

Health Program Planning: The Precede-Proceed Model

Lawrence W. Green
University of California at San Francisco
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Some Challenges of Planning Programs in Public Health

- Health behavior & environmental change are driven by more than knowledge, beliefs, and attitudes (motivation)
- Health behavior & environmental changes usually must be sustained over long periods to achieve health benefits
- Communications must be supported by **policies** and **programs**, **regulations** and **organization**
- Must adapt programs to different populations and settings, with sensitivity to their differences
- In summary: the challenges require more than merely imparting information, knowledge, or even wisdom...

PRECEDE-PROCEED Model

- Predisposing,
- Reinforcing, &
- Enabling
- Constructs in
- Educational/Ecological
- Diagnosis &
- Evaluation
- Policy,
- Regulatory &
- Organizational
- Constructs in
- Educational &
- Environmental
- Development

Green & Kreuter, *Health Program Planning*, 4th ed., NY, London: McGraw-Hill, 2005.

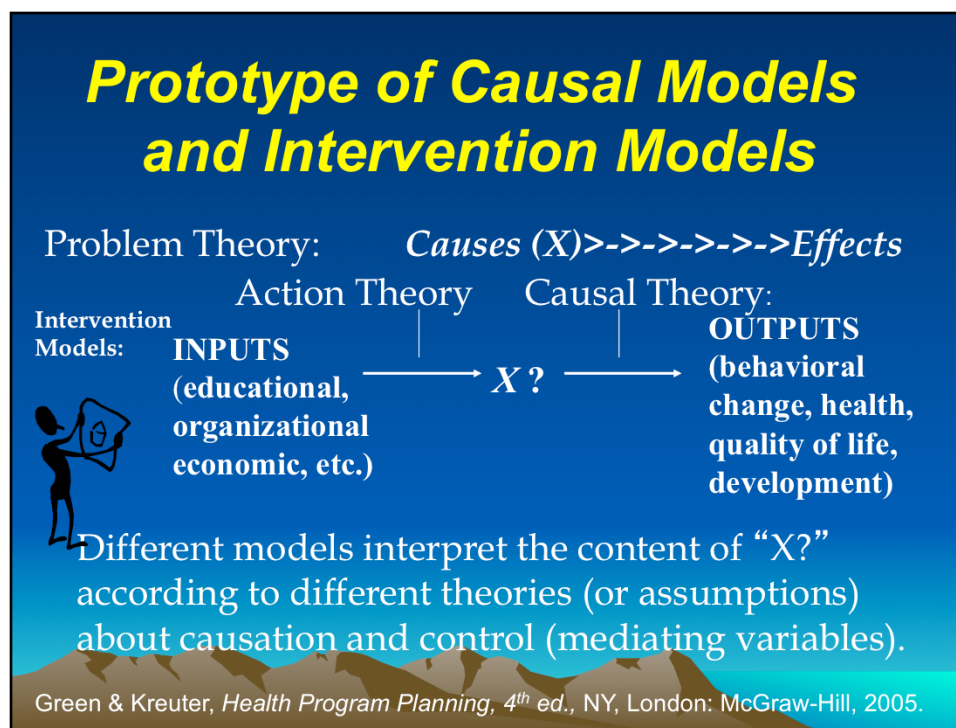
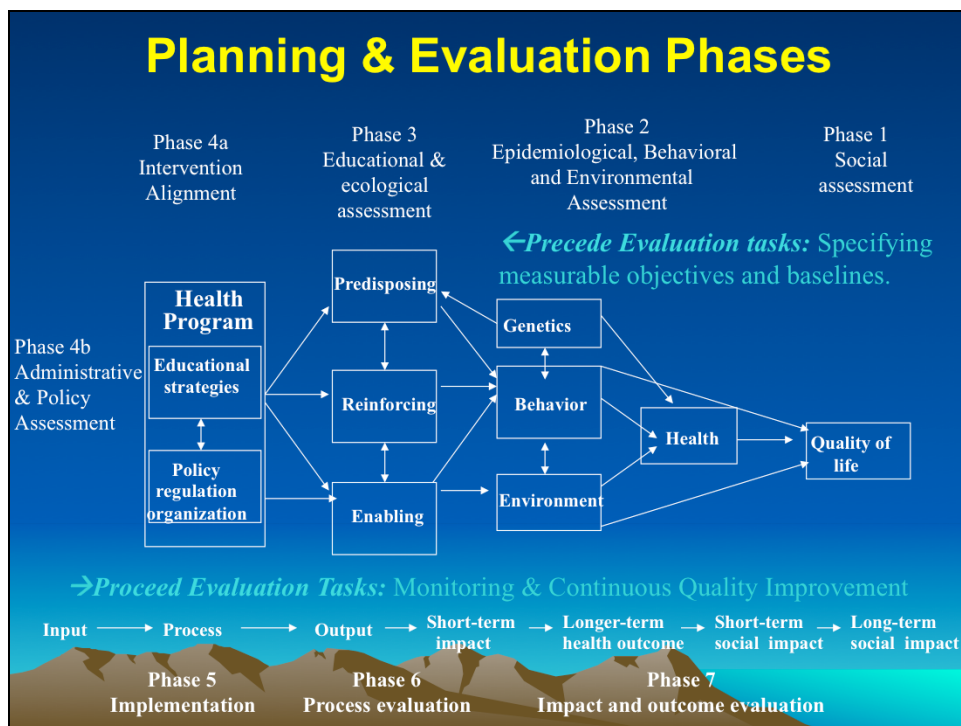


