

A Guide for Making Presentations of Health Proposals

Thomas Tai-Seale, Dr.P.H.¹; Hilary Tyler, M.P.H.²

¹Assistant Professor, Department of Applied Health Science, Indiana University, School of Health, Physical Education and Recreation;

² Graduate Student, School of Health, Physical Education and Recreation, Indiana University

Corresponding author: Thomas Tai-Seale; Department of Applied Health Science, Indiana University; Poplars 615; Bloomington, IN 47405; phone: 812.855.3817; fax: 812.855.7092; email:

TAISEALE@INDIANA.EDU

Abstract

Students of health promotion and those who have recently entered the field often need detailed guidance on how to present a proposal for a health promotion program. Since most presentations involve similar steps, a guide can be constructed to assist students and others in developing presentations. Professors of health program planning may also find this training guide useful.

Introduction

Health program planners must construct compelling program proposals, as well as concisely and effectively present their proposals to administrators and funding agents. Oral communication is the most important skill in management and leadership (Davidhizar & Dowd, 1997), and oral presentation skills pervade nearly all ten areas of responsibility for the certified health education specialist (National Commission for Health Education Credentialing [NCHEC], 1998). Despite the need for strong presentation skills, health-planning literature offers little guidance regarding the construction of proposal presentations. This paper attempts to fill the gap with a guide to assist students and young professionals in planning proposal presentations to health professionals, administrators and funding agents.

The guide began five years ago as an attempt to help undergraduate health education students prepare for a 20-30 minute classroom presentation of a health proposal. To prepare for the presentation, small groups of students chose a health topic, met with faculty to discuss the formation of the presentation and rehearsed their presentation with faculty. Through these interactions it became clear that many students need very specific instructions about how and what to present. The guide has now been refined through six course offerings and has also been reviewed by three senior health administrators who regularly evaluate professional health promotion presentations. While no single presentation guide can fit the needs of all health proposal presenters, this guide that has been successfully used in developing a wide variety of health proposal presentations provides a firm starting point for beginners.

The General Approach

Since health administrators and funding agents must justify their decisions to fund a program with rational, data-based arguments, presenters should do best to construct their presentations to fulfill these needs. Audience needs should always guide the content of a presentation (Hoff, 1992). Further, as most evaluators of health proposals will be familiar with standard

planning models, or will at least expect the rational, problem-solving approach presented in these models, presenters should consider designing their presentation to fit the order of the steps used in these planning models. That is, most presentations should begin with a problem, systematically examine the causes, identify the most important and changeable ones, describe the methods to be used to address the causes selected for program development, and discuss the evaluation needed to determine if the problem has been solved.

General Stylistic Advice

Presenters should be aware that presentation style greatly affects audience attentiveness, understanding and interest. Presenters must dress in professional attire and act in professional demeanor to establish that the presenters recognize the formal nature of the presentation and value the time that evaluators have invested in considering the proposal. A professional demeanor includes planning to begin and end on time, having good posture and speaking in standard formal English without slang or imprecise expressions.

The presentation should be personalized to the mission and priorities of the reviewing agency, and it should be addressed to the people in the room – not to the speaker's notes or the overhead projector. Part of making a presentation personal is ensuring that the tone of speech is conversational, not mechanical or automatic. Presenters need to understand that audience members cannot possibly remember everything that's been said. Consequently, presenters should make clear the connections between different parts of the presentation. In addition, if presenters want the audience to look at a particular number, or to consider the importance of a statement or piece of data, they should say so – audiences usually respond well to direct requests (Louis and Sutton, 1991). Further, if they want to help maintain attention, presenters should avoid using undefined or overly technical terms, and they should respond immediately and with respect to any obvious sign of concern in the audience. Finally, while the presentation should be formal, presenters should convey enough personal enthusiasm to demonstrate a sincere commitment to the proposal. Indeed, the demonstration of an emotional

commitment to a project may result in a more positive feeling toward the proposal (Monahan, 1995).

Presenters should convey a spirit of confidence in their proposal that comes from knowing it well and believing in it; rarely should they rely on notes. The presentation should not be read, since it is an inappropriate use of evaluators' time and would show a lack of adequate preparation and interest in the audience (Davidhizer & Dowd, 1997). By scheduling a presentation, evaluators are signaling that they want to hear what the presenters have to say and that they want to use the meeting to gauge the competence of those making the proposal.

The length of any one style of presentation must also be considered. Presentation experts suggest changing the style every seven to ten minutes to maintain attention (Hoff, 1992; Peoples, 1992). Changes can be simple like shifting from one speaker to another, modifying the type of material presented, varying the speaker's location or altering the degree of audience involvement, but a change should not be disruptive. As presenters gain more confidence and acquire the ability to read the audience's needs, they can consider more dramatic adjustments in presentation style to help ensure attention.

Visual aids

It has become standard to use visual aids in presentations and, of course, these must be of high quality. If overheads or slides are used, color is always appreciated, and the text must be at least 20 points in height and have no more than 6 or 7 lines of type. Graphics can be integrated with the text of a visual aid - if the image complements the words. Do not overuse overheads or slides. They require a dark room and draw attention away from the presenter. Use them only for important points, dramatic short quotes, and bulleted summaries. In addition, overheads and slides should not be continually projected after the subject changes, and presenters should strive to make the transition between overheads rapid and graceful - do not wait until the presentation to remove the overhead separators or to order the visual aids. Perhaps because overheads and slides are so commonly used, the audience may appreciate more novel visual or audio aids. For example, a very short audio-tape of a person with a health problem talking about the point you want to make is a good way to re-gather audience attention.

Handouts

Presenters should provide handouts that summarize the important presentation points and expand concepts that cannot be discussed in the allotted presentation time. A simple graph or table presented in the handouts can shave minutes off of what would otherwise require a lengthy explanation in the presentation (Peoples, 1992). Besides shortening the presentation time, handouts provide a way for audience members to later recall the details of what they have been told. Handouts should be error-free and easy to

read. They should be bound and come with a table of contents, headers, and numbered pages. The order of material in the handouts should generally parallel that of the presentation. While color graphics and high quality paper in the handouts indicate that the presenters want to impress the evaluators with professional-looking products, evaluators always consider these of lesser importance than the quality of the analysis. Few evaluators will care if the handouts are in black and white and on regular paper. Keep in mind, however, that color graphics prepared for projection during the oral presentation often do not reproduce well in black and white. It is often necessary to redo these in gray-scale if they are to be used in the handouts. When references to the literature are made in the handouts, they should be numbered in text with the full citation given at the end of the document as in the system used by Index Medicus or the American Medical Association. Citing the author and the year of publication in text, as prescribed in the formatting system of the American Psychological Association, is common in many academic journals, but makes the text harder to read. Distribute the handouts at the beginning of the presentation. When presenters want audience members to consider data in the handouts, they should direct the audience to the appropriate page and allow time for members to find and consider it.

