Review

Health Promotion and Health Education: Theories, Models and Methods

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Article history: Received 24 May 2025, Reviewed 12 June 2025, Accepted for publication 19 June 2025

Abstract

Background: Health education and promotion have evolved to address complex health challenges by integrating epidemiology, behavioural, and social sciences. Despite their theoretical foundations, gaps persist between theories and real-world applications due to poor adaptation and implementation strategies.

Methods: This narrative review analysed peer-reviewed articles, books, and reports from PubMed, Google Scholar, WHO, and CDC publications. Search terms included health education, health promotion, health communication, and behaviour change theories.

Result: Effective health promotion relies on theory-guided approaches operating at different levels. At the individual Level, models such as the Health Belief Model, Theory of Planned Behaviour, and Transtheoretical Model help to understand perceptions, intentions, and motivation for healthy behaviours. Interpersonal Level theories like Social Cognitive Theory emphasise the role of social influences and observational learning through networks. At the community level, Community Organisation Theory and Diffusion of Innovations highlight collective action and the spread of new ideas. Broader frameworks, including the Ecological and PRECEDE-PROCEED Models, are designed to address comprehensive determinants at multiple levels and emphasise planning, implementation and evaluation. Health promotion techniques and methods operationalise these theories and highlight a shift from individual-focused strategies to approaches that challenge systemic barriers and social norms for lasting behaviour change.

Conclusion: While health education and promotion effectively improve public health and reduce inequalities, significant challenges remain, particularly in low- and middle-income countries facing resource constraints, weak health systems, and policy gaps. Success requires bridging research and practice through culturally relevant, adequately funded, and policy-supported interventions to achieve a sustainable public health impact.

Keywords: health education, health promotion, health communication, behavioural change theories, and models

How to cite this article

Ogbonna VI, and Okuefuna C. Health Promotion and Health Education: Theories, Models and Methods. The Nigerian Health Journal 2025; 25(2):493 – 504. https://doi.org/10.71637/tnhj.v25i2.1111

Introduction

Health education and health promotion represent two interconnected yet distinct approaches to improving public health outcomes.[1] Health education primarily focuses on providing information and developing skills that enable individuals to make informed health decisions. It is characterised by its emphasis on knowledge transfer and behavioural change at the individual level.[1] Meanwhile, health promotion encompasses a broader spectrum of interventions to enable individuals and communities to increase control over their health determinants.[2]

The distinction between these approaches is important for public health practitioners and policymakers. While health education is a vital component of health promotion, the latter extends beyond educational strategies to include building healthy public policy, creating supportive environments, strengthening community action, developing personal skills, and reorienting health services.[3]

This comprehensive approach recognises that individual health behaviours are shaped by complex social, economic, and environmental factors that must be addressed collectively to achieve sustainable health gains.[4] As healthcare systems worldwide shift toward preventive approaches, both fields have proven essential in reducing the burden of preventable diseases, promoting health equity, and enhancing quality of life across populations.[3]

Despite well-established theories, there remains a significant gap between theoretical constructs and real-world implementation. Up to 89% of health interventions do not appear to be based on theories, and many theory-based interventions do not fully apply the theory.[5] In a systematic study to assess the implementation of health education and health promotion theories in interventions, only 9% reportedly used theory to inform the development of an intervention.[6] On the other hand, theoretical frameworks often fail to effectively translate into practice because they do not sufficiently account for real-world complexities such as low health literacy and evolving media landscapes.[5]

Health promotion theories and models remain an important tool in addressing these issues, yet their implementation is still fragmented, underfunded or culturally insensitive. There is a need to develop and deliver comprehensive, inclusive, accessible and health promotion programs that empower individuals and communities to make informed decisions for healthier lifestyles.

This review assessed health education and health promotion theories, providing a foundational understanding of their principles and applications. It also examined various health promotion models, highlighting their relevance and effectiveness in addressing public health challenges. Additionally, it assessed the different methods employed in health education and promotion, emphasising both traditional and modern approaches. Finally, discussed contemporary issues in the field, with a particular focus on health communication and its growing significance in today's dynamic health landscape.

