# A Field Guide to *Affective* Online Health Promotion

## 10 Ways to Overcome the Limitations of Organizational Thinking

**Neil Hammond**



Learnbase

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10 Ways To Overcome the Limitations of Organizational Thinking
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## *A Note on the Research*

*The evidence and observations that inform this guide come from direct client work across the health promotion and clinical education sectors over the past decade, and research projects I have led that have not been published or made available outside the organizations involved. For that reason this guide does not carry citations. The findings are real and the patterns are consistent, but my primary obligation to the organizations whose work is reflected here is confidentiality, and that takes precedence over academic convention.*

*What this guide offers is practitioner knowledge of the kind that accumulates from being in the room when platforms are planned, watching real users navigate them, and seeing the same problems appear across different organizations and different clinical domains with enough regularity to offer you these ten paths (and four lenses) to making affective online health promotion.*

# The Four Lenses

I've spent the better part of a decade working directly with publicly funded health promotion and health literacy organizations on digital learning strategy, platform and app design, and creative resource and course creation. Behind that work have been both major research initiatives and incremental discoveries, all conducted through Learnbase, the Canadian learning design and technology agency I founded in 2012.

We've designed and conceptualized popular public programs, specialist clinician training, and learning and knowledge ecosystems for hospitals, health services, government initiatives, and NGO education outreach. Our research and insights come from conducting large-scale research for public health services and needs and impact analysis across more than 50 programs.

The findings in this guide are drawn entirely from that body of work. When I refer to "the research" or "our research," I'm referring to work my team and I conducted. Where I say "we found" or "in our experience," I mean exactly that.

The patterns described here are ones we've encountered repeatedly, across different organizations, different clinical domains, and different technical implementations. They're not isolated findings from a single project. They're consistent enough that I feel confident naming them, and significant enough that I think the sector as a whole needs to reckon with them.

Underlying our approach is a framework of four lenses we use to assess any health promotion learning environment. They're not a hierarchy or a sequence. There are four concurrent dimensions, each of which needs to be deliberately attended to when designing, building, or reviewing a digital health promotion platform.

This framework draws its inspiration from Integral Theory, adapting and focusing the approach into a practical tool for analyzing and designing digital learning platforms and programs.

Most platforms and programs we encounter are built almost entirely through only the first two.

**The Organizational Lens** covers the procedures, policies, mandates, regulations, and institutional practices and budget scopes and team capacities that shape what gets built and why.



**The Activity Lens** covers active behavioral pathways for users rather than just looking at a static library of resources, focusing on how a platform usefully steers an overwhelmed visitor through an intentional sequence of interactions with content.



**The Affective Lens** attends to the inner state of the individual visitor: their emotional context, cognitive load, and the internal conditions that determine whether engagement, and learning, is actually possible.



**The Connective Lens** encompasses dialogue and shared discovery: the conversations, forums, and peer interactions through which people find that others share their experience, and through which durable change becomes more likely. It also provides the organization with a qualitative feedback loop to inform the continual honing of the service.



The ten chapters that follow examine what happens when the four lenses are more equally considered and balanced within a program.

Have a site/platform you would like us to review through the lenses and perspectives in this field guide? Let us help get you started with some targeted *affective* feedback.

**Scan the QR code or use the link below to request your review.**

https://learnbase.com/affective-site-snapshot

# 1. Avoiding the Link Farm

There is a sequence in digital health promotion design that is so widespread it has become almost invisible. An organization decides it needs a digital presence for its health promotion. It has credible, evidence-based content and plenty of clinical expertise behind it. It builds a library of searchable, categorized resources, articles, toolkits, and curated links organized by topic, format and audience type.

The library grows as more resources pour in. The content improves. Advisory teams weigh in… and the engagement numbers stay stubbornly flat.

