THIRD EDITION

PLANNING HEALTH PROMOTION PROGRAMS

An Intervention Mapping Approach

L. Kay Bartholomew
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PLANNING HEALTH PROMOTION PROGRAMS

FOUNDATIONS

CHAPTER ONE

OVERVIEW OF INTERVENTION MAPPING

LEARNING OBJECTIVES

- Explain the rationale for a systematic approach to intervention development
- Describe ecological and systems approaches to intervention development
- Explain the types of logic models that can be used to conceptualize various phases of program development
- List the steps, processes, and products of Intervention Mapping
- Explain how to use core processes for developing theory- and evidence-based interventions

In this chapter we present the perspective from which Intervention Mapping was conceived as well as its purpose. We also present a preview of the program-planning framework, which is detailed in the remaining chapters.

The purpose of Intervention Mapping is to provide health promotion program planners with a framework for effective decision making at each step in intervention planning, implementation, and evaluation. Health promotion has been defined as combinations of educational, political, regulatory, and organizational supports for behavior and environmental changes that are conducive to health (Green & Kreuter, 2005), and health education is a subset of health promotion applications that are primarily based on education. We recognize this distinction but also the fact that many people in the health field practice health promotion; some of them specialize in health education. Often the boundaries are quite blurred. This book uses the terms *health educator*, *health promoter*, and *program planner* interchangeably when a subject is needed to mean someone who is planning an intervention meant to produce health outcomes. An intervention can be designed to change environmental or behavioral factors related to health, but the most immediate impact of an intervention is usually on a set of well-defined determinants of behavior and environmental conditions.

BOX 1.1

MAYOR'S PROJECT

Imagine a health educator in a city health department. The city's mayor, who has recently received strong criticism for inattention to a number of critical health issues, has now announced that a local foundation has agreed to work with the city to provide funding to address health issues. Youth violence, childhood obesity, adolescent smoking, and other substance abuse as well as the high incidence of HIV/AIDS are among the many issues competing for the mayor's attention. Not only does the allocated sum of money represent a gross underestimation of what is needed to address these issues, but also the city council is strongly divided on which health issue should receive priority. Council members do agree, however, that to dilute effort among the different issues would be a questionable decision, likely resulting in little or no impact on any single issue. As a response to increasing pressures, the mayor makes a bold political move and presents a challenge to the interest groups lobbying for public assistance. The mayor agrees to help secure funds on a yearly basis, contingent on the designated planning group's demonstrating significant, measurable improvements in the issues at hand by the end of each fiscal year.

The head of the health promotion division of the city health department has appointed the health educator to lead the project. Although apprehensive about the professional challenge as well as the complications inherent in facilitating a highly visible, political project, the health educator is encouraged by the prospect of working with community and public health leaders.

The first step the health educator takes is to put together the planning group for the project. She considers the stakeholders concerned with health in the city. These are individuals, groups, or other entities that can affect or be affected by a proposed project. She develops a list of community and public health leaders and invites these individuals to an initial meeting, the purpose of which is to expand this core group. She uses a ''snowball'' approach whereby each attendee suggests other community members who may be interested in this project. The superintendent of schools begins the process by suggesting interested parents, teachers, and administrators. Later these individuals may have additional suggestions. After the first meeting, the health educator has a list of 25 people to invite to join the planning group.

Twenty-five people is a lot for one group, and the health educator knows that this multifaceted group will have to develop a common vocabulary and understanding, work toward consensus to make decisions, maintain respect during conflicts, and involve additional people throughout the community in the process. Members must be engaged, create working groups, believe that the effort is a

partnership and not an involuntary mandate, and work toward sustainability of the project (Becker, Israel, & Allen, 2005; Cavanaugh & Cheney, 2002; Economos & Irish-Hauser, 2007; Faridi, Grunbaum, Gray, Franks, & Simoes, 2007). The health educator knows that she has taken on a complex task, but she is energized by the possibilities.

The composition of the city's planning group is diverse, and group members are spurred by the mayor's challenge and enthusiastic to contribute their expertise. With this early momentum, the group devotes several weeks to a needs assessment, guided by the PRECEDE model (Green & Kreuter, 1999). The members consider the various quality-of-life issues relevant to each of the health problems, the segments of the population affected by each issue, associated environmental and behavioral risk factors for each health problem, and determinants of the risk factors.

Planning group members recognize the relative importance of all of the health issues discussed by the group and they want to work with community members to ascertain what problem might be most relevant to the community and most feasible to implement.

Even though the planning group comprises many segments of the city's leadership, health sector, and neighborhoods, the members realize that they do not have a deep enough understanding of what health problems might be of most relevance in their community. A subgroup takes on the role of community liaison to meet with members of various communities within the city to discuss health problems. The community liaison group wants to understand community members' perceptions of their needs, but it is equally concerned with understanding the strengths of the communities and their unique potential contributions to a partnership to tackle a health problem. The subgroup invites members of each interested neighborhood to join the planning group. Jointly, the planning group, the communities, and the funders agree to select a problem as the focus of a health education and promotion intervention.

The group's initial work on the needs assessment identified childhood obesity as the most important problem in the community. This initial work facilitated group cohesion and cultivated even greater enthusiasm about generating a solution for the health problem; however, considerable needs assessment work remained to be done (see Mayor's Project, Chapter Four). Several members of the group even began to imagine the victory that would be had if the group were to produce a change in half the allotted time because so much of the needed background information had already been gathered. The health educator remained apprehensive about the time frame yet comfortable with the group's pace and productivity. Now that the group has decided which issue to address, it faces the challenge of moving to the program-planning phase. In her previous work the health educator had implemented and evaluated programs designed by others, but she had not

created new programs. Bolstered by its good work, the group schedules the first program-planning meeting.

What the health educator hadn't anticipated was that in the course of conducting the initial part of the needs assessment, each group member had independently begun to conceive of the next step in the planning process as well as to visualize the kind of intervention that would be most suitable to address the problem. The day of the meeting arrived, and on the agenda was a discussion of how the group should begin program planning. What follows is a snapshot of dialogue from the planning group that illustrates several differing perspectives.

School Board Member: As we see from the work of our community liaison group, parents are concerned about obesity in children. According to community development techniques, we have to start where the people are. I think we should begin by conducting a series of focus groups with parents and have them tell us what to do.

City Council Representative: But we also heard a lot about the barriers to eating good food and exercising. Some of these barriers are environmental. I think we ought to develop a program for the Department of Parks and Recreation.

Community Member Parent: Well, I think a school-based program is most important. Our children need to learn what to eat.

Community Member/Teacher: Yes, educating children is a factor, but what about the quality of food they are served at home and in the schools?

Community Agency Participant: I think the program should focus on television watching and sedentary behavior. All community members just need to get up and move!

Parks and Recreation Representative: We are talking about one dimension of the problem at a time. This is a very big, very complicated problem. How will we ever address everything? Maybe it is just too big. Maybe we need to take on a simpler problem.

Religious Leader: Well, it is big. Maybe we will need an agency coordinator. I say we find a nonprofit group to serve as a community coordinating center from which various interventions and services can be implemented. That way, programs are sustainable and a variety of activities can be offered.

Youth Club Board Member: One of the national obesity programs has great brochures and videos—in three languages. We have numerous testimonials from