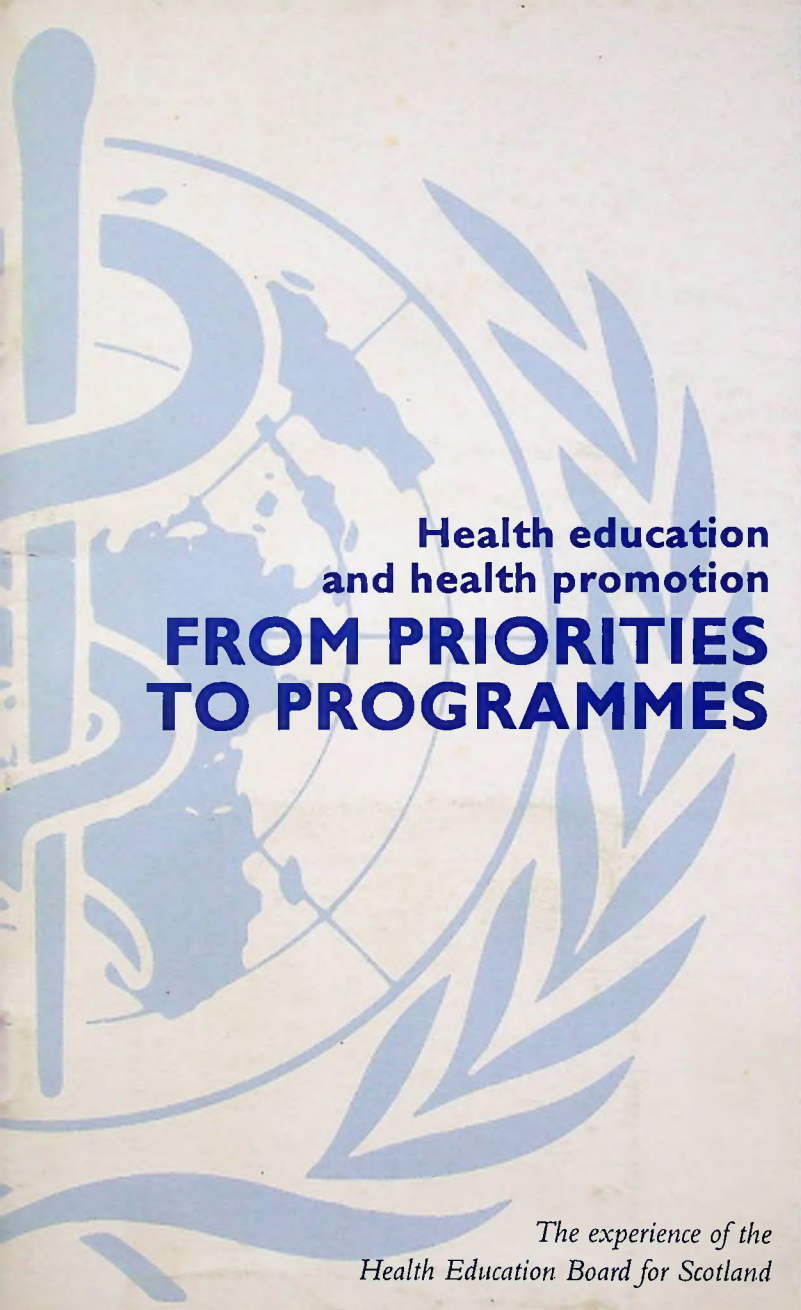

Health education and health promotion
FROM PRIORITIES TO PROGRAMMES

The experience of the Health Education Board for Scotland

HEALTH PROMOTION COUNTRY SERIES
NUMBER 1

Health education and health promotion

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Target 13 – Healthy Public Policy

By the year 2000, all Member States should have developed, and be implementing, intersectoral policies for the promotion of healthy lifestyles, with systems ensuring public participation in policy-making and implementation.

Keywords:
- Health education
- Health promotion
- International cooperation
- United Kingdom
- Europe

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FOREWORD

Most European countries are currently introducing reforms in the field of health policy. The great majority of these reforms, however, are limited to issues of the financing and provision of medical and hospital services. Only a very few reformers examine the type of policies needed to create health. It is vital to ensure that health promotion plays an increasingly prominent role in the reforms.

The concept and principles of health promotion as defined in the Ottawa Charter for Health Promotion continue to do much to carry the current debate on reforms forward. WHO/EURO in its role of providing leadership in health development has taken several initiatives, to provide information and expertise, with the aim of meeting the challenges and opportunities for health promotion in today's fast changing Europe.

A new 'health promotion country series' of publications is the latest of these initiatives. It has been launched with the aim of increasing opportunities for exchanging information and sharing experiences in health promotion policy formulation and delivery across national boundaries. The theme chosen for this first issue is in response to requests by a number of WHO Member States and

collaborating centres for examples of how health promotion is conceived and delivered by focusing on schools, workplaces and other key settings where people spend their everyday lives.

