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Settings for Health Promotion: An Analytic Framework to Guide Intervention Design and Implementation

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Taking a settings approach to health promotion means addressing the contexts within which people live, work, and play and making these the object of inquiry and intervention as well as the needs and capacities of people to be found in different settings. This approach can increase the likelihood of success because it offers opportunities to situate practice in its context. Members of the setting can optimize interventions for specific contextual contingencies, target crucial factors in the organizational context influencing behavior, and render settings themselves more health promoting. A number of attempts have been made to systematize evidence regarding the effectiveness of interventions in different types of settings (e.g., school-based health promotion, community development). Few, if any, attempts have been made to systematically develop a template or framework for analyzing those features of settings that should influence intervention design and delivery. This article lays out the core elements of such a framework in the form of a nested series of questions to guide analysis. Furthermore, it offers advice on additional considerations that should be taken into account when operationalizing a settings approach in the field.

Keywords: *settings; analysis framework; health promotion; school health*

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INTRODUCTION: PUTTING CONTEXT AND CAPACITY BACK INTO BEST PRACTICES

Health promotion is increasingly cast as requiring the identification of best practices through careful and rigorous empirical evaluative research and applying these as faithfully as possible in practice (deviating as little as possible from what works according to the evidence). Practitioners might be forgiven for feeling that at times what is implied is both the possibility and the desirability of one-size-fits-all interventions and that the significance of place has become all but irrelevant. Yet thoughtful and engaged practitioners everywhere know this logic to be flawed. Interventions wither or thrive based on complex interactions between key personalities, circumstances, and coincidences. These include, but are not limited to, timely funding opportunities, changes in leadership, ideas whose time is right, organizational constraints, available resources, and local history of management–labor relations. In other words, no two settings are alike. Ergo, at a minimum, allowances must be made for the uniqueness of settings across time and space.

A settings approach to health promotion has been widely advocated as offering opportunities to situate

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practice in its social context, optimize interventions for specific contextual contingencies, target crucial factors in the organizational context influencing behavior, and render settings themselves more health enhancing (Baric, 1993; Frohlich & Poland, 2007; Poland, Green, & Rootman, 2000; St. Leger, 1997; Whitelaw et al., 2001). A settings approach to health promotion is an orientation to practice that organizes it in relation to the environments in which people live, work, and play. Inspired in part by the work of Aaron Antonovsky on salutogenesis (1996; Kickbusch, 1996; Poland, 2008), as well as ecological approaches (Hancock, 1985; McLeroy, Bibeau, Streckler, & Glanz, 1988; Richard, Potvin, Kischuk, Prlic, & Green, 1996), a settings approach views the physical, organizational, and social contexts in which people are found as the objects of inquiry and intervention, and not just the people contained in or defined by that setting. Its emergence stems in part from the recognition that arguably, the bulk of health promotion practice has been oriented to such settings (schools, workplaces, communities) and seeks to increase the sophistication with which knowledge about settings is mobilized in the planning, implementation, and evaluation of health promotion interventions (see also Wenzel, 1997). Widely promulgated by the World Health Organization (WHO), health-promoting networks and groups of researchers and practitioners have formed around schools (Deschenes, Martin, & Hill, 2003; Lister-Sharp, Chapman, Stewart-Brown, & Sowden, 1999; St. Leger, 2001; Stewart-Brown, 2006; WHO Expert Committee on Comprehensive School Health Education and Promotion, 1997), universities (Dooris, 2001), workplaces (Chu et al., 2000; Polanyi, Frank, Shannon, Sullivan, & Lavis, 2000; WHO, 1999), hospitals (Johnson & Baum, 2001; Pelikan & Lobnig, 1997; Wise & Nutbeam, 2007), cities and communities (Ashton, 1992; Davies & Kelly, 1993; Duhl, 1986; Goumans & Springett, 1997; Hancock, 1987, 1988; Tsouros, 1995; WHO, 1992), prisons (Gatherer, Moller, & Hayton, 2005), and islands (Galea, 2000).

