An incisive, up-to-date, and comprehensive treatment of effective health promotion programs

In the newly revised Third Edition of *Health Promotion Programs: From Theory to Practice*, health and behavior experts Drs. Carl I. Fertman and Melissa L. Grim deliver a robust exploration of the history and rapid evolution of health promotion programs over the last three decades. The authors describe knowledge advances in health and behavior that have impacted the planning, implementation and evaluation of effective health promotion programs.

With thoroughly updated content, statistics, data, figures, and tables, the book discusses new resources, programs, and initiatives begun since the publication of the Second Edition in 2016. "Key Terms" and "For Practice and Discussion Questions" have been revised, and the authors promote the use of health theory by providing the reader with suggestions, models, boxes, and templates.

Championed is health promotion program planning, implementation and evaluation rooted in health equity and social justice. Health theory and evidence-based practice permeates the book.

Readers will also find:

- A thorough introduction to health promotion programs, including the historical context of health promotion, settings and stakeholders for health promotion programs, advisory boards, and technology disruption and opportunities for health promotion
- Comprehensive explorations of health equity and social justice, including discussions of vulnerable and under-served population groups, racial and ethnic disparities in health, and minority group engagement
- Practical discussions of theory in health promotion programs, including foundational theories and health program planning models
- In-depth examinations of health promotion program planning, including needs assessment and program support

Perfect for undergraduate and graduate students studying public health, health administration, nursing, health education, and medical research, *Health Promotion Programs: From Theory to Practice* is also ideal for medical students seeking a one-stop resource on foundational concepts and cutting-edge developments in population health and health promotion programs.

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Society for Public Health Education (SOPHE) is dedicated to promoting health education and promotion leaders to advance healthy and equitable communities across the globe. Founded in 1950, SOPHE is the leading association for health promotion professionals, faculty and students.

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Health Promotion Programs

Third Edition

Third Edition

Health Promotion Programs

From Theory to Practice

Carl I. Fertman | Melissa L. Grim

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HEALTH PROMOTION PROGRAMS

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FROM THEORY TO PRACTICE

Third Edition

Edited by
Carl I. Fertman
Melissa L. Grim

Society for Public Health Education

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For my wife, Barbara Murock, promoter of love, family, health, and biking

For all the generations from, between and beyond Eliezer to Kai with gratitude

—Carl I. Fertman

For my husband, Mike, and daughters, Evie and Jill, for filling our home with love and a constant supply of laughter.

—Melissa L. Grim

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We acknowledge and recognize Diane Allensworth, who served as co-editor for the first and second editions. Diane's early and continuous support of the book made the difference in the decision to publish the book. We appreciate her commitment and vision for health promotion programs in all places people live, work, study, play, and worship.

We thank the current and past chapter authors as well as their supporting organizations and families. We recognize the School of Education, University of Pittsburgh and College of Education and Human Development, Radford University for their support and effort on behalf of the text.

We appreciate and acknowledge the hundreds of SOPHE members and the SOPHE staff and board members who work to promote people's health worldwide. Thank you.

Carl I. Fertman
Pittsburgh, Pennsylvania
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January 2022

ABOUT THE COMPANION WEBSITE

This book is accompanied by a companion website.
www.wiley.com\go\fertman\healthpromotionprograms3e

The website includes for use in the classroom, for students' self-reflection and for online courses:

- Lectures PowerPoint slides
- Chapter test banks
- Case studies
- Planning health promotion program course project model
- Cross-reference to NCHES competencies
- Tables, figures and sidebars from the book in PDF form

PREFACE

We are pleased to share this third edition of *Health Promotion Programs: From Theory to Practice*. The pandemic in 2020 shed a blinding light on critical conversations about equity and systemic injustice, which attained both new urgency and a well-deserved central role in our national conversation health and health promotion. We have all seen, in real time, how structural discrimination and obstacles to opportunity do their work in a crisis. In our communities, every burden—from rates of infection and care outcomes, to economic adversity, to the challenges of virtual learning when schools are closed—falls heaviest on those for whom true equity has always been farthest from reach. *Health Promotion Programs: From Theory to Practice* is being published as the pandemic recedes; however, we can't simply assume that healing and recovery follow. It falls on all of us—individuals and communities, companies and governments—to ensure that what's ahead is not just the end of a disease but a durable and hopeful future for all who sacrificed and endured during this unprecedented time.

Today, health promotion programs have evolved to be integral to promoting a culture of health and wellness and to healthcare across the United States and internationally. The Society for Public Health Education (SOPHE) recognized the need for a book to help advance the field. Escalating rates of chronic disease, soaring healthcare costs, and increasing diversity of the U.S. population, as well as aging of the current health education workforce, all call for training a new generation of health promoters. The SOPHE board of trustees, executive director, and members offer this book, which combines the theoretical and practice base of the field with step-by-step practical sections on how to develop, implement, and evaluate health promotion programs. SOPHE hopes that this book, read in its entirety or in part, will help not only students who choose to major or minor in health education, health promotion, community health, public health, or health-related fields (e.g., environmental health, physical fitness, allied health, nursing, or medicine), but also professionals already working who want to acquire the technical knowledge and skills to develop successful health promotion programs. Acquiring the competencies to effectively plan, implement, and evaluate health promotion programs can improve health outcomes, promote behavioral and social change, and contribute to health equity and social justice. This book offers a concise summary of the many years of research in the fields of health education and health promotion, along with the expertise of many SOPHE members working in diverse

contemporary settings and programs. The book also reflects SOPHE's mission and its commitment to professional preparation and continuing education for the purpose of improving the quantity and quality of the lives of individuals and communities.

