PLANNING, IMPLEMENTING, AND EVALUATING

HEALTH PROMOTION PROGRAMS

EIGHTH EDITION

James F. McKenzie
Brad L. Neiger
Rosemary Thackeray

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This book is dedicated to eight very special people:
Sherry, Ralph, NaTel, Bonnie, Anne, Greg, Mitchell, and Julia,
and to our teachers and mentors:
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(deceased), Noreen Clark (deceased), Enrico A.
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Brief Contents

Contents

Preface

Planning, Implementing, and Evaluating Health Promotion Programs, Eighth Edition, is written for students who are enrolled in a professional course in health promotion program planning. It is designed to help them understand and develop the skills that are necessary to carry out program planning regardless of the setting. The book is unique among the health promotion planning textbooks on the market in that it provides readers with both theoretical and practical information. A straightforward, step-by-step format is used to make concepts clear and the full process of health promotion planning understandable. This book provides, under a single cover, material on all three areas of program development: planning, implementing, and evaluating. And its new 4-color design brings concepts to life unlike ever before.

Learning Aids

Each chapter includes chapter objectives, a list of key terms, presentation of content, chapter summary, review questions, activities, and weblinks. In addition, many of the key concepts are further explained with information presented in boxes, figures, and tables.

Chapter Objectives

The chapter objectives identify the content and skills that should be mastered after reading the chapter, answering the review questions, completing the activities, and using the weblinks. Most of the objectives are written using the cognitive and psychomotor (behavior) educational domains. For most effective use of the objectives, we suggest that they be reviewed before reading the chapter. This will help readers focus on the major points in each chapter and facilitate answering the questions and completing the activities at the end.

Key Terms

Key terms are introduced in each chapter and are important to the understanding of the content. The terms are presented in a list at the beginning of each chapter and are printed in boldface at the appropriate points within the chapter. In addition, all the key terms are presented in the glossary along with other important terms. Again, as with the chapter objectives, we suggest that readers skim the key terms list before reading the chapter. Then, as they read the chapter, particular attention should be paid to the definition of each term.

Presentation of Content

Although each chapter could be expanded—in some cases, entire books have been written on topics we have covered in a chapter or less—we believe that each chapter contains the necessary information to help students understand and develop many of the skills required to be successful health promotion planners, implementers, and evaluators.

Responsibilities and Competencies Boxes

Within the first few pages of all except the first chapter, readers will find a box that contains the responsibilities and competencies for health education specialists that are applicable to the content of the chapter. The responsibilities and competencies presented in each chapter are the result of the most recent practice analysis—the *Health Education Specialist Practice Analysis II 2020* (HESPA II 2020), which is published in *A Competency-Based Framework for Health Education Specialists—2020* (NCHEC & SOPHE, 2020). These boxes will help readers understand how the chapter content applies to the responsibilities and competencies required of health education specialists. In addition, these boxes should help guide candidates as they prepare to take either the Certified Health Education Specialist (CHES®) or Master Certified Health Education Specialist (MCHES®) exam. A complete listing of the Responsibilities, Competencies, and Subcompetencies can be found online at https://www.nchec.org/responsibilities-and-competencies.

Chapter Summary

At the end of each chapter, readers will find a one- or two-paragraph review of the major concepts covered in the chapter.

Review Questions

The questions at the end of each chapter provide readers with some feedback regarding their mastery of the content. These questions also reinforce the objectives and key terms presented in each chapter.

Activities

Each chapter includes several activities that allow students to use their new knowledge and skills. The activities are presented in several different formats for the sake of variety and to appeal to the different learning styles of students. It should be noted that, depending on the ones selected for completion, the activities in one chapter can build on those in a previous chapter and lead to the final product of a completely developed health promotion program plan.

Weblinks

The final portion of each chapter consists of a list of updated links on the Internet. These links encourage students to explore a number of different websites that are available to support planning, implementing, and evaluating programs.

New to This Edition

In revising *Planning, Implementing, and Evaluating Health Promotion Programs, Eighth Edition*, we incorporated as many suggestions from reviewers, colleagues, and former students as possible. Since the last edition of this book was published, several major documents that impact the program planning have been released/revised. In addition to the new Responsibilities, Competencies, and Subcompetencies (NCHEC & SOPHE, 2020) noted above, there is a revised Code of Ethics for the Health Education Profession (CNHEO, 2020), a Report of the Joint Committee on Health Education and Promotion Terminology (Videto & Dennis, 2021), and a new set of goals and objectives for the nation—*Healthy People 2030* (USDHHS, 2020). The content of these documents is reflected in this updated book. There also has been a slight reordering and retitling of the chapters in this edition of the book. The chapter on marketing has moved from Chapter 12 to Chapter 9. The rationale behind this change is based on the importance of marketing to creating an intervention that will be adopted by the priority population. This change has also

impacted the order and titles of Chapters 10 through 12. In addition to updating material, adding new visual components, and, where appropriate, new application boxes throughout the text, the following points reflect the major changes in this new edition:

- Chapter 1 now includes discussions about the six dimensions of wellness and the social determinates of health, and an overview of *Healthy People 2030*.
- Chapter 2 has been expanded to include additional information on *The Community Guide* and provides an updated example of a written program rationale.
- Chapter 3 has been streamlined to provide more information about fewer planning models with emphasis on the Generalized Model. Because of the role that nonprofit hospitals play in community health, new information about ACHI's Community Assessment Toolkit has been added.
- Chapter 4 includes new information about issues to consider before conducting a needs assessment and additional information on conducting surveys as a means of collecting needs assessment data.
- Chapter 5 now incorporates more practical examples to explain the different levels of measurement and how best to sample a population.
- Chapter 6 now includes an expanded discussion on the various levels of objectives and how to go about developing objectives.
- Chapter 7 includes additional information on the socioecological approach and its application to creating an intervention.
- Chapter 8 features new information on Public Health 3.0, Design Thinking, and systems thinking. The chapter also includes a new section on how to select the right strategies for an intervention, and expansions of advocacy strategies, and the levels of evidence, including a flow chart to aid in determining the level of evidence for an intervention. And, information about logic models has been moved to this chapter.
- Chapter 9, Marketing (formerly Chapter 12), includes new marketing examples and several new boxes, which make the text less dense and easier to read.
- Chapter 10, Community Organizing and Community Building (formerly Chapter 9), provides more information on the need for community organization and an expanded discussion of working with diverse populations.
- Chapter 11, Preparing for Implementation (formerly Chapter 10—Identification and Allocation of Resources), has been reworked to provide background information about successful implementation including creating an action plan. Also, information about timelines has been moved to this chapter.
- Chapter 12, Carrying out Implementation and Management, includes three new sections on sustainability, cultural humility, and on reaching out to the media.
- Chapter 13 now includes information on the need to conduct meaningful evaluation regardless of program type, size, or duration. The chapter also includes expanded content on the purposes of evaluation and practical issues or barriers in conducting an evaluation.
- Chapter 14 includes several new figures and new boxes to illustrate case studies for (1) pretesting, (2) pilot testing, (3) quasi-experimental design, (4) one group pretest-posttest design, (5) process evaluation, and (6) interrupted time series design.
- Chapter 15 now includes updated guidelines for developing a written report, a new table showing nonparametric statistics and their parametric equivalents, and a new section on data visualization.

Acknowledgments

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J. F. M.
B. L. N.
R. T.

CHAPTER 1

Introduction to Health Education, Health Promotion, and Program Planning

CHAPTER OBJECTIVES

After reading this chapter and answering the questions at the end, you should be able to:

1. Describe health and its value.
2. Describe the evolution of health education and health promotion.
3. Explain the technical difference between health education and health promotion and how they work in unison.
4. Explain the lengths to which the health education profession checks and validates its core responsibilities and competencies.
5. Identify the assumptions of health promotion.
6. Describe the significance of program planning and the basic elements of the Generalized Model.

KEY TERMS

advanced 1-level practice
advanced 2-level practice
Certified Health Education Specialist (CHES®)
community
entry-level practice
Framework
health
health education
health education specialist
health promotion
Healthy People
Master Certified Health Education Specialist (MCHES®)
pre-planning
primary prevention
priority population
Role Delineation Project
secondary prevention
social determinants of health
stakeholders
tertiary prevention
wellness

Health is a means to an end. It enables us to pursue things that matter most in our lives and helps us thrive and achieve our potential. It allows us to work and enjoy life and recover from setbacks and tragedies. Although health is not synonymous with longevity, being healthy for as long as possible provides more opportunities for fulfillment. The Greek physician, Hippocrates, known as the Father of Medicine (see **Figure 1.1**), discerningly observed that "health is the greatest of human blessings." But health is also complicated. It is a multidimensional state influenced by genetics, behavior, the environment, our communities, and adequate health care, among other things.

The World Health Organization (WHO) further defines **health** as a "state of complete physical, mental, and social well-being and not merely the absence of disease and infirmity" (WHO, 2021a). The National Wellness Institute has long asserted that **wellness** (i.e., "an active process through which people become aware of, and make choices toward, a more successful existence") consists of the six dimensions displayed in **Figure 1.2** (National Wellness Institute, 2021). Over the decades, several other models have portrayed relationships between these or similar dimensions in various other forms. While labels and terminology change over time, health's multidimensionality has held constant in scientific and popular literature.

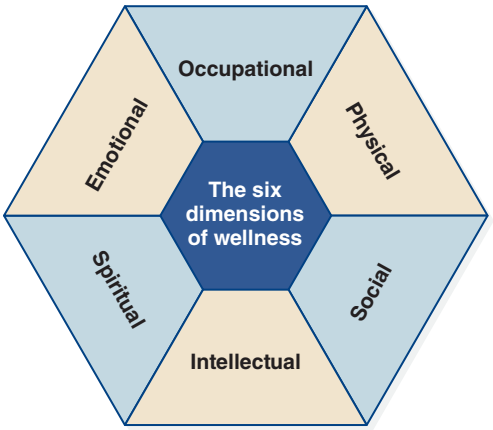


Figure 1.2 The Six Dimensions of Wellness.

Reproduced from Hettler, B. (1976). *Six dimensions of wellness model.* Reprinted with permission from the National Wellness Institute, Inc. NationalWellness.org.

In more recent decades, the **social determinants of health** (see **Figure 1.3**) have become an increasingly useful paradigm to portray the multidimensionality of health. The social determinants of health are the "conditions in the environments where

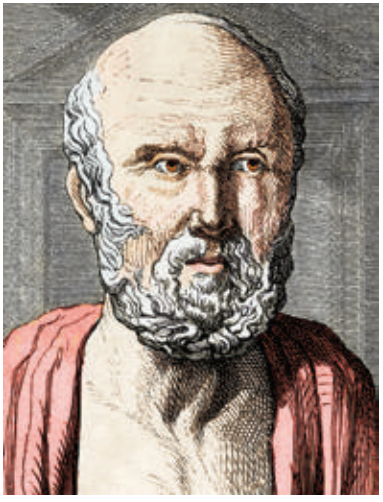


Figure 1.1 Hippocrates, the Father of Medicine.