The Scottish experience, to which this first number of the new series is devoted, offers a clear example of how to progress topics (such as smoking, alcohol misuse, coronary heart disease and cancer) in settings. Dr Andrew Tannahill's analysis demonstrates why certain decisions have been taken by the Scottish national health education organisation, and the consequences they are likely to have. The paper was originally presented at the 4th meeting of WHO health promotion counterparts and collaborating centres held in Tampere, Finland in November 1993. Dr Tannahill's contribution proved to be an invaluable catalyst for discussion and exchanges among the member states represented at the meeting. One outcome of the debate at the meeting is that the health promotion unit of WHO/EURO decided to produce the country series of publications.

It is our hope that the series will provide special insights into opportunities and problems faced by countries, and inspiration towards rising to meet them.

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INTRODUCTION

The Health Education Board for Scotland (HEBS) was established on 1 April 1991, replacing the Scottish Health Education Group (SHEG) as the national agency for health education in Scotland. The creation of the new organisation followed a fundamental review of health education commissioned by The Scottish Office, and arose from the publication of *Health Education in Scotland: a National Policy Statement*[1]. The latter stressed the importance of health education, within the broader context of health promotion; presented priorities, objectives and targets for achievement; and outlined the roles and responsibilities of a number of relevant agencies and groups. The principles set out in that document were further developed in a subsequent national policy statement, *Scotland's Health: a Challenge to Us All*[2].

The national policy statements identified the following as first order priorities towards which health education efforts in Scotland would be principally directed:

- coronary heart disease
- smoking
- alcohol misuse

- drug misuse
- cancer
- HIV/AIDS
- accidents
- dental and oral health.

In addressing these priorities, a combination of specific measures and a more general 'positive healthy lifestyle' approach was called for. The importance of diet and exercise in the promotion of health was highlighted.

PRIORITIES TO PROGRAMMES:

the traditional approach

As is usually the case, the top priorities set out in the national policy statements are health-related topics—specific risk factors and categories of health/ill-health. An important early task for HEBS was to decide how these priorities could be best translated into national programmes of health education action.

The traditional answer to this question is to devise a programme for each topic. Thus it is commonplace for health education/promotion agencies to have a coronary heart disease (CHD) programme, a smoking programme, a cancer programme, a dental/oral health programme, an alcohol programme, and so on. Each of these programmes has to try to reach the public through mass media and through a range of settings and sectors—schools, health care settings, the workplace, various other community settings and the voluntary sector (Figure 1). In other words, they each must attempt to operate in the same range of health education 'arenas'. This topic-based approach is seriously flawed.

The first, and most fundamental, problem with the approach arises from the fact that there are extensive overlaps between topics. Links between the Scottish first order priorities are shown in

Fig. 1. Priorities to programmes: the traditional approach

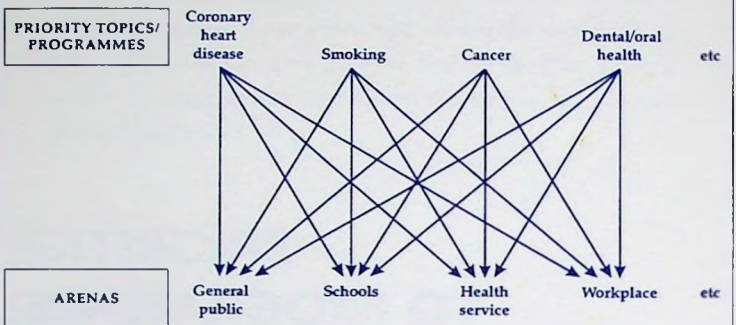
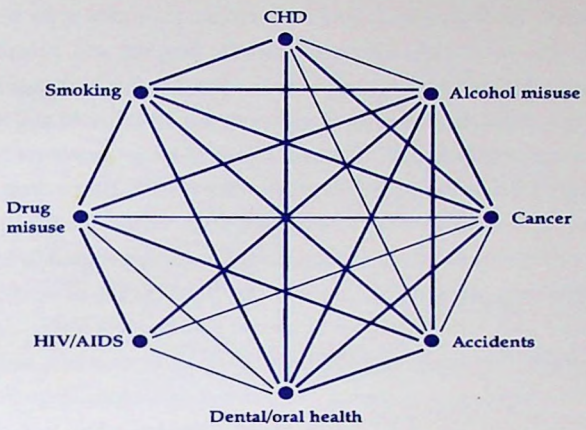


Figure 2 (the most direct and significant being represented by the thicker lines.). The topic of alcohol misuse provides a good example of the overlaps. Misuse of alcohol is an established risk factor for a number of cancers; it is commonly implicated in the causation of accidents; through depression of inhibitions and impairment of condom commitment and competence, it may affect sexual behaviour in such a way as to increase the risk of transmission of HIV (as well as the risk of other sexually transmitted infections and of unwanted pregnancy); it can contribute to a number of dental/oral health problems, including oral cancer and traumatic damage (through accidents and assaults); as a behaviour it has links with the use of tobacco and other drugs; and it is a risk factor for hypertension, which is in turn associated with CHD.