Undergraduate and graduate programs that prepare professionals to work in public health, health education, and health promotion and wellness have been flourishing in the United States and throughout the world for more than half a century. Thousands of students graduate every year with a baccalaureate or advanced degree in health promotion and get jobs in schools, colleges, businesses, healthcare facilities and systems, community organizations, and government.

We are enormously grateful to the many SOPHE members who wrote this book. Their expertise in many fields, including health education, public health, sociology, anthropology, psychology, nursing, medicine, physical education, nutrition, allied health, and many others, have been braided into this health promotion anthology. They have shared the foundations of the field as well as their own practical experiences in health promotion planning. May this book help teach, guide, inspire, ignite, catalyze, and transform students and professionals in their quest to develop successful health promotion programs that address the health challenges of both today and tomorrow.

ABOUT THE THIRD EDITION

The main purpose of the third edition is the same as the previous editions: to provide a comprehensive introduction to health promotion programs by combining the theory and practice with a hands-on guide to program planning, implementation, and evaluation. One of the fundamental premises of this book is the importance of using an approach based in both research and practice to guide and inform planning, implementation, and evaluation of health promotion programs. A secondary goal is to present the widespread opportunities to implement health promotion programs in schools, colleges and universities, communities, workplaces, and healthcare organizations and systems. This text addresses the needs of students and professionals who are pursuing careers in health education as well as nursing, medicine, public health, and allied health.

The third edition presents the new opportunities for health promotion by embracing healthy equity and social justice in the application of health theories and health program planning models for diverse populations and settings. These issues are broad and of growing importance, so they are integrated into all of the chapters and in particular highlighted in the chapters that address health promotion in schools, colleges and universities, workplaces, healthcare organizations, and communities. We believe that these strengthen the book and increase its appropriateness for use with students and in settings around the world.

Who Should Read This Book

This book is aimed at three audiences. The first audience is students pursuing a major or minor in health education, health promotion, community health, public health, or health-related fields such as environmental health, physical activity and education, allied health, nursing, or medicine. The second audience is young and mid-career practitioners, practicing managers, researchers, and instructors who for the first time are responsible for teaching, designing, or leading health promotion programs. The third audience is colleagues and professionals not trained in the health fields but working in settings where health promotion programs are increasingly prevalent and might be under their supervision (for example, school superintendents and principals, human resource directors working in business and healthcare, college deans of student affairs, faculty members, board members of nonprofit organizations, community members, and employers and staff members in businesses and healthcare organizations).

Overview of the Contents

This volume presents an up-to-date understanding of health promotion program planning, implementation, and evaluation in a variety of settings. The book is divided into five parts. Part One presents the foundations of health promotion programs: what health and health promotion are, the history of health promotion, sites of health promotion programs, and the key people (stakeholders) involved in programs. Highlighted and explored are the two guiding forces in planning, implementing, and evaluating health promotion programs. The first is promoting health equity and social justice. The second is the use of health theories and planning models.

Parts Two (planning), Three (implementing), and Four (evaluating) provide a step-by-step guide to planning, implementing, and evaluating a health promotion program. Each chapter within these parts covers specific phases of health promotion program planning, implementation, evaluation, and sustainability. Practical tips and specific examples aim to facilitate readers' understanding of the phases as well as to build technical skills in designing and leading evidence-based health promotion programs.

Part Five presents health promotion programs across five settings: schools (preschool–12), colleges and universities, healthcare organizations, workplaces, and communities. Each chapter presents keys for effective site-specific programs to promote health.

At the beginning of each chapter, the Learning Objectives give a framework and guide to the chapter topics. The key terms at the end of each chapter can be used as a reference while reading this book as well as a way to recap key definitions in planning, implementation, and evaluation of health promotion programs.

Practical examples throughout the book reinforce the need for health promotion programs to be based on in-depth understanding of the intended audiences' perceptions, beliefs, attitudes, behaviors, and barriers to change as well as the cultural, social, and environmental context in which they live. By referring to current theories and models of health promotion, the book also reinforces the need for health promotion practitioners to base their programs on theories, models, and approaches that guide and inform health promotion program design, implementation, and evaluation.

Each chapter ends with practice and discussion questions that help the reader to reflect on as well as utilize the key terms. Finally, all chapters are interconnected but are also designed to stand alone and provide a comprehensive overview of the topics they cover.

