priority determinants analysis

Key/Sources: *[1]Baxter et al 2009; [2]Hauck et al 2011; [3]Meedya et al 2010; [4]Ogbo et al 2017; [5]Quinlivan et al 2015; [6]Rollins et al 2016; [7]Smith et al 2018.*

and breastfeeding, limited exposure to advertising and promotion of infant formula through the media

Reinforcing: infants thriving as a result of managing infant issues well, 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 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), and women experiencing domestic violence (Ogbo et al 2017).

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 priority issues of a community identified in Stage 1 of the health promotion practice cycle (Fig. 4.1) within the available resources. A 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 textbook we use the term "goals" for consistency. The skills to develop a health promotion program are an essential part of a health practitioner's "toolkit". Well-constructed goals, objectives and sub-objectives clearly define changes the health promotion program aims to achieve in the long, intermediate and short term. 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 to achieve the goals and objectives. It is also the essential foundation for developing the evaluation plan that will enable the health practitioner to evaluate whether the program achieved what it set out to achieve. Fig. 4.3 (program logic) illustrates the relationship between goals, objectives, sub-objectives, strategies and evaluation. Program logic is underpinned by a theory of change. Fig. 4.4 provides a worked example of the development of a program goal, objectives and sub-objectives for the health and wellbeing priority issue of breastfeeding.

Goal

A health promotion program goal expresses the change in the health and wellbeing priority issue that the community wants to achieve. Sometimes a change can only be achieved in

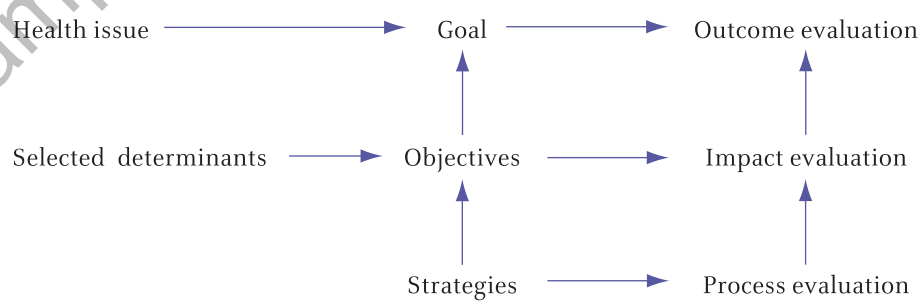
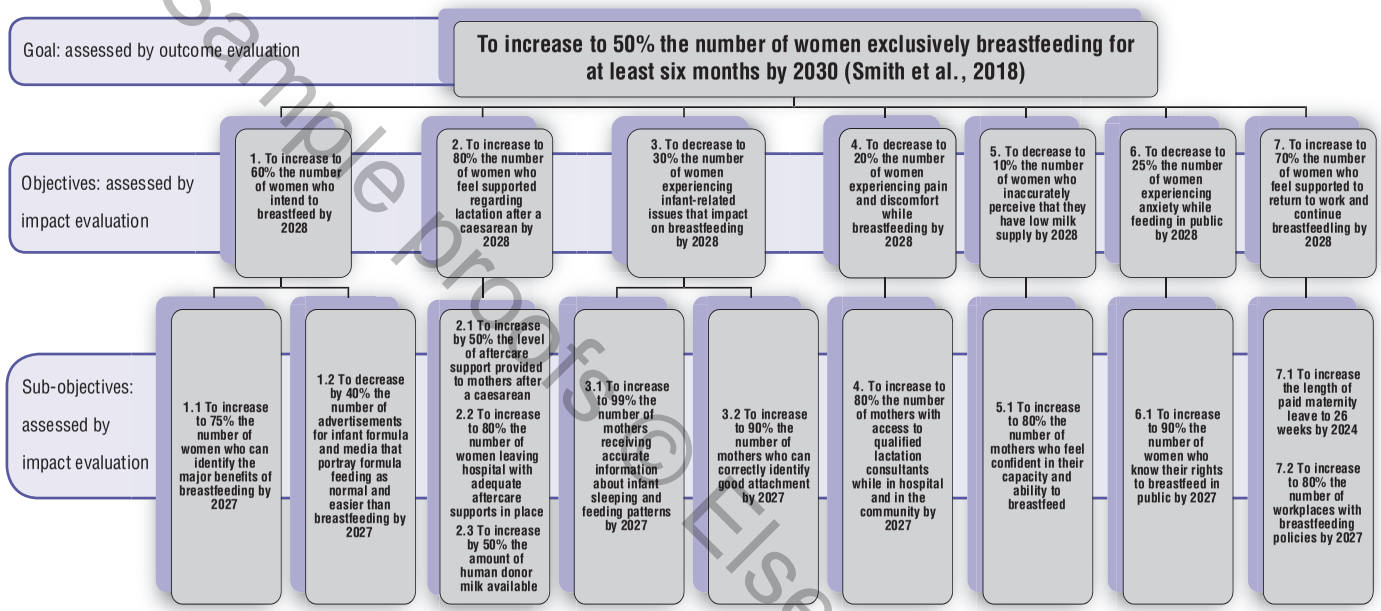