The existence of these and many other overlaps means that health education programmes centred on individual disease and risk factor topics lend themselves to duplication of effort, without adequate coordination of the content and timing of activities. This is at best wasteful, at worst damaging. Separate initiatives on specific

Fig. 2. Links between priority topics



topics often, in effect, compete with one another, and there is a danger of inconsistency[3] of 'messages', which may provide the public and professionals alike with just the excuse they need to take no action. Coordination of effort—of content and timing—across topics is central to efficiency and effectiveness in health education. This requires an approach different from the topic-based approach. It quite simply makes no sense to deal with topics in absolute or relative isolation from one another.

Added to the problems of undesirable duplication of activities is the fact that it is unrealistic to expect a manager or team concerned with a given topic to exploit the potential in all of the various arenas. Moreover, the principal qualities necessary to be an expert in a topic differ from those needed to deliver health education programmes. The acquisition and maintenance of topic-based expertise calls for the investigative and critical appraisal skills of the researcher, while programme delivery requires skills in education, communication, networking and project management. This distinction has long been neglected.

Also, it is necessary to consider the perspectives of those who work in the various key settings and sectors, who can provide (or deny) access to these arenas, and whose active participation is essential for success. Such people include education authority representatives and officials, and headteachers of schools; hospital and primary care managers, doctors and nurses; heads of industrial and commercial companies, workplace managers and trade union officials; and workers in voluntary organisations. To them topic-based programmes result in a feeling of being bombarded (from above—the classic 'top-down' situation) by a disjointed set of demands from various people, pressing the importance of their own topics with little or no regard to initiatives on other topics. In such a situation, the headteacher of a school, for example, may feel unable to incorporate a whole series of programmes into an already crowded curriculum, and may reasonably also feel unhappy at not having been involved at development stages. Moreover, he or she is likely to be concerned at the fact that the topic-based approach is disjointed and overlooks the need to develop an infrastructure and methodologies specifically geared to the school setting, relevant to the full range of preventive topics as well as to the promotion of lifeskills, fitness and well-being, and providing appropriate inputs at the various stages of the school career. The undesirability of trying to incorporate topic-based programmes into the curricula and extracurricular activities of schools is widely recognised, and comprehensive, coordinated schools health education programmes are established, or being established, in many countries. The same reasoning is equally applicable to all other settings and sectors.

PRIORITIES TO PROGRAMMES:

the HEBS approach

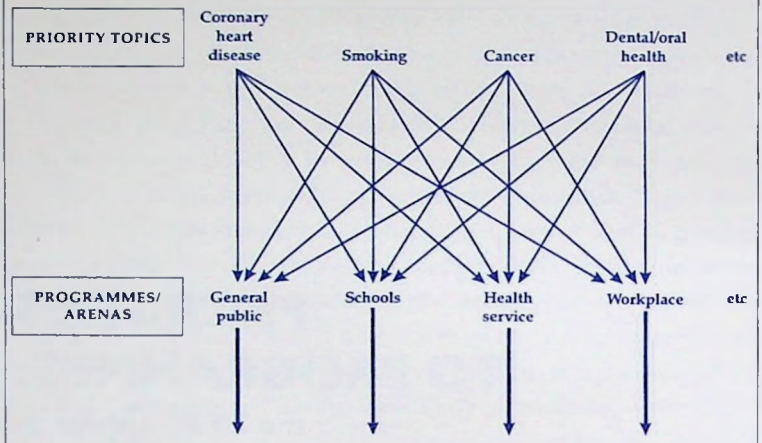
The foregoing considerations led HEBS to the intention to discard topic-based programmes in favour of coordinated programmes centred on key arenas for health education (Figure 3). Thus, a coordinated programme of health education for the general public, with extensive use of high-profile mass media initiatives, would be combined with a set of programmes relating to important settings and sectors. A further programme would be required to enable HEBS to capitalise on emergent opportunities, respond to urgent needs and take part in special events on particular topics.

The following programme headings were proposed:

- general public
- community
- health service
- schools
- voluntary sector
- workplace
- special projects.