In our research across a wide range of publicly funded health literacy platforms, this pattern repeated itself with consistency. Organizations were investing in content production while users were not finding, or not absorbing, what was already there. One platform we analyzed had introduced a feature allowing visitors to save and organize their own collections of resources, but fewer than 1 in 5,000 users had ever viewed the page explaining how to use it. Another platform's most directly useful section, connecting visitors to clinical peer support, was accessed by 0.25% of all site traffic. The content and the connectivity existed, but the connection between the two was not being made.

The instinctive response to findings like these is to look for content gaps. Perhaps the resource for this particular condition is missing or perhaps the filter taxonomy is too coarse. Perhaps users need a better search interface. While these are reasonable operational questions, they miss addressing the underlying issue.

This issue is a misreading of who actually shows up and how they show up.

## The Assumptions Built Into the Architecture

Conventional adult education, andragogy, that informs health promotion initiatives, rests on a set of assumptions about the learner. It assumes that they are self-directed, internally motivated, and will seek out information as they need it. The organization's job, within this model, is to make good information accessible. The learner, it is presumed, arrives ready to engage, identifies what they need, finds it, and applies it. The platform is a *library* because the learner is presumed to be a *researcher*.

This model has its place. But it carries a significant blind spot. It treats the learner's readiness to engage as a given. It takes no account of the internal state they bring with them when they arrive. An emphasis is placed on searching rather than *finding*. Can you think of any offline activity where a 'search' does not denote a stress-inducing context?

Our research included focus group sessions utilizing broader clinician and caregiver personas to bridge general concepts with our practical data. Neither group resembled the andragogical model's self-directed adult learner. As we detail in Chapter 6, our inquiries into their day-to-day experiences revealed communities operating under profound layers of acute stress, cognitive overload, and systemic exhaustion.

These are not people who will work methodically through a resource library. They need to feel, before anything else, that the platform they have landed on understands their situation. The inner state of the user, what we refer to as the Affective Lens of a platform, determines whether any of the content it contains will be absorbed at all.

> *A platform that ignores the affective state of its users is not a health promotion tool. It is a filing system with good intentions.*

## The Organizational Blindspot

Most health promotion platforms are built primarily from two perspectives. On one hand what the organization has produced, its content, its expertise, and its range of topics covered. On the other is what the system requires, compliance, mandates, evidence-based standards. Both are legitimate and necessary. The problem arises when they become the dominant logic of the platform's design.

When organizational priorities shape the architecture of a site, the visitor experience tends to reflect it. Menus are organized around content categories. Navigation communicates the breadth and depth of what the organization offers. The front page becomes, in effect, a showcase, demonstrating institutional capability rather than orienting the individual visitor.

In practice, this means that someone arriving in a state of overwhelm is presented with a comprehensive, well-structured library of resources and invited to find their own way in. As we explore through the analytics data in Chapter 2, this institutional showcase frequently triggers an immediate drop-off in engagement. When a site communicates overwhelming volume instead of recognition and relevance, up to 60% of visitors will exit the platform before going anywhere at all.

Compare this with platforms that lead from the opposite direction, avoiding the 'here is what we have' and replacing it with 'who are you, and what do you need right now?' These sites typically reduce menus, minimize text, and build their architecture around getting a specific person to a specific place as efficiently as possible. They prioritize the Affective Lens, attending to the individual's inner state and context, before presenting any content at all.

## The Content Ownership Problem

There is a further dimension to the resource library model worth examining: the tendency to create a 'link farm'. Many health promotion platforms carry a significant proportion of content that is externally sourced: links to third-party resources curated from elsewhere on the web. In some cases, this constitutes the majority of what a resource library contains.

The capacity rationale is straightforward: producing original content is resource-intensive, and curating quality external material is a legitimate service. But there are compounding problems. When a user follows an external link, they leave the platform. If the linked destination is poorly designed, outdated, or disorienting, the damage to trust falls on the referring site, not the destination. More significantly, the research found that clinicians, when asked which resources they most valued and most readily recommended, consistently rated *internally* produced content higher than curated external links, even when their actual referral behaviour told a different story.

