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.

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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

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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

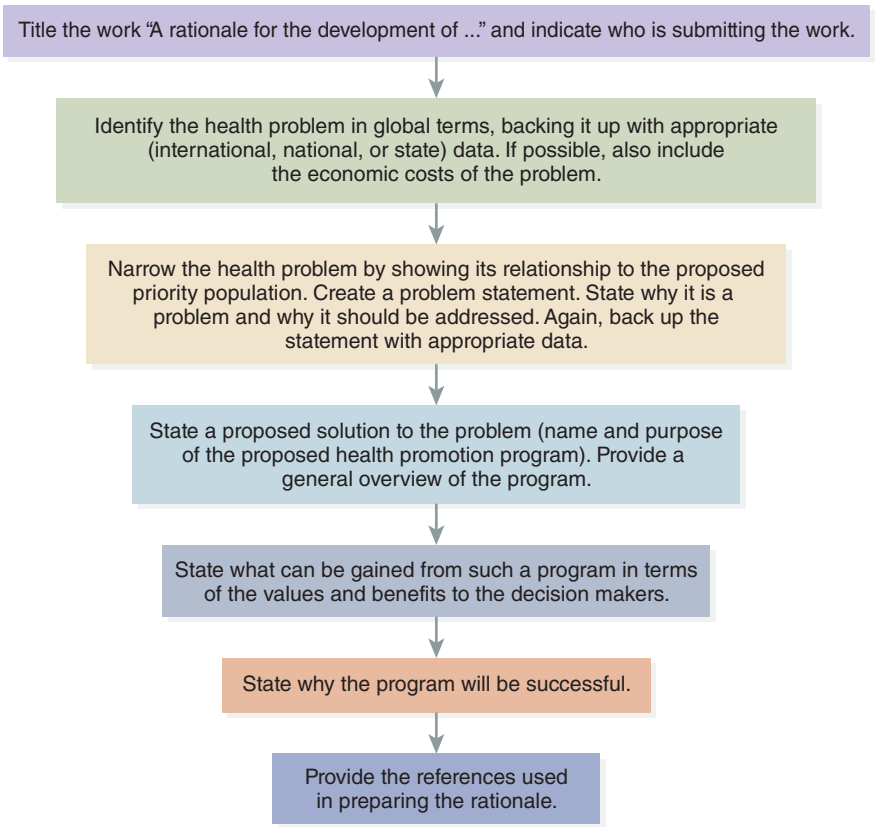
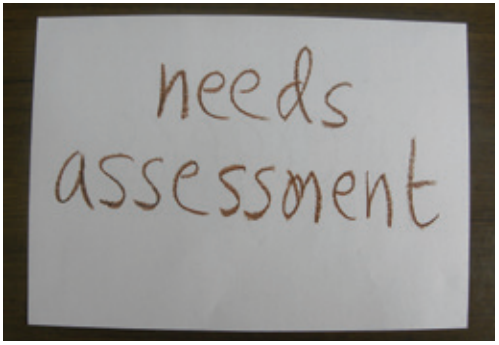


Figure 2.1 Creating the Program Rationale.