Numbers

Presenters should give the evaluators objective measures of the rationale for the proposed program. While these measures are almost always numerical, a good presenter does not flood the audience with numbers. Rather, he or she is selective in the data presented verbally, while providing a more complete account of the numerical results in the handouts. During the presentation, only important numbers should be emphasized, with the method of emphasis varying depending on the audience. For senior health officials, little more than a pause is required after presenting a number to allow time for them to consider its value. For those less familiar with evaluating numbers, it is almost always a good idea to translate a number into more familiar or graphic terms. General prevalence rates, for example, could be converted to the number of cases within a particular area. Particularly important numbers could be emphasized by presenting the number alone and in very large font with a graphic splash on an overhead or slide.

Evaluators often expect to see types of numerical data presented in particular ways. For example, when rates are compared across a few locations, most evaluators expect to see this data presented as a histogram where the rate (the dependent variable) is charted on the Y-axis - see Figure 1. Comparing rates across many locations requires a table, not a chart.

When trend data is presented, the expectation is that a line graph should be used where the Y-axis charts the trend and the X-axis the time.

When the proportion of a sample that differs in response to a nominal variable is to be presented, a pie chart is usually used –provided there are not too many categories of the variable. For example (see Figure 2), a pie chart could be used to chart the proportion of a sample that indicated the causes of poor mental health. When there are more than five or six categories of responses with many not being frequently cited, then those should be combined into an “other” category; otherwise, the pie would be too crowded. When presenting a pie chart, the pieces should be presented in descending order –with “other” at the end – as in Figure 2. If there are too many categories and no clear dominant causes, a table should be used instead of a pie chart.

When reporting the results of a response to a dichotomous variable, like the percent of a sample that reports having hypertension, it is not necessary to chart both responses – those that indicate having hypertension and those that do not. Anytime one response automatically indicates the value of the alternative response, there is no need to chart both.

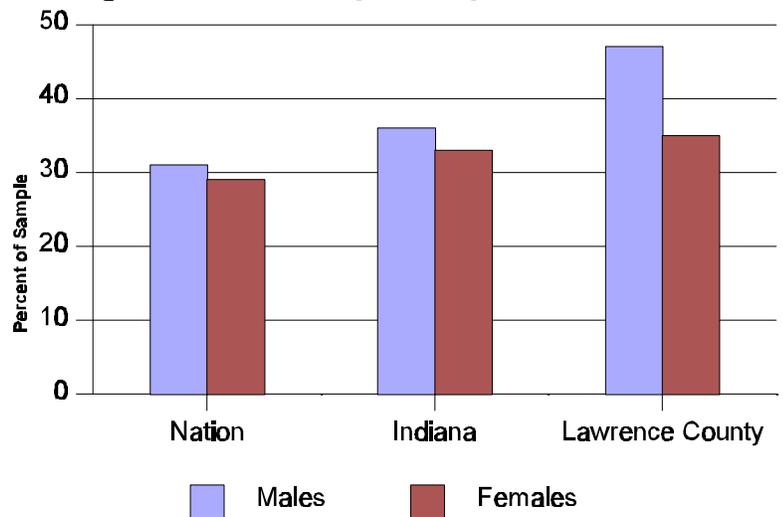
In presentations and handouts the word “figure” is generally used for anything other than a table such as charts, graphs, and images of all kinds. Whether used in handouts or for presentation, figures should be self-contained -with all the information necessary to understand it contained within it. In regards to a chart, the length of a chart should be a little more than one and a half times the height (1:1.6) and unobtrusive grid lines should be used in charts to help the reader find the value of the observation (Wallgren et al, 1996). All figures should be titled at the top and the title is usually centered. Authorities differ in their recommendations for titling, but for presentations an economy of words is usually best. The title should usually identify the variable being measured first (e.g. cause of death), then among who (e.g. for males age 44-55) and, if necessary, when (1997-2000). Opinion is divided about capitalization in titles. Capitalizing the first letter of important words is probably the most common practice. The title font is usually sans serif – like Helvetica or Arial, and not more than 8pts larger than the axis heading text. All axes should have headings, usually in sans serif type, which can supply any additional information needed to interpret a figure. Usually only the first word in an axis heading is capitalized and this heading is usually centered. The Y-axis heading may be written above the Y-axis or written vertically from the bottom up (i.e. rotated end-up 90-degrees from normal writing) and centered to the left of the Y-axis. While figures in the handouts must be numbered, it is not necessary to number them for the presentation unless the audience must follow along

with the handouts. Figures usually have simple-line borders. Legends, if used, are usually within the borders and near the figure. If the data in figures comes from another source, this is identified in small font at the bottom of the figure with the word “source” italicized (e.g. *Source: CDC*).

With tables, a simple format, like that used in this article is usually best. (Pay particular attention to where lines are and are not used.) All tables should have brief titles that do not repeat information in the headings. As with figure titles, all the important words in a table title are usually capitalized. Each column must have a heading. Spanner headings, those that label a span of columns, should be included as needed. Only the first letter of the first word in a heading is capitalized. Authorities differ in terms of the type of font they recommend. Times Roman is usually acceptable. Keep in mind that while large tables can be included in the handouts, only small tables can be projected as graphic objects during the presentation. Also consider that if the real object in presenting a projected table is to draw attention to a certain number. This is often best done by taking the number out of the table and presenting it as a separate graphic object.

While numbers that support your proposal should always be provided to evaluators, there are times when it may have more impact to highlight stories. While professional health planners rue decision-making by anecdote, the reality is that people remember stories better than numbers. Consequently, when making a presentation to an audience with limited or no epidemiological training, consider using stories and case studies to convey disease impact. Senior health agencies often do this when making or distributing

Figure 1. Adult Obesity Level By Gender



reports to broad audiences. Consider, for example, UNICEF’s annual report of the State of the World’s Children. While this report contains many pages of numbers in tables, these are at the end of the document. The authors usually begin the report with an elegant narrative, richly supplemented with case studies, that tells the story of the effects of a disease on both individuals and society. If you do choose to emphasize stories in the presentation, do not forget to include the numbers as a separate handout.

