

Module 4

Theories

Introduction

In this module, you will get the opportunity to consider some of the key theories underpinning health promotion to which you were initially introduced in Module 1. Here, you will consider these theories at the individual, community, organizational and public policy levels.

You will be able to examine these issues in the seven sections in this module.

Introduction

Learning Outcomes

Reflective Exercise: Considering Patterns of Change

Content Discussion

- What is a Theory?
- Four Broad Categories of Theories
- Theories Explaining Behaviour Change in Individuals

Reflective Exercise: Consolidating your Learning

- Community Change Theories
- Theories Explaining Change in Organizations
- Development of Healthy Public Policies

Reflective Exercise: Linking Theory to Practice

Readings and Resources

Learning Outcomes

By the end of this module, you will:

- understand the purpose and origins of health promotion theories;
- become familiar with some of the key theories used in health promotion practice;
- be able to identify common features shared by health promotion theories that explain individual and community behaviour; and
- understand how theories are applied to promote health at the individual, community and societal levels.

Reflective Exercise

Considering Patterns of Change

Before you start working through this module, consider the following questions and contribute to your Reflective Journal.

Points to Ponder

In your opinion, what are the key factors encouraging change in individuals and communities? For example, what factors would cause an individual to change his/her diet, or a community to take action on child poverty?

1. Can any of the factors you cited be explained or predicted? In other words, do you think that individuals or communities follow consistent patterns of change?

Content Discussion

What is a Theory?

Let's consider a commonly used definition of theory. A theory is:

“systematically organized knowledge applicable in a relatively wide variety of circumstances devised to analyze, predict or otherwise explain the nature or behaviour of a specified set of phenomena that could be used as the basis for action” (Van Ryn and Heany, 1992).

More simply put, a **theory** is a structured logical explanation, or a way of examining or describing a certain phenomenon, such as the factors promoting or inhibiting health.

How are Theories used in Health Promotion?

Health promoters apply theories to:

- understand the individuals, organizations and communities they work with;
- guide the selection and development of appropriate health promotion strategies; and/or
- explain the factors promoting and inhibiting change at the individual, community and societal levels.

Origins of Health Promotion Theories

Most health promotion theories come from the behavioural and social sciences, borrowing heavily from disciplines such as psychology, sociology, marketing, consumer behaviour, management and political science. Such diversity reflects the fact that health promotion practice is not only concerned with individual health behaviours, but also with the organization of society and the role of policy, organizational and community structures in promoting health.

It's also important for you to remember that most health promotion theories were developed by social scientists in the United States. As such, they reflect predominantly

western (American) values and assumptions and do not account for the diverse range of perspectives influencing the way health is perceived by different cultures around the world.

Most of the theories used in health promotion are not highly developed, nor have they been extensively tested. For these reasons, they may be more accurately referred to as theoretical frameworks or models (Nutbeam, 1998).

Note to Learners: As you read through this module, bear in mind that we have been selective in the theories presented here. There is a large literature on other approaches. For an alternative look, see the Communication Initiative website, which is steeped in critical theories, theories of social change, development communication etc. <http://www.comminit.com/>

Four Broad Categories of Theories

This module presents **four broad categories** of health promotion theories for your consideration:

- theories explaining health behaviour change in individuals
- theories explaining change in communities
- theories explaining change in organizations
- theories explaining the development of healthy public policy

Note to Learners: You should note that the theories discussed under each of the four broad categories share a number of common features. As you read through this discussion, think about those features and the practical considerations they may raise in the work you do.

Some Considerations When Reviewing Theories

When considering theories for developing health promotion programs, it's important to remember these next four points.

- There are no 'right' or 'wrong' theories, just different ways of looking at health issues.
- Theories should be viewed as 'guidelines' for understanding change and developing appropriate programs, not 'absolute' rules or laws governing how change takes place.

- Many of the theories discussed in this module are based on very narrow assumptions about individual behaviour change and do not adequately account for the social, economic and environmental determinants shaping an individual's ability to make health choices.
- Theories should never be applied without a thorough understanding of the individuals, groups, organizations and communities you are working with to bring about health promoting changes.