FIGURE 4.3 Health promotion program logic



Timeframes and percentages are aspirational due to the lack of specialised indicators in the Australian National Breastfeeding Strategy 2019 and Beyond.

FIGURE 4.4 Goal objectives and sub-objectives

the long term depending on the nature of the issue. In the breastfeeding example, the priority issue is exclusive breastfeeding until six months 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 2030 (Smith et al 2018).

Objectives and sub-objectives

Objectives state what must change for the goal to be achieved. They address the determinants of the health and wellbeing priority issue identified in the analysis. Depending on the nature of the priority issue, 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 necessary to achieve the goal. Sub-objectives identify the type and degree of changes to the contributing determinants necessary to achieve the objectives. Writing goals, objectives and sub-objectives takes considerable time, research and practice to ensure they are SMART, which means they need to be:

- **S**pecific: clearly state who is the focus, where the program will occur and use terms that are able to be operationally defined
- **M**easurable: indicate the degree of change expected in the health and wellbeing priority issue (goal) or determinant (objective or sub-objective)
- **A**chievable: ensure the degree of change is realistic and able to be achieved in the timeframe with available resources; refer to what other programs have managed to achieve as a guide
- **R**elevant: ensure that the goal is directly relevant to the health and wellbeing priority issue, and the objectives and sub-objectives are directly relevant to the determinants and contributing determinants
- **T**imescale: state when the change is to be achieved by.

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 2028. 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 2027, 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 2027. The program plan must identify which women it is referring to, where the program will be focused (e.g. local, regional, state-wide or national), and the operational definitions of the constructs of exclusive breastfeeding, intention, knowledge and the number of advertisements and media.

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 youth, with less access to systems of power and privilege. 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 youth who have less access to systems of power and privilege.

Although terms such as "vulnerable", "marginalised" and "at risk" are used to describe populations that experience higher rates of health and wellbeing issues, a critical health promotion approach requires us to reflect on the negative impact of the use of these deficit-oriented terms on people. As a result of our critical refection on this matter we have identified the need to use terms that re-orient the focus away from people experiencing health and wellbeing inequities and move towards terms that reflect the socio-economic and political systems at the root of these inequities. We therefore describe "people with less access to systems of power and privilege" as "priority populations", and recommend the use of these terms rather than the more commonly used deficit-oriented terms.

Strategies and activities

Once the program goal, objectives and sub-objectives have been established, a complementary mix of health promotion strategies to bring about the planned changes can be developed. This combination of strategies is referred to as a health promotion strategy portfolio. Strategies should be based on theories or models appropriate to the nature of the strategy. Strategies and theories are explored further in the subsequent chapters. 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 priority issues will require building healthy public policy, creating supportive environments and strengthening community action. Some priority issues 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 issue 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's capacity to address the priority issue. 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 youth with less access to systems of power and privilege, you may decide that strengthening community action and creating supportive environments are the major strategies you will use to achieve this goal and objective in the priority population. To strengthen community action, you may initiate an activity to develop a youth health social media page. Another activity may include engaging young people to develop this health page. To create a supportive social environment, your activities may include identifying potential youth facilitators from the priority population for the development of peer support programs in your town. All 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.

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.

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 has also been described as a "complex process of measurement and judgment which includes gathering and organising and interpreting information" (Bedworth & Bedworth 1992, p. 407). 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. i134). Evaluation may be as specific as determining the effectiveness of an educational workshop, or as broad as assessing the effectiveness of a community-driven social activity.