An environmental scan we conducted revealed a sharp discrepancy between the design quality of a platform's curated list and the external sites clinicians chose to recommend independently. The links quietly sitting inside institutional libraries frequently carried a dated, unmaintained appearance, whereas the resources clinicians actively trusted on their own looked contemporary and professional. This qualitative gap suggests that the resource library model can accumulate content without adequately monitoring whether that content continues to serve users well.

## Questions Worth Asking About Your Own Platform

- What does the first screen of your homepage actually communicate? Does it orient the individual visitor, or does it demonstrate the breadth of what your organization offers?
- If a member of your target audience, say, a parent of a child recently diagnosed with ADHD, arrived on your platform at 11 p.m., anxious and unsure where to start, what would their experience be in the first thirty seconds?
- What proportion of your resource library content is internally produced? Is there a deliberate strategy behind that balance?
- When a user follows an external link from your platform, what happens to them? Do they come back?
- And when engagement metrics are disappointing, what is the first question your team asks?

# 2. What Your Analytics Are Missing

Digital health promotion teams are rarely short of data. Most platforms running on modern content management systems generate a continuous stream of analytics on sessions, page views, bounce rates, click-throughs, time on page, entry and exit points. The question is not whether the data is available but more what *story* the team tells themselves when the numbers are not encouraging.

In our research across several publicly funded health literacy platforms, a consistent pattern emerged. When engagement metrics were disappointing, teams read them as a content problem. Conclusions are drawn that the platform needed more resources, more topics covered, a better search function, perhaps a more granular filter taxonomy. These responses are not wrong exactly, they are just answering the wrong question. The underlying issue, in the majority of cases, had nothing to do with what the platform contained.

## The Bounce Rate as Affective Signal

A bounce rate measures the proportion of visitors who arrive at a page and leave without taking any further action. In the health and medical sector, an acceptable homepage bounce rate sits between 25% and 40%. Most major platforms we assessed had homepage bounce rates of 60% or above.

The content behind those homepages tended to be substantial, clinically credible, and regularly updated. The problem was rarely what the sites contained, but with what the sites communicated in the first few seconds of a visit. Visitors were scanning the landing page and leaving. They were not finding their way in, and more precisely, they were not reassured that the site had anticipated them.

The instinctive Organizational Lens response to a figure like this is to treat it as a placement problem. Does the most important content need better promotion, does navigation need restructuring, or is a more prominent call to action missing? These adjustments are worth making, but they treat the bounce rate as a navigational failure when it is, more accurately, an affective one.

A homepage built to demonstrate institutional breadth, showcasing the full range of what an organization offers across multiple audience types, asks the visitor to do significant cognitive work before they have established any sense of personal relevance. For a caregiver arriving after a volatile evening at home, a time-strapped clinician seeking an immediate resource, or an educator already running on fumes by mid-morning, that kind of ask is simply too high. They leave. The platform records this as a bounce and the team schedules a content planning meeting.

> *The bounce rate is often the most honest signal a platform has about whether its Affective Lens is functioning. Most teams are not reading it that way.*

## The Gap Between Reported Satisfaction and Observed Behaviour

One of the more methodologically revealing decisions in our research has been to pair standard survey instruments with observed user sessions. Participants navigated specific health platforms while their screen activity was recorded, then completed a satisfaction questionnaire about the experience. The gap between the two data sources was, at times, striking.

Users routinely rated their experience as satisfactory or above. Many also reported wishing the platform had more of certain types of resources. In the majority of cases, those resources already existed on the platform. Users had simply not found them, and had no idea those resources existed.

This is a well-documented characteristic of how people interact with information-dense environments: satisfaction is assessed relative to expectation, not relative to what was actually available. A user who arrives looking for something specific, finds something that partially addresses their question and leaves, may report satisfaction while having missed the more precise resource that was a few more clicks from where they stopped. Their assessment is genuine but it just doesn't quite tell you what you need to know about whether the platform is working.

Satisfaction surveys, used in isolation, will not indicate what users do not know they do not know. They are not, as they are often treated, confirmation that the platform is performing as intended. Observation is the only method that reliably reveals this gap, and in our experience it is the most consistently underinvested form of research in the sector.