Fig. 5-3, p. 199. Most models for planning contain an implicit or an explicit set of assumptions about causation. Unfortunately, these assumptions are too often implicit, so we are left to guess what factor X involves. Is it just behavior, or is it just environment, or is it some combination of lifestyle, environment and health services.

Examples of Causal Theories on Which PRECEDE-PROCEED is Based

- Psychological theories: X includes a behavior, and its antecedents such as attitudes, beliefs, values, perceptions, and other cognitive variables
- Sociological theories: X includes social norms, networks, diffusion, organizational functioning, and inter-organizational exchange & coalitions.
- Economic theories: X includes consumer behavior and organizational response to consumer demand; governmental subsidies or incentives, taxes.
- Pathophysiological theories: X includes organisms or environmental exposure processes.

The “X” in the previous slide can be any of the specific constructs or variables suggested by these types of theories to explain the correlation and to infer a mechanism between an intervention or characteristic of the person or population on the left and the outcome on the right.



This rendition of the new model emphasizes the importance of evaluation as an early and continuous part of planning, and not just an afterthought to be undertaken after the program is planned and implemented. Continuous Quality Improvement (CQI), as an approach to evaluation, seeks a practitioner-based evaluation process with rapid feedback of results so that practitioners can adjust their practice and improve the program continuously rather than awaiting a formal evaluation report after long-term effects have been assessed.