Why evaluate?

Evaluation contributes to the evidence-base 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 and wellbeing of the priority population. Evaluation is the process of sharing rather than 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 communities and priority populations 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 determine whether the health and wellbeing priorities of the community align with their organisational priorities. 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 find themselves experiencing some difficulty as they attempt to grapple with their dual accountabilities to central planning agencies and communities. Using the values and principles of critical health promotion, the principles of CPHC as a foundation for evaluating health promotion programs may not align with bureaucratic expectations about evaluation, which may result in challenges for the health practitioner. Some of the different and competing perspectives that may contribute to decisions about the 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 the 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.

Evaluation 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, allocate time to formally review the program activities and their progress towards sub-objectives, objectives and goals. It is vital that health practitioners build knowledge and skills in 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. It is important to ask questions, such as "What went well?", "What did not work so well?", "What would I/we do differently next time?", "Who did and did not participate?", and "Are the critical health promotion values and principles being enacted?", to regularly reflect on across the life of the program. 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.

Who is the evaluation for?

Multiple stakeholders have an interest in the evaluation of health promotion programs. The challenge is to ensure the evaluation process reflects the values of the community, as

well as those of the health and/or funding agencies. 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.

Despite the claim 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. 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.

Planning for evaluation

Evaluation planning is an integral part of health promotion practice and takes place in the planning phase of the health promotion cycle. Guiding principles for planning an evaluation include: having a clear evaluation process; the evaluation being useful, relevant and practical for end users; and using multiple and appropriate data-collection methods. Evaluation findings need to be plausible and reflect the experience of all stakeholders, which means paying attention to power structures and politics. There are several considerations to guide planning an evaluation:

- Identifying the purpose of the evaluation
- Determining the most appropriate design for the specific type of evaluation
- 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 evaluation results will be disseminated
- Resourcing for the evaluation.

Evaluation ethics

The four principles of ethical practice outlined below are integral to evaluation research: merit and integrity, justice, beneficence and respect (NHMRC et al 2023).

Merit and integrity

Applying the ethical principle of merit and integrity means that the evaluator must be competent and experienced, the evaluation 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 communities within a population are 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 protective consideration for people with least access to power and privilege; for example, women, prisoners, people living in low resource circumstances, and those living with chronic conditions in low resource settings.

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. 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.

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. 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.

Health promotion evaluation framework

There are various types of evaluation that need to be included in the health promotion evaluation framework. Taking a systems approach to evaluation by integrating a range of evaluation types should paint a relatively comprehensive picture of a health promotion initiative. Types of evaluation most commonly used in health promotion are formative, process, impact and outcome evaluation (Bauman & Nutbeam 2023).

Formative evaluation

Formative evaluation takes place when a new health promotion program is being planned, and in development before it is implemented, or when an existing program is being reviewed and modified for further implementation. It involves identifying all of the elements of a program and then pre-testing the full range of resources, methods and processes to ensure that what is proposed is appropriate for the intended community or population, is doable within available resources and likely to achieve intended goals and objectives. Formative evaluation should be carried out in consultation with all of the stakeholders, including the community for which the program is designed. This is a good time to implement a co-design process to ensure the perspectives and opinions of all stakeholders are included in design-making about the program.

A range of evaluation research methods can be used to test various elements of a health promotion program. For example, a scoping review can be used to investigate what health promotion strategies have been implemented in the past to address a particular health and wellbeing issue in a community. Focus groups may be used to gather qualitative feedback from young people about a proposed strategy to enhance their engagement in activities to build their social connections in the community. A survey may be used to

collect qualitative and quantitative data from a particular group within a community about the appropriateness and viability of a proposed program, including any resources. Formative evaluation is the point in time when any resources that have been developed as part of the program should be pilot-tested.

Process evaluation

Process evaluation involves 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 implemented in a program, to understand what did or did not work and why. Key process evaluation questions include:

- Who is being served by the program? Who is missing? Why? What can be done to increase the involvement of priority communities?
- How are power and decision-making shared between health practitioners and participants?
- How is Cultural Safety being addressed in the program?
- What do the participants, staff and organisational partners think about the program? Are they happy or satisfied with the program and different elements of the program?
- Is the program or activity being implemented as planned? If not, why not?
- Are human, financial and other resources available for the program?
- What is working well? What is not working well? Why?
- To what extent is there genuine collaboration between partners involved in the program?
- Are the program materials and services of good quality?
- Are there other unplanned opportunities that have arisen to enhance the reach and quality of the program?
- What external or other factors are influencing the implementation of the program?