Features

You'll find the following features in each chapter of the book to use in the classroom, for students' self-reflection and online:

- Learning objectives
- Tables, figures and sidebars
- Practice and discussion questions
- Lists of key terms

Editors' Note

As editors, we hope that we contribute to preventing disease and promoting health. We believe that understanding the theory and practice of health promotion program planning, implementation, and evaluation will allow more individuals and groups to enjoy the benefits of good health and will encourage more schools, colleges and universities, workplaces, healthcare organizations, and communities to be designated as health-promoting sites. We are grateful to the SOPHE members who have authored chapters in this text and admire their commitment and dedication to making a difference in the health outcomes of the individuals, communities, groups, and organizations they serve.

Health Promotion Programs: From Theory to Practice has been established as a widely used text and reference book both in the United States and internationally. It is our hope that the third edition will continue to be relevant and useful and stimulate readers' interest and knowledge in health promotion programs that utilize health theory to promote health equity. We aspire to provide readers with information and skills to ask critical questions, think conceptually, and stretch their thinking to promote health across diverse populations and settings.

We appreciate the opportunity to plan and edit this text, which the SOPHE board of trustees, executive director, staff, and members provided to us. SOPHE provides leadership and works to contribute to the health of all people, health equity and social justice through advances in health promotion theory and research, excellence in professional preparation and practice, and advocacy for public policies conducive to health. SOPHE and its members advocate for and support the work of thousands of professionals who are committed to improving people's health where they live, work, study, play, and worship. We hope that this book helps advance these goals and helps guide and inspire a healthier world.

To the Instructor

An instructor's supplement is available at www.wiley.com\go\fertman\healthpromotionprograms3e. Additional materials such as videos, podcasts, and readings can be found at www.josseybasspublichealth.com.

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SOPHE

The Society for Public Health Education (SOPHE) is a nonprofit professional organization founded in 1950. SOPHE's mission is to provide global leadership to the profession of health education and health promotion and to promote the health of society through advances in health education theory and research, excellence in professional preparation and practice, advocacy for public policies conducive to health, and the achievement of health equity for all. SOPHE is the only independent professional organization devoted exclusively to health education and health promotion.

SOPHE's membership extends health education principles and practices to many settings, including schools, universities, medical and healthcare settings, workplaces, voluntary health agencies, international organizations, and federal, state, and local governments.

Contact SOPHE at 10 G Street N.W., Suite 605, Washington, DC 20002-4242. Telephone: (202) 408-9804. Website: www.sophe.org.

PART ONE

HEALTH PROMOTION PROGRAM FOUNDATIONS

CHAPTER 1

WHAT ARE HEALTH PROMOTION PROGRAMS?

Carl I. Fertman, Melissa L. Grim, and M. Elaine Auld

Health Promotion in a New Health Era

In 2020 the new decade opened with COVID-19 ushering in a new health era with a new context for **health**, **health promotion**, and **health promotion programs**. The public paid attention to COVID-19. Fear was rampant. COVID-19 caused the public to be anxious and afraid. Hope about vaccines, drugs, and cures was high. The pandemic showed the power of actions at multiple levels by individuals, groups, healthcare systems, community human service organizations, businesses, **schools**, **colleges and universities**, and governments to combat the virus. The actions span from individual behaviors to governmental policies and legislation—hand washing, social distancing, and self-quarantine combined with stay-at-home orders and travel restrictions. Businesses made employee and customer health promotion and safety a priority. The actions had clear health outcomes that impacted individuals and whole populations of people and **communities** across the globe.

Conversely, the lack of action and delays to address the virus, to promote and protect health, had pervasive and negative, if not fatal, consequences for individuals and whole populations of people. The balance between health and economic systems was tested and debated, providing a context for action. Promoting and protecting health was laid bare at the intersection of health and economic status, with all sectors of the economy impacted by the virus, but with different economic groups and communities experiencing the virus in distinct and different ways. The lack of **social justice** and

LEARNING OBJECTIVES

- Understand health promotion in a new decade in a new health era.
- Define *health* and *health promotion*, and describe the role of health promotion in fostering good health and quality of life.
- Summarize the key historical developments in health promotion over the last century.
- Compare and contrast health education and health promotion.
- Describe the nature and advantages of each health promotion program setting and identify health promotion program stakeholders.
- Discuss the forces shaping the new emerging era of health promotion.

Health Promotion Programs: From Theory to Practice, Third Edition. Edited by Carl I. Fertman and Melissa L. Grim.

Companion Website: www.wiley.com\go\fertman\healthpromotionprograms3e

health equity added to the COVID-19 burden that many individuals and communities were already experiencing.

COVID-19 is a brutal exclamation point to America's pervasive ill health. Americans with obesity, diabetes, heart disease, and other diet-related diseases were three times more likely to suffer worsened outcomes from COVID-19, including death. Had we flattened the still-rising curves of these conditions, it is quite possible that our fight against the virus would have looked very different. The need for health promotion programs is greater than ever.