The details of, and rationale for, the way ahead were presented in the HEBS *Strategic Statement*[4], a consultation document distributed

Fig. 3. Priorities to programmes: the HEBS approach



widely within Scotland in March 1992. The Board's proposals were widely welcomed and became the central plank of the Board's strategy, as presented in the *Strategic Plan 1992 to 1997*[5]. The programmes, each headed by a programme manager in the Programmes Division, are now at various stages of development.

The programmes together facilitate:

- comprehensive coverage of the community, reaching people wherever they live, work, spend leisure time or seek help
- linkages between national-level health education and more local efforts
- the drawing together of topics in a systematic and coordinated way
- appropriate phasing of action on the various topics, avoiding 'overloading' of the public, health promoting agencies and professionals at any point in time
- the mounting of mutually reinforcing activities in multiple arenas, as appropriate
- the striking of an appropriate balance in setting/sector-based

programmes between activities which support and capitalise on general public programme initiatives and work which arises more directly from specific needs and opportunities in particular settings/sectors

- the achievement of a judicious mix of preventive health education and positive health education, the latter placing an emphasis on enhancing positive health attributes[6], such as lifeskills, and on promoting physical, mental and social well-being and fitness
- the development of infrastructures and sound methodologies tailored to the needs and circumstances of each of the arenas, and of relevance across the spectrum of health education topics
- appropriate participation by a wide range of individuals and agencies in devising and implementing programmes and projects
- the design and implementation of education and training initiatives for existing and potential 'health promoters' in the various arenas
- responsiveness to the needs of the community.

Strong topic-based inputs are provided by specialist officers in the Development and Evaluation Division of HEBS, each with responsibility for a cluster of topics. In relation to their topics, these officers play key roles in needs assessment, the shaping of programme content, and pre- and post-implementation evaluation of initiatives.

THE BROADER CONTEXT OF HEALTH PROMOTION

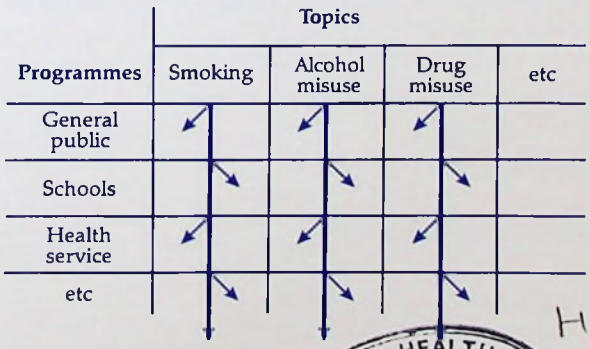
An additional advantage of the strong emphasis on settings and sectors is the ease with which health education efforts may be placed within the broader context of health promotion, which is commonly viewed as embracing preventive services (such as immunisation and screening) and health protection policies, as well as health education[7,8]. Thus, for example, the HEBS workplace programme, once fully established, will aim to develop the full potential of the workplace as a setting for health promotion, encouraging the provision of appropriate preventive services and the devising of policies designed to create environments conducive to good health. Similarly, the schools programme is set within the concept of the health promoting school[9,10].

IMPLEMENTATION

HEBS has had to move as quickly as possible towards the new approach while maintaining, and indeed expanding, outputs on priority topics.

In the transition phase, activities continued to be centred mainly on topics, but attention was paid to the needs and opportunities

Fig. 4. Implementation of the HEBS approach: transitional stage

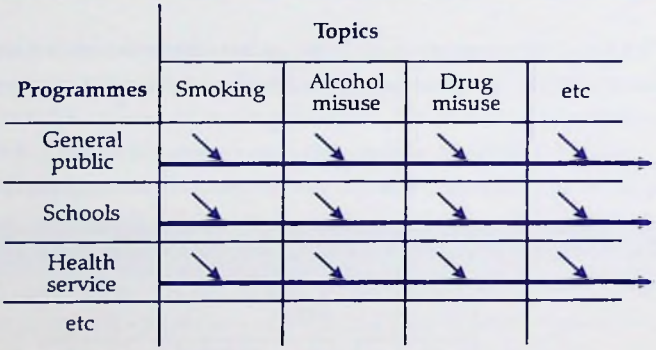


for action on particular topics in each of the planned programme arenas (Figure 4). The resulting topic-based initiatives in the arenas provided foundations on which to build the new programmes.

As the programme managers have taken up post during the past year, the dynamic has changed from 'down the columns' of the programmes/topics matrix (Figure 4) to 'across the rows' (Figure 5). That is to say, the programme managers have begun to develop networks, infrastructures and methodologies within their arenas, while incorporating appropriate activities on specific topics with the support of the newly-appointed specialist development and evaluation officers.

The transition has been remarkably smooth, and the benefits of the new way of working are already being seen within HEBS and beyond. The approach is commended to other agencies.

Fig. 5. Implementation of the HEBS approach: fully established



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