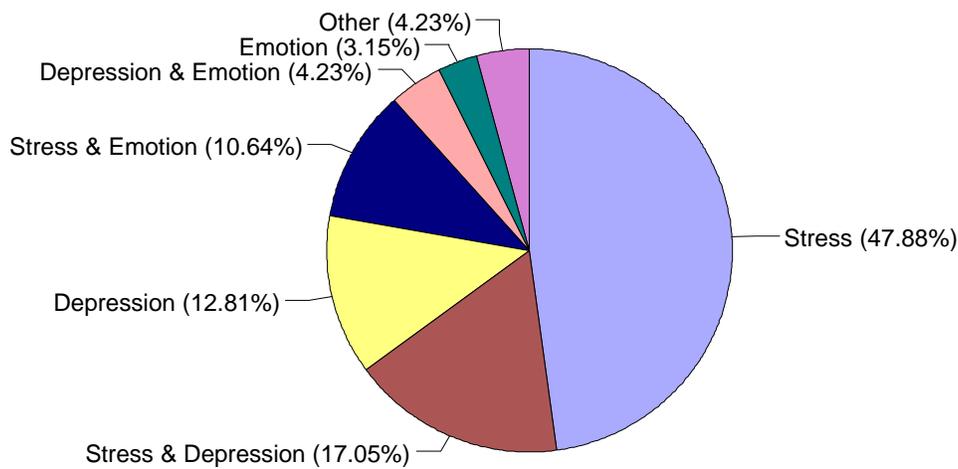
Suggested Presentation Steps

The nine steps of a presentation are given in Table 1; however, there are two possible beginning points. Most presentations of health program proposals begin with the assertion that a health problem, for example diabetes or fetal alcohol syndrome, is important and warrants an intervention. That is, most presentations begin at Step 1 in the table. Under some circumstances, however, it may be appropriate for a

presenter to begin directly with an appeal to address a particular cause of a health problem – for example, smoking or water pollution. This is beginning point 2 at Step 2 in the table. Even when the presentation begins with Step 2, much of the material from Step 1 must still be reviewed; thus, there are still nine presentation steps, it’s just that the order of presentation of the first steps is initially reversed. The description of what must be presented at the second beginning point begins below in the section labeled “Presenting a Single Cause.” Readers are cautioned, however, to read each step below in order, as some of the material discussed in Step 1 will also be needed if you enter the presentation at Step 2.

The pace must be brisk in a 20-minute presentation. In general, presenters should move through the beginning and ending steps quickly, saving most of the presentation time to discuss the rationale for the proposed target and strategy of change (Step 4) and the methods (Step 5). At the end of the presentation, presenters usually ask for questions.

Fig 2. Causes of Mental Health Problems Among 246 Residents Reporting Problems



Step 1: Establish the importance of a health problem

The first step in most health presentations is usually to identify the health problem, - the disease, medical condition, or injury to which the proposal relates - and to describe its importance in particular populations. The health problem is usually discovered through a previous assessment of need at the international, national, regional, state, or local level and thus material from these assessments are presented first.

In cases where diseases and medical conditions are interrelated, the first task of the presenter is to make clear which portion of the problem is the focus of the proposal and why. For example, heart disease and diabetes are interrelated health problems. If the presenters mention both, the proposal evaluators will want to know if the proposal will focus on one or more health problem outcome measures. The choice of one health problem over a related one often needs to be defended with epidemiological data. Presentation tips on this type of defense are given below in the section on the literature review of cause -see Step 2.

Establishing health problem importance

While numerous indicators of a health problem's importance exist, changes in health status, indicators

of the severity of the health problem, and costs to society are the most common.

The most fundamental health status change is from being without a disease, injury or medical condition to being with one. Consequently, most presentations begin with an indication of the incidence and/or prevalence of a health problem in a defined area and among sub-populations particularly affected. In addition, presenters should note any increase in the problem's occurrence and any difference between the rate of occurrence in one area and the rate in comparison areas. For example, the difference in the rate of a health problem between nation, state, and county, should be reported, usually as a histogram see Figure 1. If local data is not available, synthetic estimates can be made using regional or national estimates applied to local levels – provided comparable demographics. For example, if the incidence of a disease on a national basis is .006 and if the proposal is for a city of 30,000 that is demographically similar to the nation, then the presenters could estimate that the disease would affect 180 people per year in this city. All synthetic estimates should be clearly identified as such in the presentation.

Table 1. Presentation Steps

Beginning place	Step No.	Presentation task
1	1	Establish the importance of a health problem.
2	2	Establish the importance of selected causes.
	3	Review the history of area interventions and resources for change.
	4	Identify the target of change and defend the change strategy.
	5	Describe the methods to be used.
	6	Present the marketing plan.
	7	Describe the evaluation plan.
	8	Present the timeline and organizational chain of command
	9	Present the budget.

After the discussion of incidence, prevalence, trends, and comparisons presenters should give an indication, either verbally or in handouts, of the severity and consequence of the health problem. Typical indicators include the: mortality rate, number of days spent in a hospital due to a condition, years of life lost, and disability-free years of life lost among those who have had the problem. These correlate well with the funding given in the United States by the National Institutes of Health (Gross et al, 1999) and are often important to evaluators in deciding which proposals to fund.

In addition, presenters should briefly identify the frequency and severity of the sequelae of a health problem. For example, if a medical condition like low birth weight leads to disease, death, or disabling conditions, the frequencies of these events among those

with the condition should be reported. Similarly, if a disease like hypertension leads to other diseases like stroke, the frequency of this should be conveyed, along with any increased risk due to this consequence.

When possible, presenters should include estimates of the direct costs of a disease or injury, such as the cost of hospital care, pharmaceuticals, and special equipment. Further, they should consider including estimates of the indirect costs, such as the number of lost workdays and the subsequent loss of income to an economy. Finally, presenters should consider including, at least as a handout, more subtle changes in health status that have occurred as a consequence of a health problem, such as a change in a quality of life indicator (Bowling, 1997), or the psychosocial costs of a health problem, such as decreased self-esteem.

As with incidence and prevalence, any trend indicating an increase in the severity of or cost associated with the problem should be reported, as should any significant difference between comparison communities.

The Internet has made the task of finding data on the magnitude of health problems increasingly easier. The governments of many countries and several international agencies maintain on-line data bases that give the incidence and prevalence of diseases and injuries along with data on many of the other indicators mentioned above.

Presenting Outcome Objectives

At the end of Step 1, the presenters should propose a limited set of program outcome objectives. Objectives generally identify four change factors: (1) what will change, (2) how much change is necessary to consider the objective met, (3) who will change, and (4) when the change will be completed. The presentation of the outcome objective should be straightforward. For example, the presenter could announce that the program goal is to reduce the prevalence of Condition A from B% to C% by Time D in Population E. If the presenters are not ready to identify Population E, the presenters can simply indicate that the program will be focused on the target population that will be described later in the presentation. Note also that objectives are most informative when they are given in relation to the current baseline indicators.

If possible, presenters should also use the wording of standard objectives used by senior health planning agencies. For example, in the United States the health goals for the nation are contained in a set of documents called *Healthy People 2010* published by the Department of Health and Human Services. Writing local objectives in terms similar to national health objectives not only helps proposal evaluators see the problem in perspective, it alerts them to the possibility of funding from agencies concerned with national health problems.

Step 2: Establish the Importance of Selected Causes
Causes, intimately connected with a disease, injury, or medical condition, are often considered part of the health problem. Proposal evaluators need to be assured that the proposal addresses the most significant and malleable causes of a population's problem. Further, they need to know if the presenters have considered that there may be diverse causes of the health problem among different groups in the population being considered. Occasionally, evaluators will want presenters to address a single cause. This special case (beginning point 2) is discussed under the heading "Presenting a Single Cause" at the end of this section.

