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Degree of Doctor of Psychology (Health)

Health Promotion: Evaluation, discourse and practice

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City University

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Introduction

This dissertation for the Degree of Doctor of Psychology (Health) presents three pieces of work: 1) A Re-analysis of a Systematic Review of Psychological Interventions Used to Aid Smoking Cessation; 2) Evaluation and Discourse Analysis of the EC's Health Promotion Programme; 3) A consultancy case study: Evaluation of Educational Needs Assessment Methods Used in General Practices in Barking and Havering and Redbridge and Waltham Forest. The theme that ties these three pieces of work together is evaluation.

The re-analysis of the systematic review of psychological methods for smoking cessation shows how errors can be made in evaluation and how different researchers can obtain different results in what is considered to be a method that reduces bias and produces an accurate picture of 'evidence' to inform health policy and practice.

The evaluation of the EC's Health Promotion Programme gives insight into a case study of an evaluation to inform health promotion policy at an European level. This piece of work presents the results of an independent evaluation. It highlights unexpected difficulties of drawing conclusions from data such as the practical problems of obtaining data and also the pressures that may come from the commissioners of evaluations.

The discourse analysis of the Health Promotion Programme reveals how current discourses in health promotion may compel health promotion practitioners to carry out a certain type of evaluation in which in truth they may have little understanding or commitment. As a result, the practice of evaluation becomes a formality or ritual which is a burden to carry out. A panel of health promotion expert assessors found a lack of acceptable evaluation of projects that were funded by the European Commission. This suggests that if evaluation can be avoided, it will be.

The same themes of lack of understanding, commitment and time for evaluation were unveiled in the case study. The consultancy case study evaluated educational needs assessment methods used in general practices. The use of evidence-based practice requires that practitioners understand how to evaluate research and incorporate it into their practice. This needs more emphasis in the education and training of health professionals. However there has been a move away from the more didactic approach to education in primary care to one of listening to people's needs and preferred methods of learning. At the same time the ubiquitous need to evaluate to find the best method prevails. This is regardless of obvious limitations to the interpretation of findings. In this case study, it seemed as though the evaluation was an after-thought, rushed to satisfy some other group higher up the hierarchy in the health authority. Similarly, the discourse analysis pointed to a situation in which the Commission's services are constructed as superior, thus leaving no mechanism to question their knowledge or ways of working. While there may be efforts on one level to encourage a two-way flow of information and knowledge, on another level, a construction of decision-makers as being superior means that information and knowledge only flow one way, top down.

All three pieces of work have shown that practical limitations restrict the interpretation of evaluations. Lack of time, incomplete data, commitment and knowledge of evaluation revealed here lead to questions about the possibility and desirability of evidence-based health promotion. For evaluation to advance, there is a need for a better understanding of its purpose and for it to have more meaning for all of the stakeholders involved. This requires a rethink concerning evaluation methods in health promotion that recognise the restraints of evaluation and start inquiry from this premise.

Acknowledgements

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alongside my daily duties and responsibilities. Dr Carla Willig was also a great help. She helped keep me focused, especially with the discourse analysis. I also thank Jennifer McKinley, Astrid Von Volckamer and Rhona McGurk for helping to collect data. Thank you to the health promotion expert panel for taking part in the evaluation. The primary care health professionals involved in the evaluation of educational needs assessments are also thanked. Finally I thank my family, Maria, Jason and Dan for all their support and for putting up with my moods during times of frustration.

A Re-Analysis of A Systematic Review of Psychological Interventions Used to Aid Smoking Cessation

A Re-Analysis of A Systematic Review of Psychological Interventions Used to Aid Smoking Cessation

Introduction

It is recognised that tobacco is the single most important 'avoidable' cause of chronic ill health and premature death in developed countries. It is estimated that there are over billion smokers in the world today, with almost one third living in China (Department of Health, 1998a). Smoking causes a quarter of all the deaths in middle age, with most mortalities being among male and still rising rates among females. However women are at a higher risk than men from some cancers such as lung and bladder (Bosch, 2001). In developing countries many men have started smoking and mortality from tobacco deaths is increasing. It has been predicted that by the year 2020, the annual death rate will be 10 million (Peto, 1994). A report from the US Surgeon General recently stated that death rates from lung cancer among white women in the United States increased by 600% between 1950 and 2000. In 1950, lung cancer accounted for 3% of all female cancer deaths, whereas in 2000 it accounted for an estimated 25% (Charatan, 2001). However in the 1950s, the prevalence of smoking among Danish women was 40%. Not surprising then that the life expectancy of Danish women is shorter than that of women in other European countries (Juel, 2000).

While overall smoking rates in the UK have fallen over the last few decades, they have barely fallen the 'least advantaged adults' (Department of Health, 1998b). Interestingly a study that investigated international variations in smoking associated with educational level found that in the age group 45-74 higher rate of smokers among lower educated people was only found in some countries (Cavelaars et al 2000). Among women, this pattern was found in Great Britain, Norway and Sweden. However an opposite pattern was found in southern Europe, higher educated women smoked more. A similar pattern was also found in men however the pattern was less noticeable. The authors concluded

that the international variations in social gradients in smoking are likely to be related to the differences between countries in their stage of the smoking epidemic.

A number of studies have reported that some two-thirds of current smokers report that they would like to quit (WHO, 1999). Nearly 80% of current smokers have made at least one attempt to do so. However, the majority of attempts are unsuccessful. Seventy-five per cent of current smokers in the UK who have tried to quit have started again within 6 months (Graham and Derr, 1999). Although the vast majority of smokers who quit do so without any assistance (Glynn, Boyd & Gruman, 1990), individual unaided quit attempts tend to have a low long term success rate. It has been estimated that fewer than 10% of those who quit on their own maintain abstinence for one year (Cohen, Lichtenstein, Prochaska, 1989). The WHO's targets for 2015 aim for the proportion of non-smokers in all 51 countries of the European region of the WHO to be at least 80% in people less than 15 years of age and close to 100% in those less than 15 years. In order to achieve these targets, successful smoking cessation methods need to be found.

Government Strategies in England to Aid Smoking Cessation

In 1998 £60 million was pledged in England to invest in smoking cessation resources over three years (Department of Health, 1998b) The large focus of the expenditure of this money was on providing free nicotine replacement therapy (NRT). Money was also spent on a campaign in the year 2000 entitled 'Don't give up giving up'. This campaign tried to persuade smokers to call a telephone help-line for information. The campaign was based on DiClemente and Prochaska's (1982) model of stages of change. It aimed to encourage smokers who had given up smoking in the past not to be disheartened by any failed attempts by making them aware of the different stages of change. In other words, presenting failed attempts as part of the process of change. The 'Don't Give Up Giving Up' campaign was widely publicized on billboards, television, radio and the internet. Information was available in braille, on audio cassette and in several languages. Smokers were encouraged to use NRT. This campaign has been criticised by Sykes and Marks (2000) for only telling smokers what they already know and not providing any actual skills to quit smoking. Bandura (1997) criticised the stages of change model used in the

campaign. He stated that the stages are artificial and do not reflect the constant process of change. Sykes and Marks (2001) conducted a randomised controlled trial (RCT) of a smoking cessation programme based on cognitive behaviour therapy (CBT) for smokers. The programme called the QUIT FOR LIFE Programme gives smokers a choice of techniques to aid cessation. The control condition in the study was also based on DiClemente and Prochaska's (1982) model of stages of change. It was found that at six months, only 5.6% of participants in the control group were abstinent compared to 17.2% who had used CBT. In addition 11.5% of participants who had used the CBT programme had reduced their cigarette consumption by at least 25% of pre-treatment level. Foulds (2000) reported that the 'Don't Give Up Giving Up' campaign increased calls for smoking cessation information by 250%. Eighty-two per cent of these callers were sent a pamphlet containing information based on the stages of change model. An analysis of cost-effectiveness in a later publication by Marks and Sykes (2002) suggested that sending this material despite being cheap to produce is not cost-effective as so few people quit smoking using this material. However a therapy based on the principles of cognitive behaviour therapy, which is more expensive than a pamphlet, was found to be 3.38 times more cost-effective as many more people quit using this method.

The Evidence

The campaign described above was informed by the 'Report of the Scientific Committee on Tobacco and Health' (Department of Health, 1998a). This report included evidence of a systematic review of the effectiveness of interventions intended to help people stop smoking (Law and Tang, 1995). It looked at several types of interventions:

1) Advice and encouragement [by a doctor once during a routine consultation; with additional encouragement/support; nurses in health promotion clinics; support group sessions; in special circumstances; men at high risk of ischaemic heart disease]
2) Behaviour modification therapy [non-specific approaches; aversion; rapid or satiation smoking; silver acetate; sensory deprivation; hypnosis]
3) Pharmacological treatments to allay withdrawal symptoms [nicotine replacement therapy; clonidine; tranquillisers and other agents]
4) Miscellaneous treatments

5) Gradual reduction in nicotine intake.

Law and Tang (1995) reported that the randomised trials that they analysed do not support the use of behaviour modification therapy in helping people to stop smoking. They analysed 30 trials of non-specific approaches, 13 papers looked at trials of group interventions led by a psychologist. They found a statistically significant effect that was confirmed by biochemical markers. However the average size of the effect was only 2%. This was no greater than that of simple unsolicited advice from doctors. As the degree of personal contact in behaviour modification therapy is greater, Law and Tang concluded that these interventions are several times more expensive than simple advice and could not be recommended on grounds of cost effectiveness. However they presented no data on cost-effectiveness. Also Law and Tang did not evaluate the quality of the studies. The average size of the effect for hypnosis was 24%. However no studies used biochemical markers. It was concluded that the effect of hypnosis was unproven. They found an effect size of 13% for nicotine replacement (NRT) for smokers who seek help in cessation. They found that acupuncture is ineffective and that the efficacy of other pharmacological treatments is not proven. They did not find a difference in sudden cessation or a gradual reduction. It was concluded that doctors should take time to advise all their patients who smoke to quit. Smokers who wished to stop should be given additional support and be encouraged to use NRT.

Aims

A major feature of *The New NHS* white paper published in 1997 by the Department of Health was 'clinical governance'. Clinical governance included the implementation of best practice across organisations and the use of evidence-based interventions. Systematic reviews and randomised controlled trials were seen as the gold standard for determining 'evidence-based practice'. Close inspection of the systematic review conducted by Law and Tang (1995) raises questions about the quality of the review. This re-analysis of their systematic review partially replicated the Law and Tang study by investigating the effect of interventions for smoking cessation led by psychologists. Law and Tang consulted only Medline. PsychInfo was also consulted in this study and a quality assessment of the RCTs was carried out.

Methodology

Systematic Review Protocol

After reading the Law and Tang article and deciding the rationale for the study, a protocol was drawn up (see Appendix 1). This formed the framework of the systematic review. It was based on guidelines produced by the NHS Centre for Reviews and Dissemination (2001).

Search Strategy

All of the 'non-specific' behaviour modification articles reviewed by Law and Tang (1995) were collated. Only the studies led by a psychologist were included in this analysis. PsychInfo was then searched by one researcher for psychology led interventions to aid smoking cessation from 1967-1995. This time period was chosen as the oldest article reviewed by Law and Tang was 1967 and their review was published in 1995. Once articles had been identified, they were screened for inclusion using the criteria below. Another researcher then screened the selected studies for inclusion.

Study Selection Criteria

Participants

Adults (>16 years of age) using a psychological intervention to aid smoking cessation irrespective of their interest in stopping smoking.

Interventions

Non-specific approaches such as relaxation as an alternative to smoking, visualisation, identification of triggers, emphasis on positive reasons for stopping. Therapy led by a psychologist.

Outcomes

Cessation or significant reduction for at least four months (this was originally intended to be six months but it was noticed that Law and Tang included one study at 4 months).

Study design

Randomised controlled trials

Search Terms

The following search terms were used to find articles in PsychInfo

Smoking cessation/tobacco smoking +

a) relaxation;

b) visualisation

c) visualization

d) imagery

e) trigger

f) positive reasons

g) psychological

h) behaviour therapy

i) randomised controlled trial

g) randomized controlled trial

k) post-treatment follow-up

l) follow-up study

m) psychotherapy

Quality Assessment Checklist

A checklist was designed to assess the quality of each of the papers. A score of 0 to 10 was given for each paper. One point was given for each of the following criteria

1. Adequate randomisation
2. Adequate participants (i.e. includes power analysis or over 100 participants in each group)
3. Biomarkers confirm self-reported cessation status in 95% of cases
4. Suitable comparison interventions
5. Similar groups at baseline
6. No other confounding intervention
7. Acceptable drop-out rate (25% or less)
8. Motivation to quit measured
9. Reliable measurement techniques
10. Appropriate statistical analyses

The quality assessments were carried out independently by two researchers. The quality assessments were then compared. If the total scores for a paper differed by more than 2 points, the score was considered a disagreement. There was a disagreement on four papers. The researchers discussed these papers until an agreement of a difference of 2 points was reached. The scores were then averaged. The median score was 7. Papers with a score of 5 and above were considered being of 'Good' quality. Papers with a score of less than 5 were considered being of 'Poor' quality. The scores can be seen in Table 1. By assessing the quality of the RCTs, it was found that some studies should not have been included in the systematic review. An exclusion list was drawn up and the two researchers independently selected the studies for exclusion. The reasons are described in the results section.

Results

Table 1: Quality Assessments for Trials of Group Sessions Led by a Psychologist in the Law and Tang Review

STUDY	RATING
1. Barbarin, O. A. (1978). Comparison of symbolic and over aversion in the self-control of smoking. *Journal of Consulting and Clinical Psychology*, 46, 1569 –1571.	4.5
2. Cottraux, J.A., Harf, R., Boissel, J-P, Schbath, J., Bouvard, M. & Gillet, J. (1983). Smoking cessation with behaviour therapy or acupuncture – A controlled study. *Behaviour Research Therapy*, 21, 417-424.	8
3. Delahunt, J.& Curran, J.P. (1976). Effectiveness of negative practice and self-control techniques in the reduction of smoking behaviour. *Journal of Counsulting and Clinical Psychology*, 44, 1002-1007.	5
4. Elliott, C.H., Denny, D.R. (1978). A multiple-component treatment approach to smoking reduction. *Journal of Counsulting and Clinical Psychology*, 46, 1330-1339.	6.5
5. Fee, W. (1977). Searching for the simple answer to cure the smoking habit. *Health and Social Service Journal*, 87, 292-293.	1.5
6. Glasgow, R.E., Schafer, L. & O'Neill, H. K. (1981). Self-help books and amount of therapist contact in smoking cessation programs. *Journal of Consulting and Clinical Psychology*, 49, 659-667.	7.5
7. Hall, S. M., Rugg, D., Tunstall, C. , & Jones, R.T. (1984). Preventing relapse to cigarette smoking by behavioural skill training. *Journal of Consulting and Clinical Psychology*, 52, 372-382.	8

8. Lowe, M.R., Green, L., Kurtz, S.M.S., Ashenberg, Z.S. & Fisher, E.B. (1980). Self-initiated, cue extinction and covert sensitization procedures in smoking cessation. *Journal of Behavioral Medicine,* 3, 357-372.	7
9. Ginsberg, D., Hall, S.M. & Rosinski, M. (1992). Partner support, psychological treatment, and nicotine gum in smoking treatment: An incremental study. *The International Journal of the Addictions,* 27, 503-514.	7.5
10. Mothersill, K.J., McDowell, I., & Rosser, W. (1988). Subject characteristics and long-term post-program smoking cessation. *Addictive Behaviour*, 13, 29-36.	8
11. Raw, M & Russell, M.A.H. (1980). Rapid smoking, cue exposure and support in the modification of smoking. *Behaviour Research and Therapy*, 18, 363 to 372.	4.5
12. Rosser, W.W. (1984). The role of the family physician in smoking cessation. *Canadian Family Physician,* 30, 160-165.	4.5
13. Thompson, R.S., Michnich, M.E., Friedlander, L. , Gilson, B., Grothaus, L.C. & Storer, B. (1988). Effectiveness of smoking cessation interventions integrated into primary care practice. *Medical Care*, 26, 62-76.	7

Inclusion of other studies

Thirteen extra studies were found using PsychInfo. However after the second researcher screened the studies for inclusion, it was agreed that only three other studies were suitable for inclusion on the grounds of their high quality (see Table 2). These studies appear in journals that are also cited by Medline. However the titles of the papers do not

suggest any psychological input. However knowing the authors to be psychologists, these papers were investigated. Jason et al (1988) used a televised broadcast to recruit smokers to their study that included weekly support groups led by a psychologist. Owen et al (1989) posted either a standard booklet outlining the effect of smoking on health or personalised smoking cessation materials. Self-efficacy and coping styles were assessed for smokers in the latter group and the material was adjusted accordingly. These smokers were also contacted by telephone by a psychologist. The intervention in Windsor et al's (1988) study consisted of an individual 20-30 minute session with a Counselling Psychologist who talked the smokers through several behavioural approaches to quitting smoking such as keeping a diary, deep breathing, commitment cards. Perceived ability to quit was also discussed.

Table 2: Other Studies Identified Using PsychInfo

STUDY	RATING
A) Jason, L.A., Tait, E., Goodman, D. & Buckenberger, L. (1988). Effects of a televised smoking cessation intervention among low-income and minority smokers. *American Journal of Community Psychology*, 16, 863-876.	7.5
B) Owen, N., Ewins, A-L., Lee, C. (1989). Smoking cessation by mail: A comparison of standard and personalized correspondence course formats. *Addictive Behaviours*, 14, 355-363.	8.5
C) Windsor, R.A., Lowe, J.B. & Bartlett (1988). The effectiveness of a worksite self-help smoking cessation program: A randomized trial. *Journal of Behavioral Medicine*, 11, 407-421.	8.5

Exclusion of eight studies

Eight studies from Law and Tang's review were excluded from the re-analysis for the following reasons:

- trials compared one kind of a treatment with another, reducing the efficacy scores computed by Law and Tang as a difference between treatments
- aversion therapy trials were included twice, distorting the results
- inappropriate control was used.

1) Raw and Russell 1980

There was no control in this study, it compared the effects of three treatments : - Support, cue exposure and rapid smoking.

2) Ginsberg et al 1992

Nicotine Replacement Therapy was used as a control for this study.

3) Fee 1977

Aversion therapy was considered the therapy.

4) Barbarin 1978

The therapy in this study was aversion.

5) Lowe et al 1980

There was no control in this study. All smokers received a psychological intervention – self-control procedures or covert sensitization.

6) Cottraux et al 1983

This study used an unsuitable control. The placebo was a pharmaceutical intervention (lactose capsules) rather than a non-specific therapist led treatment.

8) Rosser 1984

This study did not have a group session as part of the control so was in effect a self-help group.

Table 3 shows the reanalysis of the effectiveness of psychological interventions for smoking cessation. This analysis excludes studies that were considered not suitable. It includes 3 additional studies and corrects any errors in the computation of effectiveness.

Table 3: Reanalysis of Trials of Group Sessions Led by a Psychologist: Abstinence Rates at 4-12 Months Follow-Up[1]

Trial		Intervention Group		Control Group		Difference %
Author/Year[2]	Quality Rating	Quitters	%	Quitters	%	
Delahunt et al 1976 (6)	5.0	*2/9*	*22.2*	*0/13*	*0.0*	*22.2*
Elliott et al 1978 (6)	6.5	9/20	45.0	3/19	15.8	29.2
Glasgow et al 1978 (6)	7.5	6/30	20.0	*0/14*	0	*20.0B*[3]
Hall et al 1984 (6)	8	26/65	40.0	20/70	28.6	11.4B
Mothersill et al (1988) (12)	8.0	15/86	17.4	11/78	14.1	3.3
Jason et al 1988 (4)	7.5	13/66	19.7	6/71	8.2	11.5
Owens et al 1989 (9)	8.5	2/14	13.8	3/40	7.5	6.3
Windsor et al 1988 (12)	8.5	19/133	14.0	7/139	5.0	9.0B
Overall	**7.4**	**92/423**	**21.7**	**50/444**	**11.26**	**10.44**

Italics show re-computation of errors reported by original study by Law and Tang

[1] Abstinence rates are based on intention to treat point prevalence.
[2] The number in brackets is the follow-up period in months
3B indicates that biochemical markers were available for at least 90% of the followed-up sample

Discussion

This re-analysis of Law and Tang (1995) has highlighted that caution and critical appraisal are needed even when interpreting studies that use a method that aims to remove bias. It has shown that there were errors in calculating the efficacy scores and three additional studies should have been included in the review. Some doubt has been raised about the quality of the papers included in the review by Law and Tang (1995). It has to some extent supported Marks' (2001) assertion that it is a myth that evidence-based health promotion can remove entire bias by engaging methodological purity.

A recent study suggested that the brief verbal interventions proposed by Law and Tang (1995) as being cost-effective has been shown to be ineffective. Hajek, Taylor and Mills (2002) evaluated a brief verbal advice and standard booklet intervention that can be routinely delivered to smokers admitted to hospital with cardiac problems. They found that after six weeks 59% and 60% of patients remained abstinent in the control and intervention group respectively. However by 12 months, the figures were 41% and 37% respectively. When a behaviour therapy (a commitment card) component was added, patients were almost twice as likely to remain abstinent than those who did not receive the card. They concluded that single session interventions delivered within routine care may have insufficient power to influence highly dependent smokers. They also pointed to an observational finding. There was a possibility that the intervention was offered preferentially to keen patients who had signed the commitment card. They stated that more intensive training and rehearsal of behavioural procedures may have improved the delivery of the intervention. However they pointed to the practical problem of time being a serious barrier to training staff to use behavioural interventions.

The above study is only one example of brief verbal interventions not working. The policy document *Smoking Kills* highlights examples of studies that have shown this type of intervention to work (Department of Health, 1998b). Likewise, more rigorous Cochrane Reviews have supported some of the other findings of Law and Tang (1995). Abbot, Stead, White & Barnes (2002) evaluated the effects of hypnotherapy for smoking cessation. Only 2 of the 9 studies had biochemically validated results. They also found

that there was heterogeneity between the individual studies with conflicting results for the effectiveness of hypnotherapy compared to no treatment or to advice. Therefore no attempt to analyse the results was made. They did compare the effects of hypnotherapy to rapid smoking and found no effect. Similarly, White, Rampes and Ernst (2002) found that acupuncture compared to no intervention for smoking cessation appeared effective at six weeks but not at 6months and one year. Thus reaching the same conclusion as Law and Tang (1995) that acupuncture is not effective for smoking cessation.

The category 'psychologist led' in Law and Tang's review is not valuable in determining the usefulness of psychological interventions. The studies included in the review were conducted in a variety of settings, with individuals and in groups, ranged in the amount of psychologist input and included a range of psychological techniques. These variations make difficult any interpretation of the results. For example, Stead and Lancaster (1998) systematically reviewed group programmes compared to individual programmes. They found that there was an increase in cessation with the use of a group programme. Therefore studies in the review that used a group format may have been more effective because the intervention was delivered to a group rather than due to the nature of the intervention. It would have been preferable and more informative to conduct the analysis based on the type of psychological intervention. This has been conducted for hypnotherapy and aversion therapy (e.g. Abbot et al 2002 & Hajek & Stead 2002). A search (Cochrane Library, PsychInfo –September 2002) for reviews on the effectiveness of cognitive behaviour therapy (CBT) compared to no intervention control revealed that no such review was available. This could be due to the fact that relatively few RCT's of the effectiveness of CBT for smoking cessation have been conducted (see Sykes and Marks 2001). Also, Stead and Lancaster (2002) concluded that there is not enough available evidence to assess the efficacy of group therapy and intensive individual counselling. Despite extensive research on smoking cessation in psychology over many decades, there is only a limited amount of what would be considered 'quality studies' in the field of evidence-based health promotion. This may provide an explanation for Law and Tang's (1995) categorisation. Yet it still points to a need for a good quality up-to-date systematic review of psychological interventions for smoking cessation.

The practical implications of conducting rigorous RCT's in health promotion may explain the lack of 'quality' reviews in smoking cessation Firstly, there are considerations related to recruitment. Recruitment to health promotion interventions can be very costly and take time to obtain a big enough sample to demonstration effectiveness. This is a particular concern when the trials are tied to a fixed term funding arrangement. It is also difficult to disentangle the effects of a health promotion intervention from the contextual factors in which a person lives.

Although only one study, Hajek et al's (2002) research highlights the issue that the findings of controlled studies in health promotion may not necessarily work in practice due to simple and practical restraints. Learmouth and Watson (1999) conducted interviews with health promotion practitioners on the subject of evidence based health promotion. They welcomed the approach but were worried that there were not always the resources to implement such an approach. They also found that the findings from systematic reviews were not always generalisable to the group with whom they were working and that the voice of these people is often missing from such an approach. This example demonstrates that even when practitioners are motivated to adopt an evidence-based approach, in some cases their intentions are frustrated by a complex web of restrictions such as resources. Other restrictions include time pressure, lack of access to information, lack of managerial vision and restrictive hierarchies (see thesis – EC evaluation).

Nevertheless, conducting systematic reviews still has advantages. Mulrow (1994) points to nine advanatages such as reducing large quantities of information into palatable pieces and increasing the power of studies. The NHS has invested in trying to make research findings more accessible by disseminating synthesised reviews and guidelines to practitioners such as via the Cochrane Library and the NHS Centre for Reviews and Dissemination. This is an exiting development in terms of trying to bridge the gap between research and practice. Yet it assumes that dissemination of the reviews will lead to changes in practice. Gomm and Davies (2000) stated that passive dissemination can influence awareness and knowledge but does little to change in practice. They argued that

a combination of strategies for implementation are needed to influence practice such as educational, marketing, mass media, performance management and incentives.

However rigorous, systematic reviews also have to be open to interpretation. As this study has shown, different results can be found depending on who is conducting the review. While systematic reviews are intended to limit bias, they are usually carried out by researchers with experience of the research field in which they are conducting the review. Therefore, with all the goodwill in the world, it is difficult for bias to be completely eliminated. Also systematic reviews are often based on published data, thus excluding a whole range of other sources of information.

This study has highlighted the mistaken certainty that systematic reviews produce unquestionable evidence of best practice. It has shown that steps are needed to improve the quality of systematic reviews in the field of smoking cessation. It is also necessary to recognise and develop the contribution of other forms of evidence acknowledging the complexities and applicability of health promotion interventions.

References

Abbot, N.C., Stead, L.F., White, A.R. & Barnes, J. (2002). Hypnotherapy for smoking cessation (Cochrane Review). *The Cochrane Library*, 3.

Bandura, A. (1997). The anatomy of stages of change. *American Journal of Health Promotion*, 12, 8-10.

Bosch, X. (2001). Bladder cancer risk higher for women smokers. *British Medical Journal*, 322, 948b.

Cavelaars, A. E. J. M., Kunst, A. E., Geurts, J. J. M., Crisalesi, R., Grötvedt, L., Helmert, U., Lahelma, E., Lundberg, O., Matheson, J., Mielck, A., Rasmussen, N. Kr., Regidor, E., Rosário-Giraldes, M. do, Spuhler, Th., Mackenbach, J.P. (2000). Educational differences in smoking: international comparison. *British Medical Journal*, 320, 1102-1107.

Charatan, F. (2001). Lung cancer death rates rise 600% in US women. *British Medical Journal*, 322, 752.

Cohen, S., Litchenstein, E., Prochaska, J. (1989). Some misconceptions about self-quitting: evidence form ten prospective studies of persons quitting smoking themselves. *American Psychologist*, 44, 1355-1365.

Department of Health (1998a). *Report of the Scientific Committee On Tobacco And Health.* London: Department of Health.

Department of Health (1998b). *Smoking Kills*. London: Department of Health.

Department of Health(1997). *The New NHS. Modern. Dependable*. London: Department of Health.

DiClemente, C.C. and Prochaska, J.O. (1982). Self change and therapy change of smoking behavior: a comparison of processes of change in cessation and maintenance. *Addictive Behavior*, 7, 133-142.

Hajek, P. & Stead, L.F. (2002). Aversive smoking for smoking cessation (Cochrane Review). *The Cochrane Library*, 3.

Hajek, P., Taylor, T., Mills, P. (2002). Brief intervention during hospital admission to help patients to give up smoking after myocardial infarction and bypass surgery: randomised controlled trial. *British Medical Journal*,324, 87-89.

Foulds, J. (2000). The new NHS campaign. *Electronic British Medical Journal*, 320-454.

Glynn, T.J., Boyd, G.M. & Gruman, J.C. (1990). Essential elements of self-help/minimal intervention strategies for smoking cessation. *Health Education Quarterly*, 17, 3290345.

Gomm, R. & Davies, C. (2000). Using Evidence in Health and Social Care. London: Sage.

Graham, H. & Derr, G. (1999). Patterns and predictors of smoking cessation among British women. *Health Promotion International*, 14, 231-239.

Juel, K. (2000). Increased mortality among Danish women: population based register study. *British Medical Journal*, 321, 349-350.

Law, M. & Tang, J.L. (1995). An analysis of the effectiveness of interventions intended to help people stop smoking. *Archives of Internal Medicine*, 155, 1933-41

Learmouth, A.M. & Watson, N..J. (1999). Constructing evidence health promotion: Perspectives from the field. *Critical Public Health*, 9, 317-333.

Marks, D.F. & Sykes, C.M. (2002). Randomized controlled trial of cognitive behavioural therapy for smokers living in a deprived area of London: outcome at one-year follow-up. *Psychology, Health and Medicine*, 7, 17-24.

Marks, D.F. (2001).Evidence-based practice in health care. Glasgow: British Psychological Conference.

Mulrow, C.D. (1994). Rationale for systematic reviews. *British Medical Journal*, 309, 597-599.

NHS Centre for Reviews and Dissemination (2001). ' Undertaking Systematic Reviews of Research on Effectiveness. York: University of York

Stead, L.F. & Lancaster, T. (2002). Group behaviour therapy programmes for smoking cessation (Cochrane Review). *The Cochrane Library*, 3.

Stead, L.F. & Lancaster, T. (1998). Group behaviour therapy programmes for smoking cessation (Cochrane Review). *The Cochrane Library*, 3.

Sykes, C. & Marks, D. (2001). Effectiveness of a cognitive behaviour therapy self-help programme for smokers in London, UK. *Health Promotion International*, 16, 255-260.

Sykes, C. & Marks, D. (2000). Why a few tips won't go far. *Health Matters*, 40, 19

White, A.R., Rampes, H. & Ernst, E. (2002). Acupuncture for smoking cessation (Cochrane Review). *The Cochrane Library*, 3.

WHO (1999). Health 21. The Health For All Policy Framework for the WHO European Region. Copenhagen, WHO.

Appendix 1

Systematic Review Protocol

Review Question: A re- examination of the efficacy of psychological interventions to aid smoking cessation in adults.

Background

It is reported that there are over 500,000 smoking related deaths each year in the European Union [i] In 1998 £60 million was pledged in England to invest in smoking cessation resources over three years [ii] The focus of the expenditure of this money was on providing free nicotine replacement therapy (NRT). Money was also spent on a campaign in the year 2000 entitled 'Don't give up giving up'. This campaign has been criticised by Sykes and Marks[iii] for only telling smokers what they already know and not providing any actual skills to quit smoking. A major feature of *The New NHS* white paper is 'clinical governance'[iv]. Clinical governance includes the implementation of best practice across organisations and the use of evidence-based interventions. Systematic reviews and randomised controlled trials are seen as the gold standard for determining 'evidence-based'. Close inspection of the systematic review used to inform policy-makers about the efficacy of smoking cessation methods reveals a flaw[v]. Despite investigating the efficacy of psychological interventions, it failed to search a major psychological database (PsychInfo). Thus ignoring a large amount of psychological evidence related to smoking cessation. This systematic review will partial replicate Law and Tang study by searching PsychInfo for studies in the same period. However it will only analyse interventions that are skill-based ('Non-specific behaviour modification therapy'). Quality of RCT's will also be examined.

Objectives

1) Partial replication of the original study conducted by Law and Tang in 1995
2) Search PsychInfo for any missing studies up to 1995

3) Re-analyse the data with any additional studies, according to the quality of the study and according to type of intervention

Search Strategy

1) All the 'non-specific' behaviour modification articles reviewed by Law and Tang will be re-reviewed and the effect-size will be remeasured.

2) PsychInfo will be searched for psychological interventions to aid smoking cessation for articles from 1967 – 1995.

Search Terms

Smoking cessation + relaxation; smoking cessation + visualisation (visualization); smoking cessation + trigger; smoking cessation+positive reasons, smoking cessation+counselling, smoking cessation+cognitive behaviour therapy; smoking cessation+psychological; smoking cessation+ randomised (randomized) controlled trial

Study Selection Criteria

Participants

Adults (>16 years of age) using a psychological intervention to aid smoking cessation irrespective of their interest in stopping smoking

Interventions:

Non-specific approaches: relaxation as an alternative to smoking, visualisation, idenitification of triggers, emphasis on positive reasons for stopping

Outcomes:

cessation or significant reduction for at least six months verified by biological markers (carbon monoxide, thiocyonate or cotinine)

Study design:

Randomised controlled trial

3)

Database

PsychInfo

Search Procedure

CS will select studies for the inclusion into the review. Identified studies will be screened for suitability using the inclusion criteria by CS and DM.

Study Quality Assessment Checklists and Procedures

The quality of each study will be scored between 0 to 10, giving one point for:

- Adequate randomisation
- Adequate participants (i.e. includes power analysis or over 100 participants in each group)
- Biomarkers confirm self-reported cessation status in 95% of cases
- Suitable comparison interventions
- Similar groups at baseline
- No other confounding intervention
- Acceptable drop-out rate (25% or less)
- Motivation to quit measured
- Reliable measurement techniques
- Appropriate statistical analyses

The quality assessments will be done by CS and DM independently. The delphi method of achieving agreement will be used.

Data Extraction Strategy

A data extraction form will be used to obtain the necessary information from the selected studies

Data Extraction Form for the Efficacy of Psychological Interventions to Aid Smoking cessation

General Information

Date of extraction:

Study reference:

Author contact details:

Identification number in systematic review:

Notes:

Study Characteristics

Verification of study eligibility

- Participants
- Intervention
- Outcome
- Design

Methodological Quality of Study

Study design:

Quality assessment score:

Interventions

Intervention:

Number of condition groups:

Duration of intervention:

Outcome

What was measured at baseline?

What was measured after the intervention?

Who carried out the measurement?

Analysis

Statistical analyses used:

Attrition rate:

Follow-up rates for each condition

Results

	Condition A Mean (SD)	Condition B	Condition C	Condition D
Variable 1 Pre Post				
Variable 2 Pre Post				

Data analysis

When it is establish that a meta-analysis is possible and appropriate, 3 choices will be decided:

1. Which comparisons will be made
2. Which outcome measure will be used
3. Which effect measure will be used to describe effectiveness

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[i] Petro, R., Lopez, A.D., Boreham, J., Thun, M., & Heath, Jr C. (1992). Mortality from tobacco in developed countries: indirect estimation from national vital statistics. *Lancet*, 339, 1268 –78.
[ii] Secretary of State for Health (1998). *Smoking Kills*. London: Department of Health.
[iii] Sykes, C. & Marks, D. (2000). Why a few tips won't go far. *Health Matters*, 40, 19.
[iv] Secretary of State (1997). *The New NHS. Modern. Dependable*. London: Department of Health.
[v] Law, M. & Tang, J.L. (1995). An analysis of the effectiveness of interventions intended to help people stop smoking. *Archives of Internal Medicine*, 155, 1933-41.

Evaluation and Discourse Analysis of the EC's Health Promotion Programme

Chapter 1

Health Promotion in Context

Good health is the bedrock on which social progress is built. A nation of healthy people can do those things that make life worthwhile, and as the level of health increases so does the potential for happiness. Lalonde, 1974.

Historical context

All societies throughout history have had to face the realities of disease and death and develop concepts and methods to manage them. Prominent killers facing modern society such as cardiovascular diseases, cancer and AIDS force us to seek new ways of preventing their potentially serious consequences. A look at the past can offer an understanding of health promotion today and its continued dominance in our modern life.

The Mesolithic Age or transitional phase of evolution from hunter-gatherer societies into the Neolithic Age of food-raising has been estimated to occur in Europe about 3000BC. The first step to a change from hunting, fishing and gathering methods of survival to agriculture was the domestication of animals, then growing wheat, barley, corn, root crops and vegetables. Skills such as cooking and storing of food, pottery, basket weaving, ovens, smelting, trade and other skills led to improved survival techniques and population growth (Tulchinsky & Varavikova, 2000).

The earliest of civilisations made efforts to promote health and prevent disease through sanitation and housing. Ancient sites in India reveal that clean water, sewerage systems, paved streets and town planning were recognised as being important as long ago as 2000 BC. The problem of procuring drinking water had been solved in a considerable measure around the same time. For example, the Cretan-Mycenean culture had large conduits. In places where drinking water supply systems were well established, the disposal of wastes was also regulated and the sewerage system was well developed. In the Palace of Knossos in Crete which dates from the second pre-Christian millenium, there were not

only magnificent bathing facilities, but also water flushing arrangements for the toilets. (Rosen, 1993). Some ancient civilisations sought to impose rules in an effort to promote health. For example, the Babylonians drew up strict public health regulations governing personal behaviour and the Egyptians promoted the value of good diet and hygiene. This was mainly due to religious beliefs and practices in which disease was often associated with divine retribution.

The collapse of the Roman Empire brought a decline in public health systems which had previously been aware of the health implications of sanitation. Aqueducts, public bathing facilities, sewerage systems and water purification had all contributed to controlling the spread of disease. During the Middle Ages, epidemics such as the Black Death were common. The main response was isolation. However, this was not undertaken with any clear plan in mind. Some European cities introduced limited public health measures. For example, in London restrictions on pigsties and stray animals, dumping of waste were introduced as well as rules concerning the slaughter of animals. In some cities, municipal abattoirs were established in an effort to prevent offal littering the streets, whilst other cities established food inspection and market regulations to try to protect citizens from contaminated or dirty food. The rules were enforced quite vigorously, with severe penalties for those who transgressed them (Rosen, 1993).

The population growth resulting from the development of agriculture stimulated the organisation of more complex societies who were able to share in production and irrigation systems. This led to improved standards of living but also created new health hazards including the spread of diseases. Community action was required to prevent disease and promote survival. Also herbal and mystical treatments for diseases were found. For example shamans used magical or religious practices along with herbal treatment often acquired through trial and error. The increase of writing led to medical documentation, regulation of physician fees and punishment for failure. Many of the main traditions of medicine were those based on knowledge from magic or religion. Medical practice was often based on belief in the supernatural. Healers were thought to have a religious calling. The training of medical practitioners and the regulations of their

practice and ethical standards gradually evolved in a number of societies in the middle ages (Tulchinsky & Varavikova, 2000).

An example of community action against the ills of disease can be seen in the fourteenth century in Europe, when after seeing the devastating results of plagues and wars, guilds were organised. These guilds protected economic interests of traders and skilled craftsmen and developed mutual benefit funds to provide financial aid and other benefits for illness, death, widows, orphans, medical care and burial benefits for members and their families. The guilds obtained strong political powers during the late middle ages. These 'brotherhoods' helped the later development of mutual benefits or Friendly Societies, sick funds and insurance for health care based on employment groups (Tulchinsky & Varavikova, 2000).

Up until the Enlightenment period, European societies response to the threat to disease was still in a piecemeal and reactive fashion. For example, a syphilis epidemic at the end of the fifteenth century led to the closure of brothels, the medical examination of prostitutes and compulsory treatment for people with syphilis. Then a more systematic approach to public health grew slowly as the results of important studies such as the enquiry into contagion were found. During the Enlightenment period, a number of significant public health interventions also emerged. For example, the Gin Act of 1751 imposed a high tax on the product and restricted its availability. During the middle of the eighteenth century, there was also much interest in finding ways of improving the health of seamen and soldiers. John Lind showed that scurvy, which had been thought of as an unavoidable consequence of long sea voyages, was caused by an inadequate diet and could be prevented by issuing fresh fruit rations. (Baggott, 2000)

The Victorian times saw two waves in public health. The first wave was concerned with sanitary reform. The Poor Law Commission was keen to explore avenues that would reduce the burden that the poor placed on rate payers and provide a more productive labour force. It therefore supported studies to investigate the possible link between illness and poverty. These studies culminated in Chadwick's report on *The Sanitary*

Conditions of the Labouring Population of Great Britain (1842) which clarified the link between physical environment and disease. It provided detailed recommendations on sanitation and public health administration many of which were subsequently enshrined in law (Baggott, 2000).

The latter part of the Victorian period saw preventive medicine replace the sanitary idea as the dominant philosophy of public health. This was manifested by the 'medicalisation' of public health, a shift in the focus of attention from the general population towards specific subgroups and individuals and by an increasing emphasis on access to health services (Baggott, 2000).

The emergence of 'new public health'

The present public health movement in the European Union is often referred to as 'the new public health'. Baggott (2000) traces this to a number of sources such as intellectual debates about the role of medicine and the future costs of health care, high-profile failures in public health, a changes in the public perception of health risks, policy initiatives at the international and local level, and lobbying by pressure groups.

At each stage of human biological, technological and social evolution man has co-existed with diseases associated with the environment and living patterns It has been essential for humans to adapt to environmental hazards such a population growth and new environmental surroundings. As mankind evolved, nutrition and exposure to communicable diseases changed. Enhancing skills, imposing rules, regulation of 'medical' practitioners and community action have helped adaptation. Facing new challenges of adaptation by mankind to the environment has been, and remains a central issue in health to the present time (Tulchinsky & Varavikova, 2000).

Modern man's environment is a global one. Increasingly, it is recognised that it is not enough for a nation to be only concerned with the health status of its own population. As we evolve into a global community, one nation's public health concern becomes the concern of all nations (Merson, Black & Mills 2001). In the Western world scientific

innovations such as vaccines and antibiotics, improved nutrition and living standards have helped to control infectious disease as the major cause of death. Public health activities today are largely concerned with the prevention of chronic diseases and premature death through health promotion. Individuals and communities today are faced with the challenge of adaptation to the modern lifestyle – a modern life whose environment includes pollution, promoting by the media to over-indulge in alcohol, tobacco and food, availability to over-indulge, physical activity as a leisure rather than a necessity. In short modern life has created an environment which leads to behaviours that are a threat to health. These behaviours have become the focus of health promotion. Astrand's (1994) analysed the evolutionary history in relation to current lifestyles and stated that we are now living our lives, at least in developed countries, in ways that are largely unhealthy and different from what we have done for most of our past. He concludes that 'during more than 99 per cent of our existence we were hunters and food gatherers. Now we are exposed to an enormous experiment –without control groups' (pp101 – as cited in Biddle and Mutrie 2001). Thus the rules for promoting health in today's world are still being tested. Activities and trials to promote health are widening in their scope and efforts often on an international scale.

The World Health Organisation (WHO) has played a significant role in promoting international public health strategies and more recently the European Union institutions have increased their involvement in public health. The origins of health promotion as we know it today have been said to originate from the WHO's original definition of health (Tones and Tilford, 1994). The 1948 definition stated that health was 'A state of complete physical, mental and social well-being and not merely the absence of disease and infirmity.'

1977 saw the launch of 'Health for All by the Year 2000' at the 30th World Health Assembly. This 'Health for All' strategy set global health targets for the year 2000. This new movement included a more realistic definition of health than the classic 1946 version. The then Director General of WHO pointed out;

The challenging constitutional objective of the World Health Organization: the attainment by all peoples of the highest possible level of physical, mental and social well-being, is now being transformed into the dynamic notion of a Health for All movement. With this change in emphasis, public health is reinstating itself as a collective effort, drawing together a wide range of actors, institutions and sectors within society toward a goal of a 'socially and economically productive life.' This social goal...moves health from being the outcome measure of social development to being one of its major resources.

From Tones and Tilford, 1994.

Tones and Tilford (1994) pointed out that the Declaration of the Alma, Ata (WHO, 1978) was a major event in the progress towards health promotion. It made several important assertions which were later incorporated into health promotion. Above all, it declared that the 'existing gross inequality in the health status of the people particularly between developed and developing countries as well as with countries is politically, socially and economically unacceptable and is, therefore, of common concern to all countries.' Equity was seen as the foundation for achieving 'Health for All' in the year 2000. Economic and social development was therefore essential for achieving health. The public themselves were considered to have a duty to participate individually and collectively in the planning and implementation of their health care. Primary health care was also therefore considered to be a key to achieving 'Health for All' (Tones and Tilford, 1994).

The principles of the WHO 'Health for All' have been endorsed at several other international conferences such as Ottawa 1986, Adelaide 1988 and Jakarta 1997. The First International Conference actually dedicated to health promotion was held in Ottawa, Canada. The Ottawa Charter (WHO, 1986) resulted from this conference. The definition of health was revised in this charter to:

To reach a state of complete physical, mental and social well-being, an individual or group must be able to identify and to realize aspirations, to satisfy needs, and to change or cope with the environment. Health is therefore seen as a resource for everyday life, not the objective of living. Health is a positive concept emphasizing social and personal resources, as well as physical capacities.

The original 'Health for All' strategy has since been revised for the twenty-first century (WHO, 1998). In addition the WHO which had devised specific targets for Europe were revised in 1998 (WHO Regional Office for Europe, 1998). The basic principles of the 'Health for All' remained intact but there is now more emphasis on sustainable development and the link between health and the environment. Recently the WHO has also become more proactive in promoting policies at the global and regional level to fight against specific threats to health, covering issues such as the environment, diet, health inequality, alcohol and tobacco use. Although impressive in its range aims, the WHO has been criticised for its bureaucratic nature and lack of focus (Baggott, 2000).

Health promotion in the European Union

According to literature produced by the European Commission, members of the European Union (EU) face similar health problems such as:

- Inequalities in both health status and health service provision between different geographical areas and social groups;
- Variations in the utilisation of services;
- Health problems related to lifestyle behaviour and political/economic issues.

(Holland, Mossialos and Permanand, 1999).

This has prompted efforts to promote health on a European-wide scale. The European Community has always had some involvement in the field of health and in a range of policy areas with implications for health. However it was the Maastricht Treaty 1992 that provided it with necessary legal base to develop a coherent public health policy through the insertion of Articles 3 (o) and 129. Article 3(o) stipulated that the Community should contribute to the attainment of a high level of health protection, while

Article 129 identified two area for Community action: disease prevention and health protection. The means through which these objectives were to be achieved were through research, health information and education and the incorporation of health protection requirements into the Community's other policies. There was a requirement that the Member States should coordinate their policies and programmes in these areas. There was also a guideline that the Commission may take any useful initiative in this respect. The harmonisation of the laws and regulations of the Member States was however specifically excluded (Holland, Mossialos and Permanand, 1999).

Article 129 was criticised for being too vague in its definition of the specific responsibilities of both the Member States and the Commission in achieving the objectives laid down in the Article and in policy implementation. The obligation of achieving a high level of human health protection and the responsibility for directing action towards the prevention of diseases or 'major health scourges' was placed upon the Community as a whole. This meant a sharing of responsibility without providing individual competencies and also failed to make clear what is meant by 'major health scourges' (Holland, Mossialos and Permanand, 1999).

At the June 1997 Intergovernmental Conference in Amsterdam, agreement on the new Treaty resulted in a revision of Article 129 (which changed to Article 152 in the New Treaty). The main feature of the Amsterdam Treaty that has an impact on health is the provision that Community policies ought to contribute to health protection. For example having a public health input into policies such as tobacco subsidies and agriculture which had been legislated in primarily economic terms. The new Treaty acknowledged a broader definition of public health in the Community along with a greater Community role. A role which had previously been described as 'the prevention of disease' was extended to 'improving public health.' (Holland, Mossialos and Permanand, 1999).

Establishment of the EC's Health Promotion Programme

A consequence of the Maastricht Treaty on the European Union was the establishment of 'The Community Action Programme on Health Promotion, Information, Education and Training 1996-2000' or the 'Health Promotion Programme'.

The new legislation followed a series of Resolutions by the European Parliament, the Council, Ministers, and Representations of the Governments of the Member States from 1988 onwards. Various resolutions focused on:

- the effect on health of eating habits and nutrition
- abuse of drugs and pharmacological substances
- smoking
- environmental pollution
- accident prevention
- prevention of cardiovascular diseases
- schools as a setting for developing a healthy lifestyle at an early age
- local communities, homes, workplaces, and hospitals as other settings in which health education has a central role

The Decision to establish the Health Promotion Programme took into consideration the "encouraging" results of the 'The European Network of Health-Promoting Schools', a joint WHO/Council of Europe European Community Project and also gave recognition to the fact that: "socio-economic conditions such as urbanization, housing, unemployment and social exclusion have to be taken into consideration in the promotion of health, particularly for those living in deprived areas" (European Parliament and Council, 1996 – p2). The Decision also took into account the following considerations:

- health education and information are a priority for Community action in public health
- co-operation with competent international organisations and with non-member countries should be strengthened
- priority measures should be selected as well as mechanisms for evaluation, "with a view to promoting the health of all citizens of the Community"

- the programme must contribute to raising awareness of health determinants and risk factors
- the programme must encourage the development of an integrated approach to health promotion
- the activities previously undertaken, Community networks of NGOs, and mobilization of all those involved in health promotion and education should be safeguarded
- the programme must take account of past and current measures implemented by the Member States
- possible duplication of effort should be avoided by the promotion of exchange of experience and by the joint development of basic information modules for the general public, for health education and for training members of the health-care professions
- the objectives and actions undertaken to implement the programme form part of the health protection requirements referred to in Article 129 (1) of the Treaty and as such are a part of the Community's other policies
- the importance of the Commission ensuring that implementation is in close co-operation with the Member States requiring provision for a procedure "to ensure that Member States are fully involved in implementing the plan"
- the programme should run for five years
- "in order to increase the value and impact of the action programme, a continuous assessment of the measures undertaken should be carried out, with particular regard to their effectiveness and the achievement of objectives at both national and Community level and, where appropriate, the necessary adjustments should be made"

Objective of the Programme

Article 1.2 of the co-decision states that: 'The objective of the Programme shall be to contribute towards ensuring a high level of health protection and shall comprise actions aimed at:

- encouraging the 'health promotion' approach in Member States' health policies by lending support to various co-operation measures (exchanges of experience, pilot projects, networks, etc)
- -encouraging the adoption of healthy lifestyles and behaviour
- promoting awareness of risk factors and health-enhancing aspects
- encouraging intersectoral and multidisciplinary approaches to health promotion, taking account of the socio-economic factors and the physical environment necessary for the health of the individual and the community, especially disadvantaged groups.

The Programme had an overarching objective of contributing towards ensuring a high level of health protection and is constituted of actions with the above four aims. Article 1.3 of the co-decision defines five areas of action to be implemented by the Programme and each of these areas has its own objectives and set of actions or measures. The Commission is obliged to ensure the implementation of the actions in close co-operation with the Member States and to co-operate with the institutions and organisations that are active in the field of health promotion, information, education and training. A budget of 35 MEURO in annual appropriations was allocated to implement the Programme. This Health Promotion Programme will be the focus of analysis of this thesis.

Theories in Health Promotion

Turning now to the theories that inform health promotion practice and research. Promotion of health is more systematic than it has ever been and is supported by policies. However there is no single theory that dominates health promotion practice. Nutbeam and Harris (1999) who are leading figures in the health promotion world believe that this would not be desirable given the range of health problems and their determinants, the diversity of populations and settings and differences in available resources and skills among practitioners. They point out that most health promotion theories come from the behavioural and social sciences such as psychology, sociology, management, consumer behaviour and marketing. This diversity reflects the fact that health promotion practice is not only concerned with the behaviour of individuals but also the ways in which society is organised and the role of policy and organisational structures in health promotion.

They provide a summary of the models used in health promotion which is replicated in Table 1.

Table 1: Summary of models in health promotion presented in Nutbeam and Harris (1999)

Area of Change	**Theories or Models**
1) Theories that explain health behaviours change by focusing on the individual	Health belief model Theory of reasoned Action Transtheoretical (stage of change) model Social learning theory
2) Theories that explain change in communities and community action for health	Community mobilisation • Social planning • Social action • Community development Diffusion of innovation
3) Theories that guide the use of communication strategies for change to promote health	Communication for behaviour change Social marketing
4) Models that explain changes in organisations and the creation of health-supportive organisational practices	Theories of organisational change Models of intersectoral action
5) Models that explain the development and implementation of healthy public policy	Ecological framework for policy development Determinants of policy making Indicators of health promotion policy

Theories that explain health behaviours change by focusing on the individual are rooted in the academic discipline of health psychology. Four of the most influential theories according to Nutbeam and Harris (1999) are described below. These theories were drawn upon in the establishment of the EC's Health Promotion Programme.