© Sheila Terry/Science Photo Library.

Figure 1.3 Social Determinants of Health.

Reproduced from U.S. Department of Health and Human Services (USDHHS). (2020b). *Healthy People 2030: Social determinants of health.* Retrieved October 21, 2020, from https://health.gov/healthypeople/objectives-and-data/social-determinants-health

people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks" (USDHHS, 2020a). "Factors such as safe housing and quality of neighborhoods, transportation, access to health care and other services, discrimination, violence, education, employment, and income, have a significant impact on people's health and well-being" (USDHHS, 2020b).

Understanding the multidimensionality and related complexity of changing and improving health assists those working in health promotion to approach their work with humility, especially when considering the number of health problems affecting our global population. For example, a lack of the most basic human needs (e.g., clean water, food, safe shelter) represents the most significant health priority in some locations. Infectious or communicable diseases are a primary concern in other populations. In contrast, other parts of the world are impacted more by chronic diseases (i.e., diseases of long duration requiring constant and specialized care). Concurrently, unintentional injuries (e.g., automobile crashes, drownings, falls) and intentional injuries (i.e., suicide and homicide) affect all populations.

Double or triple burdens of disease occur in populations, meaning that two or three (or even more) of these categorical problems exist concurrently. For example, in the United States, heart disease is the leading cause of death for men, women, and people of most racial and ethnic groups (CDC, 2021l), while cancer accounts for almost as many deaths (National Cancer Institute (NCI), 2020). At the same time, the United States has experienced an increase in homicides and aggravated assaults (National Commission of COVID-19 and Criminal Justice, 2020) and a significant number of deaths due to suicide (CDC, 2021n) and unintentional injuries (CDC, 2021a). Moreover, the National Institute of Mental Health (2021) reported that nearly 20% of adults live with a mental illness, defined as a mental, behavioral, or emotional disorder. Simultaneously, the CDC (2021c) reported that anxiety and depression affect many children and have increased over time, and that poor mental health is increasing among adolescents (CDC, 2021d and 2021e). In addition, in the early 2020s, the COVID-19 pandemic was on track to become one of the leading causes of death in the United States (CDC, 2021g).

These data provide only a snippet of the enormity of work facing those involved in health promotion-related professions. When we factor in the multidimensionality of health and the disparities of disease, we can better understand and appreciate that health promotion requires us to think holistically and scientifically in clinical, behavioral, and social terms. It also demands that we conduct all planning and evaluation efforts strategically using best practices proven over time. Finally, it requires that programs or interventions are tailored to the needs of the people who receive them.

As we move forward in the 2020s, the good news is that the world's population lives longer and healthier lives and that we are making "enormously encouraging progress" (WHO, 2020). While inequality persists (WHO, 2020), behaviors can change, social conditions can improve, and health disparities can decrease. Another cause for optimism is that health promotion's collective work across various sectors over time has contributed to these health improvements (CDC, 1999b; CDC, 2011c).

Most health promotion scholars would identify 1974 as a seminal year that positioned health promotion as a significant element of national health programming and policy. That year, Canada published its landmark policy statement, *A New Perspective on the Health of Canadians*, (see **Figure 1.4**) often referred to as the Lalonde Report (Lalonde, 1974).

The Lalonde Report introduced the "Health Field Concept," which included four determinants of health, human biology, healthcare systems, the environment, and lifestyle, and called attention to a fragmentation of efforts to respond effectively to health problems

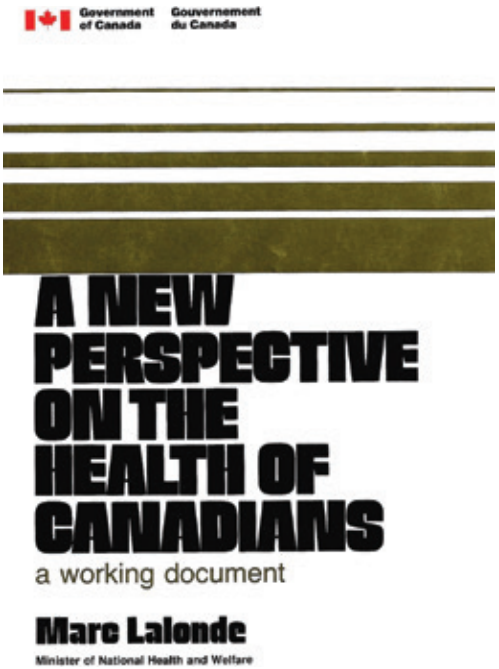


Figure 1.4 The Lalonde Report.

Courtesy of Ministry of National Health and Welfare, Canada.

(Glouberman & Millar, 2003). Moreover, the report identified the need for intersectoral collaboration and use of multiple interventions, such as health education, social marketing, community development, and legislative and healthy public policy approaches, to successfully address the determinants of health (Glouberman & Millar, 2003). In the United States, Congress passed the groundbreaking Health Information and Health Promotion Act, which created the Office of Health Information and Health Promotion, later renamed the Office of Disease Prevention and Health Promotion (Green 1999, p. 69). This office still operates today as part of the U.S. Department of Health and Human Services.

These historic actions paved the way for ***Healthy People***: *The Surgeon General's Report on Health Promotion and Disease Prevention* (USDHEW, 1979), which helped establish the relationship between personal behavior and health status. The document also provided recommendations to reduce health risks and enhance health. Perhaps more significantly, *Healthy People* summarized research in an understandable way to the general public. *Healthy People* also cleared the way for the first set of health goals and objectives for the nation, titled *Promoting Health/Preventing Disease: Objectives for the Nation* (USDHHS, 1980).

These 10-year goals and objectives, previously known as *Healthy People 1990, 2000, 2010, 2020*, and now *Healthy People 2030*, helped define and guide the U.S. health agenda since their inception (USDHHS, 2020c). And, in part, they have kept the importance of good health visible to all Americans. The *Healthy People 2030* framework builds upon an underlying value of thriving and equitable societies that address social determinants of health to eliminate or reduce health disparities. It aims to improve health for all across the physical, mental, and social dimensions of health (USDHHS, 2020a).

The Healthy People framework has demonstrated that a widely accessible plan can become the basis for local, state, and national health programming to bring populations together to improve health and reduce the burden of death and disease. It has also helped monitor health problems and has facilitated the sharing of high-quality data (USDHHS, 2020c). Perhaps most significantly for this book's purposes, *Healthy People* has given rise to the work of health promotion and health education and the significance of effective program planning.

Health Education and Health Promotion

Health education is defined as "any combination of planned learning experiences in which theory and evidence-based/evidence-informed practices are used to provide equitable opportunities for the acquisition of knowledge, attitudes, and skills that are needed to adapt, adopt, and maintain healthy behaviors"

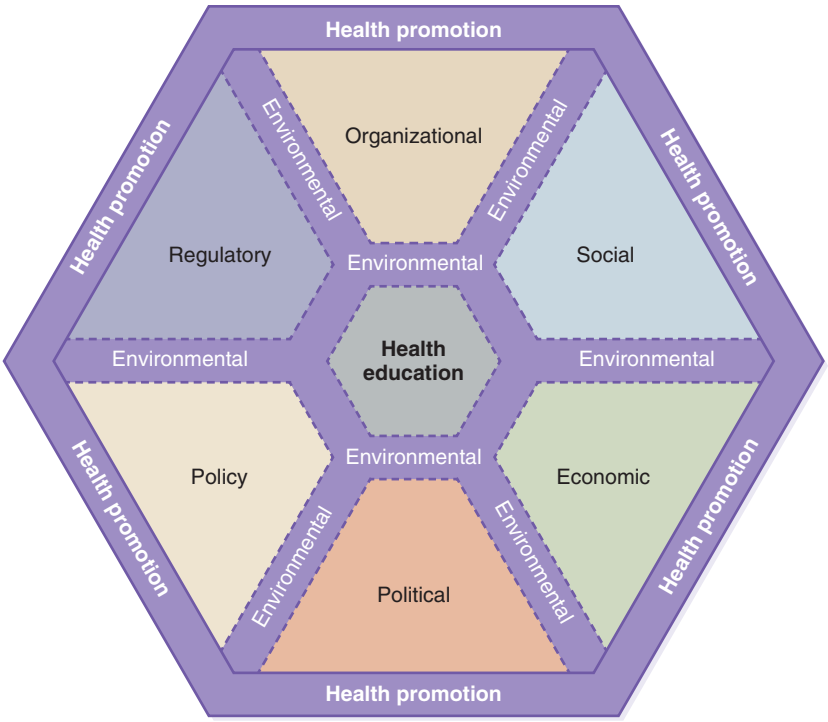


Figure 1.5 Relationship Between Health Education and Health Promotion.

(Green & Kreuter, 2005, as cited in Videto & Dennis, 2021, p. 13).

In contrast (see **Figure 1.5**), **health promotion** is defined more broadly as "any planned combination of educational, political, environmental, regulatory, or organizational approaches that support actions and conditions of living and are conducive to the health of individuals, groups, and communities (Green & Kreuter, 2005, as cited in Videto & Dennis, 2021, p. 14).

Based on these definitions, health education involves communication efforts to influence the antecedents to behavior change, such as knowledge, attitudes, skills, beliefs, and values (Sharma, 2022). It is delivered in various settings (e.g., homes, healthcare sites, communities, schools (K–12), colleges and universities, and worksites) and uses several communication methods or channels as displayed in **Box 1.1**.

Both health education and health promotion involve primary, secondary, and tertiary prevention (see **Table 1.1**). According to Videto and Dennis (2021), **primary prevention** is "actions and interventions designed for individuals or populations to

Box 1.1 Examples of Channels Used in Health Education

- Face-to-face or remote classes or webinars
- Video conferencing
- Hard copy or electronic documents
- Social media
- Texting and blogging
- Seminars or other forums
- Counseling or small group discussions
- Chat groups
- Podcasts
- Websites and apps

Table 1.1 Primary, Secondary, and Tertiary Prevention

Level of Prevention	Explained	Health Status	Examples
Primary Prevention	Actions & interventions to identify risks & reduce susceptibility to health threats	Healthy with no current signs of disease or condition	■ Rules, ordinances, & laws to protect health (e.g., no smoking policies, use of safety belts) ■ Exercise or smoking cessation classes ■ COVID-19 immunizations
Secondary Prevention	Early diagnosis & treatment to prevent progress or recurrence	Early stage of disease or condition	■ Self-breast or self-testicular exams ■ Use of medications to control disease or condition (e.g., for high blood pressure or high cholesterol)
Tertiary Prevention	Treatment of disease, condition, or injury to reduce complications or disability	Disease treatment or rehabilitation	■ Support groups (e.g., Alcoholics Anonymous) ■ Rehabilitation programs (e.g., cardiac or stroke programs) ■ Occupational therapy programs

Information taken from Cottrell, R. R., Seabert, D., Spear, C., & McKenzie, J. F. (2023). *Principles of health promotion and education* (8th ed.). Jones and Bartlett Learning; and Videto, D. M., & Dennis, D. L. (2021, Spring). Report of the 2020 joint committee on health education and promotion terminology. *The Health Educator, 53*(1), 4–21.

identify risks and reduce susceptibility or exposure to health threats prior to disease onset" (p. 15), while **secondary prevention** "detects and treats disease in early stages to prevent progress or recurrence" (p. 15), and **tertiary prevention** "alleviates the effects of the disease and injury" (p. 15).