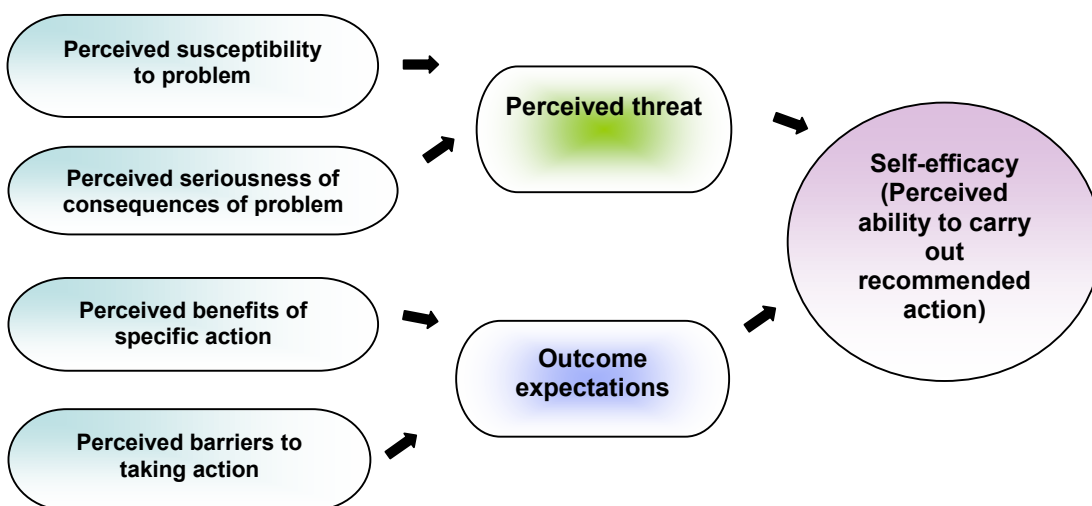
Theories Explaining Behaviour Change in Individuals

The Health Belief Model

The Health Belief Model (see Figure 4.1) is one of the **oldest theories** designed to explain health behaviour; it argues that behaviour can best be understood if beliefs about health are clear. The model predicts that individuals will act to protect or promote their health if they believe that:

- they are **susceptible** to a condition or problem
- the consequences of the condition are **severe**
- the recommended actions to deal with the problem are **beneficial**
- the benefits of taking action outweigh the costs or **barriers**

Figure 4.1: Major Elements of the Health Belief



For example, if the Health Belief Model was applied to prevent the spread of HIV/AIDS, individuals would be more likely to practice safe sex if they believe that:

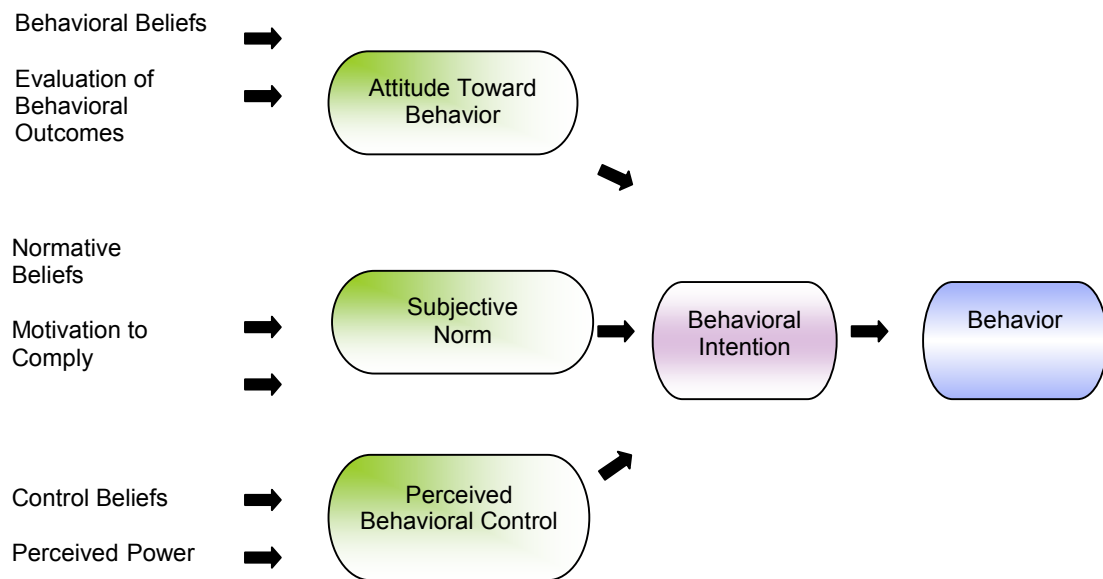
- they are at risk of HIV infection
- the consequences of the infection are serious
- safe sex practices (e.g., condom use) are effective in reducing the risk of infection
- the benefits of safe sex practices outweigh the potential costs and barriers