The health belief model

This model focuses on two aspects of individuals' representations of health and health behaviour: threat perception and evaluation of behaviour. Threat perception is dependent upon two beliefs, perceived susceptibility and severity. The model predicts that people will take action to protect or promote health if they perceive themselves to be susceptible to a condition or problem and if they perceive the condition or problem to have potentially serious consequences. Behavioural evaluation also consists of two distinct sets of beliefs, benefits and barriers. The model states that a person will take action if the benefits of taking action outweigh the costs or barriers. Additionally the model proposes that cues to action can trigger health behaviour when appropriate beliefs are held. Cues can include individual perceptions of symptoms, social influence and health education campaigns. In a later version of the model, the individual's health motivation was included (Conner & Norman,1996).

The health belief model does not link the six variables accounting for variance in an observed or reported health behaviour. Rather it is operationalised as a series of up to six separate independent variables. Also the definitions of the six variables have been debated. Conner and Norman (1996) cite Rosenstock (1974) and Becker and Maiman (1975) who illustrate how various researchers used somewhat different operationalisations of these constructs. They also point to a meta-analysis by Harrison, Mullen and Green (1992) who concluded that the health belief model's lack of operational homogeneity continues to weaken its status as a coherent psychological model of the prerequisites of health behaviour.

However a review by Janz and Becker (1984) produced supporting evidence for the health belief model's predictions. In quantifying their findings, Janz and Becker used a vote count procedure. 'A significance ratio was calculated wherein the number of positive and statistically significant findings for a HBM (health belief model) dimension are divided by the total number of studies which reported significance levels for that dimension' (Conner and Norman, 1996, p29). The significance ratio indicates the percentage of times each health belief construct was statistically significant in the

predicted direction across 46 studies. The construct 'susceptibility' was significant in 81 per cent of 37 studies, 'severity' was significant in 65 per cent of 37 studies, 'benefits' was significant in 78 per cent of 37 studies and 'barriers' 89 per cent in 28 studies. When they examined only prospective studies (n=18), the ratios were 82, 65, 81 and 100 per cent for 'susceptibility', 'severity', 'benefits' and 'barriers' based on 17, 17, 16 and 11 studies respectively, thus showing that 'barriers' is the most reliable predictor of behaviour.

Yet if more refined research methods are employed in reviewing the health belief model, a different picture emerges. As pointed out by Conner and Norman (1996), in Janz and Becker's review, the significance ratios only indicate how often the health belief model components are significantly associated with behaviour. They do not show how large the effect is, i.e. the effect size. Also the significance ratios give equal weighting to findings from studies with large numbers and small numbers. They do not differentiate between bivariate relationships between a health belief model component and behaviour and multivariate associations. They also do not have any way of counting unpublished studies which tend to contain non-significant differences. Harrison et al's review in 1992 does take these factors into consideration. They identified 234 published empirical tests of the health belief model for behaviour change. Only 16 of these studies measured all four components and included reliability checks. They converted the results for the health belief model's components for each study into a common effect size. The average correlations across all studies were 0.15, 0.08, 0.13 and –0.21 for 'susceptibility', 'severity', 'benefits' and 'barriers' respectively. The correlations were all statistically significant but the effect sizes were all small. The individual components only accounted for between one half and 4 per cent of the variance in behaviour. Harrison et al also found different associations for the health belief components for cross-sectional versus prospective designs. 'Benefits' and 'barriers' had significantly larger effect sizes in the prospective studies. The effect size for 'severity' was significantly larger in the cross-sectional studies.

Despite its weaknesses the health belief model has been applied to a whole range of health promotion interventions as it is amenable to educational intervention (Conner & Norman, 1996). Nutbeam and Harris (1999) in their G*uide to health promotion theory* do not mention the above limitations and weakness of supporting evidence for the health belief model. However they do acknowledge that the health belief model is a psycho-social model and is limited to accounting for as much of the variance in an individual's health behaviour as can be explained by their attitudes and beliefs.

Theory of planned behaviour

This theory is an extension of the earlier theory of reasoned action (Fishbein and Ajzen, 1975). The theory of planned behaviour describes how the influences upon a person determine his/her decision to follow a particular behaviour. The most immediate determinants of behaviour are one's intention to engage in that behaviour and one's perceptions of control over that behaviour. Behavioural intentions are also thought to be influenced by attitude towards behaviours and subjective norms. Attitudes are determined by the belief that a desired outcome that is beneficial to health will occur if a particular behaviour is followed. Subjective norms relate to a person's beliefs about what other people think he or she should do and by a person's motivation to comply with other people's wishes. The social influences vary in strength according to the degree to which a person values social approval by a particular group. Conner and Sparks (1996) point out that the theory of planned behaviour has been widely tested and successfully applied to the understanding of a variety of behaviours. They point out however that the model does not assess health threat as in the health belief model.

A recent study published in 2001 by Quine, Rutter and Arnold shows that the theory of planned behaviour may be better than the health belief model at predicting health behaviour, at least in understanding the use of protective helmets among schoolboy cyclists . The study by Quine et al (2001) reports a prospective and longitudinal comparison of the health belief model and the theory of planned behaviour in which the models were used to predict and understand the use of protective helmets in 162 schoolboy cyclists ages 11-18 years. Correlations and path analyses were used to identify

predictors of intention to wear a helmet and actual helmet use at what they defined as time period 2. For the health belief model in its original form, the variance explained at time period 2 for helmet use was 18% against 43% for the theory of planned behaviour. For the health belief model, only 2 of the 6 paths produced reliable effects (perceived benefits and perceived barriers), and the path for perceived benefits was the stronger. For the theory of planned behaviour, however, 4 of the 5 paths were reliable, indicating greater economy and less redundancy than in the health belief model. Subjective norm was the leading predictor of intention. Perceived behavioural control influenced helmet use at time 2 directly as well as indirectly through intention.

Such studies encourage the use of the theory of planned behaviour as a model for understanding health behaviour. Yet Conner and Sparks (1996) point out that the model actually only explains a small amount of variance. They are further critical by stating the theory of planned behaviour is limited because it deals with perceptions of control and not with actual control issues themselves. They also draw attention to the broad social environment that influence people's health and behaviour. They claim the problems of control that people experience in particular contexts needs to be identified. It is highly likely that these problems will represent actual control problems that are beyond the influence of the person and his/her perceptions.

Transtheoretical (stages of change) model

This model was developed by Prochaska and DiClimente (1984). It describes and attempts to explain the different stages of change in the behaviour change process. The model has two basic dimensions which describe the different stages of change and the processes of change relevant to the different stage. The model is based on the notion that behaviour change is a process, not an event and that people have varying levels of motivation. In its most recent version, there are six stages of change. Firstly, precontemplation. This describes the stage in which individuals are not even considering changing behaviour or who are consciously intending not to change. Secondly, contemplation describes the stage at which a person considers making a change to a specific behaviour. Preparation is the next stage in which a person makes a serious

commitment to change. Fourth is the action stage in which behaviour change is initiated. The maintenance stage occurs when the change is sustained. This stage may also be the relapse stage. The sixth stage, termination (or acquisition), represents a stage where individuals have changed their behaviour (Nutbeam and Harris, 1999). The model assumes that individuals cycle through the stages perhaps several times before they achieve successful long-term behaviour change. Nutbeam and Harris (1999) describe this model as ' somewhat optimistic' (p28). It has been used in several health promotion campaigns. Notably a smoking cessation campaign in 2000 in England entitled 'Don't give up giving up' used this model.

This model however has received severe criticism from some psychologists. Bandura (1998) fluently describes the thoughts of some psychologists on the stage theories. He states they are 'undergoing a dignified burial in psychology' (p. 630). He further explains that human functioning is too multifaceted and multidetermined to be shrunk to a few discrete categories. Yet he is aware that many health researchers are still using the stages of change notion as their guiding scheme. He claims that in a genuine stage theory, the stages constitute a fixed sequence that everyone must pass through. However most people do not exhibit a stable progression through the postulated sequence. For example, for smokers who suddenly stop smoking and remain abstinent, there is no progression through the stages. Shift from one descriptive category of intention to another, or from a short duration of behaviour to a longer duration, Bandura notes 'does not make the stage approach a dynamic process model' (p631). Bandura (1998) highlights the fact that the stages of change model simply describes behaviour rather than specify determinants or operative mechanisms. Linking interventions to stages therefore is loose and debatable.

Sykes and Marks (2001) argue along a similar line. They evaluated a smoking cessation programme based on cognitive behaviour therapy and a control based on the stages of change model called 'Stopping Smoking Made Easier' (SSME). At 6-months follow up 21 (17.2%) of 122 participants receiving therapy were abstinent and 14 (11.5%) had reduced cigarette consumption by at least 25% of pre-treatment level. Six (5.6%) of 107 participants in the control group were abstinent and none had reduced consumption.

SSME offers no techniques to implement its advice. It is concluded that simply informing smokers of the smoking cessation process is not enough to base an intervention for cessation. Many smokers are already aware of this process. They know what they should do to stop smoking but they do no have the skills to implement this knowledge. Smokers need more than information; they need the skills and techniques to enable them to control the psychological processes underlying smoking.

Sutton (2000) draws attention to a methodological flaw in stages of change research. He points out that the vast majority of studies investigating stage theories of health behaviour such as the transtheoretical model have used a cross-sectional research design. He argues that linear patterns are not consistent with the stage model assumption that different causal factors are important at the different stages. Sutton (2000) states that researchers who use cross-sectional designs should specify predictions concerning the patterns to be expected under a stage model and under possible rival models, and that data should be interpreted accordingly. He highlights the fact that for stronger inferences to be drawn from this model, researchers should conduct prospective longitudinal and experimental studies. However he recognises the difficulty of such research by starting this recommendation with '(w)herever possible.'

Social learning theory

Nutbeam and Harris (1999) state that the social learning theory is widely considered to be the most complete theory currently applied to health promotion because it addresses the underlying determinants of health behaviour and methods of promoting change. Schwarzer and Fuchs (1996) say that the notion of self-efficacy which forms part of the social learning theory has become so appealing to health psychologists that it has been adopted as part of most health behaviour theories.

Social learning theory is based on an understanding of the interaction which occurs between an individual and his/her environment. This theory was articulated by Bandura in 1977. Bandura believed in the principle of 'reciprocal determinism' which describes the way in which behaviour and environment continuously interact and influence each

other. It is thought that an understanding of this interaction and the way in which modification of social norms can impact on behaviour have an important role to play in health promotion interventions (Nutbeam and Harris, 1999).

Bandura also believed that two cognitive processes were important in behaviour. These are outcome efficacy expectations and self-efficacy expectations. An outcome expectation is a belief that a behaviour will produce a specified effect. Self-efficacy is a belief that in one's ability or competence to perform a behaviour. Self-efficacy beliefs are situation specific and behaviour specific.

Schwarzer and Fuchs (1996) point to a number of convincing studies on adoption of health practices that have measured self-efficacy and shown positive influences in initiating behaviour change. However they state that as well as the construct of self-efficacy, theoretical approaches to the adoption and maintenance of health behaviours 'should include distinct stages of motivation and volition' (p. 186). They assert that "self-efficacy is not the 'magic bullet' to solve all problems that can arise in the prediction and treatment of behavioural change." They note that peer pressure and social support also have potential as resources factors. Yet social influence is not unconfounded by self-efficacy. An individual's resistance self-efficacy influences the degree to which peer pressure makes a difference. One's self-efficacy to build, maintain and mobilise networks also influences social support.

There seems to be a common theme in the criticisms of the psychological theories used in health promotion, mainly that behaviour change concerns more than a focus on the individual. Bunton, Murphy and Bennett (1991) argued that explanations of how individual features of change fit and are maintained or opposed within social structures, sub-cultures and everyday contexts remain underdeveloped. Therefore these theories do not place the individual within the context of his/her wider environment. Bennett and Murphy (1998) stated that those working in health promotion should work with and for individuals and communities. Marks (1996) recommended that health psychologists move away from a scope that is too individualistic. This would be in line with Bandura's

(2000) opinions who believes that effective health promotion may depend upon developing 'collective self-efficacy' by raising public awareness of the implications of policy development and empowering people to become involved in political action which may influence corporate and political agendas.

The above theories represent those pointed out by Nutbeam and Harris (1999) to be the most influential to health promotion practice. However the identification of factors that predict health behaviours is a major focus of health psychology research and other related disciplines that has developed and strengthened in its knowledge. According to Gollwitzer and Oettinggen (2000) the models described above primarily focus on motivational variables. For example, the theory of planned behaviour specifies the motivational determinants of values and expectancies. Health behaviour attitudes are based on beliefs about the likely outcome of these behaviours and the evaluation of these outcomes. Additionally, subjective norms derive from what other people think one should do and the motivations to comply with these norms. An important aspect of this model is the proposal that the listed determinants affect behaviour by the mediation of a behavioural intention. The behavioural intention variable captures the individual's goal to perform the specified behaviour. The strength of the behavioural intention is said to be dependent on the strengths of the motivational variables. The stronger the intention the more effective the translation of the intention into a behaviour. This means that the effective translation of intention into behaviour is a function of the strength of the behavioural intention which is determined by motivational variables. Gollwitzer and Oettinggen (2000) argued that the individual cannot perform over and above the strength of the behavioural intention which means that volitional strategies play no role over and above the individual's motivation. Gollwitzer and Oettinggen (2000) pointed out that usually health behaviours are not highly motivated to begin with (e.g. reducing alcohol consumption or switching from a high fat diet to a low fat) and the respective beliefs are seldom strongly held the perceived incentives are usually low. Moreover when an individual attempts to implement a health goal, they are faced with comprising distractions and temptations (e.g.having to work late instead of going to the gym, social drinking and eating). Therefore Gollwitzer and Oettinggen (2000) pointed out that

strategies are needed that go beyond the strength of a person's intention or goal and thus motivation and relate to how the goal is framed or to volitional skills necessary for effectively translating a given intention into a goal-directed behaviour. They proposed that intentions are more likely to be enacted if they are translated into 'implementation intentions' specifying when and where a particular act is to be undertaken. Gollwitzer and Oettinggen were not the first to talk about the relevance of implementation intentions. For example, Leventhal (1970) found that fear arousing techniques were most likely to influence behaviour when they were accompanied by instructions on how to act. Gollwitzer (1993) showed that those who have formed implementation intentions were better able to recall presented descriptions of the means to carry out an action and were more likely to identify environmental cues relevant to their planned action. He stated that the elaboration of intentions into implementation intentions facilitates the identification of action-relevant context cues which in turn lead to automatic action initiation. The emphasis on automaticity is important. Bargh (1990) proposed that when we repeatedly perform a behaviour in a particular context, the motive and its implementation instructions become part of our representation of that situation. As a result, once we perceive the situation, the overall motive or goal and the means to implement it are automatically triggered in memory. Therefore action is facilitated without conscious decision-making. Therefore in practice it would be better to try to guide individuals to form implementation intentions as part of an automatic process.

Another model that is useful to health promotion is the elaboration likelihood model of persuasion (Petty and Cacioppo, 1986). This model proposed that the extent to which a message induces message relevant thought will affect persuasion. When strong arguments are presented cognitive elaboration will enhance persuasiveness but when the argument is weak, then greater message-relevant thought may decrease persuasiveness. The processing of potentially persuasive messages involves assimilation and evaluation of presented arguments in relation to established knowledge and views. This is most likely to occur when the message content is judged to be personally relevant and when there are few barriers to in-depth processing such as when the message is easy to understand and there is time to consider it, without distraction. When a message is not

relevant or difficult to process, it may be evaluated in terms of other features such as the attractiveness or expertise of the person presenting the argument. This type of processing may lead to a type of persuasion in which recipients take the source's word for it. However this type of persuasion is less likely to be long term or withstand future contradictions. Eagly and Chaiken (1993) suggested that fear arousal could discourage systematic processing and could sensitise recipients to heuristic cues. Thus poor arguments could be made more persuasive and strong arguments could be reduced (as cited by Abraham, Norman and Conner, 2000).

The lesson for health promotion is that it should seek to present logical statements that emphasise the positive outcomes of health-related behaviours in a way which focuses on goals which are important to the intended audience. Messages from others with whom the targeted audience identify, who below to the same group or are valued by the targeted group may be more persuasive. Messages also need to attract attention, be easily understood and remembered. Ley (1988) noted that simplification, categorisation of message components, stressing important components, repetition and use of specific illustrations can enhance comprehension and retention of messages.

The above research as well as many other theories and sources can all influence health promotion practice. Theories that explain health behaviours change by focusing on the individual have been criticised. It has been pointed out human behaviour is too multifaceted and multidetermined to fit into a few categories (e.g. Bandura 2000). They have also been criticised for relying on self-report measures. Yet Abraham and Sheeran (2000) highlighted that reviews suggest that self-report measures based on social cognition models do reliably distinguish between those who do and do not undertake a range of health behaviours. They also claimed that interventions based on social cognition models have been shown to be more effective than interventions without such theoretical foundations. They stated that social cognition models appear to offer a theoretical, evidence-based foundation for health promotion activities.

Yet surprisingly Abraham, Norman and Conner (2000) pointed out that there have been few interventions based on these models. They highlighted some of the practical difficulties of designing interventions based on such models and described the strengths and weaknesses of changing cognitions to promote behaviour change. They see a need to develop more theoretically integrated models of behaviour change and test such theories with controlled experimental work to allow attribution of effects to particular treatments and show that effects can be explained by predicted changes in mediating cognition. Yet one has to wonder if this really is the way forward as we have seen such models explain a small percentage of variance in behaviour change and experimental work on such models is often impractical and false in context. Even if a theoretically integrated model of behaviour change were developed and tested that accounted for a higher percentage of variance in behaviour change, pragmatic and cost-effectiveness issues would still have to be dealt with. Appropriate methods to evaluate it would have to be found. Abraham, Norman and Conner (2000) touched on an alternative approach by ending their chapter with a few lines highlighting that Bandura's (2000) opinion would mean a community-development role for health psychologists. However they concluded that '(p)ublic support may be essential to securing appropriate levels of investment in applying psychological theory to the development of behaviour change interventions and ensuring the growth of evidence-based health promotion. (p362).' Bennett (2000), on the other hand, argued that despite a great deal of financial and research commitment, the evidence he reviewed has not shown even some of the most sophisticated health promotion programmes to be effective in facilitating appropriate behavioural change and stated that there is a need for health promotion to develop its methods and the issues in which it is concerned.

Aims of thesis

The above gives a glimpse into the lack of a consensus in one discipline that informs health promotion. This thesis offers insight into the current climate of health promotion by looking at the EC's Health Promotion Programme. On the one hand there is a climate of evidence-based practice where there is a great emphasis on evaluation. On the other hand, new approaches to health promotion emphasise the importance of community

development. This study had two phases. In phase 1, a case study of a health promotion process evaluation conducted for the European Commission will be presented (Chapters 2-5). In phase 2, I explore some critiques of health promotion and analyse the discourses used in the EC's Health Promotion Work Programme (Chapter 7). The aim of the study is to analyse current modes of thinking about health promotion and to highlight how health promotion evaluation works in practice and how discourses might influence the practice of health promotion.

Chapter 2

Background to the evaluation of the 'Programme of Community Action on Health Promotion, Information, Education and Training 1996-2000'.

Chapters 2 to 5 describe Phase 1 of the empirical study. This chapter gives a background to the evaluation and preparation of the methodology of the EC's Health Promotion Programme. It puts the rationale for the evaluation and the reflections into context. The following chapters present the methodology, findings and a discussion, before moving to an in-depth analysis of the discourse of the EC Programme in Chapter 6.

Evaluation of the 'Programme of Community Action on Health Promotion, Information, Education and Training 1996-2000.'

In addition to the policies concerning the environmental and socio-economic conditions necessary to ensure individual and collective health, the European Community has introduced a series of health protection measures and policies such as the 'Community Action Programme on Health Promotion, Information, Education and Training' (the Health Promotion Programme). This was established within the framework for action in the field of public health (1996 to 2000) by a decision of the European Parliament and the Council of the European Union on 29 March 1996 (Decision No 645/96/EC).

When drawing up its proposal for a health promotion programme, the Commission adopted a number of principles and concepts (European Commission, 1997):

The health of an individual or group is determined by three groups of factors:

(1) environmental factors and socio-economic conditions;

(2) genetic factors, expressed as anatomical and physiological characteristics;

(3) behavioural factors for which the individual is responsible (diet, alcohol, smoking, physical exercise, drugs etc) influenced by society, culture, education, training and information

The European Commission adopted the principle that health promotion should focus on health rather than illness. The Commission believes that the main objective of health promotion programme to promote health should be the development and encouragement of a health promotion approach in the Member States' and Community's health policies. The programme proposed five areas of action:

(1) Health information

The programme aims to help improve understanding of the mechanisms for devising messages and assessing health information measures, by encouraging exchanges of information, skills and experience. Additionally the programme aims to play a role in promoting the exchange of information and documentation between reference centres at national level and between those responsible for public health and health promotion policies.

(2) Health education

The European Commission (1997) states that '(h)ealth education is the cornerstone of health promotion policy. It is through education that the individual can move from simple awareness of a risk to a realization of what the risk means in terms of health and ultimately, to the adoption of a responsible and positive behaviour and lifestyle.'

(3) Vocational training in public health and health promotion

The Programme aims to develop and adapt training of the various types of players involved in health promotion. An understanding of what is available in public health and health promotion training at the Community level is to be sought.

(4) Specific prevention and health promotion measures

This area of action is aimed at vulnerable groups such as the poor, the socially excluded, communities of immigrants and the elderly.

(5) Health promotion structures and strategies

The Programme aims to encourage exchanges of experience and evaluation of the results of health promotion policies throughout the Member States in the hope of developing joint strategies.

The framework for monitoring and evaluation of the Health Promotion Programme is defined by Article 7 of Decision No 645/96/EC that states:

"*1.The Commission, taking into account the reports drawn up by the Member States and with the participation, where necessary, of independent experts, shall ensure that an evaluation is made of the actions undertaken*

In November 1998, after a successful tender, Middlesex University Health Research Centre, being completely independent from the Programme signed a contract with the Commission to undertake the evaluation. A report by Marks, Sykes, McGurk and Von Volkamer (1999) was presented to the Commission's services. Following editing, the report was forwarded by the European Commission to the European Parliament, the Council, the Economic and Social Committee and the Committee of the Regions.

Procedures for the selection of projects

A document prepared by the Commission's services stated the project will be funded that met the following criteria:

1. The project must relate to one or more measures of the priorities set in the annual work programme.
2. The project must produce real added value for the European Community.
3. Applications must indicate clearly the project's objectives and the needs which the project meets, and must describe in detail the activities envisaged, the results anticipated, and the research approach and working methods for achieving the project's objectives.
4. The project must include appropriate arrangements for the evaluation, dissemination and exploitation of the results, including information concerning the support from the European Commission.

Preparing the methodology for the evaluation

A timeframe of six months was allocated to phase 1 of the evaluation which was concerned primarily with the first year of the Programme (1996) when 52 projects were supported. MacDonald and Davies (1998) pointed out that health promotion has suffered by being too ambitious in terms of the demands it puts upon itself to evaluate outcomes. They state that the traditional biomedical approach to evaluation has recently received a lot of criticism and that there is an emerging consensus that an over concentration on outcomes and quantitative

data is outmoded and an inappropriate way to measure the effectiveness of health promotion programmes and interventions. They suggest that there is a need to adopt an approach to evaluation that implicitly acknowledges the need for outcome evaluation but explicitly concentrates on process data that help us understand the relationship between the social and structural influences that determine health. This view is also shared by Nutbeam (1998) who pointed out that the link between health promotion action and eventual health outcomes is usually complex and difficult to trace. Nutbeam (1999) argued that research methods must reflect this complexity and use different sources of data for evaluation, both quantitative and qualitative. In addition to the recognition of qualitative data in health promotion evaluation, Everitt and Hardiker (1997) stated that there is also a need to look at multiple perspectives. Nutbeam (1999) gave examples of the different perspectives and emphasis on what represents 'success' for a health promotion programme. For policy makers and budget managers, success is often defined in terms of the relationship between investment and the achievement of health outcomes in the short-term. For health promotion practitioners, success can be defined in terms of the practicality of implementation of a programme and the possibilities of engaging people and organisations in action for health. For the population who are to benefit from health promotion action, relevance to perceived needs and opportunities for community participation may define success. For academic researchers, success is more likely to be defined in terms of methodological rigour, maintenance of programme integrity and achievement of pre-determined outcomes.

This evaluation of the Health Promotion Programme concentrated on process. It was carried out from the multiple perspectives of the Commission's services, committee members of the Health Promotion Programme, project leaders, unsuccessful applicants, and an independent European health promotion expert panel. Various sources of documentation were analysed both qualitatively and quantitatively.

Evidence-based Health Promotion

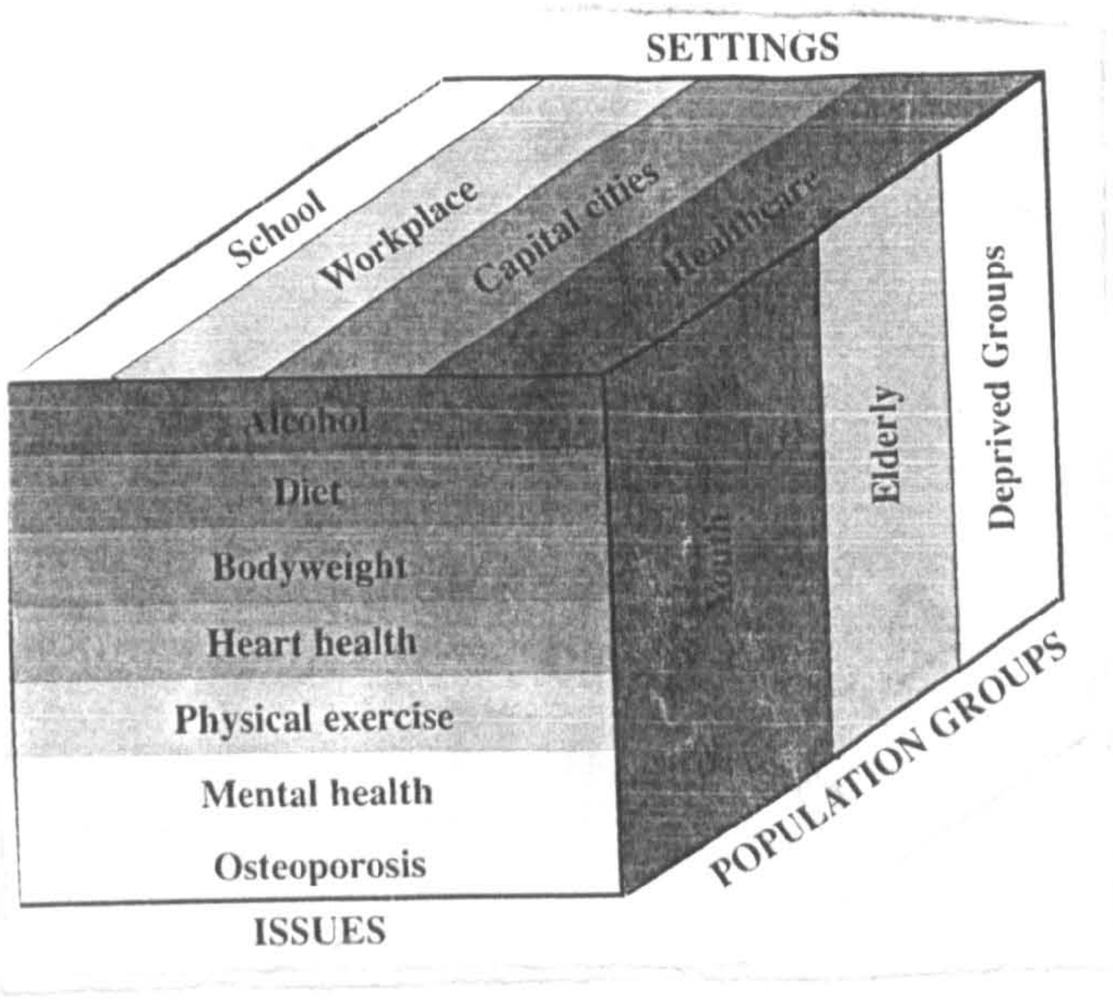
Health care systems today place an emphasis on 'quality', 'quality-control', 'consumer satisfaction' and 'cost-effectiveness'. The culture of 'evidence based policy' is also extending to public health. In Britain, there is a national framework called 'clinical governance' through which National Health Service (NHS) organisations are accountable for continuously improving the quality and clinical effectiveness of their services. 'Putting evidence into

practice' is the key buzz word. Evaluation with an emphasis on randomised controlled trials is the means by which a practice becomes 'evidence-based'. The NHS Plan (Department of Health, 2000) intends to produce clear guidance on the best treatment and interventions and evidence-based practise is an important part of this plan.

Within the current economic and political climate, there has been a pressure for health promotion to 'borrow' this medical paradigm (Judd, Frankish and Moulton 2001). In terms of evidence-based health promotion in England, the Health Development Agency (HAD) commissions reviews and evaluations of health promotion, disseminates guidelines and promotes implementation. As well as supporting the national implementation of the NHS plan, the HAD also aims to support the implementation of the New Labour government's health strategy for England *Saving Lives: Our Healthier Nation* (Department of Health, 1999). HAD Evidence Base, the internet resource to aid implementation of this aim, states unequivocally that it provides 'access to the best available information on what works to improve health and reduce health inequalities'. Likewise the EC's Health Promotion Work Programme stresses that projects must focus on models of 'good practice' and 'best practice' through evaluation.

An evaluation report of the previous health promoting strategy for England, *Health of the Nation*, recommended among other things that a new health strategy should address the underlying determinants of health and inequalities and use a matrix model as shown in figure 1 (Department of Health, 1998). This was in fact not used in *Saving Lives: Our Healthier Nation*. However it was used in the EC's 'Programme of Community Action on Health Promotion, Information, Education and Training, 1996-2000.' This matrix is considered to have many advantages as it enables consideration of both disease and population-based models of health (Department of Health, 1998). The matrix emerged in part from a perception of an over-reliance on individualistic methods.

Figure 1: Health Promotion Matrix of Issues, Population Groups and Settings.



Macintyre et al (2001) reported their experience of trying to use evidence to inform health policy. Their experience led them to ask whether researchers, government ministers and civil servants are truly committed to developing and using the best evidence. Macintyre et al (2001) formed part of an evaluation group to assist the independent inquiry into inequalities in health. They had 'to examine the quality of the evidence underpinning the scientific advisory group's emerging recommendations and to identify any gaps' (p322). They designed a rigorous methodology to carry out this work including a matrix for evaluating policy proposals. However they were unable to use the matrix due a lack of available information. They were disappointed to see that there was little empirical evidence about the effectiveness of strategies for reducing health inequalities. In fact they stated that many of the submissions to the inquiry consisted of wish lists of potentially useful interventions without evidence of their effectiveness in practice. The evidence for effectiveness that did exist was based on individual interventions and not community interventions thus reflecting a gap in such evaluations. Macintyre et al (2001) conclude that civil servants and politicians need to be aware that in many fields there are no unequivocal answers to "what works?" This question focuses on outcome evaluation. It has been argued that health promotion needs new indicators of success and that outcome evaluation is often not appropriate (e.g. Macdonald, 2000). The following study is a process evaluation that was conducted to inform health promotion policy-makers in the European Commission. The results are presented along with reflections on involvement in this type of evaluation.

Chapter 3

Evaluation of the 'Programme of Community Action on Health Promotion, Information, Education and Training 1996-2000': Methodology

Aims

The aims of the evaluation were as follows:

- To examine the effectiveness and efficiency of the Community Programme of Action on Health Promotion, Information, Education and Training (1996-2000) with a view to:

  - helping to improve the implementation of the Programme, and provide a basis for decisions on future measures.

  - identifying the "Community added value" of the Programme in comparison to the situation that would obtain if this Programme did not exist

  - developing a methodology for the evaluation which is rigorous, fair, valid, reliable, independent and impartial

The four sources of information that could be employed were:

(i) The Commission's services' database of records on grants made, selection procedures, projects supported and not supported;
(ii) Responses supplied by applicants (unsuccessful and successful) to a questionnaire;
(iii) Opinions of independent experts of the quality of the projects in relation to the aims which they set for themselves;
(iv) Reports from the Member States

Commission Services' Records and Procedures

Between 1996-2000, the European Parliament issued 5 yearly Work Programmes. These were published in the *Official Journal of the European Communities*. It is the role of the European Commission to ensure the Work Programmes are carried out. The Commission services are in charge of the administration and an allocated budget, in this case, 35 million ECU over 5 years.

This part of the evaluation included projects accepted and refused in 1996, 1997, and 1998. Members of the Evaluation Team visited the offices of DGV/F/3 of the Commission's services in the Euroforum Building, Luxembourg. All records concerning project applications received in the period 1995-1998 and other relevant background documentation were obtained.

Applicants' Reports

Questionnaires were sent to 50 project leaders of supported projects in 1996 (two of the fifty-two projects funded in 1996 were not carried out). Thirty-two were completed and returned, achieving a response rate of 64 per cent.

Out of the total number of 306 unsuccessful projects, a sample of 70 was selected, whereby it was aimed to keep the number of questionnaires sent to a particular country proportional to the number of applications made by that country. Only 66 questionnaires were delivered successfully (problems with fax, wrong address). However, only twenty-one replies were received, giving a response rate of 31%.

Opinions of an independent European health promotion expert panel

Recruitment of panel members

A Panel of Independent Experts was recruited from across the 15 Member States and 3 EEA/EFTA countries (Iceland, Norway, and Liechtenstein). Notices seeking independent and qualified expert assessors were posted early in December 1998 to European subscribers of *Health Promotion International* and to other qualified personnel.

A list of specialist assessors were drawn up who met the following criteria:

- scientific experience and reputation;
- expertise relevant to the health promotion programme;
- independence, honesty and integrity as assessed by independent referees' reports;
- linguistic competence.

Of crucial importance was independence. According to the terms of the evaluation contract, expert evaluators must not, within the past 5 years, have been in a decision making or advisory role in relation to the Programme; neither they nor their employer must have benefited within the same period either directly or indirectly from a grant issued from the Programme; experts were required to withdraw from submitting in his/her name or as an applicant or as a partner an application within the Programme for a period of two years commencing at the end of his/her duties.

<u>Selection and training of panel members</u>

There was a two-stage process:

Stage 1: Preliminary selection was based on information concerning the applicants' technical, scientific and linguistic expertise including their personal statements, curriculum vitae, and referees' reports. Before attending a training workshop, applicants were asked to sign a declaration of independence as defined by the paragraph above

Stage 2: Final selection was dependent upon satisfactory performance at a training workshop in which applicants were briefed and assessed using a mock evaluation exercise.

<u>Project Assessment by the Panel</u>

The assessment of the projects consisted of quality measures reflecting the objectives and content of the projects subsidised by the Programme. Each assessor was sent a complete set of information in a batch of 1-10 projects. Project information consisted of:

- the initial description of the project

- the final report submitted after completion of the project, including the evaluation submitted by the recipient (if applicable), and (if available) a summary sheet submitted by the recipient

Assessors were sent only those projects that fell within their range of technical/scientific and linguistic expertise. Each assessor used a standard set of criteria and rating scales, which was as follows:

1. relevance of project objectives to the aims of the Programme
2. feasibility of project objectives
3. appropriateness of the amount of funding requested
4. appropriateness of the amount awarded
5. achievement of project objectives
6. relevance of project content to the project objectives
7. is the project methodology the most appropriate for the project's purposes?
8. is the analysis appropriate for the type of information collected?
9. are the conclusions and/or recommendations appropriate?
10. the quality of the evaluation employed within the project, e.g. any measured outcomes?
11. quality of dissemination: are the lessons learned disseminated promptly and to the right audiences?
12. the overall quality of final project report
13. the overall contribution of project to the programme
14. the "Community added value" of the project

There were no defined agreement of the definitions of the above criteria. Each of these fourteen attributes were rated by the assessor on a five-point rating scale as follows:

5	excellent
4	good
3	satisfactory

2 poor

1 very poor

In addition to their quantitative ratings, assessors also submitted a brief (1-2 page) analysis of each project that was analysed qualitatively. Two or more panel members evaluated 29 of the 49 projects carried out in 1996 (one of the final reports for the 50 completed projects was not available). Larger scale projects valued at 200,000 EURO or more were assessed by three or more panel members. Seventeen projects were evaluated by two panel members, eight by three members, three by four members, and one by five members. The remaining 20 projects were evaluated by a single panel member.

Reports from the Member States

Article 7 of Decision No 645/96/EC states that the Commission must take account of reports of the representatives of the Member States in the evaluation of the actions undertaken in the Programme (European Commission, 1996). These representatives formed part of the Health Promotion Programme's Committee along with representatives from the Commission services. According to the evaluation procedure (Article 5.2.d of Decision No 645/96/EC) Member States are required to produce reports, if necessary using a common framework and based on information transmitted in accordance with article 5.4 of Decision No 645/96/EC concerning:

- their prevention policy, including performance indicators if possible;

- links developed between Community policies and national policies in the course of the actions undertaken (co-operation between Member States, co-ordination of national policies, exchanges of experience and information between Member States).

Following consultation with the Evaluation Steering Group, Unit F/3 of DGV and the Evaluation Team, a questionnaire was devised that enabled a reporting exercise

that was short and focused. The questionnaire aimed to assess the impact and implementation of the Health Promotion Programme in the Member States.

To facilitate the acquisition of the maximum amount of relevant information without preconceptions as to the range of possible answers, all questions were open-ended. It contained two parts: Part A was concerned with the European added value of the Programme, Part B was concerned with the operational aspects of the Programme.

Responses were received from all 15 Member States and from two EEA countries, Iceland and Norway. The results were analysed in both quantitative and qualitative form. Replies were classified into the following categories: "Positive Reply"; "Negative Reply"; "Not Mentioned"; and "Other". Two members of the Evaluation Team carried out this process in a series of iterations. In parallel with the classification procedure, the two evaluators identified themes in the Member States' extended replies to each question. Once themes had been identified, the content of all replies was analysed and tabulated.

Additions to the Scope of the Methodology of the Evaluation

At a second meeting of the Health Promotion Evaluation Steering Group held on 11 May 1999, a request was made to extend the scope of the evaluation by adding brief case studies of three networks supported by the Programme. The Head of the Evaluation Team agreed.

Chapter 4

Evaluation of the 'Programme of Community Action on Health Promotion, Information, Education and Training 1996-2000': Results

This chapter looks at some of the results that were presented to the Commission services along with recommendations for future Health Promotion Work programmes. The results have not been coded in any way as there are no confidentiality issues at stake. All data shown here have been made public.

The Commission services' records

The Evaluation Team examined various factors that were thought to have potential relevance to whether an application was accepted or rejected. An example of this would be number of partner Member States. As one of the overall aims of the Programme was to increase collaboration between European Member States one would expect that projects involving several Member States would be judged more favourably than those only involving one or two Member States. Another example is Member State of origin: certain Member States may have a higher proportion of projects accepted than other Member States.

Using a copy of the Commission Service's database and the annual Programme reports, a variety of statistical analyses were conducted to investigate the decision procedures and funding allocations over the first four years of the Programme, 1996-9. Table 1 shows the project applications on the database by year of the Programme and whether the applications were accepted or refused. The information for 1999 was incomplete, as not all funding decisions had been made by the time the information needed to be analysed. The data suggest that the overall acceptance rate remained approximately constant at 16-18%.

Table 1 Acceptances rates during each year of the Programme

Year of Programme	Number Accepted	Proportion Accepted	Number Refused	Proportion Refused	Number where no indication	Proportion where no indication	Total
1996	52	18%	246	82%	0	0%	298
1997	35	18%	164	82%	0	0%	199
1998	34	17%	166	83%	0	0%	200
1999	21	16%	96	75%	11	9%	128

Table 2 shows that data concerning the number of Member States that the projects proposed to involve. This analysis divided projects into 15 categories, ranging from 1 to 15 Member States. However, because of small numbers of projects with 8 to 14 partners, a single category was constructed which encompassed projects with 8-14 Member States. The effect of number of Member States on acceptance rate was found to be significant ($\chi 2=269.75$, DF=8, $p<0.01$). The greater the number of Member States participating in a project, the greater the chance of acceptance:

- Projects that involved all 15 Member States had a 59% chance
- Those involving 8-14 Member States had a 17% chance
- Those involving 3-7 Member States had a 7% chance
- Those with two Member States had a 5% chance
- Those with only one Member State had a 0% chance

Table 2: Acceptance Rates by Number of Member States

Number of Member States*	Accepted *	Proportion Accepted	Refused	Proportion Refused	TOTAL
1	0	0%	27	100%	27
2	8	5%	165	95%	173
3	5	3%	171	97%	176
4	13	8%	145	92%	158
5	6	7%	84	93%	90
6	7	10%	64	90%	71
7	4	9%	40	91%	44
8	6		23		29
9	1		14		15
10	0		9		9
11	5	17%	3	83%	8
12	0		6		6
13	0		4		4
14	1		4		5
15	82	59%	58	41%	140
Totals	138		817		955

* For 19 projects this information was missing from the database and for 33 projects information regarding acceptance /refusal was missing

Table 3 shows the Member States and EEA countries from which applications were submitted, along with their success rates. For the purposes of analyses the following countries were omitted because of the small number of projects: Iceland, Luxembourg and Norway. A significant difference in acceptance rates was evident for applications submitted from different countries ($\chi 2=180.167$, DF=14, $p<0.01$). Acceptance rates for applications from Spain, Greece and Italy were particularly low: 2%, 4% and 1% respectively. The remaining Member States' acceptance rates ranged between 10% (Austria) and 26% (Sweden and Belgium). Applications that were

submitted from European-wide organisations stood out as having the highest acceptance rate (89%).

There are a number of possible reasons why applications from some countries did not do as well others. One reason could be that some Member States might have submitted many applications that were unsuitable for the Programme because they did not meet the published criteria (e.g. they did not involve a minimum of two partners). One of the principal aims of the Programme was to increase collaboration between European Member States. Therefore projects which did not propose many Member States were less suitable for the Programme. One way of evaluating this was to use the number of proposed partner Member States as an indicator of "Programme suitability", and to compare applications from different countries.

Table 3: Acceptance Rates for Each Member State/EEA Country

Member State*	Number Accepted	Proportion Accepted	Number Refused	Proportion Refused	Total
Austria	3	11%	25	89%	28
Belgium	19	26%	55	74%	74
Denmark	3	14%	18	86%	21
Finland	8	24%	25	76%	33
France	21	19%	93	81%	114
Germany	16	15%	88	85%	104
Greece	3	4%	73	96%	76
Iceland	0	0%	1	100%	1
Ireland	5	22%	18	78%	23
Italy	2	1%	135	99%	137
Luxembourg	1	14%	6	86%	7
Netherlands	6	17%	29	83%	35
Norway	1	100%	0	0%	1
Portugal	3	10%	26	90%	29
Spain	2	2%	101	98%	103
Sweden	8	26%	23	74%	31
UK	16	13%	104	87%	120
Pan European	25	89%	3	11%	28

* For 9 projects this information was missing

** For 33 projects this information was missing

Applications from each State were categorised according to the number of partners: 0-6, 7-14, or 15 Member States. In addition to the countries that were omitted from the previous analyses the following were also omitted because of small numbers in each category: Austria, Denmark, Finland, Ireland, Netherlands, Portugal and Sweden.

Table 4 shows that there was a significant difference between Member States in the number of partners proposed in their applications ($\chi 2=95.608$, DF=12, $p<0.01$). Greece, Italy and Spain had the greatest proportion of projects in the 0-6 category (93%, 94% and 93% respectively). They also had the least proportion of projects in the 15 Member States category (4%, 3% and 2% respectively). Belgium, France, Germany and the UK, on the other hand, had the greatest proportions of projects in the 15 Member States category. This analysis could help to explain why the majority of applications from some counties were not accepted for support from the Programme.

Table 4: Number of Member States Proposed in Applications from Seven Member States

	0-6 Member States	Proportion 0-6 MS	7-14 Member States	Proportion 7-14 MS	15 Member States	Proportion 15 MS	Total
Belgium	41	57%	8	11%	23	32%	72
France	81	71%	20	18%	13	11%	114
Germany	86	81%	6	6%	14	13%	106
Greece	70	93%	2	3%	3	4%	75
Italy	134	94%	4	3%	4	3%	142
Spain	98	93%	5	5%	2	2%	105
UK	84	70%	16	13%	21	17%	121

Each project on the Commission Services' database is categorised in a domain [Health Promotion Strategies and Structures (A), Specific Prevention and Health Promotion Measures (B), Health Information (C), Health Education (D), Vocational Training in Public Health and Health Promotion (E), Out of Programme (O), Unspecified (U)].

The highest number of applications was received in area (B)'Specific Prevention and Health Promotion Measures'. The areas which received the least number of applications across the four years were (A)'Health Promotion Strategies and Structures' and (E)'Vocational Training in Public Health and Health Promotion'. Both these areas stress the importance of exchanges of experience and information at a community level. Thus they would contribute to increasing the community-added value of the Programme.

Projects were categorised according to how much funding was requested as follows:-

- below 24,999 EUROS
- 25,000 – 74,999 EUROS
- 75,000 – 124,999 EUROS
- 125,000 EUROS and above.

There was no significant difference in the acceptance rates between applications requesting different levels of funding ($\chi 2=4.005$, DF=3, p=0.262).

This begs the question why did Greece, Italy and Spain have greater numbers proposals with a low number of partners in their application. It could be that these countries have the least amount of exchanges with other countries. If this is the case, then these exchanges need to be encouraged. It could also be related to the fact that the official languages for the call for and submissions of proposals are in English, French and German. This could represent a language bias. This is an example of needing more in-depth evaluation to make sense of the quantitative findings.

Applicants' Reports

The project leaders' responses are given in Tables 5 and 6. It can be seen that the majority of funded project leaders reported that they were content with the administrative arrangements while the non-funded project leaders were considerably less content. It is difficult to interpret these findings. It could be that the Commission services paid more attention to funded projects. Although the interviewer noted that the project leaders that had received funding seemed more guarded with their answers. One person asked if responses were anonymous as they were applying for repeated funding.

Table 5: Project Leaders' Responses – Funded Projects (1996)

QUESTIONS ↓		ANSWERS →	NO		YES		N.A.	
			N	%	N	%	N	%
(i)	Were arrangements for the provision of information on the progress of your application and its outcome clearly explained and properly followed?	4	12.5	28	87.5	-	-
(ii)	Were arrangements for any necessary changes to the project (reduced funding, time of delivery of reports, etc.) clearly explained and properly followed?	3	9.4	26	81.2	3	9.4
(iii)	Were applications processed efficiently and in good time?	5	15.5	26	81.2	1	3.3
(iv)	Did funds reach you in good time?	8	25.0	24	75.0	-	-
(v)	Did Commission services provide effective and efficient administration of the project after it started?	4	12.5	22	68.8	6	18.8

Table 6: Project Leaders' Responses – Unsuccessful Projects (1996)

Questions ↓		**Answers** →	**NO**		**YES**		**N.A.**	
			N	%	N	%	N	%
(i)	Were arrangements for the provision of information on the progress of your application and its outcome clearly explained and properly followed?		15	71.4	6	28.6	-	-
(ii)	Were arrangements for any necessary changes to the project (reduced funding, time of delivery of reports, etc.) clearly explained and properly followed?		19	90.5	2	9.5	-	-
(iii)	Were applications processed efficiently and in good time?		11	52.4	9	42.9	1	4.7

Opinions of an independent European health promotion expert panel

Inter-expert agreement

The inter-expert agreement in the experts' use of the rating scale was evaluated for the 29 projects that had been assessed by more than one expert. In total there were 71 pairs of rating-sets obtained from two or more experts for these 29 projects. Each rating-set contained 14 ratings along the five-point scale. The level of agreement for each pair of rating-sets was assessed by counting the number of times the two experts agreed, disagreed by 1 rating scale point, disagreed by 2 points, disagreed by 3 points, disagreed by 4 points, or disagreed conceptually about whether or not a rating could be given for the 14 criteria rated in each set. The results are shown in Table 7. The maximum and minimum possible levels of agreement are 14 and 0 respectively. The results suggest that on average the experts agreed exactly for 3.83 of the 14 criteria and disagreed by 1 point for another 4.56 of the 14 criteria. On average therefore, a pair of experts agreed within one scale point of each other on an average of 8.39 of the 14 criteria. In fact there was agreement within one scale point on at least 9 of the 14 criteria on 50% of occasions.

Although this level of agreement is not perfect, it suggests that the experts were using the rating scale in a reasonably consistent manner.

Table 7: Average Levels of Agreement between Experts Assessing the Same Project

Level of agreement	Agree	Disagree by 1 point	Disagree by 2 points	Disagree by 3 points	Disagree By 4 points	Conceptual Disagree-ment
Average (Max = 14)	3.83	4.56	2.31	0.25	0.13	2.65

Average ratings for areas and projects

The average ratings (averaged across the 14 scales) for projects implemented in each priority were as follows:

Health Promotion Strategies and Structures (A) :	3.27
Specific Prevention and Health Promotion Measures (B):	3.38
Health Information (C):	3.50
Health Education (D):	3.26
Vocational Training in Public Health and Health Promotion (E):	3.00

Table 8: Distribution of Average Ratings along the Five-point Scale of the 49 Projects(5-Excellent; 4-Good; 3-Satisfactory; 2-Poor; 1-Very poor)

< 2.5	2.50-2.99	3.0-3.49	3.50-3.99	> 4.0
6 projects	6 projects	15 projects	16 projects	6 projects

Table 8 shows that only 6 of the 49 projects (12.2%) received an average between 'Good' and 'Excellent', 16 projects (33.2%) received an average more than halfway between 'Satisfactory' and 'Good', and another 15 projects received an average above 'Satisfactory'. In sum, nearly a

quarter of the projects were rated less than satisfactory. The majority of the projects were rated satisfactory to good. The average score for achievement of project objectives was 3.05 (satisfactory). These ratings seem disappointing given that 35 million ECUS were available for this Programmme; projects were supposed to have been evaluated by a health promotion panel of experts in the European Union and the projects were carried out by some leading health promotion experts in the EU. Results from the representatives of Members States reveal possible explanations for these poor ratings.

Community Added Value

Of particular interest and relevance to this Programme was Community Added Value (CAV). This refers to how much co-operation between Member States took place and how far this co-operation added value to health promotion in the Community. If the Programme has been implemented in the manner intended, then there should be a positive relationship between the EC funding that was allocated to a project in the Programme, the number of Member States participating, and the project's Community added value. The average ratings of CAV for each domain of activity were as follows:

Health Promotion Strategies and Structures (A)	3.50
Specific Prevention and Health Promotion Measures (B):	3.66
Health Information (C):	4.00
Health Education (D):	3.24
Vocational Training in Public Health and Health Promotion (E):	2.83

Areas A, B, C and D gained ratings between 'Satisfactory' and 'Good'. Area E received an average score slightly below 'Satisfactory'. The area with the highest score (C) scored significantly more highly than the area with the lowest score (E) ($p = .0139$). The differences between other domains were not statistically significant.

Support for the effectiveness of the Programme was evident from a multiple regression analysis. The CAV ratings of projects could be predicted from the EC funding received and numbers of countries participating ($R = .444$; R squared = .197; $p = .007$). This analysis modestly suggest

that the Health Promotion Programme is being effectively implemented in terms of CAV. This is despite the areas that could have potentially contributed to CAV received least funding (A and E). However the results are not simple to interpret and the evidence is not overwhelming. The most important predictor of high CAV appears to be the number of partners, not level of funding. To illustrate this situation, projects receiving the lowest and highest ratings for CAV could be compared.

