PERSPECTIVES

Planning in Dutch health promotion practice: a comprehensive view

JEANETTE LEZWIJN1,2*, ANNEMARIE WAGEMAKERS2, LENNEKE VAANDRAGER2, MARIA KOELEN2 and CEES VAN WOERKUM3

1 GGD Gelre-IJssel (Community Health Service), AGORA Academic Collaborative Centre, PO Box 51, 7300 AB Apeldoorn, The Netherlands, 2 Department of Social Sciences (Health & Society), Wageningen UR, Wageningen, The Netherlands and 3 Department of Social Sciences (Communication and Innovation Studies), Wageningen UR, Wageningen, The Netherlands

*Corresponding author. E-mail: j.lezwijn@ggdgelre-ijssel.nl

SUMMARY

Health promotion has a strong tradition of using planning models based on an a priori set of goals and processes defined by professionals. Those rational models only partly fit with today’s view and practice of health promotion, where programmes can be considered as processes because they are guided by principles such as community participation and intersectoral collaboration. The aim of this paper is to provide a comprehensive view on approaches to planning in health promotion practice. To investigate these, Whittington’s typology has been used. Whittington identifies four approaches to planning, i.e. classical, evolutionary, processual and systemic. In a retrospective multiple case study, we describe actual planning processes used in the development and implementation of a healthy ageing programme in three Dutch municipalities. These processes were described using data gathered by: interviews, participant observation and document analysis, and external auditing. Characteristics of the four planning approaches were used to interpret the data. The results show that, in practice, all forms of planning approaches were used, depending on the degree of complexity and dynamics of the context, the phase of the health promotion programme, and the time available. Our findings suggest that in the emergent practice of health promotion different approaches to planning are used. To make those planning approaches explicit and manageable for practice and science, discussion and reflection between stakeholders are essential.

Key words: planning models; Whittington’s typology; complexity; systemic planning

INTRODUCTION

In health promotion practice, planning models such as the Precede-Proceed model (Green and Kreuter, 2005) and Intervention Mapping (Bartholomew et al., 2006) have a firm place. These models have been developed to guide the professional to identify factors that influence a population’s health status or quality of life, support in designing and evaluating interventions and help to make effective decisions at each phase of the programme. In the planning models, roughly five phases are distinguished: problem definition, goal setting, programme development, programme implementation and evaluation. The focus is mainly on the content of a programme (e.g. a specific topic or lifestyle) and is often formulated in terms of determinants of health and health outcomes or determinants of health-related behaviour (Laverack and Labonte, 2000; Koelen and van den Ban, 2004; Green and Kreuter, 2005;...
Bartholomew et al., 2006; Butterfoss, 2007; Wagemakers et al., 2010a). Health professionals are academically trained to explicitly use planning models when developing, implementing and evaluating health promotion programmes. In funding schemes, detailed planning is one of the quality criteria to assess programmes. The underlying assumption of such models is that health goals and objectives for health promotion activities can be defined in advance and that a health promotion programme needs to be planned in advance.

However, the current definition of health promotion, ‘the process of enabling individuals and communities to increase control over, and to improve their health’ [(WHO, 1986), p. 5], but also the current practice of health promotion, challenges stakeholders (i.e. scientists, health professionals, policy-makers, the local community and the target population) to develop, implement and evaluate health promotion programmes in complex contexts (Koelen and van de Ban, 2004). Together, stakeholders set goals and objectives, and opportunities are addressed in a flexible and tailored way. This means that principles like building and sustaining community participation and intersectoral collaboration, also called coordinated action (Koelen et al., 2008), are core approaches because of the changes they can bring about in both the physical and the social environment of health (WHO, 1986, 2005; Evans et al., 2007; Wagemakers et al., 2010a). Coordinated action processes are often dynamic and complex, because of stakeholders’ different backgrounds, interests, values, perceptions and knowledge (Boutilier et al., 1997; Butterfoss, 2007; Koelen et al., 2008; Naaldenberg et al., 2009). So, in reality health promotion is a process in which a programme gradually develops and is subject to on-going adaptations and changes that can relate to topics, to partners involved—as partners drop out and new ones join—but also to processes to reach the programme goals and objectives.