Key Terminologies

Health is defined as more than just the absence of disease. It refers to a state of complete physical, mental, and social well-being.[7] Health Information comprises Facts, data or knowledge about health, including disease symptoms, treatment options and preventive measures.[8] Health Education involves a combination of learning experiences designed to help individuals and communities voluntarily improve their health by increasing their knowledge and influencing their attitudes.[7] Health Promotion, on the other hand, is the process of enabling people to increase control over, and to improve their health.[9]

Review Methodology

This review employed a structured narrative literature review approach to examine core theories, models, and methods in health education and promotion. The narrative design enabled thematic exploration of diverse frameworks while maintaining academic depth and clarity. This was to compile relevant, evidence-based frameworks that inform health education and health promotion practices and strategies.

Relevant articles were retrieved from key academic and public health databases, including PubMed and Google Scholar, alongside official reports from the WHO and CDC. Boolean operators (*AND*, *OR*, *NOT*) were used to refine keyword searches such as *health education*, *health promotion*, *behaviour change*, *health communication*, and

Print ISSN: 0189-9287 Online ISSN: 2992-345X

specific theories like the *Health Belief Model*, *Social Cognitive Theory*, *PRECEDE-PROCEED*, and the *Transtheoretical Model*. The review comprises literature published between 2000 and 2024, with inclusion of seminal works predating this period. Inclusion criteria consisted of peer-reviewed journal articles, authoritative books, and government or WHO publications written in English. Studies that lacked relevance, methodological clarity, or scholarly credibility were excluded. A two-step process, screening titles/abstracts followed by full-text reviews, was used to select studies, which were then organised into themes covering theories, intervention methods, and communication strategies. Findings were synthesised to support a broad understanding and practical relevance.

Overview of Theories, Models, And Methods

Theories, models, and methods in health education and promotion facilitate the understanding of health behaviours and the formulation of intervention strategies.[14] Theories offer relevant clues as to why individuals and communities do or do not adopt certain health behaviours. It also identifies key factors that influence individuals' health decisions.[15] Models typically provide practical frameworks derived from theories that guide intervention planning and implementation.[16] Methods represent specific techniques and approaches used to facilitate health behaviour change.

Health education and promotion interventions are most effective when grounded in sound theoretical frameworks. As shown in Figure 1, these theories examine predictors and precursors of health behaviours at individual, interpersonal, community and ecological levels.[14]

Individual-Level Theories

This group of theories operate on key assumptions that behavioural change is primarily driven by personal beliefs, attitudes and motivations. [14] They include:

The Health Belief Model (HBM)

This is a psychological framework that was developed by Behavioural scientists working for the U.S Public Health Service in the 1950s to help explain and predict health behaviours.[15,17] It is based on the idea that individuals' actions regarding their health are influenced by their personal beliefs and perceptions. The model identifies four constructs that shape whether a person will engage in preventive health behaviours, as shown in Figure 1: perceived susceptibility, perceived severity, perceived benefits, and perceived barriers.[7,18]

Perceived susceptibility refers to a person's sense of vulnerability to a given health problem, while perceived severity relates to their beliefs about the seriousness of the condition and its consequences. [11]
Perceived benefits involve the advantages a person believes they will gain from taking a specific health action, and perceived barriers are the challenges or obstacles they anticipate encountering if they choose to act. [18]

Over time, two additional components were added to the model: cues to action and self-efficacy. Cues to action are factors that initiate engagement in health-promoting behaviours, such as the appearance of symptoms or exposure to public health campaigns. [15] Self-efficacy refers to the perceived ability of an individual to successfully carry out the recommended health behaviour.[15,17]

According to the principles of HBM, people are more inclined to adopt health-protective behaviours when they feel they are at risk for a serious condition, recognise the advantages of taking action, perceive the barriers to action as manageable, and are assured that they can carry out the required steps. [11]

Theory of Planned Behaviour (TPB)

Proposed by Ajzen in 1991 as an expansion of the Theory of Reasoned Action, the TPB explains the function of intentions in the behavioural decision-making processes of human beings. According to this theory, three main factors affect an individual's behavioural intentions.[7,19] The first is the attitude toward the behaviour, which refers to the person's positive or negative consideration of the outcome of performing the behaviour. The second is subjective norms, which involve the perceived social pressure from important others to either engage in or avoid the behaviour.[20] The third factor is perceived behavioural control, which refers to an individual's perceived ability to perform a behaviour, influenced by internal (skills, willpower) and external (resources, barriers) factors. It directly impacts intentions and, when accurate, can predict actual behaviour. High perceived control strengthens intention-behaviour consistency.[14]