Eight projects scored 4.5 or above on CAV. Eight projects scored 2 on CAV. Four high CAV projects cost at least 188,000 EURO and the other four cost only 8,000-62,000 EURO each. The eight low CAV projects cost a maximum of 110,000 EURO. This analysis suggests that high expenditure on a project is no guarantee of high CAV. The strongest predictor of CAV can be seen to be the number of Member States participating in the project. All but one of the 8 high CAV projects involved all 15 Member States compared to only one in the low CAV group. This could be taken as projects warranting the most serious consideration in terms of CAV are those that involved all 15 Member States. However, it could also reflect the way ratings were carried out by the expert assessors. They could have attributed a high score for CAV simply if projects had more Member States partners. However it is difficult to know what amount of exchanges took place between the partners. This is highlighted in the qualitative comments (table 9). Forty three percentage of projects were considered as not having enough information such as who attended meetings.

Qualitative Comments

Table 9: Themes in experts' comments

Themes	% of projects
Positive comments about the project e.g. it was necessary, interesting, attracted public awareness, made a useful contribution	50
Problems with the final report Incomplete, inconsistent with application, missing documents, unclear presentation, problems with analysis	33
Lack of evaluation / follow up	27
Not enough information presented, e.g. on selection of participants, people attending meetings, what was actually done and why, on outcomes, dissemination	43
Conclusions too general / unsubstantiated / no clear recommendations	16
Queries about the project design (including appropriateness of methodology, whether design was the most cost effective)	37
Difficult to evaluate e.g. because information was missing or not reported, objectives poorly stated, complexity of project	24
Negative comments about objectives e.g. too ambitious, no concrete objectives, no evaluation intended, inconsistencies	29
Questionable whether the project has added to existing knowledge / whether it has promoted health	27
Positive remarks about final report e.g clearly presented, addresses evaluation	29
All or some of the objectives were not met	20
Questioning about the funding awarded	24
Project was relevant to programme	24
Positive comments about objectives e.g. clearly stated, realistic, attained	22
Doubts about relevance to programme / work was already done before the contract	16
Positive comments about the way the project was managed, including the financial aspects of the project	14
Good project design	16
Not enough information on funding provided / inconsistencies in the information provided	14
Concerns about the use and management of finances	16
Duplication of efforts e.g. something similar has already been done	14
Lack of use of existing information/using outdated information	10
Problems with the application form e.g. doesn't give enough information, inconsistencies, poor quality of proposal	10
Good quality of products from project	10
Questioning the appropriateness/ relevant experience of the people involved	10
Negative comments about the way the project was managed	8
The parties involved were appropriate	6
Poor quality of the products from the project e.g. limited to only one language, unattractive	6

There were 97 independent evaluations in total for the 49 projects in the set, each with comments ranging from a couple of lines to two pages. These comments have been analysed into themes (Table 9). It can be seen from Table 9 that twenty-four projects (almost 50%) received positive comments from 28 assessors. Many other comments related to problems with final reports. This category was broken down into four sections in order to give a better indication of where the problems were. In 28 comments the assessors remarked that there was not enough information in the final report, e.g. about dissemination and selection of participants. In 15 comments there were remarks relating to lack of evaluation or follow-up. It is not always clear whether these activities occurred, but were not adequately documented, or whether they did not occur at all. In 11 comments the assessors observed that the conclusions were either too general, not supported by the data, or that there were no clear recommendations. The 25 remaining comments concerned more general problems such as the report being unclear or inconsistent. There were also some comments about poor data analysis or lack of analysis in this category. Not all comments about the final report were negative. There were 15 instances of positive remarks where the assessors thought the reports was well presented, clear, or addressed relevant issues such as evaluation. However most of the positive comments were in the opening paragraph. This could reflect a style of reviewing in which it is felt that a review should start with a positive comment.

Assessors remarked that it was questionable whether 13 of the projects had contributed to existing knowledge or had promoted health. Some of the projects that appear in this category also appear in the category pertaining to problems with the methodology or design of the project. There were 23 comments in this latter category, which included comments where the assessor questioned whether the project design was the most cost-effective way of achieving the desired results. However nine assessors stated that 8 projects had a good design. Only five of the forty-nine projects were rated as having good products. Three were rated as having poor products.

There was a mixture of positive and negative comments about the way in which the project had been managed. Ten assessors were impressed with the management of the project, including the financial aspects. However four assessors gave negative comments about the way the project appeared to have been managed.

In 5 cases the assessors felt that the people carrying out the project were not the most appropriate, or lacked necessary experience. Another area of concern was that some projects showed a lack of use of existing information, or use of out-dated information. There were seven comments of this nature. More seriously, in a further seven cases the assessors thought that the project had duplicated work that had already been done. Thus implying that project leaders had received funding for not doing any extra work, just presenting old work in a new format.

Another group of comments related to the projects' proposal and objectives. Assessors remarked that there were problems with the application form in 5 projects. There were negative comments about the objectives of 14 projects. These included remarks such as the objectives were too ambitious, or too vague. On 13 projects the assessor remarked that the objectives had not been met. However there were also 11 positive comments about the project objectives, such as they were clear or that they had been achieved.

Assessors questioned the relevance of the project to the programme for 8 projects. There was concern with the use and management of the finances for 8 projects. It was felt that not enough information on finances was presented or that there were inconsistencies in the information presented for 7 projects.

Twelve projects were considered difficult to evaluate. There were a variety of reasons for this. Many were preventable, such as missing information or the poor quality of the final report.

The opinions of the expert assessors show that the Health Promotion Programme has produced some good work. However they have also shown that many areas of improvement and monitoring are needed. In such a large Programme it is expected that some projects will not be entirely satisfactory. However this should be a very small minority of projects. Paying for work from public funds that has already been carried out is not acceptable at all. Systems in the monitoring of proposals need to be improved and high penalties should be enforced if it is found that this is the case.

Report from the Member States and EEA Countries

Part A: The impact of the Programme (see tables 10-11)

Thirteen Member States and Iceland stated that the Programme had an impact on the development of health promotion in their countries. Eight Member States and Iceland stated that the Programme has contributed in one way or another to national health promotion policy or developments (A, D, DK, EL, IC, IRL, FIN, P, S). Only three countries (DK, NO, UK) stated that the Programme had not had any impact on the development of health promotion in their countries. Two of these three (UK and NO) stated that their national health promotion policies were already well founded. Two of the three countries (DK and NO) that stated that the Programme did not have an impact on their national health promotion policies, however, did mention some positive impact in particular health promoting settings such as schools and workplaces

The most impact was reported to be in settings, with fourteen countries reporting that there had been an impact. Promoting health in settings intends to work at the community level rather than the individual level. This is supported by other comments throughout different parts of the questionnaire. Nine Member States (A, B, E, D, DK, IRL, L, NL, P), Iceland and Norway mentioned the European health promotion networks in a positive light (The European Network of Health Promoting Agencies (ENHPA) has worked closely with the Health Promotion Committee). In addition to these eleven countries, two other Member States (Greece and Finland) mentioned the transnational collaboration that has resulted from the Programme and two others (France and UK) stated that particular projects had or may have had a positive impact in their countries. Thus, a total of fifteen Member States and countries reported at least some added value from the Programme (albeit minimal in one case).

Greece, Germany and Italy stated that it is too early or too difficult to assess the impact of the Programme at the present time. France commented on the difficulties of establishing networks and the lack of dissemination of the Programme. This latter point was also mentioned by Sweden who also referred to linguistic problems between professionals and lay people, and the different structures and circumstances of the Member States. Six

countries mentioned that interventions had an impact. Germany implied that there is a lack of evaluated interventions. France also raised the issue of the lack of evaluation of projects. Also, in a preamble to the questionnaire response, France stated that institutionalised health promotion in the future should use well-thought out methodologies.

Despite a lack of information and evaluation, Member States reported a positive impact of the Programme. However only four reported any new developments that had taken place as a result of the Programme. Five more were aware of new developments in specific areas. Seven Member States gave a positive reply concerning, the usefulness of the occurred developments. Two Member States reported that the Programme has extended an interest in health promotion to actors in the field of health. France commented that strategies are needed for identifying and implementing pertinent models of health promotion and also to improve dissemination.

Table 10. Qualitative Feedback from Reports from Member States and EEA countries, Part A –

Has the Health Promotion Programme to date had an impact on the development of health promotion in your country?

	Positive Reply	**Negative Reply**	**Not mentioned**	**Other**
REPLY	A, B,E, EL, D, F, FIN, I, IC, IRL, L, NL, S, P	DK, NO,UK		
Policy	A, E, EL, I, IC, IRL, P,S	DK, F, NL	B, L, UK	D, FIN, NO
Practice	A, E, F, FIN, IC, IRL,NL	DK	B, L, P, UK	D, EL, I, NO, S
Interventions	F, FIN, IC, IRL, NL, S	D, DK	A, B, E, L, NO,UK	EL, I, P
Settings	A, B, D, DK, EL, L, F, FIN, IC, IRL, NL, NO, P, S		E, UK	I
THEMES IN EXTENDED REPLIES				
Informed national health promotion/ new policy or developments …… National policy already well formed	A, D, IRL, FIN, P …….. F, FIN, NL, NO, S,UK			
Legitimised/ recognised health promotion /interventions	A, D, IC, IRL			
Useful exchanges have taken place	E, IRL, NO			
Benefited from/interest in/networks …… Difficulties in establishing networks	A, B, E, D, DK, IC, IRL, L, NL, NO, P …… F			
Lack of dissemination	F, S			
Positive mention of particular	E, EL, DK, F, FIN,L, NL, NO			

projects			
Difficult to assess the impact	EL, D, I		
Linguistic problems (professionals v lay people)	S		
Facilitated/prompted transnational collaboration..... ..... Different structures and circumstances between Member States	A, EL, FIN, NL ..... S		
Positive impact on schools and/or workplaces and/or the community	B, EL, IC, IRL, FIN, NL, P,S		

Key: A=Austria, B=Belgium, E=Spain, EL=Greece, D=Germany, F=France, Fin=Finland, I=Italy, IC= Iceland, IRL= Ireland, Lux=Luxembourg, NL=Holland, S=Sweden, P=Portugal, NO=Norway, UK= United Kingdon, DK=Denmark

Table 11: Qualitative Feedback from Reports from Member States and EEA countries, Part A .

Have new developments taken place as a result of the Community Health Promotion Action Programme?
If so, please indicate what type of developments have occurred and in what way
-public policies, (national, local) - campaigns, (involvement of government, academic institutions, NGOs, at national or local levels)
- creation of new institutions (governmental, academic, NGOs)
-Would you describe any of the occurred developments as useful/not useful - in what way?

	Positive Reply	Negative Reply	**Not Mentioned**	**Other**
REPLY				
2a) New Developments?	FIN, L, NL, S	B, D, F, IRL,UK	A, DK, IC, NO	E, EL, I, P
- public policies	EL, IC, FIN, S	B, DK, F, NL, UK	A, D, E, I, IRL, L, NO, P	
- campaigns	E, EL, IC, L, NL, NO, S	B, D, DK, F, FIN,UK	A, I, IRL, P	
- new institutions	A, S	B, D, DK, IC, F, FIN, NL,UK	E, EL, I, IRL, L, NO, P	
2b) Useful?	A, E, IC, FIN, NL, P, S	B	D, EL, F, I, IRL, L, NO, UK	DK
THEMES IN EXTENDED REPLIES				
Strategies for **identifying** and implementing pertinent models are needed/ Lack of dissemination	F			
Contributed to/strengthened new projects/policies/national health promotion	DK, EL, IC, S			
Cannot assess/intangible	EL, I			
Transnational collaboration hasoccurred	NL			
(Continuity of) networks is/are important	A, IRL, NL			
Particular projects have/may have had an influence	E, L, NO,UK			
The Programme has extended an interest in health promotion to actors in the field of health	L, S			

Part B: The operational aspects of the Programme (see tables 12-17)

The application forms were criticised in a number of respects by eleven countries (B, D, DK, E, F, FIN, IC, NO, NL, P, S). The administrative and budgetary section of the form was said to be too complicated and detailed by three Member States but not detailed enough by three others. Three Member States suggested that the consent for partner collaborators is not clearly verified and maybe of a token nature. This casts doubt on the true meaning of CAV presented earlier. It seems to support the assumption that expert assessors used the amount of partners as a measure of CAV. Iceland and Norway both pointed out that the Programme is incorrect is stating that the EEA countries have to be omitted from the procedures. They stated they have a legal right to participate in the Programme. Germany stated that the application forms needed to be more reader friendly. Sweden stated that the time between the deadline for application and signing of the contract is too long. France mentioned linguistic problems and the Netherlands stated that there are many complaints of changing administrative rules.

Twelve countries gave a negative reply to the question concerning whether the applications for funding were provided to the Committee in a timely and efficient manner. Ten countries suggested that there is a lack of transparency in the Committee procedures and that the Committee lacks any real ability to influence decision making. Five countries stated that the Committee needs more information for making decisions. Denmark suggested that the discussion for allocation of funding hearing phase of the Committee is too short. Spain stated that criteria were applied inconsistently and that some projects were unrecognisable from the summaries produced by Commission Services. The Netherlands saw the need for a monitoring system but did not give details of how this should work. Norway stated that it does not have the same information as the EU countries. Ireland said that there was a danger of raising expectations of the Programme's potential. However three Member States reported that there has been a recent improvement in the Committee procedures.

Nine countries agreed that the range of activities set out in the Decision correspond with the range of activities actually accepted for funding. However only six countries believed that the projects selected would contribute the most to the objectives of the Programme. Four countries stated that funding intended for the horizontal Health Promotion Programme had been allocated to projects relating to a specific disease category (Alzheimer's Disease and Related Disorders) despite opposition from the Committee. Denmark also noted that some projects fitted the Programme exactly, which raised the question whether some projects were decided before the Programme was agreed. Denmark also said that there were some dominating projects with no impressive results and they made up a large part of the budget. The Netherlands stated that much of the funding is ad hoc. Germany stated that small, irrelevant projects without any real-added European value were funded at the beginning of the Programme. Four Member States mentioned the importance of networks in adding European value or in aiding dialogue between the Member States and the Commission. Spain commented on the exclusive use of English limiting the dissemination of information. Germany felt that it was too early to judge whether the Programme has contributed to European citizens health. France commented that evaluation of projects was needed to make this judgement. Overall the majority of countries (eleven) had a negative view of the role of the Committee in the execution of the Programme in the current decision-making arrangements, many feeling lack of control in decision-making.

The impression given by the reports of the Member States and EEA countries is that the Programme is having a limited impact on the national policies of many Member States. However the Committee felt there are some positive aspects. In particular, the European Health Promotion Networks are attracting interest among the Member States.

The operational aspects of the Programme gained considerable amounts of criticism from the Member States. The majority of national representatives on the Health Promotion Committee believe that there has been a lack of transparency in Commission Services' decision making procedures, that the expertise of Committee Members has not been fully utilised, and that the Committee has had too little influence on the process of project

selection. This could explain some of the disappointing ratings for the funded projects. A few Member States reported that improvements have recently occurred. However there are good reasons for believing that the committee procedures are not working well.

Table 12. Qualitative Feedback from Reports from Member States and EEA countries, Part B –

*1 **Are application forms clearly and concisely written; comprehensible, demanding the necessary information for the process of selection and evaluation?***

	Positive Reply	Negative Reply	Not Mentioned	Other
MEMBER STATE/COUNTRY	A, B, DK, EL, IC	E, P	UK	D, F, FIN, I, IRL, L, NL, NO, S
THEMES IN EXTENDED REPLIES				
The application forms need to be more reader friendly e.g. a coversheet containing all important information would be useful	D			
The Committee does not have access to applications/enough information/ lack of transparency	FIN, I, P, S			
The administrative and budgetary section of the form (Part 1) is too detailed/complicated/ time consuming/rigid..... The budget/ information requested is not sufficient	FIN, NL, S ..... DK, E, P			
Résumé too succinct	F			
More precise instructions are needed	B			
Incorrect information concerning EEA countries/EEA countries are left out of the procedures	IC, NO			
Many complaints of changing administrative rules	NL			
Consent from partner collaborators is not clear/verified	DK, F			
Time between deadline for application and signing of the contract is too long	S			
Linguistic problems	F			

Table 13. Qualitative Feedback from Reports from Member States and EEA countries, Part B –

2) ***Is the information concerning applications for funding provided to the Programme Committee in a timely and efficient manner so that appropriate decisions can be made?***

	Positive Reply	**Negative Reply**	**Not Mentioned**	**Other**
MEMBER STATE/COUNTRY	EL, F	A, B, D, DK,E, FIN, IC, L, NO, P, S,UK		I, IRL, NL
THEMES IN EXTENDED REPLIES				
The hearing phase is too short	DK			
Inconsistent application of criteria	E			
Unrecognisable summaries	E			
More information is needed for making decisions	A,E, FIN, IC, NL			
Lack of influence in decision making/ Commission can not take on board issues raised by Committee/ A more open system is needed showing the Committee how decisions have been made	A, D, E, IRL, FIN, NO,UK			
A monitoring system is needed	NL			
Token participation of some Member States in applications	IRL			
Norway does not have the same information as the EU countries	NO			
Danger of raising expectations of the Programme's potential	IRL			
Recent improvement in procedures	D, E, S			

Table 14. Qualitative Feedback from Reports from Member States and EEA countries, Part B –

3) Does the range of activities set out in the Decision correspond with the range of activities actually being accepted for funding?

	Positive Reply	**Negative Reply**	**Not Mentioned**	**Other**
MEMBER STATE/COUNTRY	A, B, E, EL, FIN, IC, IRL, L, P	D, F, NL, NO	I, UK	DK, S
THEMES IN EXTENDED REPLIES				
Small, irrelevant projects without any real-added European value were funded at the beginning of the Programme	D			
Lack of transparency	F, NL			
Lack of information to judge this question	F, NL, S			
HP budget been allocated to specific diseases (Alzheimer's)/ projects despite some Member States being opposed. These allocations cannot be questioned.	DK, NO			
There are some dominating projects with no impressive results and they take up a large part of the budget.	DK			

Table 15. Qualitative Feedback from Reports from Member States and EEA countries, Part B –

4) Are the projects selected those that will contribute the most to the objectives of the programme?

	Positive Reply	**Negative Reply**	**Not Mentio ned**	**Other**
MEMBER STATE/COUNTRY	B, DK, EL, FIN, NO, P	D, IC, NL,UK		A, E, F,I, IRL, L,S
THEMES IN EXTENDED REPLIES				
Encouragement of strategic initiatives, follow-up projects, local projects, laws on health promotion, campaigns, interventions dissemination and evaluation are needed	D,L,S			
Some projects fit the Programme exactly which raises the question whether these projects were decided upon beforehand.	DK			
Evaluation of the projects is needed to make this judgement	F			
Much of the funding is ad hoc	NL			
Difficult to answer/Not enough information	A,E, F, I, NL			
Vertical illness specific projects/Alzheimer's funding against the objectives of the Programme/and not decided by the Committee	D, DK, IC			
There is a variation between projects	IRL			
The exclusive use of English limits the dissemination of information	E			
The importance of networks/projects with European value in contributing to the Programme, especially in the future	D, NL, NO			
Too early to judge whether the Programme has contributed to the European citizens' health	D			
Importance of a European health policy in future	D			

Table 16. Qualitative Feedback from Reports from Member States and EEA countries, Part B –

5) ***Are the views of the Member States effectively obtained and considered at the appropriate stages in the management of the Programme?***

	Positive Reply	**Negative Reply**	**Not Mentioned**	**Other**
MEMBER STATE/COUNTRY	EL, FIN	B, D, DK, F, IC, IRL, S, P, UK	I	A, E, L, NL, NO
THEMES IN EXTENDED REPLIES				
Minimal ability to influence the Commission's decision/decisions are made without debate/The MS views/expertise are not considered to the full	B, D, DK, IC, IRL, P, S			
Transparency of the decision making for funded projects was not evident and makes things difficult	D, F, UK			
Establishing institutions with no long term sustainability	S			
Initial management and internal communication problems were evident	D			
The special committees are effective in considering the MS views e.g. setting up the work programme	A, DK, L			
Lack of time for views to be considered	DK			
Integration problems	NO			
Limited/late communication	A, F			
In future the mandate given to the pilot networks should be debated by the Committee	F			
Networks have aided dialogue between the MS and the Commission	A			

Table 17. Qualitative Feedback from Reports from Member States and EEA countries, Part B –

6) Overall, is the role of the Programme committee in the execution of the programmes effective, efficient and productive?

	Positive Reply	Negative Reply	Not Mentioned	Other
MEMBER STATE/COUNTRY	EL	D, FIN, IC, IRL, NL, UK		A, B, DK, E, F, I, L, NO, S, P
THEMES IN EXTENDED REPLIES				
Better use of the Committee's expertise is needed	A, E, NO, S			
The Programme committee 's role is largely restricted to co-planning of annual Work Programme	D, P			
Recent improvements are evident	F, S			
It is not efficient/necessary/information is late/there are time restrictions	A, DK, IC			
The Commission's work has been hindered by lack of resources but has made progress all the same	IRL			
Transparency /more discussion /debate /information needed to establish priorities and/or improvements in project evaluation	IRL, F, NL, FIN, P			
As effective as it can be given its size and differing national agendas	EL			
There is concern about approval for funding out of the Programme	UK			
Difficult to answer	I			
The Committee is not in a position to assure a correct carrying out of the Programme	F			
Bureaucracy hinders the Programme	S			

European Health Promotion Networks

An increasing amount of funding has been dedicated to projects that, directly or indirectly, contribute to the development of new policy. One of the primary tools for developing health promotion policies has been the establishment of partnerships in the form of European networks, putting together expertise and knowledge from the Member States into new organisations. Networks are groups of organisations across all Member States, and beyond, who pool experiences and exchange information with a view to developing policies and agreeing models of good practice for health promotion throughout the European Union. To date, seven networks have been established within the Programme:

Broadcasting Health Network
European Network of Health Promoting Agencies (ENHPA)
European Network of Health Promoting Schools (ENHPS)
Network of health Enhancing Physical Activity (HEPA)
Megapoles – Public Health Network for Capital Cities/Regions
European Network of Mental Health Promotion (ENMHP)
European Network of Workplace Health Promotion

It is unlikely that these networks would have existed to anything like the same extent without the support of the Community Action Programme. Because of the pivotal importance of these networks to the objectives of the Programme, it was decided to study their characteristics in more detail. However due to practical and time restraints the analysis is rather cursory. Two networks were selected for preliminary study by two members of the evaluation team:

Broadcasting Health Network
European Network of Health Promoting Agencies (ENHPA)

Broadcasting Health Network

<u>Aims, Objectives, Budget, and Co-ordination</u>

The aims of this network are:

- To open up a dialogue at a national and European level between broadcasters and health promoters in each European member state and Norway
- To compare current practice in health promotion using radio and TV across Europe
- To discuss methodologies in health promotion connecting to broadcasting
- To develop an effective code of good practice to ensure that joint public health promotion and broadcasting expertise can be disseminated across Europe and implemented at local, regional, national and international level
- To improve the quality and effectiveness of health messages across Europe

The objectives of the network are:

- To develop and expand a network of partners, both health promoters and broadcasters, across the EU and Norway
- To exchange experience and expertise from their respective fields and countries
- To explore what viewers and listeners want and need from health promotion on radio and television
- To create a map of existing health promotion broadcasting throughout the EU and Norway
- To devise and carry out enhanced broadcast health projects with partners from all MSs and Norway, following an agreed common framework
- To monitor and evaluate the broadcast health projects
- To investigate behavioural change associated with these projects
- To analyses the evaluation of the broadcast health projects to determine the most effective methods of combining health promotion and broadcasting
- To devise and publish guidelines for good practice
- To disseminate the findings and guidelines for good practice to broadcasters and health promoters throughout Europe, including future members of the EU.

The co-ordinators of the project were Broadcasting Support Services (BSS), an independent charity, and the BBC. The Broadcasting Health project began in June 1997 and consisted of a preliminary phase from September 1997 until October 1998 with a budget of 1,801,468 EURO of which 739,048 EURO (approximately £492,500) was awarded by the EC. Each 'country co-ordinator' received a fee of 4,800 EURO for helping to recruit the other partner, publicise the

network, and liaise with the co-ordinating team. Partners were also reimbursed for their travel and subsistence when attending meetings.

Network Activities

The activities of the network to date have consisted of the following:

- meetings - three meetings of partners held in Brussels, Seville, and Brussels., working group meetings in Padova, Stockholm and Vienna, meetings for the "Common Framework" in London and Luxembourg, a research meeting in February 1998

- recruiting and liaison
- producing written materials – conference papers, reports, website, leaflet
- research – a map from Thames Valley University and agenda setting from the Research Practice
- dissemination – meetings and newsletter articles
- administration

Research Findings

Mapping

A study was commissioned by Broadcasting Health "to map current ideas and practices in relation to health promotion and broadcasting." The researchers reported their findings in October 1998. These findings were summarised by Broadcasting Health as follows:

- *Media influences people, knowledge and behaviour, but doesn't bring about behavioural change on its own*
- *Media is event-orientated, not issue-orientated*
- *Health promotion is focused on non-tangible events, or events which may or may not occur in the future*
- *Different criteria for success: audience figures vs evidence of behavioural change*
- *Single message campaigns less effective than those backed by comprehensive package of measures*

- *Health programming across Europe tends to be at peak viewing times*
- *'Health' issues occur in a whole range of factual and fictional programming*
- *Health promoters are dissatisfied with media as lacking social responsibility – too often sensationalise a subject*
- *Evaluation vital for health promoters but not part of broadcaster's remit*
- *Range of programmes across Europe very diverse – scheduling, format, frequency*
- *Range of processes in links between health promoters and broadcasters*
- *Broadcasting is changing rapidly offering new opportunities and challenges to health promoters*

A criticism of this report is that it draws upon limited evidence to make its conclusion. For example, the first statement concerning the inability of the media to bring about behaviour change "on its own" must be questioned in the light of the marketing efforts of industry in both print and broadcasting media. There was no mention of research that views advertising as existing purely because of its proven ability to increase sales, a salient form of behaviour change (e.g. Dibb, 1993). There are many examples of human behaviours that have been changed or affected purely by the content of broadcasting on its own, both inside and outside of the health domain. Copycat killings, school massacres, anxiety in patients in cancer screening programmes, food and meat scares are all vivid examples. In a news item in *Health Matters*, Daniele Lowy, said, "When important health issues are covered you can't just leave people high and dry" (p3). This follows research published in the *British Medical Journal* reporting a 17% rise in attempted overdoses in the week after BBC's *Casualty* showed an attempted suicide by using paracetamol (Hawton, Simkin, Deeks, O'Connor, Keen, Altman, Philo, Bulstrode, 1999). Recently, the Food Standards Agency has commissioned research to look into the promotional activities carried out by the food industry and how they are linked to children's eating habits. This follows concern by the European Commission about the marketing tactics to sell unhealthy foods to children (Revill, 2002).

However, research focusing on using the media to change unhealthy behaviours seems to show limited success (e.g. Flay, 1987; Lau, Kane, Berry, Ware & Roy, 1980; Owen, Bauman, Oldenbueg & Brian, 1995; Romer & Hornik, 1992). It would have been interesting if the report

looked at the circumstances in which behaviour can be influenced by the media and compared research from the commercial sector with research from the field of health promotion.

Agenda Setting and Audience Research

The Phase 1 Final Report of Broadcasting Health states that: "Despite being planned and discussed since the outset of the project the research had to be carried out in a rush in the end of phase 1." An organisation, The Research Practice, ran some focus groups in September and October 1998. Four group discussions were held in each of the 16 countries. The groups consisted of 8 people who were either male or female, and aged either 20-35 or 40-60, but all from the lower socio-economic grades (C2, D, E). All participants considered themselves to be regular viewers of TV and regular listeners to radio.

The stated objectives of the study were: to understand what 'health' means to people; to explore respondents' understandings of actions which can be taken to promote health and the causes of health problems; to discuss the health matters which concern respondents of different types (i.e. different age/lifestyle, sex, etc); to examine the place of 'health' in their hierarchy of personal concerns; to explore the ways respondents acquire health information and elicit views on the credibility of each source of information; to investigate respondents' perceptions, needs and wants from health broadcasting.

The findings resulting from the group discussions can be illustrated by some quotations:

"Health means different things to different people, but demographically similar groups think the same right across Europe."

"There were great differences between the sexes

Women:

generally well informed but still didn't take action.

Men:

don't feel health is relevant until they become older

don't feel well served by the media –schedule, content, presentation

aren't well informed or motivated to take action..."

"TV was seen as:
a source of entertainment, can turn it off
central to households and prompts discussion
a means of breaking taboos and create social environment where sensitive matters can be discussed
vivid, dramatic, enormous emotional power..."

"Radio was seen as something that was:
Listened to whilst doing something else
Less emotive, have to use your imagination..."

The report of the findings is to evaluate. Also it has been written without any reference to the huge and relevant literature on health promotion and health psychology.

Conclusions

This project was ambitious and expensive (739,048 EURO). It attempted to link two professions together and also to form a European-wide network. The idea could have potential but it is felt that this potential has yet to be achieved. Exchanges of experience occurred at the most basic level, but there was no attempt to identify best practice and, to date, no transfer of best practice seems to have occurred. The European added value was minimal. It seemed that the research had been conducted in a hurried manner. The findings tell us little that is new. If a network concerned with broadcasting and health is to continue, it needs a new approach that shows consultation of various sources of information and a tangible outcome that show more than expenditure on administration, travel and subsistence.

European Network of Health Promoting Agencies (ENHPA)

Background

The Regional Office for Europe of the International Union for Health Promotion and Education (IUH-PE/EURO) began the co-ordination and facilitation of a European Network of Health

Promotion Agencies (ENHPA) in 1996. The European Network of Health Promotion Agencies was officially established during the first business meeting of the project in Helsinki by the key agencies for health promotion in the EU Member States. In 1997 national agencies from Norway and Iceland also joined the network. In order to develop a full picture of the ENHPA, the work of the Liaison Office (a sub-project of the ENHPA) needs to be examined.

Aims, Objectives, Membership, Structure and Management

Aim: 'The members of the European Network of Health Promotion Agencies commit themselves to joint actions to improve the quality and to increase the capacity of health promotion in Europe.'

Objectives:

1. Facilitation of the exchange of information on experiences and models of good practice with respect to health promotion in Europe;
2. Improvement of the profile of health promotion among key decision makers in Europe as a valuable instrument in health policies;
3. Improvement of the conditions for the effective operation of health promotion in Europe across settings, population groups and health problems;
4. Improvement of co-operation between professionals, organisations and networks in health promotion, both nationally and internationally.

The Liaison Office has its own objectives in supporting the ENHPA.

The core of the European Network of Health Promotion Agencies consists of all national health promotion agencies - or the closest equivalent of such an agency in countries where they do not exist - in all EU-Member States. Some of the representatives of the national agencies participated in the Health Promotion Programme Evaluation Steering Committee. Each country participating in the ENHPA has a National Co-ordinator who is responsible for management, co-ordination and the day-to-day development of the network at country level.

Information Exchange

There is a website for the ENHPA. It works very well and the layout is easy to follow. This website provides a substantial amount of information and a dedication to the field of European health promotion is evident. It includes a database of the multilingual thesaurus that is easy to use; ENHPA recommendations that are clear and coherent and useful information for potential applicants for funding from the Health Promotion Programme. An email discussion group is linked to the website. The Liaison Office sends information on up to date health issues to all ENHPA members via this email discussion group. This was judged to be a good usage of electronic communications technology.

ENHPA NEWS, a quarterly bulletin, is sent to the ENHPA members and all those directly or indirectly involved in the ENHPA, a total of 55 people. Some members request additional copies to disseminate in their own country. EURONEWS, one of the activities of IUHPE/EURO, contains information about ENHPA. This is a quarterly journal that is sent to all 400 members. The Liaison Office has published an article in 'Eurohealth' in 1998 about the network – (objective 1).

ENHPA Technical Secretariat

The tasks of the Technical Secretariat consist of the following: co-ordination of the network including organising meetings; a clearing-house function, providing a help-desk for network members in order to assist their search for information on health promotion activities in Europe; the management of various sub-projects; publication of EuroNEWS; development and management of the ENHPA website and updating a database of individuals and organisations working in the field of health promotion in Europe - (objective 4). In 1996, the ENHPA was estimated to cost 519,945 EURO. An expert assessor evaluated the "Follow-up project European network of health promotion institutes". It received an average score of 4.00 (= "Good"). On the whole, the comments were positive. There were some concerns about the lack of dissemination reported outside the network and lack of evaluation. The assessor also felt that no new knowledge had emerged from the sub-projects.

Liaison Office

The Liaison Office was created to meet the needs of providing information to ENHPA members on health issues at the European level and to raise the profile of health promotion within the European Institutions. The office was established in 1997 in Brussels. The Health Education Authority in London manages the two Liaison Officers.

The Liaison Office is very active in networking with policy makers and health-related organisations and participation in health related meetings and networks. For example, the Liaison Officers attended all of the sessions of the Environment, Health and Consumer Affairs Committee in the European Parliament as well as other committees discussing issues relevant to health. Desk research was carried out in order to identify the different Directorates General within the European Commission which may be directly or indirectly related to health. This publication could be useful for many health professionals apart from the ENHPA members themselves. A portable exhibition called 'Closing the health gap' has been put together by the Liaison Office. This was to assist ENHPA members to raise the profile of health promotion at a European level in the Member States, Norway and Iceland. The 'Closing the health gap' exhibition was also exhibited to launch and introduce the ENHPA to Members of the European Parliament, the European Commission, the Council of Ministers and the wider NGO community in Brussels – (justification for objective 2).

The Liaison Office was judged by the evaluation team to be fulfilling an important role. It potentially could have a useful role in promoting health in Europe. This project cost 598,198 EURO. The Liaison Office is based at the same address as the European Public Health Alliance in order to exchange information and avoid duplication. Such sharing of facilities could be developed for all of the networks supported by the Health Promotion Programme and could lead to significant savings in expenditure.

Multilingual Thesaurus

This is another sub-project in which the ENHPA has been involved. The evaluation team were sent the 'Deutsch, ENGLISH, Français, Nederlands' version of the thesaurus by the ENHPA secretariat. It is professionally presented and appears to be a very useful tool for health

promotion professionals working in Europe. However there were no records to indicate how much this part of the project cost. Nor is it known to whom it was disseminated. This is a product that could be useful for all future applicants to the Health Promotion Programme. It is a useful reference that could be given to translators working on new projects. However there have been no efforts made to evaluate its usefulness.

A project entitled "The contribution of Southern European countries in the elaboration of a European multilingual thesaurus for health promotion and education" was evaluated by two expert assessors. One gave this project an average rating of 4.25 (more than "Good") while the second gave it an average rating of 3.66 (between "Satisfactory" and "Good"). The latter assessor pointed out that the Portuguese 'translation wasn't carried out with the rigour that is required in a work for consultation and explanation purposes.' The assessor highlighted many incorrect or inaccurate translations and printing mistakes.

Socio-Economically Disadvantaged Groups

The network has produced four interesting reports on this subject: "An overview of the causes of the socio-economic disparity in health"; "An overview of the health status of European migrants"; "Health promotion amongst low-income groups: a review of forty interventions"; and "Review of policies for socio-economically groups". A final report was produced with several recommendations. It was not reported to whom these reports were disseminated. This could potentially prove useful (especially if translated) to health professionals in Europe (justification for objective 3). However no steps to evaluate this work were taken. Neither is there any information showing how the forty interventions were chosen, the review criteria and who reviewed the interventions.

Conclusion

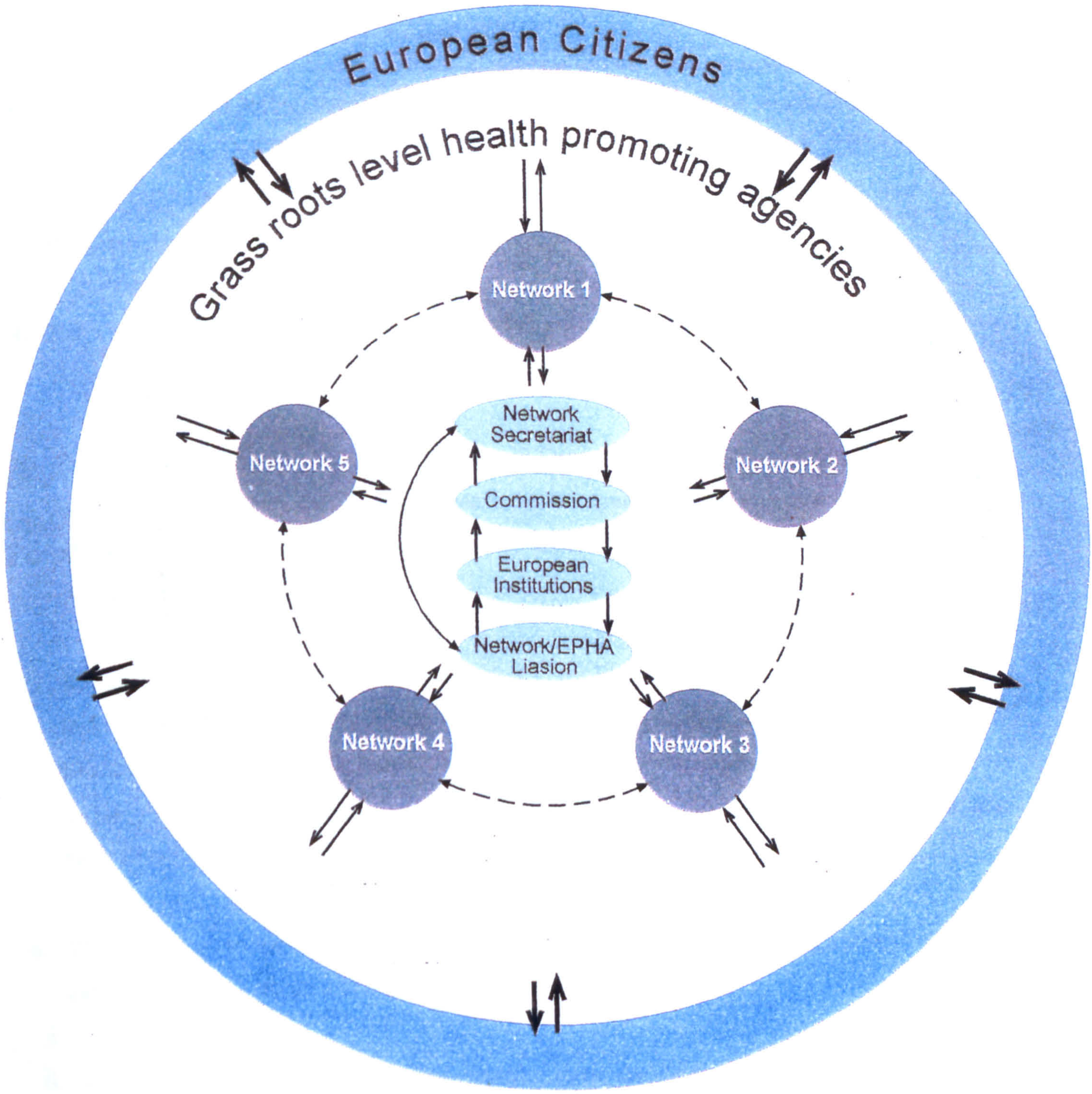
On the surface, it appears from the well-presented glossy documentation and descriptions of how objectives have been met, that the ENHPA is being managed in an efficient and professional manner and that the network is meeting its objectives to a large degree. The Evaluation Team formed the opinion that, once the multilingual thesaurus has been corrected and piloted, it should prove to be a good product for improving the conditions for effective operations of health promotion in Europe. However no systematic efforts have been put in place to evaluate the aims

of this project and disseminate findings. The documentation seems to have remained in a small circle of people in the ENHPA and produced for the benefit of the European Commission services (i.e. to show an outcome and justification of the funding). It is unclear to what extent new knowledge or facts have been found.

Conclusion

The networks are ambitious and expensive operations at a relatively early stage of development. There is little evidence that all the funding for these networks is having any impact on the European citizens. A lot of money seems to be spent on administration rather than action. European added value, in terms of exchange of information, seems to be developing but more needs to be done to produce tangible outcomes in the form of exchanges of good practice. The networks need to develop ways of working more closely with each other. A shared infrastructure in the form of common coordinating and liaison offices could bring major increases in efficiency and effectiveness. A possible new structure for the future organisation of the networks is illustrated in Figure 2. In this proposed new structure, the networks include a common infrastructure with a single liaison office and coordination centre. The proposed new structure would aim to strengthen the links between the centre (the European institutions and networks) and health promoting organisations at the level of citizens. If the full value of health promotion networks is to be obtained, there needs to be a strategy for shared resources, evaluation, dissemination and participation beyond the level of project teams.

Figure 2. Proposed Organisation of European Health Promotion Networks



Recommendations

The following recommendations were presented to the European Commission services:

1. The Commission's Unit DGV/F/3 should strive to increase the transparency of its decision-making procedures and the timeliness of its communications to the Health Promotion Committee.

2. The allocation of funding across the priority areas of the Programme should be more evenly distributed across the five domains. Implementation of the Programme should be accelerated in area (D) Health Education and (E) Vocational Training in Public Health and Health Promotion.

3. Extra efforts should to be made to increase the participation of Member States in Southern Europe.

4. The evaluation suggests that good levels of European added value are already evident. However efforts should be made to increase the European added value of the Programme by all available means. The guidelines should be clarified with respect to the activities regarded as having Community added value.

5. The guidelines should be revised to state that: " (a) Projects with all 15 Member States will receive highest priority; (b) Under normal circumstances, projects with fewer than eight Member States will not be considered for funding; however, pilot projects investigating transfer of specific, innovative methods to other Member States will be supported if they have fewer than eight participants."

6. The guidelines should specify that applicants will be required to demonstrate the following aspects of project design and implementation:

i. A sound methodology

ii. In the case of quantitative studies, sample sizes should be representative of the target population, large enough to yield meaningful results, and matched across Member States for age, sex, socio-economic status

iii. Analyses of the results should be appropriate to the information collected

iv. Evaluation should be carried out

v. Dissemination of the findings should be arranged

vi. Evidence of genuine collaboration between Member States must be demonstrated

The guidelines should provide a clear set of instructions on the expected structure and word length of the interim and final reports.

7. Part One of the application form should contain a section that requires specification of the parts of the budget to be allocated to evaluation and dissemination. Part Two of the form should be revised and expanded to include specific half-page sections for descriptions of the design, methodology, participants, analysis, evaluation and dissemination of projects.

8. Evaluation and dissemination of projects should be significantly improved. Evaluation and dissemination activities must be included in applicants' description of tasks and written into contracts. If a project evaluation has not been conducted and/or if sufficient efforts to disseminate the results have not been demonstrated, the final payment to the contractor should be withheld.

9. The administrative officers in Unit DGV/F/3 should aim at a high level of consistency in the acceptance rates of applications.

10. The quality and completeness of the information on the database needs to be radically improved so that the Unit staff and Programme evaluators can obtain information that is accurate and complete. The information should be consistent from year to year and identify projects in receipt of funding for a second or third year. The information on the database should be consistent with the information in the annual reports on the Programme.

11. A Decision on future actions should establish an external and independent advisory committee composed of high level experts in European health promotion. The scientific advisory committee should advise the Commission concerning the priorities for the programme, make recommendations concerning funding, and evaluate the final reports of the

supported projects. The members of the advisory committee should be paid fees set a level that is commensurate with their responsibilities and their independence and impartiality should be assured.

12. In future actions it should be made possible for projects to be funded for two or more years without the need for re-application.

13. Future actions should prioritise the continued support of the European health promotion networks that have made good progress within the 1996-2000 Programme. However the supported networks should work more closely together using a shared infrastructure designed to increase efficiency and economies of scale. Stronger links between the networks and health promoting organisations should be formed with the objective of improving participation and empowerment at grass roots level. The impact of the networks on specific outcomes in the European population should be monitored and evaluated in future actions.

14. Future actions should give priority to research into lay people's health beliefs in the light of different cultures, educational and socio-economic groups so that European health promotion can be made more effective and dissemination can be targeted appropriately at different segments of the population.

15. Future actions should be advertised more widely than in the *Official Journal of the European Communities* to attract applicants from a broader cross-section of the Community.

Chapter 5

Evaluation of the 'Programme of Community Action on Health Promotion, Information, Education and Training 1996-2000':

Reflections and Discussion

This chapter presents a reflective discussion of the evaluation process described in Chapters 3 to 5.

Reflections

The evaluation team was made up of a project leader, project manager, assistant project manager, secretary and a panel of expert assessors. My position was project manager. I learnt a great deal about evaluation and the consultancy process which would be later applied to my case study. The ability to be flexible, having good communication and negotiation skills, efficient organisation, record keeping and the ability to be proactive are the most essential competencies for such work.

Bureaucracy

Obtaining information from the Commission's services was a frustrating and exhausting process. At first I could not understand why it should be so difficult. After all, we were all supposed to be collaborating on the evaluation and it would be useful to the Commission's services. I soon discovered that this was not the attitude of the staff in the Commission's services. According to them, we were being paid to conduct the evaluation and it should not interfere with their work and evaluation was something that was a low priority and not understood. This was highlighted on a visit in June 2000 to collect data from the Commission's services' offices in Luxembourg. Three members of the team went to spend three days collating data. Some of the staff thought that we would be conducting and finishing the evaluation during the three days. In fact, the evaluation was supposed to take six months. We never obtained all the information that we requested. This was due to the fact it was not available.

We were faced with a huge amount of bureaucracy when conducting this evaluation. It was vital to keep accurate records of every Euro spent. This sometimes conflicted with the

smooth running of the project. For example, when the assessors came to London for a training workshop, some of them incurred simple subsistence expenses that were not permitted. We were obliged under the terms of the contract to obtain the cheapest flights which meant buying non-refundable tickets. So when we had to purchase another flight ticket for an assessor who had to change her schedule due to family commitments, it caused problems explaining to the Commissions services why we had purchased two tickets for this particular assessor. Financial matters were always frustrating as we were treated as frauds until proven innocent. We were eventually paid nine months later than agreed causing the University to go into debt during this wait. Clearly the Commissions services' agenda differed from that of the evaluation team. This consumed a great deal of my energy. It was difficult enough conducting what was supposed to be a one year's evaluation in six months. Yet the lack of cooperation from the major stakeholders intensified the burden.

Lack of Openness

Nevertheless, this evaluation produced the framework for a more in-depth evaluation. In order to look deeper and find out more about what constitutes a good project, it was proposed that the next stage of the evaluation use the theory of action research (Stringer, 1999) and realistic evaluation (Pawson and Tilley, 1997). However we were not naïve about the use of such theories. We were prepared for the reality of a lot of hard work. These methods are worthwhile only when the necessary groundwork has been done. This requires communication, commitment and openness from both the researchers and the stakeholders. Often the realities of workloads do not allow a commitment and terminology barriers prevent communication and openness. It was proposed that informal meetings and negotiations with senior management would help get action research and realistic evaluation techniques off to a good start followed by workshops with members of staff to discuss the evaluation.

At first the most fulfilling part of this evaluation for me was knowing that the evaluation would be given to the European Parliament and that the recommendations could potentially influence European policy and serve as...a true 'agent of social change' as Marks (1999) suggested. However the events that followed submission of the first report led to disappointment. The report contained some controversial findings (not presented here). The Commission services asked the evaluation team to remove some findings from the report. This posed a dilemma of on the one hand subscribing to an ethos of openness and transparency and a professional consultancy issue in which the consultant should be flexible

to the client's requirements. As the Commission services offered an explanation for the findings, they were not mentioned in the final report submitted to the Commission services. However relations between the two teams changed and became more difficult. After many bureaucratic hurdles, we were finally paid for the report and awarded the contract for the second phase of the evaluation.

At this point the EC monitoring of the evaluation was taken over by the Evaluation Cellule in Brussels. A new methodology focusing on an in-depth process evaluation and what constitutes a good project was written and submitted for approval. Approval was never received. The new manager was adamant that the methodology should focus on outcomes and not be re-started until 2001 when the Programme would have been completed. Despite the fact that the design of the methodology had been part of the tender, we were informed that the evaluation should concentrate on outcome evaluation. We were given the chance to propose a new methodology. However in the meantime, the evaluation team was falsely accused of financial irregularities. The evaluation was suspended but not cancelled. Not canceling the contract mean that salaries still had to be paid. The evaluation team acted in a cooperative manner and suspended the project until further notice. However months passed with no news so we decided to follow up the matter. This was not welcomed by the Evaluation Cellule. Our questions were met with arrogance and disbelief that we were questioning the Commission. This led to a frustrating situation where working relations worsened as time went by. A year later the contract was canceled for spurious reasons claiming that 'the poor working relations of those leading the contract on both sides has led us to the conclusion that it would be difficult to arrive at a satisfactory outcome for this contract.' Thus approximately £80,000 of public money was wasted during this period.

This experience raised questions about the culture of unaccountability in the European Commission. This is a public organisation that prides itself on openness, transparency and 'best practice.' However this was not my experience. This culture is not conducive to evaluations that have a true commitment to independence, impartiality and improvement rather than to a process designed to only illuminate the positive aspects of a Programme.

Discussion

Performance

Information on the Commissions Services' database was analysed for factors that discriminated between funded projects and those that were refused. Significant differences were evident both in numbers of applications and in acceptance rates for different Member States. Not very surprisingly, projects with many participating Member States were found to have a higher chance of being supported. Disappointingly for them, some Member States were consistently submitting applications with few participating Member States and were receiving very low levels of funding. Projects submitted from Italy, Spain and Greece had only 4%, 2% and 1% accepted respectively. Looking at the distribution of applicants, it can be seen that it is those 'in the know' who repeatedly apply for this funding.

Apparently applicants in some Member States had not fully understood the objectives of the Programme. This raises the question - Was every opportunity taken to make the objectives clear? In some Member States the field of health promotion is still in the formative stages and more support and transfer of information is needed. A crucial part of this transfer of information requires accurate record keeping and systematic documentation. However this evaluation has shown that this is often not the case. Obtaining a more even distribution of financial support is also an important issue that needs to be addressed.

Numbers of applications and acceptance rates varied significantly across the five areas of activity to which the applications are allocated. Areas B and D received the greatest numbers of applications while A and E received the least. These differences have implications for the way in which the annual Work Programmes are prepared and applicants are encouraged to apply. Applications in areas A, D and E need to be particularly encouraged in future.

The expert assessors' opinions of the Programme suggested that there were a number of "teething problems" with the administration of the Programme. However the assessors awarded some commendably high ratings for the projects supported in 1996, (especially in areas C, B, and A).

The reports of the EU Member States identified a need to transfer good practices and identify and implement pertinent health promotion models. However at the same time they perceived

a lack of evaluation. Therefore the Programme can by no means be said to have identified any models of good practice. The Programme did however facilitate trans-national collaboration as a huge part of the budgets were dedicated to travel and subsistence.

Nutbeam's (1999) view that intervention programmes have to be of sufficient duration to detect changes rings true in this evaluation. Projects in the Health Promotion Programme are funded for one year with a possibility of applying for an extension of one year (without extra funding). The expert assessors rated 'achievement of project objectives' as only 3.05 on average the fifth lowest score out of the 14 criteria). Impressive-sounding project objectives may well increase the chances of receiving funding. However the reality of achieving the objectives in such a short time span soon becomes apparent. A longer duration of projects would help overcome this problem.

Lack of evaluation

The experts identified weaknesses and gaps. The almost complete lack of evaluation in most of the supported projects is the most serious weakness. This was the poorest aspect of the projects funded in 1996. Areas that the experts rated at only 'satisfactory' level included analysis, conclusions, dissemination, report, and contribution. Evaluation should be well thought out before the implementation of a project rather than something that is added on the end of a project. This will help with the crucial step of collecting data. This would have also helped this evaluation of the programme as a whole. Obtaining public information should not be one of the most difficult aspects of an evaluation.

Steps should be taken to improve the quality of all of these aspects of project management, methodology and reporting. The perception and ethos of report writing as a pure formality that is required simply in order to obtain a final payment from the Commission, must be changed. In many instances the final report may be the only tangible outcome of the Community's expenditure on a project. It is also often the only product of the project that is used to inform other professionals in the field and policy-makers. Poorly written reports, no matter how good the project, do little to advance knowledge in health promotion.

