HEALTH PROMOTION METHOD & APPROACHES

APPROACHES TO HEALTHY PROMOTION (THE EXAMPLE OF HEALTHY EATING)

APPROACH	AIMS	METHODS	WORKER/CLIENT RELATIONSHIP
Medical	To identify those at risk from disease.	Primary health care consultation, e.g. measurement of body mass index.	Expert led. Passive, conforming client.
Behaviour change	To encourage individuals to take responsibility for their own health and choose healthier lifestyles.	Persuasion through one-to-one advice, information, mass campaigns, e.g. “Look After Your Heart” dietary messages.	Expert led. Dependent client. Victim blaming ideology.

APPROACH	AIMS	METHODS	WORKER/CLIENT RELATIONSHIP
Educational	To increase knowledge and skills about healthy lifestyles.	Information. Exploration of attitudes through small group work. Development of skills, e.g. women's health group.	May be expert led May also involve client in negotiation of issues for discussion.
Empowerment	To work with clients or communities to meet their perceived needs.	Advocacy Negotiation Networking Facilitation e.g. food co-op, fat women's group.	Health promoter is facilitator. Client becomes empowered.
Social change	To address inequities in health based on class, race, gender, geography.	Development of organisational policy, e.g. hospital catering policy. Public health legislation, e.g. food labelling. Lobbying. Fiscal controls, e.g. subsidy to farmers to produce lean meat.	Entails social regulation and is top-down.

AIMS AND METHODS IN HEALTH PROMOTION

AIM	APPROPRIATE METHOD
Health awareness goal Raising awareness, or consciousness, of health issues.	Talks, group work, mass media, displays and exhibitions, campaign.
Improving knowledge Providing information.	One-to-one teaching, displays and exhibitions, written materials, mass media, campaigns, group teaching.
Self-empowering Improving self-awareness, elf-esteem, decision making.	Group work, practising decision-making, values clarification, social skills training, simulation, gaming and role play, assertiveness training, counselling.
Changing attitudes and behaviour Changing the lifestyles of individuals.	Group work, skills training, self-help groups, one-to-one instruction, group or individual therapy, written material, advice.
Societal/environmental change Changing the physical or social environment.	Positive action for under-served groups, lobbying, pressure groups, community-based work, advocacy schemes, environmental measures, planning and policy making, organisational change, enforcement of laws and regulations.

SUMMARY OF INTERVENTION STRATEGIES

TYPE	DESIGN EMPHASIS
Cognitive interventions	Design to use both information and emotions to change perceptions
Structural interventions	Designed to use changes in the behavioural environment/ context to influence behaviour
Behavioural interventions	designed to provide incentives (natural or external) to reward desired behaviour
Policy interventions	Designed to use social force or approval to influence behaviours and related determinants
Marketing interventions	Designed to create exchange relationships with specific target population to provide benefits with lower obstacles/cost
Participatory interventions	Designed to maximize in the most feasible manner the active involvement of the target population in every programme stage on the premise that people ultimately know what is best for themselves and will sustain self-designed interventions longer than those externally imposed.

SUMMARY OF MEDIA METHODS

TYPE	CHARACTERISTICS
	Limited reach media
PHAMPLETS	Information transmission. Best where cognition rather than emotion is desired outcome.
INFORMATION SHEET	Quick convenient information. Use as series with storage folder. Not for complex behaviour change.
NEWSLETTERS	Continuity. Personalised. Labour intensive and requires detailed commitment and needs assessment before commencing.
POSTERS	Agenda setting function. Visual message. Creative input required. Possibility of graffiti might be considered.
T-SHIRTS	Emotive. Personal. Useful for cementing attitudes and commitment to program/idea.
STICKERS	Short messages to identify/motivate the user and cement commitment. Cheap, persuasive.
VIDEOS	Instructional. Motivational. Useful for personal viewing with adults as back-up to other programmes.