For this book's purposes, we view health education as a subset of health promotion, which includes strategies such as policy and advocacy, multisectoral support, and community mobilization, etc. The WHO's Health Promotion Conferences, which began in Ottawa in 1986, have added to our working definition of health promotion. These conferences have emphasized concepts such as creating supportive environments, capacity building for health promotion, evidence-based applications, "health in all policies approaches," and sustainable development (WHO, 2017). The 2016 Shanghai Conference was founded on what was characterized as three thematic pillars: good governance, healthy cities, and health literacy, all important elements of health promotion.

Assumptions of Health Promotion

Bates and Winder (1984) originally outlined what they viewed as critical assumptions of health education. Their assumptions have been modified here, and we refer to them as the assumptions of health promotion (see **Box 1.2**). If these assumptions hold and become central to health promotion practice, we can move forward with confidence that our work will lead to better health outcomes for all.

The importance of these assumptions is made clearer if we refer to the definitions of health education and health promotion presented earlier in the chapter. Implicit in those definitions is the goal of having program participants voluntarily adopt actions conducive to health. Conversely, we cannot expect people to adopt lifelong health-enhancing behavior if we are scientifically uniformed or overbearing in our approach. Nor can we expect people to change behaviors

Box 1.2 Assumptions of Health Promotion

1. Health status can be changed (WHO, 2020).
2. Behavior can be changed, and those changes can influence health (IOM, 2001, p. 333).
3. Initiating and maintaining behavior change is complex and difficult (Pellmar, Brandt, & Baird, 2002).
4. Before behaviors can change, the determinant(s) of behavior, the nature of the behavior, and the motivation for the behavior must be understood (DiClemente et al., 2019). Individuals must be ready to change.
5. Health is multidimensional and is determined by fluid interactions between individual behavior, social factors, biology and genetics, health services, and policymaking (USDHHS, n.d.a.; Pellmar et al., 2002). Successful health promotion efforts tailor interventions to the unique characteristics of a **priority population**, defined as "a group or subset of a group of people who are the focus of an assessment or an intervention due to their identified, common characteristics" (Agency for Healthcare Research and Quality, 2019, as cited in Videto & Dennis., p. 15).

just because they have been exposed to a health promotion program. Health education specialists should not expect to motivate change in every person in a priority population. However, the likelihood of change and healthier behaviors improve when health promotion programs are facilitated by professionals with the relevant skills and training.

While we distinguish between health education and health promotion in theory, it may be more useful to view them as complementary and synergistic. In practice, the terms are interchangeable. For example, how can we engage in the broader work of health promotion without engaging in health education? Conversely, health education is more effective with the social scaffolding provided by health promotion efforts. From a practice perspective, "the terms health education and health promotion have different definitions both within the United States and between the United States and other countries," but ultimately, despite variation in terminology and distinctions in definition, health education and health promotion are conceptually more alike than distinct (Taub et al., 2009, p. 441).

One difference among the terms worth considering has less to do with the definition of processes and scope and more to do with professional structure. For example, there is an entire professional discipline and network referred to as health education. A consortium of nine professional societies is known collectively as the Coalition of National Health Education Organizations (CNHEO) (2021). The organization that has provided credentialing certification to tens of thousands of professionals is named the National Commission for Health Education Credentialing (NCHEC). Besides preparing health education specialists for their careers, we have designed this book to prepare individuals for the examination associated with receiving either the **Certified Health Education Specialist (CHES®)** or **Master Certified Health Education Specialist (MCHES®)** designations. These designations are meaningful and represent professional competency and commitment to ongoing professional development (NCHEC, 2021).

The title, **health education specialist**, is defined as "an individual who has met, at a minimum, baccalaureate-level health education academic preparation" (NCHEC, 2017, as cited in Videto & Dennis, 2021, p. 17). The use of the title, health education specialist is becoming more standard in practice. However, other designations such as health educator, community health worker or specialist, and health promotion or prevention specialist are also commonly used. While "health educator" has significant

historical professional meaning and is used by the Bureau of Labor Statistics as an official job classification, we use the designation in this book only as a reference to a formal title in the chronological development of the profession.

Health Education as a Profession

As we know it today, health education has evolved partly through the scientific method, partly through trial and error, more generally through collaboration with allied professions, and in response to societal and professional norms and expectations. In the late nineteenth century, academic programs preparing school health educators, followed by the preparation of public health educators, began laying the foundation for the profession (NCHEC & SOPHE, 2020).

Health education took firmer root in the 1930s and 1940s with more precise terminology and job duties, mainly applied to school and public health education efforts (Armstrong et al., 1934). In the 1940s, quality assurance associated with specific standards began to appear (NCHEC & SOPHE, 2020). Professional associations in the Coalition of National Health Education Organizations emerged and performed substantial work to establish strategic direction for health education. As one current example, the coalition recently produced its *Code of Ethics for the Health Education Profession* (Coalition of National Health Education Organizations (CNHEO), 2020). This document outlines core ethical expectations for health education specialists, expectations for practice, and responsibility in professional preparation and continuing education. It provides an excellent foundation to guide the work of all health education specialists.

Perhaps the most significant advancements to develop health education occurred in the late 1970s with role delineation efforts that would lead to modern-day credentialing. This work helped clarify the health education specialist's evolutionary functions and established primary responsibilities and competencies for the profession.

In January of 1978, the landmark **Role Delineation Project** began (NCHEC & SOPHE, 2000). The result was a generic role for an entry-level health educator composed of seven areas of responsibility or the expectations of a new professional entering the job market regardless of the work setting. Once the role of the entry-level health educator was delineated, the next task was to translate the role into a structure that professional preparation programs (i.e., colleges and universities) in health education could use to design competency-based curricula. The resulting document, *A Framework for the Development of Competency-Based Curricula for Entry Level Health Educators* (NCHEC, 1985), and its revised version, *A Competency-Based Framework for the Professional Development of Certified Health Education Specialists* (NCHEC, 1996), provided such a structure. These documents were collectively called the ***Framework*** and became the foundation for the creation of NCHEC in 1988 and the subsequent delivery of credentialing in the late 1980s with the first certification examination in 1990 (NCHEC & SOPHE, 2020).

Even though the seven areas of responsibility defined the role of the entry-level health educator, they did not fully reflect the work of a health educator with an advanced degree. Thus, over a 4-year period beginning in 1992, the profession worked to define the role of an advanced-level practitioner. By July 1997, the governing boards of NCHEC, the American Association of Health Education (AAHE), and the Society for Public Health Education (SOPHE) endorsed three additional responsibilities for the advanced-level health educator. Those responsibilities focused on research, administration, and the advancement of the profession (AAHE, NCHEC, & SOPHE, 1999).

The seven entry-level and three advanced-level responsibilities served the profession well. However, through the years, additional revalidation studies modified the language and intent of the responsibilities and related competencies and subcompetencies. For example, a 6-year multiphase study known as the *National Health Educator Competencies Update Project* (CUP) included the development of a three-tiered hierarchical model of practice. The three levels of practice included **Entry-level** (fewer than 5 years of experience with a baccalaureate or master's degree), **Advanced 1-Level** (5 or more years of experience with a baccalaureate or master's degree), and **Advanced 2-Level** (5 or more years of experience with a doctoral degree) (NCHEC & SOPHE, 2020).

The results of the CUP, which were published approximately 20 years after the initial role delineation project, lead to the creation of a revised framework titled, *A Competency-Based Framework for Health Educators* (NCHEC, SOPHE, & AAHE, 2006). Subsequent validation studies, including the Health Educator Job Analysis in 2010 and the Health Education Specialist Practice Analysis in 2015 brought several other modifications including tiered subcompetencies and a transition from the title of health educator to health education specialist (NCHEC & SOPHE, 2020).

The NCHEC and the SOPHE co-sponsored the most recent health education specialist practice analysis, named the Health Education Specialist Practice Analysis II 2020 (NCHEC & SOPHE, 2020). As in previous analyses, its purpose was to "revalidate the contemporary practice of entry- and advanced-level health education specialists and use findings to update the CHES® and MCHES® exams, as well as to report validated changes since the HEPSA I" (NCHEC & SOPHE, 2020, p. 13)." An eighth area of responsibility, ethics and professionalism, was added to the original seven responsibilities. At present, the health education profession is based on eight areas of responsibility (see **Box 1.3**), 35 competencies and 193 subcompetencies (NCHEC & SOPHE, 2020).

In reviewing the eight areas of responsibility, it is clear that five of the eight are directly related to program planning, implementation, and evaluation and that the other three could be associated with these processes, depending on the type of program being planned. In effect, these responsibilities distinguish the brand and expectations of health education specialists from other professionals who provide similar services. Those with CHES® and MCHES® certification have preparation in all of the responsibilities listed in Box 1.3, including program planning, implementation, and evaluation, which might

Box 1.3 Areas of Responsibility for Health Education Specialists

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

be considered cornerstones of the health education profession.

The importance of the defined role of the health education specialist is becoming greater as the profession continues to mature. This is exhibited by its use in several major professional activities. First, the *Framework* has provided a guide for colleges and universities to use when designing and revising their curricula in health education. Second, as stated, the *Framework is* used by the NCHEC to develop the core criteria for certifying individuals as health education specialists.

Third, the *Framework* is used by program-accrediting bodies to review college and university academic programs in health education.

The use of the *Framework* to guide academic curricula, provide the core criteria for the health-education specialist examinations, and form the basis of program accreditation processes has done much to advance the health education profession. In 1998, the U.S. Department of Commerce and Labor formally acknowledged "health educator" as a distinct occupation. Such recognition was justified, based to a large extent, on the ability of the profession to specify its unique skills (AAHE, NCHEC, & SOPHE, 1999, p. 9).

Program Planning

Because several of the responsibilities involve program planning, implementation, and evaluation, health education specialists need to become proficient in these processes. All three processes require time, effort, practice, and on-the-job training to do them well. Even the most experienced health education specialists find program planning challenging because of constant changes to settings, resources, and priority populations.

Hunnicutt (2007) offered four reasons why systematic planning is important. The first is that planning forces planners to think through details in advance. Detailed plans can help to avoid future problems. Second, planning helps to make a program transparent. Good planning keeps the program **stakeholders** (any person, community, or organization with a vested interest in a program; e.g., decision makers, partners, clients) informed. The planning process should not be mysterious or secretive. Third, planning is empowering. It helps everyone involved feel more confident that actions being taken are justified and reasonable. And fourth, planning creates alignment. This helps all members of an organization feel they are working toward the same goals and objectives. As noted by Bryson (2018, p. 33), strategic planning "can help organizations clarify and resolve the most important issues they face. It can help them build on strengths and take advantage of major opportunities while they overcome and minimize weaknesses and serious challenges. It can help them be much more effective in what seems to be a more hostile world."