Community Added Value

The experts' assessments of the Programme suggested that there had been moderately high Community added value in comparison to the situation that would obtain if the Programme did not exist. The expert assessors awarded some high ratings for the CAV of projects supported in 1996 (especially in areas C, B, and A). The experts generally gave higher ratings of CAV to projects with 8 or more partners.

Community added value (CAV) is an important concept in the context of any Community Action Programme. The meaning of the concept should have been agreed and defined by the experts assessors before usage. This is a limitation of this questionnaire. Five possible interpretation of CAV are:

i. Getting to know each other and exchanging experiences
ii. Parallel development of innovative approaches
iii. Import, export or adoption of new approaches and their adaptation to one's own situation
iv. Joint development – division of tasks with a common objective
v. Transnational exchanges of trainees or trainers

Recommendation 13 suggested that stronger links between the networks and health promoting organisations should be formed with the objective of improving participation and empowerment at grass roots level. Thirty five million ECUS (EURO'S) were spent on this programme. Yet the processes suggest that it is not directly improving the lives of European citizens. This recommendation is in line with the current World Health Organisation's policy. It has announced a new civil society initiative in an attempt to improve its relationships with Non-Governmental Organisations and grassroots organisations (Communiqué, 2001).

It was made clear at the outset that this evaluation was entirely concerned with the processes of implementation rather than tangible outcomes in the form of any changes towards "a high level of human health protection" in the European population. This evaluation's aims were modest and were concerned with the first phase only of the Community's first Health Promotion Programme, the first horizontal public health programme of the European Community.

Process Vs Outcomes

It would have been premature and technically extremely difficult to attempt an evaluation of the impact of the Programme on the health of the population. The first projects, financed in 1996, were only finally completed in 1999. Many other projects financed from 1999 to 2000 are still in progress. Also the scope of the projects is such that any health impacts on the population are going to be highly specific, localised and distributed across the Community. Yet, the Evalution Cellule in Brussels, no doubt concerned with 'evidence-based' health promotion and traditional evaluation methods wanted the evaluation team to focus on outcome evaluation in Phase 2 of the evaluation.

This first phase of the evaluation focused mainly on quantitative data to produce a framework for a more in-depth analysis. The second phase of the evaluation was supposed to be more in-depth. However due to problems revealed in the 'Reflections' section, this was never carried out. The main focus would have been health promotion practitioners, i.e. successful applicants. A methodology was developed to systematically look into why some projects achieved their goals and not others based on some of the ideas presented by Judge (2000). He described the concept of 'realistic evaluation', an approach first developed by Pawson and Tilley (1997). This approach tries to develop an understanding of why a programme works, for whom and in what circumstances. Judge (2000) also discussed the theory of change which originated from Carol Weiss and colleagues in the 1970s (Connell & Kubisch 1998). The approach aims to clarify the overall vision or theory of an initiative, meaning, the long-term outcomes and the strategies that are intended to produce change. Wimbush and Watson (2000) also discuss these theories of evaluation in a positive light and point to several examples of projects that have used this approach in the UK with encouraging early results.

The philosophy of action research (Stringer, 1999) also would have also played a role. The evaluation team would have facilitated action and acted as a catalyst to assist the project leaders to define their problems clearly and to support them in working toward effective solutions. However this approach along with realistic evaluation and theory of change assumes a positive collaboration between the evaluators and the stakeholders with clear communication, open dialogue and negotiation. As the 'Reflections' section revealed, this was not the case for this evaluation project and the 2 units in the European Commission involved in it. Large organisations that commission evaluations and are faced with inefficiency, bureaucratic rules and regulations, lack of transparency, conflicting agendas,

esoteric terminologies, are not always welcoming to contemporary evaluation theories. This places a considerable burden on evaluators concerned with finding the best methodology of evaluating publicly funded programmes. Backett-Milburn, Platt and Watson (1998) described how purchasers, commissioners and researchers communicate and interact often with only a partial understanding of each other's culuture, ethos, working practices and constraints. They argued that it is important to reflect on these underlying processes and how they influence the production and use of health promotion research. Therefore improvements in the knowledge of health promotion may not only depend on the individual's readiness to change (Scott, Kinnersley & Rollnick 1994) but also on health researchers' and health policy makers' readiness to change and learn.

Conclusion

This evaluation of the EC's Health Promotion Programme has produced a mixed picture based on one evaluation team's experiences with 2 units in the EC and one EC Programme. The evaluation methodology employed was restrictive and modest. The second phase of the evaluation aimed to broaden its scope. In the current climate of evidence-based practice appropriate methods to evaluate health promotion are needed. This is especially true as health promotion is a dynamic discipline that is changing its focus and beginning to scrutinise its methods. The concept of 'realistic evaluation' (Pawson and Tilley, 1997) is appealing for this new focus. However foresight, commitment, collaboration, communication and accurate record keeping are essential. Unfortunately I found no evidence of these qualities in my work with 2 units in the European Commission. Like Macintyre et al (2001), it leads to a questioning of the true commitment and possibility to develop and use best evidence. Implementing 'evidence-based practice' seems instinctively desirable. Questioning it almost seems 'blasphemous'. However practical, resource and system restraints often reduce the quality of research. Evidence, in reality, consists of negotiable, value-laden and contextually dependent items of information (Marks, 2001). It is not 100% objective. Contradictions in research findings exist. There is disagreement about how best to conduct research, interpret findings and focus new developments (e.g. chapter one has briefly highlighted current differences in research findings in health psychology and the systematic review has highlighted this for the field of smoking cessation research).

The practice of 'evidence-based practice' currently only uses a partial view of knowledge, mainly working from a hypothetico-deductive epistemology. Evaluations that focus on causation do not fit social programmes. Policy-makers and administrators in charge of health promotion budgets need to be aware of changes in the field as much as health promotion practitioners. Again this requires collaboration and clear dissemination of knowledge. Researchers and policy-makers also need to reflect on the nature of research so that the illusion of unequivocal best evidence in public health is dispelled. The focus needs to move to evaluation where from the onset the objectives and perspectives are clear, limitations and constraints are acknowledged, the context is described and all stakeholders are open and collaborative. This will help enable a clearer, open and more truthful picture of the evaluation findings to be obtained.

Chapter 6

Discourses in the EC's Health Promotion Programme

To whom are social problems a problem?...usually to those outside the boundaries of what we have defined as the problem. (p12) Ryan , 1976

This chapter looks at some of the criticisms of health promotion as an applied discipline. The EC's Health Promotion Programme is looked at from the perspective of discourse analysis.

Lupton's critique of health promotion

So far in this thesis the notion and practice of health promotion has not been questioned. However there is a body of literature that questions the fundamental ideas of health promotion. Lupton (1997), a well-known figure in critical health psychology, argued that health can not be understood simply as the presence or absence of disease. Rather she views health as representing a moral imperative that is embedded in social and cultural norms and expressed in public policies.

Already holding two degrees in the humanities and social sciences, sociology and anthropology, Deborah Lupton undertook a Masters of Public Health. She found it surprising and unsettling the extent to which the rationale, models of human behaviour, methods of research and major strategies of public health were unquestioned by her peers who were qualified in such areas as medicine, nursing and health services management. She noticed that health promoters have for some time critiqued the thinking underlying medical practice but they have not fully directed this critique at health promotion's own epistemology and practices. Lupton (1997) disassociates herself from two other schools of critiques in health promotion. Firstly the right-wing position that sees health education and promotion as apparatuses of an overly-authoritarian and preaching 'Nanny State.' Secondly the so-called 'radical' critique of health promotion who have pointed to the

continuing disparities between the mortality and morbidity rates of the poor and working classes and the upper and middle classes. Critiques from this position have called for health promotion to be more radical and to facilitate social change. This approach focuses on strategies of community development, advocacy politics and empowerment. Rather Lupton (1997) emphasized that practices and discourses of public health are not value-free or neutral but socially contextual, highly political and change in time and space. She argued that the institutions of public health and health promotion often overtly display signs of the state's attempts to shape the behaviour of its citizens. For Lupton, it is not the overt discourses such as 'practise safe sex' and practices that seek to constrain the individuals' freedom of action that are the most interesting. However it is the way that these discourses invite individuals voluntarily to conform to their objectives, to discipline themselves and to turn the gaze up on themselves in the name of health, often evoking feelings of guilt, anxiety and repulsion and blame. Lupton argued that public health and health promotional discourses and practices privilege a certain type of subject who is self-regulated, 'health' – conscious, middle-class, rational and civilised and bodies that are contained and controlled.

Lupton pointed to a study by Johnson (1991) that demonstrates the extent to which some people have used health promotion discourses to make sense of illness in ways that cast moral judgements on certain illnesses. In a study with American interviewees who had had one or more heart attacks, respondents scrutinised their lifestyles for reasons why they had become ill. Some felt they themselves were to blame and had 'got what [they] deserved.' Others found it difficult to understand their heart attacks and felt 'cheated' as they had lived their lives according to the rules prescribed by health promotion.

Lupton (1997) also noted that communication in the health promotion world is far from a two-way process. She highlighted the ease of slipping between simply informing the public about health matters and implicitly forcing them to take up what are considered healthy behaviours. For example, she noted that once a health message has been disseminated, health promoters discharge their responsibility and the emphasis turns to

the individual to act upon this knowledge to prevent illness. If the target audience do not respond to the message then according to mainstream health promotion models of behaviour, they have adopted defense mechanisms or maladaptive coping responses or they lack the required level of personal control and feelings of self-efficacy.

Lupton (1997) points out that the discipline called 'social marketing', where traditional business strategies are applied to social issues, has been adopted by some health promotion agencies. She pointed out that the consumer as represented in the discourse of social marketing is a paradoxical figure. On the one hand, the discourse of meeting the consumer's needs constructs the individual as an actively choosing subject who makes use of rational purchasing behaviour and as a customer who is always right. Yet social marketing also constructs the consumer as malleable and amenable to persuasion. From this perspective, the customer is not always right but in fact is ignorant. Lupton concluded that social marketing 'is simply the old simplistic health promotion approach to persuasion dressed up in marketing jargon about products and consumers'. The health promotion viewpoint that sees the media as their enemy because of their influential role in presenting positive portrayals of unhealthy lifestyles also represents audiences as vulnerable and open to media manipulation. Therefore presenting the public as victims.

Lupton (1997) argued that health promotion texts are full of assertions concerning the importance of adopting appropriate language and discourse strategies to achieve the goal of manipulation often based on emotional appeals. She pointed out that the health promotion texts outline ways to achieve more 'effective' health communication campaigns by carefully 'targeting' or 'segmenting' the audience, emphasizing 'positive' behaviour change and 'current rewards' and using commercial marketing strategies to attract audiences' attention. It is noted that this approach to mass media is primarily influenced by the stimulus-response model of communication or, as Fiske (1990) called it, the 'process' school. The reason being that it is interested in questions of 'efficiency' and 'accuracy' and with determining the linear mechanistic processes by which meaning is purposively generated by the producer of a discrete message with the intention of

affecting the minds of the receivers. Lupton (1997) argued that this approach that still dominates health education and health promotion concepts. She criticized Backer, Rogers and Sopory (1992), who despite evidence of a growing awareness in some of the health promotional literature of the complexity of the interaction between media products and their audiences portray health promotion media messages as having a linear and measurable effect on audiences. It is this linear mechanistic approach to health promotion that focuses on outcome evaluation in health promotion. Likewise, in 1993, Lupton pointed out that the methodologies used to assess health risk perception are deemed unquestionably to be objective, systematic and scientific.

Lupton observed that health promotion trials use the language of medical trials to test the efficacy of drugs. She argued that such health promotion is represented as 'therapeutic' with better communication the basic 'prescription' to treat the pathogen of misunderstanding. Radley (1998) points out that health education programmes assume a cause and effect relationship between experts' advice and layperson's actions. He suggested that this could be one reason why people do not follow the advice of the programmes. He criticised this approach for failing to recognize that people conduct their lives according to many other beliefs besides health such as cultural beliefs, financial beliefs, family beliefs. In fact some people hardly place any value on health.

In summary, Lupton (1997) pointed to a discourse in the health promotion world that seeks to constrain individual freedom and one that blames the individual for not being healthy. She argued that ways to promote health use a discourse that implies use of linear mechanistic methods. She is interested in how and why some people take up self-restraint discourses in health promotion and become self-regulators of their bodies.

Understanding the emphasis on personal control

Both Ogden (1995) and Armstrong (1993) offered explanations for the constructions of identity of the individual in public health. Ogden (1995) traced the way in which psychological theory has constructed what she calls the 'risky self'. She described

psychological theories that at the beginning of the twentieth century saw the individual as a passive responder to external events. So for the case of addiction, early models saw the individual as being the recipient of external action and the addict as an unfortunate victim. Ogden (1995) went on to describe how in the Sixties there was a shift in the construction of the individual's identity in psychological theory. The individual was seen as more interactive. The individual was conceptualised as processing information from the environment. Thus the individual, now with an increasing sense of agency, was not just shaped by external stimuli but was an interactive processor of the stimuli.

Ogden (1995) pointed to the example of Bandura's experiments on aggression that examined the effect of modeling on shaping childhood aggression. The child's behaviour was conceptualised as a product of interactions between individuals and between the outside world. It was in this context of the changing construction of the identity of the individual in psychology that the health belief model was first defined. Not only did this model conceptualise external events as cues to action that were perceived and appraised by the individual but this model also examined the interrelationship between the individual and their environment in terms of an interplay between cognitions and the external world. This was operationalised as perceived severity and perceived susceptibility of the potential ill health. Ogden (1995) pointed out that the major criticism of the health belief model was that it did not include the concept of self-efficacy. This variable has recently been considered so important that the model was later reformulated to include it. It is also a variable that has been added to other models such as the protection motivation theory (Rogers, 1983) and the health action process (Schwarzer, 1992). Thus Ogden (1995) stated that the individual in psychological theory nowadays is seen as interacting with their own inner self. She illustrated this with the example of addiction in which the determinant of behaviour is no longer the external substance, nor the individual's interaction with that substance, but the individual's inner self. Therefore the environment has been largely removed from the equation. Ogden (1995) stated that:

'*The contemporary intra-active individual is characterized by an agency and an intentionality which is directed internally towards their inner self. The late twentieth century object of psychological thought has become a subjective entity whose subject is the self*' (p. 412)....and who

'has become at risk from his or herself'(p. 413).

Armstrong (1993) offered a sociological explanation for the shift in the construction of the identity of the individual. He saw the shift as a result of a change in hygiene rules. Armstrong (1993) identified four regimes of public health that can be identified over the last two centuries: - quarantine, sanitary science, social medicine and the 'new' public health. Armstrong (1993) described illness in the mid-nineteenth century as somehow residing in places under a system of quarantine. Lines were drawn between 'healthy' and 'unhealthy' spaces. Later quarantine methods were seen as obsolete and the true safeguards against disease were seen a sanitary measures. This period was concerned with monitoring the passage of substances such as water, air, faeces and semen across the boundary of the body. Armstrong stated that 'the focus of late nineteenth–century public health became the zone which separated anatomical space from environmental space, and its regime of hygiene developed as the monitoring of matter which crossed between these two great spaces, especially in its manifestation as dirt' (p. 396). In the early twentieth century, the third model of 'personal hygiene' appeared. This focused on personal cleanliness and bowel movements. Risks to health were again located within a space and it was the boundaries between people that provided the target for the regime of personal hygiene. So an individual who did not take a regular bath would be seen not only as a health risk to him/herself but also to any nearby person. The individual's health status was threatened by their interactions with other individuals. Armstrong (1993) described the model that is widely used today as the 'new' public health. The new 'danger' is seen now as arising from 'the interactions of those other bodies with nature' (p. 404). Thus risks are located everywhere.

Odgen (1995) argued that the risks identified by Armstrong (1993) may not actually be located in the environment nor in the spaces produced by interpersonal interactions with this environment but, as the psychological literature indicates, risks are to be found within the self. She highlighted this point by noting that the contemporary health promotion movement does not focus on lifestyle but that the movement emphasizes personal control over lifestyle. Odgen (1995) concluded:

> *In the last decades of the twentieth century, the surveillance machinery, which finds reflection in the individualistic and self reliance ethic of the New Right has successfully penetrated the spaces of the body to reconstruct an intra-identity which is increasingly compartmentalised into the controlling self and the risky self.*
>
> (p. 413-414)

Ogden's (1995) conclusions are similar to Lupton's (1997) concerns about health promotion forcing people to turn their gaze inwards in the name of health. Ogden (1995) however placed this observation in a political and cultural context. In this chapter I shall explore whether this emphasis on personal control is dominant in the European Community's Health Promotion Programme.

Further critiques of health promotion

From the above positions, it can be argued that responsibility for public health has shifted away from the state to the individual (Willig, 2000). However some people argue that there is still too much state intervention in public health. For example, Fitzpatrick (2001) saw public health as a programme of social control packaged as health promotion. For Fitzpatrick (2001), the 'Don't Die of Ignorance' campaign in England was not a rational response to a new disease, rather, for him, it seemed to be about the promotion of a new code of sexual behaviour. He felt that fears were being needlessly inflamed to establish new norms of acceptable and appropriate behaviour. He believes that medicine in Britain has become a quasi-religious crusade against the old sins of the flesh. Working as a

general practitioner, he noticed two types of patients. Firstly, the 'worried well' who are usually young and in professional occupations, who worry about their diet and take regular exercise. The other type, usually old and former manual workers, have never been concerned about health and have rarely modified their lifestyles or consulted a doctor with a view to preserving their health. He feels that to the old and less affluent people, health promotion campaigns simply confirm the shift of the health service away from any real concern for their needs such as heated homes and money to pay the bills.

However Fitzpatrick (2001) did not acknowledge that the two views on health that he has encountered may be due to the fact that people have different meanings of health. In the same way, politicians often have different meanings and different realities to the public. This is highlighted by the Conservative government's response in the UK to the first outbreak of HIV. After lots of press attention about HIV, Mrs Thatcher decided that something had to be done. It is reported that she personally found the subject distasteful and delegated the job first of all to the Secretary of State and Social Security then to the Deputy Prime Minister (Garfield, 2001). In March 1986, a group of civil servants held a meeting at the Department of Health and Social Security to discuss the topic of anal sex. In this meeting, one minister had problems pronouncing 'vagina' and another minister asked 'Oral sex? Do we know how many people do this sort of thing?' (Garfield, 2001). Therefore public health campaigns may not be a clever attempt at social control and establishing new norms of behaviour. Rather it may be that the people involved in decision making in public health have different realities to the public they serve and act consequently according to their own realities and culture. This is not a defense or a belief that this way is inevitable. It does not deny political influence on health promotion. It is another explanation for what could simply be ignorance in the appropriately termed 'Don't Die of Ignorance' campaign.

Meanings of health and illness

Stainton Rogers (1991) has explored the differing beliefs about health and illness that lay people and medical professionals hold. She argued that the theories about health and responsibility and locus of control available at the time of her writing were far too simplistic and ideologically suspect. For Stainton Rogers (1991), the theories failed to reflect the inventiveness and diversity of people's explanations. Her own methodology is aimed towards reflecting this inventiveness and diversity. She used Q method to interview a range of 70 people on the subject of health and illness. Q method does not set out to measure anything objectively. Participants in a study using Q method have the opportunity to express their viewpoints or beliefs by sorting a number of items. The items are usually statements but other items such as photographs and posters have been used. Participants sort the items using a grid that specifies sub-categories of agreement and disagreement. The data are then coded numerically and entered into a factor analysis.

Stainton Rogers (1991) came up with seven accounts from her interviews. These accounts explaining health and illness were labeled 'cultural critique', 'willpower', 'health promotion', 'the body as machine', 'inequality of access', 'body under siege' and 'robust individualism.' For Stainton Rogers (1991), people are highly skilled at weaving explanation to suit particular circumstances. This is highlighted by one woman's response that Stainton Rogers (1991) uses to illustrate the 'health promotion' account of health and illness. The woman, a nurse who taught health promotion in a school of nursing, focused her accounts on health rather than illness. For her, health was a fundamental human right, a positive state of well-being and 'one of the most important things in life.' According to Stainton Rogers (1991), within this account good health is never a matter of luck. This respondent strongly rejected the notion that 'life is too short and too sweet to spend too much time worrying about health'. The nurse stated:

> *This is rubbish. It implies that living healthily is boring and miserable, when the opposite is true. Eating well and taking exercise are not just good for you, they*

are enjoyable – and feeling fit (which you can only do if you live a healthy lifestyle) is to be able to enjoy life to the full.

Stainton Rogers, (1991), p146.

A contrast with another account of health – the 'cultural critique' reveals a different explanation. For example, a doctor stated:

I worry about the people who live in dreadful housing, who work long hours and who cannot afford to feed themselves or their children properly. They don't stand a chance. They simply do not have the chance to be healthy.

Stainton Rogers, (1991), p139.

This is a similar view to that of the doctor, Fitzpatrick (2001). Health is explained in terms of power, status and wealth. There has been an increase in emphasis for doctors to take part in health promotion in England (e.g. Department of Health and Social Security, 1977; Department of Health, 1992). However doctors see a different reality to health promotion professionals. They see people who are ill and hear about their circumstances. Doctors may feel powerless to promote health when they know about a patient's different reality. They may also feel helpless and a failure if they don't succeed in promoting health and preventing illness. Therefore viewing health in terms of external forces suits their circumstances.

Respondents who fitted into the 'willpower' account of health disagreed that the worst off in our society have little choice about the unhealthy lives they lead. The following comments were expressed:

Even the poorest people have a lot they can do for themselves.

False, almost everyone can be clean.

Stainton Rogers, (1991), p144.

These comments were expressed by a student and a secretary. People from the lower middle classes may see themselves as close to those that are less well off. They may justify their better health position in terms of their own strengths. By seeing health as related to personal control, they may feel that they can avoid the bad health of people not so far down the social ladder from them.

Stainton Rogers (1991) asked what are the theoretical implications of construing people as active weavers rather than just passive users of explanations. She wanted to confront theories that claim that the way people think is determined by specific, enduring personality traits or by psychological mechanisms or social forces.

She comments on Mischels' (1966) portrayal of self-control:

> *By treating self-control as an 'essence' hermetically sealed into individual heads it pretends that people never argue about it, gossip about it, read about it in books, or watch it portrayed in movies. It denies it is a theme that is culturally articulated in aphorisms and fables...It assumes that it is only experts who are aware of such a dispositional tension, and that ordinary people lack any reflexive self- or other awareness.*

Seedhouse (1997) has analysed health promotion from a philosophical background. He argued that health has different meanings for different people. Therefore for Seedhouse, 'health for all' is a 'logical impossibility.' He argued that unless health promoters explicitly agreed about the meaning of health and health promotion, then any feeling of accord will only be illusory. He stated that this 'illusion of shared meaning' can have damaging consequences for both giver and receiver of health promotion. For example if

people working in health promotion have different ideas about what health is and how to promote it, then everything they do in the name of health promotion including allocation of resources will be affected.

Seedhouse (1997) believed that current definitions of health in the health promotion world are vague (e.g. Ottawa Charter, WHO, 1986). Only when health promoters insist on clarity and ask questions such as 'but what precisely do you mean?' (p. 33), will health promotion begin to come of age. The aforementioned critiques of health promotion have revealed the importance of the way in which health promotion texts construct meaning around health and the individual. The next section explores the constructions in the text of the EC's Health Promotion Programme.

Discourse Analysis of the EC's Health Promotion Programme

Discourse Analysis

It has been argued that there has been an overemphasis on the role of cognitions and a neglect of the social context within which health-related behaviours take place (Willig, 2000). A social constructionist epistemological position is becoming popular in health psychology. This is different to the more commonly used positivist epistemological position used in 'mainstream' health psychology which suggests there is a direct relationship between the world and perception and understanding of it and that truth and knowledge are 'out there' to be found. According to a social constructionist approach, health psychologists should study the explanations of health which are available within a culture and not just the individuals who use the explanations (Willig, 2000). According to social constructionism, human experience, including our perception is mediated historically, culturally and through language. Research conducted from a social constructionist position is concerned with identifying the various ways of constructing social reality that are available in a particular culture, to explore the conditions of their use and discover their implications for human experience and social practice (Willig, 2001). Social constructionists use various types of data such as semi-structured interviews, diaries, focus groups transcripts and texts. Discourse analysis is a key tool

used in social constructionist research. Discourse analysis assumes that language does not simply reflect social reality but that it constructs it, language constitutes the building blocks of social reality. Discourse analysis rejects the idea that there are objective truths that can be pinpointed if the appropriate scientific methods are used (Coyle, 1995). There are two commonly used versions of discourse analysis used in health psychology. One version described by Potter and Wetherell (1987) is concerned with what people do with language. Another version, Foucauldian discourse analysis is concerned with the availability of discursive resources and the way that discourse constructs subjectivity, selfhood and power relations (Willig, 2000).

According to discourse analysists, a discourse is selected from a range of available linguistic resources to create a version of events. Those using the discourse may not be aware of the constructive process in which they are engaged but this does not mean that it does not exist. Discourse analysis is concerned with how language constructs versions of the world and what is gained from these constructions (Coyle, 1995).

Willig (2000) pointed out that there are two major ways in which discourse analysis in health psychology has been applied to understanding health and illness. Firstly, discourse analysis has been used to deconstruct expert discourses whereby dominant discourses are carefully examined and the use of categories and constructions legitimating a particular version of reality and experience are analysed. A major theme that has emerged from these studies is that health discourses today have an emphasis on self-control and self-monitoring. The second way that discourse analysis has been used involves non-experts texts and the analysis of the extent to which dominant discourse are found in lay people's talk about health and illness.

Aim

The following study attempted to deconstruct the expert discourses found in the EC's Health Promotion Programme and trace the implications of the available discourses and constructions. It aimed to answer the following:

What kind of discourses does the EC's Health Promotion Work Programme use and how do they position the individual?

Method

Foucauldian Discourse Analysis

The EC's Health Promotion Work Programme is drawn up by the European Parliament, which is an institution with a great deal of power. Foucauldian discourse analysis was adopted as according to this approach, discourses are strongly implicated in the exercise of power. The Foucauldian version of discourse analysis explores the relationship between discourses and institutions and how discourses are bound up with institutional practices such as ways of organising, regulating and administering social life. It looks at how discourses legitimatise and reinforce existing and social and institutional structures and how these structures also support and validate discourses (Willig, 2001).

Willig (2001) clearly defined the characteristics of Foucauldian discourse analysis. She stated that this approach considers discourses to be facilitating, limiting, enabling and constraining what can be said, by whom, where and when. She described this viewpoint as focusing on a discursive economy – the availability of discursive resources within a culture and its implications for those who live within it. She quoted Parker's (1994) definition of discourses as 'a set of statements that construct objects and an array of subject positions' (p. 245). Subsequently, certain ways of seeing the world and certain ways of being are made available by these constructions.

A key feature of Foucauldian discourse analysis, making it different from discursive psychology, is it asks questions about the relationship between discourse and how people

think or feel and what they may do. Thus exploring the role of discourse and the implications for selfhood and subjective experience.

The Analytical Process

Discourse analysis is not a research method with a rigorous set of formal procedures to guide it. It has been said that the key to analysing discourse is scholarship rather than adherence to a methodology. Emphasis is placed on the reading and interpretation of text backed up by quotes from the text. According to Potter and Wetherell (1987) the first step is said to be the suspension of belief in what is normally taken for granted in language use (as cited by Coyle, 1995). There have been some attempts to offer systematic guides on conducting discourse analysis. Potter and Wetherell (1987) offered a 20 step guide. Parker (1992) outlined seven criteria for discovering discourses along with three auxiliary criteria concerned with institutions, power and ideology. Recently, Willig (2001) has produced a six stage guide which the author considers to be very useful for those embarking on discourse analysis for the first time.

These six stages of discourse analysis set by Willig (2001), as outlined below were used to analyse the discourses in 5 years of the EC's Work Programme on Health Promotion. These stages allowed the discursive resources and the subject positions of the EC's Work Programme to be unraveled and mapped. The implications for subjectivity and practice were then explored.

Stage 1: Discursive constructions

This stage aims to find the discursive objects of the text. It also looks at how the discursive objects are constructed through language.

Stage 2 : Discourses

This stage aims to locate the various discursive constructions of the objects within wider discourses.

Stage 3: Action Orientation

This stage took a closer examination of the discursive contexts within which the different constructions of the object are used. It asks – what is gained from constructing the object in this particular way at this particular point within the text?

Stage 4: Positionings

This stage took a closer look at how the constructions of the discursive objects and the wider discourses offer subject positions.

Stage 5: Practice

This stage explores the ways in which discursive constructions and the subject positions contained within them open up or close down opportunities for action.

Stage 6: Subjectivity

This final stage traces the consequences of taking up various subject positions for the "participants' " subjective experience.

Text

Between the years 1996 - 2000, the European Parliament issued 5 yearly Work Programmes. These are published in the *Official Journal of the European Communities*. More recently the Work Programmes have been published on the internet. It was the role of the European Commission to ensure the Work Programmes were carried out. The Commission services were in charge of the administration and an allocated budget of 35 million ECU (EURO) over 5 years. Each Work Programme described the yearly aims and objectives. The Work Programmes started with a general introduction, followed by sections on Budget, Implementation of the Programme, Priority Areas and Other Priority Areas. The Budget section was not analysed.

By reading the texts several times and engaging in the texts, the discourses identified are outlined and described below using quotes from the Work Programmes. The full texts

can be found in Appendix 1. Quotes are followed by the Work Programme year and line numbers in brackets.

The Six Stages of Analysis

Stage 1: Discursive constructions

This stage found five discursive objects in the EC's Work Programme on Health Promotion that are outlined below.

Health Promotion

As a result of having structures and strategies available, health promotion is constructed as being enabling by promoting situations that are conducive to health. Risk factors, especially, cardiovascular disease, are constructed as being health promotion's enemy. However health promotion's measures to tackle the risk are presented as being diplomatic as the measures not involve force.

Health promotion is constructed as enabling. For example, it 'enables people to adopt and maintain healthy lifestyles and healthy behaviour' (1996, lines 6-7). It promotes 'the creation of sustainable environments and alternatives conducive to health' (1996, lines 7-8). It increases 'individuals' and 'communities control over their health and its improvement' (1996, line 8).

Health promotion is represented as being made up of structures and strategies. At a European level, these structures and strategies are presented as being diverse,

> *Each country has its own health promotion structures and strategies. The diverse health promotion policies of the Member States will need to be described, compared and disseminated. Some Member States have listed their top ten priorities in the field of public health* (1996, lines 34-36).

Some structures and strategies in health promotion are better than others, 'An analysis and comparison of Member States' nutritional policies will be carried out to illustrate

each country's strengths and weaknesses' (1996, lines 51-52). Some of health promotion's structures and strategies need improvement, 'Attention will also be paid to improve knowledge of mechanisms for devising health messages and assessing health information methods,' (1997, lines 15-16; 1998, lines 13-14; 1999, lines 18-19; 2000, lines 26-27).

Certain 'risk factors' are constructed as health promotion's enemy. In particular risk factors that cause the leading health problem in Europe, cardiovascular disease (CVD). However health promotion is presented as not being afraid because it has a strategy to deal with this because there 'is scientific evidence and practical experience allowing us to reduce these problems by introducing measures to combat certain risk factors and promote health behaviour' (1996, lines 55-57). The proposed strategy is a 'cardiovascular prevention awareness week'. However when discussing specific risk factors such as alcohol, the language is not as war-like. It is collaborative and diplomatic, 'In relation to alcohol, a meeting bringing together representatives of the scientific community, of the alcohol industry and wine produces, of NGOs active in the field, of health promotion bodies….' (1996, lines 76-80). In 1998, the discussion of alcohol and health was continuous. Therefore, health promotion is constructed as being patient and persistent in its goals. By 1999, the 'drafting of a Commission communication on alcohol and health is planned' (lines 10-101). By 2000, the final results of the European Comparative Alcohol Study were planned to be available (lines 98-99).

Evidence based knowledge

The Programme portrays the idea that there is a bank of a certain kind of knowledge outside the sphere of health promotion that it needs to grasp, form models of good/best practice and share. Projects that use this knowledge and share it are given priority. Several quotes from 1998 highlight this. For example, 'Initiatives aiming at putting existing knowledge into practice to influence determinants of major health problems will be given priority' (line 67); 'Identification and wide dissemination of existing knowledge and working methods will be supported' (lines 159-160); 'The development and

dissemination of the best health education experiments and methods tailored to different population groups and different settings will be fostered' (lines 18-19).

Traditional scientific knowledge is constructed as being the only and at the same time the best knowledge available to health promotion, 'scientific review and analysis of health promotion intervention activities in Europe will be carried out' (1997, lines 136-137).

Evaluation is represented as the means by which health promotion can contribute towards evidence-based knowledge, 'Evaluation and quality assurance will be developed as an integral part of the programme' (1998, line 37; 1999, line31; 2000; line 36).

Health Promotion Experts

Health promotion experts are constructed as being like a new emerging club/association trying to organise its members. Health promotion experts are constructed as a group who have something to share and give to others and at the same time they are represented as needing to raise their status.

The experts have various mechanisms to achieve these aims. It was planned to publish a 'Who's who in public health' (1996, line 91) and a directory of training schemes in public health and health promotion (1996, line 105). This club is European, therefore to handle the different languages, a multilingual glossary of public health terms was supported (1996, lines 93-95). In line with the spirit of a club, an annual 'major prize competition for health education' was funded in 1996 (lines 87-89). It uses 'modern communication technologies' to organize its members (1998, lines 157-158). By potentially establishing a European Master's Degree in Public Health in collaboration with a 'maximum number of universities' (1997, line 124), the club's status could be raised. It is a benevolent club that shares its knowledge by arranging summer schools and training courses in public health (1998, lines 145-153).

The Health Promotion Programme (the Commission and the Commission services)

The Health Promotion Programme and by default those who coordinate it - the Commission and the Commission services - are constructed as being modern, insightful and concerned with the best (this construct will be referred interchangeably as the Programme and the Commission). Scientific methods and targeting are presented as the best measures in order to be modern and insightful. The Commission is represented as being active in its goal to promote health. It is presented as a networker who actively seeks to extend global links. It is presented as an organization that gets things off the ground. Yet, it is seen as organization that will not be taken for granted as it does not provide funding long-term. It is also constructed as being concerned with value, efficiency and maximum impact.

The Programme is represented as being modern. For example, in 1996 we see that the Commission is ready for a 'new approach' (line 9). In 1999, there was 'support for the up-dating and large use of an Internet information base' (lines 107-108). In 2000, there was an aim to produce a state-of-the art dietary guideline in Europe (lines 90-91).

It is also presented as being concerned with the 'best'. For example, in 1997, an aim of the network of health promoting schools was 'the dissemination of best practices' (line 109). In the same light, another aim for 1997 was the 'development and dissemination of the best health education experiments and methods' (lines 20-21). This also reveals an emphasis on the Programme being scientific with the mention of experiments. This is further revealed by another aim - 'Scientific review and analysis of health promotion interventions activities in Europe will be carried out (1997, lines 136-137).

It aims to collate facts through traditional methods, such as, surveys and feasibility studies. For example, 'A survey of similar work....will be carried out' (1996, lines 36-37); 'The Commission intends to carry our feasibility studies on the setting up of a permanent body (the European Health Observatory) responsible for monitoring and evaluating the health data and indicators in the Community area.' (1996, lines 41- 43).

The Programme makes use of targeting. It targets certain populations, setting and actions or issues. This can be seen in the subheadings of the Programme and also within the text, 'Priority areas and key functions will be specified in order to launch targeted actions' (1997, lines 32-33).

The Programme is constructed as insightful. For example, 'Unlike the earlier programmes (cancer, AIDS, drugs), it focuses not on diseases but on health determinants (1996, lines 4-5). It is presented as a Programme that is aware of a project leaders potential burdens. In 1996, it stated that new application forms had been designed that 'put more emphasis on project descriptions and less on administrative information' (line 19). In 1997, it stated it would 'contribute to analyzing the institutional difficulties encountered in developing health promotion' (lines 30 – 31).

The Programme is represented as being concerned with value. Firstly value for money, for example 'the projects implemented will need to be evaluated from both the technical and the financial angle (1996, lines 29-30). Secondly, European-added value, 'All projects must have a transnational dimension and should involve as many Member States and EEA countries as possible' (1998, lines 47-48). It is also represented as being concerned with efficiency, 'special emphasis will be placed on the evaluation of how the projects are indeed benefiting the European Union and its citizens' (1997, lines 44-45). In 2000, the final year of funding, an aim was to 'ensure that the experiences gained and the benefits form the investment incurred in activities and networks are fully utilized in future developments relating to health promotion and public health (lines 3-5). The Programme is also concerned with maximum impact. It is stated that the projects need to be evaluated with the question – 'How could the results be more widely disseminated?' (1996, lines 30 –31).

As well as being an instigator of action, 'The Commission…intends to define mental health within the context of modern prevention and health promotion policies' (1996,

lines 63-64), it also follows up others actions, 'The Commission intends to follow up this initiative with a view to creating a network of national agencies' (1996, lines 82-84). However the Programme is not a long-term provider. It encourages sustainability. This can be seen in the networks, ' Once firmly established, the networks shall find other sources for funding as bodies cannot be financially supported on a long-term basis' (1999, lines 23-25).

The Commission is presented as a networker whose role is to create links, 'Interlinkages with other relevant Community programmes will be strengthened, and partnerships with the private sector, NGOs and international organizations developed' (1997, lines 33-35). The links are also of a global nature, 'In order to appreciate the global nature of health promotion, participation in the XVI World conference on Health Promotion due to be held in Puerto …' (1998, lines 71 –73).

In summary, the Programme is constructed as being modern and insightful and therefore actively seeks the best in terms of efficiency and impact.

Recipients of Health Promotion

The public and health promotion practitioners are constructed as groups who receive health promotion. Both of these groups are presented as objects of a scientific study. As a result of observing these groups, it has been noted that some variations exist in the groups and that there are certain variables, such as, 'their vulnerability' that need to be taken into consideration when promoting health. There are contradictions in the constructs. On the one hand, the public are represented as in need of empowerment and inclusion, yet the strategies of health promotions disempower and exclude by their vagueness. Health promotion practitioners are presented as a tool for filtering health promotion knowledge down to the public. However, they are represented as not be quite ready to do this, as they are in need of knowledge and guidance.

1) The public

The public who receives health promotion can be divided into several groups. There is the general European citizen, which is either represented as an individual or a community. There are also 'vulnerable or disadvantaged groups' (e.g. 1997, line 14) and targeted groups, such as pregnant women, the elderly and young children (1998, lines 81-82). Groups are seen as disadvantaged as a result of 'their vulnerability or social exclusion or of social and cultural differences' (1996, line 50). The use of 'their' implies some responsibility for and ownership of being 'disadvantaged'. Interestingly, behavioural risk factors are not given any possession or ownership. For example, the text describes 'the issue of alcohol' (1999, line 104) and 'the issue of body weight' (1997, line 73). It does not refer to any action, such as, excessive consumption of alcohol or food. It appears that there has been a shift in the blame. Recipients of health promotion are constructed as being at risk of, simply 'alcohol'. It is almost as if alcohol is a free floating issue that the public have no control over. It is not represented as a behavioural factor. Yet at the same time, the public is constructed as being at risk of other factors such as 'social exclusion' that the individual can be empowered to control.

The Commission gave priority to projects that gave 'control over' individuals and communities health (e.g. 1997, line 30). This implies that the now 'enlightened' Commission is handing back 'control' of health to people, just as a diplomat hands back control to a newly independent country. A strategy for helping a specific issue that affects 'the well being of people' (body weight) is to set up a 'scientific expert group' to organise a conference on 'this matter' (1997, lines 74-77). This strategy is far from 'empowering' which is another aim of the Commission – 'Attention will be paid to .... including means and methods for empowerment and citizen's participation in health development' (198, lines 64-66). In fact, it treats people like the objects of a scientific study. Likewise, another contradiction is the aim of 'facilitation of exchange of information and experience' as a strategy for 'empowering' citizens (1999, lines 71-72). In 2000, with the aim of the development of 'heart health', a 'high profile conference for public health

experts, health professional and policy makers is scheduled' (lines 93- 96). There is no mention of involving European citizens. Describing the conference as 'high profile' is more indicative of a concern with health promotion's status than 'empowerment' or 'exchange of information and experience.

Similar to traditional scientific study, the Programme also aims to observe and monitor the recipients of health promotion. In 1996, the Commission planned to carry out 'feasibility studies on the setting up of a permanent body (the European Health Observatory) responsible for monitoring and evaluating health data and indicators in the Community area' (lines 41-43). Also health promotion interventions that European citizens receive were to be subject to a 'scientific review and analysis' (1998, line 155). These strategies are not in tune with giving individuals and communities control over their health.

2) Health promotion practitioners

These include health care professionals and those 'in the front line of health promotion (e.g. teachers, educators, social workers)' (1996, line 23). This group is represented as in need of health promotion knowledge and guidance. The Programme aims to 'familiarize' this group with health promotion (1997, line 23). The knowledge has to be coordinated and similar. Any variation in knowledge has to be regulated and made similar. This is evidenced by the proposal for a European Master's degree in public health and the statement that at the moment degrees are 'extremely variable' (1996, line 108-112).

This group is also represented as subjects of a science. The Programme states that projects should 'pay attention to the role of health care personnel' in health promotion. It also indicates a top-down approach in which health promotion 'experts' filter knowledge to practitioners who in turn pass this knowledge to European citizens. This is further seen in the aim of using 'modern communication technologies' to 'increase information exchange within the European health promotion community and with the public' (1998, lines 157-159). Clearly, the health promotion community (or 'experts' and practitioners) and the public are seen as two different entities that need some form of modern

technology to communicate. This conjures up an image of health promotion experts existing in one box and the public in another, both far removed from each other yet 'modern technology' is going to some how bring these groups closer. This aim in fact sums up paradoxical intentions of the Programme. It indicates that the health promotion community is separate from the other community about which it refers (i.e. the public community). It also demonstrates inconsistency. On the one hand, the Programme is concerned with disadvantaged groups, yet chooses a method to communicate with this group that is no doubt not readily available to them.

Stage 2 : Discourses

Three discourses have been identified. On the one hand, a religious discourse is used to construct the Programme. Yet a war discourse is used to construct its implementation. Theses discourses are embedded in a scientific discourse.

Religious Discourse

The constructions in the Health Promotion Programme resonate with a religious discourse. The Programme is constructed as insightful, almost enlightened on a mission or crusade with a message to spread. In order for the spreading of the message to be effective, organisation of believers has to take place. One way the Programme is organised, is by training health promotion practitioners to spread the message, in a similar way to disciples spreading Christianity. Just like a religion, it is concerned with sharing and giving. In a similar vein to extreme interpretations of religious literature, there is a clear emphasis and distinction on what is good and bad. Those who partake in what is considered good will be given the 'best' and they will reap the benefits in terms of good health and interventions that are based on scientific findings. Like the protestant religion, not wasting, patience and control are clearly valued.

However the religion of the Programme is constructed as being new and modern. It is represented as different to traditional religions, in that as long as followers believe in the principles of health promotion, differences can be accommodated. It is inspiring rather

than over protective and not unconditionally generous. Rather this religion is in tune with the principles of the western world where nothing is for free and where links and partnerships with the private sector especially on a global scale are important.

War Discourse

By contrast, the construction of health promotion having an enemy draws upon a war discourse. The health promotion experts are represented in the same way politicians and diplomats handle potential threats of war. Experts meet to decide structure and strategies to combat the enemy. Members of the public are not invited to these meetings. The decisions are then instructed to health promotion practitioners, just like soldiers at 'the front line'. It is interesting that a clear picture of risk factors and their harm is presented. However, the structures and strategies to deal with the risk factors are not clearly presented. This is also evident in times of war, when the enemy is clearly known to the public. However the structures and strategies to deal with the enemy are mostly secret.

Just as in times of war, health promotion is concerned with 'targeting'. Health promotion is seen as having useful assets at hand to help its cause - control, exchanges of information, diplomacy and modern technology. These assets are also useful in a war situation. In times of war, we often see vulnerable people, the victims of the enemy. These serve to justify the war. In a similar light, the Programme presents a picture of vulnerable and disadvantaged groups. Vulnerable people are almost blamed for colluding with the enemy (risk factors). However because the Programme is enlightened and modern, it is willing to let these vulnerable groups join the 'good' side if they defect and denounce the enemy.

Scientific Discourse

Knowledge and evidence are conceptualised as being scientific in the Health Promotion Programme. Health promotion is represented as needing knowledge and evidence to implement its principles. As it is concerned with the best, only knowledge and evidence that are based on traditional scientific methods will suffice. There is no mention that any

other kinds of knowledge exist. Therefore there is an emphasis on traditionally scientific methods of collating information, such as monitoring, observing and experiments. Just as in science, these methods produce facts that are often unquestionable. Even the objects of health promotion's study, people, are called 'matter' as in the field of science (1997, line 77). In a similar way to the scientific world, the Programme attempts to organise key players in such a way that the world of the experts is separate from its subject area and clear boundaries are evident. This is supposed to encourage objectivity. The five yearly Work Programmes are very similar. In fact, they are very repetitive, thus giving an impression of being replicable and reliable which are qualities endorsed by a scientific discourse.

Stage 3: Action Orientation

By locating health promotion within a religious discourse, health promotion is seen as something that is good and charitable. An incentive to being involved in health promotion is the moral high ground. By presenting health promotion as being concerned with linking and networking, it is seen as desirable as others also want to be involved. By presenting itself as insightful, new and modern, it cannot be accused of being 'out of touch' as some religions have been. Nor can it be accused of wasting money. Therefore it removes itself from the image of the 'nanny state'. Due to the fact that patience is seen as a virtue and the targets so difficult to hit, and so many in number, expectations can be lowered when all targets are not met by the deadline set many years before.

The religious discourse creates a feeling of being on a mission that could motivate those working in health promotion (the disciples) and give them reasons for their work. Likewise the war discourse could incite action. As a result of the war discourse, strategies to promote health do not have to be explicit. By presenting factors such as social exclusion as belonging to vulnerable groups, responsibility for bad health is taken away from other sources of power such as the European Parliament. It could even lead to a situation in which these groups are blamed for being socially excluded. The war discourse sees the Commission as handing back control and also responsibility to vulnerable citizens. This represents the solution to social exclusion, empowerment, as being fair and

honest. Empowerment implies that those who lack power can be given it by some undefined, almost miraculous means.

By employing a scientific discourse the facts produced from scientific methods are unquestioned. Therefore, potentially, there should be minimum resistance. The experts could be seen as knowing what they are doing and responsibility for health could remain with the experts. The scientific discourse also means that certain types of projects are funded that focus on traditional scientific methods of collecting data. Yet when there is a top-down approach to data collection, the aim of empowerment is contradicted. This approach also disempowers as it excludes needs, wants and feelings from data collection, monitoring and surveillance. The scientific discourse also justifies monitoring, surveying and observing citizens as these methods are represented as necessary to promote health.

Stage 4: Positionings.

The construction of the public as receivers of health promotion positions the public as passive. The scientific discourse reinforces this passive positioning. The public is represented as a well-known object of study that has been well researched and a subject on which there are lots of available facts that now needs to be put into practice. The war discourse positions the public as being in danger yet safe and protected as the Commission has the war under its control.

Although there is mention of the individual's existence, the focus of health promotion's attention is on groups and communities. Therefore the individual is positioned as belonging to a group or a category. The groups and communities are positioned as being diverse. For example, health promotion targets disadvantaged groups, pregnant women, the elderly and children. The very description of 'disadvantaged groups' who need to be empowered positions these groups as victims who have been given a chance, because the Programme is going to allow this empowering to take place. The groups are positioned as homogenous. There is no mention of differences within groups. For example, there is no mention of language or cultural differences that exist in the different 'disadvantaged' groups in the European Union. Language differences are only mentioned in relation to

the experts of health promotion. This again positions the public as passive through this symbolic omission that implies the public does not have a voice.

Being constructed as insightful positions the Commission as superior. Having structures and strategies available, and being constructed as an instigator of action, positions the Commission as being organized, dynamic and innovative. The admission that improvements are needed constructs the Commission as having a human quality, of being adaptable, flexible and amenable to change. Being constructed as a body that is involved in networking, linking and building partnerships positions the Commission as being influential. Both the war and religious discourse position the Commission as being benevolent and a protector, a Crusader even. The discourses imply action is being taken for the sake of the public to prevent it from harm. The Commission is also constructed as benevolent by its emphasis on sharing and exchanging information. The Commission's emphasis on efficiency and not wasting money positions it as being frugal, a quality needed in wartime and valued by some religions.

The war and religious discourses and the construction of health promotion practitioners as in need of knowledge positions the practitioners as instruments of policy who need to be tuned before they can perform well.

Stage 5: Practice

Positioning the public as passive and homogenous, albeit within categories of vulnerability, legitimizes the use of traditional scientific methodology to study health promotion. On the one hand, there is some variance in the groups to be studied, yet, at the same time, they are homogenous and passive thus there is a lack of confounding variables. Positioning the public as being given a chance and being protected could mean that some members of the public (via the passing on of the discourses of their representatives in the European Parliament), feel indebted and grateful to the Commission for its Health Programme. However being protected might actually make people less likely to take responsibility for their health behaviours. Being represented as passive and protected closes down opportunities for empowerment.

Being positioned as superior means that any actions the Commission takes in the name of health promotion is legitimised. Their superiority also makes their action unaccountable, especially to the public and health promotion practitioners, as they are positioned as being below the Commission. It also may mean that the Commission becomes out of touch with the reality of people's lives they are trying to improve.

As instruments of policy, health promotion practitioners are not likely to question their 'masters' upon whom they rely for their expertise and legitimisation of their posts. At the same time, the legitimisation of the need for health promotion practitioners legitimises public spending on their posts.

Being constructed as organized, dynamic, innovative, influential and benevolent with a human quality makes questioning or criticising the Commission's legitimacy difficult because to do so would mean being the opposite of these qualities. Being constructed as frugal makes the Commission even more admirable as it claims a range of qualities and great things with limited resources. However the admiration may be short-lived as the reality may be that many more resources are needed to achieve the goals of health promotion in the European Union. Thus there is a risk of a gap between the reality and the desired outcome which could lead to failure to have an impact on the health of European citizens.

Stage 6: Subjectivity

This final stage traces the consequences of taking up various subject positions for the "participants' " subjective experience.

Not taking part in the advocated health promoting behaviours may lead some individuals to feel guilty as they have not shown enough gratitude to the benevolent experts. Being positioned as victims may reinforce any feelings of low self-esteem which in turn lead some individuals to behave like victims. Thus, any efforts to empower such people will be redundant and meaningless if people feel they are seen and treated as victims. The lack of acknowledgement of individual differences may make some individuals feel like rebelling and expressing their individuality in unhealthy behaviours. On the other hand,

being positioned as in danger may scare some individuals who may consequently act in an obsessive way with regards to health promoting behaviours.

Being positioned as superior and benevolent may make some members of the Commission feel proud. Any questioning of their knowledge or aims to do good may leave them feeling offended. This superiority means that information and knowledge only flow one way - top down. It means there are no mechanisms for a two-way flow of information and knowledge. This may frustrate health promotion practitioners as they see the realities of health promotion efforts at grass roots level and yet they may find questioning the structure and strategies problematic as this would question their existence.

Summary

The EC's Health Promotion Programme and its key players are constructed as being concerned with doing good and efficiency. European citizens are constructed as recipients of this good and efficient force. The identified discourses legitimize these constructions. Yet these discourses and their positionings could also mean the Programme has the opposite effect to that intended. The Programme could encourage two extreme forms of behaviour, namely rebelling against health promotion advice or becoming obsessed with the advice. The contradiction of aiming to empower yet having clear distinctions of power and superiority reinforces the gap between the two worlds of the health promotion receivers and health promotion advisors. Being out of touch with a group that you believe should be empowered is not conducive to empowerment. Evaluation is seen as crucial for improving the knowledge of health promotion yet the recommended methods of evaluation are not in line with an empowering approach as the power is taken away. The public become 'subjects' of the Programme rather than true participants.