The problem is that, because of the complex, dynamic and therefore unpredictable circumstances wherein stakeholders participate (Laverack and Labonte, 2000; Van Woerkum et al., 2007; Evans et al., 2007), the frequently used planning models, based on means-end planning (Van Woerkum et al., 2007), do not completely fit. This has not gone unnoticed by the creators of these models, since already several adaptations have been made to their models, especially regarding the context and external influences. Our assumption is that a more comprehensive view on planning in health promotion practice is needed. Such a comprehensive view also includes planning approaches that do more justice to the dynamics and complexities of the context wherein the health promotion programme takes place. Such planning approaches are found in the organizational and management literature. In these sectors, issues have been raised concerning planning and dealing with the unpredictability of markets and environments, and the importance of context and local rules (Mintzberg, 1994; Whittington, 2001; Van Woerkum et al., 2007). Consequently, different approaches to planning have come into existence, fitting these emerging practices.

One example of a frequently used planning typology has been developed by Whittington (Whittington, 2001). This typology is based on processes of what really happens in practice (Mintzberg, 1994) and especially on the dynamic environment of commercial enterprises. Whittington (Whittington, 2001) distinguishes four types of planning approaches: (i) classical, (ii) evolutionary, (iii) processual and (iv) systemic.

The classical approach to planning, which is the oldest approach and often used in health promotion, is a typical top-down approach. It assumes a rational process of deliberate calculation and analysis a priori, designed to reach predefined goals and objectives as set by professionals (Whittington, 2001). Within a classical planning approach, the context is seen as predictable (Whittington, 2001; Boyne et al., 2004; Van Woerkum et al., 2007). In the evolutionary approach to planning, the goals to reach are predefined by professionals (e.g. profit maximization) but not the way to reach these goals. A variety of products, or activities, are developed and offered to beneficiaries. Their reaction is decisive in whether a product is successful and will survive or continue. In the processual approach, goals are formulated and strategies to achieve these goals are gradually, step by step, developed. Professionals may take the lead, but work in close collaboration with a variety of stakeholders. Evaluation of each step provides input to decide upon the next step. The systemic approach is a bottom-up approach, connected to the local context. It assumes a high interdependency between relevant actors...
in a project, with which relationships have to be developed. When a certain degree of collaboration is established, stakeholders together will formulate specific goals and objectives, and ways to reach these goals and objectives (Whittington, 2001; Wink et al., 2007; Van Woerkum et al., 2007). It is characteristic of the three latter planning approaches that at the start of a programme the planning processes are not yet specified. Table 1 explicates the differences between the four planning approaches.

In this retrospective multiple case study, the planning processes with regard to healthy ageing strategies of three Dutch municipalities are analysed according to the four planning approaches in Whittington’s typology. The aim of this paper is to provide an answer to two research questions: (i) What planning approaches are actually used in local health promotion practice? (ii) What factors influence the use of a particular planning approach?

First, we describe the data sources and method of analysis. Next, in the results section, we address the planning processes that have been applied in the three municipalities and interpret them according to the planning approaches derived from Whittington’s typology and discuss some factors influencing the approach adopted. Finally, we reflect upon the implications for health promotion practice and research.

**METHODS**

**Setting**

The research took place in the academic collaborative AGORA, wherein a university and a community health service collaborate with the aim of contributing to the development, implementation and evaluation of programmes to improve healthy ageing in three municipalities. The case studies were conducted in the years 2007, 2008 and 2009.

**Data sources and analysis**

In order to describe the planning processes for the development and implementation of the healthy ageing strategy, three data sources were used in retrospect, namely: interviews, notes from participant observation and documents. For a complete overview of the data used, see Table 2. Triangulation of the data obtained by different research methods contributed to the reliability of the data (Koelen et al., 2001; Cohen and Crabtree, 2008).

Data from 44 semi-structured interviews with professionals (health, welfare, policy) were used to describe the local situation in the three municipalities. The 44 interviews, 36 of which were conducted by the first author, were held during the summer of 2007 and transcribed verbatim. Originally, these interviews were aimed at getting more insight into the processes of coordinated action for healthy ageing in the three municipalities, including building relationships with relevant stakeholders. For the study at hand, a secondary analysis has been carried out on the available data to reconstruct the starting point for a new programme in each of the municipalities.

In addition, throughout the study, participant observation was carried out in each of the municipalities. To gain insight into the planning...
process, field notes were compiled of both formal and informal personal contacts of the first author with local stakeholders, and of local group sessions about healthy ageing. The elements described in the field notes were the Who, What, When, Where, Why and How of actions within the municipality and, when possible, their underlying decisions (Bogdewic, 1992). Examples of elements described in the field notes are: Who is involved? What role do they have? Why are they involved? What happens in that municipality? When does it happen? Where does it happen? Why does it happen? How is the process going?