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Collectively, these three elements influence a person's intention, which in turn serves as the immediate predictor of their actual behaviour. Notably, perceived behavioural control can directly impact behaviour, especially when it accurately mirrors real-world conditions of control.[19] The TPB has been applied extensively in health promotion interventions, particularly in areas like physical activity, dietary behaviour, and substance use prevention.[19,20]

In direct contrast to the above, Theory of Reasoned Action (TRA) (Fishbein & Ajzen, 1975) posits that behavioural intention, the strongest predictor of actual behaviour, is determined by attitudes (personal evaluation of the behaviour) and subjective norms (perceived social pressure) only. [21] The TRA assumes individuals have complete volitional control over their actions, making it most applicable to behaviours that are purely choice-based.[7]

The Transtheoretical Model (TTM)

This model, developed by Prochaska and DiClemente in 1983, and commonly known as the Stages of Change Model, conceptualises behaviour change as a gradual and dynamic process occurring across five distinct stages:[22–25] The precontemplation stage describes individuals who are not change and have no intention to modify their behaviour within the next six months. This is followed by the contemplation stage, where the person becomes ambivalent but open to change, actively considering making a behaviour modification within the next six months. [23]

The third stage, preparation, involves clear intention and planning to act within the next month, representing a crucial transition from thinking about change to preparing for it. [22–25] The action occurs when the individual has actively changed their behaviour within the past six months, demonstrating concrete steps towards their desired outcome. [25] Finally, the maintenance phase focuses on sustaining the new behaviour over time, with ongoing efforts to prevent relapse and consolidate changes made.[22]

This model recognises that behaviour change is a dynamic process that occurs over time with potential for relapse. It emphasises that interventions should be tailored to an individual's readiness to change, so as to ensure the likelihood of successful, long-term behaviour modification.[23] The TTM has been particularly influential in addressing addictive behaviours, weight management, and physical activity promotion.[22,23]

Interpersonal-Level Theories

These focus on the influence of social relationships, such as family, peers and coworkers, on individual behaviour. Common examples include: [14]

Social Cognitive Theory (SCT)

Proposed by Albert Bandura, SCT emphasises the dynamic interaction between personal factors, environmental influences, and behaviour (reciprocal determinism).[14] Key concepts include observational learning, behavioural capability, reinforcement, expectations, and self-efficacy, as shown in Figure 2. Social cognitive theory has informed numerous health education interventions, particularly those focusing on skill development and environmental supports for behaviour change. Its key concepts include:[11] observational learning, self-efficacy, outcome expectations, behavioural capability and reinforcement

SCT recognises that individuals learn not only through direct experience but also by observing others' behaviours and their consequences. The theory has been applied extensively in school-based health interventions, workplace wellness programs, and community-based initiatives.

Social Network Theory

This theory focuses on how social relationships and networks influence health behaviours and outcomes. It suggests that an individual's position within social networks, the characteristics of those networks, and the nature of social ties can significantly impact health behaviour adoption and maintenance. Social network interventions leverage existing social structures to diffuse health information and promote behaviour change.[7,14]

Community-Level Theories

These recognise the role of group dynamics, social norms and organisational or institutional influence in shaping individual and collective behaviour. Some examples include: [14]

Community Organisation Theory

This approach emphasises community participation, empowerment, and capacity building. It focuses on

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helping communities identify common problems, mobilise resources, and develop and implement strategies to reach collective goals. [7,8] Key principles include empowerment, community competence, participation and relevance, issue selection and critical consciousness.

Community organisation approaches have been successfully applied in diverse settings, from rural health initiatives to urban neighbourhood health promotion programs.