## Hidden in Plain Sight

In one platform assessed during the research, a section connecting visitors to peer support and clinical guidance was the most directly useful feature on the entire site, at least in terms of what users actually needed when they arrived. It was visited by 0.25% of all site traffic, and had a 50% bounce rate on arrival, meaning half the people who did find it left immediately without engaging.

A related support tool designed to connect users with direct help was accessed by roughly 1% of visitors. Both features were well designed and well resourced, but neither was being found at any meaningful scale.

The standard response is to treat this as a visibility problem and move the feature higher up the page, add a button to the homepage, run a promotional campaign. These measures would help. But the more fundamental issue is that a visitor arriving in a state of distress or uncertainty does not navigate a site the way a calm, self-directed information-seeker does. They are not methodically working through menus. They are scanning quickly for signals that the site understands why they came. If those signals are not immediately present, a significant proportion of the visitors who most need the support available will not persist long enough to reach it. The content is there but the platform doesn't meet the user where they are. The design lacks the perspectives and insight of an Affective Lens, the insights that come through looking *as* the audiences, not just *at* them.

## When Click Data Misleads

A further finding from the observed user sessions illustrates how easily analytics can produce a false sense of progress. One platform had introduced a set of visitor role buttons on the homepage, designed to help users self-select into a relevant content pathway. Analytics indicated these buttons were being used by a significant proportion of homepage visitors.

The observed sessions told a different story.

Users were consistently moving past the buttons without registering what they were for. Those who did click them were often doing so without understanding that clicking would filter their subsequent experience. The buttons were generating clicks but they were not performing their intended function. If you had only the analytics, you would conclude the feature was working. If you had watched a dozen users navigate the page, you would know it was not.

The implication for how platforms are evaluated is significant. A feature that generates clicks is not necessarily a feature that is serving its design intent, and decisions about what to build, retain, or promote should not rest on click data alone. Understanding what a click actually represents requires qualitative observation alongside the quantitative record.

## The Production Reflex

There is a structural pressure in publicly funded health organizations to demonstrate productivity through the countable outputs of resources published, courses launched and toolkits released. These are legitimate markers of organizational activity, and the people who produce them are genuinely committed to the mission they serve. The difficulty is that this production pressure tends to operate independently of evidence about whether what has already been built is being found, absorbed, or doing anything useful for the people it was designed for.

In our research, resources were being added to platforms whose existing content was already substantially undiscovered by the users who most needed it. The response to low engagement was an initiative to add further content. It rarely involved sitting with a sample of actual users and watching what happened when they tried to find something.

This is the Organizational Lens running without feedback from the Affective Lens reality of the people the platform is supposed to serve. As the platform grows, the engagement problems persist. The next funding cycle produces more content to add to the library. There is a better way to spend that time and money, and it begins with combining quantitative data with qualitative observations of target users.

## Questions Worth Asking About Your Own Platform

- When you look at your homepage bounce rate, what explanation does your team reach for first? Is it framed as a content gap, a navigation problem, or something more fundamental about how the platform communicates its relevance in the first moments of a visit?
- Is the part of your platform most likely to connect a visitor with direct support among your most visited pages? If not, what do you make of that?
- When were your satisfaction survey results and your observed user behaviour last considered together? Do they tell a consistent story?
- When engagement metrics are disappointing, what is the first question your organization asks? And when did you last watch a real user, someone representative of your primary audience, try to find something on your platform?



# 3. Beware of Asking People What They Want

Most health promotion organizations that commission digital platform development do some form of user consultation before they build anything. Surveys sent, focus and advisory groups assembled, stakeholder interviews conducted and needs assessed. The intention is sound in trying to ensure that what gets built reflects the genuine needs of the people it is designed for, rather than the assumptions of the team producing it.

The problem is that this process, conducted in the conventional way, tends to produce answers that are as conventional as the questions. And the products that emerge from those answers tend to look, with remarkable consistency, like the products that already exist.