Finally, documents were collected, i.e. agendas, minutes of meetings and local policy documents on healthy ageing strategies. The documents were critically scrutinized on the same elements as Bogdewic (Bogdewic, 1992) to make local ideas about healthy ageing, actions and (underlying) decisions transparent.

For data analyses, the four planning approaches were operationalized according to the characteristics as described in Table 1. These characteristics were applied alongside the five phases of planning, i.e. problem definition, goal setting, programme development, implementation and evaluation.

The analyses consisted of three steps. First, the first two authors categorized the data into the identified planning phases and in an iterative process added labels according to the characteristics derived from Whittington’s typology. Next, in four sessions of about 1 h each, all the authors discussed, and reflected on, the categorization and coding. These discussions also resulted in the identification of the factors influencing the actual use of planning approaches. Finally, an external audit was carried out to examine the accuracy and interpretation of the description of the planning processes (Cohen and Crabtree, 2008) by three researchers who were not involved in this study but were familiar with the healthy ageing project in the three municipalities.

Table 2: Overview of data collection methods in the three municipalities

<table>
<thead>
<tr>
<th>Methods</th>
<th>Data</th>
</tr>
</thead>
<tbody>
<tr>
<td>Interviews</td>
<td>Transcriptions of 44 semi-structured interviews with aldermen, local policy-makers and representatives of organizations in three municipalities. Of these interviews, 36 were conducted by the first author. Mental health care 4 interviews General practitioners 2 interviews Home care organizations 4 interviews Volunteer organizations 4 interviews Well-being organizations 7 interviews Public housing 5 interviews Care institutions 3 interviews Aldermen 3 interviews Municipal policy-makers 11 interviews</td>
</tr>
<tr>
<td>Participant observation</td>
<td>Field notes of the first author’s formal and informal contacts within three municipalities in 2007, 2008 and 2009</td>
</tr>
<tr>
<td>External auditing</td>
<td>Three researchers from AGORA and the community health service not involved in this specific study, but familiar with the healthy ageing project, reflected on the processes in the three municipalities and read drafts of this paper</td>
</tr>
</tbody>
</table>
RESULTS

The planning approaches are first described for each case separately in five phases, i.e. problem definition, goal setting, programme development, programme implementation and programme evaluation, to show the evolution in local planning processes (see Table 3). Next, factors influencing the use of a particular planning approach are described.

Planning processes in Epe

Epe is a rural municipality surrounded by a forested area and consists of four small villages. Until 2007, an active local network in the field of healthy ageing did not exist. In 2007, the healthy ageing programme was initiated by professionals from the community health service participating in AGORA, together with the regional mental health organization. In line with national policy (Ministerie van VWS, 2006), a pilot programme on loneliness prevention was initiated. On the basis of epidemiological data from a senior inhabitants’ health survey (aged 65 and older) of the community health services (GGD Gelre-IJssel, 2006), the two organizations defined the problem (loneliness) and formulated the goal. The goal was to reduce loneliness among non-institutionalized older people aged 65 years or over by 10% in 2 years, i.e. from a mean score of 2.6 to 2.4 on the De Jong-Gierveld loneliness scale (De Vlaming et al., 2010)—a scale frequently used in the Netherlands (De Jong-Gierveld, 1987). Setting such a specific goal, based on rational epidemiological information, prior to the actual development and implementation of the programme can be categorized as a classical approach to planning. Next, in order to obtain involvement and input for the development of a programme to reduce loneliness, a group session (June 2007; N = 39) was organized with local stakeholders, including homecare, Elderly Welfare, women associates, several churches and representatives of elderly associations. In this session, the problem of loneliness and possibilities to prevent and reduce loneliness were discussed. Organizing such a group session can be categorized as a processual approach to planning as it seeks active interaction with local stakeholders. On the basis of the discussion, a professional from the community health service wrote a programme plan with specific objectives and accompanying activities, which again can be considered a classical approach. The plan entailed a variety of new and existing activities as proposed by the local stakeholders, such as courses for the elderly and for intermediaries, health education activities, newspaper articles, posters and an evaluation plan for each activity. This can be seen as a form of evolutionary planning. Professionals again took the lead in implementing the planned activities, resembling the classical approach.