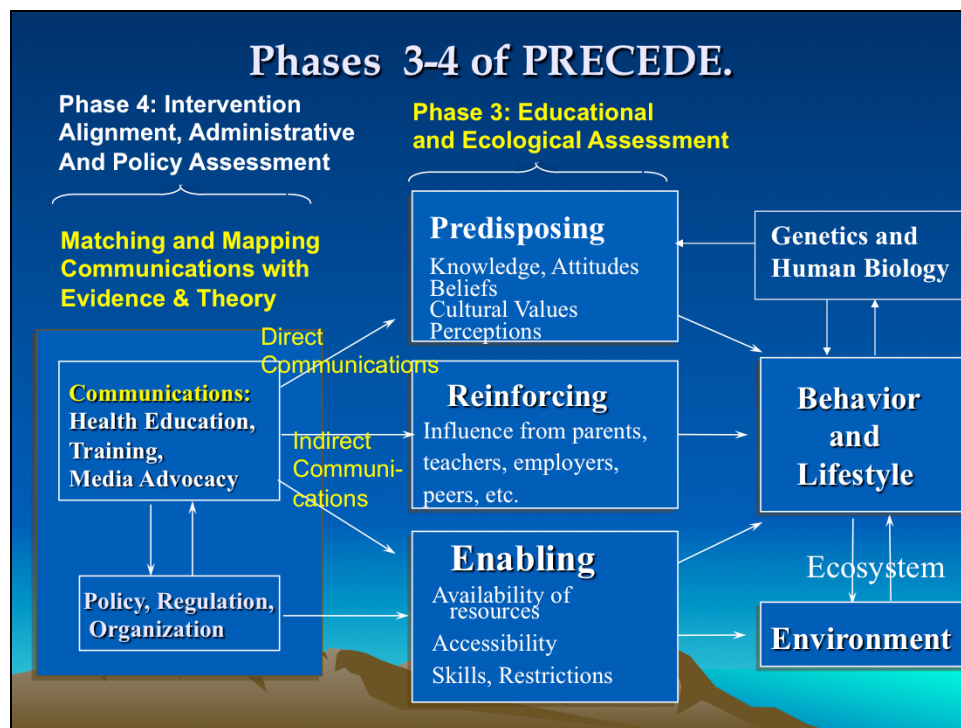
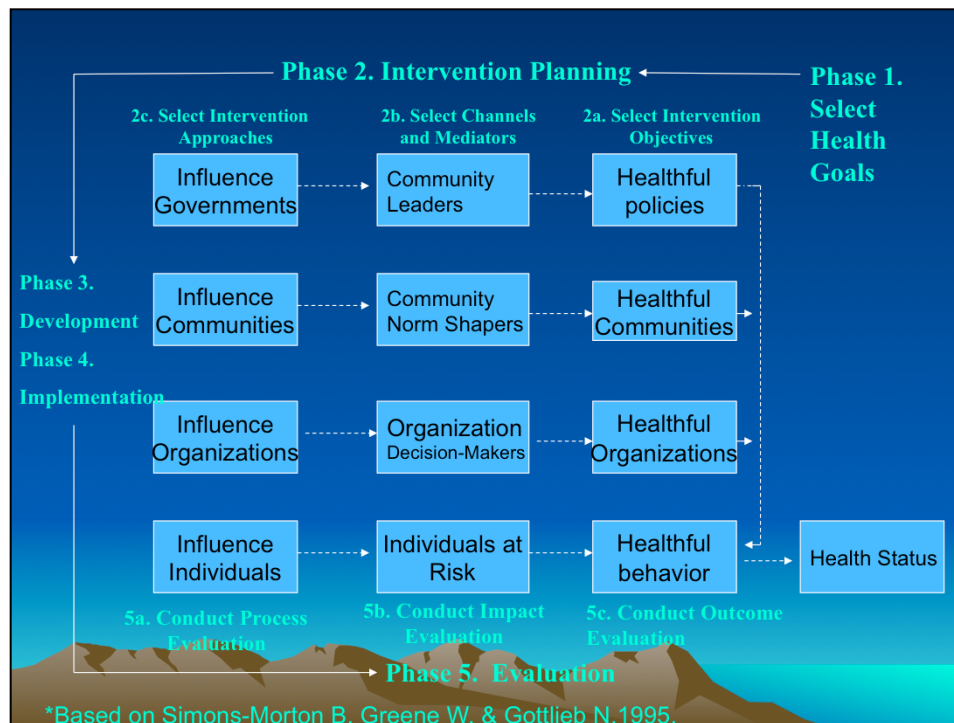


Figure 1-4. Phase 3 takes the behavioral and environmental priorities for change (and possibly genetic or human biological priorities) set in the last part of Phase 2 (Epidemiological Assessment) and examines the factors influencing them, using research and theory to construct an inventory of such factors and then to assess the relative importance of these factors, data on their prevalence in the population, and evidence on the changeability of them. Priorities and objectives among the predisposing, enabling, and reinforcing factors are then handed off to Phase 4 to align evidence and theory on effective interventions for each of the levels and channels of influence to affect the predisposing, enabling and reinforcing factors.