Diffusion of Innovations Theory (DOI)

Developed by Everett Rogers, this theory explains how new ideas, products, or practices spread through populations over time.[26] According to Rogers, adoption of innovations follows a predictable pattern, with adopters falling into five categories: innovators, early adopters, early majority, late majority, and laggards, as shown in Figure 3. The theory identifies five key attributes that influence adoption rates:[3,7,14]

The first stage is **knowledge**, where an individual becomes aware of the innovation and begins to understand how it functions. [3,7,14] This is followed by **persuasion**, during which the individual forms a positive or negative attitude toward the innovation. [14] Next is the **decision** stage, where the individual chooses whether to adopt or reject the innovation. If adoption occurs, the **implementation** stage follows, involving the actual use of the innovation. [7,14] Finally, the **confirmation** stage is reached, in which the individual seeks reinforcement for the adoption decision or reconsiders and possibly reverses it based on continued experience. [8,10]

Several factors influence the adoption of an innovation. One key factor is **relative advantage**, which refers to whether the innovation is perceived as better than what currently exists. **Compatibility** is another important consideration—this assesses how well the innovation aligns with existing values, experiences, and needs. **Complexity** examines the ease of use; innovations that are simpler to understand and implement are more likely to be adopted.[26] **Trialability** allows potential adopters to experiment with the innovation on a limited basis before making a full commitment, which can ease the adoption process. **Observability** pertains to the visibility of the innovation's results; when benefits are easily seen by others, adoption is more likely.[27]

In addition to these factors, **communication channels** play a critical role. **Mass media** channels are effective for creating initial awareness of the innovation, while **social networks** are instrumental in influencing attitudes, shaping opinions, and supporting the decision-making process regarding adoption.[26,27]

The DOI Theory effectively predicts innovation spread and helps target adopter groups. [3,7] However, it assumes rational decision-making while ignoring the emotional factor. Furthermore, the theory proves less effective in rapidly changing digital environments where the pace of technological advancement and the complexity of interconnected systems challenge the traditional linear adoption models. [3,7]

Ecological Models

The Socio-Ecological Model

This was popularised by McLeroy, who recognises that behaviour is determined by multiple levels of influence.[16,28] This comprehensive framework encompasses individual factors such as knowledge, attitudes, and skills, which form the foundation of personal health behaviours. Beyond the individual level, the model considers interpersonal processes and primary groups, including the influence of family, friends, and peers who shape social norms and provide support or barriers to behaviour change, as shown in Figure 4. [28]

The model extends to institutional factors examining how organisations, schools, and workplaces create environments that either facilitate or hinder healthy choices through their policies, structures and cultural practices. [16,28] At the community level, it addresses complex relationships among organisations and how these interconnections influence population health outcomes.[16] Finally, the model incorporates public policy factors, recognising how laws and regulations create a broader societal context within which health behaviours occur. [16,28]

The socio-ecological model provides a comprehensive framework for health promotion interventions by addressing multiple determinants of health simultaneously.[7] It encourages interventions that combine individual, social, and environmental approaches for maximum effectiveness.[7,28]

Print ISSN: 0189-9287 Online ISSN: 2992-345X

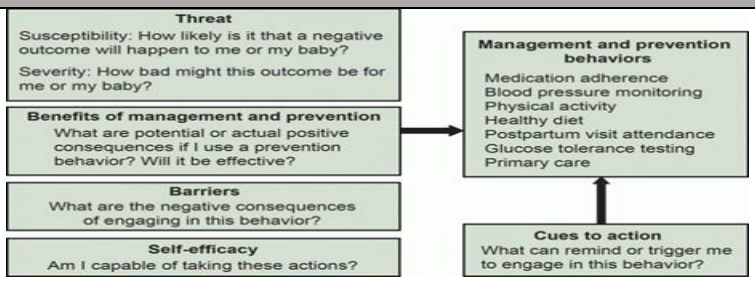
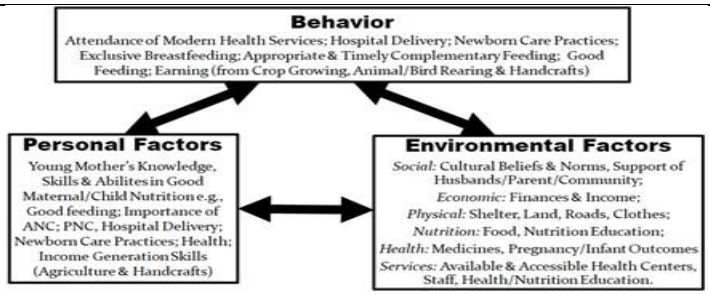
Category of Theories	*Picture Illustration*
Individual Level Theories • Health Belief Model • Theory of Planned Behaviour • Trans-Theoretical Theory	 *Figure a: The Constructs of the Health Belief Model.* [10]
Interpersonal Level Theory • Social Cognitive Theory • Social Network Theory	 *Figure b: Social Cognitive Theory Framework.* [11]
Community Level Theory • Community Organisation theory • Diffusion of Innovation	 *Figure c: Diffusion of Innovation.* [12]
Ecological Theories • Socio-Ecological Model	 *Figure d: Socio-Ecological Model.* [13]
Systematic Planning Framework	PRECEDE-PROCEED Model