Discussion

Three discourses have been identified in the EC's Health Promotion Programme and the implications of the discourses have been explored. Individuals are positioned only as members of groups or communities. Therefore the examination of the positioning of the individual focused on the individual in a group or a community. This analysis suggests that the Programme concerned with being insightful and all encompassing has gone for the middle ground. It has attempted to take into consideration the two critiques of health promotion. It disassociates itself from the right-wing critique that sees health promotion as a preaching 'Nanny State' and takes on board the 'radical' critique that sees poverty, inequity and social exclusion as the root causes of poor health (see Lupton, 1997). Taking the middle ground reveals the highly political nature of health promotion. Such a strategy may be necessary in a political context but the reality of this strategy may also lead to a 'stale-mate' situation where no progress is made. Even worse, it may lead to a step backward in the field of health promotion.

In accepting that poverty, inequity and social exclusion are related to poor health, the Programme has shifted the blame. So it is not the individual who is at risk from the self in terms of lifestyle (see Ogden 1995). Instead the individual is constructed in a similar way to that, that Odgen (1995) stated was being used by psychological theory at the beginning of the twentieth century. Although it is not the individual who is represented as the passive responder but the individual who forms part of a group or community. This construction of the individual as being part of a community could reflect the cultural context of the EC, that is more concerned with communities rather than individuals and the use of the matrix model of health promotion. However it appears that health promotion policies in general are now adopting this community approach to health promotion (e.g. see Department of Health, 1999). It would be interesting to compare the discourses of the EC's Health Promotion Programme with the England's *Saving Lives: Our Healthier Nation.*

The groups and communities in the Programme are represented as having ownership of the 'external cues' that shape them such as poverty, inequity and social exclusion. However these external cues as described by Ogden (1995) may need some political action rather than simply a political recognition. Therefore these constructions do not empower individuals. They victimise them further. They are represented as no longer being victims of their own behaviour but victims of their own external cues. In fact the Programme seems to mystify any relation to health being related to individual behaviour. It is almost as if the 'insightfulness' of the Commission precludes any political incorrectness such as reference to individual behaviour and health promotion. The concept of surveillance that both Lupton (1997) and Ogden (1995) discuss is evident in this Programme. However the reflection is on the collective rather than the individual.

The discourses and positioning in the Programme are far from empowering. Poverty and social exclusion continue to be problems causing health inequalities (Campbell and Jovchelovitch, 2000). Constructing poverty and social exclusion as being variables that groups and communities can control is set for failure, as many other political, social and economic factors are involved. These constructions could give hope but there is danger of them eventually reinforcing despair and low-self esteem, especially as these determinants are represented as scientific facts.

Several studies have shown that disempowering discourses in relation to health are employed by the public and the media. For example Gillies (1999) interviewed four working-class female smokers. She identified a discourse of addiction. She argued that the dominant construction of smoking as a physiological addiction is disempowering as it 'evokes a frightening world view that portrays it as hopeless for people to try to control their own lives or habits' (p. 81). Willig (1998) interviewed sixteen heterosexual adults about sexual risk-taking within the context of HIV/AIDS. She found that the way the interviewees positioned themselves with regard to the practice of safer sex was disempowering. For example, sex was constructed as a temptation. This, she argued positioned the interviewees as 'permanently vulnerable to the powerful pull of extramarital passion' (p. 389). Lyons and Willott (1999) examined a three week special

feature on 'A woman's guide to men's health' featured in the British newspaper *The Mail on Sunday* in February 1998. They found that men were constructed as victims who required 'looking after'. They also found that the 'rational self' discourse identified in previous research into the portrayal of health information in popular culture was only directed at women. Thus to some extent this challenged traditional gender dichotomies that portray women negatively as irrational and emotional and men as rational and cerebral. Lupton (1994) analysed the discourse surrounding breast cancer in the Australian press between 1987 and 1990. She identified a war discourse whose purpose, she argued, was to instill fear and disempower the patient at the same time. She quoted Montgomery (1991) who stated that – 'When taken as a whole and stripped of its everyday, naturalized character, the language of militarism portrays its users as a terrorized and occupied people' (p. 84).

The Programme intends to improve knowledge and practice in the field of health promotion. Yet the dominance of the scientific discourse could prevent advancement. This discourse only values one type of research and evaluation. It values research that positions people as subjects to be observed and measured and it values outcome evaluation. Thus no allowance is given to how people feel about certain issues in health promotion. Meanings, values placed on health and definitions are not explored. It has been pointed out above that there are great variations of these concepts (Seedhouse, 1997; Stainton Rogers, 1991; Radley, 1998). In omitting to define health or refer to different meaning of health, the Programme remains vague. This vagueness further disempowers because the promises of improvement can not be pinpointed. Ironically this vagueness is not conducive to traditional scientific evaluation as success and failure can not be measured if what you are measuring is not clearly defined.

Seedhouse's (1997) claim that there is an illusion of shared meaning in health promotion has been demonstrated in this analysis of the EC's Health Promotion Programme. Experts and recipients of health promotion are clearly constructed as existing in two separate worlds with different realities. However it is assumed that the meanings of health are the same in both worlds and there is no variation inside each of the two worlds. The

Programme promotes the reification of these different worlds. No efforts to bring the worlds closer are made. It reinforces a hierarchy of power. Communication in this Programme has been shown to be far from a two-way process and, in fact is top-down. Information and knowledge are filtered using a top-down process with an assumption of a cause and effect relationship between experts' advice and layperson's actions.

This analysis has supported Lupton's (1997) claim that health promotion is not value-free or neutral but socially contextual, highly political and changes in time and place. It has also offered insight into how the discourses in health promotion might invite individuals or communities to conform to the health promotion objectives and discipline themselves and turn the gaze upon themselves in the name of health. The scientific discourse presents health promotion facts as unquestionable and the war discourse clearly describes the enemy in terms of risk factors. Thus it could be that fear and feelings of vulnerability make individuals gaze inwards and grasp at what appears unquestionably to be their saviour/protector – health promoting behaviours. Also engaging in health promotion is represented as desirable, modern and morally good. This may also encourage people to gaze inwards and follow health promotion advice.

As with any method of analysis, there are limitations to discourse analysis. This analysis is itself a discursive construction based on the experiences of the author who has been involved in an evaluation of the EC's Health Promotion Programme. This experience would have influenced the analysis. The author had a unique experience of being both an outsider conducting an evaluation but also worked closely within the Commission services. It may be argued that having had this experience a rather subjective interpretation has been made. However having the insight into the EC may have also enhanced the analysis. Parker (1992) argued that it is useful to have knowledge of a culture whose discourse you are analysing. Likewise, those involved in writing the Programme may not be aware of the identified discourses, nor recognize them. However this does not mean they do not exist. Yet the Health Promotion Work Programmes would have been drawn up by Members of the European Parliament, most for whom English was not their first language. Therefore some of the analysis may reflect linguistic

difficulties rather than linguistic meaning. Having said that, the EC employ some of the most highly skilled translators in the EU.

The uniqueness of the Foucauldain discourse analysis is exploring issues of subjectivity. Yet it is this part of the analysis that is most speculative. Subjects of the text may disagree, even be upset, with the analysis. However the process of discourse analysis is a journey of unraveling a text. The author, in writing up the analysis, is sharing this journey with the reader. The reader cannot be expected to experience the same level of understanding of the text without having undergone the unraveling. Likewise, if the reader does analyse the text, a different interpretation may occur. It would be interesting to compare a discourse analysis of the EC's Health Promotion Programme by an author who had not been involved in any EC organisation. It would be interesting not as a validation tool but as a comparison of interpretations. Sharing of discourse analyses should be treated with sensitivity. A clear explanation from the author that an interpretation is being described rather than a fact presented may be necessary. This is especially true when the subjects of the analysis could be offended.

Coyle (1995) pointed to another pertinent criticism that 'in analyses of power, discourse analysis encourages an over-attention to how imbalanced power relations are reproduced in language and an under emphasis on the endurance of such power relations independent of language'(p. 256). Parker (1992) argued that discourse analysis should become a like a variety of action research, in which once discourses have been identified, the internal system of any discourse and its relation to others is challenged. Recently, the Critical Health Psychology Association has tried to address the imbalance of power. For example, Prilletensky and Prilletensky (2003) have proposed several ideas for health interventions focusing on empowerment and partnerships that take into consideration the imbalance of power. They stated that wellness cannot be fragmented into economic, social and psychosocial health and that health psychologists should not fragment their work.

Conclusion

This analysis aimed to map the discursive world of the EC's Health Promotion Programme and trace possible constructions. This approach assumes that there is no one version of the world and that 'no version of the world remains dominant forever because the social construction of reality through discourse is characterized by change and transformation' (Willig, 2001, p.121). During 1996 - 2000, the EC's Health Promotion Programme aimed to empower and improve the health of European citizens. As attempts to do this were made within the constraints of a power hierarchy and an illusion of shared meaning, it may transpire that these aims will not be achieved unless genuine efforts are made to empower and reduce inequality. This may lead to a new wave of discourses in health promotion. It will be interesting to compare this analysis with analyses of future Programmes.

Chapter 7
Discussion and Conclusion

This chapter aims to bring together the evaluation and the discourse analysis of the EC's Health Promotion Programme as a platform for a discussion of the current climate of health promotion.

Synthesis of results

Interestingly the evaluation, reflections and the discourse analysis seem to complement each other to some extent. The positioning of the Commission as being superior supports the findings of the reflection and some of the comments from representatives of the Member States. For example, ten countries thought that there is a lack of transparency in the Committee procedures. This Committee is chaired by a senior employee of the Commission services. Spain stated that criteria were applied inconsistently and that some projects were unrecognisable from the summaries produced by the Commission services. Likewise Denmark also noted that some projects fitted the Programme exactly, which raised the question whether some projects were decided before the Programme had been agreed. This also reflects the concerns of the assessors that some projects had duplicated work already done. Spain's criticism needs further explanation of the funding procedures. Applications are received by the Commission services who summarise and shortlist the projects. The Health Promotion Programme Committee receives the summaries on the day of the Committee meeting and is required to confirm the proposed allocation of funds. Thus time restraints prevent a through analysis of all the projects by the whole Committee. These findings all point to a system in which the Commission's services are unaccountable and make decisions prior to any discussion by the representatives of the Member States.

The discourse analysis revealed a scientific discourse in the Programme that values the use of outcome evaluation. This was highlighted in the evaluation team's experience of proposing a methodology for the second phase of the evaluation. It was stated that the methodology must focus on outcome evaluation. This is despite there being no baseline data coupled with inaccurate and incomplete records held by the

Commission's services. A further hindrance to such an evaluation is revealed in the comments by the expert panel about the funded projects. Seven of the major themes revealed such an evaluation would be difficult. For example 43% of projects were considered not to have enough information in the final reports, 27% lacked follow-up and 24% were difficult to evaluate due to missing information, poorly stated objectives and complexity. Despite this lack of information, representatives from thirteen Member States and Iceland felt confident enough to state the Programme had an impact on the development of health promotion in their country. Only France explicitly mentioned that the lack of evaluation prevented such an assessment. This reinforces the results of the discourse analysis in which the world of the experts/the Commission is very different from the world of the health promotion practitioners. The practitioners and project leaders are expected to focus on outcome evaluation and employ traditional scientific methods. However the people that dictate such methods are not putting them into practice in their own work and can make judgements that are not based on evidence.

The matrix model focuses on settings and communities. This focus was picked up in the discourse analysis. The discourse analysis identified communities or disadvantaged groups as discursive constructions. The quantitative analysis found that most funding went to areas of action that focused on vulnerable groups.

The current climate of health promotion

The findings from this thesis have highlighted the juxtaposition of two themes in health promotion today. Firstly, there seems to be an emphasis on community based health promotion. Secondly there is an emphasis on evidence-based health promotion.

The criticisms of the focus on communities/groups highlighted by the discourse analysis warned of the danger of seeing these groups as one homogenous mass. However in practice this does not have to be the case. Raeburn and Rootman (1998) offered insight into a approach to health promotion called 'people-centred health promotion'. They observed that the history of health promotion since the 1970s has swung from one ideological stance to another, with fundamentally different views

being expressed about the nature of health promotion. They claimed to move beyond the lifestyle versus social model debate and focus on the primary concern of health promotion, i.e. people.

Raeburn and Rootman (1998) agreed that the term 'health promotion' tells us very little as almost any undertaking in the health field can be seen as promoting health. They stated that the prevention and reduction of disease and disabilities rather than the promotion of health as a positive concept is more accurate. Their approach is person-centred and in short focuses on 'empowerment'. They admit that this is an overworked concept but point out that it has many interpretations. For example, they think that governmental and health agencies only pay lip-service to 'empowerment' and the other 'trendy' concepts that go along with this such as 'participation', 'consultation,' 'community boards' and 'democracy'.

Raeburn and Rootman (1998) advocate 'community control' for their empowering/community development approach to health promotion. However they are aware of the difficult reality to such an approach. They know that any action of value requires people to have real power to make decisions and the resources to implement decisions. Policy-makers and politicians, however, have little desire to give away their control to allow scarce resources to go directly to the community. Behind their concept of health promotion is the notion of people building their own sense of personal strength by determining their own destinies and having the personal and material resources in a supportive environment. This is similar but more extended notion of 'collective self-efficacy' described by Bandura (2000) (see chapter one)

A definition of health promotion is provided by Raeburn and Rootman (1998) as follows:

> *...health promotion is an enterprise involving the development over time, in individual and communities of basic and positive states of and conditions for physical, mental, social and spiritual health. The control of and resources for this enterprise need to be primarily in the hands of people themselves, but with*

> *the back-up and support of professionals, policy-makers and the overall political system. At the heart of this enterprise are two key concepts: one of development (personal and community), and the other of empowerment.* (p.11).

Jason (1997), a community health psychologist, talks in similar vein but offers more practical advise to people working in this field. Like Raeburn and Rootman (1998), he emphasised the importance community involvement. He warns that often in 'community work', the communities become the subject of interventions rather than being co-creators and professional attention wanes and fades away, leaving the intervention hanging in a state of limbo. He states that practitioners working in such programmes must be able to provide ideas, expertise, resources and support before, during and after the intervention.

Jason (1997) shares a rather unglamorous example of community health psychology. This was his first attempt at working from this community perspective. He offered to help a community in Chicago with its number one health problem. This problem, he discovered, was dog litter. Dog litter was making the community environment unpleasant and representing a health hazard due to spread of infection and disease.

His study consisted of researchers observing for five hours a day the number of dogs who defecated and the number of dog defecations picked up by dog owners during a seven-day baseline period. The researchers collected and weighed all defecations that had not been picked up by dog owners. Only 5% of dog owners were observed picking up their dog litter and more than 19 pounds of litter was deposited in one target block.

The intervention comprised of posting up anti-litter signs. However relatively few changes were made. In the next stage, all dog owners on the block were given instructions and demonstrations (i.e. modeling) on the use of a plastic bag to pick up the dog litter. At 25 months after the intervention, a 89% reduction in dog litter at the site was reported.

Jason was asked to present the results at the City Hall in support of a proposed law that would require dog owners to have 'pooper-scoopers' in their possession when they walked their dogs. The study had received a lot of local publicity and had helped change politicians' perception of the problem. The law was passed.

In the foreword to Jason's book, Adelman and Frey warned that we must not romanticise about the communities of yesteryears. These communities were often insulated, only accepting members if they were of a certain race, religion, or ethnicity and only followed strict rules of conduct. In today's multicultural world, we need to move away from this type of community. Today's community needs to accept difference and dissent as well as sustain collective visions and values. Adelman and Frey observed a problem when talking about 'community'. Often, 'community' is referenced to as a noun, 'like some construction project that is finished when particular types of communication are practiced' (p. xii). They advised that 'community' is referenced to as a verb, as processual and continually in flux. Therefore it is better to speak of 'community building'.

Sowers, Garcia and Seitz (1996) placed community-based prevention programmes in historical context. The first approach to prevention programmes focused on risk and resiliency factors; secondly developmental approaches focused on healthy human development, thirdly approaches focused social influence; now we are seeing the community-specific approach emerge. They reported that these models have had varying degrees of success. 'Community development' approaches are the newest and most all-encompassing of the 'community-specific approach. They are also the most complex and hard work. Sowers et al (1996) referred to the five basic 'principles of practice' that have been noted by practitioners and researchers in the field. These are:

(1) begin from a base of community ownership of the problems and the solutions;
(2) plan thoroughly, using relevant theory, data and local experience bases for programme decisions;

(3) know what types of interventions are most acceptable and feasible (in the absence of certainty about what is most effective) for specific population and circumstances;

(4) have an organizational advocacy plan to orchestrate multiple intervention strategies into a complementary, cohesive programme;

(5) obtain feedback and evaluation of progress as the programme proceeds

(Sowers, Garcia and Seitz , 1996, 228).

Sowers et al (1996) draw attention to the difficulty of these problems. For example, the first principle requires defining a community. This is not an easy task as geographic boundaries are not always easily defined. Once a community has been defined, getting a community to assume responsibility for its problem would be a difficult task. Like the findings of the discourse analysis, Sowers et al (1996) stated the focus on the community is also slightly reminiscent of the 'victim-blaming' era of health promotion. However they argued that if the techniques of this approach are applied correctly then there should not be a discourse of blame rather the emphasis should be on reflection, empowerment and negotiation and re-negotiation.

Campbell and Jovchelovitch (2000) summarised the debate that the concept of what is know as 'social capital'. This may provide a framework for conceptualising the features of a community that are most likely to enable and support health-enhancing behaviours. Putman (1993) defines social capital as community cohesion which is a result of four factors:

"(i) the existence of a dense range of local community organisations and networks; (ii) high levels of civic engagement or participation in these community networks; (iii) a strong and positive local identity and a sense of solidarity and equality with other community members; and (iv) generalised norms of trust and reciprocal help and support between community members, whether or not they are personally known to one another" (Campbell and Jovchelovitch, 2000).

Social capital is thought to be helpful in health promotion as communities that are strong in social capital can provide a supportive context within which people can

collectively re-negotiate social identities in ways that promote the increased likelihood of health-enhancing behaviours. Equally communities with strong social capital are more likely to have high levels of perceived control over their lives which is a health-enhancing factor.

Campbell and Jovchelovitch (2000) pointed out that the concept of social capital has been criticised for its failure to recognise the way in which various forms of social exclusion can undermine the resources in marginalised communities. They also highlighted the danger that such a concept has the potential to be 'hijacked' by neoliberal, free market theorists who might believe that grassroots organisation have the power to take over functions previously assigned to governments such as welfare and thus justify any spending cuts. Campbell and Jovchelovitch (2000) argued that social capital does have the potential to be a useful framework for conceptualising community-level influences on health. However they stated that much work has to be done on design and evaluation of health promotion programmes using such a concept. Also they argued that the concept needs further development along two dimensions. Firstly, they argued that there is a need to theorise the larger power mechanisms that shape and constrain the potential influence of social capital on health. 'Secondly, there is a need to explicate the social psychological mechanisms whereby social capital and community participation it entails impact on health.' (p 263).

It seems that health promotion has reached a crossroad. Methods of promoting health have been tried and tested. The dilemmas have been pointed out. An injection of new hope – 'the community-development' approach is enabling some professionals to cross this crossroad. This new hope is further enthralling and exciting as there is a huge risk element involved. However on the whole there is still an element of a top-down approach in policy that dictates expectations and methods of evaluation. A true commitment to a community development approach to health promotion cannot afford this type of mentality. Neither can it be assumed that local people will automatically trust and cooperate with outsider workers on 'another social experiment'. Wolff (2001a) warns of the danger of 'overcoalitioned communities' It needs participation and constructive dialogue between what 'we know; and 'they know'. It requires a recognition of different types of knowledge and expertise

(Campbell and Jovchelvitch, 2000). It requires patience in building trust, perseverance, risk and hard work. The recommendations beginning to emerge from leading figures all seem to emphasize this point [e.g. Campbell and Jovchelovitch (2000), Folayemi (2001), Foster-Fishman, Berkowitz, Lounsbury, Jacobson & Allen (2001), Jason (1997),Wolff (2001a)]. Evaluation techniques in which the overall vision, meaning, motivations and long term outcomes for *all* stakeholders will help determine which projects are based on a true commitment to a community development approach to health promotion and clarify the process of successful projects that have an impact on health. Wolff (2001b) warns that community coalition building cannot be recommended as a catchall panacea but that the future holds a great promise for community coalitions as powerful interventions for change.

Therefore in order for community-based health promotion to progress there is still a need for serious consideration by practitioners, lay-participants and policy-makers of new methods of evaluation. These methods need to be mutually beneficial to all stakeholders and should not disempower. Judd et al (2001) noted that community practitioners and lay participants often feel that evaluations are imposed upon them and that traditional methods of evaluation do not take into account the uniqueness of their community, its programme, resources and skills. This observation matches the findings of the discourse analysis.

The notion of 'evidence-based practice' has already received many criticisms and has been the centre of much debate (e.g. Marks, 2001; Macintyre, Chalmers, Horton & Smith 2001; Speller, Learmouth & Harrison, 1997; Trinder & Reynolds, 2000; Whitelaw & Williams, 1994). A key question in this debate is what data provides evidence for evidence-based decisions. Marks (2001) pointed out that *Saving Lives: Our Healthier Nation* was developed at the same time that an evaluation of the previous government's policy the *Health of the Nation* (Department of Health, 1992) was being conducted, thus not allowing any time for recommendations to be implemented. Marks (2001) notes that the evaluation report 'Health of the Nation – a policy assessed' (Department of Health. 1998) gave pointers for a new health strategy which included developing the evidence base for both target setting and other implementation activities. He quotes the evaluation as stating:

"The *Health of the Nation* failed over its five year life span to realise its full potential and was handicapped from the outset by numerous flaws of both a conceptual and process-type nature." (Department of Health, 1998, 13).

"Local authorities in general perceived the *Health of the Nation* to be dominated by 'medical conditions' and heavily 'medically led'." (Department of Health, 1998, 15).

The evaluation report recommended among other things that a new health strategy should address the underlying determinants of health and inequalities and suggested that a matrix model as used in the EC's Health Promotion Programme has many advantages. However this matrix was not used in *Saving lives: Our Healthier Nation.* Thus the report highlighted the debate about whose or what data provides evidence. Judd et al (2001) stated that recently health promotion programmes, their evaluations and standards of acceptability seem to be driven more by a concern for the electoral cycle than by scientific evidence or community relevance.

Judd et al (2000) have proposed that there are three elements that are central to evaluation of community-based health promotion programmes. They argue that their approach offers a means of creating a situation in which policy-makers and funders are more supportive of evaluation designs that fit with community realities and community stakeholders are more capable and consistent in rigorously evaluating community-based health promotion programmes and policies.

They offered a taxonomy of 'standards' for community-based health promotion programmes that emphasise the visions, motivations and meanings of policy-makers and community stakeholders. Along with the use of the 'standards' they stated that community-based evaluation should adopt a 'salutogenic' stance and values base and use an inclusive, empowering dialogue that engages all relevant stakeholders in the setting of standards for a given initiative. Antonovsky (1979; 1996) proposed the 'salutogenic' orientation to health. Salutogenesis focuses on health as opposed to disease or illness. Judd et al (2001) proposed that adoption of a salutogenic

perspective highlights the importance of starting from a consideration of how health is created and maintained through community-based health promotion.

Despite proposing three elements of importance, the main focus of the paper by Judd et al (2001) is on the 'standards'. They identified eight approaches to setting standards and argued that these should be considered in evaluation of community health promotion: arbitrary, experiential and utility standards in which planning and evaluation are primarily driven by the perceived needs, values and expectations of practitioners, lay participants or professional decision-makers. Historical, scientific and normative standards where planning and evaluation are driven by empirical objective data. Propriety and feasibility standards wherein the primary concern is for consideration of available resources, existing policies, legislation and administrative factors.

Judd et al (2001) acknowledged the need for advancement in evaluation of community based health promotion. They have proposed elements for improvement that recognise that good science poorly applied will not advance the quality and utility of community-based evaluations and that community-based health promotion programmes in which there is little or no attention is paid to evaluation is inappropriate. They stated that policy-makers, funders and taxpayers have a right to demand accountability and some measure of the success of health promotion programmes. Inclusive and empowering dialogue are proposed as a key element in which the standards can be understood and used. However no mechanisms for dialogue are offered.

It appears that there is no recipe for a community development approach to health promotion and its evaluation. However dialogue is a crucial ingredient. It can be seen from the reflections of the evaluation of the EC's Health Promotion Programme that a mechanism for improving dialogue between all stakeholders is essential. It is no use simply stating that dialogue is needed for effective community-based health promotion and evaluation. Tools need to be created and used to improve dialogue before the planning of evaluation even takes place.

A systems thinking approach as described by Senge, Kleiner, Roberts, Ross and Smith (2001) is starting to be used in some community-based health promotion programmes. They have written a pragmatic guide to aid collaboration and dialogue in organisations and groups of people working together. Systems thinking intends to avoid a top-down or bottom-up approach but aims to be participatory at all levels. It encompasses a fairly large body of methods, tools and principles, all oriented to looking at the inter-relatedness of forces and seeing them as part of a common process. Senge et al (2001) also describes tools for helping groups of people build and keep a common vision and adopt a clear picture of the current reality and build ways together to closer the vision.

Conclusion

The juxtaposition of community-based health promotion and evidence-based health promotion may at first seem a contradiction. Effort is being made to bring the themes together. This requires a recognition that community-based health promotion needs key elements for it to work. These elements cannot be created overnight because policy has latched on to a new idea and dictates its implementation. Practitioners of community-based health promotion need to see the importance of evaluation and move away from the culture of 'tag-on' evaluations. It has to be understood that policy-makers require some form of evaluation as they are accountable for spending public money. We need some ways of identifying innovation and waste. Facilitated dialogue can help practitioners, policy-makers and funders understand each others perspectives. However evaluation needs to be more flexible. We need to recognise the myopic love affair with evaluation as a measure of good or bad. Evaluation can be far more sophisticated. It can be a method to help us learn and improve. Evaluation in health promotion needs to recognise that the question 'what works?' depends very much on which data you consult. There needs to be a shift from the dominance of outcome orientated evaluation. This is not to deny that there is a place for such evaluations. It simply means that more diverse means of evaluation that highlight the concerns of all stakeholders need to be given more credence and be better understood by policy-makers and funders. This requires time, reflection and commitment. In practice, we still seem to be far from taking these requirements seriously. Stakeholders need to feel comfortable spending time on activities that build a true

commitment to projects, a true sense of partnership between all stakeholders and develop appropriate methods of evaluation. At the moment, the culture of evidence-based practice does not allow time to be spent on such activities because they are difficult to measure in a traditional way. From the onset of projects, there is a race, almost a panic, to spend time chasing outcomes. Perhaps in time the discourse of evidence based health promotion will be dropped and replaced. I sense it will. This leaves me with one question. Does a discourse produce an action and practice or do actions and practice produce a discourse? If the latter, then small gradual changes in actions and practice will eventually transform the current discourse of health promotion. For me, health promotion is an evolutionary process that is driven by a collective quest to progress human existence. Therefore I feel health promotion will continue to dominate our lives. However it is gradually adopting a different guise.

References

Adelman, M. B & Frey, L.R. (1997). Foreword: Communication and community building. In L.A. Jason, *Community building. Values for a sustainable future.* (pp.ix-xxii) Westport: Praeger.

Abraham, C. & Sheeran, P. (2000). Understanding and changing health behaviour: From health beliefs to self-regulation. In P. Norman, C. Abraham & M, Conner (Eds.), *Understanding and changing health behaviour from health beliefs to self-regulation* (pp. 3 -26). Amsterdam: Harwood Academic Publishers.

Abraham, C., Norman, P. & Conner, M. (2000). Towards a psychology of helath-related behaviour change. In P. Norman, C. Abraham & M, Conner (Eds.), *Understanding and changing health behaviour from health beliefs to self-regulation* (pp. 343-369). Amsterdam: Harwood Academic Publishers.

Antonovsky, A. (1979). *Health, Stress and Coping.* Jossey-Bass, San Francisco.

Antonovsky, A. (1996). The salutogenic model as a theory to guide health promotion. *Health Promotion International*, 11, 11-18.

Armstrong, D. (1993). Public health spaces and the fabrication of identity. *Sociology*, 27, 393-410

Astrand, P.O. (1994). Physical activity and fitness. Evolutionary perspective and trends for the future. In C. Bouchard, R. J. Shephard & T. Stephens (Eds.), *Physical activity, fitness and health.* (pp. 98-105). Champaign: Human Kinetics,

Backer, T.E., Rogers, E.M. and Sopory, P. (1992). *Designing health communication campaigns: What works?* Newbury Park, CA: Sage.

Backett-Milburn, K., Platt, S., & Watson, J. (1998). Understanding the commissioning process: the background to effective health promotion research and evaluation. *Health Education Journal*, 57, 174-183.

Baggott, R. (2000). *Public health. Policy and politics*. Hampshire: MacMillan Press Ltd.
Bandura, A. (1977). Self-efficacy:towards a unifying theory of behavioural change. *Psychological Review*, 84, 191-215.

Bandura, A. (1977). Self efficacy: Towards a unifying theory of behaviour change, *Psychological Review*, 84, 191-215.

Bandura, A. (1998). Health promotion from the perspective of social cognitive theory. *Psychology and Health,* 13, 623-649.

Bandura, A. (2000). Health promotion from the perspective of social cognitive theory. In P. Norman, C. Abraham & M, Conner (Eds.), *Understanding and changing health behaviour from health beliefs to self-regulation* (pp. 299-339). Amsterdam: Harwood Academic Publishers.

Bargh, J.A. (1990). Auto-motives: Preconscious determinants of thought and behaviour. In E.T. Higgins & R.M. Sorrentino (Eds.), *Handbook of Motivation and Cognition: Foundations of Social Behaviour,* New York: The Guildford Press.

Becker, M.H. & Maiman, L.A. (1975). Sociobehavioural determinants of compliance with health and medical care recommendations. *Medical Care*, 13-10-24.

Bennett, P. (2000). *Introduction to clinical health psychology*. Buckingham: Open University Press.

Bennett, P. & Murphy, S. (1998). *Psychology and health promotion*. Buckingham: Open University Press.

Biddle, S. J.H. & Mutrie, N. (2001). *Psychology of physical activity. Determinants, well-being and interventions*. London: Routledge.

Coyle, A. (1995). Discourse analysis. In G. Breakwell, S. Hammond, & C.F. Schaw, (Eds.). *Research methods in psychology*. London: Sage.

Bunton, R., Murphy, S. & Bennett, P. (1991). Theories of behavioural change and their use in health promotion: some neglected areas. *Health Education Research. Theory and Practice.* 6, 153-162.

Callahan, D. (1990). *What kind of life: The limits of medical progress.* New York: Simon: Schuster.

Campbell, C & Jovchelovitch, S. (2000). Health, community and development: Towards a social psychology of participation. *Journal of Community and Applied Social Psychology*, 10, 255-270.

Chadwick, E. (1842). *Report on the Sanitary Conditions of the Labouring Population of Great Britain.* London: Poor Law Commission.

Communiqué, (2001). WHO responds to PHA. London: Medact.

Connell, J.P. & Kubisch, A.C. (1998). Applying a theory of change approach to the evaluation of comprehensive community initiative: progress, prospects, and problems. In K. Fullbright Anderson, K. Kubisch & J.P. Connell (Eds.), *New approaches to evaluating community initiatives. Volume 2 Theory, measurement and analysis.* (pp 15-44) Washington DC: The Aspen Institute.

Conner, M. & Sparks, P. (1996). The theory of planned behaviour and health behaviours. In M. Conner & P. Norman, P. (Eds.), *Predicting health behaviour* (pp. 121-162). Buckingham: Open University Press.

Conner, M. & Norman, P. (1996). *Predicting health behaviour*. Buckingham: Open University Press.

Department of Health (2000). 'The NHS Plan. A plan for investment. A plan for reform. London: HMSO.

Department of Health (1999). 'Saving Lives. Our Healthier Nation.' London: HMSO.

Department of Health (1998). 'Health of the Nation – a policy assessed.' London: The Stationery Office.

Department of Health (1992). 'Health of the Nation'. London: HMSO.

Department of Health and Social Security (1977). 'Prevention and Health: Everybody's Business.' London: HMSO.

Dibb,E. (1993). 'Children: Advertisers' Dream, Nutrition Nightmare? London: National food Alliance.

European Commission (1997). 'Public health in Europe.' Luxembourg: Office for Official Publications of the European Communities.

European Parliament and Council (1996). Decision No645/96EC –Adopting a programme of Community action on health promotion, information, education and training within the framework for action in the field of public health (1996-2000). *Official Journal of the European Communities*, 39, 1-8.

Everitt, A. & Hardiker, P. (1997). Towards a critical approach to evaluation. In M.Sidell, L.Jones, J. Katz & A. Peberdy (Eds.), *Debates and dilemmas in promoting health. A reader*. Hampshire: Open University Press.

Fishbein, M. & Ajzen, I. (1975). *Belief, Attitude, Intention, and Behavior*. New York: Wiley.

Fiske, J. (1990). *Introduction to communication studies*. London: Routledge.

Fitzpatrick (2001). *The tyranny of health. Doctors and the regulation of lifestyle*. London: Routledge.

Fitzpatrick, M. (2001). The tyranny of health. Doctors and the regulation of lifestyle. London: Routledge.

Flay, B. R. (1987). Mass media and smoking cessation: A critical review. *American Journal of Public Health*, 77, 153-160.

Folayemi, B. (2001). Case story # 1: Building the grassroots coalition. *American Journal of Community Psychology*, 29, 193-197.

Foster-Fishman, P.G., Berkowitz, S.L., Lounsbury, D.W., Jacobson, S. & Allen, N.A. (2001). Building collaborative capacity in community coalitions: A review and integrative framework. *American Journal of Community Psychology*, 29, 241-261.

Garfield, S. (2001). 'AIDS. The first 20 years'. *The Observer Magazine*, June, 16-24.

Gilles, V. (1999). An analysis of the discursive positions of women smokers. In C. Willig (Ed.), *Applied discourse analysis. Social and psychological interventions*, Buckingham: Open University Press.

Gollwitzer, P.M. & Oettingen, G. (2000). The emergence and implementation of health goal. In P. Norman, C. Abraham & M, Conner (Eds.), *Understanding and changing health behaviour from health beliefs to self-regulation* (pp. 229-260). Amsterdam: Harwood Academic Publishers.

Harrison, J.A., Mullen, P.D. & Green, L.W. (1992). A meta-analysis of studies of the health belief model with adults. *Health Education Research*, 7, 107-16.

Hawton, K., Simkin, S., Deeks, J.L., O'Connor, S., Keen, A., Altman, D.G., Philo, G. & Bulstrode, C. (1999). Effects of a drug overdose in a television drama on presentations to hospital for self poisoning: time series and questionnaire study. *British Medical Journal*,318, 972-977.

Holland, W., Mossialos, E. & Permanand, G. (1999). Public health policies and priorities in Europe. In W.Holland & E. Mossialos (Eds.), *Public health policies in the European Union.* (pp.1-48) Hampshire: Ashgate Publishing Limited.

Johnson, J.L. (1991). Learning to live again: the process of adjustment following a heart attack. In J.M. Morse & J.L. Johnson, J.L. (Eds.), *The illness experience: Dimensions of suffering.* Newbury Park: Sage.

Janz, N. & Becker, M.H. (1984). The health belief model: a decade later. *Health Education Quarterly*, 11, 1-47.

Jason, L. (1997). *Community building. Values for a sustainable future.* Westport; Praeger.

Judd, J.C., Frankish, J. & Moulton, G. (2001). Setting standards in the evaluation of community-based health promotion programmes – a unifying approach. *Health Promotion International*, 16, 367-380.

Judge, K. (2000). Editorial. Testing evaluation to the limits: the case of the English Health Action Zones. *Journal of Health Services Research and Policy*, 5, 1-4.

Lalonde, M. (1974). *A new perspective on the health of canadians. A working document.* Ottawa, Government of Canada.

Lau, R., Kane, R., Berry, S., Ware, J., & Roy, D. (1980). Channeling health: A review of the evaluation of televised health campaigns. *Health Education Quarterly*, 7, 56-89.

Lewando-Hundt, G. and Al Zaroo, S. (2000). Evaluating the dissemination of health promotion research. In M.Thorogood and Y. Coombes (Eds.), *Evaluating Health Promotion. Practice and Methods*. Oxford: Oxford University Press.

Leventhal, H. (1970). Findings and theory in the study in the study of fear communication. In L. Berkowitz (Ed.), *Advances in Experimental Social Psychology*, 5, (pp. 119-186). San Diego: Academic Press.

Ley, P. (1988). *Communicating with Patients; Improving Communication, Satisfaction and Compliance*. London: Chapman and Hall.

Lowy, D. (1999). TV soaps hit home with health messages. *Health Matters*, 36,3.

Lupton, D. (1993). Risk as moral danger: the social and political functions of risk discourse in public health. *International Journal of Health Services*, 23 425-435.

Lupton, D. (1994). Femininity, responsibility, and the technological imperative: Discourses on breast cancer in the Australian press. *International Journal of Health Services*, 24, 73-89.

Lupton, D. (1997). *The imperative of public health: Public health and the regulated body*. London: Sage.

Lyons, A.C. & Willott, S. (1999). From suet pudding to superhero: representations of men's health for women. *Health: An Interdisciplinary Journal for the Social Study of Health, Illness and Medicine*, 3, 283-302.

Macdonald, G. (2000). A new evidence framework for health promotion practice. *Health Education Journal*, 59, 3-11.

Macintyre, S., Chalmers, I., Horton, R. & Smith, R. (2001). Using evidence to inform health policy: case study. *British Medical Journal*, 322, 222-225.

Marks, D.F. (2001).Evidence-based practice in health care. Glasgow: British Psychological Conference.

Marks, D. F. (1999).Health psychology as agent of change. Newfoundland: Reconstructing Health Psychology.

Marks, D.F. (1994). Psychology's role in The Health of the Nation. *The Psychologist*, March, 119-121.

Marks, D.F., Sykes, C.M., McGurk, R. & von Volkamer, A. (1999). 'Evaluation of the Programme of Community Action on Health Promotion, Information, Education and Training 1996-2000. Interim Report.' Middlesex University Health Research Centre, London.

Marks, D. F. (1996). Health psychology in context. *Journal of Health Psychology*, 1, 7-21

McDonald, G. & Davies, J.K. (1998). Reflection and vision. Proving and improving the promotion of health. In J. K.Davies & G. MacDonald (Eds.), *Quality, evidence and effectiveness in health promotion. Striving for certainties.* London: Routledge.

McDonald, G. & Davies, J.K. (1998). Reflection and vision. Proving and improving the promotion of health. In J. K.Davies & G. MacDonald (Eds.), *Quality, evidence and effectiveness in health promotion. Striving for certainties.* London: Routledge.

Merson, M. H., Black, R.E. & Mills, A. J. (2001). *International public health. Diseases, programs, systems and policies.* Maryland: Aspen Publication.

Mischel, W. (1966). Theory and research on the antecedents of self-imposed delay of reward. In B.A. Maher (Ed.), *Progress in experimental personality research*, 3, New York: Academic Press.

Montgomery, S.L. (1991). Codes and combat in biomedical discourse. *Science As Culture*, 2, 341-391.

Nutbeam, D. (1999).Health promotion effectiveness-The questions to be answered. In International Union for Health Promotion and Education, *The evidence of health promotion effectiveness. Shaping public health in a new Europe.* Brussels- Luxembourg: ECSC-EC-EAEC.

Nutbeam, D. & Harris, E. (1999). *Theory in a nutshell. A guide to health promotion theory.* Roseville: McGraw-Hill Book Company Australia Pty Limited.

Nutbeam, D. (1998). Evaluating health promotion-progress, problems and solutions. *Health Promotion International*, 13, 27-44.

Ogden, J. (1995). Psychosocial theory and the creation of the risky self. *Social Science Medicine*, 40, 409-415

Owen, N., Bauman, A., Booth, M., Oldenburg, B. (1995). Serial mass-media campaigns to promote physical activity: Reinforcing or redundant? *American Journal of Public Health*, 85, 244 –248.

Parker, I. (1992). *Discourse dynamics. Critical analysis for social and individual psychology*. London: Routledge.

Parker, I. (1994). Reflexive research and the grounding of analysis. Social psychology and the psy-complex. *Journal of Community and Applied Social Psychology*, 4, 239-52.

Pawson, R. & Tilley, N. (1997). *Realistic evaluation.* London: Sage.

Prilleltensky, I. & Prilleltensky, O. (2003). Towards a critical health psychology practice. *Journal of Health Psychology* (in press).

Prochaska, J.O. & DiClemente, C.C. (1984). *The transtheoretical approach: Crossing traditional boundaries of change*. Homewood: Irwin.

Putman, R. (1993). *Making democracy work.* Princeton University Press: New Jersey.

Quine, L., Rutter, D.R. & Laurence, A. (2001). Comparing the theory of planned behaviour and the health belief model: The example of helmet use among schoolboy cyclists. In P. Norman, C. Abraham & M. Conner (Eds.), *Understanding and changing health behaviour: From health beliefs to self-regulation,* (pp. 73-98), Amstersdam: Harwood Academic Publishers.

Radley, A. (1998). *Making sense of illness. The social psychology of health and disease.* London: Sage.

Raeburn, J & Rootman, I. (1998). *People-centred health promotion.* Chichester: Wiley.

Revill, J. (2002). 'NHS wakes up to child obesity crisis.' *The Observer,* Nov., 5.

Rogers, R.W. (1983). Cognitive and physiological processess in fear appeals and attitude change: a revised theory of protection motivation. In J.R. Cacioppo & R.E. Petty (Eds.), *Social psychology: A source book.* (pp. 153- 176). New York: Guildford.

Romer, D. & Hornik, R. C. (1992), Using mass media for prevention of HIV infection among adolescents. In R. J. DiClemente (Ed.), *Adolescents and AIDS: A generation in jeopardy.* Washington: Hemisphere.

Rosen, G. (1993). *A history of public health.* New York: John Hopkins University Press.

Rosenstock, I.M. (1974). Historical origens of the health belief model. *Health Education Monographs*, 2, 1-8.

Ryan, W. (1976). *Blaming the victim.* New York: Random House Inc.

Schwarzer, R. & Fuchs, R. (1996). Self efficacy and health behaviours. In M. Conner & P. Norman, P.(Eds.), *Predicting health behaviour*. Buckingham: Open University Press.

Schwarzer, R. (1992). Self efficacy in the adoption and maintenance of health behaviours: theoretical approaches a new model. In R. Schwarzer (Ed.), *Self efficacy: Thought control of action.* Washington: Hemisphere.

Scott, N.C.H., Kinnersley, P., Rollnick, S. (1994). The limits to health promotion. They lie in individuals' readiness to change. *British Medical Journal*, 309, 971-972.

Seedhouse, D. (1997). *Health promotion. Philosophy, prejudice and practice.* Chichester: Wiley.

Senge, P.M, Kleiner, A., Roberts, C., Ross, R.B. and Smith, B.J. (2001). *The fifth discipline fieldbook. Strategies and tools for building a learning organisation.* London: Nicholas Brealey Publishing.

Sowers, W. M., Garcia, F. W. & Seitz, S. L. (1996). Introduction: Community-based prevention: An evolving paradigm. *The Journal of Primary Prevention*, 16, 225-231.

Speller, V., Learmonth, A. & Harrison, D. (1997). The search for evidence of effective health promotion. *British Medical Journal*, 315, 361-363.

Stainton Rogers, W. (1991). *Explaining health and illness. An exploration of diversity.* New York: Harvester Wheatsheaf.

Stringer ET. (1999). *Action Research.* London: Sage.

Sutton, S. (2000). Interpreting cross-sectional data on stages of change. *Psychology and Health*, 15, 163-171.

Sykes C. M. & Marks, D.F. (2001). Effectiveness of a cognitive behaviour therapy self-help program for smokers in London, UK. *Health Promotion International,* 16, 255-260.

Tones, K. & Tilford, S. (1994). *Health Education: Effectiveness, efficiency and equity.* London: Chapman & Hall.

Trinder, L & Reynolds, S. (2000). *Evidence-based practice. A critical appraisal.* London: Blackwell Science Ltd.

Tulchinsky, T.H. & Varavikova, E. A. (2000). *The new public health. An introduction for the 21st Century.* San Diego: Academic Press.

Whitelaw, A. & Williams, J. (1994). Relating health education research to health policy. *Health Education Research. Theory & Practice*, 9, 519-526.

WHO (World Health Organization) Regional Office for Europe (1998). *Health 21: The health for all policy framework for the twenty first century*. Copenhagen: WHO.

WHO (World Health Organization) (1998). *Health for all for the 21st century.* Geneva: WHO.

WHO (World Health Organization) (1986). First International Conference on Health Promotion. The Move Towards a New Public Health: Ottawa Charter for Health Promotion, Ottawa, Nov 17-21. Ottawa: WHO/Health and Welfare Canada/Canadian Association for Public Health.

WHO (World Health Organistion) (1978). Declaration of Alma-Ata. Alma-Ata: WHO.

Willig, C. (2001). *Introduction to qualitative research in psychology. Adventures in theory and method.* Buckingham: Open University Press.

Willig, C. (2000). A discourse-dynamic approach to the study of subjectivity in health psychology. *Theory & Psychology*, 10, 547570.

Willig, C. (1998). Constructions of sexual activity and their implications for sexual practice. Lessons for sex education. *Journal of Health Psychology*, 3, 383-392.

Wimbush, E, & Watson, J. (2000), An evaluation framework for health promotion: Theory, quality and effectiveness. *Evaluation*, 6, 301-321.

Wolff, T. (2001a). A practioner's guide to successful coalitions. *American Journal of Community Psychology*, 29, 173-191.

Wolff, T. (2001b). The future of community coalition building. *American Journal of Community Psychology*, 29, 263-284.

Zola, I.K. (1972). Medicine as an institution of social control. *Sociological Review*, 20, 487-504.

Appendix 1
EC's Health Promotion Work Programmes 1996- 2000

1996 WORK PROGRAMME

of Community Action on Health Promotion, Information, Education and Training

1 INTRODUCTION

On 29 March 1996 the European Parliament and the Council adopted the programme of Community action on health promotion, information, education and training (1996 - 2000), with a budget of ECU 35 million.

This is the first public health programme of a horizontal nature. Unlike the earlier programmes (cancer, AIDS, drugs), it focuses not on diseases but on health determinants. It focuses on promoting health, i. e. enabling people to adopt and maintain healthy lifestyles and healthy behaviour, promoting the creation of sustainable environments and alternatives conducive to health and increasing individuals' and communities' control over their health and its improvement. This is a new approach for the Commission, and for several of the Member States too.

The programme will, in particular, provide support for initiatives in areas of action which the Union and the Member States regard as priorities and which present a clear European added-value.

2 1996 BUDGET

The budgetary authorities of the Union, the European Parliament and the Council have allotted an appropriation of ECU 12.5 million to budget heading B3-4300 "Public health, health promotion, information on health, health education and public health training".

A little over half of this budget is not intended for the health promotion programme:

- ECU 1.5 million is for measures in the area of public health policy;

- ECU 5 million is for transnational measures directed either towards improving the quality of life of persons with Alzheimer's disease or similar forms of neuro-degenerative disease, or towards carers[1];

- ECU 0.2 million is earmarked to support the activities of the European Public Health Alliance (EPHA).

The actual budget for the health promotion programme is therefore ECU 5.8 million, of which 4 million, as specified in an amendment, is earmarked for health promotion measures focusing on

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1 The Committee does not consider this item as part of the Health Promotion Programme.

informing citizens of the advantages which the internal market has brought them in the field of public health.

3 IMPLEMENTATION OF THE PROGRAMME

3.1 Expressions of interest

The numerous applications for funding received far exceed the budget available as described in paragraph 2. Therefore, it is not intended to publish a general call for proposals unless it is considered a priority by the Committee.

3.2 Grant application forms

New application forms for all of the programmes already adopted are presently under preparation. These will put more emphasis on project descriptions and less on administrative information.

3.3 Evaluation of projects

Rather than being faced with a large variety of project proposals, the Commission needs to steer proposals towards strategic priority areas defined by the Commission.
Project selection will be done on the basis of predetermined criteria (cf. attached document).

3.4 Annual review

The summaries of the project proposals received in 1996 will be grouped in an annual report. For those projects accepted for Commission funding there will be a supplementary summary concerning the action planned.

3.5 Project results

The projects implemented will need to be evaluated from both the technical and the financial angle. What added-value did the project bring to the programme? How could the results be more widely disseminated? Monitoring and evaluation of funded projects will be improved.

4 PRIORITIES FOR 1996

4.1 Health promotion strategies and structures

Each country has its own health promotion structures and strategies. The diverse health promotion policies of the Member States will need to be described, compared and disseminated (1).[2]

Some Member States have listed their topten priorities in the field of public health. A survey of similar work in all Member States will be carried out, and a list of European priorities drawn up (1)

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2 The numbers in parenthesis refer to the accepted programme of Community action

The Commission intends to support studies on project evaluation methods and quality standards in the field of health promotion. Projects aiming at putting existing knowledge into practice will be given special priority.

The Commission intends to carry out feasibility studies on the setting up of a permanent body (the European Health Observatory) responsible for monitoring and evaluating health data and indicators in the Community area.

4.2 Specific prevention and promotion measures

The specific measures reflect the areas given in the adopted programme of Community action on health promotion, information, education and training. The aim is to integrate the issues of a vertical nature (CVD, mental health, osteoporosis) with horizontal ones, as these often are in practice.

Support for integrated health promotion projects aimed at groups which are disadvantaged as a result of their vulnerability or social exclusion or of social and cultural differences (3).

An analysis and comparison of Member States' nutritional policies will be carried out to illustrate each country's strengths and weaknesses. The information is planned to serve as a basis for informing the citizens of Europe, each country's strengths serving as a reference for the other countries (4).

Cardiovascular disease is the leading health problem in Europe. There is scientific evidence and practical experience allowing us to reduce these problems by introducing measures to combat certain risk factors and promote healthy behaviour. A project is proposed concerning a cardiovascular prevention awareness week (5).

The Commission plans to produce, in cooperation with doctors, pharmacists and the manufacturers of non-prescription medicines, a guide on the advantages and disadvantages of self-medication (6).

With regard to physical activity, there is a need to evaluate national situations prior to the implementation of concerted measures to promote regular physical activity (8).

The Commission, in cooperation with representatives from various organisations in five Member States, intends to define mental health within the context of modern prevention and health promotion policies. The draft produced will be presented and discussed at European level at a seminar towards the end of 1996 (8).

A meeting was organised in February 1996 on the subject of osteoporosis. The established working parties will deliver their reports at the beginning of 1997. Based on these, recommendations will be drawn up for health professionals, decision-makers and the general public (9).

An assessment of the primary health care needs of the elderly in Europe is currently in progress. The results of this should be ready by the end of 1996 (9).

The SENECA/EURONUT network concerning the nutrition of the elderly, supported by the Commission for 10 years, will be reactivated (9).

The Commission intends to support the network of health promotion for the elderly, "Ageing Well In Europe" and to create a high-level committee on health promotion for the elderly (9).

In relation to alcohol, a meeting bringing together representatives of the scientific community, of the alcohol industry and wine producers, of NGOs active in the field, of health promotion bodies, as well as of the relevant Commission services, shall help to determine the key issues and concrete priority actions to be supported or launched within an integrated European health promotion approach towards alcohol (i.e. network, European database, policy paper).

4.3 Health information

A first meeting of the national health promotion structures took place at the end of 1995. The Commission intends to follow up this initiative with a view to creating a network of national agencies (12).

A presentation of the activities undertaken in the Member States will be given at a European conference (10).

A major prize competition for health education has been existing for several years. Funding for this competition will be provided with the aim of extending it to cover the European Community as a whole (10).

Who are the key players in the field of health promotion and public health? How can a partner be found for a transnational project? A publication "Who's who in public health" will be developed in order to provide answers to questions of this type.

Many difficulties are encountered in coping with the technical terms used in public health and health promotion, the meanings of which sometimes differ from one language to another. Production of a multilingual glossary will be supported (12).

A number of proposals have been made for the creation of specific television channels or radio programmes on health. Support will be given to efforts to strengthen the position of health in broadcasting and to increase European exchange of experiences in this field.