Impact and outcome evaluation

In impact evaluation, the immediate effects of the program are assessed. The evaluation questions relate to whether and the extent to which the objectives and sub-objectives of the program have been achieved. Impact evaluation therefore relates to changes in the immediate and contributing determinants of the health and wellbeing priority. Outcome evaluation assesses the long-term effects of the program. The evaluation 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. 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 impact and outcome evaluation, there are three main evaluation designs: experimental, quasi-experimental and non-experimental. There are advantages and disadvantages of each evaluation design. Experimental designs involve random allocation of participants into a health promotion program group or a control group. Statistical methods are used to determine

differences in health and wellbeing outcomes between the groups. The sample size is necessarily large to obtain statistical significance. There are strict protocols around the conduct of the research, which enable the evaluation to be replicated. Experimental designs have traditionally been highly regarded, but they are time-consuming and costly, and randomisation may discriminate against priority groups within the population. 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. Non-experimental designs do not use any comparison groups and may involve pre-test and post-test, or post-test only. Pre-test/post-test designs are used in both quasi-experimental and non-experimental designs.

Part of impact and outcome evaluation might involve analysis of the cost versus benefits of a health promotion initiative, sometimes referred to as economic evaluation. In this type of evaluation, the resources consumed, such as time and money, are assessed relative to the impacts or outcomes in the priority population. For example social return on investment 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 and would require the assistance of a health economist.

Evaluating the achievement of a health promotion program goal and objectives may be incomplete as it may not identify unexpected impact and/or outcome, which may be positive or negative. These unanticipated changes are also important to capture and reliance solely on evaluation of goals and objectives could result in them being missed. For these reasons, some evaluation not directly linked to the goal and objectives is useful.

Evaluation reports

Having done the evaluation, it is then necessary to write the evaluation report to communicate the process, impact and outcome evaluation findings. This helps health practitioners, organisations and funding bodies to make decisions about the program's effectiveness and future. The evaluation report brings the community health and wellbeing priorities to the attention of others and promotes greater understanding of the health promotion program. All stakeholders need to have access to the evaluation findings, particularly those who designed the program, or for whom the program was designed. For the evaluation report to meet the needs of the widest possible audience, health practitioners must consider who the report is for and the most appropriate medium. 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 and often the only component of the report that will be read, therefore it must succinctly 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. Individual, community or policy changes may take place as a result of disseminating the evaluation report.

CONCLUSION

This chapter has described the health promotion practice cycle of community assessment, program planning, implementation and evaluation, 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 for critical 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. Planning a health promotion program to address health and wellbeing priorities involves developing the goal, objectives, strategies, activities and evaluation plan, together with identifying the required resources to deliver the health promotion program plan. Implementation involves implementing the health promotion strategies and activities and documenting the process. Evaluation includes formative, process, impact and outcome evaluation. Formative evaluation is undertaken in the planning or renewal stages of a health promotion program. Process evaluation involves evaluating the implementation of program strategies and activities as the program is implemented. Impact and outcome evaluation evaluates the extent to which the program objectives and goal have been achieved. All stages of the health promotion practice cycle should be transparent and detailed documentation of processes and dissemination of evaluation findings are important to contribute to the evidence base for health promotion.

PUTTING THE OTTAWA CHARTER INTO PRACTICE

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. The content of this chapter will assist health practitioners to develop the necessary professional knowledge and skills to work in different settings for health promotion, and advocate for and develop healthy public policy.

Build healthy public policy

1. What agency protocols exist to support health promotion community assessment, planning, implementation and evaluation?
2. What global, national, regional and local policies address the health and wellbeing priorities of a community?
3. What policies, legislation, standards or codes of practice are required to address the health and wellbeing priorities of a community?

Create supportive environments

4. What existing environmental structures or institutions address the health and wellbeing priorities of a community? These may be in social, cultural, economic, commercial, digital, built or natural environments.
5. What environmental structures or institutions are required to address the health and wellbeing priorities of a community?
6. How can communities be adequately supported so they are not set up to fail?