Figure 1. A Summary of Health Promotion Theories and Their Visual Illustrations

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Precede-Proceed Model

This was developed by Green and Kreuter, it serves as a framework for guiding the development, implementation, and evaluation of health promotion programs.[29] This systematic planning framework is structured around two complementary phases: PRECEDE which focuses on diagnostic planning (social, epidemiological, behavioural, environmental, educational, and administrative assessments), and PROCEED which addresses implementation and evaluation components of health promotion.[14]

Planning stage encompasses the PRECEDE Phase an acronym for Predisposing, Reinforcing, and Enabling Constructs in Educational/Environmental Diagnosis and Evaluation. This phase consists of several assessments to identify priorities before developing an intervention:[29]

The social assessment forms the foundation by identifying community needs and desires while considering the community's problem-solving capacity, strengths, resources and readiness to change.[29,31] This assessment relies heavily on community participation to determine their felt needs and employs various methodological approaches including focus groups, surveys, and community forums to gather comprehensive data.[30] Following the social assessment, the epidemiological assessment examines specific health problems that may contribute to the quality-of-life of the community. This phase involves analysing health statistics, morbidity and mortality data and prioritising health problems based on prevalence, severity, and preventability. [29,31]

The behavioural and environmental assessment then delves deeper into the factors influencing health outcomes by examining behavioural patterns at multiple levels. [29,31] This includes proximal behaviours directly causing health issues, like teen smoking, distal behaviours of others influencing risk, like a parent supplying cigarettes and the most distal actions by decision-makers shaping environments, such as law enforcement (Tobacco tax) or institutional food choices affecting individual health behaviours.[30] The educational and ecological assessment examines the underlying factors that influence the targeted behaviours and environmental conditions. [29,31] These factors are categorised into three distinct groups: predisposing factors, which include knowledge, attitudes, beliefs, values, and perceptions; reinforcing factors encompassing rewards, feedback, and social support; and enabling factors consisting of skills, resources, and barriers. [30] The final component of the PRECEDE phase is the administrative and policy assessment, which evaluates organisational and policy factors that could influence program implementation by examining available resources, existing constraints, current policies, organisational capabilities and limitations.[29,31]

The implementation & Evaluation Stage is addressed through the PROCEED Phase (Policy, Regulatory, and Organisational Constructs in Educational and Environmental Development).[7,29,31] this phase begins with implementation which involves putting planned intervention into action based on the assessment findings.[7,29,31] During this stage appropriate educational strategies developed, supportive environments are created and necessary policies are established to facilitate program success. [29,31]

The Evaluation component encompasses multiple levels of assessment. Process evaluation monitors program implementation by measuring reach, fidelity, and quality of implementation while providing continuous feedback for ongoing adjustments. [7,29,31] Output valuation assesses immediate effects on target behaviours and environmental factors by measuring changes in predisposing, enabling, and reinforcing factors while tracking behavioural and environmental changes. Impact Evaluation measures long-term health and quality of life outcomes by examining health status indicators and assessing improvements in overall quality of. [29]

The PRECEDE-PROCEED Model demonstrates several notable strengths that make it particularly valuable for health promotion program activities. First, it provides a systematic and logical approach that considers multiple determinants of health, ensuring comprehensive program development. Secondly, it emphasises community participation and stakeholder involvement, fostering ownership and sustainability. Thirdly, it provides clear direction for evaluation at multiple levels, enabling practitioners to assess program effectiveness and efficiency. The framework's flexibility and adaptability make it suitable for addressing various health issues across different settings, while it considers both individual and environmental influences on health.