While health problems have genetic, behavioral, and/or environmental causes, most health promotion proposals are concerned only with behavioral and/or environmental causes. Behavioral causes usually refer

to the actions of those with the health problem that have contributed to the problem. Environmental causes refer to things beyond the control of the affected person that contributes to their problem. Behavioral and environmental causes often interact, as will be demonstrated in the example below on low birth weight. After establishing the importance of a health problem (in Step 1) presenters should establish (in Step 2) the relative importance of the behavioral and environmental causes, identifying those that have been carried forward for program development. This is accomplished through a literature review and an assessment of the relative strengths of local causes.

Literature Review of the Causes

Proposal evaluators will expect that presenters are familiar with what the recent academic journals say about the causes of a health problem and the relative strength of these causes. Consequently, presenters should include a brief review of these previous findings. Unless a strong case can be made that the findings of the causes of a health problem as discussed in the literature apply to the population of interest, presenters should refrain from making frequent or detailed reference to these findings. The literature review serves primarily as a primer to the discussion about local causes. It is included in the presentation to assure the audience that the consideration of cause has been thorough.

One way to shorten the literature review is to simply announce the number of articles that were reviewed and to summarize the most important conclusion, perhaps as an overhead. The real work of the literature review can be presented as a table in the handouts. The table should separate behavioral and environmental causes (or present them as separate tables) and should group together studies related to the same cause. (If there are many studies on different causes to report, separate tables can be used to review the findings for each cause.) The table should have at least four columns: one to identify the study authors, one to summarize the study demographics, one to specify the sample size, and one to cite the magnitude of risk discovered for each measured risk factor. This type of table will satisfy most proposal evaluators, while research proposals to specialized audiences may require more detailed tables. Sometimes a column must be included that identifies the operational measures used to define the causal risk factors and associated health conditions. Also, indicating the type of study that produced the data, whether it was a cross-sectional, prospective cohort, case-control, or some other type of study helps evaluators gage the strength of the associated data. In addition to the summary table, a copy of references should be included in the handouts.

Reporting Risk Data

Relative risk and odds-ratios express the strength of a relationship between a causal risk factor and a health

problem in the academic literature. When making a presentation to an audience that might not understand these epidemiological measures, simpler expressions can be used. For example, instead of saying that the relative risk of death from heart disease for those who took up moderate exercise during a study was .77 compared to those who remained sedentary, the presenter could say that those who took up exercise had a 23% lower death rate from heart disease.

Local Assessment of Cause

As noted above, in cases where a health problem is likely to have unique local determinates- these should be highlighted in the presentation. Since the last decade, program planners and evaluators have become more aware of the importance of environmental causes. Increasingly, researchers recognize that it often requires more than the actions of individuals to promote their own health to effectively address health problems (Green and Kreuter, 1991). Local assessments should pay special attention to these issues.

To make the case that all possible causes have been considered in the analysis of cause, presenters are encouraged to use an ecological framework. For example, in one commonly used ecological model (McLeroy et al, 1988) there are five levels of causal determinants: interpersonal, intra-personal, community, institutional, and policy. All but one if these are environmental. A presenter could indicate with a slide or overhead how data at each ecological level was gathered for the assessment of cause.

Regardless of how many ecological levels were considered in the analysis of cause, presenters should identify from whom they gathered data and how this was done. If multiple methods of data collection were used, such as focus groups, community forums, interviews, and/or other needs assessment techniques (see Witkin and Altschuld, 1995) - this should be mentioned. The validity of the findings increases when different methods yield similar results. In addition to describing the data collection process, the data collection instruments and specific questions asked should be included in handouts. Seeing the questions asked often helps evaluators understand the validity and results of a survey. It also helps them judge the validity of comparisons made to other data.

In presenting any local estimation of cause presenters should consider that the determination of cause requires that a factor be differentially associated with one outcome over another. For example, low birth weight may be caused by many variables including lack of access to care. To make the case that lack of access is a cause, presenters must show data that indicates that those with access have a lower incidence of low birth weight than those who do not. The two by two table where the row labels usually identify the condition of exposure (exposed to cause, not exposed to cause) and the column labels identify

the outcome (with health problem/not with health problem) is probably the simplest way to present this type of evidence.

Table 2. Low Birth Weight and Access to Prenatal Care Services in Community X

Condition of Access	Birth-weight	
	Normal	Low
Low Access	20	80
High Access	80	20

Selecting Causes to Address

While programs that simultaneously address multiple causes of a health problem are becoming more common, a deficiency of resources often causes program planners to limit program interventions to fewer causes. In this case, the presenters must argue that they have chosen to address the most important and changeable cause of a health problem. In regards to importance, presenters must make the case that they have chosen risk factors that (1) are strongly associated with the specific health problem under consideration, (2) affect a sizeable portion of the population under consideration, and (3) are not being effectively addressed by other programs in the community. Sometimes, however, a risk factor for a particular disease should be considered more important if it is associated with multiple diseases. Consider smoking, for example. While smokers have roughly twice the risk of heart disease than non-smokers, the overall health impact of smoking in a community is much greater than this risk implies as smoking contributes to many other diseases. Consequently, risk factors that contribute to multiple diseases should be considered of greater importance than those that do not.

In regards to change, those risk factors that can be addressed with the least resources usually have priority over more costly interventions. In addition, a community or agencies in the community may be more willing to take on some risk factors than others. Again, both importance and changeability must be considered when considering which cause to select for program development.

Program planners should be aware that when they select one health problem or cause over another for program development, they are de-selecting other problems and causes for program attention and consequently failing to address the needs of those with this problem or cause. Thus, selecting a single health problem or cause for program development may not be the best thing a health-planning agency concerned with addressing the needs of a whole community could do. A more comprehensive approach to planning for the needs of a community would be to assure that some

group or agency in the community is addressing each of the health problems and causes in the community. Once this is assured, each group could continue working on a problem or cause as explained below.

Presenting Impact Objectives

Having identified the most significant and malleable causes of a health problem among particular groups (segments of the target population), and having satisfied evaluators that the estimates are valid, the final task in Step 2 is to propose behavioral or environmental objectives –also known as impact objectives. Once again, the presentation should be straightforward. Presenters could, for example, propose to reduce Behavioral Cause A from a prevalence of B% to C% in Time D among Population E. Environmental objectives could take the form: to reduce exposure to Toxin A from B% to C%, or to increase access to Service A from B% to C% in Time D among Population E. As with the program outcome objective, if the proposal is related to a population that has not yet been described, this group can be identified simply as “the target group to be described.”

Presenting a Single Cause

There are two exceptions to the rule of beginning a presentation with a description of a health problem and its importance: (1) If the presentation is being made to an agency that focuses exclusively on this health problem, this step can be eliminated – the proposal evaluators already know the importance of the problem, and (2) if the presenters have been asked to develop a proposal related to a particular cause. In this second case, however, if the agency considering the proposal must decide between funding proposals related to different health problems, it is wise to make the case that the health problems associated with the cause are important. That is, presenters will still have to address issues normally covered in Step 1.