Through a careful analysis of the intervention setting (be it the home, community, school, or workplace), practitioners can forestall the possibility that a crucial oversight could wash their project up, stall progress, or make them seem naive and out of touch with local reality. This usually involves more than simply tweaking a standard intervention protocol to make it fit in a particular setting. To optimize the likelihood of success (buy-in, organizational and personal change, etc.), careful stock must be taken of the local place-specific context of intervention. A detailed analysis of the setting (who is there; how they think or operate; implicit social norms; hierarchies of power; accountability mechanisms; local moral, political, and organizational culture; physical and psychosocial environment; broader sociopolitical and economic context, etc.) can help practitioners skillfully anticipate and navigate potentially murky waters filled with hidden obstacles. We wish to underscore that we do not advocate throwing the baby out with the bath water; rather than being dismissive of the intent behind, or thrust of, the movement toward best practice or evidence-based practice, we seek a modest but, in our view, essential reframing that acknowledges the importance of learning from the experiences of others (through many forms of both rigorous and anecdotal evidence) and also the importance of assessing and comparing the circumstances and contexts in which outcomes were achieved elsewhere with those pertaining to the setting in which an intervention is being proposed (or what is called assessing *transferability* in case study research). A settings approach is envisaged not as a substitute for evidence-based best practice but rather as an essential component thereof (Poland, Lehoux, Holmes, & Andrews, 2005).

A number of attempts have been made to systematize evidence regarding the effectiveness of interventions in different types of settings (e.g., school-based health promotion, community development). A few have recommended frameworks for conceptualizing and organizing practice (e.g., Lee, Cheng, & St. Leger, 2005; Paton, Sengupta, & Hassan, 2005; Whitelaw et al., 2001). However few, if any, attempts have been made to systematically unpack those aspects of settings that matter most to an understanding of the variability of health promotion practice, as well as to the experiences of intervention participants, in a way that could directly impact policy, practice, and research. The need to revisit our basic starting points in assessing health promotion effectiveness has been underlined in recent reviews of school health promotion

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research (Deschenes et al., 2003; Macdonald et al., 1996; McCall, 2004; Rowling & Jeffreys, 2006) that have called for new ways to understand the comprehensive approaches and coordinated programs being delivered in complex environments.

Furthermore, policy makers and researchers (Scheirer, 2005; St. Leger, 2005; Stokols, 1996) are now calling for new ecological forms of analysis that can explain how multiple, coordinated programs can be sustained after external funding or expert technical support is reduced or withdrawn. Calls for capacity building in health promotion (Best et al., 2003; McLeroy, 2006; O'Loughlin, Renauld, Richalrd, Gomez, & Paradis, 1998) are echoed by new approaches centered on continuous improvement in education (Fullan, 2001; Galbraith, 2004; Reilly, 1999; Sanders et al., 2004; Senge, 1990; Zmuda, Kukils, & Kline, 2004).

The deficiencies of this controlled, linear thinking approach is illustrated by one of the largest intervention studies ever completed on coordinated approaches to school health promotion. The Child and Adolescent Trial for Cardiovascular Health (CATCH) was the largest school-based field trial ever sponsored by the National Institutes of Health in the United States. The CATCH coordinated set of interventions included (a) classroom instruction guided by a specific curriculum supplement, (b) family component, (c) physical education curriculum supplement, (d) a food service component (Eat Smart), and (e) a smoke-free school policy. Results from the main trial showed that children from CATCH schools had lower consumption of fat and higher levels of self-reported physical activity. Retrospective analysis of the CATCH study (Heath & Coleman, 2003) showed that institutionalization had occurred after a few years. Perry et al. (1997) also found strong correlations between the positive health outcomes achieved and effective implementation. Participation, dose, fidelity, and compatibility in the implementation of food service and physical activity programs in 56 schools in four states were measured and found to be correlated with successful program effects. Hoelscher et al. (2004) reported on the maintenance of the CATCH coordinated program. This study compared 56 former CATCH and 40 former control schools as well as 12 new schools defined as the unexposed control group and found no significant posttrial differences in school menus or in time assigned to physical education. At follow-up, about one third of the original CATCH and control schools were still using the CATCH materials. Furthermore, as with many other successful programs, the foundation that had been supporting the CATCH program in its home state of Texas has now decided to end that funding.