Strengthen community action

7. What methods can be used to engage people in the health promotion cycle?
8. Is the process of engaging community members clearly documented?
9. Who is participating in the community assessment, planning, implementation and evaluation stages of the health promotion program?
10. What roles do they have?
11. What is their role in decision-making?
12. Who is not participating in the community assessment, planning, implementation and evaluation stages of the health promotion program?
13. How could they be more engaged?
14. Can the community showcase its skills to others?
15. What community development strategies or actions are being used in the implementation of the health promotion program?

Develop personal skills

16. Are community members supported to develop their skills in community assessment, planning, implementation and evaluation?

Reorient health services

17. What role are health services playing in the community assessment, planning, implementation and evaluation of health promotion programs?
18. What resources are health services contributing to health promotion programs?
19. What policies or strategic plans do health services have in place for working with communities on health promotion programs?
20. To what extent are health promotion responsibilities, qualifications and accreditation included in the job descriptions of health practitioners?
21. To what degree do health services support shared decision-making with the communities that they work with?
22. Do the health services have a process to respond to the evaluation results of health promotion programs?

MORE TO EXPLORE

COMMUNITY ASSESSMENT, PLANNING, IMPLEMENTATION AND EVALUATION TOOLS

- Conducting a community needs assessment: www.ourcommunity.com.au/management/view_help_sheet.do?articleid=10.
- Planning and Evaluation Wizard (PEW): www.flinders.edu.au/content/dam/documents/research/southgate-institute/planning-evaluation-wizard/developing-case-key-questions.pdf
- VicHealth Partnerships Analysis Tool: www.vichealth.vic.gov.au/sites/default/files/2023-05/VH_Partnerships-Analysis-Tool_web%5B1%5D.pdf

LITERATURE REVIEWS

- JBI Collaboration: jbi.global/
- PHIDU (Public Health Information Development Unit), Torrens University Australia, phidu.torrens.edu.au/#JtKQqgqt0eBzCAiH.97

PLANNING AND EVALUATION MODELS IN HEALTH PROMOTION

- The PRECEDE–PROCEED Model of health program planning and evaluation: www.lgreen.net
- RE-AIM and PRISM Framework: re-aim.org/

ETHICS IN RESEARCH AND EVALUATION

- Health Research Council of New Zealand: www.hrc.govt.nz/
- National Statement on Ethical Conduct in Human Research, Preamble, Ethical background: National Health and Medical Research Council: www.nhmrc.gov.au/about-us/publications/national-statement-ethical-conduct-human-research-2023
- National Statement on Ethical Conduct in Human Research, Section 1: Values and principles of ethical conduct. National Health and Medical Research Council: www.nhmrc.gov.au/sites/default/files/documents/attachments/publications/National-Statement-Ethical-Conduct-Human-Research-2023.pdf

FUNDING

- FundsforNGOs: Grants and Resources for Sustainability (www.fundsforngos.org/), is a social enterprise that provides support for NGOs, companies and individuals globally to improve access to resources that enable a sustainable environment and alleviate poverty.
- Our Community (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 pro forma; small grants offered by local government and local service clubs are a good place to start.
- Philanthropy Australia (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.
- Community Matters (www.communitymatters.govt.nz/) is a New Zealand organisation that works with and supports communities to access resources for community-based projects.

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. 4.3 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 Lotus Critical Health Promotion Model values and principles in Table 4.4. 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 programs that you are aware of.

REFERENCES

Aitken, J. C., Dickson-Swift, V., & Kenny, A. (2015). Linking community engagement and therapeutic landscapes to develop new social prescriptions for health and well-being. Bendigo: La Trobe Rural Health School Higher Degree Research Festival, 27 November 2015.

Allen, J., & Flack, F. (2015). Evaluation in health promotion: thoughts from inside a human research ethics committee. Health Promotion Journal of Australia, 26(3), 182–185.

Arnstein, S.R. (1971). Eight rungs on the ladder of citizen participation. In: E.S. Cahn & B.A. Passett (eds), Citizen participation: effecting community changes. New York, NY: Praeger Publishers.

Bajayo, R. (2012). Building community resilience to climate change through public health planning. Health Promotion Journal of Australia, 23(1), 30–36.

Baum, F., Lawless, A., Delany, T., et al. (2014). Evaluation of health in all policies: concept, theory and application. Health Promotion International, 29(supp1), i130–i142.