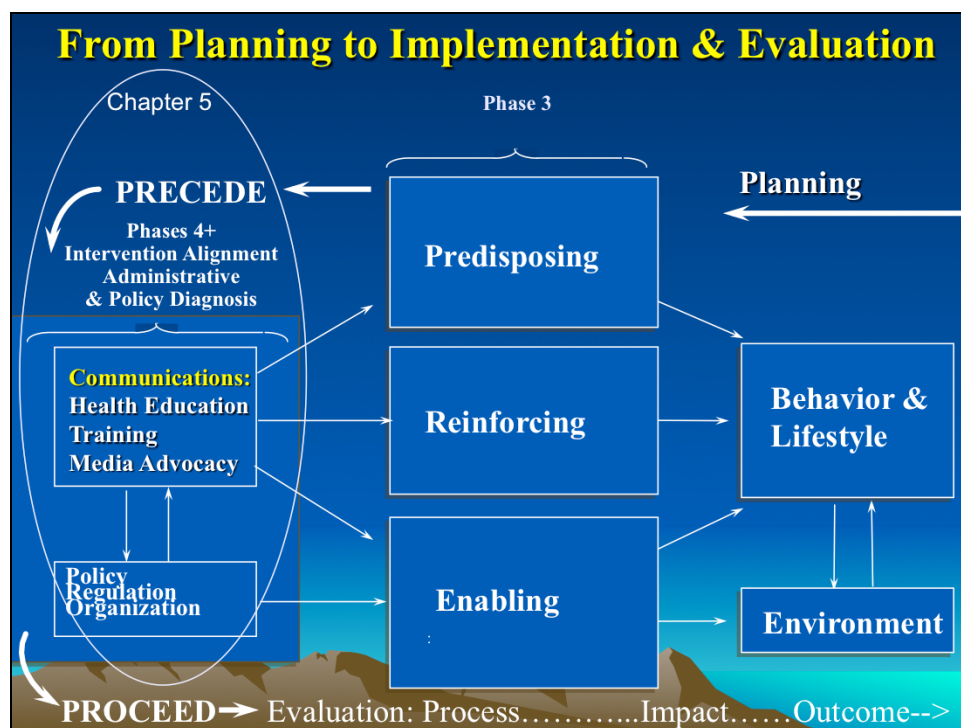
Phase 4 encompasses a range of “matching, mapping, pooling, and patching” analyses and development activities to align interventions, assess organizational and community policies in support of them, and resources needed and available to support their implementation.

Note to instructor: From this point forward into the implementation and evaluation of the program, the numbering of phases loses meaning, insofar as the implementation and evaluation steps are ideally interactive and iterative, with each evaluation finding feeding back into implementation adjustments in a continuous quality improvement process. Phase 5 may be considered the end planning and the beginning of implementation, but in fact, planning is also iterative and interactive with implementation and evaluation, insofar as experience in implementation and data from evaluation inform changes in the plan, and adjustments in the policy, organizational arrangements, and resources supporting the plan.

Green LW, & Kreuter MW, *Health Program Planning*, 4th ed., N.Y.: McGraw-Hill, 2005, Ch. 2.



The first step in aligning interventions with program requirements identified in preceding phases is to match objectives, channels, and intervention approaches with ecological levels, as suggested here by the MATCH model. Fig. 5-2, p. 199.



The ambiguity in numbering of phases after phase 4 is a matter of preference in how much they can be blended and handled simultaneously or must be employed sequentially. We prefer the approach of treating evaluation as part of the implementation process, and after the initial roll out of the program, post-implementation evaluation becomes increasingly integrated with planning as well. This approach to planning, implementation and evaluation is consistent with the Continuous Quality Improvement process applied to processes and short-term outputs, and the principles of surveillance applied to population-level monitoring of outcomes.

Green LW, & Kreuter MW, *Health Program Planning*, 4th ed., N.Y.: McGraw-Hill, 2005, Ch. 2.

ALIGNING INTERVENTIONS WITH EVIDENCE, THEORY, EXPERIENCE, POLICY, IMPLEMENTATION AND EVALUATION

Chapter 5: TURNING THE CORNER FROM PRECEDE to PROCEED

*Green & Kreuter, Health Program Planning: An
Educational and Ecological Approach. 4th ed.
NY: McGraw-Hill, 2005.*

This series lays out the major considerations in developing the interventions, organizing the players, and regulating the implementation of the program.