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



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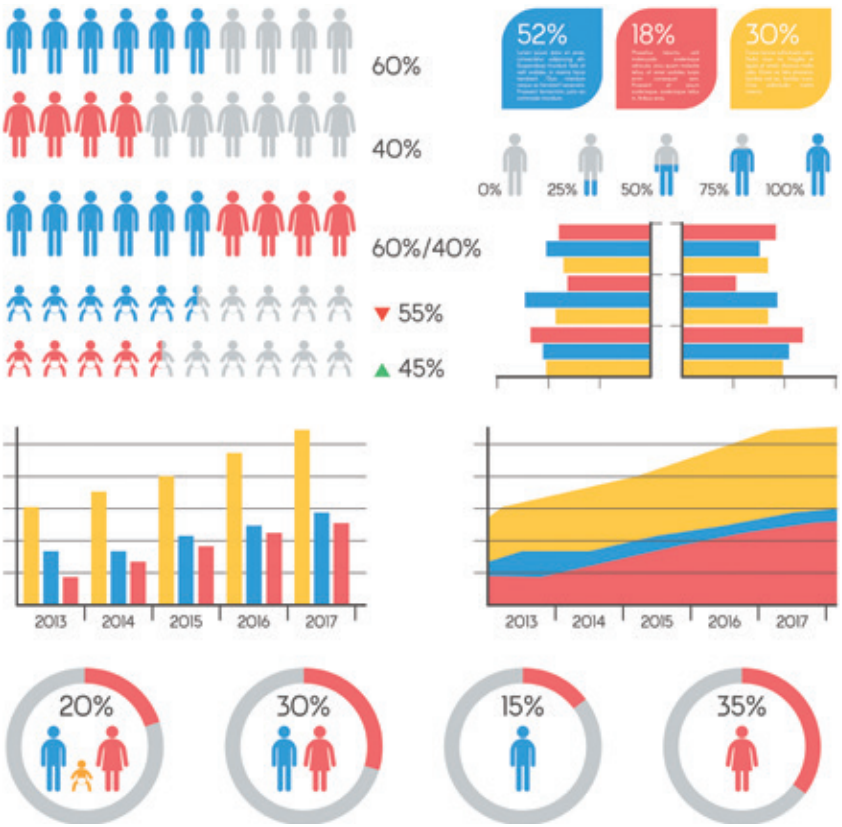
wants of the priority population can be very useful in generating a rationale for a proposed program, more than likely at this point in the planning process, a formal needs assessment will not have been completed. Often, a complete needs assessment does not take place until decision makers give permission 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.

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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

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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).

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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.

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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.

identify the **planning parameters** within which they will work. There are several questions to which committee members should have answers before they become too deeply involved in the planning process. In an earlier work (McKenzie, 1988), several such questions were presented, using the example of school-based health promotion programs. The questions are modified for presentation here. It should be noted; however, that not all of the questions would be appropriate for every program because of the different circumstances of each setting and the answers to some of the questions may have already been obtained during pre-planning.

1. What is the decision makers' philosophical perspective on health promotion programs? What are the values and benefits of the programs to the decision makers (Chapman, 1997)? Do they see the programs as something important or as "extras"?
2. What type of commitment are decision makers willing to make to the program? Are they interested in the program becoming institutionalized? That is, are they interested in seeing that the "program becomes imbedded within the host organization, so that the program becomes sustained and durable" (Goodman et al., 1993, p. 163)? Or are they more interested in providing a one-time or pilot program? (Note: Goodman and colleagues [1993] developed a scale for measuring institutionalization.)
3. What type of financial support are decision makers willing to provide? Does it include personnel for leadership and clerical duties? Released/assigned time for managing the program and participation? Space? Equipment? Materials?
4. Are decision makers willing to consider changing the **organizational culture** (Terry, 2012)? That is, are decision makers interested in establishing a health supporting culture (Golaszewski et al., 2008) that is based on health-related values, beliefs, and practices? Among other things, such a culture might include health-supporting policies, services, and facilities.
5. Will all individuals in the priority population have an opportunity to take advantage of the program, or will it be available only to certain subgroups?
6. What type of committee will the planning committee be? Will it be a *permanent* or a *temporary* (*ad hoc*) committee (Hitt et al., 2012)? A permanent committee would indicate that decision makers want the planning committee to be a part of the ongoing structure of the organization.
7. What is the authority of the planning committee? Will it be an advisory group or a programmatic decision-making group? What will the chain of command be for program approval?

After the planning parameters have been defined, the planning committee should understand how the decision makers view the program and should know what type and number of resources and amount of support to expect. Identifying the parameters early will save the planning committee a great deal of effort and energy throughout the planning process.