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Health Promotion Methods and Techniques

Operationalising health promotion models involves translating theoretical frameworks into practical strategies and interventions to improve health outcomes. Health promotion techniques play a vital role in this process by providing actionable methods to implement the principles of these models in a real-world setting. These techniques include.[9,32]

- Health Communication
- Health Education: Empowers individuals with knowledge, skills and awareness to make informed decisions. Utilises various methods/approaches to achieve this purpose:[2,8,9]
  - Individual approach: Counselling, home visits,
  - Group Approach: lectures, demonstrations, discussions, panels, symposium, workshops, conferences, seminars, role plays
  - Mass Approach: TV, Radio, Newspaper, Internet, films, social media
- Policy approaches: include legislative advocacy, fiscal measures, taxation, and regulatory oversight, e.g. establishing policies for smoke-free zones, adding a tax to unhealthy food options, and the use of safety equipment in a work setting to avoid injury.[8]
- System Changes: Fundamental shift in an organisational culture, beliefs, relationships, policies, and goals. e.g. implementing new technologies, creating training or certification systems that align with policies.[8,33]
  - Environmental change: Involve changing the economic, social, or physical surroundings or contexts that affect health outcomes. Increasing the availability of fresh, healthy foods in schools, and clean environments. [9,32]

Health Communication

The study and use of communication strategies to inform and influence, these strategies could be written, verbal or visual.[34] Effective communication is crucial to ensure optimum utilization of health information for individuals and communities to adopt healthy living practices.

The key components of health communication include the sender such as the health professionals or media who initiates the health communication.[35] The message which must be clear and culturally appropriate. [36] The channel through which messages are delivered such as mass media, interpersonal communication, or digital platforms, and the receiver, who is the target audience. Additionally, feedback from the receiver helps the sender assess the effectiveness of the message, while noise refers to any interference that may distort or hinder communication. This process is typically presented in a linear flow: **Sender > Message > Channel > Receiver > Feedback.** [9,32]

Strategic Shifts in Health Communication

The field of communication has evolved over the years with shifts in approach driven by deeper insights into human behaviour and the social dynamics that shape it. Changes have been the transitions from Information Education and Communication (IEC), Behaviour Change Communication (BCC), to Social and Behaviour Change Communication (SBCC). [34,37]

1. Information, Education and Communication (IEC): Popular in the 1960s-1970s. **The traditional** approach focused on **delivering health-related knowledge** through information sharing, educational activities, and communication. The assumption was that providing people with the right information would automatically lead to behaviour change. The mass media's focus was on disseminating information, raising awareness to educating people about health and social issues. Methods such as Radio, TV, Posters, Leaflets were employed, and messages were driven with standardised content such as "Don't Smoke Campaigns. [34,37]

- **Limitations:** Often **linear and top-down**, lacking attention to cultural, social, and emotional contexts. Did not always result in sustained behaviour change.

2. Behavioural Change Communication: A more **targeted and evidence-based** approach aimed at **influencing specific behaviours** by addressing the underlying psychological theories. The communication model was two-way, tailored to a specific audience.[10,15] This concept emerged in the 1980s–1990s as a **response to IEC's limitations**. Key Features included **community involvement** and **empowerment**. Focuses on **actual behaviour change**, not just awareness. Example: Community discussion on proper handwashing techniques to reduce diarrheal diseases **Limitations**: Primary focus on individual behaviour changes neglecting social and structural influences. [34,37]
3. Social Behavioural Change Communication

Print ISSN: 0189-9287 Online ISSN: 2992-345X

- A broader, more **comprehensive and coordinated approach** to health communication that aligns communication efforts with **specific health objectives and policy goals**. Gained prominence in the 2000s with emphasis on **planning, integration, and evaluation**. Draws on **marketing, advocacy, and public relations** techniques, also Integrates audience segmentation, participatory methods and the social ecological model in its approach. [34,37] Engages multiple communication channels, mass media, inter-personal, digital, and social media. Addresses systemic barriers such as inequities and promotes sustainable change by shifting social norms. Ensures communication is aligned with health system priorities and sustainable development goals (SDGs).[38] A good example is the Breakthrough Action Nigeria (HIV program) addressed individual knowledge on HIV care and treatment, increased uptake of HIV Testing and the problem of stigma at the community level.