Policy changes may be required to bring about the necessary reallocation of resources needed to support the program. Before seeking policy changes, however, the more expedient means of mobilizing a program are to organize or reorganize. Organizing a program within a department is the easiest; organizing a program requiring interdepartmental cooperation is next; organizing interorganizationally is the most difficult.

Best Practices vs. Best Processes

- **Best practices** are interventions recommended on the basis of systematic reviews of evidence from controlled studies that substantiate their *efficacy* in the situations in which they were tested, but not necessarily their *effectiveness* in other populations and circumstances.
- **Best processes** are methods such as those of PRECEDE and the matching of interventions to align and adapt them to the needs of a particular population and setting.

Green & Kreuter, *Health Program Planning: An Educational and Ecological Approach*. 4th ed. NY: McGraw-Hill, 2005.

P. 193. Endnote 1 cites the article detailing these distinctions, available full-text online at <http://www.ajhb.org/25-3.htm>. It also gives a second reference that provides an example of the limitations of “best practice” evidence when applied in a different population and situation than those in which the “best practice” was tested. This distinction and its implications for program planning have been a major justification for the diagnostic-planning approach that PRECEDE has always taken, but with the accumulation of more evidence from more sources (see Fig. 5-1 in next slide), it has also enabled this edition to offer a more systematic approach to the “matching, mapping, pooling, and patching” of interventions for specific populations and circumstances. These processes for a population are similar to what one might do in “tailoring” an intervention to an individual’s needs and propensities.

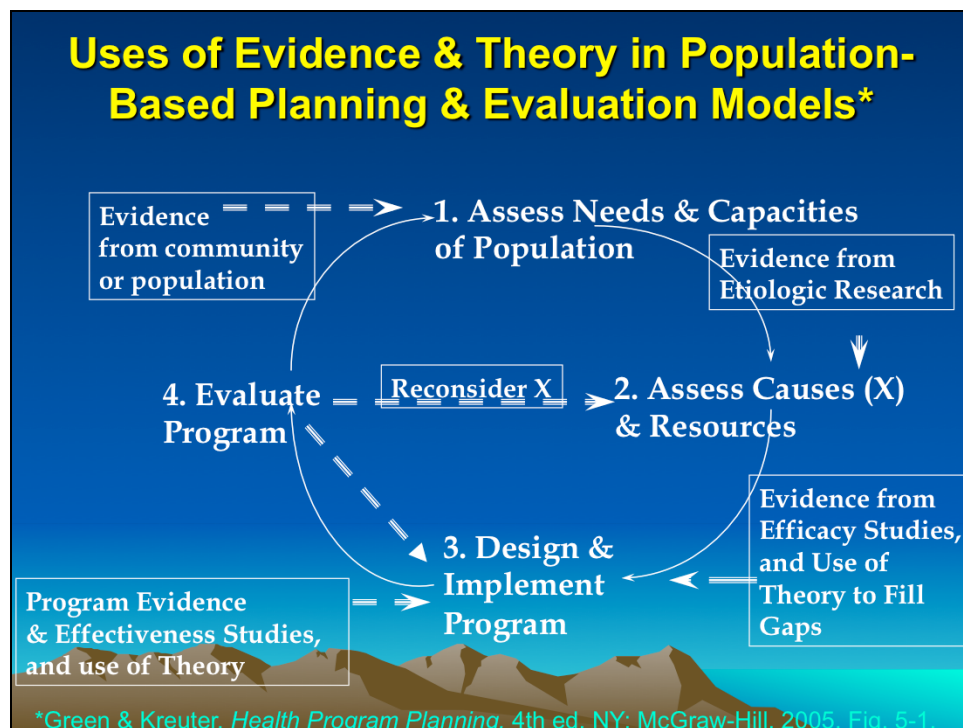


Fig. 5-1, p. 193. When we speak of evidence-based practice in population health, unlike the evidence that might be sufficient in medical practice, we need to be clear about what best practices means. It does not mean that if you insert magic bullet A into your community program guns you can count on outcome B for a whole population. For medicine, the biological organism is very uniform across the human species.

We are dealing with human behavior...whole populations...culture, social forces, norms,