There is something significant about the CATCH interventions that we need to take into account if we are to sustain such programs. The school setting is simply unable to sustain high-profile programs like CATCH without changing many of the practices within that setting. And it is not as simple as telling teachers what to teach and how to teach it. The framework presented in this article provides a way of starting that process.

In this article, we lay out the core elements of a template or framework that could be used by practitioners to systematically analyze those features of settings that can have the strongest impact on intervention design and delivery. We present this in the form of a nested series of questions to guide analysis. We have used one of the settings most often studied in the research, the school, to illustrate aspects of the framework. Furthermore, we offer advice on additional factors that should be taken into account when operationalizing a settings approach in the field.

The impetus for evolving the framework and writing this article arose from the authors' experiences in developing and implementing a graduate-level course titled Settings and Strategies for Health Promotion.[1] We wanted to create a framework for guiding analysis and, eventually, intervention design, implementation, and evaluation. Questions raised in the concluding chapter of Poland et al. (2000) were expanded, organized, and refined over a 2 year period. As we applied them in practice settings, and with graduate health promotion students across Canada (most were practitioners as well), we saw the potential for contribution to the field.

THE FRAMEWORK

The analytic framework we are advancing comprises three parts: (a) understanding settings, (b) changing settings, and (c) knowledge development and knowledge translation. Each of these is discussed below, in the course of which the rationale for this way of organizing the material is clarified.

As noted above, the proposed framework is constructed of a series of questions that practitioners can pose (of themselves and of stakeholders) to better understand the culture, history, and unique context of each intervention setting. Posing questions invites wider participation in the (co)learning process and is less prescriptive than frameworks that more tightly specify what is to be included and how. By framing questions, we acknowledge there are multiple perspectives and answers and that this diversity can be helpful rather than obstructive. For this reason, although the analytic framework that we advance in this article may be used as a rough, quick assessment tool prior to work involving people in a setting, it should ultimately be used *with* the people in the setting themselves. These

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TABLE 1
Understanding Settings

Diversity across and within categories of settings

1. What makes this category of setting (e.g., hospitals) different from (or similar to) other categories of settings (e.g., schools, workplaces)?
2. What diversity can be expected within this category of setting? (e.g., inner city vs. suburban or rural schools; large, corporate vs. small, family-run workplaces, etc.)

Received knowledge

3. What assumptions are usually made about this setting? Are these assumptions warranted in this case?
4. How has the conceptualization (as well as role and nature) of this setting evolved over time?

Localized determinants of health

5. How does the setting interact with other related settings and systems as well as the local environment to accomplish its goals?
6. What elements of the physical and built environment are causing ill health in this setting? (ergonomics, noxious hazards, physical and social isolation or lack of opportunities for interaction, access to green space, etc.)
7. To what extent do the following aspects of the psychosocial environment have a bearing on health and the possibilities for intervention in this setting?
   - social composition with respect to age, gender, race, and class
   - stress, decision latitude, control over pace, and demands of work
   - status hierarchies
   - work–life balance
   - behavioral norms and expectations (social sanctions)
   - quality of human relations (trust, reciprocity, local social capital and social cohesion, bullying)
   - lines of accountability and reporting structures
   - organizational culture and readiness for change
   - internal politics, recent history of accommodation, or prior conflict

Stakeholders and interests

8. Who are the primary stakeholders in this setting or affecting this setting?
9. What are their agendas, their stake in change or the status quo, access to resources?
10. What are the functions of this setting for different stakeholders (e.g., hospital functions as site of healing for patients, home for long-term or palliative care patients, workplace for staff, site of professional and class conflict)
11. Who is absent from this setting? Why?
12. What is the meaning of health from different stakeholder perspectives and its salience to them?
13. How widely are the determinants of health as they are experienced in this setting understood and acted on?

