
HEALTH PROMOTION PLANNING

An Educational and Environmental Approach

SECOND EDITION

Lawrence W. Green
Marshall W. Kreuter

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Lawrence W. Green

Institute of Health Promotion Research
University of British Columbia

Marshall W. Kreuter

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Preface

This book and the previous edition, which was called *Health Education Planning: A Diagnostic Approach*, have been written to provide a conceptual synthesis of the roots and foundations of health education and, more recently, health promotion following a period of rapid growth and development. Before 1980, the field of action represented by health education and health promotion lacked a clear articulation of its boundaries, its methods and procedures, and the distinctions between health education and health promotion. The philosophy, intellectual roots, and systematic descriptions of health education subspecialties were well represented in textbooks, and the research foundation was growing in every direction. We proposed a single framework on which disparate new research findings could be hung, a heuristic for theorists and planners, and a practical teaching and learning tool for practitioners, professors, and students trying to make sense of the field.

For most of this century, health promotion has been relegated to the status of a philosophical ideal, subsumed under the World Health Organization's definition of health. It was seldom translated into policy—and then most often only within the confines of health education and fitness programs. In 1974, the LaLonde report, *A New Perspective on the Health of Canadians*, put the term “health promotion” on a new footing by using it with policy backing for the first time. In 1975, Public Law 94-317 gave policy support to health promotion in the United States with the Health Information and Health Promotion Act and the creation of the federal Office of Disease Prevention and Health Promotion. Since then, a wide range of government and private-sector initiatives to support a more healthful lifestyle for whole communities, and even societies, have been implemented. Major clean air initiatives and a host of local ordinances have been passed to control smoking in public places. Consumer organizations and self-help groups advocate healthful living conditions and resources to increase personal control over the factors influencing health. Increased cooperation between levels of government and between health agencies and other sectors has produced new health promotion

opportunities and activities, notably in schools and worksites, but also in whole communities, states, and nations where coalitions have taken hold. Media have given increased attention to health issues, and initiatives to demand greater equity and social justice in access to health resources have been passed. However, some social equity has been lost, as well.

In the tumult of these times, when health promotion engages behavioral and social scientists, epidemiologists, physicians, nurses, political activists, physical educators, communications and marketing specialists, and others, the linchpin for health promotion is the status of health education in all its various dimensions. We place emphasis here on the single word “education,” not “information,” nor even “health education.” Education for health empowers through the development of understanding, motivation, and skills. We emphasize not just the knowledge and skills to reduce behavioral risks, as important as they are, but also those elements that engage people more actively in their community’s affairs, such as participating effectively in making health and social policy, demanding enforcement of regulations on environmental polluters, and organizing advocacy for new or revised laws and regulations. These public dimensions of health promotion require education of the electorate no less than the personal risk-reduction dimensions.

Health promotion now affords new opportunities and challenges for health practitioners as they seek to strengthen the organizational, economic, and environmental supports necessary for healthful living in modern society. We hope this book offers help to those who would accept these challenges.

Despite enormous expansion in the scope of health promotion policy and practice, responsibility for health promotion planning is still left largely to those identified as health educators. There has been no significant movement to create a new profession called health promotion, and we are not advocating such a movement with the retitling of this book. Professional training for health promotion is centered still in the departments of health education and community health of health professional schools. To varying degrees, training also occurs in the form of electives in schools of public health, medicine, nursing, dentistry, pharmacy, allied health, and physical education and recreation. Health promotion planning continues to depend on health education specialists not only because they hold many of the key positions from which to mount the expanded functions of health promotion, but also because they possess the essential combination of skills in program planning and behavioral diagnosis described in the first edition of this book. However, the field of health promotion does offer a more open invitation for people in other professions and for laypersons to take leadership roles not frequently offered by the increasingly professionalized field of health education.

Our task in this second edition has been to catch up with the rapid developments in policy, research, and practice. While maintaining the integrity of the PRECEDE planning framework that has been widely tested in various settings at the national, provincial or state, and community levels, we have expanded the model to accommodate the more comprehensive field of health promotion. Thus,

the diagnostic approach now encompasses the social forces (including political, organizational, economic, and environmental) that influence lifestyle and health, as well as the more specific behavioral influences on health and the more immediate educational influences on behavior.