At the end of 2008, activities such as the publication of articles in local newspapers and the distribution of posters about the programme had been successfully implemented. However, activities requiring the active participation of target groups, such as the training course for intermediaries and courses for the elderly to prevent and reduce loneliness, were not successful. Most of these activities had to be cancelled because of a lack of interest among the target groups. In order to search for new opportunities, the AGORA professionals organized new meetings with the stakeholder group to discuss and decide upon recruitment strategies (Wagemakers et al., 2010b). During the discussion about recruitment, stakeholders indicated that they perceived the goals and objectives of the programme as unclear. In reaction, another discussion session was organized to discuss the goals and objectives of the ‘Healthy ageing programme in Epe’. In terms of planning phases, in fact they returned to the goal setting and programme development phases, but now from a systemic approach to planning. Participants agreed upon a new activity, Neighbors Connected (Lezwijn et al., 2011), which has been developed and successfully implemented in other regions.

To summarize, the programme ‘Healthy ageing in Epe’ at the start resembled a classical approach. Evolutionary, processual and systemic approaches to planning were later on included in the programme to build collaboration with local stakeholders, since they were familiar with the local context. Evaluation on the initial goal, a 10% reduction on the loneliness scale, still stands, and so the planning process in Epe partly retains the classical approach as a guideline (see Table 3).

Planning processes in Berkelland

Berkelland is a large rural municipality formed in 2005 by merging four small municipalities.
A new local council was elected and new aldermen were appointed. The alderman for health and the local council were advised about how to deal with the elderly population in the new municipality by a panel of seniors and former representatives of the former municipalities. As those stakeholders had formerly operated in different municipalities, they did not yet know one another. As a consequence, a vision and policy on healthy ageing had to be developed. The launch of the academic collaborative AGORA was seen as an opportunity to support this.

The professionals of AGORA started by formulating a preliminary working plan with a predefined strategy to improve coordinated action for healthy ageing and discussed this strategy.
with the alderman and local policy-makers; this resembles a *processual* approach to planning. The alderman subsequently supported the organization of two group sessions: a group session for older people (N = 60) and a group session for local organizations in which, in addition to AGORA, the local municipal policy-maker and Elderly Welfare participated (N = 15). In the group sessions, the outcomes of research conducted in the municipality—i.e. the interviews with older people, local organizations and local policy-makers (Naaldenberg et al., 2011; Lezwijn et al., 2011) and in-depth analyses of monitor data (Croezen et al., 2009)—were presented and discussed, using techniques from soft systems thinking, such as mind mapping (Trochim and Kane, 2005) and stakeholder matrixes (Groot, 2002). Issues discussed, such as ‘what is needed to build a nice neighbourhood’ and ‘opportunities to collaborate’, provided input to formulate the problem to work on, the goals to reach and to develop possible healthy ageing strategies, connected to the local context. Hence, the starting point resembles a processual approach; the subsequent process resembles a *systemic approach* to planning. It focused on consciously building relationships and exploring opportunities to collaborate with stakeholders who are relevant for the local context.

As a next step, the AGORA professionals formulated a programme plan for healthy ageing; this resembles a *classical approach* to planning. Unfortunately, before the plan could be further developed into concrete activities, a new alderman, that is, a new powerful stakeholder, was appointed, and he decided to stop all healthy ageing activities abruptly. The AGORA health professionals tried hard to convince the new stakeholder to continue the programme, without success. Those efforts can be categorized as a *processual approach* to planning.

Planning processes in Berkelland mainly resembled a systemic planning approach, wherein local stakeholders actively participated, even in the process of formulating goals. However, as this case study shows, successful continuation and implementation of health promotion programmes are dependent on the political context as well.

**Planning processes in Zutphen**

Zutphen is an urban municipality. Contrary to Epe and Berkelland, Zutphen already had quite an extensive infrastructure wherein local organizations and older inhabitants participated. As there were many formal and informal meetings, coordinated by Elderly Welfare and subsidized by the municipality, stakeholders had a clear view on the different roles and responsibilities of the organizations. Furthermore, the results of formal meetings about specific subjects in the field of living, welfare and care were used as input in policy-making. In fact, the process so far can be categorized as a *systemic approach* to planning.

However, at the time the academic collaborative AGORA was launched, no concrete plans for healthy ageing strategies had been developed. For AGORA, it was quite complicated to become a stakeholder and to gain a role in the existing infrastructure around healthy ageing. By using every opportunity to have active interaction with the local stakeholders, AGORA step by step became a legitimate stakeholder, supported by the municipal policy-maker and Elderly Welfare. This stepwise process resembles a *processual approach*. AGORA participated in two group sessions, one within the existing network (N = 12) and one with other local organizations and older people (N = 27) and facilitated discussion on healthy ageing strategies and on ways to recruit older people for local activities. The group sessions facilitated local organizations and community members to define the problems, goals and objectives of a healthy ageing strategy and to participate in the development of healthy ageing activities; this can be categorized as a *systemic approach* to planning.