Effective communication is the cornerstone of successful interaction, whether in public health campaigns, education or daily life. It involves transmitting information clearly and persuasively to drive meaningful, lasting behavioural and social transformations.[35]
Principles of Effective Communication

This includes completeness, which ensures that all necessary facts are conveyed. [7] Conciseness, which focuses on delivering essential messages in limited words to the audience and Consideration, which requires a thoughtful approach which takes the audience's background and viewpoint into account. Clarity is so vital as it makes understanding easier by being specific and direct. Concreteness supports messages with facts and figures, while courtesy involves showing politeness and respect throughout the communication process. Finally, correctness ensures the use of appropriate and accurate language to avoid miscommunication.[35]

Barriers to Effective Communication
Several barriers, often referred to as "noise", can interfere with communication. This concept is categorised into: Physical noise, which includes external sounds such as traffic or conversations that distract from the message.[7] Psychological noise stems from mental distractions like stress, anxiety, and preconceived notions that hinder understanding. Semantic noise arises when jargon or complex language leads to misunderstandings. Physiological noise involves biological limitations such as hearing loss, speech disorders or fatigue that impair communication. Cultural barriers, including differences in language and communication styles, can also obstruct communication. Structural noise, such as network jams, distorted videos, further complicate the communication process. Understanding these principles and barriers is essential to achieving effective and impactful communication. [35]

Strengths and Limitations of this Review
The key strength of this review methodology lies in its structured yet flexible narrative design**,** which allows for broad thematic coverage of health education and promotion concepts. By including a wide range of peer-reviewed sources, authoritative books, and official health agency reports, the review ensures richness and credibility of content. The inclusion of both recent studies (2000–2024) and seminal works adds depth and historical context**,** enabling a balanced understanding of evolving frameworks. Visual representations of the theoretical framework in diagrams allow readers, especially practitioners, students, and policymakers, to grasp key components, relationships, and processes at a glance, which might be difficult to follow through text alone. The use of multiple databases and Boolean operators enhanced the comprehensiveness of the search strategy, reducing the likelihood of missing key literature. Thematic categorisation further supports clarity and coherence in presenting complex theoretical constructs and methods.

However, the methodology also has some limitations. Being a narrative rather than a systematic review, it does not involve statistical synthesis or meta-analysis, which limits its ability to measure the effectiveness of individual theories or interventions quantitatively. Additionally, the reliance on English-language sources may introduce language bias, excluding relevant non-English studies. The exclusion of grey literature not affiliated with major organisations could also result in publication bias, omitting innovative or context-specific findings from less formal sources. Despite these limitations, the approach remains useful for broad synthesis and practical application in public health education.

Print ISSN: 0189-9287 Online ISSN: 2992-345X

Conclusion

Health education and promotion are essential tools for advancing public health and reducing inequalities. Their evolution from basic information-sharing to theory-based and contextually tailored interventions demonstrates a growing understanding of health behaviour and its determinants.

Despite this progress, several obstacles limit their full impact, particularly in low- and middle-income settings. Resource limitations, such as insufficient funding and workforce shortages, restrict program implementation and scale. The gap between research and practice continues to hinder the application of evidence-based interventions, while unsupportive policy and environmental conditions often undermine individual-level behaviour change. Additionally, many initiatives face sustainability issues due to weak institutional structures and unstable political or financial backing.

To overcome these challenges, a coordinated, culturally relevant, and well-integrated approach is needed. With strategic investment, policy alignment, and consistent monitoring, health education and promotion can deliver lasting public health improvements, especially when rooted in theory and adapted to community realities.

List of Abbreviations

BCC (Behavioural Change Communication)
CDC (Centre for Disease Control)
DOI (Diffusion of Innovation)
HBM (Health Belief Model)
IEC (Information Education and communication)
PRECEDE Phase (Predisposing, Reinforcing, and Enabling Constructs in Educational/Environmental Diagnosis and Evaluation)
PROCEED Phase (Policy, Regulatory, and Organisational Constructs in Educational and Environmental Development)
SBCC (Social and Behavioural Change Communication)
SCT (Social Cognitive Theory)
TPB (Theory of Planned behaviour)
TRA (Theory of Reasoned Action)
TTM (Trans Theoretical Model)
TRA (Theory of Reasoned Action)
WHO (World Health Organization)

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Print ISSN: 0189-9287 Online ISSN: 2992-345X

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Print ISSN: 0189-9287 Online ISSN: 2992-345X