Bauman, A. & Nutbeam, D. (2023). Evaluation in a nutshell. Sydney: McGraw-Hill Education Australia.

Baxter, J., Cooklin, A. R., & Smith, J. (2009). Which mothers wean their babies prematurely from full breastfeeding? An Australian cohort study. Acta Paediatrica, 98(8), 1274–1277.

Bedworth, A., & Bedworth, D. (1992). The profession and practice of health education. Dubuque IA: WC Brown.

Bradshaw, J. (1972). The concept of social need. New Society, 30(March), 640–643.

Cleary, A., Fielding, K.S., Bell, S.L., et al. (2017). Exploring potential mechanisms involved in the relationship between eudaimonic wellbeing and nature connection. Landscape and Urban Planning, 158, 119–128.

Cook, N., Hughes, R., Taylor, E., et al. (2015). Shading liveable cities: exploring the ecological, financial and regulatory dimensions of the urban tree canopy. Working Paper. Available at: ro.uow.edu.au/cgi/viewcontent.cgi?article=4168&context=sspapers

Davidson, P., Halcomb, E., Gholizadeh, K. (2017). Focus groups in health research. In: E. Liamputtong (ed.). Research methods in health: foundations for evidence-based practice (3rd ed.). South Melbourne: OUP.

DeFilippis, J., & Saegert, S. (2013). The community development reader (2nd ed.). New York: Taylor and Francis.

Denzin, N.K., & Lincoln, Y.S. (eds). (2011). The SAGE handbook of qualitative research (4th ed.). Thousand Oaks CA: Sage.

Falk, I., & Kilpatrick, S. (2000). What is social capital? A study of interaction in a rural community. Sociologica Ruralis, 40(1), 87–110.

Farmer, J., Hill, C., & Munoz, S.-A. (2012). Community co-production: social enterprise in remote and rural communities. Cheltenham, UK: Edward Elgar.

Folke, C., Biggs, R., Norström, A., et al. (2016). Social-ecological resilience and biosphere-based sustainability science. Ecology and Society, 21(3), 1.

Frieling, M.A., Davis, W.R., Chiang, G. (2013). The SF-36v2 and SF-12v2 health surveys in New Zealand: norms, scoring coefficients and cross-country comparisons. Australian and New Zealand Journal of Public Health, 37(1), 24–31.

Green, L. (2005). Health program planning: an educational and ecological approach (4th ed.). New York NY: McGraw-Hill.

Hauck, Y., Fenwick, J., Dhaliwal, S., & Butt, J. (2011). A Western Australian survey of breastfeeding initiation, prevalence and early cessation patterns. Maternal and Child Health Journal, 15(2), 260–268.

Hawe, P., Degeling, D.E., & Hall, J. (1990). Evaluating health promotion: a health worker's guide. Sydney: MacLennan and Petty.

International Union for Health Promotion and Education (2016). Core competencies and professional standards for health promotion 2016. Available at: www.healthpromotion.org.au/images/docs/IUHPE_core_competencies_for_health_promotion_.pdf

Kilpatrick, S., Cheers, B., Gilles, M., & Taylor, J. (2009). Boundary crossers, communities, and health: exploring the role of rural health professionals. Health and Place, 15(1), 284–290.

Labonté, R. & Laverack, G. (2008). Health promotion in action: from local to global empowerment. Basingstoke, UK: Palgrave Macmillan.

Laverack, G. (2007). Health promotion practice building empowered communities. Maidenhead: Open University Press.

McKenzie, J.F., Neiger, B.L., & Thackeray, R. (2013). Planning, implementing, and evaluating health promotion programs: a primer (6th ed.). Boston MA: Pearson.

Meedya, S., Fahy, K., & Kable, A. (2010). Factors that positively influence breastfeeding duration to 6 months: a literature review. Women and Birth, 23(4), 135–145.

Millar, R., & Hall, K. (2013). Social Return on Investment (SROI) and performance measurement: the opportunities and barriers for social enterprises in health and social care. Public Management Review, 15(6), 923–941.