A general understanding of everything involved in planning a health promotion program can be facilitated by focusing on the Generalized Model (see **Figure 1.6**). (A more in-depth explanation of this model can be found in Chapter 3.)

This model includes the major steps involved in planning a program. However, prior to undertaking the first step in the Generalized Model, it is important to consider engaging in **pre-planning**, which allows a core group of people (or steering committee) to gather answers to key questions (see **Box 1.4**) that are critical to the planning process before the actual planning process begins. It also helps to clarify and give direction to planning, and helps stakeholders avoid confusion as the planning process progresses.

Also, before starting the actual planning process, planners need to have an adequate understanding of the community where the program will be implemented. **Community**

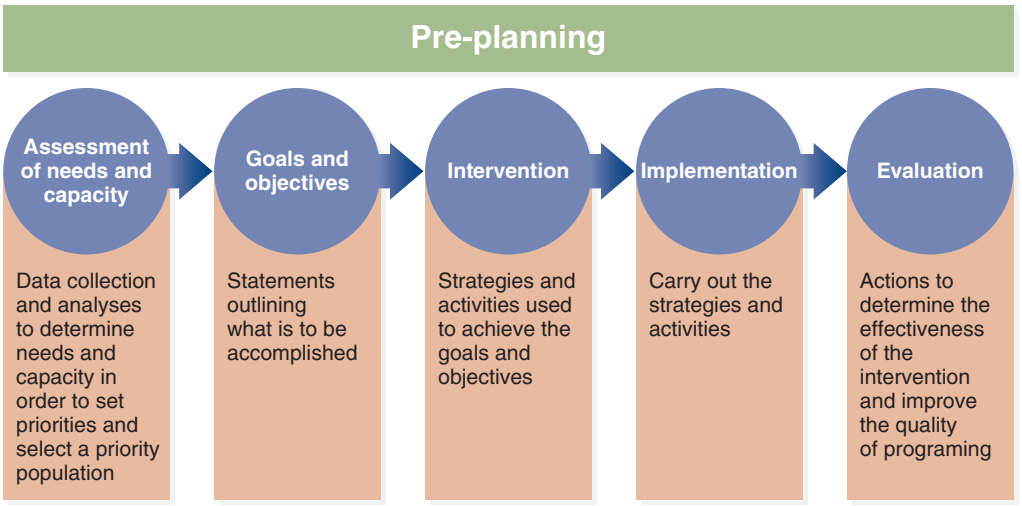


Figure 1.6 The Generalized Model.

is defined as "a collective body of individuals who share commonalities that are identified by characteristics and demographics, such as geography, interests, experiences, concerns, values, race, ethnicity [and/] or culture" (McCormack et al., 2012 as cited

Box 1.4 Key Questions to Be Answered in the Pre-Planning Process

Purpose of the Program

- Who is the priority population?
- How are we defining the community?
- What are the desired health outcomes?
- Does the community have the capacity and infrastructure to address the problem?
- Is a policy change needed?
- Are environmental changes needed?

Scope of the Planning Process

- Is it intra- or inter-organizational?
- Who are our partners or potential partners?
- What is the time frame for completing the project?

Planning Process Outcomes (Deliverables)

- Written plan?
- Program proposal?
- Program documentation or justification?

Leadership and Structure

- What authority, if any, will the planners have?
- How will the planners be organized?
- What is expected of those who participate in the planning process?

Identifying and Engaging Partners

- How will the partners be selected?
- How will programs be tailored to the priority population?
- How will we engage the priority population?
- Will the planning process use a top-down or bottom-up approach?

Identifying and Securing Resources

- How will the budget be determined (i.e., how much will the program cost and who will pay for it?)
- Will a written agreement (i.e., MOA—memorandum of agreement) outlining responsibilities be needed?
- If a MOA is needed, what will it include?
- Will external funding (i.e., grants or contracts) be needed?
- Are there community resources (e.g., volunteers, building space, donations) to support the planned program?
- How will the resources be obtained?

in Videto & Dennis, 2021, pp. 11–12). For example, a community could be a religious community, a cancer-survivor community, a workplace community, or a digital community, etc., and should not be limited to a geographic area with specific boundaries such as a neighborhood, city, county, or state. Understanding the community, or priority population, means finding out as much as possible about them to create better partnerships and programs. However, it is not enough to understand the community; planners also need to engage with members of the priority population and include them in the planning process in meaningful and productive ways.

The remaining chapters of this book present a process that health education specialists can use to plan, implement, and evaluate successful health promotion programs and will introduce you to the necessary knowledge and skills to carry out these tasks.

Summary

The increased interest in personal health and behavior change, and the flood of new health information have expanded the need for high-quality health promotion programs. Individuals are seeking guidance to enable them to make sound decisions about behavior that is conducive to their health. Properly trained health education specialists are aware of the limitations of the discipline and understand the assumptions on which health promotion is based. They also know that good planning does not happen quickly or by accident. Much time, effort, practice, and on-the-job training are needed to plan an effective program that begins with pre-planning.

Review Questions

1. Explain the role *Healthy People* played in developing health promotion.
2. What is the relationship between health education and health promotion?
3. What are the eight Areas of Responsibilities of health education specialists?
4. What assumptions are critical to health promotion?
5. What are the steps in the Generalized Model?
6. What is meant by the term *pre-planning*? Why is it important? What are some questions to answer during the pre-planning process?
7. How have stakeholders, decision makers, and communities been defined in this chapter?

Activities

1. Based on what you have read in this chapter and your knowledge of the profession of health education, write your own definitions for *health, health education, and health promotion.*
2. With your knowledge of health promotion, what other assumptions would you add to the list presented in this chapter in Box 1.2? Provide a one-paragraph rationale with at least two ideas.
3. Go to https://profiles.nlm.nih.gov/spotlight/nn/catalog/nlm:nlmuid-101584932X94-doc (Reports of the Surgeon General) and read *Healthy People: The Surgeon General's Report on Health Promotion and Disease Prevention.*

4. Assume you are in your senior year and will graduate next May with a bachelor's degree in health education. What steps do you need to take to register and prepare for the CHES® examination in April prior to your graduation. (Hint: Check the website of the National Commission for Health Education Credentialing. Inc.)
5. In a one-page paper, describe the differences and similarities in the two credentials—CHES® and MCHES®—available to health education specialists. (Hint: Check the website of the National Commission for Health Education Credentialing, Inc.)
6. In a one-page paper, describe the projected job outlook for health education specialists for the next 10 years. (Hint: Check the website of the Bureau of Labor Statistics *Occupational Outlook Handbook*.)

Weblinks

https://health.gov/healthypeople
Healthy People
This is the webpage for the U.S. government's Healthy People initiative including a complete presentation of *Healthy People 2030*.

http://www.nchec.org/
National Commission for Health Education Credentialing, Inc. (NCHEC).
The NCHEC, Inc. website provides the most current information about the CHES® and MCHES® credentials. It is also the place where you will find a complete list of the Areas of Responsibility, Competencies, and Sub Competencies.

http://www.bls.gov/ooh/community-and-social-service/health-educators.htm
Occupational Outlook Handbook
This is a webpage provided by the Bureau of Labor Statistics that describes the occupation outlook for health educators and community health workers.

PART I

Planning a Health Promotion Program

The chapters in this section of the book provide the basic information needed to plan a health promotion program. Each chapter presents readers with the information they will need to build the knowledge to develop the skills to create a successful program in a variety of settings.

CHAPTER 2

Starting the Planning Process

CHAPTER OBJECTIVES

After reading this chapter and answering the questions at the end, you should be able to:

1. Develop a rationale for planning and implementing a health promotion program.
2. Explain the importance of gaining the support of decision makers.
3. Identify the individuals who could make up a planning committee.
4. Explain what planning parameters are and the impact they have on program planning.

KEY TERMS

advisory board
cost-benefit analysis (CBA)
cost-effectiveness analysis (CEA)
decision makers
epidemiology
evidence
evidence-based practice
Guide to Community Preventive Services
organizational culture
partnering
planning committee
planning parameters
problem statement
program ownership
program rationale
return on investment (ROI)
social math
stakeholders
steering committee

As noted earlier (Chapter 1), planning a health promotion program is a multistep process that begins after preplanning. "To plan is to engage in a process or a procedure to develop a method of achieving an end" (Minelli & Breckon, 2009, p. 137). However, because of different settings and various circumstances, the multistep planning process does not always begin or proceed the same way. There are times when the need for a program is obvious. For example, if a community's immunization rates for diphtheria, tetanus, and pertussis for children up to 15 months; or for measles, mumps, and rubella among children 18 months to 18 years are less than half the national average, a program should be created and implemented. There are other times when a program has been successful in the past but needs to be improved before another round of implementation. Some situations exist where planners have the independence and authority to create and implement programs. However, when the

need is not so obvious, when health promotion programming has not been successful in the past, or when decision makers want evidence that a program is needed and will be successful, the planning process often begins with planners creating a **program rationale** or justification to gain the support of **decision makers**. For example, individuals in authority make a full range of decisions about health promotion programs and on behalf of other **stakeholders**. A stakeholder is any person or organization with a vested interest in a program. This helps ensure that the necessary foundation and resources exist, so the planning process and the eventual implementation proceed as smoothly as possible.

This chapter presents the steps of creating a program rationale to obtain the support of decision makers, identifying those who may assist in planning the program and establishing the parameters in which the planners must work. **Box 2.1** identifies the responsibilities

Box 2.1 Responsibilities and Competencies for Health Education Specialists

The content of this chapter includes information on several tasks that occur early in the program planning process. These tasks are not associated with a single area of responsibility, but rather six areas of responsibility of the health education specialist:

Responsibility I:	**Assessment of Needs and Capacity**
	Competency 1.3: Analyze the data to determine the health of the priority population(s) and the factors that influence health
Responsibility II:	**Planning**
	Competency 2.1: Engage priority populations, partners, and other stakeholders for participation in the planning process
Responsibility V:	**Advocacy**
	Competency 5.2: Engage coalitions and stakeholders in addressing the health issue and planning advocacy efforts
	Competency 5.3: Engage in advocacy
Responsibility VI:	**Communication**
	Competency 6.1: Determine factors that affect communication with the identified audience(s)
	Competency 6.3: Develop messages(s) using communication theories and/or models
	Competency 6.4: Select methods and technologies used to deliver message(s)
	Competency 6.5: Deliver the message(s) effectively using the identified media and strategies
Responsibility VII:	**Leadership and Management**
	Competency 7.1: Coordinate relationships with partners and stakeholders (e.g., individuals, teams, coalitions, and committees)
Responsibility VIII:	**Ethics and Professionalism**
	Competency 8.1: Practice in accordance with established ethical principles
	Competency 8.2: Serve as an authoritative resource on health education and promotion

and competencies for health education specialists that pertain to the material presented in this chapter.