Power, influence, and social change

14. How do power relations come into play in this setting?
15. What is the relative power of stakeholders? How is power exerted?
16. Who controls access to this setting?
17. Who sets the agenda in this setting?
18. Who participates in decision making? On what basis? On whose conditions?
19. Who has voice? What is the relative role and power of experts and of the lay public in agenda setting, problem definition, intervention planning, implementation, and evaluation?
20. What—or who—drives (or blocks) change in this setting?

questions can be used to build capacity for analysis as well as a way of opening discussion.

Understanding Settings

The first component of our framework comprises 19 questions organized under five subheadings, each designed to highlight and focus attention on a different aspect of a setting that we maintain requires consideration in program planning and implementation (see Table 1). The questions on understanding settings are grouped according to the issues and dimensions they address, as follows: (a) differences and similarities across types of settings, (b) unpacking assumptions, (c) identifying

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localized determinants of health, (d) mapping stakeholder interests, and (e) addressing power relations.

Differences and similarities across types of settings. The analysis of settings can be enhanced by first of all considering certain types (categories) of settings and what they have in common. For example, what distinguishes schools from hospitals or other settings? There are enduring features of types of settings (e.g., schools) by virtue of their standardized structure, position in an institutional field or system, systematized routines, social role, legal standing, etc. Understanding these enduring features helps practitioners to initially orient to a setting as a form of a broader type.

From this understanding of common features, practitioners must appreciate the diversity that lies behind the apparent homogeneity. For example, not all schools are alike. Even those within a publicly funded system operate in different neighborhood environments, have different racial and social-class mixes of students and teachers, evolve from different local histories, and experience different levels of parental involvement. Principals lead with different styles, staff members have different skills and sensitivities, and parent organizations vary in effectiveness and influence. Schools have different physical attributes (size, access to public transport, etc.) that influence access, and so on. As well, those working in schools will find considerable divergence about methods, even about basic issues such as how to teach reading. Some professional environments, such as schools, may discourage peer learning by allocating little time for staff exchanges and joint planning or may have professional norms that see collegial exchanges as being contrived (Tuohy & Coghlan, 1997).

Unpacking assumptions. Explicit and tacit assumptions are usually made about the setting, both by insiders and by outsiders. It is important to articulate these and to consider their validity and appropriateness or helpfulness. It is also instructive to consider how the setting is conceptualized by members and how that may change over time. These can influence possibilities for intervention and have implications for process.

For example, there is often a tacit assumption that schooling is something that is done *to* or *for* students but not necessarily *with* them. And although there is considerable attention now being paid to the social environment of schools, with evidence now accumulating in mental health studies that show health and academic benefits derived from a caring school environment, this can lead to simplistic calls for teachers to be more caring. At the same time, however, schools are expected to sort and stream young people into future careers, allocating distinction and in many cases reinforcing life changes based on class, gender, and race (Gatto, 1992; Illich, 1971). In essence, schools are supposed to fail about 10% to 15% of their students each year. There is pressure on schools to perform in this respect, with standardized tests and school rankings. And when people are not successful in a given environment, they tend to withdraw or act out within that environment. This detracts from another important function that schools are expected to play, the socialization of young people as team players.

Lately, assumptions regarding the nature of organizational development, the nature and role of leadership, and the management of change have been turned upside down by complexity science and its application to social systems (e.g., Holling, 2001), organizational change management in the health (Begun, Zimmerman, & Dooley, 2003; Plsek & Wilson, 2001; Zimmerman, Lindberg, & Plsek, 2001) and other sectors, with implications for the settings approach (Dooris et al., 2007) and the broader community and social change efforts (Westley, Zimmerman, & Patton, 2006).