When asked to make a presentation about a single cause of a health problem, presenters should usually start by identifying:

1. The strength of the relationship between the cause and the health problem(s) – as gleaned from authoritative references or local data. See “Literature Review of the Causes,” “Local Assessment of Cause,” and “Reporting Risk Data” above.
2. The severity of and numbers affected by the health problem in the area of concern – often derived by synthetic estimate. See “Establishing Health Problem Importance” above.
3. The current baseline incidence and prevalence of the cause in the population under study - noting any trends and if it is higher than in other comparison communities. See “Selecting Causes of a Health Problem” above.
4. The impact objective to be achieved. See “Presenting Impact Objectives” above.

Step 3: Review the history of area interventions and resources for change.

At some point in the presentation it is important to review past community or agency efforts to address the health problem of concern in the area of concern. We have placed this step just before the identification of the target of change and the defense of the strategy, so that it is clear to the audience that previous or on-going efforts in the area to address the problem or its causes have been considered. Demonstrating familiarity with previous or on-going work in the community communicates that the presenters have considered how their proposal relates to this work and how it builds upon previous lessons learned.

Information on the history and relative success of health programs in a community is usually obtainable from the directors of the community health agencies that run these programs or from the local health department. During the presentation, the program planners should briefly review the salient features of each program along with the measures of success. A brief narrative summary should be provided in the handouts.

Resource Assessment

Though relatively new to the literature of health promotion, resource or capacity assessment is increasingly being recognized as a necessary consideration in good planning (McKnight and Kretzmann, 1997). Indeed, the work that can be done in a community usually depends more on the resources than on any assessment of the possible intervention points. At the local level, the chief resources are the individuals and organizations in the community of interest. Individual capacities include the skills, talents, knowledge and experience of residents as well as their personal income. Organizational resources include citizens and business associations; financial institutions; and cultural, religious, and communication (media) organizations – each of which may play a role in addressing a problem cause or in refashioning a community. Resource assessment is often conducted at the same time as an assessment of the health problems and problem causes in a community. During the presentation, presenters should identify the resources that may be available to address the problems of interest.

Step 4: Identify the target of change and defend the change strategy

It is often best to begin Step 4 with a clear statement of who and what needs to be changed in order to achieve the impact objectives presented in Step 2. Note that this step begins with a specification of a behavior to be changed (the what) in a particular person or group (the who). Also note that the “who” is not always those at risk; often it is those whose actions determine the health of those at risk. Keep in mind that who and what needs to be changed may vary after the history of

what has been done in relation to the problem in the area has been considered (Step 3).

Once the who and the what are identified, the next task is to layout the strategy to change this behavior, that is, to identify the variables through which the presenters hope to change the behavior related to the impact objective. Since the task is to analyze and determine the best place to intervene to change a behavior, presenters should consider using behavior change theory when designing and presenting the strategy. The most commonly used behavioral theories in health promotion are the predisposing, reinforcing, and enabling components of PRECEDE (Green and Kreuter, 1991), the Health Belief Model (Becker, 1974), Social Cognitive Theory (Bandura, 1986), the Theory of Planned Behavior (Ajzen, 1988), and the Trans-theoretical (or Stage of Change) Model (Prochaska and DiClemente, 1983).

Presenters should not try to use or explain all these models—especially if the audience is not familiar with them. Rather, they should use the most appropriate model to make the case that they have been thorough in considering how to change behavior. The presenters should quickly and efficiently demonstrate that they have considered the most important behavior change variables and have selected the most promising ones for program development. As with the determination of the most important causes of a health problem, once again the task is to argue that some determinants (in this case of behavior) are more important and changeable than others. Presenters should use both primary (usually local) and secondary data (from the literature) to argue for their chosen strategy. As with the presentation of the cause of health problems, any literature review related to changing behavior must be brief and consigned mostly to the handouts. The most important data to present is local.

Suppose an ecological analysis has shown that low-birth weight in a certain city relates to the mother's failure to obtain adequate prenatal care. Thus, the mothers are the "who" that needs to be changed and the "what" is to get them using prenatal care on the prescribed schedule. To determine the best strategy to change the behavior, the causes of the failure to act must be examined. Several behavior change theories could be employed for this purpose. Consider, for example, the theory of planned behavior that states that the intention to act (go to prenatal care services) is affected by one's attitude toward the act, the subjective norm, and the mother's level of perceived behavioral control. Through interviews with mothers that do not use the services it is determined that their attitude toward using services is negative due to a considerable distrust of medical services. Further, many mothers report a low level of perceived behavioral control because they are uninsured and cannot pay for the services, while others have trouble

with transportation. This suggests three different strategies: remove distrust, remove the financial barrier, and improve transportation.

The data that supports these strategies could be presented in many ways. For example, the frequency of responses to questions derived from the theoretical model could be presented. In the example above, the number that strongly agreed, agreed, were unsure, disagreed, or strongly disagreed that prenatal medical services were safe could be presented. Alternatively, a two by two table could be presented that indicates the level of trust (high trust, low trust) in prenatal medical services among users and non-users of these services. A copy of the assessment instrument and complete results should be included at the end of the handout as an appendix.

Describing Segments

At this point in the presentation the audience should have a clear idea of the target of the intervention and the strategy. It may, however, help them if they can visualize the target of change and their environment as related to the problem. Marketers have found that it is often useful to portray the target segment and relevant contextual information in a compact visual image called a profile. Figure 3 provides an image and a nickname (Underserved Young Mothers) for one of the target segments described above. In the presentation, the image can be linked with characteristics known to be associated with members of the segment. The most important characteristics are those that determine the behavior in question, in this case, getting prenatal care services. Attitudes, health risks, demographic characteristics, and communication channels in this example have all been linked to a failure to get adequate prenatal services.

Strategy Objectives

Step 4 ends with the presentation of what may be called strategy objectives. These are educational or organizational objectives (learning and resource objectives in the PRECEDE model) related to the strategy. Once again the presentation should be straightforward, something like: To decrease the proportion of women who do not trust the medical system from A% to B% by Time C in Population D.

Step 5: Describe the methods

Once the history of the area's interventions, its resources for change, and the strategy objectives have been presented, the program methods can be described. The methods describe how the strategies will be achieved. Evaluators want to see a clear connection between the strategy and the methods.

A wide variety of methods are available to health promoters, as shown in Appendix 1.

Presenters should be prepared to make the case that the chosen methods will be well received by the target population.

Again, using the prenatal care example, if one of the strategy objectives is to increase to X% the

Figure 3. Underserved Young Mothers



<p>Attitudes</p> <p>Mistrusting of medical system/doctors</p> <p>Barriers</p> <p>Competing needs</p> <p>Uninsured</p>	<p>Demographic Characteristics</p> <p>18-24 ethnic/racial minorities low socioeconomic status</p> <p>Health Risks</p> <p>Inadequate nutrition</p> <p>No/Late pre-natal care</p>
---	---

proportion of women in a neighborhood who have access to prenatal exams, the methods must describe how this particular objective will be achieved. For example, the method may consist of providing free or discount coupons in the mail or in newspapers read by the target audience. Another appropriate method may be to bring services closer to the target audience's neighborhood via mobile hospital units.