Summary

Creating a program rationale to gain the support of decision makers is an important initial step in program planning. Planners should take great care in developing a rationale for "selling" the program idea to these influential people. The rationale should show how the benefits of the program align with the values of the decision makers, address the potential return on investment, and be backed by the best evidence available. A program rationale can be written using the following four

steps: (1) Identify appropriate background information, (2) title the rationale, (3) write the content of the rationale, and (4) list the references used to create the rationale. A planning committee can be most useful in helping with some of the planning activities and in helping to communicate the value and benefits of the program to the priority population. When the planning committee is being formed, consider potential collaborating partners. Planning committee members should include program stakeholders including interested individuals, doers and influencers, and others who are representative of the priority population. If the planning committee is to be effective, it will need to work efficiently and to know the planning parameters set for the program by the decision makers.

Review Questions

1. What is the reason for creating a program rationale?
2. Why is the support of decision makers important in planning a program?
3. What items should be addressed when creating a program rationale?
4. What is a problem statement? What does it include?
5. What is social math? Give an example of how it could be used in a program rationale.
6. Who would make good planning partners?
7. Who should be selected as the members of a planning committee?
8. What are *planning parameters?* Give a few examples.

Activities

1. Write a two-page rationale that sells a program you are planning to decision makers; use the guidelines presented in this chapter.
2. Select a disease (e.g., diabetes, cancer, heart disease) or a health behavior (e.g., physical inactivity, smoking) and write a paragraph describing the health problem using social math.
3. Visit the websites of the Community Preventive Services Task Force (CPSTF) and U.S. Preventive Services Task Force (USPSTF)—see Box 2.3 for URLs of the websites. At the two sites, find out what the recommendations are for clinical skin cancer screenings and educational programs for skin cancer. Summarize your findings in one to two paragraphs. Based on the recommendations, write another one to two paragraphs describing what advice you would give with regard to future health promotion programming to a local coalition that is trying to reduce the number of cases of skin cancer in its community.

Weblinks

http://www.thecommunityguide.org
Guide to Community Preventative Services
This Webpage includes evidence-based recommendations for programs and policies to promote population-based health from the Community Preventive Services Task Force.

https://www.wellsteps.com/
WellSteps
This is the home page for WellSteps, a company that helps other companies create worksite wellness programs. At the site, you will find a number of different resources and tools that can assist you as you begin the planning process. One tool found at this site is the return on investment (ROI) calculator for healthcare costs that can help you determine if a health promotion program for a company would make good economic sense.

http://www.countyhealthrankings.org
County Health Rankings & Roadmaps
At this website, you will find a set of reports that rank the overall health of every county in the United States. If you are planning countywide programs, you will find this to be a valuable resource when creating rationales. The *County Health Rankings & Roadmaps* is a part of a collaboration between the Robert Wood Johnson Foundation and the University of Wisconsin Population Health Institute.

https://www.naccho.org/
National Association of County and City Health Officials.
This is the website of directors of county and city health departments and is another useful source of information in writing the program rationale.

http://www.astho.org
Association of State and Territorial Health Officials (ASTHO)
ASTHO is the national, nonprofit organization representing the state and territorial public health agencies of the United States, the U.S. Territories, and the District of Columbia.
This website has links to all of the state and territorial health departments. If you are planning a program for the community setting, this site contains a lot of information that could help you develop a rationale for your program.

http://www.preventioninstitute.org/index.php
Prevention Institute
This website is the home page of the Prevention Institute, a California-based organization that works from the approach of what can be done before people become ill or injured. See the following for the collaboration multiplier tool – https://www.preventioninstitute.org/tools/collaboration-multiplier

https://snaped.fns.usda.gov/library/materials/chronic-disease-cost-calculator-version-2
Chronic Disease Cost Calculator Version 2
This webpage presents background information and download links to the user guide and Chronic Disease Cost Calculator Version 2.