CHAPTER 1

WHAT ARE HEALTH PROMOTION PROGRAMS?

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Health Promotion in a New Health Era

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

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

LEARNING OBJECTIVES

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

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

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

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

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

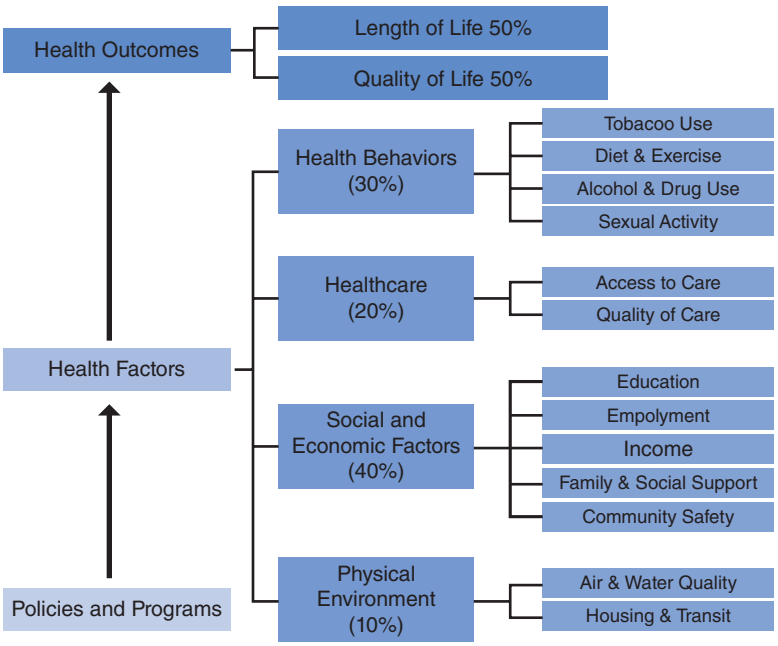

Figure 1.1 Health promotion is associated with more than just healthcare to impact health outcomes linked to length and quality of life

Source: Modified from Population Health Management: Systems and Success, UWPHI & Robert Woods Johnson Foundation, 2020.
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and multi-leveled. We work directly with people trying to figure out how to best address their health needs. We work in schools, colleges and universities, communities, **workplaces**, and **healthcare organizations**. At the same time, we are surrounded by forces greater than any organization and group of individuals. The result is that processes of planning, implementing, and evaluating health promotion programs unfold in a nonlinear progression of small steps forward and sometime a couple steps backward. It is dynamic.

Health, Health Promotion, and Health Promotion Programs

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

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

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

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

Table 1.1 Ecological Health Perspective: Levels of Influence

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

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

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

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

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

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

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

Historical Context for Health Promotion

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

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

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

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

Stage 2: Lifestyle Factors and Chronic Disease

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

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

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

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

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

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

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

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

Stage 3: Multiple Levels of Influence on Health

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

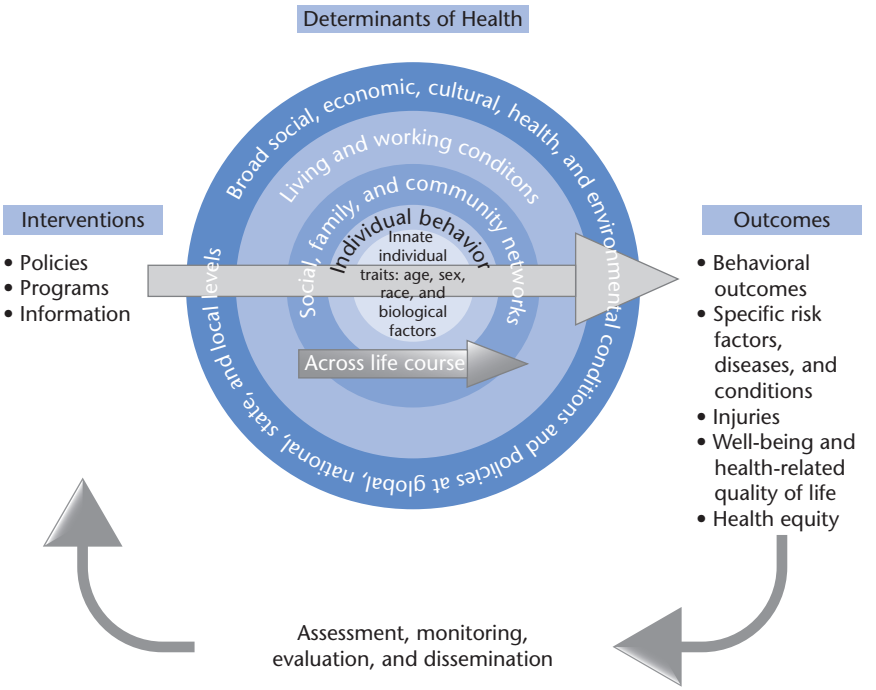

Figure 1.2 Dynamic interaction between strategies aimed at the individual and strategies for the entire population