Theories of Reasoned Action and Planned Behaviour

Like the Health Belief Model, the **theories of reasoned action and planned behaviour** (see 4.2) were developed to explain behaviour change at the individual level.

Bear in mind that these theories are based on the assumption that **intention** to act is the key determinant of behaviour, and that all other factors affecting behaviour are mediated through **behavioural intention**.

Figure 4.2: Major Elements of the Theory of Planned Behavior



Source: Adapted from Nutbeam and Harris, 1998

Figure 4.2 shows how behavioural intentions are thought to be influenced by three factors:

- **attitudes towards behaviours**, which are determined by the belief that a **desired outcome** will occur if a particular behaviour is followed and that the outcome will be beneficial to health (similar to the health belief model); for example, people will be more likely to have a positive attitude towards using sunscreen if they believe it's an effective means of achieving the desired outcome (preventing skin cancer);
- **subjective norms**, which relate to a person's beliefs about what others think she or he should do (**normative beliefs**) and by an individual's motivation to comply with the wishes of others; for example, if a smoker feels that most people do not smoke and that most of his/her friends want them to quit, then it is more likely she/he will develop subjective norms that favour quitting; and
- **perceived behavioural control** recognizes that a person's intentions will become significantly more likely to lead to behaviour if he/she feels greater personal control over a behaviour (a concept closely linked to the notion of **self efficacy** in **social learning theory**); for example, a new mother may be more

likely to breastfeed her baby if she has a higher degree of perceived behavioural control, or confidence, in her ability to breastfeed.

The theories of reasoned action and planned behaviour can be useful in thinking about what information you need to get from individuals before developing a program that meets their health needs. It highlights the importance of understanding a group's beliefs about an issue, whom they see as affecting these beliefs and their behaviour, and what they see as the barriers to taking actions that may promote their health.

The Transtheoretical (Stages of Change) Theory

This theory was developed to explain the different **stages of change** which appear to be most common for the majority of behaviour change processes. Based on the assumptions that behaviour change is an ongoing process, not an event, and that individuals have varying levels of motivation or readiness to change, the theory identifies five stages of change:

- **pre-contemplation (“ignorance is bliss”)**: the stage describing individuals who are not considering changing their behaviours, or are consciously intending not to change;
- **contemplation (“sitting on the fence”)**: the stage at which a person considers making a change to a specific behaviour;
- **preparation (“testing the waters”)**: the stage at which a person makes a serious commitment to change and begins to make the necessary preparations to do so;
- **action (“go for it”)**: the stage at which a change is initiated; and
- **maintenance (“steady as she goes”)**: sustaining the change over time.

People appear to move through these stages in a predictable way, although some move more quickly than others. The theory is circular rather than linear, as people can enter or exit at any point, and it applies equally to individuals who ‘self-initiate’ a change and those responding to advice and encouragement to change.

Stages of Change theory provides a useful way of thinking about the types of persuasion, information and supports people require to move through the change process. Table 4.1 links the stages of change to the related challenges and actions needed to help an individual who wants to lose weight.