National Health and Medical Research Council, Australian Research Council and Universities Australia (2023). National Statement on Ethical Conduct in Human Research. Canberra: National Health and Medical Research Council. Available at: www.nhmrc.gov.au/about-us/publications/national-statement-ethical-conduct-human-research-2023

O'Hara, L., & Taylor, J. (2023). QATCHEPP: A quality assessment tool for critical health promotion practice. Frontiers in Public Health, 11. doi.org/10.3389/fpubh.2023.1121932

Ogbo, F. A., Eastwood, J., Page, A., et al. (2017). Prevalence and determinants of cessation of exclusive breastfeeding in the early postnatal period in Sydney, Australia. International Breastfeeding Journal, 12(1), 16.

People's Health Movement, Medact, Medico International, Third World Network, Health Action International, & Asociación Latinoamericana de Medicina Social (2014). Global Health Watch 4: an alternative world health report. London: Zed Books.

Pérez-Wilson, P., Marcos-Marcos, J., Morgan, A., Eriksson, M., Lindström, B., et al. (2021). 'A synergy model of health': an integration of salutogenesis and the health assets model. Health Promotion International, 36(3), 884–894.

Quinlivan, J., Kua, S., Gibson, R., et al. (2015). Can we identify women who initiate and then prematurely cease breastfeeding? An Australian multicentre cohort study. International Breastfeeding Journal, 10(1), 16.

Ravaghi, H., Guisset, A.-L., Elfeky, S., et al. (2023). A scoping review of community health needs and assets assessment: concepts, rationale, tools and uses. BMC Health Services Research, 23(1), 44.

Ritchie, J., & Spencer, L. (1994). Qualitative data analysis for applied policy research. In: A. Bryman & R. Burgess (eds), Analyzing qualitative data. Routledge.

Robinson, P., & Lowe, J. (2015). Literature reviews vs systematic reviews. Australian and New Zealand Journal of Public Health, 39(2), 103.

Rollins, N.C., Bhandari, N., Hajeebhoy, N., et al. (2016). Why invest, and what it will take to improve breastfeeding practices? The Lancet, 387(10017), 491–504.

Sáinz-Ruiz, P.A., Sanz-Valero, J., Gea-Caballero, V., Melo, P., Nguyen, T.H., et al (2021). Dimensions of community assets for health. A systematised review and meta-synthesis. International Journal of Environmental Research and Public Health, 18(11), 5758.

Salihu, H.M., Salinas-Miranda, A.A., Paothong, A., Wang, W., King, L.M. (2015). Community-based decision making and priority setting using the R software: the community priority index. Computational and Mathematical Methods in Medicine, 2015, 347501.

Sarvela, P. & McDermott, R. (2003). Health promotion short course facilitators guide: Module 1. Melbourne: State Government of Victoria, Department of Human Services.

Smith, R.D., Cattaneo, A., Iellamo, A., et al. (2018). Review of effective strategies to promote breastfeeding. Available at: www.saxinstitute.org.au/publications/review-effective-strategies-promote-breastfeeding/

Steiner-Lim, G.Z., Karamacoska, D., Abramov, G., Dubois, S., Harley, A., et al. (2023). "I'm on my own, I need support": needs assessment of community aged care services. International Journal of Integrated Care, 23(3), 14.

Stephenson, C. (1996). SF-36 interim norms for Australian data. Available at: www.aihw.gov.au/getmedia/13a09319-2ec0-4030-aa54-ac43478573e1/SF-36%20Interim%20norms%20for%20Australian%20data.pdf.aspx?inline=true

Talbot, L., & Walker, R. (2007). Community perspectives on the impact of policy change on linking social capital in a rural community. Health and Place, 13(2), 482–492.

Tesoriero, F. (2010). Community development: community-based alternatives in an age of globalisation (4th ed.). Sydney: Pearson Australia.

Torrens University Australia (n.d.). PHIDU (Public Health Information Development Unit), Torrens University Australia. Available at: phidu.torrens.edu.au/#JtKQqgqtoeBzCAiH.97

Wadsworth, Y. (1997). Everyday evaluation on the run (2nd ed.). Sydney: Allen & Unwin.

Ware, J.E. (2000). SF-36 health survey update. Available at: journals.lww.com/spinejournal/Fulltext/2000/12150/SF_36_Health_Survey_Update.8.aspx

World Health Organization (WHO) (1986). The Ottawa Charter for Health Promotion. Available at: www.who.int/healthpromotion/conferences/previous/ottawa/en/

Yallop, C. (ed.) (2005). Macquarie dictionary (4th ed.). Sydney: Macquarie Library.