As presenters must be very clear as to how a strategy objective will be reached, they should consider presenting the list of methods as bulleted items under the strategy objective. Some agencies may require a set of process or task objectives related to the methods. These are rarely presented in the oral presentation, but can be included in the handouts.

Step 6: Present the marketing plan

By this stage in the presentation, a strong case has been built for the importance of the problem, the need to address its greatest causes in particular and substantial segments, the proposed strategies, and step-by-step methods. However, as is often the case, "if you build it..." they may not come. Funders and administrators do not want to sustain a program with few beneficiaries and little impact. Thus, if a program must change people's behavior to be successful, a

presenter must communicate a convincing marketing plan outlining how this will be done. The plan may grow out of an initial needs assessment or a specialized marketing assessment. Regardless of the plan's derivation, the presentation should clearly demonstrate a thorough understanding of the target segment(s) and how to change their behavior.

The essence of a marketing plan revolves around consideration of what is known as the 4Ps – product, price, placement and promotion. Some consider the target segments to be the fifth P – people. Though much can be said about these crucial marketing elements, the presentation can include a simple summary of these aspects.

The product is the intervention (behavior change) being proposed. The presenter should make it clear how it should appeal to those that should change. The price not only refers to the economic cost of the product, but the social, psychological and physical costs associated with the proposed environmental or behavioral change. The presenter must demonstrate how costs are kept low. Program distribution is considered placement – where the program will take place. The presenters should demonstrate how the placement is appropriate for the target segments.

Finally, promotion includes efforts to draw the target segments to the program. Promotional pieces may be in the form of flyers, brochures, radio or TV spots, or recommendations from a variety of others trusted by the target segments. Presenters should indicate how these channels will be used to reach the target audience.

The psycho-graphic objects created in Step 3 may also be helpful in describing how proposed marketing efforts fit the chosen segment(s). For example, in the case of the Underserved Young Mothers, presenters can easily make the case that the appropriate way to reach them includes postings in grocery stores, at welfare offices, on radio stations, TV channels or direct mailings.

Some agencies may require process objectives for the marketing plan, as with the methods objectives, these are usually included in handouts.

Step 7: Describe the evaluation plan

The evaluation plan explains how the strategy, impact and outcome objectives will be measured, and how change reflected in the measures will be analyzed, interpreted, and used to improve the program. Presenters should briefly discuss the schedule of evaluation activities and identify who will collect the data, who will review the results, and how suggested changes will be introduced. Others may also want to see the evaluation instruments, which can be included in handouts. Some agencies may also want to know how the changes observed in the program can be attributed to the program, in which case, presenters will have to introduce research design into the presentation. The research design nomenclature of Campbell and Stanley (1963) is still the most common.

Step 8: Present the organizational timeline and administrative chain of command

Once the evaluation plan has been discussed, presenters should provide a brief timeline of the activities required to train program staff, market, carryout, and evaluate the program. This step is

especially important if the proposed plan is to be carried out by the agency reviewing the presentation proposal. The timeline can be month-by-month or week-by-week, but it must provide an easy-to-follow estimation of the events leading to the program and through its evaluation. Gantt and PERT charts are the most commonly used methods of displaying organizational timelines. A Gantt chart is a bar chart that plots tasks or resources and time. The tasks or resources are usually listed in the first column while subsequent columns identify time periods. The duration of an activity is usually charted as a shaded bar or with Xs as shown in Table 3 below.

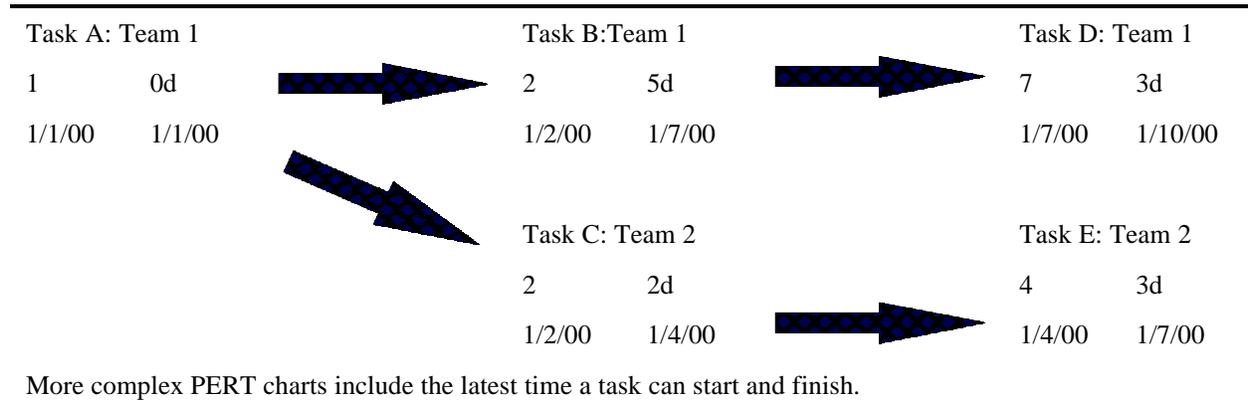
At the simplest level, the Program Evaluation and Review Technique (PERT), developed by the United States Department of Defense in the 1950s, is just a chart that shows tasks, their durations, and relationship between tasks in time. Tasks are listed in order, with simultaneous tasks shown stacked on top of each other as shown below. PERT charts vary depending on the needed complexity, but a fairly simple one indicates the earliest time a task can start from the beginning of the project (upper left box) and the duration of the task (upper right box) along with associated dates (bottom boxes). The chart below shows two teams working on different aspects of a project. To keep it simple, weekends have been counted as workdays. It shows, for example, that Team 1 will start Task D, which will last 3 days, on day 7 of the project. It also shows that Team 2 needs a product of Task A (from Team 1) to start Task C.

The chain-of-command is the second organizational item that is presented. It describes the chain of command for organizational decisions and is usually presented as a chain-of-command box set. Finally, any contractors and their qualifications should be noted and described in the handouts.

Table 3. Sample Gantt Chart

Activity	Month 1	Month 2	Month 3	Month 4
Prepare brochure	X			
Prepare radio spots	X			
Test materials		X		
Meet local leaders		X	X	X
Address community groups		X	X	X
Test knowledge				X

Figure 2. Sample PERT chart



More complex PERT charts include the latest time a task can start and finish.

Step 9: Present the budget

Though a program’s potential success may be promising, funders and administrators will wonder if the program plans can be effectively funded and if the money to be allocated will be wisely spent. The presentation should clearly demonstrate a high yield for the investment in the form of a budget. The budget usually consists of a table, like those shown in Figure 3, and a short justification narrative for each component. The table should include staff and consultant salaries, fringe benefits, office supplies, media time, travel, phone expenses and any other direct or indirect cost that may be associated with the

proposed program. Fringe benefits vary between organizations and among ranks of personnel and are usually only accrued by full-time staff. Indirect costs are used to cover the overhead of an organization and can be quite high. Some funding agencies do not allow indirect costs to be claimed. If the program will take in money, this too should be noted and subtracted from the total cost of the program.