Table 4.1: Use of Stages of Change Theory to Promote Weight Reduction

Source: Adapted from Nutbeam and Harris, 1998

Stage of Change	Challenge	Suggested Action
Pre-contemplation	Awareness raising	Provide information on the health risks of being overweight
Contemplation	Recognition of the benefits of change	Provide information on the potential benefits of weight loss
Preparation	Support to overcome barriers to weight loss	Assistance with identification of potential barriers and support for overcoming barriers
Action	Program of change	Work out a plan for weight loss and monitor progress
Maintenance	Follow-up	Organize routine follow-up. Work out a plan to prevent relapse

Social Learning Theory Social learning theory is the most comprehensive theory explaining behaviour change because it addresses both the underlying determinants of health behaviour and methods of promoting change. The theory views change as a product of the interaction between individuals and their environments.

Social learning theory is very complex, and, unlike other theories, such as the Health Belief Model, there is no framework that links the components of the theory together. The key elements of the theory are:

- reciprocal determinism
- observational learning
- expectations

- self-efficacy

Key Elements of Social Learning Theory

Reciprocal determinism – describes the way in which behaviour and the environment continuously interact and influence one another. Understanding this interaction offers an important insight into the ways in which behaviours can be modified through health promotion interventions. For example, modifying social norms about smoking is considered to be one of the most powerful ways of promoting cessation among adults.

Observational learning – is the capacity to learn by observing the behaviour of others. For example, children may be more likely to follow the example of people they admire (role models).

Expectations – are the value an individual places on the outcomes resulting from different behaviours. For example, if you believe that smoking will help you to lose weight and place great value on weight loss, then you may be more likely to take up smoking.

Self-efficacy – is an individual's belief and level of confidence in her/his own ability to successfully make a change or perform a behaviour. Social learning theory identifies self-efficacy as the most important factor for successful change.

Taken as a whole, Social Learning Theory identifies the importance of social norms and cues, environmental influences, and self confidence (self-efficacy) on health behaviour. The theory suggests that health promoters act as 'change agents', facilitating change through modification of the social environment and the development of skills and capacities that enable individuals to make healthy changes.

Note to Learners: For a more detailed explanation of social learning theory, please refer to Readings and Resources listed at the end of this Module.

Common Elements of Individual Change Theories

By now you may have realized that theories explaining individual behaviour change share a number of common elements. One example of a user-friendly framework integrating these theories was developed at a consensus conference of prominent behavioural scientists (Fishbein et al., 1991).

The scientists identified **eight conditions**, one or more of which must be true in order for a person to make a successful health-related behaviour change:

- a strong, positive intention to perform the behaviour
- an absence of environmental barriers preventing the behaviour
- skills to perform the behaviour
- advantages of performing the behaviour outweigh the disadvantages
- social pressure to perform the behaviour
- consistency between the behaviour and a person's self image
- a more positive than negative emotional reaction to performing the behaviour
- perceived self-efficacy (or confidence) to perform the behaviour

To make this framework more practical, Thesenvitz (2000) briefly explained each condition, provided some strategies for meeting each condition, and gave examples illustrating the application of these strategies. Please refer to her article if you are interested in finding out more about this synthesis of individual behaviour theories.

Reflective Exercise

Consolidating your Learning

Before you continuing working through the other three categories of theories discussed in this module, consider the following questions and contribute to your Reflective Journal.

Points to Ponder

1. To date, the theories explaining the change process in individuals have mostly been applied to “lifestyle” issues, such as smoking and diet. Do you see a place for these theories in addressing broader health determinants? Why/why not?
2. As was noted in the previous section, a group of behavioural scientists identified eight conditions, one or more of which must be present for successful behaviour change. Can you think of any conditions that are missing from the list?

Community Change Theories

Three theories are presented: the Diffusion of Innovation, Community Mobilization and a More Recent Framework.

Diffusion of Innovation Theory

Diffusion of innovation theory explains this process and identifies the most effective ways of encouraging people to adopt innovations.

An innovation is a new idea, practice or product (for example, the Internet was an innovation about ten years ago; health-related practices such as jogging were once viewed as innovations). Diffusion is the process by which a new idea, practice or product gains acceptance in a community or throughout society.