In the new health era, health promotion is about so much more than about healthcare, where the focus is on *tertiary prevention*—improving the quality of life and reducing symptoms of a disease you already have (Figure 1.1). Health promotion is about factors outside the traditional boundaries of healthcare—health behaviors (tobacco use, sexual activity), social and economic factors (employment, education, income), and physical environment (air quality, water quality). These three combined (i.e. policies, programs, and health factors) are linked to 80 percent of the health outcomes to impact and improve length and quality of life (University of Wisconsin Public Health Institute & Robert Woods Johnson Foundation, 2021).

Health promotion programs are designed, implemented, and evaluated in complex and complicated dynamic environments. They are multifaceted

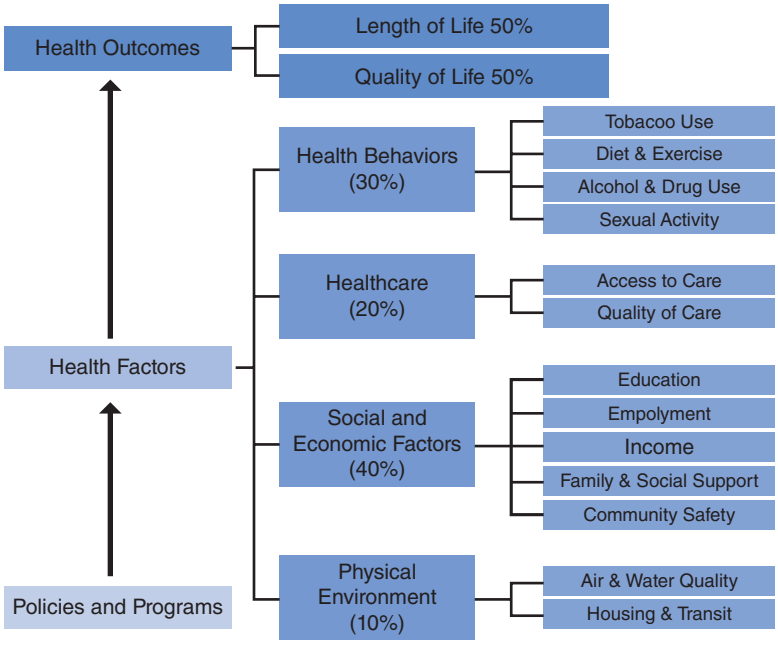

Figure 1.1 Health promotion is associated with more than just healthcare to impact health outcomes linked to length and quality of life

Source: Modified from Population Health Management: Systems and Success, UWPHI & Robert Woods Johnson Foundation, 2020.

and multi-leveled. We work directly with people trying to figure out how to best address their health needs. We work in schools, colleges and universities, communities, **workplaces**, and **healthcare organizations**. At the same time, we are surrounded by forces greater than any organization and group of individuals. The result is that processes of planning, implementing, and evaluating health promotion programs unfold in a nonlinear progression of small steps forward and sometime a couple steps backward. It is dynamic.

Health, Health Promotion, and Health Promotion Programs

Health promotion and health promotion programs are rooted in the World Health Organization's (1947) definition of health as "a state of complete physical, mental and social well-being, and not merely the absence of disease or infirmity." While most of us can identify when we are sick or have some infirmity, identifying the characteristics of complete physical, mental, and social well-being is often a bit more difficult. What does complete physical, mental, and social well-being look like? How will we know when or if we arrive at that state?

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

Arnold and Breen (2006) identified the characteristics of health not only as well-being but also as a balanced state, growth, functionality, wholeness, transcendence, and empowerment and as a resource. Perhaps the view of health as a balanced state between the individual (host), agents (such as bacteria, viruses, and toxins), and the environment is one of the most familiar. Most individuals can readily understand that occasionally the host-agent interaction becomes unbalanced and the host (the individual) no longer is able to ward off the agent (for example, when bacteria overcome a person's natural defenses, making the individual sick).

An ecological perspective on health emphasizes the interaction between and interdependence of factors within and across levels of a health problem. The ecological perspective highlights people's interaction with their physical and sociocultural environments. McLeroy et al. (1988) identified three levels of influence for health-related behaviors and conditions: (1) the **intrapersonal level** (or **individual level**), (2) the **interpersonal level**, and (3) the **population level**. The population level encompasses three

Table 1.1 Ecological Health Perspective: Levels of Influence

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

Source: Adapted from McLeroy, K. R., Bibeau, D., Steckler, A., & Glanz, K. (1988). *An ecological perspective on health promotion programs*. Health Education Quarterly, 15, 351–377.

types of factors: institutional or organizational factors, social capital factors, and public policy factors (Table 1.1).