In sum, the planning processes in Zutphen initially resembled the systemic approach to planning. A processual approach can be recognized in the coming of AGORA. Gradually, as AGORA was seen as a legitimate stakeholder, a more systemic approach to planning could be identified again (see Table 3).

**Factors influencing the use of a particular planning approach**

The results show that in practice the planning approaches proposed in Whittington’s (Whittington, 2001) typology are used both alternately and simultaneously. The use of different approaches to planning relates to several factors. In this study, we identified three factors: (i) the degree of complexity and dynamics of
the context, (ii) the phase of the health promotion programme and (iii) the time available. These factors are now discussed.

Municipalities are often complex and dynamic contexts, especially when many stakeholders are involved, with different backgrounds, interests and visions. In addition, new stakeholders join the programme whereas others leave, and this may have consequences for the continuation of the programme. The risk of using only the classical approach is that the complexity and dynamics inherent to health promotion practice are not addressed appropriately. As the Epe case shows, after starting with a classical approach wherein goals and objectives are formulated a priori, difficulties arise when the planned activities are being implemented. Discussing reasons for ‘failure’ with stakeholders revealed that the goals and objectives were interpreted differently. In Zutphen and Berkelland, such discussions took place before or during the problem definition phase. Processual, and especially systemic, approaches to planning lend themselves to dealing with the complexity of the context, since they support relationship building and collaboration with relevant stakeholders.

The second factor relates to the phase of the programme. Our case study reveals that using the classical approach in the first phases of a programme (problem definition, goal setting and programme development) leads to difficulties in the implementation phase. For implementation, stakeholder involvement is a prerequisite. To get stakeholders involved, systemic and processual planning approaches are more appropriate. This means that, especially in the first phases, the inclusion of systemic and processual approaches to planning should be common. In the later phases, the use of the classical approach can be helpful for timely implementation and evaluation of activities.

The third factor is the time available for health promotion programmes. In practice, these programmes often have to be carried out over a time span of 2–4 years. At first glance, the classical approach fits in this time span, as defining goals and processes can be rather quickly done by professionals. This leaves time for the later phases—programme development, implementation and evaluation. However, when for example there is insufficient stakeholder participation, discussions about collaboration, shared problems, goals and objectives, and strategies have to take place. This is a time-consuming process. When a systemic approach is used in the first phases of a programme, coordinated action is established before implementation, and there is a greater chance of it fitting the local context. In general, establishing coordinated action may take a long time as many stakeholders have to be involved, have to get to know each other and often several meetings are needed to define problems and goals, and to develop strategies. As can be seen in Table 3, the newly developed healthy ageing strategy did not reach the implementation phase within the time span of this research.

**DISCUSSION**

This retrospective multiple case study indicates that, in health promotion practice, health professionals, consciously or not, use other and mixed approaches to planning in addition to the classical approach. Our findings indicate that factors such as the degree of complexity and dynamics of the context, the phase of the health promotion programme and the time available to develop and implement health promotion programmes determine the planning approach. The more traditional stages heuristic in the classical approach fail to address the dynamics of multiple, interactive and iterative processes of action (deLeon, 1999; Breton and De Leeuw, 2012). In all three municipalities, the processual and systemic approaches were prominent at one or more junctures, in which relationships were built with relevant actors and ideas were exchanged. Most often, this time is not taken into account in advance, either by stakeholders or by funding agencies (Lezwijn, 2011; Koelen et al., 2012). The systemic and processual approaches better fit complexity. We are aware that such approaches are not new. Brachts’ Community Organization Model (Bracht et al., 1999) has similarities with the processual and systemic approaches to planning as participation with community members in all phases of the programme is put centre stage.

The evolutionary approach was hardly found in the three case studies. A possible explanation is that local organizations more and more have to justify their activities and that a trial-and-error approach that is common in business (e.g. every week new products appear in supermarkets and with the same speed products
that do not sell disappear) is less a part of local health promotion culture. Nevertheless, this planning approach might be quite interesting to test further in the practice of health promotion since community members define success and thus play a key role.