Research has consistently shown that people are more likely to adopt innovations, including health-related practices, if they are:

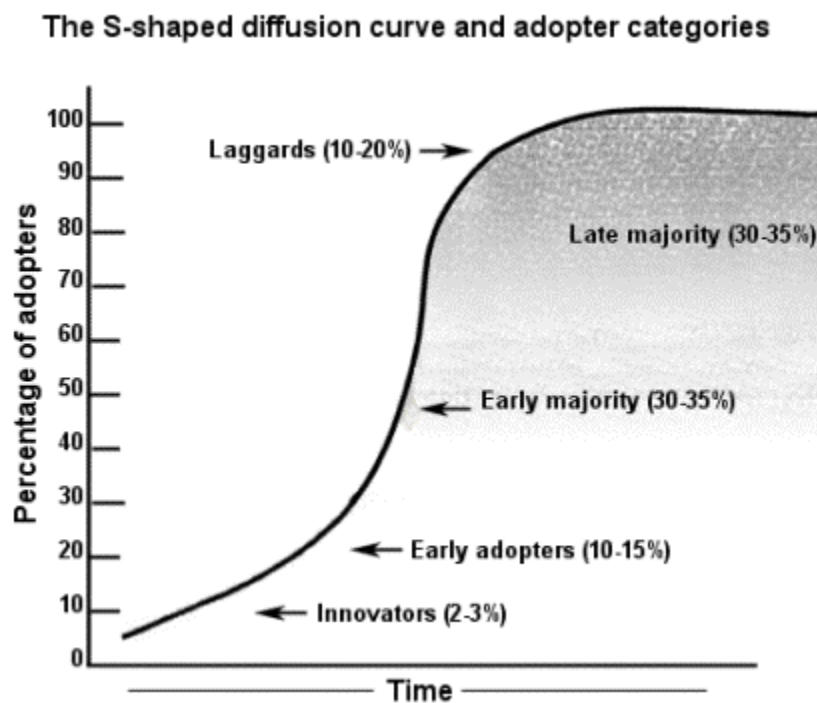
- **compatible** with their needs
- **flexible** enough to be used in a variety of situations
- **reversible** if people want to return to previous practices
- **advantageous** when compared with alternatives
- **simple** enough for people to understand and adopt
- **cost efficient**, with the perceived benefits outweighing the costs

Diffusion of innovation theory divides individuals into **five categories** according to the length of time they take to adopt an innovation:

- innovators (the source of the innovation)
- early adopters (“first on the block”)
- early majority
- late majority
- laggards

As Figure 4.3 illustrates, the adoption of innovations tends to follow an ‘S-shaped’ curve, with a small number of early adopters and a small portion of laggards adopting an innovation after the majority. Early adopters tend to be ‘trend setters’, people who are influential in encouraging others to adopt new practices.

Figure 4.3: The S-shaped Diffusion Curve and Adopter Categories



Source: Adapted from Nutbeam and Harris, 1998

Diffusion of Innovation theory has been tested in a wide variety of settings for many different purposes. The theory provides a helpful diagnostic tool for analyzing how and why populations respond to the introduction of new ideas. It's particularly useful for guiding health promotion interventions which are devoted to maximizing the adoption of ideas and practices which have been proven to be effective.

However, the theory's concept of "laggards" poses a serious limitation.

When promoting change in a community, one needs to be aware of the social, economic and structural barriers that prevent marginalized groups from making healthy choices. An uncritical adoption of the theory may only serve to reinforce structural inequalities that are not due to individual choice.

Community Mobilization: Rothman's Framework

As was noted in Module 1, the active **involvement of community members** in identifying their health priorities and developing appropriate actions to deal with these priorities is a **key feature of health promotion practice**. A number of theoretical frameworks have been developed to describe this process.

Perhaps the most influential framework illustrating the various approaches to community mobilization is **Rothman's Framework**, which describes three distinct approaches to involving communities in health promotion work (Rothman and Tropman, 1987). The three approaches are:

- social planning
- locality development
- social action

Social planning is a task-oriented method stressing rational problem solving, usually by an outside party, to address community concerns. Outside change agents gather facts about community problems and recommend the most appropriate responses.

Locality development is a more process oriented approach that attempts to build a sense of group identity and community. Community workers organize a broad cross-section of people into small, task-oriented groups to identify and resolve shared problems.