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

Health promotion programs are designed to work with a **priority population** (in the past called a *target population*)—a defined group of individuals who share some common characteristics related to the health concern being addressed. Programs are planned, implemented, and evaluated to influence the health of a priority population. The foundation of any successful program lies in gathering information about a priority population's health concerns, needs, knowledge, attitudes, skills, and desires related to the disease focus. At the planning stage, it is also important to engage schools, workplaces, healthcare organizations, and communities where the priority population lives and interacts to seek their cooperation and collaboration,

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

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

Historical Context for Health Promotion

Kickbush and Payne (2003) identified three major revolutionary stages in the quest to promote healthy individuals and healthy communities. The first stage, which focused on addressing sanitary conditions and infectious diseases, occurred in the mid-19th century. The second stage was a shift in community health practices that occurred in 1974 with the release of the **Lalonde report**, which identified evidence that an unhealthy lifestyle contributed more to premature illness and death than lack of healthcare access (Lalonde, 1974). This report set the stage for health promotion efforts. In the third stage promoting health for everyone challenged us to identify the various combinations of forces that influence the health of a population and community now within the context and consequences of COVID-19.

Stage 1: Sanitation, Infectious Disease, and Spanish Flu Pandemic

In the mid-19th century, John Snow, a physician in London, traced the source of cholera in a community to the source of water for that community. By removing the pump handle on the community's water supply, he prevented the agent (cholera bacteria) from invading community members (hosts). This discovery not only led to the development of the modern science of epidemiology but also helped governments recognize the need to combat infectious diseases. Initially, governmental efforts focused only on preventing the spread of infectious diseases across borders by implementing quarantine regulations (Fidler, 2003), but ultimately, additional ordinances and regulations governing sanitation and urban infrastructure were instituted at the community level. The Spanish flu pandemic of 1918 infected an estimated 500 million people worldwide—about one-third of the planet's population—and killed an estimated 20 million to 50 million victims, including some 675,000 Americans. The 1918 flu was first observed in Europe, the United States, and parts of Asia before swiftly spreading around the world. At the time, there were no effective drugs or vaccines to treat this killer flu strain. Government officials to prevent the virus spread and promote and protect peoples' health imposed quarantines, ordered citizens to wear masks and shut down public places, including schools, churches, and theaters. People were advised to avoid shaking hands and to stay indoors,

libraries put a halt on lending books, and regulations were passed banning spitting. By the 1940s in the United States, water and sewer systems were constructed across the nation. The regulatory focus had expanded to include dairy and meat sanitation, control of venereal disease, and promotion of prenatal care and childhood vaccinations (Perdue et al., 2003).

Stage 2: Lifestyle Factors and Chronic Disease

As environmental supports for addressing infectious diseases were initiated (for example, potable water and vaccinations), deaths from infectious diseases were reduced. Compared with people who lived a century ago, most people in our nation and other developed nations are living longer and have a better quality of life—and better health. While new infectious diseases (e.g., HIV/AIDS, bird flu, MRSA, Ebola, COVID-19) have emerged since the end of the 20th century and continue to demand the attention of health workers, the emphasis of health promotion shifted in the last quarter of the 20th century to focus on the prevention and treatment of chronic diseases and injury, which are the leading causes of illness and death. This change was stimulated, in part, by the Lalonde report, which observed in 1974 that health was determined more by lifestyle than by human biology or genetics, environmental toxins, or access to appropriate healthcare. It was estimated that one's lifestyle—specifically, those health risk behaviors practiced by individuals—could account for up to 50 percent of premature illness and death. Substituting healthy behaviors, such as avoiding tobacco use, choosing a diet that was not high in fat or calories, and engaging in regular physical activity, for high-risk behaviors (tobacco use, poor diet, and a sedentary lifestyle) could prevent the development of most chronic diseases, including heart disease, diabetes, and cancer (Breslow, 1999).

With recognition of the importance of one's lifestyle in the ultimate manifestations of disease, a shift in the understanding of disease causation occurred, making **health status** the responsibility not only of the physician, who ensures health with curative treatments, but also of the individual, whose choice of lifestyle plays an important role in preventing disease.

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

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

In the United States, the Lalonde report formed the foundation for *Healthy People: The Surgeon General's Report on Health Promotion and Disease Prevention* (U.S. Department of Health and Human Services, 1979), which sets national goals for reducing premature deaths (*Healthy People* is discussed in the next section). In the subsequent 50 years since the first *Healthy People* report, the focus on the root causes of premature illness and death now include an understanding of the social determinants of health. Choices individuals make about individual health behaviors are determined not only by personal choice but by opportunities or lack thereof in the places that they live, work, and play.

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

- Promote social responsibility for health.
- Increase investment for health developments in all sectors.
- Consolidate and expand partnerships for health.
- Increase community capacity and empower individuals.
- Secure an infrastructure for health promotion.