## How Needs Assessments Reproduce Existing Models

In our research, a recurring pattern was observed in how digital health learning projects were conceived and scoped. The process typically followed a recognizable sequence: identify a need, secure the funding, consult stakeholders about what form the solution should take, build the solution, test it, implement it. All reasonable steps, but the weak link is the consultation stage.

When stakeholders are asked what form a solution should take, they draw on what they already know. Clinical subject matter experts, who frequently drive these processes, tend to be people who have succeeded within conventional educational frameworks. They are, in many cases, products of those frameworks. They have not necessarily been through the kind

of developmental training that requires actively dismantling their own assumptions about how people learn, or engaging with what the research on cognition and motivation actually says about what determines whether a person can absorb new information under stress.

The result is predictable. Questions about what users need generate answers about content formats that already exist… more videos, more articles, a better PDF, a clearer website. The consultation process that was designed to ensure relevance, inadvertently anchors the project to a familiar repertoire of solutions. The standard andragogical default gets reproduced not because it is the best solution, but because it spun out of the framework through which both the question and the answer are generated.

> *If you ask people what they want before you have shown them what is possible, you will get answers shaped by what they already know. That is user-centred design swamped by user-confirmed bias.*

## The Limits of Self-Report

There is a further problem with conventional needs assessment that our research made particularly visible. People are not reliable reporters of their own experience, especially when they are operating under cognitive or emotional load, and the affective distortions of pressure and anxiety.

In observed user sessions, participants consistently reported satisfaction with a platform while simultaneously failing to find resources that would have been considerably more useful to them. They expressed a wish for more content that would actually duplicate what already existed on the sites. Their self-reported needs and their observed behaviour were telling different stories, and the self-report was the less accurate of the two.

Someone who navigates a health literacy platform with a specific but unarticulated need will often leave having found something that partially addressed it, report satisfaction, and have no awareness that a more precise resource existed three clicks from where they stopped. Their self-report is accurate to their subjective experience. It is not an accurate account of whether the platform served them well.

Conventional needs assessments that rely heavily on self-reporting carry this limitation directly into the design phase. Instead of simply capturing people's daily friction, we ask them to speculate on product features and solutions they have not yet seen. This happens within a standard consultation format that already carries implicit assumptions about what kinds of answers are expected and what kinds of tools are possible. The final output reflects the constraints of the methodology far more than the messy reality of the users' lives.

## What Design Thinking Actually Changes

The methodology that most directly addresses this problem is design thinking, and while the term has become sufficiently well-used in digital product development to have lost some of its precision, its core implication for health promotion is worth stating plainly.

The distinction between design thinking and conventional project development is not primarily about the steps in the process. It is about where empathy is positioned. In conventional development, empathy arrives as consultation when we ask users what they need. In design thinking, empathy is the starting condition. We research the user's world before we define the problem, and we resist defining the problem until that research has genuinely shaped our understanding of it. The difference in outcome can be substantial.

Crucially, design thinking avoids introducing prototyping to validate a solution that has already been defined. It presents users with possibilities they could not have articulated in advance. A failed prototype is not a setback in this model, but useful data. The iterative cycle of prototype, observe, and redefine is precisely the mechanism by which the process escapes the pull of gravity of existing solutions.

A concrete example emerged in our research from a health education project that had been scoped entirely around instructional videos presenting classroom strategies for teachers. The format had been defined by clinical subject matter experts before any meaningful user observation had taken place. When the project was reviewed through the four-lens framework, it became clear that the entire initiative had been conceived within the Activity Lens. There was no Affective invitation, no Connective element, and whatever Organizational authority it carried was limited to whatever a teacher (here the learner) could extract from watching a video while planning their week.

A design thinking review identified that accompanying infographic checklists, drawn from the same video content, could give teachers something to use at the point of practice rather than just something to watch in preparation. A moderated discussion thread would allow teachers to share what was working in their classrooms and raise questions that arose from real implementation. Neither of these additions had been requested by the teachers. They were not in the original brief. But once prototyped, they generated considerably stronger engagement than the videos alone, because they addressed parts of the teachers' experience that the original format had not touched.