The Need for Creating a Program Rationale to Gain the Support of Decision Makers

No matter where the setting of a health promotion program is—whether a worksite, a community, a clinic, a hospital, or a school—it is essential that the lead organization(s) for the program have support from the highest necessary level of administration (Allen & Hunnicutt, 2007; Hunnicutt & Leffelman, 2006; Ryan et al., 2008). The individuals in these top-level decision-making positions are able to provide the necessary resource support for the program.

> "Resources" usually means money, which can be turned into staff, facilities, materials, supplies, utilities, and all the myriad number of things that enable organized activity to take place over time. "Support" usually means a range of things: congruent organizational policies, program and concept visibility, expressions of priority value, personal involvement of key managers, a place at the table of organizational power, organizational credibility, and a role in integrated functioning. (Chapman, 1997, p. 1)

There will be times when the idea for, or the motivating force behind, a program comes from top-level managers (hereafter referred to as decision makers). When this happens, it is easier for program planners because they can focus more of their efforts on the program itself and its implementation. However, this scenario does not always occur in practice.

Often, the idea for a health promotion program comes from someone other than decision makers. The idea could start with an employee, an interested parent, a health education specialist within the organization, a member of a church congregation, a community organization, a business, or a concerned individual or group from within the community, etc. The idea might even be generated by an individual outside the "community," such as one who may have broader administrative or oversight responsibilities for activities in a community. An example is an employee of a state health department who provides consultation services or oversees a contract or grant with a local health department. It may also be an individual from a regional agency who is partnering with a group within the community to carry out a collaborative project. When the scenario begins at a level below decision makers, those who want to create a program must "sell" it to the decision makers. In other words, in order for resources and support to flow into health promotion programming, decision makers need to clearly perceive a set of values or benefits associated with the proposed program (Chapman, 2006). Without the support of decision makers, it becomes more difficult, if not impossible, to plan and implement a program.

When it becomes necessary to gain the support of decision makers, program planners

should develop a rationale for the program's existence. Why is it necessary to convince people about something that everyone knows is worthwhile? After all, does anyone doubt the value of trying to help people improve and maintain good health? The answer to these and similar questions is that few people are motivated by health concerns alone. Decisions to develop new programs are based on a variety of factors, including finances, policies, public image, and politics, to name a few. Thus, to sell the program to those at the top, planners need to develop a rationale that shows how the new program will help decision makers meet the organization's goals and, in turn, carry out its mission. In other words, planners need to position their program rationale politically and culturally, in line with the organization.

Steps in Creating a Program Rationale

Planners must understand that gaining the support of decision makers is one of the most important steps in the planning process and planners should not take it lightly. Many program ideas have ceased at this stage because the planners were not well prepared to communicate the value and benefits of the program. Thus, before making an appeal to decision makers, planners need to have a sound rationale for creating a program that is supported by evidence that the proposed program will benefit those for whom it is planned.

There is no formula for writing a rationale, but through experience, the authors have found a logical flow for putting ideas together to help guide planners (see **Figure 2.1**). Note that Figure 2.1 is presented as an inverted triangle. This inverted triangle is symbolic in design to reflect the flow of a program rationale beginning at the top by identifying a health problem in the broadest terms and moving toward a more focused solution at the bottom of the triangle.

Step 1: Identify Appropriate Background Information

Before planners begin to write a program rationale, they need to identify appropriate sources of information and data that they can use to justify program development. The place to begin the process of identifying appropriate sources of information and data to support the development of a program rationale is to conduct a search of existing literature. Literature includes the scientific articles, books, government publications, and other documents that explain the past and current knowledge of a particular topic. By conducting this type of search, planners gain a better understanding of the health problem(s) of concern, approaches to reducing or eliminating the health problem, and an understanding of the people for whom the program is intended (i.e., the priority population). There are a number of different ways that planners can conduct a review of the literature (see Chapter 4 for an explanation of the literature review process).

In general, useful information and data in writing a program rationale include those that (1) express the needs and wants of the priority population, commonly referred to as consumer research data, (2) describe the status of the health problem(s) within a given population, (3) show how the potential outcomes of the proposed program align with what decision makers feel

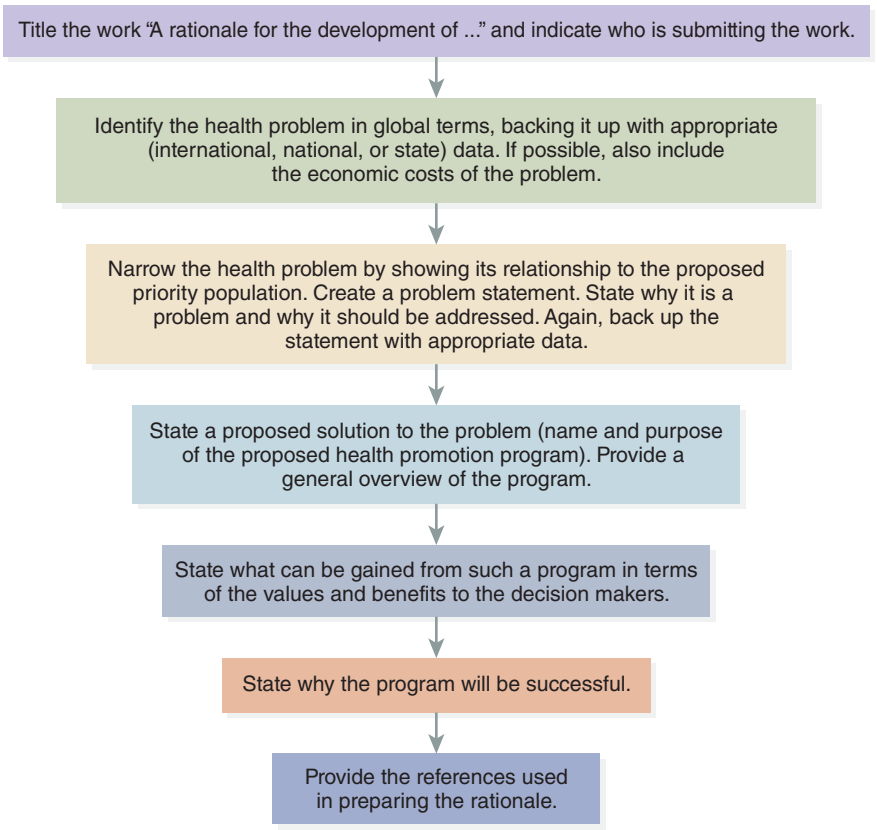
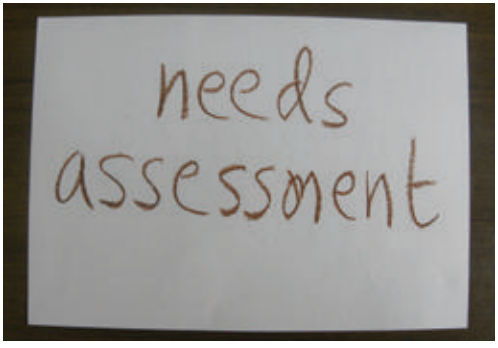


Figure 2.1 Creating the Program Rationale.

is important, (4) show compatibility with the health plan of a state or the nation, (5) provide evidence that the proposed program will make a difference, and (6) show how the proposed program will protect and preserve the single biggest asset of organizations and communities—their people.

Although many of these types of information and data are generated through a review of the literature, the first one discussed below—needs and wants of the priority population—is not.

Information and data that express the needs and wants of the priority population can be generated through a needs assessment. A *needs assessment* is the process of identifying, analyzing, and prioritizing the needs of a priority population (see Chapter 4 for a detailed explanation of the needs assessment process). It may also involve collecting consumer research data to determine the "wants" of a priority population. Even though information and data that express the needs and

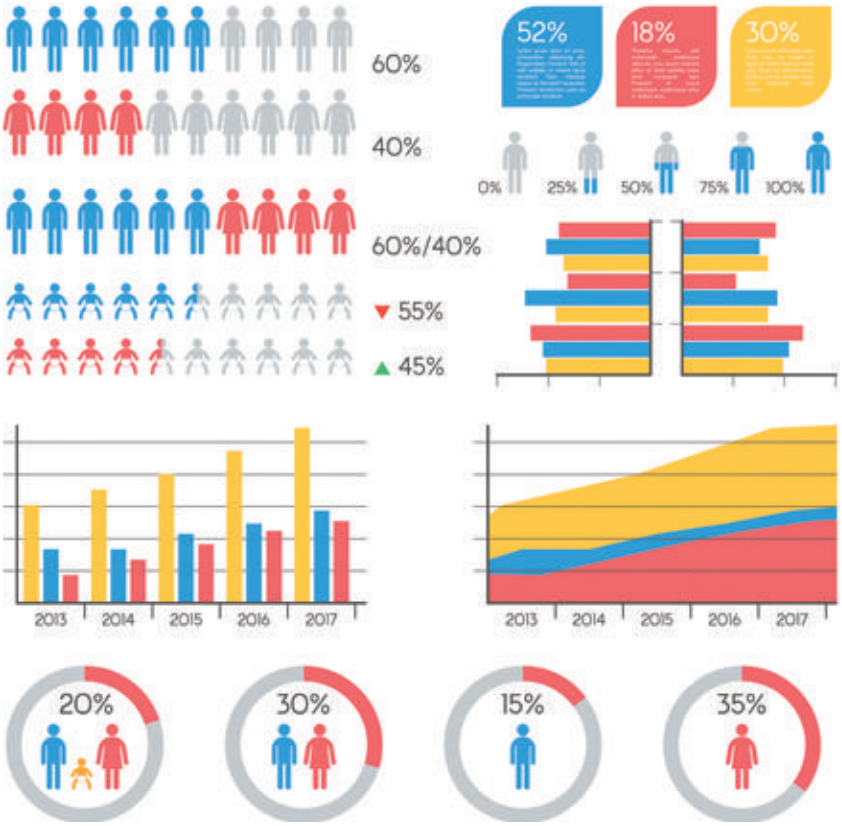


wants of the priority population can be very useful in generating a rationale for a proposed program, more than likely at this point in the planning process, a formal needs assessment will not have been completed. Often, a complete needs assessment does not take place until decision makers give permission for the planning to begin. However, the review of literature may discover information about a needs assessment of another related or similar program. If so, it can provide valuable information and data that can help to develop the program rationale.

Information and data that describe the status of a health problem within a population can be obtained by analyzing epidemiologic data. **Epidemiology** has been defined as "the study of the distribution and determinants of health-related states or events in specific populations, and the application of this study to control health problems" (Seabert et al., 2022, p. 512).

Epidemiologic data are available from a number of different sources including governmental agencies, such as health agencies, nongovernmental health organizations, and healthcare systems. **Table 2.1** provides some examples of useful sources of epidemiologic data.