4.4 Health education

Support for the European Network of Health-Promoting Schools will continue. A thorough evaluation will be made of the Commission's role and the future of the project (13).

Network to develop workplace health promotion will be established. Best practices in this field will be identified and disseminated (16).

4.5 Vocational training

A directory of existing training schemes in public health and health promotion is currently being prepared. This first directory will be completed in November, presented at a conference scheduled to be held in Dublin, and regularly updated thereafter (17).

Serious consideration needs to be given to the need for a European Master's degree in public health. A variety of public health schools have proposed to examine this question and then put proposals to all the Member States. The Master's degrees in public health that Member States award at present are extremely variable, both in form and (especially) in content. Coordination between relevant academic institutions is called for (17).

There is a strong demand to define quality standards for the diverse training modules in public health and health promotion. Several teams have already proposed examining this question. The issue takes on added importance, in that numerous new training schemes are appearing at present (18).

Three pilot summer school schemes in health promotion were subsidised by the Commission in 1995. An evaluation is called for, both into the real needs of health professionals and into the responses required as regards training at European level (20).

1997 Work Programme of the Community Action Programme on Health promotion, Information, Education and Training

1. INTRODUCTION

Health Promotion is concerned with healthy lifestyles and the creation of supporting environments. It involves inter-sectoral and multidisciplinary approaches in a variety of settings. It embraces in the health sphere, public health, prevention and promotion of health.

The Community action programme on health promotion aims at encouraging the evaluation of the impact of health promotion policies and instruments, and the development of a health promotion approach in the Member States by promoting the devising and assessment of health promotion strategies and dissemination of models of good practice.

Through specific prevention and health promotion measures, the programme aims at improving the quality of information used in health promotion in relation to certain risk factors and determinants of health. Special attention will be given to intersectoral and multidisciplinary approaches and the creation of supportive environments to health promotion for vulnerable or disadvantaged groups.

Attention will also be paid to improve knowledge of mechanisms for devising health messages and assessing health information methods, and to encourage an exchange of information and documentation between professionals and those responsible for public health and health promotion policies.

Greater integration of health education in schools, including sex education, will be encouraged. The development and dissemination of the best health education experiments and methods tailored to different population groups and different settings will be fostered.

The programme also aims at helping to familiarize both health professionals and those who decide on and administer health policy or action and those in the front line of health promotion (e.g. teachers, educators, social workers, practitioners) with knowledge, ideas and methods relating to public health, prevention and promotion of health.

Special emphasis is placed on health determinants rather than diseases. Enabling the creation of supporting environments and healthy alternatives as well as individuals' and communities' control over their health will be given priority. It will contribute to analysing the institutional difficulties encountered in developing health promotion.

In 1997 a more pro-active approach will be developed. Priority areas and key functions will be specified in order to launch targeted actions. Interlinkages with other relevant Community programmes will be strengthened, and partnerships with the private sector, NGOs and international organizations developed..

2. 1997 BUDGET

The budget line B3-4300 for Public health, health promotion, information on health, health education and public health training, has been approved by the European Parliament and amounts to ECU 7 million.

3. IMPLEMENTATION OF THE PROGRAMME

3.1. The priorities of the work programme will be published in the Official Journal of the European Communities in order to help potential actors to direct their planning and to make proposals within the framework of the timetable set for this programme. In addition, specified calls for proposals/tenders will be used in certain priority areas in order to ensure development in these areas.

3.2. Evaluation of projects

Evaluation of projects remains an integral part of every action undertaken within this programme. Special emphasis will be placed on the evaluation of how the projects are indeed benefiting the European Union and its citizens. Reports and evaluation of projects already implemented under the programme will be disseminated.

3.3. Timetable for proposals: 15 March and 15 September 1997.

3.4. Annual Review

An annual report will be produced highlighting the summaries of the project proposals received and the actions planned in the proposals accepted for funding, as well as reports from the projects already implemented under the programme.

4. PRIORITIES FOR 1997

The following areas have been identified as priorities. For convenience they have been classified under a number of headings: circumstances will dictate which approach for an intervention is most effective, i.e. General/Issues/Population groups/Settings/Training/Quality improvement/Technical development, and these headings not necessarily being mutually exclusive.

1.General

Activities coordinated at European level will be supported. Facilitation of exchange of information and experiences will be developed. Attention will be focused on the increased creation of action plans in the promotion of health and the setting up of partnerships

Initiatives aiming at putting existing knowledge into practice will be given priority.

Attention will be paid to participation of eligible non-Member States in the programme.

In order to appreciate the global nature of health promotion, the programme will actively participate in the fourth International Conference on Health Promotion in July 1997.

2.Issues

Recommendation for a healthy diet in Europe and practices on food labelling supporting healthy choices will be further developed. Special reference will be paid to CVD, cancer, diabetes, elderly, young children and workplace.

Attention will be paid to the issue of body weight as a broad concept affecting the well-being of people. Obesity, as an important health determinant, but also anorexia, bulimia and body image in relation to health promotion will be dealt with. A scientific expert group will be set up to advise the Commission and to prepare A European conference on this matter.

A broad discussion on the need and desirability of a large-scale action on CVD in 1999 will be undertaken.

Physical exercise related activities will be developed and combined with population groups and setting strategies. Focus will be on broadly applicable activities.

In the area of mental health a network of experts organizations in Member States will be established. Special attention will be paid to the development of appropriate criteria for this field, including mental well-being in a broader sense. A European conference will be organized to discuss the concepts and best practices in mental health promotion.

Alcohol and health will be further discussed with the broad scientific community and others actors in this field. A document will be drafted for discussion in the European Parliament and in the Council. Partnership

between local programmes, alcohol misuse prevention in the workplace and drink-drive projects will be supported. The creation of a European database open to all potential users will be launched.

The Commission will consider the most appropriate collaborative efforts with other Community programmes in order to develop child abuse prevention measures.

3.Population Groups

Discussions on a youth policy regarding health with relevant partners in youth, sports, culture and other areas (i.e. DG XXII) will be undertaken. Special emphasis will be given to out-of-school youth alcohol and nutrition, mental health and physical activity.

Health promotion policy guidelines for the elderly will be developed. Collaboration with other services will be strengthened, and the possibility to establish a high level committee in this area will be studied.

Special attention will be paid to deprived groups. The network of national health promotion agencies will develop the matter as a priority.

4.Settings

The network of health promoting schools' activities will concentrate on the evaluation of the impacts of the projects on the dissemination of best practices, and on involving the whole school community. A report on the project will be addressed to the Council.

The workplace health promotion network will identify and widely disseminate models of good practice in Member States. A policy for workplace health promotion will be developed, giving special emphasis to good practices in small and medium-size enterprises.

Health promotion in a metropolis will be developed as there are special challenges in this field. The capital cities areas will be used as pilot settings in this work.

Health care, as an important setting for health promotion and disease prevention will be given priority, especially paying attention to the role of health care personnel.

5.Training

The directory of training courses in public health in the Member States will be updated annually. A project to explore the benefits of establishing a European Master's Degree in Public Health (EMPH), training and degree, will be supported. Efforts will be made to include a maximum number of universities and educational institutions in the programme.

6.Quality Improvement

Quality improvement will be defined to validate training programmes for the European Master's Degree in Public Health and also in general. The first course on health promotion will be evaluated in order to explore the benefits.

7.Technical Development

Use of modern communication technologies will be supported in order to increase information exchange within the European health promotion community and with the public. Identification and wide dissemination of existing knowledge and working methods will be supported. Collaboration between broadcasting and health promotion community will be strengthened.

Scientific review and analysis of health promotion intervention activities in Europe will be carried out. Evaluation and quality assurance will be developed as an integral part of the programme.

1998 WORK PROGRAMME
OF THE COMMUNITY ACTION PROGRAMME ON
HEALTH PROMOTION, INFORMATION, EDUCATION AND TRAINING

1. INTRODUCTION

Health Promotion is concerned with healthy lifestyles and the creation of supporting environments. It involves inter-sectoral and multidisciplinary approaches in a variety of settings. It embraces in the health sphere, public health, prevention and promotion of health.

The Community action programme on health promotion aims at encouraging the evaluation of the impact of health promotion policies and instruments, and the development of a health promotion approach in the Member States by promoting the devising and assessment of health promotion strategies and dissemination of models of good practice.

Through specific prevention and health promotion measures, the programme aims at improving the quality of information used in health promotion in relation to certain risk factors and determinants of health. Special attention will be given to intersectoral and multidisciplinary approaches and the creation of supportive environments to health promotion for vulnerable or disadvantaged groups.

Attention will also be paid to improving knowledge of mechanisms for devising health messages and assessing health information methods, and to encourage an exchange of information and documentation between professionals and those responsible for public health and health promotion policies.

Greater integration of health education in schools, including sex education, will be encouraged. The development and dissemination of the best health education experiments and methods tailored to different population groups and different settings will be fostered.

The programme also aims at helping health professionals to be kept informed of new knowledge, ideas and methods relating to public health, prevention and promotion of health, as well as keeping informed those who decide on and administer health policy or action and those in the front line of health promotion (e.g teachers, educators, social workers, practitioners).

Special emphasis is placed on health determinants rather than diseases. The creation of supporting environments and healthy alternatives will be promoted as well as the possibilities for individuals and communities to have control over their health. The programme will contribute to analysing the institutional difficulties encountered in developing health promotion.

Priority areas and key functions will be specified in order to launch targeted actions which will follow the same course as those specified under the 1997 programme, namely:
General / Issues / Population Groups / Settings / Training / Quality Improvement and Technical Development

Interlinkages with other relevant Community programmes will be strengthened, and the relevant partnerships developed in the private sector and with NGOs, as well as with international organizations.

Evaluation and quality assurance will be developed as an integral part of the programme.

The Commission has already taken a proactive role in establishing and supporting European networks covering the following areas: health promotion in the workplace, schools and metropolis, mental health, self-medication, physical activity and bodyweight, nutrition, alcohol, CVD, with special emphasis on the youth and the elderly, and health promotion agencies.

2. 1998 BUDGET

The amount of funds to be allocated in 1998 to budget line B3-4300 for Public health, health promotion, information on health, health education and public health training, will be determined with the adoption of the budget of the Union for the year 1998.

3. IMPLEMENTATION OF THE PROGRAMME

3.1. Timetable

Timetable for proposals: **15 March and 15 September 1998** (date as postmark).

3.2. Nature of projects

All projects must have a **transnational dimension** and should involve as many Member States and EEA countries as possible. Priorities have been set in order to help potential actors to direct their planning and to make proposals within the framework of the timetable set for this programme. Further efforts are called for in order to establish sound projects in priority areas.

3.3. Evaluation of projects

Evaluation of projects remains an integral part of every action undertaken within this programme. Special emphasis will be placed on the evaluation of how the projects are indeed **benefiting the European Union and its citizens.** Reports and evaluation of projects already implemented under the programme will be disseminated.

3.4. Annual Review

An annual report will be produced highlighting the summaries of the project proposals received and the actions planned in the proposals accepted for funding.

PRIORITY AREAS FOR 1998

General

Facilitation of exchange of information and experiences will be developed. Attention will be paid to the development of capacity building in health promotion including means and methods for empowerment and citizens' participation in health development, as well as establishment of partnerships.

Initiatives aiming at putting existing knowledge into practice to influence determinants of major health problems will be given priority.

Attention will be paid to participation of eligible non-Member States in the programme.

In order to appreciate the global nature of health promotion, participation in the XVI World Conference on Health Promotion due to be held in Puerto Rico in 1998, organised by the IUHPE, will be considered favourably.

At the end of 1998 the Commission will submit an interim report on the Health Promotion Programme to the European Parliament and the Council, in accordance with Article 7.2. of the programme.

Issues

There is a relationship between determinants of health, lifestyles and the prevention of certain diseases such as CVD, cancer and diabetes. Special reference will be made to certain issues to address this relationship. Additionally, special reference will be made to specific groups such as pregnant women, the elderly and young children, and to special settings such as schools and the workplace.

Guidance for a **healthy diet** in Europe and practices on food labelling supporting healthy choices will be further developed.

Attention is being paid to the issue of **bodyweight** as a broad concept affecting the well-being of people. Overweight as an important health determinant will be dealt with as well as other eating disorders and body image in relation to health promotion. The group of experts set up in 1997 will support the Commission in elaborating actions in these areas. A conference on body weight and related issues will take place.

Consideration will be given to organising a major conference on **nutrition and health.** (to be confirmed)

Based on a strategy paper drafted by a group of experts, the possibility will be examined of further supporting a **European heart health initiative.**. A broad discussion on this issue will be actively supported.

The discussion on the political, social, economic and scientific dimension of **alcohol and health** will continue. The drafting of a discussion document will be finalised and followed up (to be confirmed). In cooperation with the new European **health monitoring programme** comparable data in the area of alcohol and health will be collected and made available. Support for the updating and use of a European database will continue.

The promotion of health-enhancing **physical activity** will continue by enlarging and strengthening the network activities and by initiating the implementation of the agreed European strategies within the Member States. Support for easily and broadly applicable physical activities will also continue.

In the area of **mental health promotion,** priorities will be identified based on the findings of a project to set up key concepts and a framework for action in mental health. Particular attention will be paid to children up to 6 years of age.
Guidance on the for **prevention of osteoporosis** in the European Union will be developed, together with Member States, and a presentation will be given at the European Congress on Osteoporosis which will take place in Berlin, 11-15 September 1998. The findings of this congress will be made available to both the professionals in the health sector and the public.

4.3. Population Groups

Further participation in discussions on a **youth policy** regarding health with relevant partners in the health sectors of youth, sports, culture and other areas, will be ensured. Special attention will be given to projects concerning out-of-school youth, in relation to alcohol, nutrition, mental health and physical activity.

Health promotion policy guidelines for the **elderly** will be developed. Collaboration with other services will be strengthened, and the possibility of appointing a high level group of experts in this area will be studied.

Special attention will be paid to **deprived groups**, such as migrants, immigrants, refugees, and ethnic minorities. It is anticipated that the network of national health promotion agencies will develop the matter as a priority.

Attention must be paid to include populations suffering from **chronic diseases or disabilities** such as diabetes, epilepsy etc. in health promotion activities.

4.4. Settings

Activities concerning the **European Network of health promoting schools** will concentrate on putting into practice the results of evaluation projects, concentrating on the dissemination of best practice, and on involving the school education sector as a whole.

A policy for **workplace health promotion** will be developed, giving special emphasis to small and medium-sized enterprises. Models of good practice will be

identified and widely disseminated throughout the Member States+ via the European networks.

Health promotion in capital cities of Member States and EEA countries will develop concrete activities on mutually agreed priority areas.

Health care establishments are an important setting for health promotion and disease prevention will be given priority. Key health care personnel groups will be involved in developing means to improve the knowledge, information and practice of health promotion in the daily work of professional groups dealing with health care.

4.5. Training

The directory of training courses in Public Health in the Member States will be updated annually.

The II European Summer School on Health Promotion and Public Health will take place, a follow-up to the I Summer School (held in Luxembourg in July 1997).

The setting up of **European training courses in public health** will be followed up. Once public health in general and health promotion in particular are covered, and their usefulness evaluated, courses will be set up focusing on other questions of public health, as for example for children and on nutrition.

The **European Master's Degree in Public Health** will be implemented as a follow-up to the initiation and development of this project within the framework of the 1997 programme.

4.6 Quality Improvement and Technical Development

A scientific review and analysis of health promotion intervention activities in Europe will be finalised.

Use of modern communication technologies will be supported in order to increase information exchange within the European health promotion community and with the public. Identification and wide dissemination of existing knowledge and working methods will be supported. Collaboration between the media community and the health promotion community will be strengthened.

A glossary will be published in three languages, describing 400 key concepts in public health, with view to extending it to further languages. Preparation of the European Multilingual Thesaurus on Health Promotion as a European Standard in eleven languages, to be published in 1999.

To receive the application form and information package for the above mentioned programme, please send your request in writing to:

1999 WORK PROGRAMME OF THE COMMUNITY ACTION PROGRAMME ON HEALTH PROMOTION, INFORMATION, EDUCATION AND TRAINING

1. INTRODUCTION

Health Promotion, generally speaking, is concerned with encouraging healthy lifestyles and the creation of supporting environments, involving inter-sectoral and multidisciplinary approaches. In the health sphere it embraces certain aspects of public health and disease prevention, with special emphasis being placed on health determinants rather than diseases.

The Community action programme on Health Promotion aims at increasing the impact on health by supporting health promotion activities. It contributes to guaranteeing a high level of human health protection in the definition and the implementation of all policies in the Member States and in the Community. It empowers a health promotion approach by developing health promotion strategies and disseminating models of good practice.

Since many Member States experience significant increasing rates of unemployment and social disadvantages, both of which are undoubtedly linked with the health status, it is essential that the Health Promotion Programme has a positive input upon the social and economic living conditions of the unemployed and their families. The activities of the Programme should also concentrate on promoting actions to prevent stress and to encourage the good health and well-being of all those concerned.

Through specific prevention and health promotion measures, the Health Promotion Programme aims at improving the quality of relevant information. Attention will also be paid to improving health messages in order to keep both health professionals and policy makers, in particular, up to date with any new ideas, know-how and techniques related to public health, prevention of diseases and the promotion of health.

Furthermore, the Health Promotion Programme supports the development of strategic health promotion networks in creating and launching their initiatives. Once firmly established, the networks shall find other sources for funding as bodies cannot be financially supported on a long-term basis. The Commission has already taken a proactive role in establishing and supporting European networks which cover the following areas:

Settings - health promotion in workplaces, schools and city areas,
Issues - the promotion of physical activities and mental health;
Population groups - the elderly.

Evaluation and quality assurance will be developed as an integral part of the programme. A mid-term evaluation has been commissioned and will be carried out, which covers questions such as whether the programme has attracted valid projects that can facilitate

cooperation on regional, national, supra- and international level; and whether any sustainable networks have been established which may provide the infrastructure for policy development.

Inter-linkages with other relevant Community programmes will be strengthened, and the relevant partnerships developed with the private sector, NGOs (Non Governmental Organisations), public bodies and international organisations.

In accordance with the Commission's policy that enlargement is of prime importance, the applicant countries for which the decisions of the respective Association Councils have entered into force will be encouraged to participate in the Community public health programmes and health promotion activities.

2. 1999 BUDGET

For 1999 the amount of funds to be allocated to budget line B3-4300 for Public health, Health Promotion, Information on Health, Health Education and Public Health Training, will be determined with the adoption of the European Union's budget for the year.

3. IMPLEMENTATION OF THE PROGRAMME

3.1. Timetable

Timetable for proposals: **15 September** (date as postmark).

3.2. Nature of projects

All projects must have **a transnational dimension. Priority** is given to those involving all, or almost all, Member States and EEA countries. Priority areas have been set in order to help potential actors to propose sound projects within the deadline.

3.3. Evaluation of projects

Evaluation remains an integral part of any project which is carried out within the framework of this programme. Special emphasis will be placed on the evaluation of how the projects are indeed **benefiting the health promotion and public health structures and activities in the European Union, and ultimately its citizens.**

3.4. Annual Review and Final Reports of Projects

A report is produced yearly providing a summary of the projects funded under the Health Promotion Programme.

The final reports of projects already implemented and evaluated under the programme will be disseminated.

4 PRIORITY AREAS FOR 1999

4.1. General

Initiatives aiming at putting existing knowledge into practice to influence determinants of health will be given priority. The development of infrastructures for Health Promotion will continue to be supported, with emphasis on training and quality assurance.

Attention will be paid to the development of capacity building in health promotion including means and methods for empowerment and citizens' participation in health development, as well as for the establishment of partnerships. This will include the facilitation of exchange of information and experiences.

The Health Promotion Programme will continue to concentrate on operating through three key priority dimensions which are specified below: **issues, population groups** and **settings**. These areas are inter-linked and should be considered as a whole entity, each being of equal importance. Training, quality improvement and technical developments are an integral part of all three areas.

4.2. Issues

Proposals for recommendations for a **healthy diet** in Europe will be developed, and in this respect work has now commenced to obtain an overview of the situation in Europe. The existing dietary guidelines at national and international levels will be examined. Emphasis will be put on establishing cooperation between academic experts, the food industry and consumers across the European Union. Given the cross-sectoral nature of nutrition-related issues, efforts are being made to reinforce links with other relevant Commission services to ensure the success of actions taken. Account will also be taken of the results of the Community Research Programmes concerning nutrition and health (BIOMED and FAIR).Attention will continue to be given to the issue of **bodyweight** as a broad concept affecting the well-being of people, as well as eating disorders and other problems related to body image. In this respect the work undertaken by a European network during 1998 on eating disorders, and the role of the Broadcasting Health project in relation to obesity will be important.

The **European heart health initiative** will focus on alliance building, on cross-border collaboration, information exchange, and the promotion of effective prevention interventions and policies. Participation in discussions about future European priorities in this field will be ensured, with special emphasis being put on the debate about the horizontal health promotion approach versus disease-oriented activities.

The drafting of a Commission communication on **alcohol and health** is planned, based on a review made in the Member States. The preparations for a conference on alcohol and health, due to take place in the year 2000, will be supported. Projects on the prevention of under-age drinking will be considered. The scientific, social, economic and political dimensions of the issue of alcohol

and health will be further discussed. In cooperation with the Health Monitoring Programme, comparable data in the areas relevant for health promotion will be collected and made available. Support for the up-dating and large use of an Internet information base will continue.

The promotion of **health-enhancing physical activity** will continue by enlarging and strengthening the network activities and by initiating the implementation of the strategies they have agreed upon.. Support for easily and broadly applicable physical activities will also continue.

Emphasis will be put on **mental health and unemployment.** In this connection the European Network for Mental Health Promotion will work in close cooperation with the European Network of National Health Promotion Agencies, responsible for socially disadvantaged and excluded groups, and with the European Network for Workplace Health Promotion.

During the second half of the year an international conference will be held in Finland on the **promotion of mental health,** in which the Commission will play an active role.

4.3. Population Groups

Efforts will be undertaken to make sure that health remains a major factor of youth policy developments. Special attention will be given to projects concerning out-of-school youth and disadvantaged young people.

Health promotion policy guidelines for **successful ageing** for the elderly and older people will be developed, with a view to strengthening collaboration with other services, notably in the field of research activities concerning 'the ageing of the population" within the context of the future 5th Framework Programme on Technical Research and Development. The possibility of appointing a high level group of experts in this area will be examined.1999 is the "Year of the Elderly".

Special attention will be paid to the **socially disadvantaged and excluded** groups, with the primary aim of improving their health status. It is anticipated that the networks of national health promotion agencies and the one for capital cities will develop the matter as a priority.

Attention shall be paid to support activities for people with **chronic diseases or disabilities** such as diabetes, epilepsy etc. to enable them to keep abreast of the daily challenges.

4.4. Settings

The European Network of Health Promoting Schools (ENHPS) continues developing and disseminating concepts and models of good practice.

The European Network for Workplace Health Promotion (ENWHP) will continue to concentrate on the identification of models of good practice. A reference model for SMEs (Small and Medium Sized Enterprises) will be developed on this basis, which includes criteria for quality, successful implementation, evaluation and cost-benefit relations. To support these

activities the development of a tool box is planned for successful implementation and practice.

Health promotion in capital cities of Member States and EEA countries will develop concrete activities and policies on youth and young families, disadvantaged groups and the elderly.

Health care establishments are important settings for health promotion and disease prevention. Key health care personnel groups will be involved in developing means of improving the knowledge, information and practice of health promotion and in implementing these measures in their daily work.

5.OTHER PRIORITY AREAS

5.1. *Training*

Projects on **European Master's in the field of Public Health** will be continued. Four training programmes on public health, health promotion, PH nutrition and gerontology will be implemented. Three new programmes will be developed in public health paediatrics, health economics and environmental health.

The inventory of training courses in Public Health and Health Promotion in the Member States which is available on the Internet will be updated regularly.

A European programme on **continuous training in Public Health** will be set up for health professionals.

DG XXII, the Directorate General for Education, Training and Youth, will also be closely involved in the above mentioned training activities.

The **glossary of Public Health Technical Terms**, commenced in 1998, will be extended to all the official languages of the European Union in 1999.

The III European Summer School on Health Promotion and Public Health will be held in 1999 (Luxembourg, June-July) along the same lines as the two previous years but the organiser will be chosen following a call for tender.

5.2*Quality Improvement and Technical Development*

A scientific review and analysis of the effectiveness of health promotion will be continued and recommendations for quality improvement of health promotion measures developed.

The use of modern communication technologies will be supported in order to increase an information exchange within the European health promotion community and with the public. Identification and wide dissemination of existing know-how and working methods will be supported. Collaboration between the media and the health promotion community will be strengthened.

The final coordination and the publishing of the European Multilingual Thesaurus on Health Promotion, in 12 languages (including Norwegian), is foreseen in 1999.

WORK PROGRAMME 2000
of the Community Action Programme on
Health Promotion, Information, Education and Training

1. INTRODUCTION

The year 2000 marks the conclusion of the 1st Action Programme. During this year it is important to assess the contribution the programme has made to the development of health promotion and to ensure that the experiences gained and the benefits from the investment incurred in activities and networks are fully utilised in future developments relating to health promotion and public health.

Health Promotion is concerned with encouraging healthy lifestyles and the creation of supportive environments, that maintain and improve health. It involves inter-sectoral and multidisciplinary approaches, including development of healthy public policies. In the health sphere it embraces certain aspects of public health and disease prevention, with special emphasis being placed on health determinants rather than diseases.

The Community action programme on Health Promotion aims at increasing the impact on health by supporting health promotion activities. It contributes to guaranteeing a high level of human health protection in the definition and the implementation of all policies in the Member States and in the Community. It empowers a health promotion approach by developing health promotion strategies and disseminating models of good practice.

Inequities in health are a major challenge in all Member States and EEA countries. Therefore, the activities of health promotion should increasingly and specifically address the needs of the population groups requiring most attention.

Since many Member States experience significant increasing rates of unemployment and social disadvantages, both of which are undoubtedly linked with the health status, it is essential that the Health Promotion Programme makes a positive contribution to the social and economic living conditions of the unemployed and their families. The activities of the Programme should also concentrate on promoting actions to prevent stress and to encourage the good health and well-being of all those concerned.

Through specific prevention and health promotion measures, the Health Promotion Programme aims at improving the quality of relevant information. Attention will also be paid to improving health messages in order to keep both health professionals and policy makers, in particular, up to date with any new ideas, know-how and techniques related to public health, prevention of diseases and the promotion of health.

Furthermore, the Health Promotion Programme supports the development of strategic health promotion networks in creating and launching their initiatives. The Commission has already taken a proactive role in establishing and supporting European networks which cover the following areas:

Settings - health promotion in the workplace, in schools, in megapoles, and health care;

Issues - the promotion of physical activities, nutrition and mental health.

Evaluation and quality assurance will be developed as an integral part of the programme. Preparation for the final evaluation of the programme will be initiated in order to answer the following questions:

- Has the programme attracted valid projects that can facilitate co-operation on regional, national, supra- and international level?

- Have sustainable networks been established which may provide the infrastructure for policy development?

In this area the work of the European Network of Health Promotion Agencies (ENHPA) is of particular importance.

Inter-linkages with other relevant Community programmes will be strengthened further, and the relevant partnerships developed with the private sector, NGOs (Non Governmental Organisations), public bodies and international organisations. The aim should be to maximise the impact of action and to minimise duplication of efforts so that the best use can be made of limited resources to achieve common goals. The Information and Communication Policy Steering Committee will be notified of all information and promotion activities in good time to ensure general consistency of information in this area.

In accordance with the Commission's policy that enlargement is of prime importance, the applicant countries for which the decisions of the respective Association Councils have entered into force will be encouraged to participate in the Community public health programmes and health promotion activities.

2. 2000 BUDGET

The budget for the year 2000 will be subject to the decision of the budgetary authorities.

IMPLEMENTATION OF THE PROGRAMME

3.1. Timetable

Timetable for proposals: **15 September 1999** (date as postmark).

3.2. Nature of projects

All projects must have a **transnational dimension** and be able to contribute to **policy development.** Priority is given to those involving all, or almost all, Member States and EEA countries. Priority areas have been set in order to help potential actors to propose sound projects within the deadline.

3.3. Evaluation of projects

Evaluation remains an integral part of any project which is carried out within the framework of this programme. Special emphasis will be placed on the evaluation of how the projects are indeed **benefiting the health promotion and public health structures and activities in the European Union, and ultimately its citizens.**

3.4. *Annual Review and Final Reports of Projects*

A report is produced yearly providing a summary of the projects funded under the Health Promotion Programme.

The final reports of projects already implemented and evaluated under the programme will be disseminated.

4. PRIORITY AREAS FOR 2000

4.1. *General*

Initiatives aiming at putting existing knowledge into practice to influence determinants of health, will be given priority. The development of infrastructures for health promotion in Member States and EEA countries will continue to be supported, with emphasis on capacity building in health promotion, including means and methods for empowerment and citizens' participation in health development, as well as for the establishment of partnerships. This will include the facilitation of exchange of information and experiences.

The Health Promotion Programme will continue to concentrate on operating through three key priority dimensions which are specified below: issues, population groups and settings. These areas are inter-linked and should be considered as a whole entity, each being of equal importance. Training, quality improvement and technical developments are an integral part of all three areas.

4.2. *Issues*

Based on the work of a European expert group, a consensus document on European **dietary guidelines** will be developed. A project is being elaborated, aiming at preparing a document on the state-of-the-art in Europe and the feasibility of developing food-based dietary guidelines in the European Union. Based on this work guidelines will be developed and discussed at a conference to be held at the end of the year 2000.

The development of the **European Heart Health Initiative** (EHHI) will continue. The results of this project will be presented and discussed at a high profile conference for public health experts, health professionals and policy makers, scheduled for 14 February 2000. As a concrete follow-up measure a document on the state of CVD prevention and on further needs in this field will be prepared.

The final results of the European Comparative Alcohol Study (ECAS) will be available by the end of the year 2000. Based on this review of alcohol policies in the Member States as well as on the continuing consultation of the key players involved in the discussion of the scientific, social, economic and political dimensions of the issue of 'alcohol and health', the drafting of a document on **alcohol and health** will be undertaken. Support will be given to the WHO European Conference on Alcohol and Youth foreseen towards the end of the year 2000. The co-operation with the Health Monitoring Programme in the field of collection of comparable data relevant for health promotion and the support for the feeding and large use of Internet information bases will continue.

On the basis of the work carried out by the European network to promote health-enhancing **physical activity**, guidelines on how to promote physical activity in the daily activities of European citizens is under preparation. These guidelines will also point out policy-areas of particular importance. Work will be pursued on how to incorporate the promotion of physical activity in future planning and policy-making.

The issue of **mental health and unemployment** will be developed by the European Network for Mental Health Promotion in close co-operation with the European Network of National Health Promotion Agencies and the European Network for Workplace Health Promotion.

4.3. Population Groups

Health promotion policy guidelines for **successful ageing** will be developed based on the work of a high level group of experts in this area.

Socially disadvantaged and excluded groups will be a priority of the ENHPA and the Megapoles Network, in addition to specific projects already financed under this programme. In parallel, migrants will constitute an important target group in 2000.

Attention should be paid to activities for people with **chronic diseases or disabilities** such as diabetes, epilepsy etc. to enable them to maintain good health and to live an independent and fair quality of life.

4.4. Settings

The European Network of Health Promoting Schools (ENHPS) will continue to further develop and systematically disseminate the healthy school concept, including models of good practice, by taking into account the advice of the EVA II evaluation project as well as the recommendations of the Commission report to the Council.

Within the European Network of Workplace Health Promotion (ENWHP) a thorough evaluation of identified models of good practice in **workplace health promotion** in all Member States will be undertaken.

Health promotion in capital cities (megapoles) of Member States and EEA countries will further develop concrete activities and policy recommendations. Attention will focus on out-of-school youth, disadvantaged young people, young families, and elderly people. Taking into account the outcome of the discussion on the report on the state of health of youth in the EU Member States, efforts will be undertaken to make sure that health remains a major factor of youth policy developments. Coordination with ENHPA will be encouraged in the area of disadvantaged groups.

The field of **health promotion in health care settings** will be a priority area of activities in 2000. Based on an ongoing project on the development of patient-oriented health promotion among general practitioners and pharmacists, it is intended to formulate European guidelines and recommendations for health promotion implementation strategies in general practice and pharmacies. Moreover, this project is to be expanded to cover also hospitals, focussing on the development of guidelines for good practice (e.g. on concrete health-promoting advice to be given to patients by health professionals in hospitals during their daily routine work). Attention shall be paid to include health promotion in the training of health care professionals.

5.144OTHER PRIORITY AREAS

1505.1. *Training*

151 European Master's in Public Health Nutrition will have enrolled the first students in
152September 1999. An evaluation of the first year will be conducted by the end of 2000.

153Enrolment for the European Master's in Public Health and the European Master's
154in Health Promotion will start in 2000.

155The project to develop European Master's in Gerontology will continue aiming at
156 enrolling the first students in 2001.

161 DGXXII, the Directorate General for Education, Training and Youth, will also be
162closely involved in the above mentioned training activities.

1635.2. *Technical Development, Quality Improvement and Knowledge Transfer*

164 Processes will be facilitated in order to allow for systematic review and transfer of the
165essential components (findings and structures) of the programme.

166 The use of modern communication technologies will be encouraged in order to increase
167 an information exchange within the European health promotion community and with
168 the public. Clear identification and wide dissemination of existing know-how and
169 working methods will be enhanced. Through collaboration between the media and the
170health promotion community a model of best practice in broadcasting health will be
171established.

172The Commission services will support the organisation of the XVII World Conference
173of the International Union for Health Promotion and Education (IUHPE) which is to
174 take place in Paris in July 2001. Its aim in particular will be to share and disseminate
175world-wide the experience gained within/from the framework of the Community Action
176Programme on health promotion.

179A multilingual glossary of Public Health Technical Terms covering all official
180 languages of the Community as well as Norwegian, will be made available by the end of
1812000.

Evaluation of Educational Needs Assessment in General Practices in Barking and Havering and Redbridge and Waltham Forest Health Authorities

Evaluation of Educational Needs Assessment in General Practices in Barking and Havering and Redbridge and Waltham Forest Health Authorities

Case Study for the Degree of Doctor of Psychology (Health)

Summary

This case study reports the findings of a piece of consultancy undertaken for Barking and Havering and Redbridge and Waltham Forest Health Authorities from August 2000 – January 2001. It was the first piece of consultancy I did in my own name with total responsibility. It is an evaluation of 3 approaches used in the 8 Primary Care Groups (PCG's) for assessing educational needs in general practices. Individual GP practices are not identifiable. The case study ends with a reflective analysis of my experience of conducting this work .

Final Report

Reflective Analysis

Initial Contact with Clients

A serendipitous contact with Barking and Havering Health Authority highlighted the importance of the role of networking in being offered consultancy, especially in the early stages of a career. In April 2000, I had been contacted by someone I had met on the MSc Psychology and Health at Middlesex University. Being a committee member of the Education Action Plan Steering Group, she informed me that the group were seeking the services of a consultant. They required an evaluation of the Educational Needs Assessments (ENAs) that were being used in general practices in Barking and Havering and Redbridge and Waltham Forest health authorities. My contact invited me to submit a proposal.

Before submitting the proposal I arranged an informal meeting with the Director of Education and Training for Barking and Havering. It was in this meeting (on 16 May 2000) that I discovered more about the client's terminology and I realised that it would be necessary to do more reading to enhance my understanding of primary care groups in the National Health Service. After this extra reading from a literature search that I did in the British Library, I prepared a draft bid and asked my supervisor to look it over for me. I had never prepared a bid by myself before and wanted a second opinion from somebody who had prepared many bids. So after some revision, I sent in my proposal at the end of May (see appendix 1), and waited apprehensively for the result.

I was informed that there were two proposals on the short list including my proposal and that a decision would be made after giving an 'informal' presentation to the steering group. The presentation and handling of the consultancy procedures by the Health Authority were reminiscent of the consultancy project I had worked on for the European Commission (see thesis). Firstly quite often consultants and their clients talk a different language and come from different working environments. Talking a different language was clear in the meeting with the Director of Education and Training for Barking and Havering. Working on this consultancy project has made me even more aware of the different working environments and different meanings of concepts such as 'an informal presentation'.

The date of the presentation was 12 June 2000. My supervisor came to the meeting with me to give professional and 'moral' support. Before giving the presentation we were asked to wait in a reception area until the steering group was ready for us. A member of the steering group came out of the meeting room and ushered us into the meeting room and formally introductions were made to approximately ten members of the steering group all in suits sitting around a table awaiting the presentation. Despite being told that a decision would be made on the day of the presentations we were informed at the end of my presentation that I would know the outcome the end of August 2000. This was the first sign in a sequence of events that demonstrated miscommunication and unreliability indicating for me the low priority that is often placed on evaluation in such organisations.

Two weeks after giving the presentation 12 June 2000, I was proud to be told on the telephone that my proposal had been successful and that I would receive a contract in writing. However after several telephone calls chasing the contract, all I received was a fax 24 October 2000 stating that my proposal had been accepted. No contract was ever drawn up. This was very frustrating. It also caused a professional dilemma. I knew the importance of receiving a written agreement before embarking on such work as my supervisor has always stressed the importance of a written agreement. I took a very uneasy decision of starting the work before receiving the written agreement as I had my own deadlines within which to do this work. I knew my supervisor disagreed with this decision and it felt very strange and unpleasant to go against the advise of someone I truly respected. However it also highlighted to me that I was an autonomous consultant and had to be responsible for my decisions which although was a very frightening feeling, I felt very excited about this new challenge. I eventually received the first payment for this work but it arrived 2 months late.

Implementation

Work on the evaluation started 31 August 200 with a meeting with two General Managers for Primary Care Education Training and Development. I was told quite casually that no documentation about the different models of assessment was available. The two Managers seemed unaware that this lack of information would have implications for the methodology. When I pointed out that it would be impossible to conduct part 2 of the methodology, no disappointment or concern was shown. In fact there was almost relief that less work was needed. We discussed the letter informing possible participants about the evaluation. I was told that this would go out to all practices which had taken part in the assessments. I was also told that I would be sent contact details of the people by profession who had taken part in the evaluation. A gatekeeper of information was also allocated at this meeting. It transpired that he would have to take 3 extensive periods of sick leave during the consultancy period creating enormous communication problems and much extra work for the evaluation team.

At the end of September a copy of the letter sent to practices in Redbridge and Waltham Forest was sent to me together with names and telephone numbers of the practices involved in the Force Field Analysis approach to ENA. It did not contain the details of the participants. When I requested more information, I was told it was not available. Therefore I had to contact all the practices and find out the profile of the staff employed in the practice and how many and who were involved in the ENA. This was necessary in order to obtain a stratified sample and a clear picture of the total population involved in the ENA. No telephone numbers for practices in Barking and Havering were provided by the Health Authority. I had to contact people who had been involved in some way in the ENAs and ask them to provide information about practices involved. I then had to contact practice managers or senior partners to obtain further details about participants.

Once telephoning interviewing began, the extreme shortage of time facing primary care professionals became very apparent. It soon became obvious that it would be better to fax the questionnaire. Organisational skills were vital to keep track of the questionnaires

going out and coming in and noting availability times and other miscellaneous information.

The proposal included interviewing the two General Managers for Training and Education in Primary Care. When it came to arranging this meeting, I felt it would be better to combine a steering group meeting with this part of the methodology. I wanted to get the whole steering group's opinions on some of the emerging themes from the telephone interviews. I felt more comfortable discussing possible solutions with the steering group who knew a lot more in this area than me. I started to read about action research and felt very excited about this approach to problem-solving. I was very worried though that this approach would not work with this rather formal client group. I had second thoughts and decided not to try something with which I had no experience. However the more I read about action research, the more convinced I became that this method would be the most suitable. I spoke to the 'gatekeeper' and asked him to arrange the room so that the group would be sitting in a circle without any desks. I had some cartoon representations made of the problems (see appendix 2) to aid understanding and to break the ice.

I was extremely pleased with the flow of the discussion and the genuine attempts to solve problems. One GP even said to me at the end that it was the best meeting they had had.

The discussion ended with one member of the group stating that I should extend my work to talking to the PCG board. I was shocked as this was not included in my proposal. The original proposal had already changed. These changes were managable but meant extra work. I was not prepared to take on any more work for this consultancy. This highlighted the importance of contract in such work. I had to be firm and say that this was not part of my remit. The member then started flicking through papers in a defensive manner and found something that stated that the evaluation should deal with the PCG board. I had to explain that my proposal stated it would only cover some of the wider objectives. I explained that I had already spent more time on the evaluation than originally planned and that I did not think it was my role to talk to the PCG board. It was agreed that this should be the role of the two General Managers for Training and Education in Primary Care. I had a word with the 'gatekeeper' at the end of the meeting. He explained that this particular member of the steering group was not around when the proposals were discussed.

I was really happy with the discussion but I felt that this issue of extending my work left me feeling undervalued and inflexible. I felt quite angry that I had been put in a position to refuse to extend the evaluation and to moan about how long the evaluation had taken. However I was pleased that I was assertive and expressed this concern in a professional manner.

Having employed a research assistant to work on this consultancy, I gained a deeper insight into my managing skills. I gave the responsibility of recording the discussion to the research assistant. The equipment was not checked and as a result a very poor recording of the discussion was made. In the past I had always used a non-directive

approach to managing people. However this relies very much on the research assistant being able to show initiative. I now realise that in order to get a job done properly you have to sometimes change your approach to suit the people you are managing. I am now of the opinion that it is the manager's or the project leader's role to be flexible in management styles and insightful about the people with whom they are working. I knew the research assistant had demonstrated a lack of initiative in the past. I was waiting for initiative to be shown. However at such a crucial stage of the consultancy, I feel I should have had enough insight about this research assistant and insisted that various checks of the recording equipment were made. I also believe that talking to people about their weaknesses should not be considered difficult, cruel or embarassing. If done in an open and sensitive manner, problems can be solved. I have since spoken to this assistant and resolved many problems related her display of initiative.

The final display of the lack of communication and unreliability was 8 February 2001 when I went to a meeting at the Health Authority to answer questions about the evaluation. Only one member of the Education Action Plan Steering Group showed. Despite having a good discussion with this member, I felt deflated by this symbolic gesture. My evaluation was clearly low priority. I was also annoyed with myself for not showing my annoyance. However in retrospect, it was probably more professional not to show annoyance.

Conclusions

This piece of consultancy was a positive challenge for me. The subject area was totally new. I was happy to be working on training needs in primary care although at times I found it uninspiring which led to a lack of motivation when it came to writing the report. I was amazed how similar the process and organisational dynamics were similar to another piece of consultancy I had worked on for the European Commission. My knowledge about the process of consultancy has not been particularly stretched with this work. However I have learnt a lot about managing consultancy. I have also learnt a great deal about research issues and health psychology professional issues.

I feel the open-ended interviews produced a more accurate picture of opinions about the educational needs assessments than the questionnaire. A questionnaire was too time consuming for this group of people. I think little time went into replying to the questionnaire. The design of the methodology was determined more by the limited costs and time. If more time (my time and the participants') and resources were available, it would have been better to conduct semi-structured interviews with primary care professionals at their place of work. Real life research is affected by issues of cost, time and logistics. This became very apparent to me while working on this project.

I had always understood the importance of a multi-disciplinary approach to health psychology. This piece of consultancy highlighted the importance of organistional psychology to health psychology. The similarities between the two organizations for whom I had done consultancy included: poor systems of communication; more concern about rules and regulations than the objectives of work that the rules and regulations are trying to protect; exposure to in-house politics; a lack of understanding of research

methods; late payment; efforts to extend the agreed work; poor record keeping; lack of esteem for evaluation – seen more as a burden than a help; the need for delicate negotiations and reporting of findings.

Overall this work has been a good learning experience and I am happy with the outcome.

EVALUATION OF EDUCATIONAL NEEDS ASSESSMENT METHODS USED IN GENERAL PRACTICES IN BARKING AND HAVERING AND REDBRIDGE AND WALTHAM FOREST.

FINAL REPORT

26 JANUARY 2001

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Evaluation of Educational Needs Assessment Methods used in General Practices in Barking and Havering and Redbridge and Waltham Forest

Final Report

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Evaluation of Educational Needs Assessment Methods used in General Practices in Barking and Havering and Redbridge and Waltham Forest

INTRODUCTION

The need for and importance of continuing medical education (CME) is increasingly being recognised by medical educators and health policy makers worldwide. Education in primary care is important for professionals to update skills, keep in touch with health policy and to keep informed about new advances in medicines and technology. Education in primary care also has implications for patient satisfaction, compliance and understanding which in turn have financial repercussions.

It is important for doctors to refresh their knowledge and keep up to date with new research and technologies. Work done by Boyle (1970) shows that some doctors wrongly located organs such as the heart and wrongly defined problems such as 'constipation' and 'diarrhoea'. Other studies showing inaccurate knowledge in health professionals include Scheiderich et al (1983) and Anderson et al (1983). Over recent years, due to white papers such as 'Health for All' and the 'Health of the Nation', primary care workers are spending more time in health promotion practices, which often involve making recommendations about changing behaviours such as smoking, drinking and diet. Health professionals' knowledge about these practices have been examined. Murray et al (1993) examined the dietary knowledge of primary care professionals in Scotland. GPs, community nurses and practice nurses completed a questionnaire consisting of a series of statements about diet and were asked to state whether they agreed or disagreed with them. It was found that there were high levels of correct knowledge for statements such as 'most people should eat less sugar' and 'most people should eat more fibre' and relatively poor accuracy for statements such as 'cholesterol in food is the most important dietary factor in controlling blood lipid levels.' It was concluded that primary health care professionals show generally good dietary knowledge but that 'there is clearly an urgent need to develop better teaching and training in the dietary aspects of coronary heart disease.'

Knowledge and communication styles in primary care both play a role in patient satisfaction, compliance and understanding. Ley (1988) reviewed 21 studies of hospital patients and found that 41% of patients were dissatisfied with their treatment and that 28% of general practice patients were dissatisfied. Ley (1988) found that levels of patient satisfaction stem from various components of the consultation, in particular the affective aspects (e.g. emotional support and understanding), the behavioural aspects (e.g. prescribing, adequate explanation) and the competence (e.g. appropriateness of referral, diagnosis) of the health professional. Ley (1989) also reported that satisfaction is determined by the content of the consultation and that patients want to know as much as possible. In studies looking at cancer diagnosis patients showed improved satisfaction if they were given a diagnosis of cancer rather than if this information was kept from them.

Following the recommendations of health professionals plays an important role in patient recovery. However some studies estimate that about half of the patients with chronic illnesses, such as diabetes and hypertension are non-compliant with their medication regimens and that even compliance for a behaviour such as an inhaler for asthma is poor (e.g. Dekker et al, 1992). Non-compliance has financial implications. It was estimated that in 1980 between US$396 and US$792 million per year were 'wasted' in the USA due to non-compliance of prescribed drugs (Department of Health and Human Services, 1980).

Despite the recognition that education in primary care is important there are still many more efforts needed to improve its performance and overall effectiveness. Salti (1995) points out that there is a general agreement that for CME to be effective and relevant, it should be pre-planned to fit the needs of the learners. Salisbury (1997) also points out that suitable educational ventures must be preceded by an assessment of needs, have clear objectives, use appropriate methods and be evaluated for their effectiveness.

Well-planned and designed CME can in theory change a GP's knowledge and behaviour, leading to improved knowledge and behaviour, leading to improved patient outcomes.

Needs assessments play an important role in effective CME. An analysis of 99 randomized control trials of CME interventions showed that when interventions are based on an assessment of physicians' clinical practices and learning needs, changes in GP behaviour and patient outcome are more likely to increase. This is partly explained by the fact that a careful needs assessment gives CME providers baseline data on which to develop education (Toews et al, 1996).

Another reason for the need for carefully planned educational needs assessment (ENA) is that adult learners frequently choose educational areas that are of interest to them, rather than being related to areas of educational need. Primary care workers are no exception to this rule (Myers, 1999).

The need for the introduction of assessment mechanisms that will objectively measure actual desired advancement of the learners as well as the matching of education to need has also been recognised (Myers, 1999). Myers (1999) also stated that in a culture of changing from unidisciplinary post-graduate centre-based education to a multidisciplinary practice-based system, the need to match educational provision to the real needs of the primary care team is greater than ever. He notes that 'while CME has been accepted as effective in the clinical behaviour of participants, there is still uncertainty as to the most effective method of determining the educational needs of family doctors to produce a content that is both clinically important and relevant to their practice'. Myers (1999) concludes that there is a case for developing and evaluating a wider range of methods for assessing educational needs in primary care.

Redbridge and Waltham Forest Health Authority and Barking and Havering Health Authority have worked together to develop three methods of assessing educational needs in all primary care professionals. They are working together on a project to develop Education Action Plans (EAPs) for Primary Care Groups (PCGs). This involves assisting PCG Education Leads to develop a strategic business planning approach to education, training and development for their PCG in order to produce a three year Education Action

Plan covering all primary care professionals in the PCG with a supporting financial plan both of which can be reviewed and updated from year to year.

The project is funded by a grant from the local education consortium (the Outer London Education Consortium - OLEC) and run by a multi-professional and interagency steering group or the Education Action Plan Steering Group.

The three methods of assessing educational needs to develop EAPs are Force Field Analysis (FFA), Professional Practice Development Plans (PPDPs) and Needs Assessment (NA). Details about these methods can be found in the methodology (see page 7-8). The objective of this study was to evaluate the three methods of educational needs assessments (ENAs) with the following aims:

1. To provide an independent evaluation of the approaches to practice-based ENAs being used in Redbridge and Waltham Forest and Barking and Havering Health Authorities.
2. To assess each method in terms of some wider objectives that methods must meet (1. Be applicable to all primary care professions e.g. receptionists, general practitioners, ophthalmic opticians, dentists, practice managers, practice nurses, Trust employed community staff, pharmacists, whether working on their own or in teams. 2. Produce valid results i.e. they must give an accurate picture of the education, training and development requirements in teams and individuals and it should be possible to demonstrate validity.)
3. To assess the extent to which these methods can be used in conjunction with one another.
4. To critically appraise the methods of assessing educational needs in light of the literature and recognised good practice.

METHODOLOGY

Participants

Fifty respondents took part in this evaluation (sixty percent response rate). Table 1 describes the total respondents by ENA and Table 2 shows the age range of respondents. No responses were received from Upminster PCG.

Table 1: Total Respondents

			Method of Assessment		
			Force field analysis	Professional practice development plan	Needs assessment
Occupation / gender	GP	Male	2	2	4
		Female	3	2	0
		Missing data	1	4	0
	Nurse	Male	0	0	0
		Female	5	3	2
		Missing data	0	0	0
	Practice Manager	Male	0	1	0
		Female	5	5	5
		Missing data	0	0	0
	Administrative Staff	Male	0	0	0
		Female	3	4	3
		Missing data	0	0	0
Totals			19	17	14

Table 2: Age Range

Age Range	Respondents
26 - 35	7
36 – 45	12
46 – 55	21
56 - 65	10

In order to obtain a full picture of the practices in the ENA in Barking and Havering and Redbridge and Waltham Forest Health Authorities, practices that were not sampled to take part in the evaluation were also contacted. The practice manager or the senior partner were asked how many staff it employs and how many of the staff were involved in the ENA.

Information for Redbridge and Waltham Forest Health Authority was obtained for 9 out of the 14 practices. One hundred and sixteen members of staff were employed and ninety-one were involved in the force field approach to ENA. Sixty-one practices were involved in the Professional Practice Development Plan (PPDP) approach to ENA. Information was obtained for 30 practices. Three hundred staff were employed and 197 were involved in the PPDPs. It was found that 21 practices had not yet completed the PPDPs. Thirty-nine practices were involved in the Needs Assessment approach to ENA. Information was obtained for 21 practices. Two hundred and two were employed and 60 were involved in the Needs Assessment. Information about who took part in the needs assessment could not be provided by 5 of the 21 practices.

Methods of Educational Needs Assessments

Force Field Analysis (FFA)

This involved a group of primary care tutors together with other educators and facilitators who have a multi-disciplinary background who formed the 'Quality Forum'. This group helped each practice develop it's own Professional and Practice Development Plans by using a technique called Force Field Analysis. Time was allocated for members of the practice to undergo a facilitated workshop lasting half a day in which practice goals were identified, a practice vision was produced and an action plan developed which drove the development of the practice towards achieving the identified goals.