## The Affective Snapshot

One practical approach that Learnbase has developed in response to the limits of conventional needs assessment is the affective snapshot: a deliberately open-ended qualitative inquiry into the emotional and cognitive state of a target user group, conducted before any solution has been defined or even sketched.

The affective snapshot is not a needs assessment. It does not ask users what they want or what a platform should contain. It asks about daily experience: what makes the day hard, what occupies their attention, what they reach for when they feel out of their depth, what would need to be true for them to feel genuinely supported. The answers to these questions shape not just what content gets developed but how the platform meets the user before any content is presented at all.

When we deploy this methodology, the findings consistently disrupt standard institutional assumptions. Instead of generating a checklist of feature requests or content topics, the process uncovers the hidden emotional friction: the isolation, systemic fatigue, and underlying anxieties that dictates whether a user can engage with a platform at all. As we will explore in detail in Chapter 6, when you map this inner landscape first, the entire design brief changes.

## A Note on Who Drives the Process

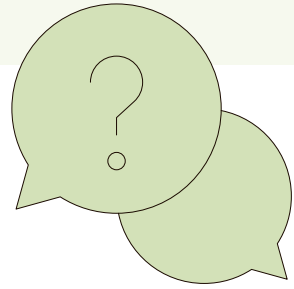
We have observed a consistent structural pattern in how health promotion digital projects are initiated. Clinical subject matter experts, understandably, tend to lead both the definition of the problem and the specification of the solution. They are closest to the clinical need. They hold the content expertise. They are often the ones who secured the funding. Their involvement is essential.

It is also, as a matter of structural observation rather than criticism, a limitation. Clinical expertise in a content domain is not the same as expertise in how people learn, what determines whether digital engagement is possible under conditions of stress, or what makes one navigational architecture more effective than another for a user arriving in a particular emotional state. When clinical experts are the primary authors of a project brief, the brief tends to reflect their expertise. The result, reliably, is platforms that are clinically sound and pedagogically unremarkable.

Empathic design practice, learning design, and affective snapshot methodology are specialist competencies. Bringing them into the project team at the outset, rather than as a delivery-stage add-on, is one of the more consequential structural decisions an organization can make about the quality of what it builds.

## Questions Worth Asking About Your Own Platform

- When your organization consults users about what a digital platform should contain or how it should work, who is in the room, and at what stage of the process does that conversation happen? Are users being asked to describe their experience, or to validate a solution that has already taken shape?
- If you conducted an affective snapshot with your primary user group, what do you think you would find? How different would those findings be from what is currently reflected in your platform's design?
- How much of your current platform's architecture reflects decisions made primarily by clinical subject matter experts? How much was shaped by learning design or empathic design expertise?
- How can you invite users to actively and consciously articulate precisely what they need?
- Has a prototype or pilot in your organization ever been treated as a productive failure, something that changed the direction of a project rather than simply being refined until it worked? And if not, what does that suggest about where the real design decisions are actually being made?





# 4. Putting the Who Before the What

As part of our research into digital health promotion platforms, we conducted an environmental scan of approximately 140 websites, each of which had been recommended either by practising clinicians or by a publicly funded health literacy team. The scan assessed content quality, navigational architecture, design principles, and the degree to which each site demonstrated awareness of the emotional state of its likely visitor.

From 140 sites, five were shortlisted as genuinely exemplary: jigsaw.ie, kooth.com, understood.org, Foundry (foundrybc.ca), and Anxiety Canada (anxietycanada.com). What separated them from the rest was not the volume or clinical quality of their content, though in most cases that was strong. It was something that operated before content, in the first moments of a visit, before a single resource had been found or a single menu item clicked. These sites communicated, with considerable design intelligence, that they knew who had arrived and why.

We refer to this as the 'who before what' approach. It is simpler to describe than it is to execute, and most health promotion platforms, as our broader research made clear, have not yet made it central to how they design.