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

Stage 3: Multiple Levels of Influence on Health

The third stage of health promotion started at beginning of the 21st century with the realization that even within high income countries there could be a difference of almost 20 years in life expectancy—even in those countries that had a well-developed healthcare system providing care to all citizens (Kaplan et al., 2015). Individual decisions about health behaviors were rooted in the social environment in which people are born, live, work, and play (Marmot, 2005). The social institutions (economic systems, housing, healthcare system, transportation system, educational system), the surrounding environment, social relationships, and civic engagement all provide opportunities for individuals to make healthy choices—or not. One's opportunities for a healthy life style are severely limited if there is no affordable low-income housing, no transportation infrastructure that

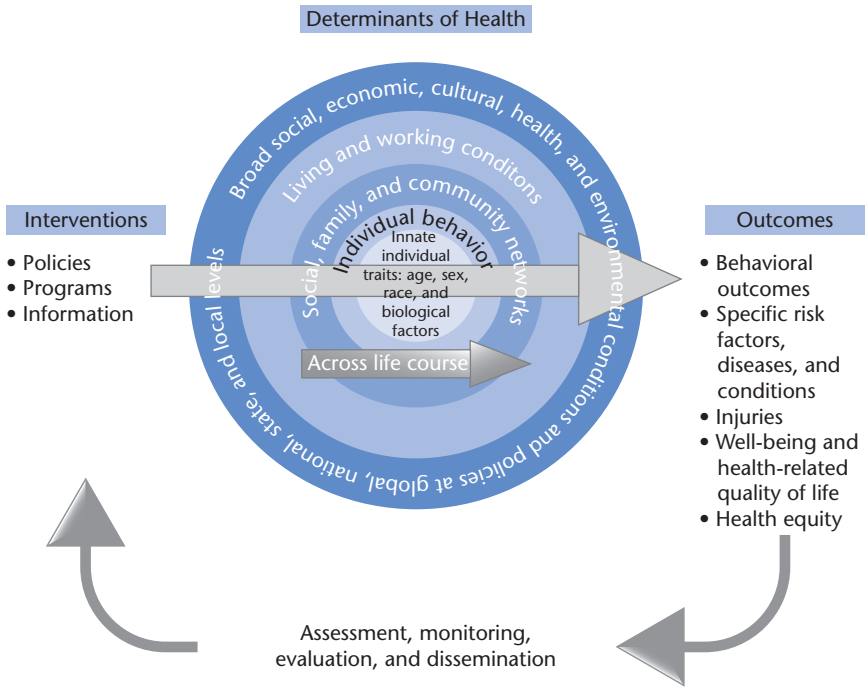

Figure 1.2 Dynamic interaction between strategies aimed at the individual and strategies for the entire population

Source: Phase I Report - Recommendations for the Framework and Format of Healthy People, U.S. Department of Health and Human Services, 2020.

allows individuals to pursue employment outside of their neighborhood, no supermarkets in the neighborhood with fresh fruits and vegetables, no safe parks in which to play or exercise, or no quality schools to provide a quality education in the neighborhood.

Today, health promotion is a specialized area in the health fields that involves the planned change of health-related lifestyles and life conditions through a variety of individual and environmental changes. Figure 1.2 illustrates the dynamic interaction between strategies aimed at the individual and strategies for the entire population.

Healthy People 2030: A National Public-Private Partnership to Promote Health

Every decade since 1980, the U.S. Department of Health and Human Services has reinstituted the same public-private process and released an updated version of *Healthy People* that provides the overarching goals and objectives that will guide and direct the health promotion actions of federal agencies; local and state health departments; and practitioners, academics, and health workers at all levels of government.

For individuals engaged in health promotion, one value of the *Healthy People* framework is access to national data and resources. Because the initiative addresses such a broad range of health and disease topics, health

promotion program staff can usually find objectives that are similar to those they are planning to address in their locales. Using *Healthy People* information allows program staff to compare their local population data with national data and to use resources that have been generated nationally in order to achieve the national objectives.

Healthy People 2030 continues to expand the reach of health promotion, recognizing that many sectors contribute to the health of people. For *Healthy People 2030*, the World Health Organization's definition of health promotion remains relevant. However, the emphasis shifts to the social and environmental opportunities for improving population health, as noted in the WHO definition of health promotion. That definition is more empowering, more aspirational, and less prescriptive than ones adopted in earlier decades.

Although individuals share some responsibility for their health, supportive environments make their choices easier. The United States has not made the progress over decades of work needed for improving health and eliminating disparities. To achieve different outcomes in this decade, *Healthy People 2030* emphasizes and suggest different ways of prioritizing both time and money. *Healthy People 2030* follows the lead of the Robert Wood Johnson Foundation to take a holistic approach to empower individuals and communities to take actions for their own health, foster leadership for public health, promote intersectoral action to build healthy public policies, and create sustainable health systems in society. It continues to recommend interventions at the personal, organizational, social, and political levels to enable changes in lifestyles, environments, and other realms to improve or protect health. Figure 1.3 illustrates how to use the *Healthy People 2030* to promote health.

Health Education and Health Promotion

Health promotion has its roots in America in **health education** (Chen,2001). In the United States, health education has been in existence for more than a century. The first academic programs trained health educators to work in schools, but the role of health educators working within communities did not become popular until the 1940s and 1950s.

Health education promotes a variety of learning experiences to facilitate voluntary actions conducive to health (Green et al., 1980). These educational experiences facilitate gaining new knowledge, adjusting attitudes, and acquiring and practicing new skills and behaviors that could alter individual (one-to-one) or group instruction through personal online or group communication. Mass communication strategies can stimulate behavior change through public service announcements, webinars, social marketing techniques, and other evolving communications vehicles such as text messaging to blogging.