When such assumptions are made explicit, stakeholders both within and outside the setting have the opportunity to question its wisdom or to distance themselves from it. This can create new openings for more participatory approaches or at least a better understanding of the constraints within that setting.

Localized determinants of health. Elements of the physical, built, and psychosocial environments often constitute risk conditions that can have a profound impact on health. Assessing these may clarify potential targets for intervention, limits on what interventions may be possible, and any need to go beyond the boundaries of the setting to effect change. Questions 6 and 7 in Table 1 provide examples of elements to examine in the local environment.

The interactions between the school setting and its external environments (families or parents being served, neighborhood, school board, other agencies, government ministries, etc.) have been described by several researchers. Flay (2002) suggests that the school setting is almost inseparable from the community and families it serves. Cook, Herman, Phillips, and Settersten (2002) assessed some of the ways in which neighborhoods, families, friendship groups, and schools jointly effect changes in early adolescent development.

On the other hand, others (Ozer, 2006) have suggested that the school has little long-term autonomy from the prevailing social norms and economic constraints of its local context and community. Schools serving aboriginal, disadvantaged, rural, and religious will face different constraints when they implement school health programs, Ozer (2006) argues.

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Stakeholder interests and power relations. A detailed analysis of the stakeholders and vested interests in the setting is essential. This mapping of the sociopolitical landscape helps determine who to work with and how to work with them, insofar as one is able to identify stakeholders who may be expected to support, resist, or remain neutral to the proposed intervention. This, combined with an assessment of the relative power of these resistors and supporters—who controls access, who sets the agenda, who has a voice, who participates in decision making (and on whose terms), and who drives (or blocks) change in this setting?—allows the practitioner to be strategic in how she or he works within what are often complex and politically charged social environments.

Schools have been described by many as open, loosely coupled, and bureaucratic systems (Fusarelli, 2002; Griffith, 2003; Lam, 2004; Weijck, 1982). These characteristics have a bearing on how decisions are made within school systems. For example, in open, bureaucratic systems, the role of the middle manager will often be focused on maintaining boundaries within and external to the system. Some studies have examined the perceptions of school principals with regard to various health issues but few studies have examined how the role of the principal in school health promotion can be successfully influenced.

In our experience, a common question that is raised at this point is, Who does this analysis? Our response is that questions need to be addressed with people in the setting. In health promotion practice, participation at a high, "ownership" level is an ideal that is not always attainable. But in most cases it is a worthy goal. Our experience is that stakeholder analysis of the setting may be facilitated at several points during the process and that it deepens as capacity for analysis increases and as the process reveals previously hidden dynamics. This also reflects a commitment to "starting where the people are" while also building capacity for deepening the social analysis (we take up this issue later in this article).

Changing Settings

We have organized the design questions in Table 2 into six groupings: context, capacity, focus, engagement, strategy, and evaluation. The order corresponds roughly to the sequence in which these issues arise in practice, although there is an element of recursivity that also needs to be acknowledged.

Context. One is asked to consider the history of health promotion efforts in the category of setting, then the specific setting. What efforts have been aimed at changing behaviors within this kind of setting or changing the setting itself? How have approaches changed over time, and how might we explain these changes?

For example, school health promotion has evolved from medically driven, curriculum-focused exhortations to teachers to teach facts about single health issues. Subsequently, more comprehensive approaches (linking different clusters of health problems and factors), and then coordinated programs (across several systems and at different levels within those systems), have given way most recently to whole-school approaches that emphasize multiple policy, educational, service, and environmental interventions. Funding for research and policy making has not always kept up with these new understandings.