This approach was used in Chingford, Wanstead and Woodstead PCG, Redbridge PCG and Walthamstow, Leyton and Leytonstone PCG.

Professional Practice Development Plans (PPDPs)

Two-hour workshops were held and practices were asked to send at least one representative. The purpose of the workshop was to train a representative to complete a 6 page form which looked at training needs, budget and resources analysis, training and

development plans, review of training and development and training and development benefits.

This approach was used in Barking PCG, Dagenham PCG and Upminster PCG.

Needs Assessment (NA)

This involved external consultants BHB Consulting assessing needs in Hornchurch PCG and Romford PCG. Overall practice needs were assessed using a questionnaire format. The questionnaire included a one page section on the staff's immediate and future training needs.

Procedure

Semi-structured questionnaire

The names and telephone numbers of practices participating the educational needs assessments in Barking and Havering and Redbridge and Waltham Forest Health Authorities were collated. This included 14 practices in Redbridge and Waltham Forest and 100 practices in Barking and Havering. A letter informing possible participants about the evaluation was sent to all 14 practices in Redbridge and Waltham Forest and to a sample of 58 practices in Barking and Havering. Practice Managers or Senior Partners were contacted and given more detail about the evaluation. They were asked for details about their staff profile.

The aim was to telephone interview using a semi-structured questionnaire 17 primary care professionals from 4 occupational groups (GP, Nurse, Practice Manager and Administrative staff) for each model of educational needs assessment. Respondents were contacted and given a brief overview of the evaluation. Unstructured telephone interviews lasting between 1 and 5 minutes followed for 26 respondents. Respondents were then asked if they had time to respond to a questionnaire. The questionnaire elicited general information, the respondent's opinion about the impact of the ENA, assessed the findings of the ENA and some of the wider objectives of the Education Action Plans.

Of the first 10 respondents contacted, only one respondent had time to respond on the telephone. The others requested that the questionnaire be faxed. It was then decided that faxing the questionnaire would be the best method of collecting data. Twenty-eight questionnaires were faxed (7 to each occupational group) to participants in each of the 3 educational needs assessments in the hope that approximately 17 from each assessment model would be returned. Another 8 people were contacted but not faxed questionnaires as they were adamant that their practices had not taken part in such assessments (1 in Redbridge PCG, 1 in Walthamstow, Leyton and Leytonstone PCG, 2 in Barking PCG, 4 in Romford PCG). A further 4 were contacted but unwilling to take part in the evaluation for various reasons, including not having enough time. Of the 50 returning questionnaires, 10 mentioned that the assessment took place a long time ago and it was difficult to remember the exact details. A further 10 felt that the questionnaire added extra burden to their workload but filled out the questionnaire anyway. Respondents were reminded up to 3 times about returning the questionnaire. Five of the thirty-four practices who did not send back questionnaires mentioned that they did not have enough time when reminded about responding to the questionnaire.

Problem-solving with the Education Action Steering Group

Thirty responses were analysed and 3 problem areas were identified. A meeting was held with 7 members of the steering group to discuss these problem areas. This meeting was based on the philosophy of action research (Stringer, 1999) in that the researcher's role is to facilitate action and act as a catalyst to assist stakeholders in defining their problems clearly and to support them in working toward effective solutions. Inevitably talking about these problems also led to a discussion about other issues. These issues will be mentioned in the 'Discussion' section, where relevant.

RESULTS

Figure 1 shows that the majority of respondents consider the principle of education action plans to be very important. Seventeen out of nineteen respondents who undertook force-field analysis, 14 out of 17 who completed a professional practice plan and 9 out of 14 using the needs assessment thought the principle of education action plans is very important. Only 7 respondents thought that the principle of education action plans was a little important and only 2 respondents considered education action plans not to be important at all. One respondent did not reply. Figure 2 shows the considered level of importance of EAPs by primary care group. Table 3 shows the considered level of importance of education action plans by method of assessment and by occupation.

Table 3: Importance of education action plans by method of assessment and by occupation

			Method of Assessment		
			Force field analysis	Professional practice development plan	Needs assessment
Occupation/ Importance of education action plans	GP	Very	6	4	4
		A little	0	0	0
		Not at all	0	0	0
		Missing data	0	0	0
	Nurse	Very	4	3	1
		A little	1	0	1
		Not at all	0	0	0
		Missing data	0	0	0
	Practice Manager	Very	4	3	4
		A little	1	2	1
		Not at all	0	0	0
		Missing data	0	1	0
	Administrative Staff	Very	3	4	0
		A little	0	0	1
		Not at all	0	0	2
		Missing data	0	0	0

Figure 3 shows levels of satisfaction of method of assessment. Forty-one out of 50 respondents (82%) were very satisfied or satisfied with the approach used to assess educational needs. The majority of respondents who were very satisfied took part in force-field analysis. That is 32% of force-field respondents were very satisfied. By

contrast, 29% of PPDP respondents and 21% of NA respondents and 0% of FFA respondents were not satisfied. Figure 4 shows level of satisfaction with method of assessment by PCG. This shows that the 5 respondents who were not satisfied with the PPDP method were all from Dagenham PCG. Table 4 shows the level of satisfaction with method of assessment by occupation of participants.

Table 4: Level of satisfaction with method of assessment by occupation of participants

			Method of Assessment		
			Force field analysis	Professional practice development plan	Needs assessment
Occupation/ Level of satisfaction	GP	Very satisfied	2	1	1
		Satisfied	3	2	3
		Not satisfied	0	1	0
		Missing data	1	0	0
	Nurse	Very satisfied	3	0	0
		Satisfied	2	2	1
		Not satisfied	0	1	1
		Missing data	0	0	0
	Practice Manager	Very satisfied	0	0	0
		Satisfied	5	4	5
		Not satisfied	0	2	0
		Missing data	0	0	0
	Administrative Staff	Very satisfied	1	0	0
		Satisfied	2	3	1
		Not satisfied	0	1	2
		Missing data	0	0	0

Table 5 shows the respondents reporting understanding the methods of assessment by occupation. Administrative staff are more likely to report not understanding the approaches (30%) than practice managers (19%), nurses (10%) and GP's (7%).

Table 5: Respondents understanding of method of assessment by occupation

			Method of Assessment		
			Force field analysis	Professional practice development plan	Needs assessment
Occupation/ Understanding approach	GP	Yes	5	3	4
		No	0	1	0
		Missing data	1	0	0
	Nurse	Yes	5	3	1
		No	0	0	1
		Missing data	0	0	0
	Practice Manager	Yes	5	3	5
		No	0	3	0
		Missing data	0	0	0
	Administrative Staff	Yes	3	2	1
		No	0	1	2
		Missing data	0	1	0

Assessing the findings of the ENA

Figure 5 shows how many respondents thought the methods had adequately identified their educational needs. Seventy-two percent of respondents thought the methods used had identified their educational needs. FFA respondents were more likely to think that their education needs had been identified (79%) compared to 65% for PPDP and 71% for NA. Tables 6 shows education needs identified by PCG. Table 7 shows education needs identified by occupation. Sixty-nine percent of GPs (1 missing response), 80% of nurses, 81% of practice managers and 86% of administrative staff (3 missing responses) who responded thought their educational needs had been identified.

Table 6: Education needs identified by method of assessment by PCG

			Method of Assessment		
			Force field analysis	Professional practice development plan	Needs assessment
PCG/ Education needs identified by method of assessment	Walthamstow, Leyton, & Leytonstone	Yes	5		
		No	0		
		Missing data	0		
	Redbridge	Yes	4		
		No	1		
		Missing data	1		
	Chingford, Wanstead, & Woodstead	Yes	6		
		No	2		
		Missing data	0		
	Dagenham	Yes		4	
		No		3	
		Missing data		0	
	Barking	Yes		7	
		No		1	
		Missing data		2	
	Upminster	Yes		0	
		No		0	
		Missing data		0	
	Hornchurch	Yes			5
		No			3
		Missing data			1
	Romford	Yes			5
		No			0
		Missing data			0

Table 7: Education needs identified by method of assessment by occupation

			Method of Assessment		
			Force field analysis	Professional practice development plan	Needs assessment
Occupation/ Needs Identified	GP	Yes	4	1	4
		No	2	2	0
		Missing data	0	1	0
	Nurse	Yes	5	3	0
		No	0	0	2
		Missing data	0	0	0
	Practice Manager	Yes	4	4	5
		No	1	2	0
		Missing data	0	0	0
	Administrative Staff	Yes	2	3	1
		No	0	0	1
		Missing data	1	1	1

Figure 6 shows respondents' opinions about courses from which they think they might benefit. IT skills were the most popular course. Figure 7 shows respondents' opinions about the courses from which they think their colleagues would benefit. IT skills were the most popular. These figures could be compared with the final results of all the education needs assessments to see whether the methods elicited similar information. Figures 8-11 show the courses that respondents think they and their colleagues would benefit from by occupation. It is only GPs who think that they would be more likely to benefit from a course on 'communicating with others' and 'communication in the workplace' than their colleagues. Practice managers think they are in more need of business skills than their colleagues. Perceived need for IT skills is quite even although there is a trend for administrative staff to see themselves more in need of IT skills than their colleagues.

Table 8 shows how adequately respondents thought their non-clinical education needs had been assessed. Despite being asked 'If applicable, Do you feel that your non-clinical educational needs were adequately assessed?' 7 out of 10 administrative staff reported that their non-clinical needs had been assessed. This raises questions about how carefully the questionnaires were completed.

Table 8: Adequate assessment of non-clinical education needs by method of assessment, by occupation

			Method of Assessment		
			Force field analysis	Professional practice development plan	Needs assessment
Occupation/ Adequately assessed non clinical needs	GP	Yes	2	2	1
		No	4	2	3
		Missing data	0	0	0
	Nurse	Yes	5	2	0
		No	0	0	1
		Missing data	0	1	1
	Practice Manager	Yes	5	3	4
		No	0	2	0
		Missing data	0	1	1
	Administrative Staff	Yes	3	3	1
		No	0	0	1
		Missing data	0	1	1

Assessing some wider objectives

Table 9 shows how suitable respondents thought the method they had used would be suitable for other PCGs by occupation. Only 2 respondents, 1 GP and 1 nurse, thought that PPDP would not be suitable for other PCGs (One respondent was from Dagenham and the other from Barking).

Table 9: Suitability of method of assessment for other PCGs, by occupation

			Method of Assessment		
			Force field analysis	Professional practice development plan	Needs assessment
Occupation/ Suitability of model of assessment for other PCGs	GP	Yes	6	3	3
		No	0	1	0
		Missing data	0	0	1
	Nurse	Yes	5	1	1
		No	0	1	0
		Missing data	0	1	1
	Practice Manager	Yes	5	5	5
		No	0	0	0
		Missing data	0	1	0
	Administrative Staff	Yes	3	4	2
		No	0	0	0
		Missing data	0	0	1

Table 10 shows what respondents thought about the use of methods with other primary care professionals. Only one practice manager thought that FFA could not be used with all primary care professionals. No respondents who used PPDPs thought it could not be used with other primary care professionals. Three respondents (2 GPs and 1 PM) who used the needs assessment thought it could not be used with all primary care professionals. Table 11 breaks this information up by PCG.

Table 12 shows responses to the question whether the methods had produced an accurate picture of educational needs. Sixty-eight percent of FFA, 71% of PPDP and 50% of NA respondents thought the method of ENA they had used had produced an accurate picture of their educational needs. Table 13 breaks this information up by PCG.

Table 10: Method of assessment used with all primary care professions (PCP) by occupation of participants

			Method of Assessment		
			Force field analysis	Professional practice development plan	Needs assessment
Occupation/ Model of assessment used with all PCP	GP	Yes	6	3	2
		No	0	0	2
		Missing data	0	1	0
	Nurse	Yes	5	2	2
		No	0	0	0
		Missing data	0	1	0
	Practice Manager	Yes	4	6	4
		No	1	0	1
		Missing data	0	0	0
	Administrative Staff	Yes	3	4	2
		No	0	0	0
		Missing data	0	0	1

Table 11: Method of assessment used with all primary care professions (PCP) by PCG

			Method of Assessment		
			Force field analysis	Professional practice development plan	Needs assessment
PCG/ Model of assessment used with all PCP	Walthamstow, Leyton, & Leytonstone	Yes	5		
		No	0		
		Missing data	0		
	Redbridge	Yes	6		
		No	0		
		Missing data	0		
	Chingford, Wanstead, & Woodstead	Yes	7		
		No	1		
		Missing data	0		
	Dagenham	Yes		6	
		No		0	
		Missing data		1	
	Barking	Yes		9	
		No		0	
		Missing data		1	
	Upminster	Yes		0	
		No		0	
		Missing data		0	
	Hornchurch	Yes			7
		No			2
		Missing data			0
	Romford	Yes			3
		No			1
		Missing data			1

Table 12: Accuracy of educational needs identified by method of assessment by occupation of participant

			Method of Assessment		
			Force field analysis	Professional practice development plan	Needs assessment
PCG/ Accuracy of educational needs identified by model of assessment	GP	Yes	4	2	2
		No	1	2	2
		Missing data	1	0	0
	Nurse	Yes	5	3	0
		No	0	0	2
		Missing data	0	0	0
	Practice Manager	Yes	2	3	4
		No	2	2	0
		Missing data	1	1	1
	Administration	Yes	2	4	1
		No	1	0	2
		Missing data	0	0	0

Table 13: Accuracy of educational needs identified by method of assessment by PCG

			Method of Assessment		
			Force field analysis	Professional practice development plan	Needs assessment
PCG/ Accuracy of educational needs identified by model of assessment	Walthamstow, Leyton, & Leytonstone	Yes	3		
		No	2		
		Missing data	0		
	Redbridge	Yes	4		
		No	0		
		Missing data	2		
	Chingford, Wanstead, & Woodstead	Yes	6		
		No	2		
		Missing data	0		
	Dagenham	Yes		3	
		No		3	
		Missing data		1	
	Barking	Yes		9	
		No		1	
		Missing data		0	
	Upminster	Yes		0	
		No		0	
		Missing data		0	
	Hornchurch	Yes			3
		No			5
		Missing data			1
	Romford	Yes			4
		No			1
		Missing data			0

Content Analysis

Additional comments were added to 25 out of 50 responses from the questionnaire. Initial interviews lasting enough time to elicit more than clarification about the evaluation were conducted with 26. The following themes have been drawn from this information.

Table 14 Themes from content analysis of questionnaires and interviews

THEME	TOTAL COMMENTS	COMMENTS/METHOD or PCG
Time	14	'Not enough time to implement it.' (FFA) 'Time factor is important.' (FFA) 'Time is precious for a single handed GP.' (PPDP) 'Time and resources to implement action plan needed.' (FFA) 'I don't have time for more paperwork' (PPDP) 'More time is needed to complete long forms.' (NA) 'I haven't had time to do it' (PPDP) 'We need more time to do it properly.' (PPDP) 'My staff are already pushed for time.' (NA)

		'To do it properly requires time commitment from the professionals and assessor to develop a clear development plan for the whole practice with objectives and time scales and specific allocated time for education clearly identified.' (PPDP) 'I agree with the approach but feel more time should be allocated for full assessment of training needs.' (FFA) 'The whole procedure was inadequate and a waste of time.' (PPDP) 'We are finding it difficult to find the time to implement the PPDP.' 'Time is a major problem especially when understaffed with maternity and sick leave.' (PPDP)
Different agendas– practices/health authority	11	'We have different agendas. We are here to look after the public.' (FFA) 'They (the HA) are on a different wave length.' (FFA) 'As long as they (the HA) can show on paper that something works, they are not bothered about what we achieve.' (FFA) 'The reality is often different to their (the HA) aims' (PPDP) 'We are here to care not fill out paperwork but we have to if we want funding' (PPDP) 'We have to do it (EAP's) to keep them (the HA) happy in order to get funding' (PPDP) 'They (the HA) keep changing their criteria and priorities are changing nearly every month' (PPDP) 'Paperwork from the HA adds extra work to workload' 'Education is important but many practice staff see their jobs as part-time...do not always see a career path.' (PPDP) 'I don't understand what they want to achieve.' (PPDP) 'Paperwork for the HA is low priority.' (PPDP) 'They (the HA) want things done yesterday.' (NA)
Lack of follow-up	10	'Little has been implemented.' (NA) 'We were not kept informed of updates.' (PPDP) 'Nothing has been implemented.' (FFA) 'We were never given a written report of findings.' (FFA) 'There should be follow-up meetings to see what was identified and to see if acted upon.' (FFA) 'We were never followed up with any other meetings. I felt that a lot of our problems were discussed but we have never heard how to solve these, if possible.' (FFA) 'Results need to be communicated. Follow-up plans are very much required.'(FFA) 'It would have been desirable if we could have concluded with action plan within a realistic time frame. The lessons learnt have in reality faded away because of a lack of concrete follow-up plan.'(FFA) 'We filled in the forms but have not yet had any feed-back so I am unable to comment further.' (PPDP) 'Only helpful if we actually get the education and support we have identified.' (PPDP)
Differences/ tensions in practices	8	'He (the GP) keeps all information to himself.' (Barking) 'We are different in our practice, we have good

		communication.' (Hornchurch) 'He (the GP) keeps us in the dark.' (Hornchurch) 'Some staff have less desire to broaden their horizon at work.' (CWW) 'I have not involved my colleagues in this work.' (Dagenham) 'I would prefer if the doctors were more involved.' (Dagenham) 'We have internal problems.' (Dagenham) 'We are 100% committed in our surgery because we are relatively small' (CWW)
Positive comments about FFA	7	'The staff facilitating were very good.' (CWW) 'It was great for the whole team to be together and it was fun.' (CWW) 'The staff were great.' (Redbridge) 'This approach made us focus as a group on what we needed to incorporate into our plans.' (CWW) 'After it was explained to all (including the doctors) we all took part with gusto! It was very informative, thought provoking exercise. We did a lot of planning after. VERY GOOD.' (CWW) 'Excellent co-ordinators.' (Redbridge) 'We enjoyed the afternoon and were able to get a lot of issues sorted out, the facilitators were very good.' (CWW)
PPDP needs explanation	5	'The form was badly designed and not adequately explained.' (Dagenham) 'Poorly designed and executed' (Dagenham) 'Did not understand at first but when explained it became clear.' (Barking) 'It was complex but gradually understood.' (Barking) 'Did not understand until clearly explained in person.' (Barking)
EAP's need to be linked	3	'Needs to link well with PCT level priorities.' (FFA) 'Need to link to personal development plans.' (FFA) 'Could be linked to clinical governance.' (PPDP)

Education Action Plan Steering Group Meeting

Three problem areas were discussed at this meeting. Below is a summary of the suggested solutions to these problems proposed by members of the steering group.

Problem One: Time

On the whole most respondents thought that the concept of education action plans was very important. However there was a problem of having the time to conduct the plans. This was more true for the needs assessment and the professional practice development plan approaches. This was reflected in the levels of satisfaction in which force field analysis was rated higher than the other approaches.

It was suggested that protected education time for practices are needed. Education would become part of the working week. For example each locality could have half a day a month of protected education time. This time would be paid.

It was agreed that force field analysis was a good approach for the very reason that time was actually allocated to conduct the education action plan. It was mentioned that quite often people fill out questionnaires without actually thinking about what they are writing. A comment about not having time for paperwork was seen to be familiar. Force field analysis gives people time to reflect together as a team. A strong message comes across that participants are part of a team. An example was given of one person who said that it was the first time her team had all got together. However it was pointed out that coming together as a team can also unleash a lot of problems. Another drawback of force field analysis is that it takes time to implement at a PCG level. It is difficult to generalise educational needs for a whole PCG from a sample of practices. Force field analysis looks at practice needs which has practical advantages however it could miss out individual needs. It was said that some type of mechanism is needed to ensure that individual needs are not lost. This was illustrated with the example of a Practice Manager stating that more IT courses are needed and a receptionist from the same practice stating she felt that the classroom environment was alien to her.

Force field analysis was seen as a good model for gaining an understanding of practice educational needs however it was felt that a mechanism is needed to deal with the identified needs. This raises questions about funding, time, coordination, locality of courses and accreditation of courses. It was suggested that this issue needs to be dealt with at a PCT level. This leads to the second problem that was discussed.

Problem Two: Lack of Follow-up

It was felt by 8 out of 30 respondents that there was a lack of follow-up to education action plans. This was particularly true for force field analysis respondents. The steering group generally agreed that there had been a lack of follow-up. This lack of follow-up

referred to actual implementation of the identified education needs. In terms of follow-up of the assessment of educational needs, the steering group pointed out that follow-up appointments were difficult to make due to the issue of time and convenience. Also turn over of staff can complicate follow-ups. It was suggested that a second appointment is made after the first appointment. No real consensus was reached for this suggestion.

Problem Three: Different Agendas

There was a "them and us" feeling arising from some participants. The steering group were surprised that this was mentioned by force field analysis participants as this approach set out to disassociate itself from the health authority. The comments however may not be specific to the educational needs assessment but be more general comments about the health authorities. The issue of clearly communicating to primary care professionals the benefits education may have to patients was discussed.

One possible solution to communication problems could be to send out a 'hello letter' addressed to all participants from the facilitator every month asking how they are getting on with their action plans.

It was mentioned that education needs assessment may not be right for all practices. The feasibility of having a process whereby practices approach health authorities for needs assessment was discussed. It was agreed that this would not be a feasible solution as it would only target volunteers who may not be representative and would ignore practices that need help.

Figure 1: Level of importance of education action plans by method of assessment

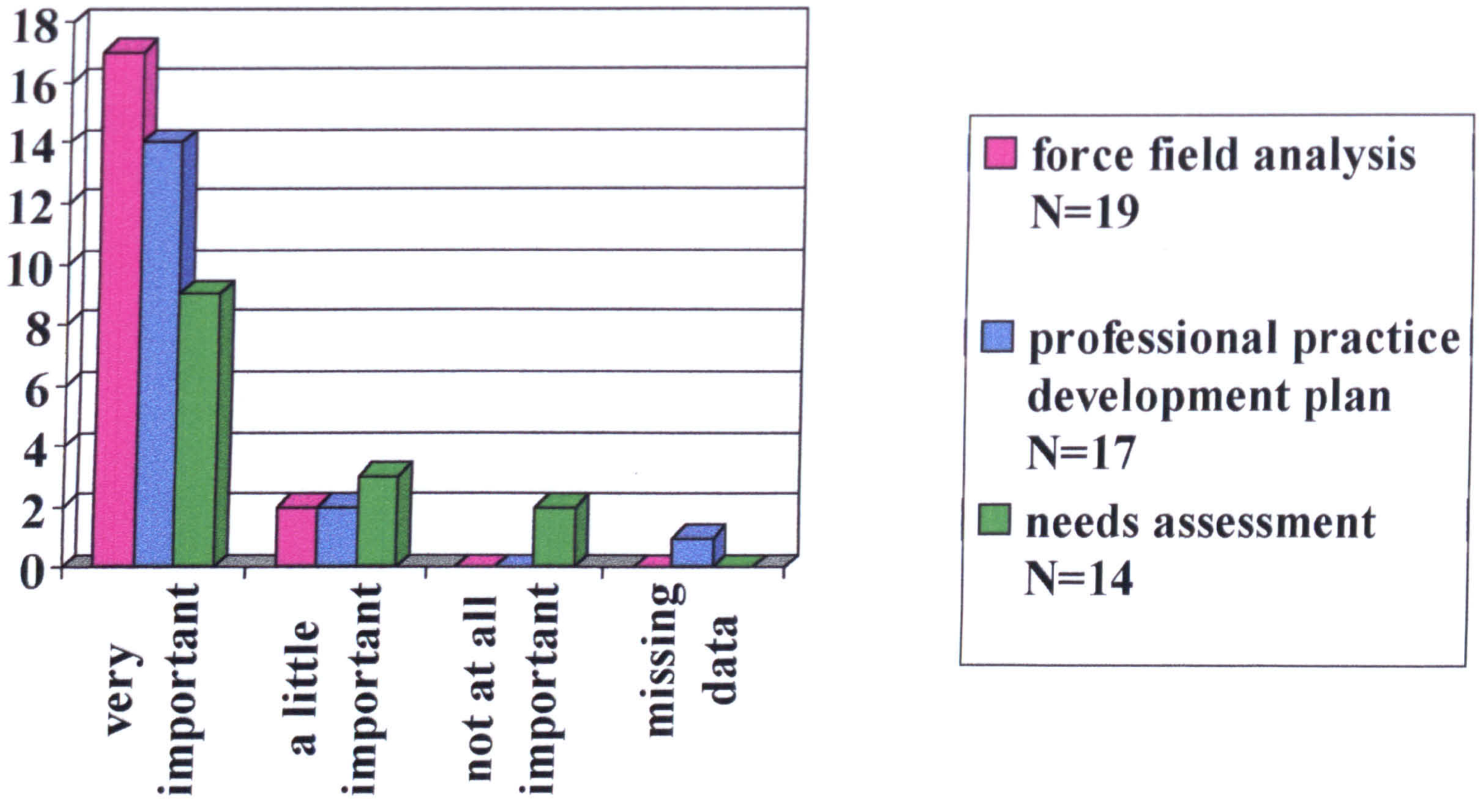


Figure 2: Level of importance of education action plans by PCG

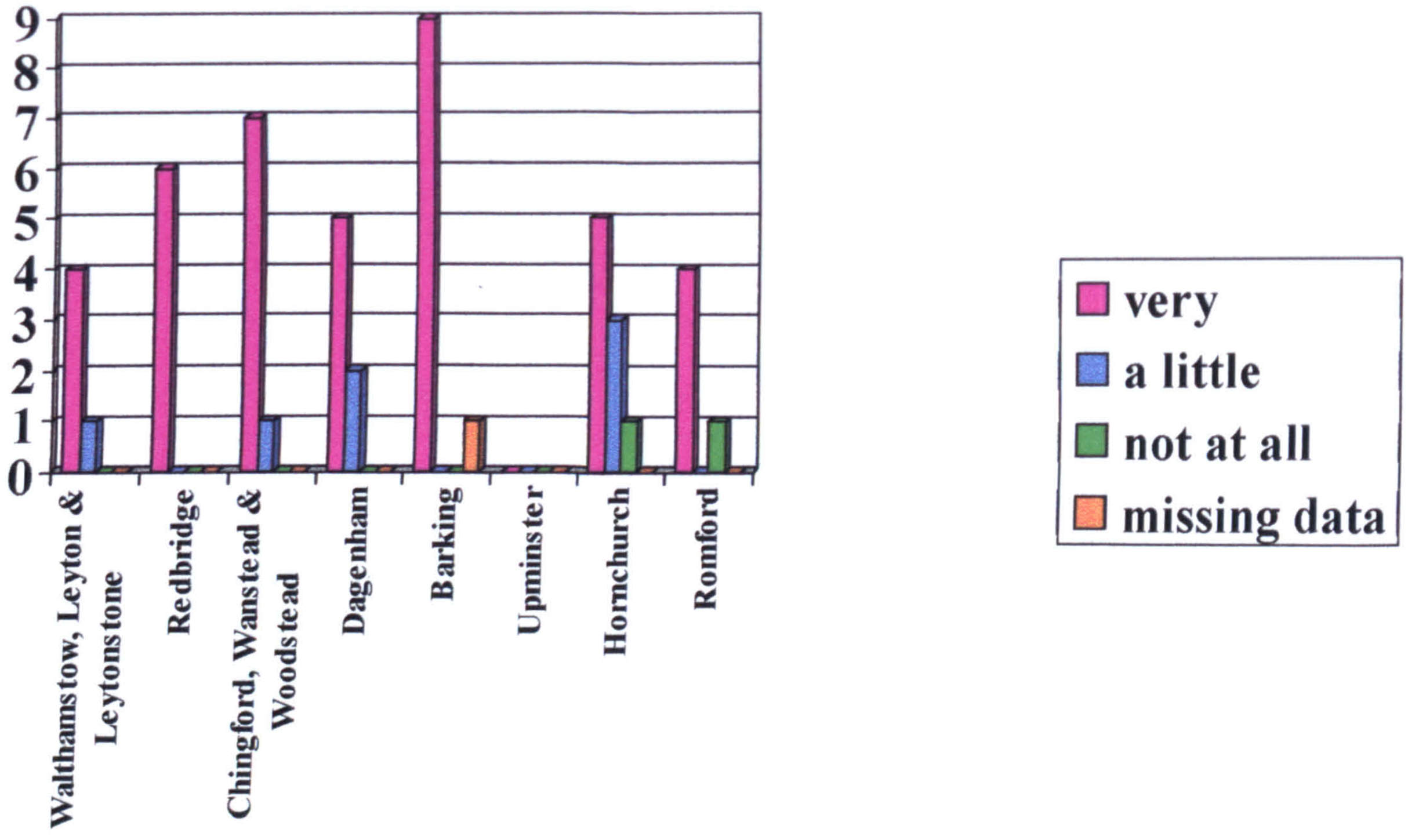


Figure 3: Level of satisfaction by method of assessment

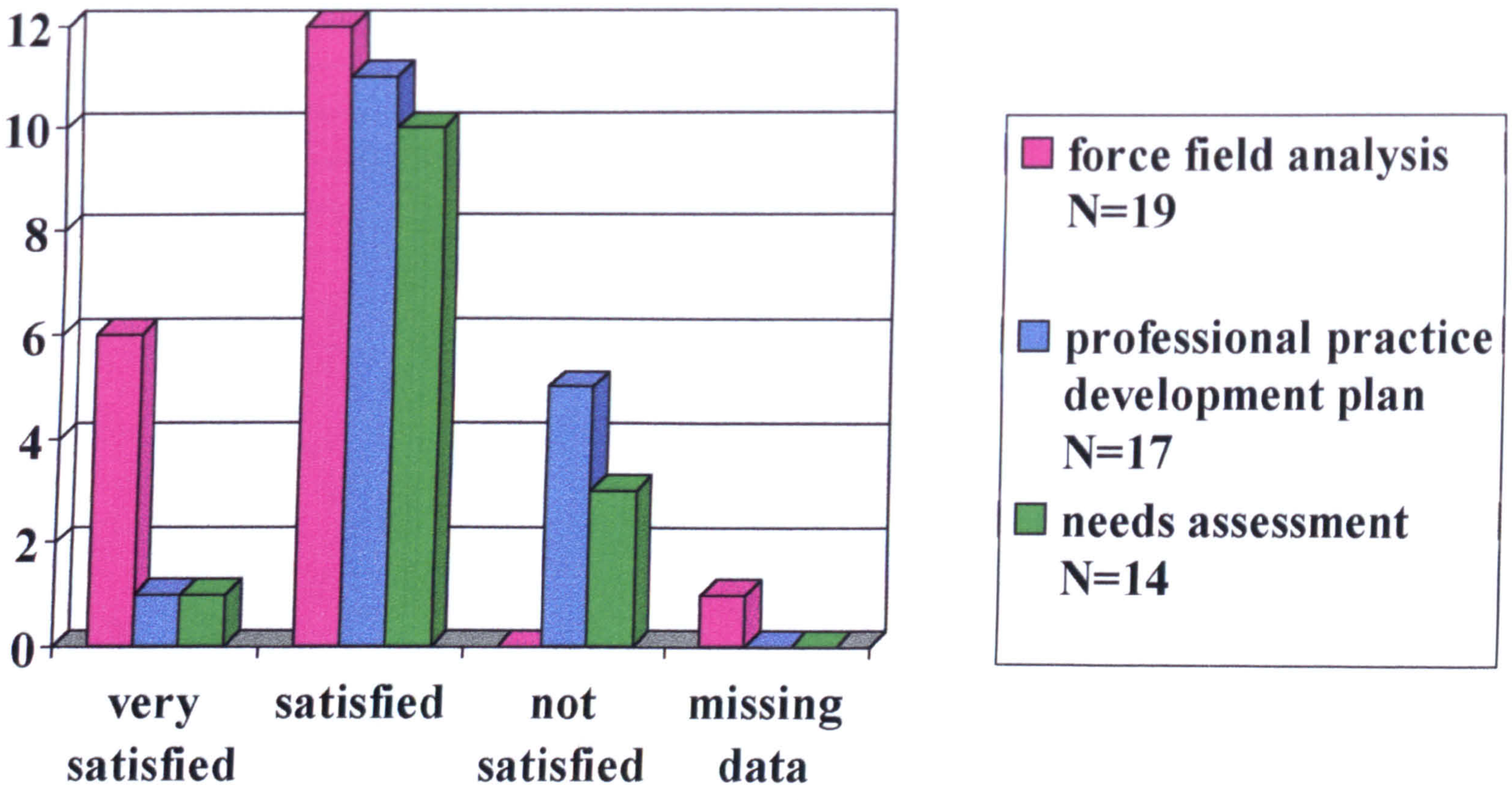


Figure 4 - Level of satisfaction with method of assessment by PCG

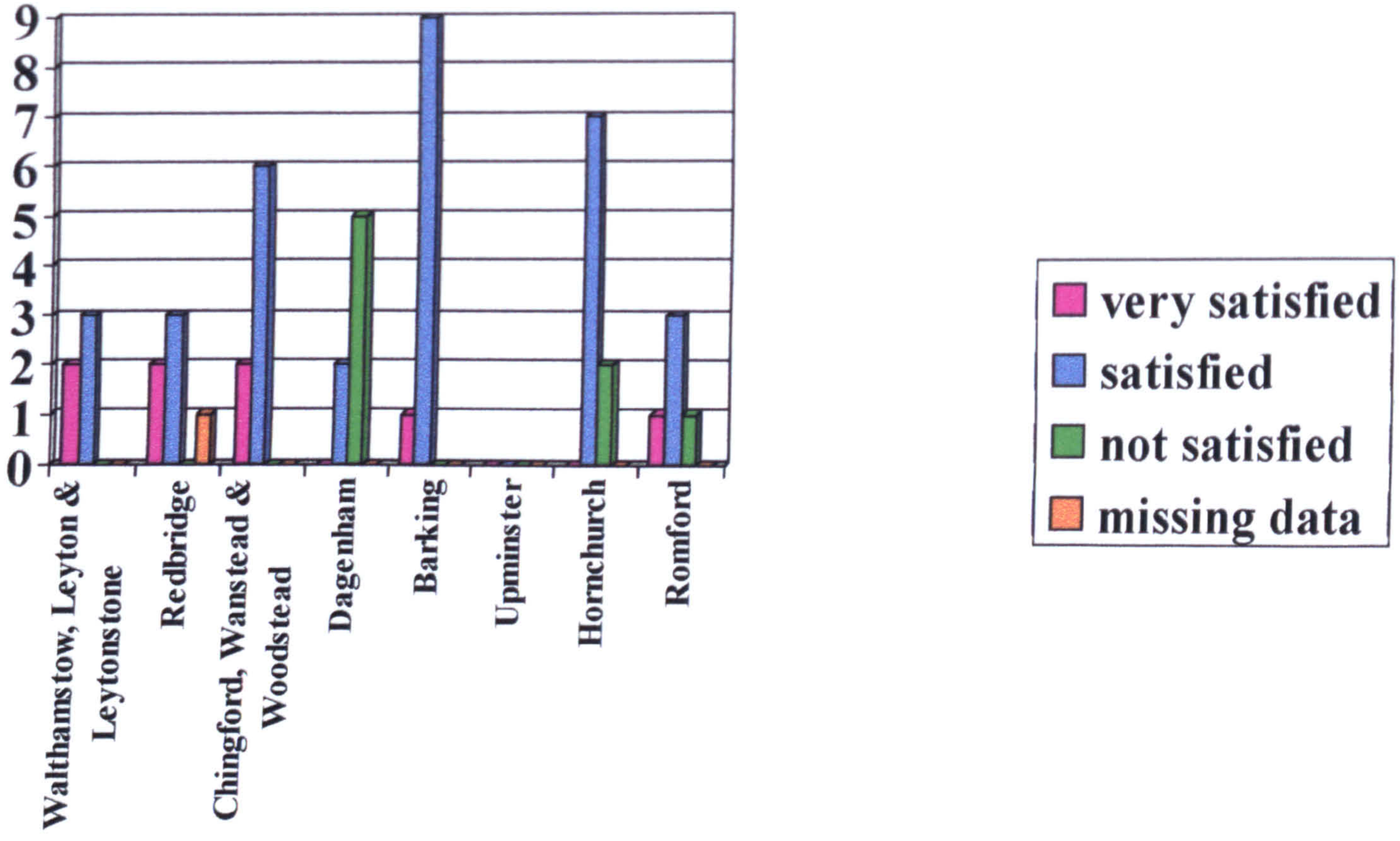


Figure 5: Education needs identified by method of assessment

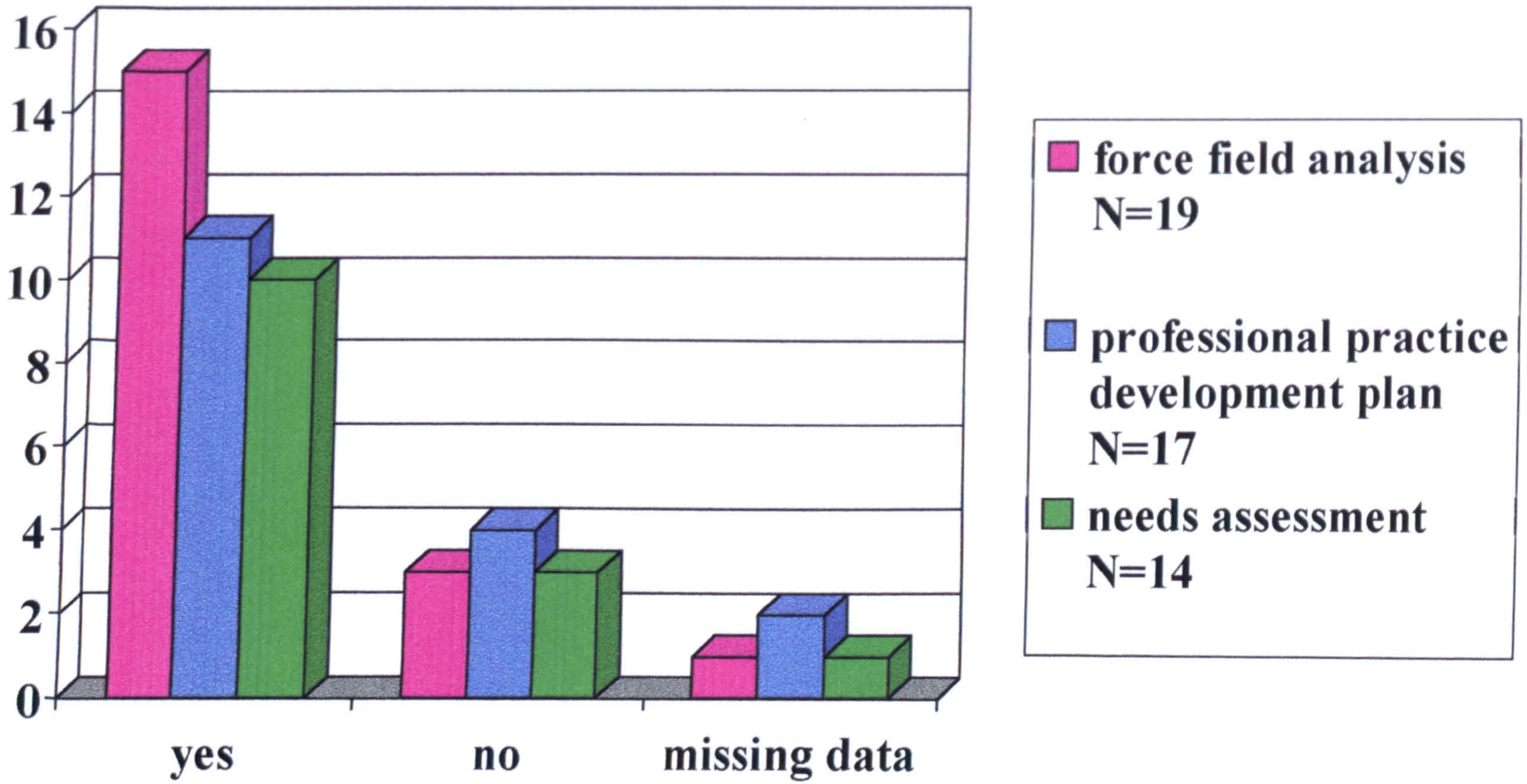


Figure 6: Courses from which respondents thought they would benefit

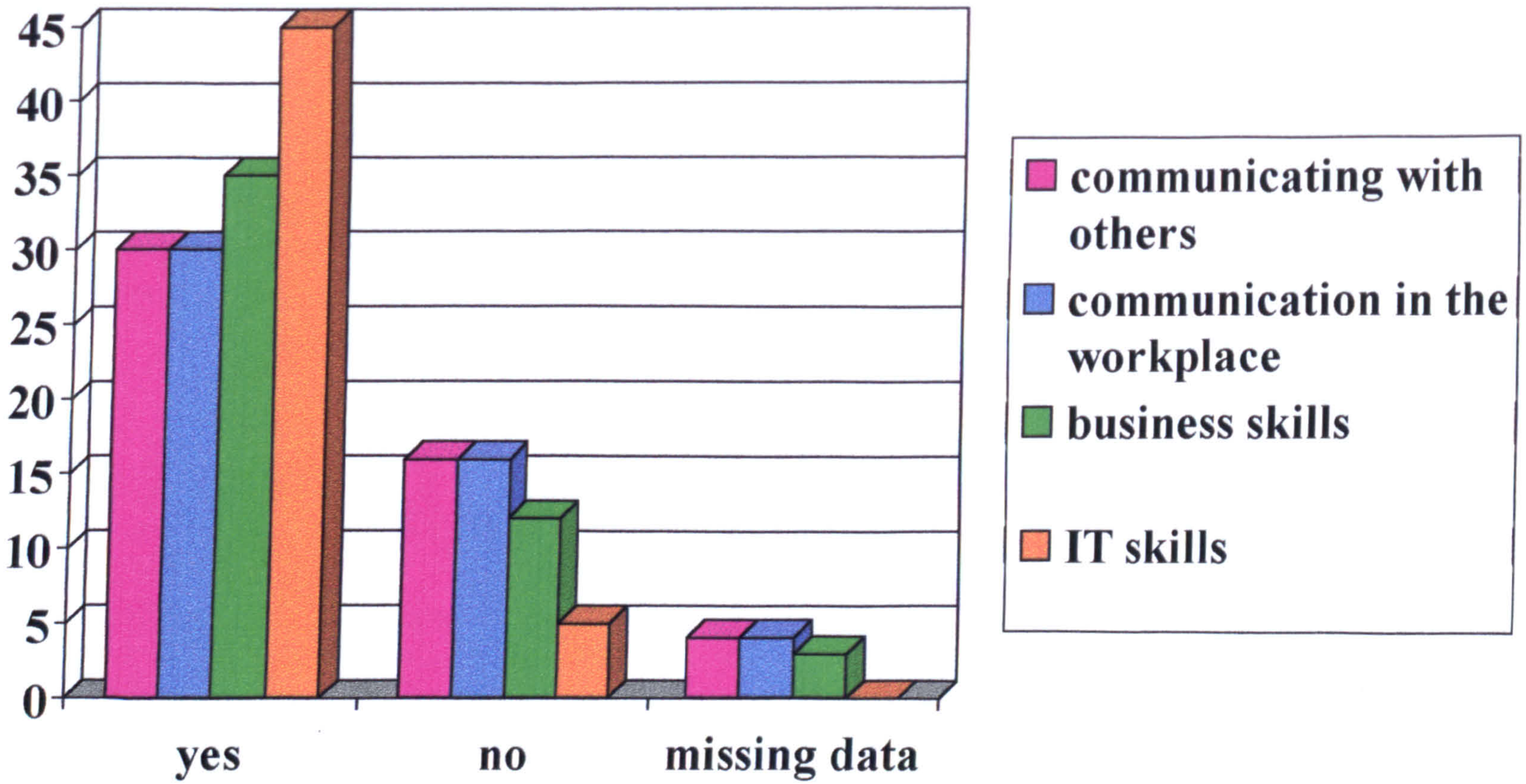


Figure 7: Courses from which respondents thought their colleagues would benefit

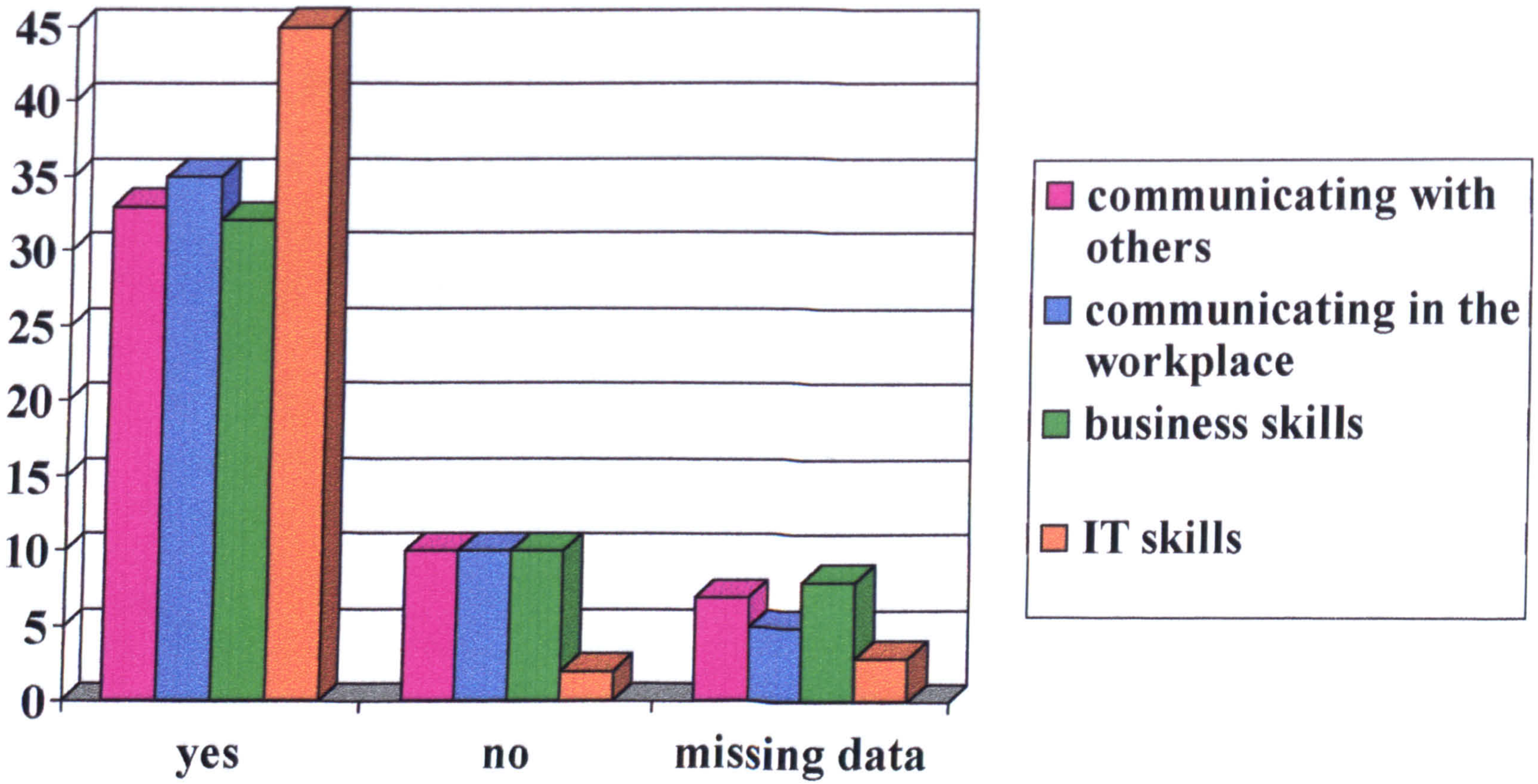


Figure 8: Respondents' opinion on need for "Communicating with others" course

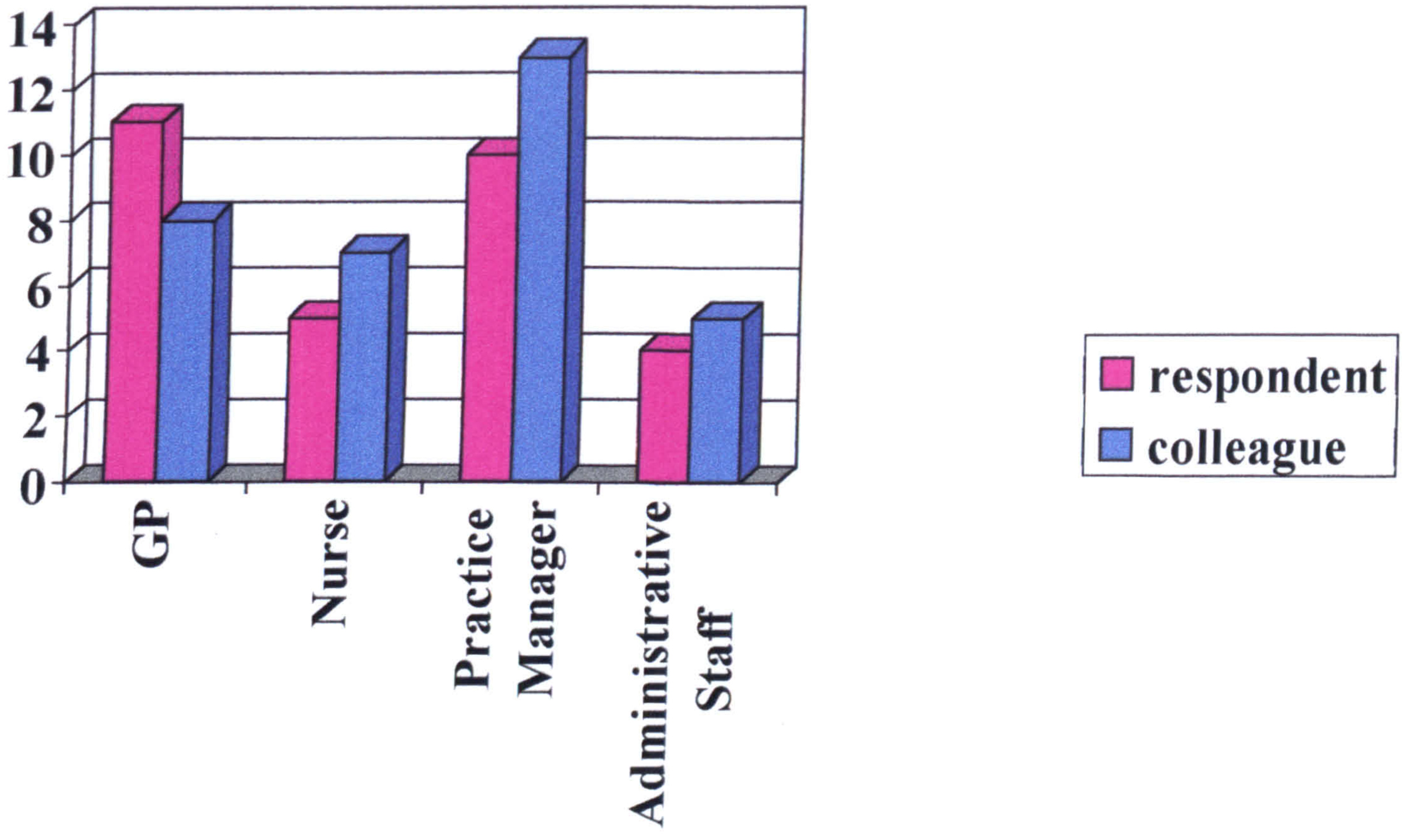


Figure 9: Respondents' opinion on need for "communication in the workplace" course