Figure 1.3 Using *Healthy People 2030* to promote health

Source: Use Healthy People 2030 in Your Work, U.S. Department of Health and Human Services, 2020.

Health promotion has been defined as the combination of two levels of action: (1) health education and (2) environmental actions to support the conditions for healthy living (Green & Kreuter, 1999). Environmental actions prioritize populations in organizations and the community. Such environmental strategies and interventions include political, economic, social, organizational, regulatory, and legislative changes that can improve the health groups of individuals (Table 1.2).

The priorities for health promotion programs identified by the World Health Organization (1998) are advocacy for health to create the essential conditions for health, enabling all people to achieve their full health potential and mediating between the different interests in society in the pursuit of health.

Table 1.2 Components of Health Promotion Programs

Health Education to Improve Individual Health	Environmental Actions to Promote Health
Health knowledge	Advocacy
Health attitudes	Environmental change related to variables influencing health outcomes (e.g., education, transportation, housing, criminal justice reform)
Health skills	Legislation
Social support	Policy mandates, regulations
Health behaviors	Financial investment in communities and other resource/community development
Health indicators	Organizational development
Health status	Criminal justice reforms

Table 1.3 Eight Competencies: Areas of Responsibilities for Health Education Specialists (HESPA II 2020)

AREA I	Assessment of Needs and Capacity
AREA II	Planning
AREA III	Implementation
AREA IV	Evaluation and Research
AREA V	Advocacy
AREA VI	Communication
AREA VII	Leadership and Management
AREA VIII	Ethics and Professionalism

Source: HESPA II 2020, Responsibilities and Competencies for Health Education Specialists, NCHEC. © 2020, National Commission for Health Education Credentialing, Inc.

Health promotion uses complementary strategies at both personal and population levels. In the past, *health education* was used as a term to encompass the wider range of environmental actions. These methods are now encompassed in the term *health promotion*, and a narrower definition of health education is used to emphasize the distinction.

Health education as a discipline has a distinct body of knowledge, a code of ethics, a skill-based set of competencies that is scientifically updated every five years, a rigorous system of quality assurance, and a system for credentialing health education professionals (Knowlden et al., 2020). With the latest credentialing study, there are now eight *competencies* (areas of responsibilities for health education specialists) as the centerpiece of credentialing as well as the foundation for preparation programs (Table 1.3). Approximately 250 professional preparation programs offer degrees in health education at the baccalaureate, master's, or doctoral levels (Alber et al., 2020).

The distinct occupation of health educator is recognized and tracked by the U.S. Department of Labor, which estimated that there were 123,800 health educators in the workforce in 2018 (U.S. Department of Labor, Bureau of Labor Statistics, 2020a). According to the Bureau of Labor

Statistics, the demand for health educators is expected to increase by more than 19 percent, almost twice as fast as all other occupations of 11 percent growth (U.S. Department of Labor, Bureau of Labor Statistics, 2020b). The growth is driven by efforts to improve health outcomes and to reduce healthcare costs by teaching people about healthy habits and behaviors and utilization of available healthcare services.

Settings for Health Promotion Programs

Earlier in this chapter, we discussed the impact of the *Jakarta Declaration* in giving prominence to the concept of the health setting as the place or social context in which people engage in daily activities and in which environmental, organizational, and personal factors interact to affect health and well-being. Health is promoted through interactions with people who work in various settings, through people's use of settings to gain access to health services, and through the interaction of different settings.

Schools

Schools are pivotal to the growth and development of healthy children and adolescents. School settings include childcare; preschool; kindergarten; elementary, middle, and high schools; and vocational-technical programs. The model for promoting and protecting the health of children and adolescents in schools is to place students in the center of the entire school community to promote their cognitive, physical, social, and emotional development with coordinated health policies, processes, and practices that promote learning and health. In schools, health promotion happens in ten areas: (1) Health Education, (2) Physical Education and Physical Activity, (3) Nutrition Environment and Services, (4) Health Services, (5) Counseling, Psychological, and Social Services, (6) Social and Emotional Climate, (7) Physical Environment, (8) Employee Wellness, (9) Family Engagement, and (10) Community Involvement (ASCD®, 2021). Health promotion in schools is done in the context of the community. Recognizing that schools are part of and an extension of the larger community within which it operates and serves its students (ASCD®, 2021).

Colleges and Universities

Colleges and universities—including 2-year college (community college), certificate programs, advanced vocational training, 4-year college (bachelor programs), graduate programs, and professional programs—place a prominent role in promoting the health of young adults as well as nontraditional students (for example, adults seeking a career change or retired individuals seeking enrichment). Boosting educational attainment beyond high school has been more prominent in recent years. Given the future of

work and the increasing role of technology, education beyond high school becomes even more relevant for workers to compete in the labor market. These sites have extensive programming and structures to provide healthcare and promote healthy lifestyles. Initiatives such as *Healthy Campus 2020* (American College Health Association, 2020) empower schools to improve health and well-being by creating a culture where social and physical environments promote health. Health promotion initiatives at colleges and universities need to be part of how the sites assertively address persistent racial/ethnic gaps in educational attainment. Even as we see higher rates of attainment among the younger working-age population, gaps among particular components of that group are also larger in spite of so many efforts to close them (Prescott, 2019).