In addition to the prior analysis of the setting (Table 1), we ask what the health promoter brings to this particular setting—the skills, capacities, resources, and sensitivities of relevance. This includes similarities or differences with key stakeholder groups (e.g., race, class, gender, physical ability, sexual orientation) that may act as points of friction or affinity. An analysis of the context for change efforts must also grapple with what supports must be in place (or barriers removed) outside the setting in the broader sociopolitical, community, and/or economic context. This may necessitate work in advocacy, coalition building, strategic partnerships, or deepening and widening community participation, including vital work across settings—what is currently referred to as "joined up" settings work (Dooris, 2004).

Capacity. The capacity of the setting for change should be considered as well. Dimensions of community, professional, agency, government, and overall system capacity have been identified in studies such as those connected with the Canadian Heart Health Strategy (Elliot, Taylor, Cameron, & Schabas, 1998). For schools, the WHO (2003) has identified several relevant capacities, and these have been adapted and used here in Canada by the School Health Research Network (McCall, 2004). These capacities include

- coordinated policies across several systems that influence the setting;
- infrastructure and assigned staffing to support coordination of multiple programs;
- formal and informal mechanisms for cooperation across systems and professions;
- ongoing workforce development;
- ongoing knowledge exchange, transfer, and development;

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TABLE 2
Changing Settings

Context
1. What is the history of health promotion in this setting?
2. What explains the changing approaches to this setting?
3. What does the health promoter bring to this work? (background, training, skills and abilities, sensitivities, assumptions; also similarities or differences in terms of race, class, and gender with respect to key stakeholder groups and the impacts this may have on practice)
4. What is the role of the broader sociopolitical context in supporting or limiting change efforts? Is there a need for higher level policy change and advocacy work across settings and locales?

Capacity
5. What capacities are required among professionals for this setting to promote health effectively?
6. What capacities are required within local communities to make this setting effective?
7. What capacities are required among local agencies for this setting to be effective?
8. What capacities are required among governments for this setting to be effective in promoting health?

Focus
9. How should one select which setting to work in?
10. What emphasis should be given to physical health, as distinct from (but clearly related to) emotional, mental, and spiritual dimensions of health?
11. Should one direct interventions to those with power and privilege or to those who are relatively less advantaged?

Engagement
12. What are the issues involved in engaging in this setting? (negotiating and gaining entry, developing trust, managing relationships and competing agendas, etc.)
13. How will you successfully manage (sometimes competing or unrealistic) expectations regarding intervention in this setting?

Strategy
14. What emphasis is put on changing individual behavior as opposed to structural and organizational change? (changing persons in the setting and/or changing the setting itself to become more health promoting)
15. How should one work with broader and indirect stakeholders outside the setting of focus? (e.g., role of families in shaping the behavior of school-yard bullies)
16. How participatory an approach are you willing to undertake? Whose participation will be sought, and how will differences in agendas and power of different stakeholders be handled?
17. What (types and nature of) evidence is drawn on in intervention design? How is local experience and local input blended with evidence-based practice to produce optimal interventions?

Evaluation
18. How do we (and other stakeholders) define and measure the success of a health promotion intervention in this setting?
19. What unintended consequences (positive and negative) can be identified?
20. What is known about the distribution of costs and benefits associated with this intervention in this setting? (equity and social justice considerations)

- regular monitoring and reporting on progress;
- explicit procedures to identify emerging issues and trends and priorities; and
- explicit plans for sustainability.

Focus. To focus the intervention, we have included questions that address the basis on which practitioners, in consultation with others, select (a) the setting, (b) the issues, and (c) the priority population. Issue selection is a key step in health promotion and development with communities and an opportunity to put the process in the hands of those in the setting. However, we recognize that because of the context, it may take some time to realize the goal of internal direction. The question of whether to work with or around power (see above) is a key issue to be addressed, although it is not always made an explicit choice.