Within this expanded scope, we continue to emphasize an educational approach to health promotion as the essential starting point, even when the ultimate interventions must be more coercive, regulatory, or economic. Indeed, the public support and acceptance of new legislation and regulation depends on adequate preparation of the citizenry through an educational process. Many good legislative bills that would have improved the public's health have failed to pass or have been repealed because their sponsors failed to build an educated constituency for them. The continuing commitment to an educational approach to health, even within the political context of health promotion, is reflected in the new subtitle of this edition.

Our attempt here to address the essentially political dimension of health promotion is a departure from our more strictly scientific and technological approach to health education in the previous edition. We attempted then to avoid ideological traps by taking a value-free stance with respect to methods, except for one overriding principle or philosophy—that behavior change should be voluntary. We remain committed to that educational philosophy in this edition, and it remains the basis for the development of an educational diagnostic model. At the same time, we recognize that the social policy targets of health promotion sometimes call for aggressive and even coercive measures to regulate the behavior of those individuals, corporations, and government officials whose actions influence the health of others. The essential rule of thumb we suggest for justifying more coercive means of changing behavior or lifestyle is when the behavior in question is one that threatens the health or well-being of others, such as drunk driving or the promotion of unhealthful products to children. This rule runs into gray areas, of course, when the alleged threat to the well-being of others is something more remote, such as the long-term economic cost to society incurred by people who smoke or engage in other high-risk behavior today that *might* result in chronic illness or disability later. It also runs into value conflicts with constitutional protections such as the First Amendment right to free speech, which protects advertising as well as the press.

As we come to grips with more and more of these value-laden choices in health promotion, we must develop and sharpen the political understanding and skill of those who plan health promotion programs. We have put this burden particularly on Chapter 2, the quality-of-life assessment or “social diagnosis.” The emphasis is on methods of assuring the active involvement of people in assessing their own needs and evaluating their own progress and programs. This is especially relevant at the local level, where values can be weighed within the context of the social culture and economy. Again, the educational perspective prevails, with the emphasis on participation and enabling people to take greater control of the decisions influencing their quality of life, but we have tried to reflect more on

the political realities in carrying out this frequently neglected phase of the diagnostic process.

The original framework, which we called PRECEDE in the previous edition, remains largely intact in this edition. PRECEDE stands for “predisposing, reinforcing, and enabling constructs in educational diagnosis and evaluation.” To accommodate the broader mandate of health promotion, we have superimposed an additional set of procedures which we call PROCEED for “policy, regulatory, and organizational constructs in educational and environmental development.” The burden of this component of the combined model falls on what we called the administrative diagnosis in the previous edition. The administrative diagnosis is the final planning step to “precede” implementation. From there we “proceed” to promote the plan or policy, regulate the environment, and organize the resources and services, as required by the plan or policy. The promotional, regulatory, and organizational components of PROCEED take the student or practitioner beyond educational interventions to the political, managerial, and economic actions necessary to make social systems and environments more conducive to healthful lifestyles and a more complete state of physical, mental, and social well-being for all.

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The frameworks for planning presented in this text grew out of our combined experience in practice, research, teaching, consultation, and government service—all guided and enriched by significant teachers, colleagues, and students. PRECEDE included an amalgamation of Ronald Andersen’s *Behavioral Model of Families’ Use of Health Services*, Albert Bandura’s Social Learning Theory, Hochbaum, Rosenstock, and Becker’s Health Belief Model, Fishbein’s behavioral intention mode, J. Mayone Stycos’ decision model on couples’ adoption of family planning methods, Kurt Lewin’s force-field analysis, and Edward E. Bartlett’s methods and strategies in health education. These models and our collaboration with Sigrid Deeds, David Levine, Kay Partridge, Virginia Li, and others at Johns Hopkins University in the 1970s influenced our way of thinking about health education planning, needs assessment, and evaluation.

Similarly, PROCEED was a product of the Health Field Concept of Laframboise and the LaLonde report; of our experience with Joseph Califano, Julius Richmond, James O. Mason, Michael McGinnis, Martha Katz, Donald Iverson, Lloyd Kolbe, Henry Montes, Patricia Mullen, Dennis Tolsma, and others in the U.S. federal initiative in disease prevention and health promotion, including participation in the development of the national objectives for 1990, the Model Standards for Community Preventive Health Services, and in similar processes with several state and local health agencies; of the work of Judith Ottoson, Guy

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Lawrence W. Green, Vancouver
Marshall W. Kreuter, Atlanta

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