Epidemiologic data gain additional significance when it can be shown that the described health problem(s) is(are) the result of modifiable health behaviors and that investing resources to promote healthy lifestyles and prevent health problems makes sense economically. Here are a couple of examples where



Epidemiologic Data.

Table 2.1 Sources of Epidemiologic Data

Source	Example Data
Global	
World Health Organization	World Health Statistics Report (https://www.who.int/data/gho/publications/world-health-statistics) Pan American Health Organization Statistical Data (https://www.paho.org/en/statistical-data) (http://www.who.int/gho/countries/en/)
National	
Centers for Disease Control and Prevention	National Health and Nutrition Examination Survey (NHANES) (https://www.cdc.gov/nchs/nhanes/index.htm)
National Center for Health Statistics	National Health Interview Survey (NHIS) (https://www.cdc.gov/nchs/nhis/index.htm)
State	
Centers for Disease Control and Prevention	Behavioral Risk Factor Surveillance System (BRFSS) (https://www.cdc.gov/brfss/index.html) Youth Risk Behavior Surveillance System (YRBSS) (http://www.cdc.gov/healthyyouth/data/yrbs/index.htm)
Kaiser Family Foundation	State Health Facts (https://www.kff.org/statedata/)
Local	
Robert Wood Johnson Foundation & University of Wisconsin Population Health Institute	County Health Rankings & Roadmaps (http://www.countyhealthrankings.org/)

modifiable health behaviors and health-related costs have been connected. The first deals with smoking. Approximately 14% of U.S. adults 18 years of age and older are cigarette smokers (CDC, 2020a). It has been estimated that the total economic cost burden of tobacco use in the U.S. is more than $300 billion annually. This includes direct costs and lost productivity (CDC, 2021i). Almost equal amounts are spent on direct medical care ($170 billion) and productivity losses due to premature death and exposure to secondhand smoke ($156 billion) (CDC, 2021i). The second example deals with diabetes. It has been estimated that annual medical and lost productivity costs associated with diabetes are approximately $327 billion (CDC, 2021k). We know that not all cases of diabetes are related to health behavior, but it is known that for people with prediabetes, lifestyle changes, including a 5–7% weight loss and at least 150 minutes of physical activity per week, can reduce the rate of onset of type 2 diabetes by 58% (CDC, 2012b). In addition, we know that people with diagnosed diabetes have medical expenditures that are about 2.3 times higher than medical expenditures for people without diabetes (CDC, 2012b).

When a rationale includes an economic component, it is often reported based on a **cost-benefit analysis (CBA)**. A CBA of a health promotion program will yield the dollar benefit received from the dollars

invested in the program. In contrast, **cost-effectiveness analysis (CEA)** measures the cost of a program based on health outcomes achieved (Erwin & Brownson, 2017). For example, planners may report that for every $2,000 spent on community smoking cessation programs, one person will quit smoking permanently (Drouin et al., 2021), or that for every $400 spent in a school-based obesity prevention program involving active physical education, one student will decrease body mass index by one category (e.g., obese to overweight or overweight to normal) (Gortmaker et al., 2015).

A common way of reporting a CBA is through a metric called **return on investment (ROI)**. ROI "measures the costs of a program (i.e., the investment) versus the financial return realized by that program" (Cavallo, 2006, p. 1) (see **Box 2.2** for formulas to calculate ROI). An example of ROI is a study that examined the economic impact of an investment of $10 per person per year in a proven community-based program to increase physical activity, improve nutrition, and prevent smoking and other tobacco use. The results of the study showed that the nation could save billions of dollars annually and have an ROI in one year of 0.96 to 1, 5.6 to 1 in 5 years, and 6.2 to 1 in 10–20 years (TFAH, 2009).

However, it should be noted that "proving" the economic impact of health promotion programs is not easy. There are a number of reasons for this including the multiple causes of many health problems, the complex interventions needed to deal with them, and the complexity of conducting research studies measuring behavior change and associated

Box 2.2 Return on Investment

In general, ROI compares the dollars invested in something to the dollars in benefits produced by that investment:

$$\text{ROI} = \frac{(\text{benefits of investment} - \text{amount invested})}{\text{amount invested}}$$

In the case of an investment in a prevention program, ROI compares the savings produced by the intervention, net cost of the program, to how much the program cost:

$$\text{ROI} = \frac{\text{net savings}}{\text{cost of intervention}}$$

When ROI equals 0, the program pays for itself. When ROI is greater than 0, the program is producing savings that exceed the cost of the program.

cost savings. Additionally, McGinnis and colleagues (2002) suggested that part of the problem is that health promotion programs are held to a different standard than medical treatment programs when cost-effectiveness is being considered.

> In a vexing example of double standards, public investments in health promotion seem to require evidence that future savings in health and other social costs will offset the investments in prevention. Medical treatments do not need to measure up to the standard; all that is required here is evidence of safety and effectiveness. The cost-effectiveness challenge often is made tougher by a sense that the benefits need to accrue directly and in short term to the payer making investments. Neither of these two conditions applies in many interventions in health promotion. (p. 84)

A helpful tool for calculating the financial burden of chronic diseases has been the Chronic Disease Cost Calculator Version 2 created by the Centers for Disease Control and Prevention and RTI International (see the link for the website in the weblinks section at the end of the chapter).

Other information and data that are useful in creating a program rationale are those that show how the potential outcomes of the proposed program align with what decision makers feel is important. Planners can often get a sense of what decision makers value by reviewing the organization's mission statement, annual report, and/or budget for health-related items. Planners could also interview decision makers directly to determine what is important to them. **Table 2.2** provides a list of values or benefits that can be derived from health promotion programs, while **Table 2.3** provides a list of sources where information about values or benefits could be found.

A fourth source of information for a program rationale is a comparison between the proposed program and the health plan for the nation or a state. Comparing the health needs of the priority population with those of other citizens of the state or of all Americans, as outlined in the goals and objectives of the nation (USDHHS, 2021d), should enable planners to show the compatibility between the goals of the proposed program and those of the nation's health plan (see Chapter 6 for a discussion of the *Healthy People 2030* goals and objectives).

A fifth source of information and data is *evidence* that the proposed program will be effective and make a difference if implemented.

Table 2.2 Values or Benefits from Health Promotion Programs

Value or Benefit for:	Types of Values or Benefits
Community	Establishing good health as a norm; improved quality of life; improved economic well-being of the community; providing a model for other communities
Employee/Individual	Improved health status; reduction in health risks; improved health behavior; improved job satisfaction; lower out-of-pocket costs for health care; increased well-being, self-image, and self-esteem
Employer	Increased worker morale; enhanced worker performance/productivity; recruitment and retention tool; reduced absenteeism; reduced disability days/claims, reduced health care costs; enhanced corporate image

Information from American Cancer Society (ACS). (2009). *Workplace solutions: Creating a culture of health.* Retrieved May 13, 2011, from http://www.cancer.org/aboutus/drlensblog/post/2009/06/23/workplace-solutions-creating-a-culture-of-health.aspx; Chapman, L. S. (1997). Securing support from top management. *The Art of Health Promotion, 1*(2), 1–7.

Table 2.3 Selected Sources of Information About Values or Benefits of Health Promotion Programs

Source	Location of Information
American Heart Association—Workplace Health	https://www.heart.org/en/professional/workplace-health
Centers for Disease Control and Prevention National Center for Health Statistics	http://www.cdc.gov/nchs/
Centers for Disease Control and Prevention and NIOSH Total Worker Health® Program	https://www.cdc.gov/niosh/twh/default.html
Centers for Disease Control and Prevention Workplace Health Promotion	http://www.cdc.gov/workplacehealthpromotion/
The Community Toolbox	http://ctb.ku.edu/en
National Committee for Quality Assurance	http://www.ncqa.org
Business Group on Health	https://www.businessgrouphealth.org/
Prevention Institute	http://www.preventioninstitute.org/
Robert Wood Johnson Foundation	http://www.rwjf.org/en.html
Trust for America's Health	https://www.tfah.org/
U.S. Department of Health & Human Services Office of Assistant Secretary for Planning & Evaluation	https://aspe.hhs.gov
Wellness Council of America (WELCOA)	https://www.welcoa.org

By **evidence** we mean the body of data that can be used to make decisions when planning a program. Such data can come from needs assessments, knowledge about the causes of a health problem, research that has tested the effectiveness of an intervention, and evaluations conducted on other health promotion programs. When program planners systematically find, appraise, and use evidence as the basis for decision making when planning a health promotion program, it is referred to as **evidence-based practice** (Cottrell & McKenzie, 2011).

Various forms of evidence can be placed on a continuum anchored at one end by *objective evidence* (or science-based evidence) and *subjective evidence* at the other end of the continuum (Chambers & Kerner, 2007), which may include hearsay or anecdotal evidence from program participants (Howlett et al., 2014). Others have organized the various forms of evidence as a hierarchy within an *evidence pyramid* with

objective evidence at the top of the pyramid and subjective evidence at the base of the pyramid. Irrespective of format for aligning and presenting the various forms of evidence, "more objective types of evidence include systematic reviews, whereas more subjective data involve personal experience and observations as well as anecdotes" (Brownson et al., 2014, p. 1). Because it is derived from a scientific process, objective evidence is seen as a higher quality of evidence. Planners should strive to use the *best evidence possible* but also understand that "evidence is usually imperfect" (Brownson et al., 2011, p. 6) and, as planners, they will often be faced with having to use the *best evidence available* (Muir Gray, 1997). Over the years, the number of organizations/agencies that have worked to identify evidence of various types of health-related programs (i.e., health care, disease prevention, health promotion) has increased (see **Box 2.3** for examples). A most useful source for those planning health promotion programs is the ***Guide to Community Preventive Services***, referred to simply as *The Community Guide* (Community Preventive Services Task Force, 2021a).

Box 2.3 Examples of Sources of Evidence

The Campbell Collaboration

Type of evidence: Produces systematic reviews on the effects of governmental and other social interventions including crime and justice, education, international development, and social welfare.

Website: http://www.campbellcollaboration.org/

Centre for Reviews and Dissemination; The University of York

Type of evidence: Systematic reviews and economic evaluations covering a wide variety of healthcare topics, many of which impact national policy.

Website: https://www.york.ac.uk/crd/

Cochrane

Type of evidence: Synthesized research evidence on health and health care. Can be searched using various terms including health education and health promotion.

Website: http://www.cochrane.org/

Canadian Task Force on Preventive Health Care

Type of evidence: Practice guidelines that support primary care providers in delivering preventive health care. Also, has information for the general public.

Website: http://www.canadiantaskforce.ca

Health Evidence, McMaster University, Canada

Type of evidence: Effectiveness of public health interventions (and related cost data) in Canada.

Website: http://healthevidence.org

National Cancer Institute

Document: *Research-tested Intervention Programs*

Type of evidence: A searchable database of cancer control interventions and program materials that are designed to provide program planners and public health practitioners with easy and immediate access to program materials.