Engagement. This phase of the work involves strategic choices. One may negotiate entry in a variety of ways,

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TABLE 3
Knowledge Development and Knowledge Translation

1. What do we still need to know about the settings approach? About this setting in particular?
2. What forms of knowledge and information allow one to understand this setting? What counts as legitimate knowledge and who participates in its creation and dissemination?
3. What gaps can be discerned between theory and practice? Are we successfully "walking the talk"?

depending on the context and focus. In a corporate setting, one could, for example work through powerful gatekeepers such as business owners. They may facilitate access but could also try to control the agenda. Alignment with those in power may alienate you from other stakeholders such as unions and shop floor workers. Building trust with multiple stakeholders may require declaring allegiances and demonstrating these through tangible action and taking risks. There will be choices about how to manage relationships, competing agendas, and competing and/or unrealistic expectations associated with the intervention in a particular setting. Some stakeholders may be overly optimistic and others pessimistic about the prospects for change based on prior failures or successes, or see your intervention as a test or answer to other problems in the setting—giving you additional baggage to handle.

Not explicitly specified in our model, but often equally important, is the issue of *dis*engagement. Tentative advance decisions about how to transfer ownership, fulfill promises, and when to withdraw from a setting can be helpful to all involved. Practitioners should also be aware that when interventions do not go well or expectations for change are dashed, they risk being made scapegoats from one or more sides.

Strategy. Issues of strategy take their cue from prior analysis of context, and decisions regarding focus and engagement, and are informed by other questions. For example, what emphasis will be put on individual behavior change versus structural or organizational change, or changing those in the setting versus changing the setting itself? Whitelaw et al. (2001) outline five different types of settings-based health promotion practice: (a) a "passive" model, wherein the setting is seen as a convenient way of targeting traditional health education to a "captive" audience; (b) a more "active" focus on individual behavior change that incorporates some attention to organizational or systemic enablers and barriers; (c) a "vehicle" model that involves tangible projects that target aspects of the setting itself seen to require modification; (d) an "organic" model that also focuses on healthy settings but does so through grassroots participation, community development, and empowerment approaches; and lastly (e) a "comprehensive" model that seeks fundamental and enduring change in setting structure and culture through the use of powerful leaders and policy levers. Our proposed framework invites anguish on this. We promote diverse stakeholder participation and broadening the scope to consider changes needed beyond the setting to catalyze, support, and sustain change within the setting.

We also advocate for reflexivity concerning the nature of evidence that informs intervention design, including the tradeoffs that will be made between scientific evidence (e.g., best practices) and local lay knowledge, experience, and preferences.

Evaluation. Last but not least, change efforts within settings must grapple with how different stakeholders define and measure success in health promotion interventions. Much has been written on the evaluation of health promotion initiatives. It is not our intent to reproduce or wade into that here. However, we recommend two additional considerations at this stage that are less often discussed in the evaluation literature: (a) an examination of unintended consequences (both positive and negative) and (b) the relative distribution of costs and benefits resulting from the intervention across stakeholder groups. This links directly to the ideology of health promotion and attentiveness to issues of equity and social justice as foundational in health promotion practice.

Knowledge Development and Knowledge Translation

The questions in this final component of the framework address the identification of gaps in our knowledge about settings and the settings approach (including how knowledge is built over time) as well as the interface between knowledge (production, dissemination) and practice (Table 3). This latter dimension includes not only knowledge translation as that has been recently understood but also a closer examination of the extent to which we are able to walk the talk in health promotion. Unless health promotion practice is

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empowering, laudable rhetoric remains empty rhetoric. This latter point is not trivial, insofar as health promotion has been accused from several quarters of failing to translate a liberal and enthusiastic use of concepts like empowerment into practices that have a demonstrably empowering impact. This has led some commentators to wonder whether discourses of empowerment and social justice serve to forestall criticism and cover for business-as-usual (Stevenson & Burke, 1992). Ideally these issues would be front and center in any program evaluation. Although much of the evaluation literature seems to miss these issues, there are a few exceptions (e.g., Fetterman, Kaftarian, & Wandersman, 1996; Kahan & Goodstadt, 2001; Poland, 1996). Our strong recommendation would be to pursue the historic ideals of health promotion (e.g., ownership-level participation, empowerment) to create positive, sustainable change.