There are some methodological issues with our study. First, although not explicitly addressed in this article, the paradigm underlying this study resembles the paradigm of social constructivism. In this paradigm, the social construction of reality is an on-going, dynamic process that is reproduced by people acting on their interpretations and their knowledge of it. It was not until AGORA had been running for a number of years that we realized that we should publish about the planning approaches as we have done in this article.

Second, the choice of Whittington’s typology is quite arbitrary. This typology was developed in the field of organization and management. To our knowledge, in the field of health promotion it has been applied only by Wink et al. (2007). In their study, the typology was used to analyse success factors and points of improvement in a Dutch health campaign to stimulate physical exercise. A third methodological issue is that it was not always easy to classify the planning approaches according to Whittington’s typology, making this classification multi-interpretable. The difference between the classical approach and the other three is quite clear, but the difference between, for example, the processual and the systemic approaches is fuzzier. They both include active interaction with stakeholders. The main difference is that the systemic approach has a clear focus on connection to the local context. An additional difficulty is that all case studies reflect a mix of planning approaches. Nevertheless, Whittington’s planning typology enabled us to identify meaningful processes in practice, thereby answering the question of ‘what happened’ in the municipalities. Our analysis revealed factors relating to the use of planning approaches in the three participating municipalities, thereby answering the question of ‘what explains what happened’.

Nevertheless, health promotion planning needs to evolve even beyond Whittington’s perspectives. One way to further underpin those insights or ‘mechanisms at work’ and make them manageable might be to explore the actor network theory (ANT) (Callon, 1986; Latour, 1996). ANT tries to explain how heterogeneous networks such as stakeholders in local healthy ageing strategies come together to act as a whole. As part of this, it may look at explicit strategies for relating different elements together in a network so that they form an obviously coherent whole.

The use of different approaches to planning has consequences for both practice and research. In practice, health professionals often use the classical approach to planning in programme documents, not least because they are trained to do so and because it is required by funding agencies. Consequently, the focus is often on the content of a programme and not on the processes to get there, such as building and sustaining coordinated action. The consequence is that, later on, other planning processes need to be incorporated into the programme, which often takes extra effort and time. As our cases show, the planning approaches need to be flexible and need room for discussion and reflection. In fact, stakeholders need to discuss and reflect on ‘what is happening’ and ‘why it is happening’—thereby constructing their social reality.

As Whittington (Whittington, 2001) concludes, classical planning has its place, but so too do evolutionary, processual and systemic approaches. The dominant focus on classic planning approaches has consequences for research as well. Since evaluation of health programmes is often based on the classical approach to planning (Wink et al., 2007), the processes and in-between results of coordinated action, as well as the consequences of contextual complexity, are not reported and not made visible. In other words, the classical approach to planning focuses mainly on outcomes and consequently overlooks the processes leading to these outcomes. The use of systemic and processual approaches to planning contributes to insight into these processes, provided that the processes are made explicit and transparent. Action research can contribute to gaining insight into such processes (e.g. Koelen et al., 2001; Nutbeam and Bauman, 2006; Rice and Franceschini, 2007; Wagemakers et al., 2010a). For instance, discussions between stakeholders in local practice and reflection on the process and the content of the programme contribute to evaluation but also to the evolution of the programme. Then, opportunities arise to search for reasons why planning processes in practice
evolve in a certain way. This in turn stimulates co-learning and capacity building among the stakeholders (Israel et al., 2008). Therefore, in health promotion we should stop innovating, but we should apply what we know from other situations.

CONCLUSION

To conclude, in local health promotion practice, different planning approaches are used. The choice of which particular planning approach to use depends on several factors within health promotion practice, such as (i) the degree of complexity and dynamics of the context, (ii) the phase of the health promotion programme and (iii) the time available. A classical approach alone, which is often the planning approach described in project documents, does not fit the complex, dynamic and unpredictable circumstances of health promotion. An evolutionary approach is less common in health promotion practice and might be an interesting planning approach to develop further. Discussion and reflection among local stakeholders are essential to make planning approaches explicit and manageable.

ACKNOWLEDGEMENTS

This study is part of the healthy ageing project of Academic Collaborative Center AGORA. The authors wish to thank all members of AGORA, GGD Gelre-IJssel and the different stakeholders in the municipalities of Epe, Berkelland and Zutphen for giving insight into their work.

FUNDING

This work was supported by The Netherlands Organization for Health Research and Development ZonMW (project number 50-50400-98-008).

REFERENCES