Website: http://rtips.cancer.gov/rtips/index.do

Substance Abuse and Mental Health Services Administration

Document: *Evidence Based Practices Resource Center*

Type of Evidence: Searchable online registry of substance abuse and mental health interventions to incorporate evidence-based practices into communities or clinical settings.

Website: https://www.samhsa.gov/resource-search/ebp

(continues)

Box 2.3 Examples of Sources of Evidence *(continued)*

Task Force on Community Preventive Services

Document: *Guide to Community Preventive Services*
Type of evidence: Programs and policies to improve health and prevent disease in communities.

Website: http://www.thecommunityguide.org

U.S. Preventive Services Task Force

Document: *The Guide to Clinical Preventive Services*
Type of evidence: Recommendations on the use of clinical preventive services such as screening tests, counseling services, and preventive medications.

Website: http://www.ahrq.gov/professionals/clinicians-providers/guidelines-recommendations/uspstf/index.html

World Health Organization

Document: *Health Evidence Network (HEN)*
Type of evidence: Summarized evidence for public health, health care, and health systems policymakers.

Website: http://www.euro.who.int/en/data-and-evidence/evidence-informed-policy-making/health-evidence-network-hen

The Community Guide summarizes the findings from systematic reviews of public health interventions covering a variety of topics. The Community Guide is an essential planning tool for several reasons:

- It uses a science-based approach to determine the effectiveness of an intervention and whether it is cost-effective.
- It helps identify appropriate interventions for behavior change, disease prevention, and environmental change.
- It identifies where there is sufficient evidence and where more research is needed related to effective interventions.
- It complements the science and rationale associated with Healthy People 2030 and the Guide to Clinical Preventive Services (Community Preventive Services Task Force, 2021b).

The Community Guide was developed and is continually updated by the nonfederal Task Force on Community Preventive Services. The Task Force, which is composed of public health experts who are appointed by the CDC director, is charged with reviewing and assessing the quality of available evidence and developing appropriate recommendations. Of special note, the Community Guide presents three categories of findings based on systematic reviews of peer-reviewed literature. *Recommended* means evidence exists that the intervention is effective, *insufficient evidence* means that available studies do not provide sufficient evidence to determine intervention effectiveness and *recommended against* means evidence exists that the intervention is harmful or ineffective (Community Preventive Services Task Force, 2021c).

Finally, when preparing a rationale to gain the support of decision makers, planners should not overlook the most important resource of any community—the people who make up the community. Promoting, maintaining, and, in some cases restoring human health should be at the core of any health promotion program. Whatever the setting, better health of those in the priority population provides for a better quality of life. For those planners who end up practicing in a worksite setting, the importance of protecting the health of employees (i.e., protecting human resources) should be noted in developing a rationale. "Labor costs typically represent 60–70% of total annual operating costs for most organizations" (Chapman, 2006, p. 10); thus, employees are a company's single biggest asset. "Fit and healthy people are more productive, are better able to meet extraordinary demands and deal with stress, are absent

less, reflect better on the company or community as exemplars, and so forth" (Chapman, 2006, p. 29).

Step 2: Title the Rationale

Once planners have identified and are familiar with the sources of information and data that they can use to initiate program development, they are ready to begin the process of putting a rationale together. Thus, the next step is giving a title to the rationale. This can be quite simple in nature, such as "A Rationale for (Title of Program): A Program to Enhance the Health of (Name of Priority Population)."

Step 3: Writing the Content of the Rationale

The first paragraph or two of the program rationale should identify the health problem from a global or macro perspective, whether it be international, national, regional, state, or local. In other words, begin the rationale by presenting the problem at the most macro level for which supporting data are available. So, if there is international information and data on the problem, for example HIV/AIDS, begin describing the problem at that level. If data are not available to present the problem at the international level, for example people without health insurance, move down to the next level where the rationale can be supported with data. If available, also include the economic costs of such a problem because it will strengthen the rationale. "Much of the decision-making that occurs, for change to take place in an organization is based on financial considerations, and any change within an organization typically must be supported by a positive return on investment. Lacking sound financial support or a firm understanding of the financial implications, a good idea may not be realized in practice" (Gambatese, 2008, p. 153). Most health problems are also present at other levels. Presenting the problem at these higher levels shows decision makers that dealing with the health problem is consistent with the concerns of others.

Showing the relationship of the health problem to the "bigger problem" at the international, national, and/or state levels is the next step in presenting the rationale. Thus, the next portion of the rationale is to identify the health problem that is the focus of the rationale. This declaration of the health problem is referred to as the **problem statement** or *statement of the problem*.

The problem statement should begin with a concise explanation of the issue that needs to be considered (WKKF, 2004). The statement should also include *why* it is a problem and *why* it should be addressed (see **Box 2.4**). If available, the statement should also include supporting data for the problem, including what could possibly happen if the problem is not corrected. Such data may come from a needs assessment if it has already been completed or from related literature.

In presenting the problem statement, you may find it useful to use the technique of social math. **Social math** has been defined as "the practice of translating statistics and other data so they become interesting to the journalist and meaningful to the audience" (Dorfman et al., 2004, p. 112).

Box 2.4 Examples of Problem Statements

For a local-level program

Chlamydia is the most commonly reported bacterial sexually transmitted infection in the United States (CDC, 2021d), with new infections in a given year totaling $691 million in direct lifetime medical costs (CDC, 2021m). In Davis County, Utah, chlamydia increased by 500% from 2000 to 2018, with 1,158 total cases in 2018 (Davis County Health Department, 2021). Although county rates were considerably less than national rates and increased testing explained some of the surge in cases, the Davis County Health Department faces a significant health problem, particularly in female populations between the ages of 15 and 24 years. While both males and females are affected by chlamydia, serious health problems are more common in women. These include pelvic inflammatory disease, inability to get pregnant, ectopic pregnancy (i.e., pregnancy outside of the uterus), and increased risk of giving or getting HIV (CDC, 2021e). These risks are complicated because most people who have chlamydia do not show symptoms. However, with effective programs to identify those at risk and encourage testing, chlamydia is easily treated with antibiotics (CDC 2021d).

For a state-level program

Overweight and obesity are critical health threats facing the state of Alabama. Between 1990, 2000, and 2010, Alabama's adult obesity rates increased from 11.2% to 22.6% to 36.1%, respectively (Alabama Public Health, 2021a). Both overweight and obesity substantially increase the risks for heart disease, stroke, diabetes, and cancer. Obesity is responsible for over 9% of all medical costs with per-cost spending among obese patients approximately $1,429 higher annually compared with patients at a healthy weight (Alabama Public Health, 2021b). The annual costs (direct and indirect) of obesity in the United States are approximately $340 billion (Obesity Action Coalition, 2021). However, there is good evidence indicating that both the physical and financial costs of overweight and obesity are preventable.

In other words, data, especially large numbers, are presented in such a way that makes them easier to grasp by putting them in a context that gives instant meaning. "It is critical to select a social math fact that is 100 percent accurate, visual if possible, dramatic, and appropriate for the target audience" (NCIPC, 2008, p. 17). For example, $3.8 trillion was spent on health care in 2019 in the United States (Centers for Medicare & Medicaid Services, 2021). While $3.8 trillion is an astronomically large number and hard to comprehend, translating it to spending $11,582 for every person in the United States (Centers for Medicare & Medicaid Services, 2021) makes it more understandable and relevant. (See **Box 2.5** for other examples.)

Box 2.5 Examples of Social Math

- *Break the numbers down by time.* If you know the amount over a year, what does that look like per hour? Per minute? For example, the average annual salary of a childcare worker nationally is $25,460, roughly $12.24 per hour. While many people understand that an annual salary of $25,460 is low, breaking the figure down by the hour reinforces that point—and makes the need for some kind of intervention even clearer.
- *Break down the numbers by place.* Comparing a statistic with a well-known place can give people a sense of the

statistic's magnitude. For instance, approximately 250,000 children are on waiting lists for childcare subsidies in California. That is enough children to fill almost every seat in every Major League Baseball stadium in California. Such a comparison helps us visualize the scope of the problem and makes a solution all the more imperative.

- *Provide comparisons with familiar things.* Providing a comparison with something that is familiar can have great impact. For example, "While Head Start is a successful, celebrated educational program; it is so underfunded that it serves only about three-fifths of eligible children. Applying that proportion to Social Security would mean that almost a million currently eligible seniors wouldn't receive benefits."
- *Provide ironic comparisons.* For example, the average annual cost of full-time, licensed, center-based care for a child under age 2 years in California is twice the tuition at the University of California at Berkeley. Parents and the public focus so much on the cost of college when earlier education is dramatically more expensive.
- *Localize the numbers.* Make comparisons that will resonate with community members. For example, saying, "Center-based childcare for an infant costs $11,450 per year in Seattle, Washington," is one thing. Saying, "In Seattle, Washington, a father making minimum wage would have to spend 79 percent of his income per year to place his baby in a licensed care center," is much more powerful because it illustrates how it is nearly impossible.

Reproduced from National Center for Injury Prevention and Control. (2008, revised 2010). *Adding power to our voices: A framing guide for communicating about injury*. Author. Retrieved June 30, 2021, from http://www.ncdsv.org/images/CDC_AddingPowerToOurVoices-AFramingGuideForCommunicatingAboutInjury_2010.pdf

At this point in the rationale, propose a solution to the problem. The solution should include the name and purpose of the proposed health promotion program, and a general overview of what the program may include. Since the writing of a program rationale often precedes much of the formal planning process, the general overview of the program is often based on an educated guess or best estimate. For example, if the purpose of a program is to improve the immunization rate of children in the community, a best estimate of the eventual program might include interventions to increase awareness and knowledge about immunizations, and the reduction of the barriers that limit access to receiving immunizations. Following such an overview, include statements indicating what can be gained from the program. Do your best to align the potential values and benefits of the program with what is important to members of the priority population and the decision makers.

Next, state why this program will be successful. This is the place to use the results of *evidence-based practice* to support the rationale. It can also be helpful to point out the similarity of the priority population to others with which similar programs have been successful. And finally, using the argument that the timing is right for the program can also be useful (i.e., there is no better time than now to work to solve the problem facing the priority population).

Step 4: Listing the References Used to Create the Rationale

The final step in creating a rationale is to include a list of the references used in preparing the rationale. Having a reference list shows decision makers that you studied the available information before presenting your idea. (See **Box 2.6** for an example of a program rationale.)

Box 2.6 Example of Program Rationale

A Rationale for a Comprehensive Tobacco Control Program in Philadelphia County, Pennsylvania

The World Health Organization (WHO) has noted that "the tobacco epidemic is one of the biggest public health threats the world has ever faced, killing more than eight million people a year around the world. More than seven million of those deaths are the result of direct tobacco use while around 1.2 million are the result of non-smokers being exposed to second-hand smoke (WHO, 2021b, p. 1)." In other words, approximately one in 10 adult deaths worldwide are attributed to tobacco use and if trends continue, tobacco use will cause over 1 billion deaths in the twenty-first century (Campaign for Tobacco Free Kids, 2021). To further quantify the burden of tobacco on the people of the world is to note that 8 million deaths is approximately the equivalent of losing the entire population of the state of Washington each year.