Social action, a more confrontational approach, seeks to address imbalances of power between marginalized community groups and dominant segments of the community.

Table 4.2 provides a clearer distinction between these approaches according to key variables.

Table 4.2: Three Models of Community Organization Practice According to Selected Practice Variables

	<i>Model A: Social Planning</i>	<i>Model B: Locality Development</i>	<i>Model C: Social Action</i>
1. Goal categories of community action	Problem solving with regards to substantive community problems (task goals)	Self-help; community capacity and integration (process goals)	Shifting of power relationships and resources; basic institutional change (task and process goals)
2. Assumptions concerning community structure and problem conditions	Substantive social problems; mental and physical health, housing, recreation	Lack of relationships and democratic problem-solving capacities; static traditional community	Disadvantaged populations, social injustice, deprivation, inequity
3. Basic change strategy	Fact gathering about problems and decisions on the most rational course of action	Broad cross-section of people involved in determining and solving their own problems	Crystallization of issues and organization of people to take action against enemy targets
4. Characteristic change tactics	Consensus or conflict	Consensus: communication among community groups and interest; group discussion	Conflict or contest: confrontation, direct action, negotiation
5. Salient practitioner role	Fact gatherer and analyst, program implementor, facilitator	Enabler-catalyst, coordinator; teacher of problem-solving skills and ethical values	Activist advocate: agitator, broker, negotiator, partisan
6. Medium of change	Manipulation of formal organizations and data	Manipulation of small task-oriented groups	Manipulation of mass organizations and political processes
7. Orientation toward power structure(s)	Power structure as employers and sponsors	Members of power structure as collaborators in a common venture	Power structure as external target of action: oppressors to be coerced or overturned
8. Boundary definition of the community client system or constituency	Total community or community segment (including "functional" community)	Total geographic community	Community segment
9. Assumptions regarding interests of the	Interests reconcilable or in conflict	Common interests or reconcilable differences	Conflicting interests which are not easily reconcilable: scarce resources

	Model A: Social Planning	Model B: Locality Development	Model C: Social Action
community subparts			
10. Conception of the client population or constituency	Consumers	Citizens	Victims
11. Conception of client role	Consumers or recipients	Participants in an interactional problem-solving process	Employers, constituents, members

A More Recent Framework

A more recent framework developed for health promoters distinguishes between community-based strategies and community development initiatives (Boutilier, Cleverly and Labonte, 2000):

Community-based strategies link programs and services to community groups. The health issue under consideration, usually related to the prevention of health-related risk factors (e.g., tobacco, physical inactivity), is identified by the sponsoring agency. Interventions are implemented according to defined timelines, and decision-making power rests with the sponsoring organization rather than community participants.

Community development strategies are different from community-based strategies in several respects.

- The problem or issue is defined by the community rather than the sponsoring organization.
- The process of planning the community development initiative is ongoing, based on continued negotiation between organizations and community groups, with the community worker serving as a liaison.
- Community development emphasizes enhanced community capacity, the collective ability of a community to control the factors affecting their health, rather than measurable changes in health-related risk factors, as the desired outcome.

A **key principle** separating **community development** from other approaches to working with communities is that the needs, problems or issues around which a community is organized must be **identified by community members themselves**.

As Minkler and Wallerstein (1997, pp. 30-31) note:

...even though a health education professional may borrow some principles or methods from community organizing to help mount an AIDS organizing effort in the community, he or she cannot be said to be doing community development in the pure sense unless the community itself has defined AIDS as the issue it wants to address.

Note to Learners: For more information about community mobilization/ community development strategies, including actual examples of efforts to mobilize communities around health issues, please refer to Module 5.

Theories Explaining Change in Organizations

A Closer Look at One Model

Most of the theories that health promoters rely on to bring about organizational change come from the field of **management theory and practice**. This literature provides useful clues about how to analyze different organizational settings and **how to plan for change**.

Steckler, Goodman and Kegler (2002) propose a **four stage model** for organizational change that can be applied to health promotion practice.