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TYPE	CHARACTERISTICS
	Mass media reach
TELEVISION	Awareness, arousal, modelling and image creation role. May be increasingly useful in information and skills training as awareness and interest in health services.
RADIO	Informative, interactive (talkback). Cost effective and useful in creating awareness, providing information.
NEWSPAPERS	Long and short copy information. Material dependent on type of paper and day of week.
MAGAZINES	Wide readership and influence. Useful as in supportive role and to inform and provide social proof.

SUMMARY OF GROUP METHODS IN HEALTH PROMOTION

DIDACTIC GROUP METHODS	
LECTURE-DISCUSSION	Best for knowledge transmission, motivation in large groups. Requires dynamic, effective speaker with more knowledge than the audience.
SEMINAR	Smaller numbers (2-20). Leader-group feedback. Leader most knowledgeable in the group. Best for trainer learning.
CONFERENCE	Can combine lecture/seminar techniques. Best for professional development. Several authorities needed.

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EXPERIENTIAL GROUP METHODS	
SKILLS TRAINING	Requires motivated individuals. Includes explanation, demonstration and practice, e.g. relaxation, childbirth, exercise.
BEHAVIOUR MODIFICATION	Learning and unlearning of specific habits. Stimulus-response learning. Generally behaviour specific, e.g. quit smoking phobia desensitisation.
SENSITIVITIY/ ENCOUNTER	Consciousness raising. Suitable for professional training and some middle-class health goals.
INQUIRY LEARNING	Used mainly in school settings. Requires formulating and problem solving through group co-operation.
PEER GROUP DISCUSSION	Useful where shared experiences, support, awareness are important. Participants homogeneous in at least one factor, e.g. old people, prisoners, teenagers.

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SIMULATION	Useful for influencing attitudes in individuals with varying abilities. Generally in school setting, but of relevance to other groups.
ROLEPLAY	Acting of roles by group participants. Can be useful where communication difficulties exist between individuals in a setting, e.g. families, professional practice, etc.
SELF-HELP	Requires motivation and independent attitude. Valuable for ongoing peer support, values clarification, etc. Can be therapy or a forum for social action.

COMMUNITY PARTICIPATION IN PLANNING HEALTH WORK

NO PARTICIPATION	The community is told nothing, and is not involved in any way.
VERY LOW PARTICIPATION	The community is informed. The legacy makes a plan and announces it. The community is convened or notified in other ways in order to be informed; compliance is expected.
LOW PARTICIPATION	The community is offered ‘token’ consultation. The agency tries to promote a plan and seeks support or at least sufficient sanction so that the plan can go ahead. It is unwilling to modify the plan unless absolutely necessary.
MODERATE PARTICIPATION	The community advises through a consultation process. The agency presents a plan and invites questions, comments and recommendations. It is prepared to modify the plan.

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HIGH PARTICIPATION	The community plan jointly. Representatives of the agency and the community sit down together from the beginning to devise a plan.
VERY HIGH PARTICIPATION	The community has delegated authority. The agency identifies and presents an issue to the community, defines the limits and asks the community to make a series of decisions which can be embodied in a plan which it will accept.
HIGHEST PARTICIPATION	The community has control. The agency asks the community to identify the issue and make all the key decisions about goals and plans. It is willing to help the community at each step to accomplish its goals even to the extent of delegating administrative control of the work.

ADVANTAGES AND DISADVANTAGES OF THE COMMUNITY DEVELOPMENT APPROACH

ADVANTAGES	*DISADVANTAGES*
Starts with people's concerns, so it is more likely to gain support.	Time consuming.
Focuses on root causes of ill health, not symptoms.	Results are often not tangible or quantifiable.
Creates awareness of the social causes of ill health.	Evaluation is difficult.
The process of involvement is enabling and leads to greater confidence.	Without evaluation, gaining funding is difficult.
The process includes acquiring skills which are transferable, for example, communication skills, lobbying skills.	The health promoter may find his or her role contradictory. O whom are they ultimately accountable – employer or community?
If health promoter and people meet as equal, it extends principle of democratic accountability.	Work is usually with small groups of people.