The impact of tobacco use and secondhand smoke exposure in the United States, though decreasing, continues to be a significant problem in the United States. In 2019, the percentage of adult (>18 years of age) smokers in United States was 14%, which is the lowest it has ever been, although it still represents 34.1 million people (CDC, 2020a). Tobacco continues to be the single most preventable cause of disease, disability, and death in the United States. (CDC, 2020a), and accounts for approximately 480,000 deaths per year. It has been estimated that 51,000+ of those deaths are nonsmokers exposed to secondhand smoke (CDC, 2020b). In total, tobacco use and secondhand smoke exposure are responsible for 20% of all deaths in the United States annually. In addition, more than 16 million Americans are living with a disease caused by smoking (CDC, 2020b). That means that for every person who dies because of smoking, at least 30 people live with a serious smoking-related illness. Smoking causes cancer, heart disease, stroke, lung diseases, diabetes, and chronic obstructive pulmonary disease (COPD), which includes emphysema and chronic bronchitis, and it also increases risk for tuberculosis, certain eye diseases, and problems of the immune system, including rheumatoid arthritis (CDC, 2020a).

In addition to the costly physical burden of tobacco use and secondhand smoke exposure in the United States, there is also a significant economic cost. The total financial burden of tobacco in the country is more than $300 billion per year. This includes $225 billion in direct medical costs and more than $156 billion in lost productivity due to premature death and exposure to secondhand smoke (CDC, 2020b).

Tobacco use and secondhand smoke exposure are also significant problems for the residents of Pennsylvania. While the current national percentage of adult cigarette smokers is 14%, the current percentage of smokers in Pennsylvania is 17.3% (United Health Foundation, 2021). More locally, in Philadelphia, the prevalence of adult smoking is slightly higher at 18% (Pennsylvania Department of Health, 2020).

Philadelphia has implemented several interventions to reduce smoking, including enforcement of policies that restrict smoking and the purchase of tobacco products, making it more difficult for youth to access tobacco products, and various other initiatives to encourage residents to live smoke-free lives (City of Philadelphia, 2021). Although each of these efforts can contribute to a reduction in smoking, more needs to be done.

To reduce the prevalence of smoking in communities, the CDC has recommended a comprehensive approach, which it has outlined in a document titled, *Best Practices for Comprehensive Tobacco Control Programs–2014* (CDC, 2014a). The program includes five components: (1) state and community interventions, (2) mass-reach health communication interventions, (3) cessation interventions, (4) surveillance and evaluation, and (5) infrastructure administration and management.

The goals of such a program are to:

- "Prevent initiation among youth and young adults.
- Promote quitting among adults and youth.
- Eliminate exposure to secondhand smoke.

- Identify and eliminate tobacco-related disparities among population groups" (CDC, 2014a, p. 9).

This approach is not without its merits; it is recommended based on solid evidence. "The Community Preventive Services Task Force recommends comprehensive tobacco control programs based on strong evidence of effectiveness in reducing tobacco use and secondhand smoke exposure. Evidence indicates these programs reduce the prevalence of tobacco use among adults and young people, reduce tobacco product consumption, increase quitting, and contribute to reductions in tobacco-related diseases and deaths. Economic evidence indicates that comprehensive tobacco control programs are cost-effective, and savings from averted healthcare costs exceed intervention costs" (CPSTF, 2014, para. 1).

After reviewing these data, it is clear that there is a significant smoking problem in Philadelphia. In order to deal with this problem, it is recommended that the Coalition for a Smoke-Free Philly work toward an even more comprehensive tobacco control program based on *Best Practices for Comprehensive Tobacco Control Programs–2014* but adapt it to fit the population. The National Association of County and City Health Officials has created the "Guidelines for Comprehensive Local Tobacco Control Programs" (CDC, 2014a) to show how the best practice guidelines can be adapted to a local level. It is also recommended that the Coalition begin its work by reviewing the existing tobacco prevention programs in the county. Those current activities that are in line with best practices should be kept, and those that are not should either be modified to align with best practices or be discontinued. A comprehensive tobacco program has great potential for success in Philadelphia for several reasons. First, it would be an evidence-based program with strong science to back it up. Second, similar programs in other large cities in the United States have been successful (CDC, 2014a). Third, the program will be well planned and tailored to the residents of Philadelphia. There is no better time than now to invest in the health of the people of Philadelphia!

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Planning Committee

The number of people involved in the planning process is determined by the resources and circumstances of a particular situation. "One very helpful method to develop a clearer and more comprehensive planning approach is to establish a committee" (Gilmore, 2012, p. 35). Identifying individuals who would be willing to serve as members of the **planning committee** (sometimes referred to as a **steering committee** or **advisory board**) becomes one of the planner's first tasks. Because an effective planning committee is usually composed of interested and well-respected individuals, it is important to establish it carefully (Chapman, 2009).

When organizing a planning committee, it is also advisable to consider the concept of *partnering* to meet the eventual goals of the program that will be planned. **Partnering** can be defined as the association of two or more entities (i.e., individuals, groups, agencies, organizations) working together on a project of common interest. Such associations usually means sharing of resources and tasks to be completed. There are a number of reasons to partner that include things such as: (1) meeting the needs of a priority population, which could not be met by the capacities of a single individual or organization, (2) sharing of financial and other resources, (3) solving a problem or achieving a goal that is a priority to several partners, (4) bringing more stakeholders to the process, (5) bringing more credibility to the program, (6) working with others who have the same values (Picarella, 2015), (7) seeing and solving a problem from multiple perspectives and thus creating different effects (Schiavo, 2014), and (8) creating a greater response to a need because there is strength in numbers.

In looking for partners or collaborators, planners should consider these questions: (1) Who is also interested in meeting the needs of the priority population? (2) Who also sees the unmet need of a priority population as a problem? (3) Who has available resources that could help solve a problem?, and (4) Who would benefit from being your partner? The Prevention Institute has created an interactive framework and tool for analyzing collaborative efforts. The framework/tool, called the *Collaboration Multiplier*, is "designed to guide an organization to a better understanding of which partners it needs and how to engage them. It is also designed for organizations that already work together, so they may identify activities to achieve a common goal, identify missing sectors that can contribute to a solution, delineate partner perspectives and contributions, and leverage expertise and resources" (Prevention Institute, 2021, p. 1). (See the link for the website in the weblinks section at the end of the chapter.) Some examples of groups who could become partners include: two nongovernmental health organizations that are both interested in seeing a reduction in suicide, a local service organization (e.g., United Way), and a school-based clinic to improve student health, an employer, and a health insurance carrier to improve the quality of life for employees, and a local health department and pro-environmental group working to improve the air quality in a community. After giving consideration to forming partnerships, thought needs to be given to the size of the planning committee. The number of individuals on a planning committee can differ depending on the setting for the program and the size of the priority population. For example, the size of a planning committee

for an obesity program in a community of 50,000 people would probably be larger than that of a committee planning a similar program for a business with 50 employees.

Several things should be considered when developing a planning committee. McKenzie (1988) offered 10 guidelines, which have been modified through the years (see **Box 2.7**).

Box 2.7 Considerations When Developing a Planning Committee

Consideration 1	The committee should be composed of individuals who represent a variety of subgroups within the priority population. To the extent possible, the committee should have representation from all segments of the priority population. The greater the number of individuals who are represented by committee members, the greater the chance of the priority population developing a feeling of **program ownership**. With program ownership, there will be better planned programs, greater support for the programs, and people who will be willing to help sell the program to others because they feel it is theirs (Strycker et al., 1997).
Consideration 2	If the program that is being planned deals with a specific health risk or problem, it is important that someone with that health risk (e.g., smoker) or problem (e.g., diabetes) be included on the planning committee (Bartholomew et al., 2011).
Consideration 3	The committee should include willing individuals who are interested in seeing the program succeed. Select a combination of doers and influencers. Doers are people who will be willing to "roll up their sleeves" and do the necessary work to plan and implement the program. Influencers are those who, with a single phone call, email, or text, will enlist other people to participate or will help provide the resources to facilitate the program. Both doers and influencers are important to the planning process.
Consideration 4	The committee should include an individual who has a key role within the organization sponsoring the program—someone whose support would be most important to ensure success.
Consideration 5	The committee should include representatives of other stakeholders not represented in the priority population. For example, if healthcare providers are needed to implement a health promotion program, they should be represented on the planning committee.
Consideration 6	Committee membership should be reevaluated regularly to ensure that the composition lends itself to fulfilling program goals and objectives.
Consideration 7	If the planning committee will be in place for a long time, new individuals should be added periodically to generate new ideas and energy. It may be helpful to set term limits for committee members. If terms of office are used, it is advisable to stagger the length of terms so that there is always a combination of new and experienced members on the committee.
Consideration 8	Be aware of the "politics" that are always present in an organization or priority population. It is common for people to bring their private agendas and biases to committee work.

(continues)

Box 2.7 Considerations When Developing a Planning Committee *(continued)*

Consideration 9	Make sure the committee is large enough to accomplish the work, but small enough to be able to make decisions and reach consensus. If necessary, subcommittees can be formed to handle specific tasks.
Consideration 10	In some situations, there might be a need for multiple layers of planning committees. If the priority population is highly dispersed geographically and/or broken into decentralized subgroups (e.g., various offices of the same corporation, or several different local groups within the same state, or different buildings within a school corporation), these various subgroups may need their own local planning committee that operates with some latitude but maintains and complements the core planning committee as the base of the program (Chapman, 2009).

Once the planning committee has been formed, someone must be designated to lead it. The leader (chairperson) should be knowledgeable about the health problem being addressed, familiar with the community, have the respect of partners, and be capable of leading a group through the planning process. One might think that most planners, especially health education specialists, would be perfect for the committee chairperson's job. However, sometimes, it is preferable to have someone other than the program planners serve in the leadership capacity. For one thing, it helps to spread out the workload of the committee. Planners who are not good at delegating responsibility may end up with a lot of extra work when they serve as the leaders. Second, having someone else serve as the leader allows the planners to remain objective about the program. And third, the planning committee can serve in an advisory capacity to the planners, if this is considered desirable. **Figure 2.2** illustrates the composition of a balanced planning committee.

Once the planning committee has been organized and a leader is selected, the committee needs to be well-organized and well run to be effective. The committee should meet regularly, have a formal agenda for each meeting, and keep minutes of the meetings (Hunnicutt, 2007). Furthermore, the committee meetings should be efficient, energizing, productive, and represent a good use of the committee members' time. In addition, it is important for the committee to communicate frequently both with the decision makers and those in the priority population so that all can be kept informed. By communicating regularly, the committee has the unique opportunity to educate and inform others about progress and the specific priorities of the program (Hunnicutt, 2007).

Parameters for Planning

Once the support of the decision makers has been gained and a planning committee is formed, the committee members must

Figure 2.2 Makeup of a Solid Planning/Steering Committee.