The theory emphasizes the importance of recognizing the different stages of organizational change, and matching strategies to promote change in each of the stages (similar to Transtheoretical Stages of Change theory)

The four stages are:

- awareness raising
- adoption
- implementation
- institutionalization

Stage 1: Awareness Raising – This stage is intended to raise interest and create support for organizational change at a senior level by clarifying health-related problems in the organizational environment and identifying potential solutions. For example, raising awareness of the problem of school bullying may involve senior bureaucrats and trustees at a school board becoming concerned about the negative impacts of bullying on their students and the potential role in preventing bullying that can be played by the educational system.

Stage 2: Adoption – This stage involves planning for and adopting a policy, program or other innovation addressing the problem described in Stage 1. This stage also involves the identification of resources needed for implementation. Ideally, this stage will involve negotiation and the possible modification of the innovation to make it more compatible with the unique features and culture of an organization. The organizational 'gatekeepers' who are most closely involved in the day-to-day running of an organization are also the most directly involved in this stage. For example, school principals will play a lead role in adopting and implementing an anti-bullying policy at their particular school

Stage 3: Implementation – This stage is concerned with the technical aspects of program delivery, including the provision of training and material support needed for the introduction of change. The capacity building that occurs during this stage is essential

for the successful introduction and maintenance of change in organizations. Those who play a direct role in implementing the solution are most closely involved in this stage. For example, the successful implementation of an anti-bullying policy may require training sessions to increase the capacity of teachers to effectively respond to incidents of bullying.

Stage 4: Institutionalization – This stage is concerned with the long-term maintenance of an innovation. Senior administrators again become the leading players by establishing systems for monitoring and quality control, including the continued investment in resources and training.

This theory of organizational change is particularly helpful for illustrating:

- the ways in which organizations function at different levels;
- how the achievement of organizational change may be achieved through a staged process; and
- how each stage requires the involvement of different levels within an organization.

This theory is most useful in situations where an organization is a potential adopter of a previously developed program or policy. It is not as helpful when an organization is developing in a more holistic way, such as creating supportive environments for employees.

Development of Healthy Public Policies

Growing evidence that social, economic and environmental factors outside the control of individuals have a profound impact on health has resulted in increasing interest in the **development of public policies protecting and promoting health**. For example, housing, income support programs, employment, and environmental protection have a direct impact on the health of individuals and communities.

In recognition of the importance of policy, health promoters have created theoretical frameworks for understanding the development of healthy public policy. One such model, Milio's, is presented.

Note to Learners: For more information about the policy development process, including actual examples of efforts to develop healthy public policies, please refer to Module 5.

Milio's Framework

Nancy Milio, who invented the term “**healthy public policy**”, developed a conceptual framework explaining how effective policies to improve health are developed.

In this framework, policy development passes through distinct stages of initiation, action, implementation, evaluation and re-formulation. These stages are not strictly linear (step-by-step), however, as the development of healthy public policy is seen as a dynamic process, not simply writing a policy statement (Milio, 1987).

The framework identifies four main players who are critical in the development of healthy public policy:

- **policy holders** – politicians and bureaucrats
- **policy influencers** - groups inside and outside of government
- **the public** – audiences, consumers, taxpayers and voters whose opinions will affect the adoption of a policy
- **the media** – that influence both the policy makers' and public's understanding of, and attitude towards, the issue

Although policy often appears to be driven by one or more influential individuals, Milio argues that it is the organization or community that should be the focus of analysis. Within organizations and communities, key stakeholders fall into two specific groups: **policy keepers** who have the mandate for a specific policy, and **policy influencers**,

who have an interest in the issue and may try to influence the speed at which a policy is developed and implemented.

For example, the police may be seen as policy keepers in a community where individuals are advocating for stronger gun regulations. The policy influencers may consist of pro-gun lobbies, public health advocates and concerned community residents.

The theory identifies a number of key determinants influencing policy development. These include:

- the social, economic and political context in which a policy is proposed (**social climate**);
- the identification of parties with the greatest **influence** on policy development;
- the recognition of the **interests** of those wishing to influence policy development (what they will win or lose, where they are willing to compromise); and
- the **capacity** of those wishing to influence policy to achieve their objectives.