APPLYING THE FRAMEWORK

Wherever possible, practitioners engage those living in—and having major stakes in—the setting in analyzing their setting. Ideal analyses are collective analyses of a social setting in which the health promotion practitioner, participants, and stakeholders are colearners. Through the process, all should come to see things a bit differently, increase their capacity for analysis, and feel an increased sense of empowerment. Emphasizing this latter point, appropriate forms of practice (e.g., Caplan, 1993) would include an attempt at deepening the social analysis, using approaches similar to the application of Friere's work to health promotion that emphasizes starting where the people are but acting as a catalyst for working with people to move beyond their own taken-for-granted (and sometimes self-defeating) assumptions about themselves, the world, and their place in the world (Minkler & Cox, 1980; Poland, 1992; Wallerstein & Bernstein, 1988; Wallerstein & Sanchez-Merki, 1994).

This is why we also developed, for teaching purposes, a list of corollaries that we believe should underpin health promotion practice. These are grounded in a particular value base that is articulated more fully by Nelson, Poland, Murray, and Maticka-Tyndale (2004). This value base is implicit in our framework and reflected in the mix of questions. We also share these here in our belief that they should be embraced in the process of implementing a settings approach.

1. Account for the temporal patterning of behavior (different seasons of activity, seasonal deadlines, production cycles, business vs. after-hours uses of the space, etc.).
2. Look for unanticipated effects and unintended consequences (both positive and negative).
3. Be reflexive regarding ethics associated with actions, assumptions, and use of power. Begin with one's own (assumptions and actions) and expand to include others.
4. Recognize the impact of race, gender, class, and age differences between oneself and others, and among others.
5. Develop a coherent, but nonlinear, ecological logic model to describe and summarize our understanding of how this intervention addresses the determinants of health in this setting, linking specific intervention strategies to intermediate and longer term outcomes as well as to the stability and ongoing core functions of the setting.
6. Start where the people are, with their own self-understanding and perspectives, but seek to deepen the social analysis of root causes that affect their health, moving from the personal and individual to the organizational, community, and societal contexts.
7. Address how the setting itself can become more health promoting and not just how the intervention influences the people to be found in the setting.
8. Link across and going beyond settings.
   a. identify relevant stakeholders and influences outside the setting.
   b. identify the role of the broader sociopolitical context (and thus limits to change efforts, need for higher level policy change, and advocacy work across settings and locales).

CONCLUSION

A settings approach is an attractive and eminently feasible route to health promotion. An analysis of the setting at an early stage can be helpful in organizing for action and optimizing the likelihood of success. Systematic analysis can create valuable opportunities for empowerment and capacity building with those in the setting as well as those in systems that envelop the setting. In this article we have described a framework of critical questions for the analysis of settings that we developed for teaching purposes and that has benefited from input from practitioners and academic colleagues from across Canada. Its purpose is to assist in the planning, implementation, and analysis of health promotion interventions that incorporate, or take as their point of departure, a settings approach—working on, with, and through the settings in which people live, work, and play. We maintain that a reflexive engagement with issues such as stakeholder interests, power relations, implicit assumptions, and the evidence base

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for interventions (only a few of the issues we raise) will make for more relevant, sustainable, and successful interventions. This framework is currently being adapted for use in Brazil and we look forward to reporting on lessons learned at a future date. Meanwhile, we welcome comments from readers, including suggestions for improvement, stories of application, and identification of practice issues.

NOTE

1. This Web-based course was a collaborative initiative between the University of Toronto (Department of Public Health Sciences) and the University of Alberta (Centre for Health Promotion Studies) involving, at various points, faculty members L. Barrett, A. S. Brooker, I. Kalnins, G. Krupa, B. Poland, and M. Polanyi.

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