During the presentation it is helpful to have in mind several strategies for reducing the budget if necessary. Budgets are most often presented in the handouts, but presenters should have a visual prepared in case questions arise during the presentation. Two sample budget formats are given in Figure 3 below.

Figure 3. Sample Budgets

	Total hours	Hourly rate	Requested Amount
<u>Personnel</u>			
Program Director	1,333.3	\$25	33,333
Administrative assistant	1,333.3	\$15	20,000
F-T Benefits 20%			10,667
Graphics artist	20	\$20	400
Media Consultant	20	\$35	700
Office supplies			600
Telephone			350
Media time			2000
Travel			500
Total Direct			68,550
Total Indirect (50%)			34,275
TOTAL			102,825

Partial Budget Table in Alternate Form:

	Yearly salary	% of time	# of months	Requested Amount
<u>Personnel</u>				
Program Director	40,000	100%	10	33,333

Conclusion

Good presentation skills are essential in gaining support for health program proposals. By following the steps outlined above, beginning presenters can be assured that most program evaluators will understand their proposed work and see it as rational, coherent, thoroughly researched, and fitting a definite need. What remains, then, is for the presenters to sell themselves and their ability to succeed. Often this is a matter of demonstrating a proven track record or willingness to work with community partners in the complex endeavor of health promotion.

References

Ajzen, I. (1998). *Attitudes, Personality, and Behavior*. Chicago, IL: The Dorsey Press.

Bandura, A. (1986). *Social Foundations of Thought and Action: A Social Cognitive Theory*. Englewood Cliffs, NJ: Prentice Hall.

Becker, M.H. (Ed.). (1974). The health belief model and personal health behavior. *Health Education Monographs*, 2, 324-473.

Bowling, A. (1997). *Measuring Health: A Review of Quality of Life Measurement Scales*. Philadelphia, PA: Open University Press.

Campbell, D.T., & Stanley, J.C. (1963). *Experimental and Quasi-Experimental Designs for Research*. Chicago, IL: Rand McNally.

Davidhizar, R., & Dowd, S.B. (1997). The art of giving an effective presentation. *Health Care Supervisor*, 15(3), 25-31.

Green, L.W., & Kreuter, M.W. (1991). Health promotion today and a framework for planning. *Health Promotion Planning: An Educational and Environmental Approach*. Mountain View, CA: Mayfield Publishing Company.

Gross, C.P., Anderson G.F., & Powe, N.R. (1999). The relation between funding by the National Institutes

of Health and the Burden of Disease. *New England Journal of Medicine*, 340(24), 1881-1887.

Hoff, R. (1992). *I Can See You Naked*. Kansas City, MO: Andrews & McMeel.

Louis, M.R., & Sutton, R.I. (1991). Switching cognitive gears: From habits of mind to active thinking. *Human Relations*, 44, 55-76.

McLeroy, K.R., Bibeau, D., Steckler, A., & Glanz, K. (1988). An ecological perspective on health promotion programs. *Health Education Quarterly*, 15(4), 351-377.

McKnight, J.L., & Kretzmann, J.P. (1997). Mapping community capacity. In M. Minkler, (Ed.), *Community Organizing and Community Building for Health*. (pp. 157-172). New Brunswick, NJ: Rutgers University Press.

Monahan, J. (1995). Thinking positively: Using positive affect when designing health messages. In E. Maibach, & R.L. Parrott (Eds.), *Designing Health Messages*. Thousand Oaks, CA: Sage Publications.

National Commission for Health Education Credentialing. (1998). *A Competency-Based Framework for Graduate-Level Health Educators*. Allentown, PA: NCHCEC.

Peoples, D.A., (1992). *Presentations Plus: David Peoples' Proven Techniques* (2nd ed.). New York, J.Wiley.

Prochaska, J.O., & DiClemente, C.C. (1983). Stages and processes of self-change of smoking: Toward an integrative model of change. *Journal of Consulting and Clinical Psychology*, 51(3), 390-395.

Wallgren, A., Wallgren, B., Persson, R., Jorner, U., & Haaland, J.A. (1996). *Graphing Statistics and Data*. Thousand Oaks, CA: Sage Publications.

Witkin, B.R., & Altshuld, J.W. (1995). *Planning and Conducting Needs Assessments: A Practical Guide*. Thousand Oaks, CA: Sage Press Inc.

Appendix 1. Methods of Health Promotion

Method	Description
Access	Increasing the availability of a service by either extending hours, facilitating transportation, opening new service-outlets, decreasing costs, or eliminating other barriers associated with a service. Increasing access can be a method of health promotion organized by the agency offering the service or it can be the object of change for community members using some of the methods described below.
Advocacy	The attempt by individuals or groups to influence those individuals and institutions that makes health policy decisions. Advocacy at the community level often involves organizing the community and building coalitions.
Audio tapes	Pre-recorded tapes of voices and/or songs that carry a health message. For example, recordings from community members of how they have dealt with a health problem. Audio and audiovisual tapes are a cheap and effective way to provide information and influence opinion, provided the sources of information are credible and the style of presentation (for example, music background and vocabulary) fits the learners.

Audiovisual presentations	Videotapes, films, slide/tape shows, and videodiscs that you make yourself or purchase pre-made. The visual component aids in modeling a behavior. The presentations must be of reasonable quality, short duration, and adapted to the educational and cultural level of the audience. Didactic audiovisual material is best used to supplement other methods of health promotion.
Behavior modification	Changing behavior by manipulating the stimuli or contingencies related to the behavior -often associated with behavioral record keeping, removal of barriers, rewards, and punishments.
Brainstorming	A free-thinking/speaking forum guided by a facilitator focused on identifying a problem or solution. Brainstorming is often used as a method of needs assessment, but can be a health promotion method when the problem is lack of involvement or attention to a problem. The method works best with groups that work well together.
Cartoons/pictures	Humorous images used to help people develop insights into the cause or nature of a problem. Sometimes used in group settings to assist members to critically analyze a situation represented visually. This method is often useful when it is more productive to direct emotions to an image instead of a person. It is also a good method to use with audiences that do not read well.
Community forums	An open meeting in which all members of a community are called together to discuss a problem. This method, also used in needs assessment, can be used as an intervention when the strategy is to educate a community about items of concern. Community forums work best in communities that have a history of regular well-attended community meetings and on issues in which the community has previously expressed interest.
Community organization	A sustained effort to get community members involved in responding to and taking steps together to solve a problem in a community.
Computer-assisted instruction	Pre-programmed, often interactive instruction offered through a computer. Examples include: Health Risk Appraisals (HRA), dietary analyses, health games, and self-paced learning. CAI may help participants develop insights into the cause or nature of a problem by having them analyze a situation. It may also help in skill building, emotional control, and other learning.
Cooperative learning	Learning from fellow participants. Cooperative learning uses the similarities between people's experiences to help group members analyze problem situations and apply solutions.
Cost-reduction and discounts	Reducing the barrier of the costs of a service either permanently or temporarily to some or all members of a community. A means of increasing access.
Crisis simulations	Activities that take the appearance of real-life more dangerous or urgent scenarios, especially useful for practicing a skill set that is infrequently needed, but urgently needed when occasions arise. The steps of a simulation must be scripted. Examples include: First aid, building evacuation, fighting natural disasters, CPR, and self-defense.
Debates	Moderated discussion between two or more people on different sides of an issue. Useful when there is a need to increase awareness of the complexities of an issue or the starkness of contrasts. This method works when people are undecided on an issue. It requires a lot of preparation by debaters and a skilled moderator, who specifies and enforces clear rules. Examples of good topics for debate include: sex education, condom distribution, abortion, drug use, responsibility for health problems, ethics in health education, and health insurance.
Displays	Objects or visual material with explanatory text made available for public viewing - especially useful when the presenter can't or shouldn't be present. Almost any health problem can be represented by display.
Drama	Performances in which actors either utilize a script or engage in spontaneous role-play. Drama is effective in helping people see the consequences of actions and understanding other's viewpoint and feelings and can be used to change health attitudes or behaviors.