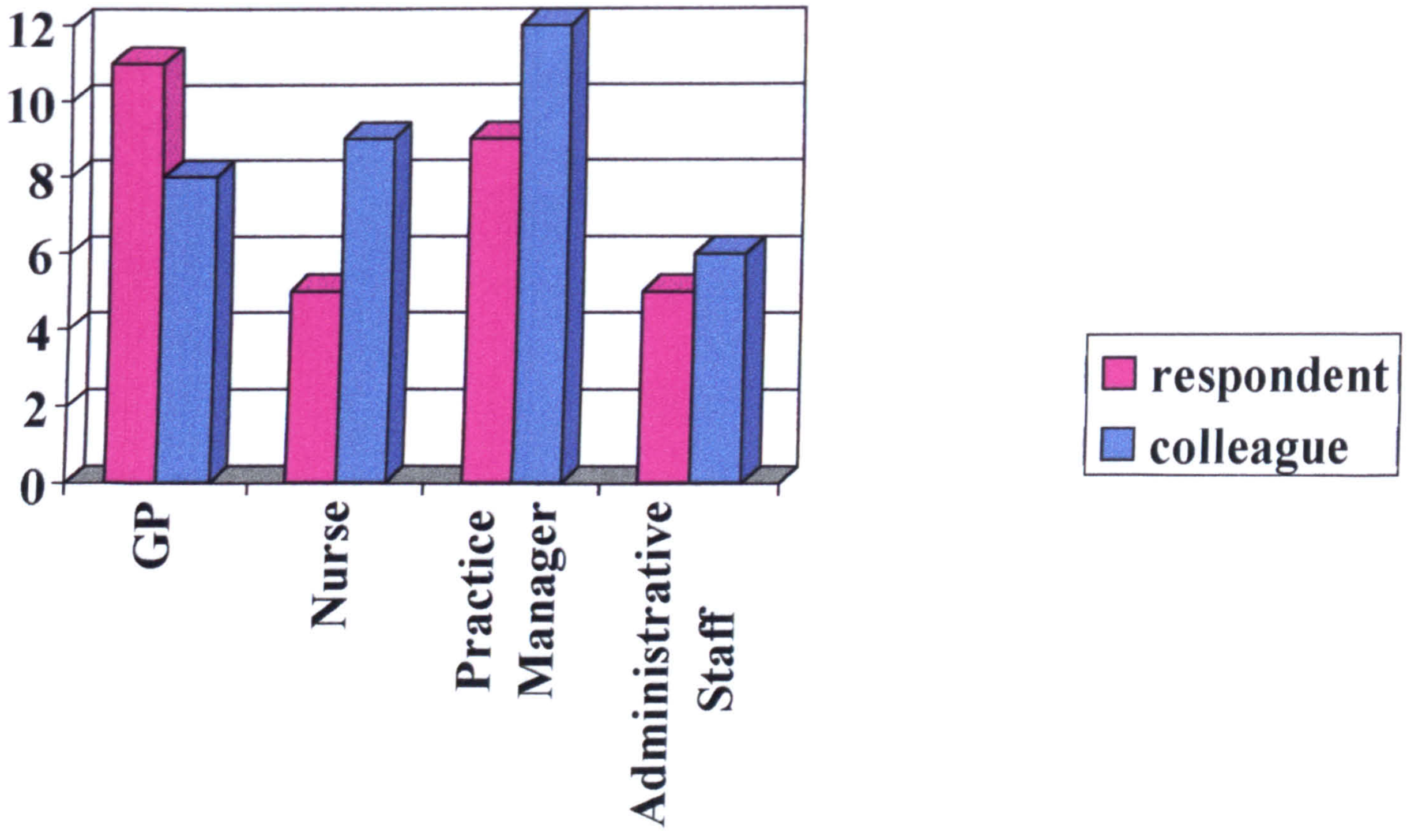


Figure 10: Respondents' opinion on need for "Business skills" course

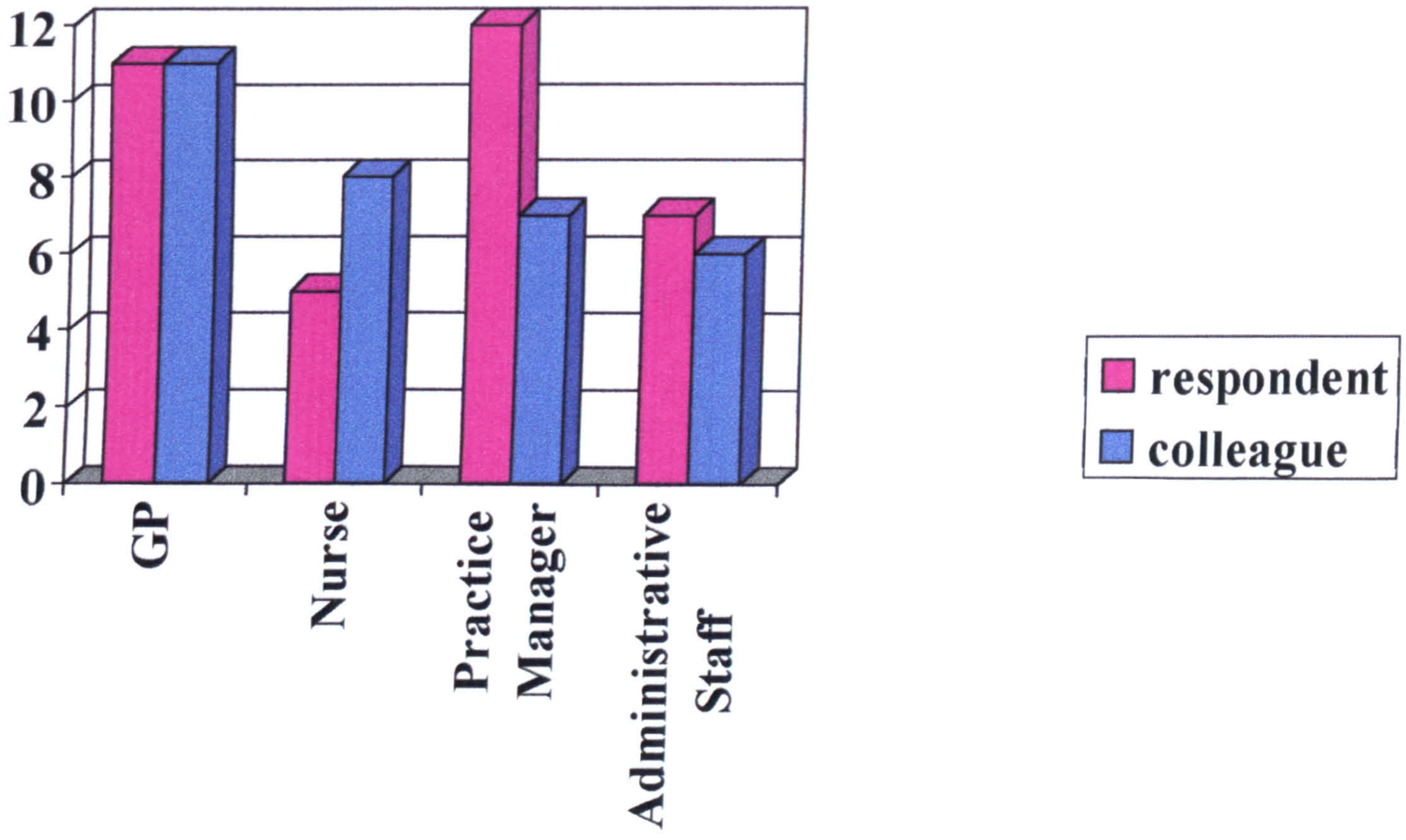
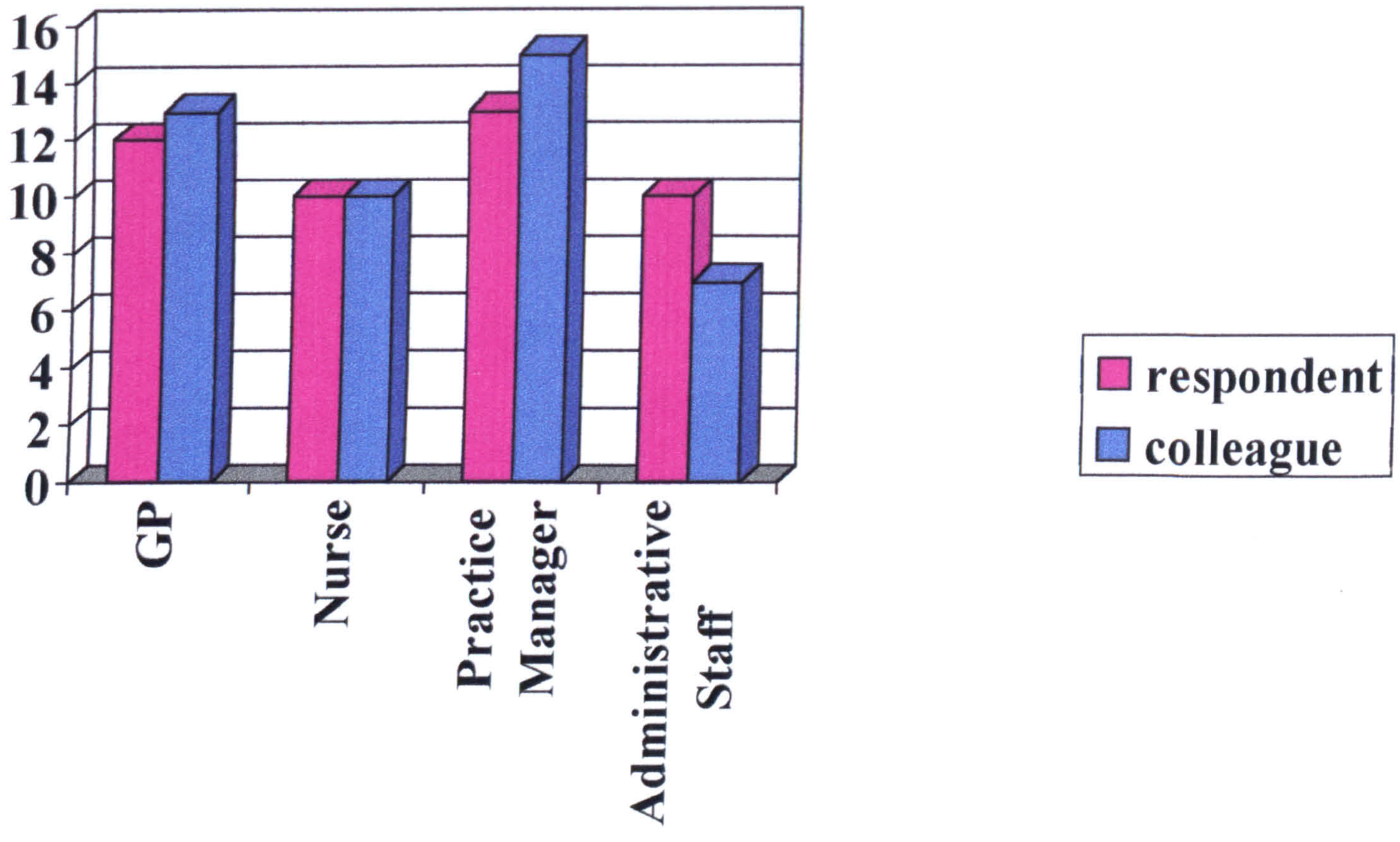


Figure 11: Respondents' opinion on need for "IT skills" course



DISCUSSION

Overall the results from the questionnaire show that most primary care professionals are happy with the principle of education action plans. Most respondents marked on the questionnaire that they were satisfied or very satisfied with the method used to assess educational needs. Yet additional comments and interviews reveal that there is need for improvement.

On the whole FFA appeared to be the best of the 3 methods. The majority of respondents who were very satisfied with their approach had taken part in FFA. Seventy-nine percent thought their educational needs had been identified, 68% thought FFA had produced an accurate picture of educational needs. Seven additional positive comments about FFA were also reported. Time has been mentioned as a restraint for activities in primary care. A positive factor of FFA is that time is actually allocated for the EAPs. Also FFA is an active approach to conducting EAPs. The downfalls of a passive approach to education in primary care have been noted in the literature (e.g. Salisbury, 1997 and Westcott, 1996). Yet there seemed to be disappointment with FFA in terms of follow-up. Six respondents felt that they had identified their needs but nothing had been done to deal with their needs. This is no doubt a resource and organisational problem rather than one that is related to FFA, per se. The Steering Group identified some more problems with FFA. FFA takes time to implement at a PCG level and it is difficult to generalise one practice needs to another. Also this approach looks at practice needs and could omit individual needs. However it has been found that when individuals assess their needs, there is little evidence to support the view that their choice necessarily matches their true educational needs (e.g. Hays et al, 1999 & Pitts and White, 1994).

One solution could be a cyclic model in which FFA assesses practice needs, resources are allocated, needs are met taking into consideration individuals learning styles (e.g. if it is found that IT skills need updating in the practice, decide who will be trained and what would be the best way for those individuals). It was also pointed out by the Steering Group that coming together as a team could unleash a lot of problems for certain teams.

This was reflected in some of the comments. Team spirit and management seems to vary according to practice. Dealing with team issues could be the first stage of the assessment.

The stages of assessing educational needs could be presented as a linear format, e.g.

- Assess team and management issues in a practice
- Conduct ENA, e.g. FFA
- Take into consideration individual learning styles
- Allocate resources
- Provide education

However by being cyclic in nature, as participants work through each of the stages, they would explore the details of their activities through a constant process of observation, reflection and action. This model would not be neat and orderly. People may find themselves working backwards through the stages, repeating processes, revising procedures or jumping stages. Practices within a PCG would be all at different stages within the cyclic model.

This approach may require a change in the culture of conducting educational action plans for some practices and would therefore need to be communicated in a sensitive and open manner. There appeared to be a feeling that practices have different agendas to health authorities, almost a 'them and us' feeling. More work is needed to overcome this feeling. This approach could give practices a sense of ownership of their educational process whereby practices decide how to approach the process and the health authority are seen as a source of guidance and advice rather than a body that dictates how and when to conduct ENAs.

On the whole there was a feeling that the methods would be suitable for other PCGs. It was felt by all PPDP respondents that PPDPs could be used by other primary care professionals. Also the PPDP approach was viewed slightly better than FFA in terms of producing an accurate picture of educational needs. NA did not fair very well, with only 50% of respondents reporting that they thought an accurate picture of their educational

needs had been produced. Despite comments about the dislike of paperwork, PPDPs which were a 6 page form produced a better picture of educational needs than a one page NA form.

Clearly respondents felt a need for more IT skills. The need for more IT courses was specifically mentioned by 5 respondents in their extra comments on the questionnaire and mentioned by 3 respondents in the telephone interview. Two practice managers in Romford said that the classroom environment has to be friendly as it could be alien to some people. This is in line with literature that recommends education should be based in the workplace (e.g. Salisbury, 1997; Hayes, 1995; Savage, 1991). Westcott (1996) also advocates workplace-centred learning however mentions a study by Kelly and Murray (1994) that found that GP's rated practice-based learning as second only to distance-based learning as the least preferred method of CME. It was interesting to see that GPs thought they were more likely to benefit from a course on 'communicating with others' and 'communication in the workplace' than their colleagues thought they would. This could reflect genuine self insight or familiarity with the discourse about GPs needing to improve communication skills.

Comments about time restraints were common. They are also common in the literature on CME (e.g. Hanlon et al 1998 and Marshall 1998). In Marshall's (1998) study participants thought that limited time would always be a barrier to effective educational interaction and that other ways of transferring information had to be considered. The use of television links, electronic communication and the internet was considered in detail in one focus group. The merits were considered to be the potential speed of interaction, the time that email communication gives people to think in comparison with the telephone and the potential to overcome the problem of availability. One specialist in the group was unhappy with the suggested methods as he thought they would "dehumanise" interaction with his colleagues. A survey by Richardson and Norris (1997) in America showed that physicians and many other health care workers were interested in on-line CME.

One respondent mentioned that ENA could be linked to clinical governance. This was also touched upon in the discussion at the steering group.

A drawback of this evaluation is only a small sample was contacted. It was not evenly stratified according to profession. It was seen that administrative staff were more likely to report not understanding methods and GPs were more likely to report understanding methods. The fact that there were more administrative staff in the PPDP sample and more GPs in the FFA sample could have effected the overall satisfaction reporting. However the extra comments were consistent with findings about FFA.

CONCLUSION

Force Field Analysis appeared to be the better method for assessing educational needs in primary care. However due to a small sample the results are not conclusive. Educational Needs Assessments and education in primary care are challenging endeavours. They require time, commitment and resources. Such endeavours are made even more challenging by the fact that practices and primary care professionals vary enormously. It seems that one method will never suit all. However it is a positive step that efforts have been to assess educational needs and attempts have been made to evaluate these methods in order to improve future assessments. Improvements in future assessments will be a challenge. However knowing that many primary care professionals do believe in the principle of education action plans should motivate those involved to be enthusiastic and positive to take this challenge forward.

RECOMMENDATIONS

- Future evaluation methodology should be agreed and planned before implementation of the work to be evaluated. Evaluation should then take place soon after implementation.

- Paperwork should be kept to a minimum.

- The feasibility of introducing protected education time should be assessed.

- Findings about interest expressed in participating in certain courses should be compared with the findings of the ENAs.

- There is a need for improvement in communication between practices and health authorities. Health authority agendas need to be communicated in a style that is in tune with the practices' agendas.

- The feasibility of introducing a cyclic model of ENAs with practices within a PCG being at different stages could be assessed. This model would emphasize the ownership of the process of ENA and take into consideration individual learning styles.

- IT courses need to be introduced as soon as possible.

REFERENCES

Anderson HR, Freeling P, Patel SP. Decision making in acute asthma. *Journal of the Royal College of General Practitioners* 1983; **33:** 105-8.

Boyle CM. Differences between patients' and doctors' interpretations of common medical terms. *BMJ* 1970; **2:** 286-9.

Dekker FW, Kaptein AA, van der Waart MAC, Gill K. Quality of self care of patients with asthma. *Journal of Asthma* 1992; **29:** 203-8.

Department of Health and Human Services. *Prescription drug products: patient package insert requirements. Federal Register.* 1980; **45:** 60754-817.

Hanlon J, Murie J, Gregan J, McEwen J, Moir D, Russell E. A Study to determine how needs assessment is being used to improve health. *Public Health* 1998; **112:**343-346.

Hayes T. Continuing medical education: a personal view. *BMJ* 1995; **310:** 994-996.

Hays RB, Smith DM, Raasch BA, Veitch PC, Jacobs H. Improving educational needs assessment for general practioners. *Aus Fam Phys* 1999; **28:** 1196-1200.

Kelly MH, Murray TS. General practitioners' view on continuing medical education. *Br J Gen Pract* 1994; **44:** 469-471.

Ley P. *Communicating with patients.* London: Croom Helm, 1988.

Ley P. Improving patients' understanding, recall, satisfaction and compliance. In: Broome A (ed). *Health psychology*. London: Chapman and Hall, 1989.

Marshall MN. Qualitative study of educational interaction between general practitioners and specialists. *BMJ* 1998; **316:** 442-445.

Murray S, Narayan V, Mitchell M, Witte H. Study of dietetic knowledge among members of the primary health care team. *Br J Gen Pract* 1993; **43:** 229-31.

Myers P. The objective assessment of general practitioners' educational needs: an under-researched area? *Br J Gen Pract* 1999; **49:** 303-307.

Pitts J, White P. Learning objectives in general practice: identification of 'wants' and 'needs'. *Educ for Gen Pract* 1994; **5;** 59-65.

Richardson ML, Norris TE. On-line delivery of continuing medical education over the world-wide web: An on-line needs assessment. *AJR* 1997; **168:** 1161-1164.

Salisbury C. The Australian quality assurance and continuing education program as a model for the reaccreditation of general practitioners in the UK. *Br J Gen Pract* 1997; **47:** 319-322.

Salti I. Continuing medical education. *Medical Education* 1995; **29:** 97-99.

Savage R. Continuing education for general practice: a life long journey. *Br J Gen Pract* 1991; **41:** 311-313.

Scheiderich SD, Friedbaum DM Peterson, LM. Registered nurses' knowledge about diabetes mellitus. *Diabetes Care* 1983; **6:** 57-61.

Stringer ET. *Action Research*. London: Sage, 1999.

Toews J, Lockyer J, Addington , McDougall G, Ward R, Simpson E. Improving the management of patients with schizophrenia in primary care: Assessing learning needs as a first step. *Can J Psychiatry* 1996; **41:** 617-622.

Westcott R. Improving continuing medical education and addressing the challenge of instituting reaccreditation. *Br J Gen Pract* 1996; **46:** 43-45.

Reflective Analysis

Initial Contact with Clients

A serendipitous contact with Barking and Havering Health Authority highlighted the importance of the role of networking in being offered consultancy, especially in the early stages of a career. In April 2000, I had been contacted by someone I had met on the MSc Psychology and Health at Middlesex University. Being a committee member of the Education Action Plan Steering Group, she informed me that the group were seeking the services of a consultant. They required an evaluation of the Educational Needs Assessments (ENAs) that were being used in general practices in Barking and Havering and Redbridge and Waltham Forest health authorities. My contact invited me to submit a proposal.

Before submitting the proposal I arranged an informal meeting with the Director of Education and Training for Barking and Havering Health Authority. It was in this meeting (on 16 May 2000) that I discovered more about the client's terminology and I realised that it would be necessary to do more reading to enhance my understanding of primary care groups in the National Health Service. After this extra reading from a literature search that I did in the British Library, I prepared a draft bid and asked my supervisor to look it over for me. I had never prepared a bid by myself before and wanted a second opinion from somebody who had prepared many bids. So after some revision, I sent in my proposal at the end of May (see appendix 1), and waited apprehensively for the result.

I was informed that there were two proposals on the short list including my proposal and that a decision would be made after giving an 'informal' presentation to the steering group. The presentation and handling of the consultancy procedures by the Health Authority were reminiscent of the consultancy project I had worked on for the European Commission (see thesis). Firstly quite often consultants and their clients talk a different

language and come from different working environments. Talking a different language was clear in the meeting with the Director of Education and Training for Barking and Havering. Working on this consultancy project has made me even more aware of the different working environments and different meanings of concepts such as 'an informal presentation'.

The date of the presentation was 12 June 2000. My supervisor came to the meeting with me to give professional and 'moral' support. Before giving the presentation we were asked to wait in a reception area until the steering group was ready for us. A member of the steering group came out of the meeting room and ushered us into the meeting room and formally introductions were made to approximately ten members of the steering group all in suits sitting around a table awaiting the presentation. Despite being told that a decision would be made on the day of the presentations we were informed at the end of my presentation that I would know the outcome the end of August 2000. This was the first sign in a sequence of events that demonstrated miscommunication and unreliability indicating for me the low priority that is often placed on evaluation in such organisations.

Two weeks after giving the presentation 12 June 2000, I was proud to be told on the telephone that my proposal had been successful and that I would receive a contract in writing. However after several telephone calls chasing the contract, all I received was a fax 24 October 2000 stating that my proposal had been accepted. No contract was ever drawn up. This was very frustrating. It also caused a professional dilemma. I knew the importance of receiving a written agreement before embarking on such work as my supervisor has always stressed the importance of a written agreement. I took a very uneasy decision of starting the work before receiving the written agreement as I had my own deadlines within which to do this work. I knew my supervisor disagreed with this decision and it felt very strange and unpleasant to go against the advise of someone I truly respected. However it also highlighted to me that I was an autonomous consultant and had to be responsible for my decisions which although was a very frightening feeling, I felt very excited about this new challenge. I eventually received the first payment for this work but it arrived 2 months late.

Implementation

Work on the evaluation started 31 August 200 with a meeting with two General Managers for Primary Care Education Training and Development. I was told quite casually that no documentation about the different models of assessment was available. The two Managers seemed unaware that this lack of information would have implications for the methodology. When I pointed out that it would be impossible to conduct part 2 of the methodology, no disappointment or concern was shown. In fact there was almost relief that less work was needed. We discussed the letter informing possible participants about the evaluation. I was told that this would go out to all practices which had taken part in the assessments. I was also told that I would be sent contact details of the people by profession who had taken part in the evaluation. A gatekeeper of information was also allocated at this meeting. It transpired that he would have to take 3 extensive periods of sick leave during the consultancy period creating enormous communication problems and much extra work for the evaluation team.

At the end of September a copy of the letter sent to practices in Redbridge and Waltham Forest was sent to me together with names and telephone numbers of the practices involved in the Force Field Analysis approach to ENA. It did not contain the details of the participants. When I requested more information, I was told it was not available. Therefore I had to contact all the practices and find out the profile of the staff employed in the practice and how many and who were involved in the ENA. This was necessary in order to obtain a stratified sample and a clear picture of the total population involved in the ENA. No telephone numbers for practices in Barking and Havering were provided by the Health Authority. I had to contact people who had been involved in some way in the ENAs and ask them to provide information about practices involved. I then had to contact practice managers or senior partners to obtain further details about participants.

Once telephoning interviewing began, the extreme shortage of time facing primary care professionals became very apparent. It soon became obvious that it would be better to

fax the questionnaire. Organisational skills were vital to keep track of the questionnaires going out and coming in and noting availability times and other miscellaneous information.

The proposal included interviewing the two General Managers for Training and Education in Primary Care. When it came to arranging this meeting, I felt it would be better to combine a steering group meeting with this part of the methodology. I wanted to get the whole steering group's opinions on some of the emerging themes from the telephone interviews. I felt more comfortable discussing possible solutions with the steering group who knew a lot more in this area than me. I started to read about action research and felt very excited about this approach to research. I was very worried though that this approach would not work with this rather formal client group. I had second thoughts and decided not to try something with which I had no experience. However the more I read about action research, the more convinced I became that this method would be the most suitable. I spoke to the 'gatekeeper' and asked him to arrange the room so that the group would be sitting in a circle without any desks. I had some cartoon representations made of the problems (see appendix 2) to aid understanding and to break the ice.

I was extremely pleased with the flow of the discussion and the genuine attempts to solve problems as a team. One GP even said to me at the end that it was the best meeting they had had.

The discussion ended with one member of the group stating that I should extend my work to talking to the PCG board. I was shocked as this was not included in my proposal. The original proposal had already changed. These changes were managable but meant extra work. I was not prepared to take on any more work for this consultancy. This highlighted the importance of contract in such work. I had to be firm and say that this was not part of my remit. The member then started flicking through papers in a defensive manner and found something that stated that the evaluation should deal with the PCG board. I had to explain that my proposal stated it would only cover some of the wider

objectives. I explained that I had already spent more time on the evaluation than originally planned and that I did not think it was my role to talk to the PCG board. It was agreed that this should be the role of the two General Managers for Training and Education in Primary Care. I had a word with the 'gatekeeper' at the end of the meeting. He explained that this particular member of the steering group was not around when the proposals were discussed.

I was really happy with the discussion but I felt that this issue of extending my work left me feeling undervalued and inflexible. I felt quite angry that I had been put in a position to refuse to extend the evaluation and to moan about how long the evaluation had taken. However I was pleased that I was assertive and expressed this concern in a professional manner.

Having employed a research assistant to work on this consultancy, I gained a deeper insight into my managing skills. I gave the responsibility of recording the discussion to the research assistant. The equipment was not checked and as a result a very poor recording of the discussion was made. In the past I had always used a non-directive approach to managing people. However this relies very much on the research assistant being able to show initiative. I now realise that in order to get a job done properly you have to sometimes change your approach to suit the people you are managing. I am now of the opinion that it is the manager's or the project leader's role to be flexible in management styles and insightful about the people with whom they are working. I knew the research assistant had demonstrated a lack of initiative in the past. I was waiting for initiative to be shown. However at such a crucial stage of the consultancy, I feel I should have had enough insight about this research assistant and insisted that various checks of the recording equipment were made. I also believe that talking to people about their weaknesses should not be considered difficult, cruel or embarassing. If done in an open and sensitive manner, problems can be solved. I have since spoken to this assistant and resolved many problems related her display of initiative.

The final display of the lack of communication and unreliability was 8 February 2001 when I went to a meeting at the Health Authority to answer questions about the evaluation. Only one member of the Education Action Plan Steering Group showed. Despite having a good discussion with this member, I felt deflated by this symbolic gesture. My evaluation was clearly low priority. I was also annoyed with myself for not showing my annoyance. However in retrospect, it was probably more professional not to show annoyance.

Conclusion

This piece of consultancy was a positive challenge for me. The subject area was totally new. I was happy to be working on training needs in primary care although at times I found it uninspiring which led to a lack of motivation when it came to writing the report. I was amazed how similar the process and organisational dynamics were similar to another piece of consultancy I had worked on for the European Commission. My knowledge about the process of consultancy has not been particularly stretched with this work. However I have learnt a lot about managing consultancy.

I feel the open-ended interviews produced a more accurate picture of opinions about the educational needs assessments than the questionnaire. A questionnaire was too time consuming for this group of people. I think little time went into replying to the questionnaire. The design of the methodology was determined more by the limited costs and time. If more time (my time and the participants') and resources were available, it would have been better to conduct semi-structured interviews with primary care professionals at their place of work.

This was the second organisation for whom I had been involved in an independent evaluation. There were similarities between the two organizations: poor systems of communication; more concern about rules and regulations than the objectives of work that the rules and regulations are trying to protect; exposure to in-house politics; a lack of understanding of research methods; late payment; efforts to extend the agreed work; poor

record keeping; lack of esteem for evaluation – seen more as a burden than a help; the need for delicate negotiations and reporting of findings.

Overall this work has been a good learning experience and I am happy with the outcome.

CATHERINE SYKES

APRIL 2001

APPENDIX 1

Proposal

****

EDUCATIONAL NEEDS ASSESSMENT IN PRIMARY CARE

Proposal for the evaluation of methods being used in general practice in Barking and Havering and Redbridge and Waltham Forest.

****

Catherine Marie Sykes, BSc, MSc, CPsychol

&

David F. Marks BSc, PhD, CPsychol, FBPsS

CONTEXT

The health authorities and primary care groups of Redbridge and Waltham Forest and Barking and Havering are working together on a project to develop "education action plans" for 8 PCG's. The project is funded by a grant from the Outer London Education Consortium and run by a multi-professional, interagency steering group. Education needs assessment (ENA) has been taking place in the 8 PCGs.

Myers (1999) has pointed out that there is uncertainty as to the most effective method of determining the educational needs of GPs to produce a content that is both clinically important and relevant to practice. Although there is an extensive literature on the reporting of the perception of GPs' learning needs, Myers (1999) states that there are relatively few studies describing objective evaluation. Various ENA techniques have been used in Redbridge and Waltham Forest and Barking and Havering. An evaluation of the methods is now needed.

AIMS OF THE EVALUATION

1. Provide an independent evaluation of two approaches to practice-based education needs assessment (ENA) being used in BH and R&WF HAs. These are to be assessed in terms of the different objectives for each method as well as the wider objectives.
2. Assess the extent to which these methods can be used in conjunction with one another.
3. Review the results being obtained by all methods to assess how they are being used to plan education.
4. Critically appraise the methods of assessing educational needs in light of the literature and recognised good practice.

METHODOLOGY

Analysis will be of four sources of information.

1. **Telephone interviews with a mixture of closed and open questions to a sample of primary care professionals who have been involved in the ENA.**

A total of 50-60 telephone interviews will carried out. The sample will be a stratified random selection from a list of staff in the 8 PCGs. The interviews will be carried out by Catherine M. Sykes (Consultant B) in conjunction with a research assistant. Answers to part A will be quantified. Answers to part C will be compared to the ENA's findings. Answers to part D will be compared to the Consultants' opinions. Content analysis of additional comments will be conducted.

Interview Questions

A) Background/ General picture

- Occupation?
- If applicable, how long since you qualified for your current post?
- How important is the principle of ENA? Very, A little, Not at all.
- Date of birth
- Gender

B) Assessing the impact of the ENA

- Are you aware of the ENA taking place in your PCG? Yes/No.
- Do you understand the ENA? Yes/No. If no, which parts?
- How satisfied are you with the ENA? Very Satisfied, Satisfied, Not Satisfied.

C) Assessing the findings of the ENA

- Do you feel that the ENA identified the educational needs of you and your colleagues? Yes/No. If no, please explain.
- Do you feel that your non-clinical educational needs were adequately assessed? Yes/No. If no, please explain.
- Do you feel that you or any of your colleagues would benefit from any of the following courses? Communicating with others; Communication in the workplace; business skills; IT skills.

D) Assessing some wider objectives.

- Would this method be suitable for other PCGs? Yes/No. If no, why?
- Could this method be applied in all primary care professions? YES/No. If no, why?
- Have the results produced an accurate picture of your educational needs? If no, please explain.

E) Other points

- Any other comments?

Timing: Interviewing would start in September 2000.

2. Assessment of the documentation of the approaches used for ENA in the 8 PCGs.

The documentation of the approaches used for ENA in the 8 PCGs will be assessed by David Marks (Consultant A) and Catherine Sykes (Consultant B). The assessment will be in terms of whether the different objectives for each method as well as the wider objectives have been met. Each objective will be assessed on a 5 point scale, 5=Excellent, 4=Very good, 3=Satisfactory 2= Poor and 1 = Very poor. The delphi method of assessment will be used to reach an agreement.

Timing: Assessment could start in August 2000 (or as soon as the reports become available).

3. Interviews with the two General Managers for Training and Education in Primary Care.

The aim of the interviews will be to find out the opinions of the General Managers for Training and Education in Primary Care in terms of the extent to which the ENA can be used in conjunction with one another and to assess how the results of the ENA can be used to plan education. Any issues which emerge from the telephone survey will also be discussed. Content analysis of interviews will be conducted.

Timing: November 2000

4. Literature on ENA and 'recognised good practice'.

The evaluation will be carried out in the light of the review conducted by Myers (1999). A current Medline search for related articles will also be conducted.

Timing: Articles relating to ENA and recognised good practice will be consulted throughout the evaluation.

PRACTICAL ISSUES

The evaluators will require the following:

5. A letter to be sent out to possible participants informing them about the evaluation.
- A list of names and telephone numbers of the participants involved in the ENA
- Documentation of the approaches used for ENA in the 8 PCGs and the resulting reports.
- A contact person to whom queries can be directed.

OUTCOME

The evaluators will provide the Steering Group with a final report by 26 January 2001.

CONFIDENTIALITY

Confidentiality will be respected by the evaluators. Anonymity of contributors will be assured. The report will be the property of the steering group and distribution at their discretion.

COSTING

Consultant A	@ £450 per day x 2 days	= £ 900
Consultant B	@ £225per day x 18 days	= £4, 050
Research Assistant	@ £105 per day x 5 days	= £ 525
Office cost:		
Telephone charges (interviews and internet searches)		=£ 150
Stationery		=£ 85
Photocopying and binding		=£ 75
Postage		=£ 15
British Library costs		=£ 125
Travel		=£ 75
Total		=£6, 000

TERMS OF PAYMENT

An invoice for half of the cost will be sent prior to commencement of the evaluation. An invoice for the balance will be sent on completion of the evaluation.

REFERENCE

Myers, P. (1999). The objective assessment of general practitioners' educational needs: an under-researched area? *British Journal of General Practice*, 49 (441):303-7.

APPENDIX 2

Preliminary Feedback

Evaluation of Educational Needs Assessment in Barking and Havering and Redbridge and Waltham Forest

4 December 2000

Preliminary Feedback

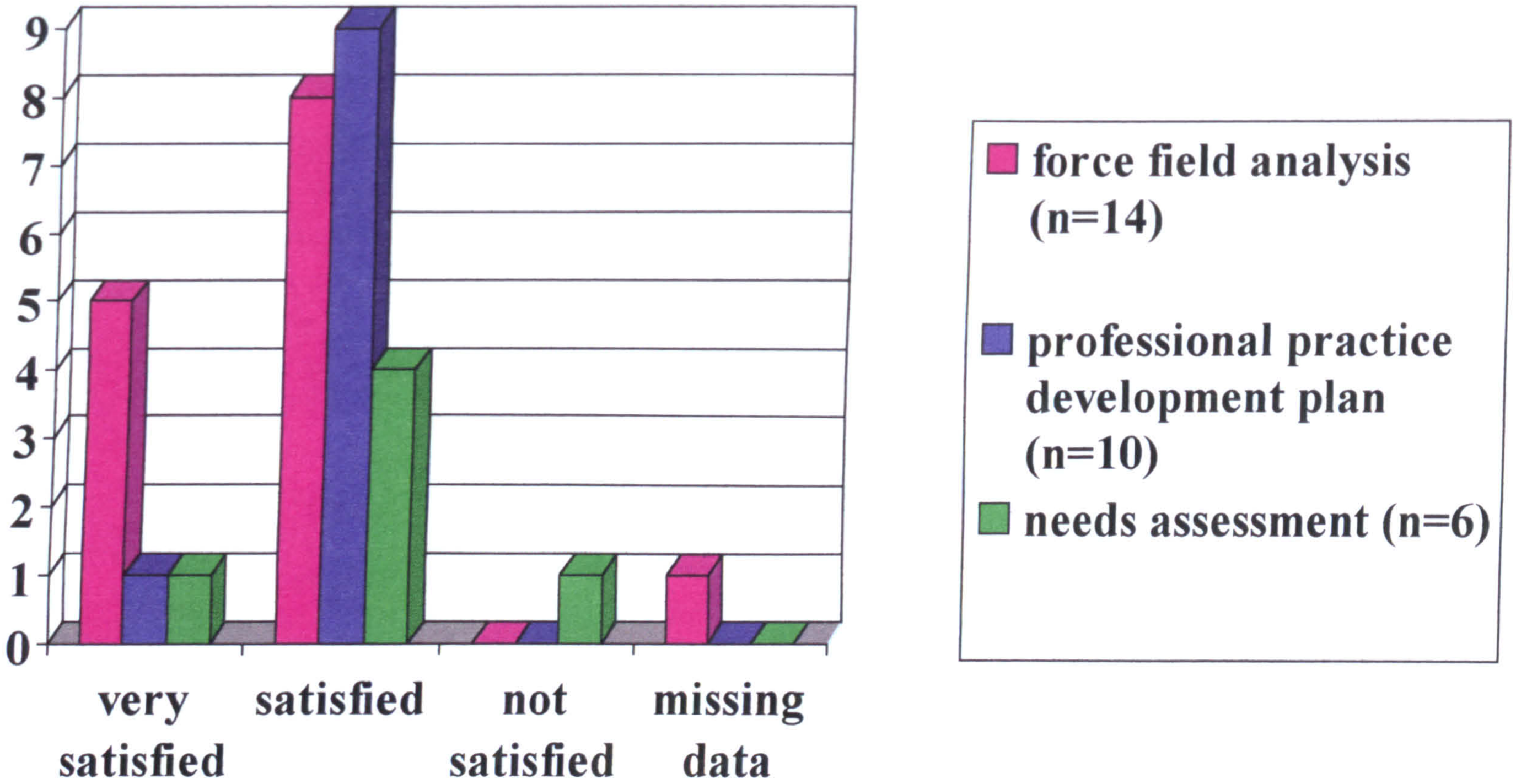
Models of Assessment

- Force -field Analysis } WLL,R, CWW

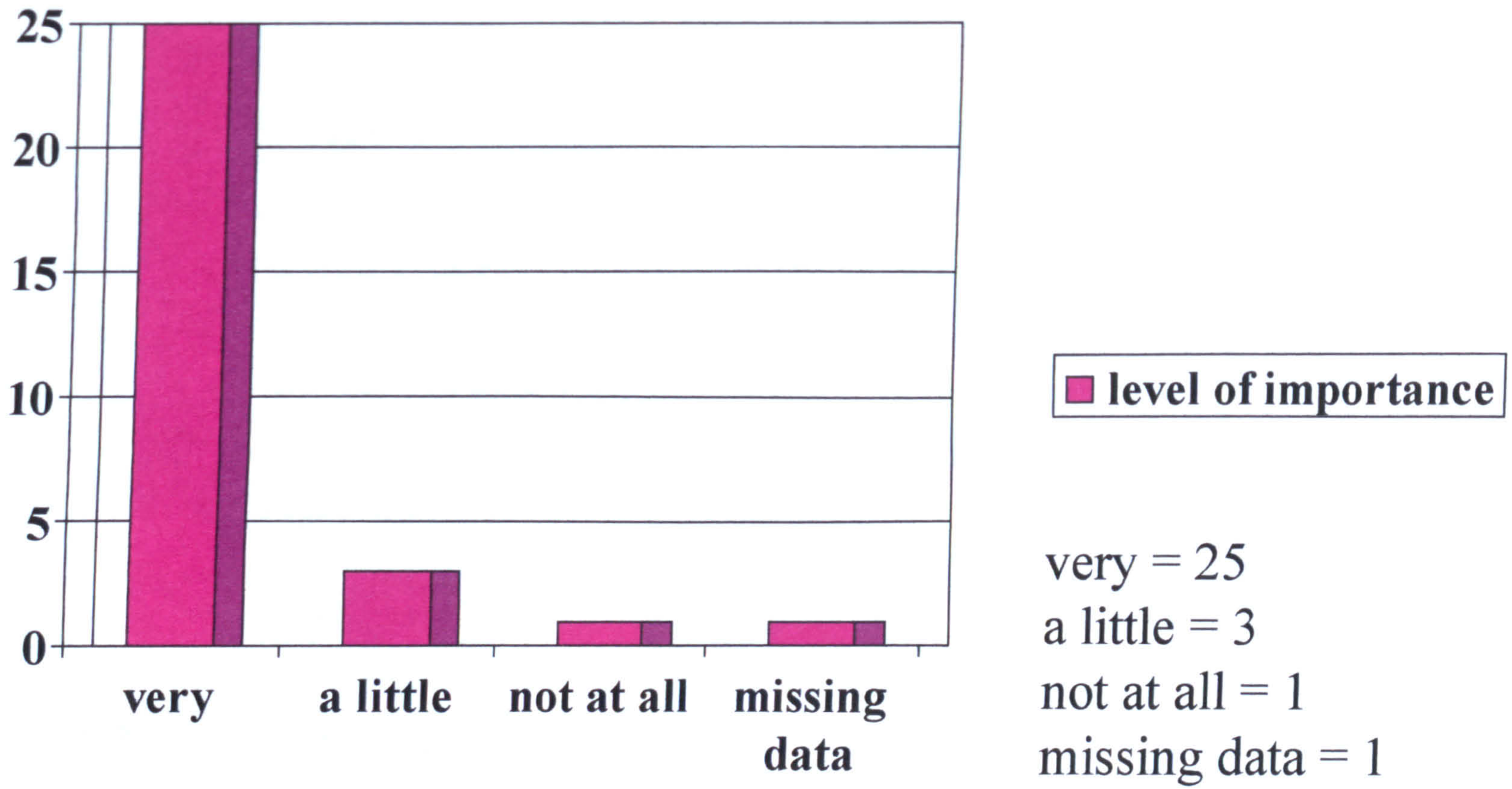
- PPDP } Upminster, Barking, Dagenham

- Needs Assessment } Hornchurch, Romford

Level of Satisfaction - Models of Assessment

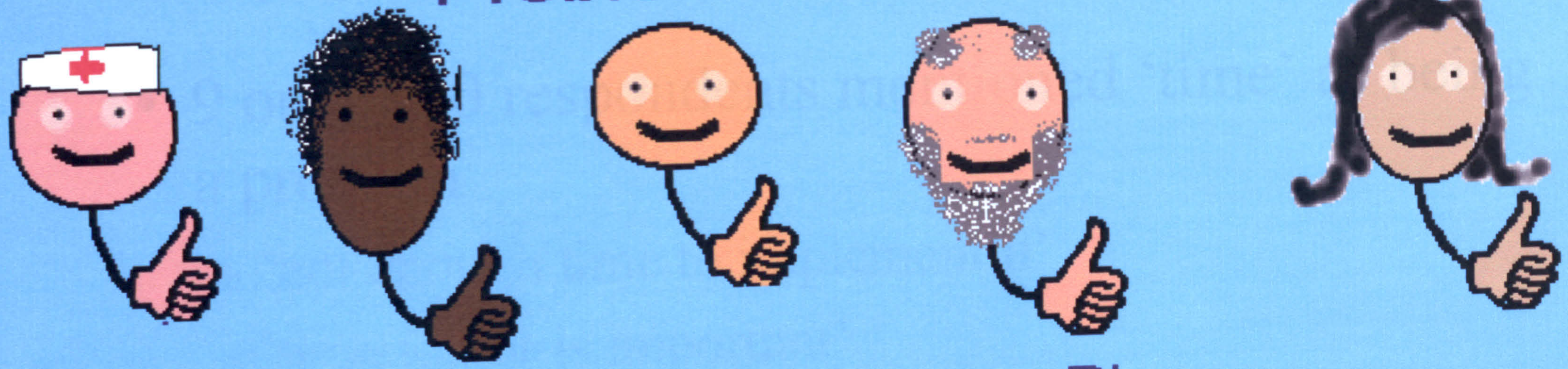


Education Action Plans
Level of Importance - 30 respondents

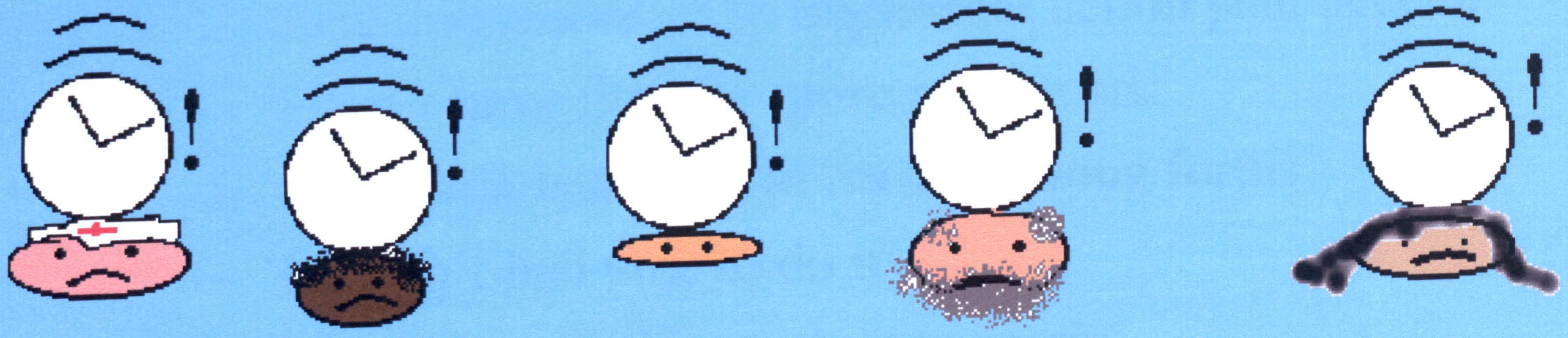


very = 25
a little = 3
not at all = 1
missing data = 1

Problem 1 : TIME



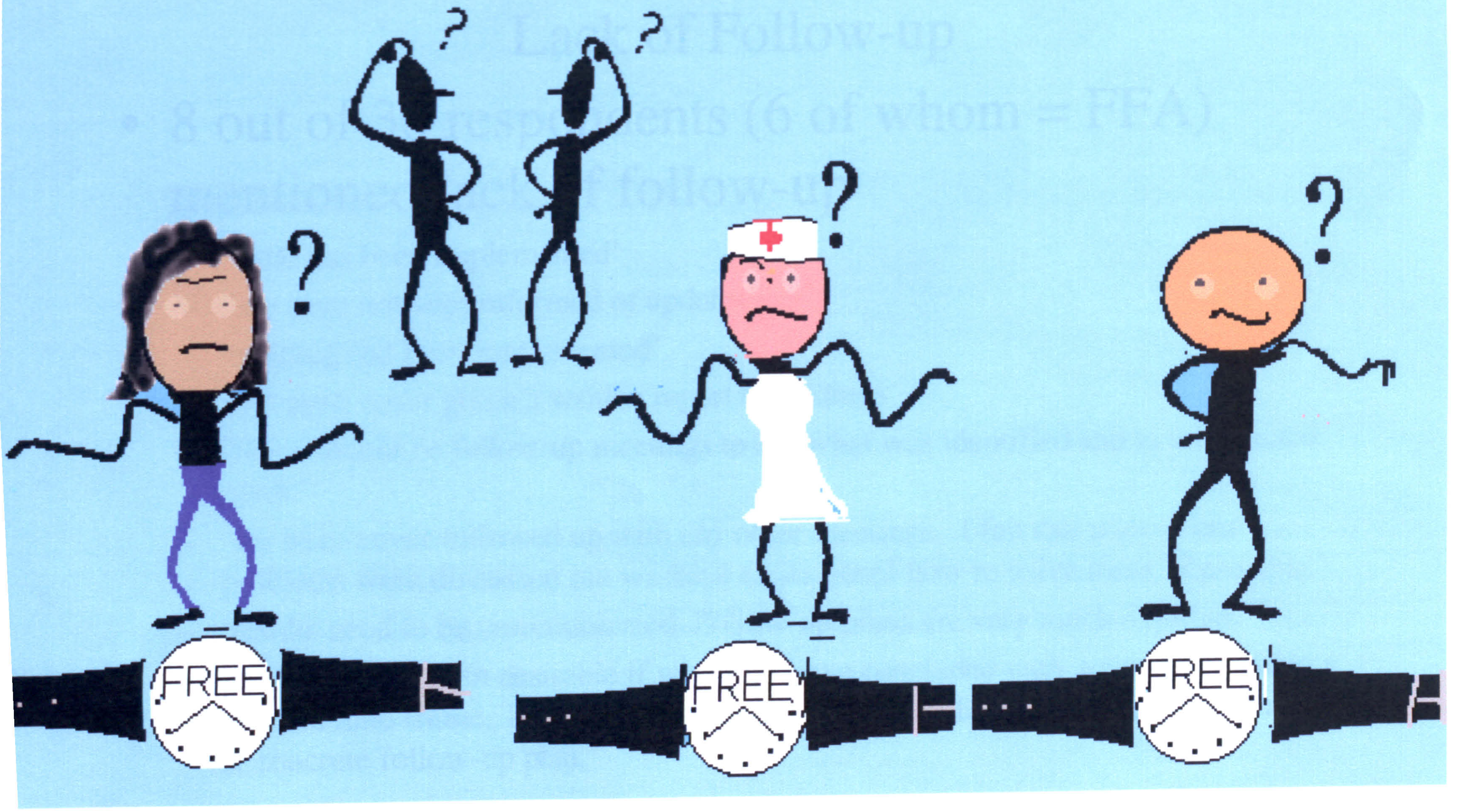
Education Action Plans



Time

- 9 out of 30 respondents mentioned 'time' as being a problem
  - 'not enough time to implement it'
  - 'time factor is important'
  - 'time is precious for a single handed GP'
  - 'time and resources to implement action plan needed'
  - 'I don't have time for more paperwork'
  - 'more time is needed to complete long forms'
  - 'I haven't had time to do it'
  - 'we need more time to do it properly'
  - 'my staff are already pushed for time'

Problem 2 : LACK OF FOLLOW UP.



Lack of Follow-up

- 8 out of 30 respondents (6 of whom = FFA) mentioned lack of follow-up
  - 'little has been implemented'
  - 'we were not kept informed of updates'
  - 'nothing has been implemented'
  - 'we were never given a written report of findings'
  - 'there should be follow-up meetings to see what was identified and to see if acted upon.'
  - 'we were never followed up with any other meetings. I felt that a lot of our problems were discussed but we have never heard how to solve these, if possible.'
  - 'results need to be communicated. Follow-up plans are very much required.'
  - 'it would have been desirable if we could have concluded with action plan within a realistic time frame. The lessons learnt have in reality faded away because of a lack of concrete follow-up plan.'

Problem 3: Different Agendas

- 7 out of 30 respondents felt that practices and health authorities have different agendas
  - 'We have different agendas. We are here to look after the public.'
  - 'They (the HA) are on a different wave length.'
  - 'As long as they (the HA) can show on paper that something works, they are not bothered about what we achieve.'
  - 'The reality is often different to their (the HA) aims.'
  - 'We are here to care not fill out paperwork but we have to if we want funding.'
  - 'We have to do it (education action plans) to keep them (the HA) happy in order to get funding.'
  - 'They (the HA) want things done yesterday.'

IT Training

- 28 out of 30 (93%) stated that they needed IT courses.
- 4 out of 30 specifically mentioned that IT was needed in their extra comments
- 2 practice managers in Romford said that the classroom environment has to be friendly as it could be alien to some people
- 1 GP mentioned that mixed classes (i.e. by profession) may be threatening to some people