Of all the determinants affecting policy development, **the social climate** has the greatest influence. For example, community groups wanting stricter gun control regulations may find that their power to influence change increased as a result of increased gun crimes and gun-related homicides in a community (a changing social climate).

Milio's theory presents a clear picture of the groups who have a role in policy development. At the same time, it highlights the need to view policy development as a dynamic process that can be influenced at many stages by those with an interest in the policy, as well as changes to the social climate in which the policy makers are operating. How this social climate is shaped will depend on how the media report, or fail to report, the issue affected by policy.

Reflective Exercise

Linking Theory to Practice

Think about your learning, consider these questions and compare your thoughts now with those you described in your Journal when you completed the Reflective Exercise at the beginning of this module.

Think of a time when you tried to create change around a health-related issue. This could involve persuading a friend or family member to adopt a healthy behaviour (e.g., quit smoking), getting your organization or workplace to take action on a health related issue (e.g., institute a family-friendly flex time policy), or advocating for a health-related change in your community (e.g., clean up an environmental hazard).

Points to Ponder

1. Based on your experience, how was your change strategy similar to the theories discussed in this module? How did it differ from the theories?
2. If you were successful in bringing about the change, what seemed to work? Can you link your success to any of the theories presented in this module?
3. What, if anything, would you have done differently? Which of the theories presented in this module could have helped you to bring about your desired change?

Readings and Resources

You can find out more about health promotion theories by accessing these **online resources**.

Telford, L. "Why should health promoters be theoretical?" **Ontario Health Promotion Email Bulletin 150.1**, March 31, 2000. <http://www.ohpe.ca>

Thesenvitz, J. "Changing behaviours: a practical framework." **Ontario Health Promotion Email Bulletin 180.1**, October 27, 2000. <http://www.ohpe.ca> or direct to article at

<http://www.ohpe.ca/ebulletin/FullFeature.cfm?ID=180&ROWNUMBER=111>

<http://www.comminit.com/social-change.html>

For those of you who may want more information on health promotion theories, these **print resources** may be of interest. If they are not available in your local library, consider requesting them through Inter Library Loan.

Boutlier, M., Cleverly, S., and Labonte, R. "Community as a setting for health promotion." In B.D. Poland, L.W. Green and I. Rootman (Eds.) **Settings for Health Promotion: Linking Theory and Practice**. Thousand Oaks, California: Sage Publications, 250-307, 2000.

Fishbein, M. et al. **Factors influencing Behavior and Behavior Change**. Final report prepared for NIMH theorists workshop, Washington D.C.

Glanz, K., Rimer, B.K., and Lewis, F.M. (Eds.) **Health Behavior and Health Education: Theory, Research and Practice** (3rd Edition). San Francisco: Jossey Bass, 2002.

Milio, N. "Making healthy public policy - developing the science by learning the art: an ecological framework for policy studies." **Health Promotion 2** (3), 263-274, 1987.

Minkler, M., and Wallerstein, N. "Improving health through community organization and community building: a health education perspective." In M. Minkler (Ed.). **Community Organizing and Community Building for Health**. New Brunswick, New Jersey: Rutgers University Press, 30-52, 1997.

Nutbeam, D., and Harris, E. **Theory in a Nutshell: A Practitioner's Guide to Commonly Used Theories and Models in Health Promotion**. Sydney, Australia: National Centre for Health Promotion, 1998.

Rothman, J., and Tropman, J.E. "Models of community organization and macro practice: their mixing and phasing." In F.M. Cox et al. (Eds). **Strategies of Community Organization (4th Edition)**. Itasca, Illinois: Peacock, 1987.

Steckler, A., Goodman, R., and Kegler, M.C. "Mobilizing organizations for health enhancement: theories of organizational change." In K. Glanz, B.K. Rimer and F.M. Lewis (Eds). **Health Behavior and Health Education: Theory, Research and Practice (3rd Edition)**. San Francisco: Jossey-Bass, 335-360, 2002.

Van Ryn, M., and Heaney, C.A. "What's the use of theory." **Health Education Quarterly** **19** (3), 315-330, 1992.