The PRECEDE-PROCEED Framework

Lawrence Green (1968)

Purpose

Lawrence Green’s process for planning effective health education programs was intended to overcome criticisms of health education as arbitrary, negative ("Don't smoke") and ineffective (1). The combined PRECEDE-PROCEED model of health education was developed over a 20 year period starting in 1968. It systematically guides the development and evaluation of a health education program and re-orients health education from focusing on inputs (what is being taught) to outcomes (the change that is being sought). Those who plan health education should begin from the desired outcome and work backward to identify the factors that precede it, and then proceed systematically to design ways to modify these factors.

Conceptual Basis

Green saw health education as "a process which bridges the gap between health information and health practices. Health education motivates the person to take the information and do something with it - to keep himself healthier by avoiding actions that are harmful and by forming habits that are beneficial." (the President's Committee on Health Education). "Health education is any combination of learning experiences designed to facilitate voluntary adaptations of behavior conducive to health." By comparison, health promotion is broader: “any combination of health education and related organizational, economic, and environmental supports for behavior conducive to health.” (2, p16).

Several basic principles underlie Green’s model:

- Success in achieving change increases where the target audience actively participates in identifying health issues, defining goals and implementing solutions;
- The media, political and social forces are important environmental influences on health behavior;
- Health behavior must be voluntary; and because of wide variation in personal goals and desires, rigid criteria should not be imposed on health behaviors – save for those considered by society as a whole to be unacceptable, such as illicit drug use.
**Description**

PRECEDE is an acronym for “Predisposing, Reinforcing and Enabling factors, and Causes in Educational Diagnosis and Evaluation”. It emphasizes the importance of careful preparation before any intervention program is launched, and comprises a diagnostic approach for deciding what type of intervention is likely to be useful in altering behavior, and then for assessing its likely impact. Premises include: health education requires voluntary cooperation of the client; health behavior is determined personally; the more actively the client participates the more they will learn. The PRECEDE model assumes that the many factors that influence health behaviors should be identified in order to plan an appropriate educational intervention (3). Green identified common fallacies in existing health education thinking:

- The empty vessel fallacy (people have empty minds eagerly waiting to be filled);
- Fallacy of the inherent superiority of some methods (instead, methods should be appropriately applied; there is nothing inherently superior or inferior about any one method);
- Fallacy of the more, the better. In fact what is important is the degree of active involvement of the listener; passive participation is less effective;
- Fallacy of technology as the solution;
- Green suggests that "motivates" is the wrong word: one cannot motivate someone, but rather facilitate their own motivational processes to influence behavior.

There are seven phases in PRECEDE:

**Phase 1.** What quality of life issues concern the people to be served? This is the *social diagnosis*. Here, program planners must collect information on how population members perceive broad issues facing them, including health issues, and what factors they identify as causing these. Several methods may be used: community forums, nominal and focus groups, interviews and surveys, and central location intercept.

**Phase 2.** The second phase provides a more objective determination of specific health problems linked to the quality of life issues in phase 1, including behavioral and environmental determinants. This is the *epidemiological diagnosis*, typically involving vital statistics, disability surveys or other morbidity data. After all the factors are identified, priorities are set among them to guide the intervention program.
Responsibilities are then proposed for who will tackle each issue identified. The priorities inform program objectives that define who does what, the and changes expected in the target population, and by when the benefit should occur. The combination of phases 1 and 2 results in the program objectives, indicating the goals to be achieved.

Phase 3. For each health problem identified, phase 3 identifies health behaviors and other factors in the environment that contribute to the problems, whether or not these are modifiable. This is the behavioral diagnosis. An assessment of how readily modifiable each factor may be contributes to setting priorities, guided by a simple matrix:

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<thead>
<tr>
<th></th>
<th>More important</th>
<th>Less important</th>
</tr>
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<tbody>
<tr>
<td>More modifiable</td>
<td>High priority for intervention</td>
<td>Low priority, unless political</td>
</tr>
<tr>
<td></td>
<td></td>
<td>considerations dictate</td>
</tr>
<tr>
<td>Less modifiable</td>
<td>Innovations required to develop</td>
<td>No program required</td>
</tr>
<tr>
<td></td>
<td>interventions</td>
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Phase 4. This considers the causes of the health behaviors identified in Phase 3: what factors which, if changed, would be most likely to affect the behaviors? As with the Health Belief Model, three classes of influence are considered:

- Predisposing factors (attitudes, beliefs, values, perceptions). These facilitate or hinder motivation for change;
- Enabling factors, which facilitate or oppose the proposed changes (barriers created by society, social support, legislation, skills and knowledge);
- Reinforcing factors include rewards or losses resulting from each health behavior and that may strengthen (or discourage) motivation to alter the behavior: family influences, peer group pressures are examples.

Priorities again reflect importance and modifiability. This forms the educational and organizational diagnosis, from which learning objectives are identified.

Phase 5. This considers administrative and organizational issues to be addressed before an educational program is implemented. What resources are available? What personnel is available, and how many will be required? What budget is required and available? What timetable is suitable? What other
departments and agencies need to be involved? This represents the *administrative and policy diagnosis* of the situation. The administrative diagnosis considers the policies, resources and organizational situation that could facilitate or hinder implementation of the program. The policy diagnosis covers the relationship of the proposed program to the rest of the organization, and potential conflicts between them.

**Phase 6.** Only in the *implementation* stage is the program actually designed; usually a combination of interventions.

**Phase 7.** The *evaluation stage* requires a process evaluation, covering the stages of program implementation; an impact evaluation which measures its effect on predisposing, enabling and reinforcing factors, and an outcome evaluation that considers impact on health behaviors and overall quality of life. This may take years to obtain.

**The PROCEED Model.**

This was added to the PRECEDE in the later 1980s, because Green recognized a need to broaden the scope of health education to effectively change health behaviors. PROCEED moved upstream to consider political, managerial and economic inputs that would modify social environments so as to promote healthy lifestyles. The model includes policy, environmental regulations and organization of the necessary resources. PROCEED is an acronym for Policy, Regulatory, Organizational Constructs in Educational and Environmental Development.

**Validation**

Used by Taylor in promoting a community breast cancer screening project (4)

**Alternative Forms**

The Centers for Disease Control proposed a modified, 10-step version of the framework (5).

**References**

(1) Green L.W. Prevention and health education. In: Last JM, editor. Maxcy Rosenau public health