Healthcare Organizations

Healthcare organizations provide services and treatment to reduce the impact and burden of illness, injury, and disability and to improve the health and functioning of individuals. Healthcare practitioners work with individuals in community hospitals, specialty hospitals, community health centers, physician offices, clinics, rehabilitation centers, skilled nursing and long-term care facilities, and home health and other health-related entities. Traditionally, these sites are thought of as being part of the healthcare industry, which is one of the largest industries in the United States and provides 18 million jobs. The U.S. Department of Labor, Bureau of Labor Statistics (2020b) reports the healthcare and social assistance sector is expected to make up 40 percent, or 3.4 million, of the overall increase in employment from 2018 to 2028. Six of the 10 fastest-growing occupations from 2018 to 2028 are expected to be healthcare. The roughly 595,000 establishments that make up the healthcare industry vary greatly in size, staffing patterns, and organizational structures. About 76 percent of healthcare establishments are offices of physicians, dentists, or other health practitioners. Although hospitals constitute only 1 percent of all healthcare establishments, they employ 35 percent of all healthcare workers (OER, 2020). While health promotion programs might seem out of place in a treatment facility, in fact, much work is done in such facilities to reduce the negative consequences associated with disease.

Communities

Communities are usually defined as places where people live—for example, neighborhoods, towns, villages, cities, and suburbs. However, communities are more than physical settings. They are also groups of people who come together for a common purpose. The people do not need to live near each other. People are members of many different communities at the same time (families, cultural and racial groups, faith organizations, sports team

fans, hobby enthusiasts, motorcycle riders, hunger awareness groups, environmental organizations, animal rights groups, and so on). These community groups often have their own physical locations (for example, community recreation centers, golf, swimming, and tennis clubs; temples, churches, and mosques; or parks). These affinity groups all exist within communities, as part of communities, and at the same time, they are their own community. Health promotion programs frequently seek out people both in the physical environment of the neighborhood where they live and within the affinity groups that they form and call their community.

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

Community health organizations have their roots in local community members' health concerns, issues, and problems. These organizations work at the grassroots level, frequently operating a range of health promotion programs that target community members. In this text, the term *community health organization* is synonymous with the terms *community agency*, *program*, *initiative*, *human services*, and *project*. Some community health organizations do not choose to use these terms in their names, deciding to use a name that reflects whom they serve, the health issue they address, or their mission—for example, the American Cancer Society, Caring Place, Compass Mark, Youth Center, Maximizing Adolescent Potentials, Bright Beginnings, Strength and Courage, Healthy Hearts, or Drug Free Youth. Regardless of their names, the common bond for community health organizations is their shared health focus.

Workplaces

Workplaces are anywhere that people are employed—business and industry (small, large, and multinational), governmental offices (local, state, and federal), schools, universities, community based organizations, and healthcare organizations. It has become increasingly clear that it makes financial sense to encourage and support employees' healthy practices. Employers, both on their own initiative and because of the Affordable Care Act and federal regulations administered by the Occupational Safety and Health Administration, have been active in creating healthy and safe workplaces.

As employers become aware that behaviors such as smoking, lack of physical activity, and poor nutritional habits adversely affect the health and productivity of their employees, they are providing their employees with a variety of workplace–based health promotion programs. These programs have been shown to improve employee health, increase productivity, and yield a significant value for employers (Fertman, 2015; National Institute for Occupational Safety and Health, 2021).

Stakeholders in Health Promotion Programs

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

Involving Stakeholders

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

Advisory Boards

Most health promotion programs form some type of advisory board or advisory group (also sometimes called a *team*, *task force*, *planning committee*, *coalition*, or *ad hoc committee*) to provide program support, guidance,

and oversight throughout the program planning, implementation, and evaluation process. For example, during planning, advisory board members are involved with determining program priorities as part of the needs assessment, developing program goals and objectives, and selecting program interventions. During implementation, they might participate in the initial program offering, program participant recruitment, material development, advocacy, and grant writing. During evaluation they often review reports and give feedback on how best to disseminate and use the evaluation results and findings. Some **advisory boards** are formal, with bylaws, regular meeting schedules, member responsibilities, and budgets. Others are informal, perhaps without any meetings but acting instead as a loose network of individuals who will offer advice and information when called upon by program staff.

Champions and Advocates

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

Emerging Health Promotion Era

For the health and health promotion professionals, a new health promotion era is emerging from the pandemic. COVID-19 is now part of our lives. The work of promoting health gained prominence and importance, but at the same time is intertwined with larger and more volatile societal forces. Furthermore, health and health promotion are now a global challenge that requires a coordinated global response. The race to find vaccines, drugs, and effective testing is a global pursuit. This reality shapes our work.