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

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

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

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

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

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

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

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

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

Health Education and Health Promotion

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

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

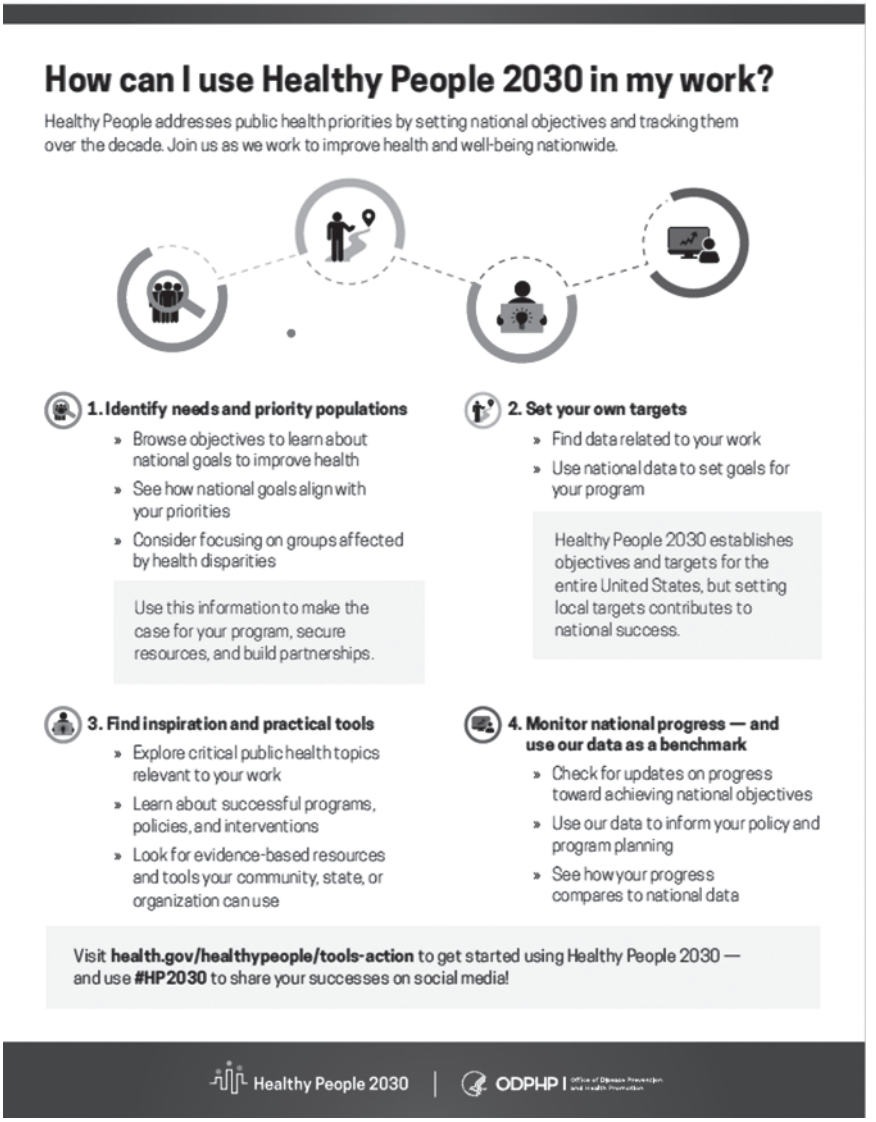

Figure 1.3 Using *Healthy People 2030* to promote health

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

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

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

Table 1.2 Components of Health Promotion Programs

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

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

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

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

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

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

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

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

Settings for Health Promotion Programs

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

Schools

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

Colleges and Universities

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

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

Healthcare Organizations

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

Communities

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

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

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

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

Workplaces

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

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

Stakeholders in Health Promotion Programs

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

Involving Stakeholders

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

Advisory Boards

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

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

Champions and Advocates

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

Emerging Health Promotion Era

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

It is a given that we carefully and continuously monitor socioeconomic factors. We know to identify environmental threats and opportunities, including changes in governmental policies, legislation, and public policy statements to help formulate and take action to promote the health of the individuals and communities for which we care and serve. In the new era fragmentation within the general population is accelerating, causing tension and conflict that at times creates both opportunities and barriers to health and improved quality of life for individuals and communities.