Educational tracts	Brochures, pamphlets, and other printed material primarily for education - the mainstay of small-scale health education efforts for years. Educational tracts are appropriate with literate audiences motivated to read. The text must fit the reading level and culture of the audience.
Empowerment	The process of people assuming control of their own affairs. A form of community organization in which rank-in-file residents set their own agenda, and develop their own programs and methods.
Experiments/demonstrations	Live display of cause and effect relationships. For example, demonstrating the amount of tar in a cigarette, adding pollutants until it kills a fish or someone saves it – a good exercise to demonstrate the need for social action (use an artificial fish).
Field trips	Visiting service locations, educational displays, or authorities in a health topic being studied. Field trips to services are a good method to rehearse a visit that the learner will have to repeat independently. They can also be used to increase social awareness of a problem and to enhance learning through new presentations of health relationships.
Fliers	Printed material for posting or handing out, usually to announce an event or service, but also to spread news. Appropriate with literate audiences motivated to read. The text must fit the reading level and culture of the audience.
Get-acquainted activities	Social activities designed to help people get to know each other and especially useful in preparation to undertake any form of community organization, social action, or coalition building. Also useful in facilitating social support for people with a common problem.
Guest speakers	Inviting people with the health problem of concern or experts with this topic to address a group. When the speaker has a problem that group members also share, modeling facilitates learning.
Guided group discussions	This is a hybrid between lecture and cooperative learning. Here the facilitator maintains control of the group, but allows the group to have selected discussions. The selection is used to reinforce desired concepts.
Guided imagery	A process whereby a facilitator asks participants to close their eyes and then takes them on an imaginary trip or asks them to focus on certain (often biologic) activities. For example, guided imagery can be used to reduce stress or pain, heighten awareness, increase self-efficacy or enhance self-image. The technique is useful for developing skills and thought for later use.
Health games/competitions	Games or competitions in which the objective is to increase learning or facilitate behavior change. These activities work among people that respond to social pressure or rewards. Examples include: game-show type knowledge competitions, sport simulations, relays for exercise, weight loss and smoke-out competitions.
Incentives	Offering rewards or reduced costs in exchange for a specific action often within a specific time. One of the tools of behavior modification.
Lay health workers	Members of a target population that receive training on specific health issues or medical interventions and then disseminate these messages and treatments throughout their community.
Lectures	Detailed discussion of a topic by an expert. To be effective, the speaker must be credible, organize thoughts well, and communicate key points confidently in a short amount of time without distracting habits or over reliance on notes. As learners are passive, this method has severe limits if used alone.
Mass media ads and stories	Health information and human-interest stories related to health can often be distributed through newspapers, magazines, radio, and television. The message must be designed to fit the particular needs of the media and its target audience and should supply contacts for more information.
Models	Facsimiles of the human body such as CPR mannequins, anatomical models, and models of body parts for self-exam can be used to facilitate learning through physical interaction with representations of the object of study.
Musical performances	Music can be used to carry health messages in the lyrics and to attract attention to displays or groups with health messages. The music must “fit” the target audience and not overpower the message.

Newsletters	Mailing health information to people can be used to deliver information, reinforce concepts previously presented, and encourage health actions. Because newsletters are fairly inexpensive, several different versions can often be created, each with a message addressed to a different sub-population.
Organizational development	Helping an organization mature to more effectively meet internal and external demands may be an appropriate method if a health problem is caused by an organizational deficiency. This intervention usually requires experts external to the organization who are skilled in organizational analysis, management, conflict resolution, communication, and problem solving.
Organizational negotiating	The process of trying to get what you want from another organization. Training in the variety of approaches that can be used in dealing with other organizations often helps community organizations concerned with health get what they want.
Panels	A selection of experts or people otherwise experienced with a topic answering questions from the press or public. Panels are useful in helping people compare different solutions to a problem.
Peer education	Individuals or groups who have experienced or solved a problem and who report their experiences to others like them. This approach works well in groups that may be resistant to change from outsiders and may also be effective in building competencies.
Personal communication	Face-to-face dialogue, telephone calls, emails, and other direct communications to people at risk or to those that affect those at risk may be used to change attitudes about a health issue and induce action.
Problem-solving	Trying to form an action plan in regards to a problem with a person or group. This and inquiry learning, formulating and testing one's own hypotheses, can be used to address health problems. This activity is central to some forms of empowerment and is helpful when participants need to develop an understanding of a complex problem, often with hidden variables.
Puppets	Inanimate small-scale representations of people engaged in action and dialogue. Puppets are especially useful for younger audiences and can be used to explore sensitive and emotional topics such as violence, sexuality, family conflict, drug use, and social inaction.
Self-appraisals/tests	Assessment of personal habits or feelings, Health Risk Assessments, food intake measures, and evaluations of learning or learning experiences can be used to change attitudes and habits related to health.
Self-help manuals	Step by step printed instructions on how to do things. Self-help manuals can be used to make changes like smoking cessation, weight loss, and depression treatment. Manuals work best for motivated, literate, and independently minded individuals who only need a little help to complete a task.
Social actions	Organized opposition to some policy or action manifest as strikes, demonstrations, petitions, boycotts, pickets, referenda, legal action, lobbying, or organization to elect sympathetic candidates. Social action is useful when increasing social pressure on a particular individual or agency is likely to be effective. Protests must be well planned and coordinated. Participants must have a clear idea of who's in charge, who speaks for the group, what participants can say, what everyone is to do, and for how long.
Values clarification	Identifying and sharing the values behind decisions that have been made. This is useful when the analysis and rediscovery of values is apt to affect health decisions.
Word games/puzzles	Vocabulary puzzles, "Scrabble," and other games can through recall facilitate learning of knowledge and skill steps related to health.