In the new era health promotion and healthcare practice uses digital information, artificial intelligence, and communication technologies to improve people's health and healthcare. The increasing use of technologies, especially the Internet and personal mobile devices, to manage health highlights the potential of technology tools to improve population health. COVID-19 caused a massive acceleration in the use of telehealth. Consumer adoption skyrocketed, from 11 percent of U.S. consumers using telehealth to 46 percent of consumers now using telehealth to replace cancelled healthcare visits. No longer are healthcare and health promotion programs just at a given site (i.e. school, workplace, clinic, hospital). Technology supports individuals' engagement and full participation in promoting their health as well as being decision makers in their healthcare. We are not limited to a physical place, and therefore health promotion programs are not limited to a particular site. They can and do work within homes, schools, universities, communities, and workplaces, thereby involving family, colleagues, peers, co-workers, and friends. A key in the new health era is equity in peoples' capacity and resources to access technology to promote their health.

In the new era, health promotion is intertwined within the healthcare system which is dominated by large commercial interests driven by investors' demand for profit, by non-profits almost equally focused on revenues, and by government policy decisions that are sometimes shaped by larger ideological, political, and budgetary concerns. For better and worse, healthcare has become big money and big politics. As a result, for the foreseeable future, the structure and cost of healthcare in the United States will continue to be a problem. The healthcare system is overwhelming for even the most sophisticated consumer. We need to know how to navigate the systems for ourselves and the people we serve.

Health is political. It is part of the American psyche. The health of Americans is a priority, but what that means—and what role the federal government plays—has changed significantly over the years and particularly in relation to promoting health. While many Presidents of the United States have made incremental changes to federal health policy and the American psyche, it has often been those changes that affect our social determinants that had the greatest influence on our access to better healthcare, health promotion, and prevention of disease.

The most recent example of governmental health action is the 2010 **Patient Protection and Affordable Care Act (ACA)**. While the ACA did not accomplish all of the reforms many had hoped, it opened the door for significant changes to the status quo and ensured that for decades its reforms are the starting point for future health reform and technologies. It can be expected, particularly in presidential election years candidates will campaign on platforms to dismantle the ACA, call to replace it with a more universally available healthcare plan, while others will want to improve the ACA.

Summary

Health promotion programs represent an evolution that has passed through revolutionary steps in the quest to promote health. Today, health promotion programs use both health education and environmental actions to promote good health and quality of life for all. The *Healthy People* initiative is a public-private partnership that allows local health promotion programs to link their health promotion programming with national data and information.

Health promotion programs are the product of deliberate effort and work by many people and organizations to address a health concern in a community, school, college and universities, healthcare organization, or workplace. And even though individuals across these sites may share broad categories of health concerns focused on diseases and human behavior, each setting is unique. Effective health promotion programs reflect the individual needs of a priority population as well as their political, social, ethnic, economic, religious, and cultural backgrounds.

Health promotion programs involve stakeholders, advisory boards, champions, and advocates in program planning, implementation, and evaluation in order to ensure effective programming.

A new health promotion era emerged from the pandemic. COVID-19 fundamentally changed many aspects of peoples' lives. The work of promoting health has gained prominence and importance but at the same time is intertwined with larger and more volatile societal forces. It is our professional responsibility to figure out how to forge ahead to do the work of health promotion for our community and society.

For Practice and Discussion

1. What preliminary ideas did you have about the definition and role of health promotion programs prior to reading this chapter? How do these compare with what you have learned in this chapter? How do you see the relationship between health promotion, health equity, and social justice?

2. Visit the *Healthy People 2030* website (www.healthypeople.gov). Pick a chapter and explore the objectives. As you explore the chapter, think of your school and how you might use the *Healthy People 2030* information for a specific objective to build a case for implementing a health promotion program to address the identified health concern on your campus. Prepare a brief (250-word) statement to use to support your argument for a program.
3. What do you think it would be like to work in a health promotion program? This chapter talks about health promotion programs in five settings—schools, workplaces, colleges and universities, healthcare organizations, and communities. Which setting is of most interest for you with regard to working in a health promotion program? What is attractive about this setting and the people in the setting? Who are the setting stakeholders?
4. What role does technology play in how you, family members, and friends promote your own health? How often do you use the Internet to find health information? What wearable technologies and apps do you use?
5. How do you navigate the societal forces (social justice and equity, technology, healthcare system, health is political) in the emerging health era to formulate and take action to promote the health of the individuals and communities for which you care and serve?

KEY TERMS

Advocate
Advisory boards
Champion
Colleges and universities
Communities
Ecological health perspective
Health
Health education
Health equity
Health promotion
Health promotion programs
Health status
Healthcare organizations
Healthy People 2030
Interpersonal level
Intrapersonal level
Jakarta Declaration
Lalonde report
Ottawa Charter
Patient Protection and Affordable Care Act or Affordable Care Act (ACA)
Population level
Priority population
Schools
Settings
Social Determinants of Health
Social justice
Stakeholders
Workplaces
World Health Organization

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