## What 'Who Before What' Actually Means

The conventional architecture of a health promotion website is organized from the perspective of an Organizational Lens: the content categories, resource types, program areas, and professional domains. The visitor arrives and is invited to navigate this organizational structure to find what they need. The implicit assumption is that the visitor knows what they are looking for, has the cognitive bandwidth to work through a structured menu system, and will persist until they find it.

The best-performing sites in our environmental scan operated on a different assumption entirely. They treated the first moments of a visit as an opportunity to establish recognition before presenting any content at all. Recognition, in this context, means communicating to the visitor: we know the kind of person you are, we know something about why you are here, and this site was built with you specifically in mind. That communication happens through visual design, through the language used in the first few lines of text on the page, through the navigational structure, and through what the site chooses not to put on its homepage as much as what it does.

> *Who we are is more important than what we have to offer. The best platforms understand this. Most platforms have not yet acted on it.*

## What the Environmental Scan Found

Each of the five shortlisted sites had made a fundamental decision that most health promotion platforms avoid: they had chosen a primary audience and built their entire design around that choice. Not in a way that excluded other visitors, but in a way that made one group of people feel immediately and specifically addressed.

Kooth.com, a UK-based youth mental health platform, offered as its primary homepage action an immediate invitation to talk online, connecting visitors with both peers and professionals before any resource had been browsed. The navigation was stripped back to two core offerings: live discussion and a searchable article database, both entirely internally produced. The homepage carried minimal text. The design used generous blank space, soft colour, and visual language calibrated precisely for a young person who might be arriving anxious, uncertain, going through a tough time. There was no clutter or organizational grandstanding. The site knew who it was for, and had designed every element accordingly.

Understood.org, a New York-based non-profit built for people who learn and think differently, had made empathy so central to its design that it was embedded in the organization's name itself. The opening homepage statement addresses the visitor directly and personally, and this constitutes almost the entirety of what appears on the screen when the page loads. The 'about us' information, standard front-and-centre content on most organizational sites, was reduced to a small icon in the corner. Approximately 99% of the

homepage was dedicated to communicating that the site understood its audience. The navigation then used an interactive sentence-completion feature, beginning with 'how can we help?', that asked visitors to identify themselves before presenting any content pathway. The effect was of being met, rather than being presented to.

Jigsaw.ie, an Irish youth mental health charity, had built its entire online strategy around just two features: live one-to-one chat and a searchable article database. Despite an ambitious national agenda, the digital presence was deliberately minimal. What looked like restraint was, in practice, a precise strategic decision to offer fewer things and make each of them work exceptionally well for the person most likely to arrive.

## The Design Logic Behind Blank Space

One finding from the environmental scan that surprised some members of the research team, though in retrospect it should not have, was the consistent and deliberate use of blank space across all five shortlisted sites. In each case, at any given point in a visitor's journey, at least half of the visible screen was empty.

Rather than being a stylistic preference or a decorative graphic design choice, it is an affective design decision grounded in an understanding of the cognitive and emotional state of the likely visitor. A person arriving on a mental health platform is not, in most cases, in an optimal state for processing dense information. Blank space reduces visual anxiety. It slows the eye. It signals that the site is not going to overwhelm the visitor with everything it has. It communicates a kind of patience.

Contrast this with the more common approach, where homepages are populated with featured resources, promotional banners, multiple navigation pathways, audience-selection buttons, news items, and social media feeds, all competing for attention simultaneously. The intention is to demonstrate range and relevance. The effect, particularly for a visitor in a heightened emotional state, is frequently the opposite. The page communicates volume, options, choices, pathways. The visitor faced with too many choices and no clear signal that any of them are specifically for them will simply leave.

The 60% homepage bounce rates are, in part, a consequence of this design orientation. The Affective Lens has not been applied to what the visitor sees in the first three seconds.

## Funnelled Navigation and the Smorgasbord Problem

The environmental scan drew a clear distinction between two navigational philosophies that we have come to refer to as *funnelling* and *smorgasbord*.

Smorgasbord navigation presents the visitor with the full spread of what is available and invites them to select. It is familiar, organizationally comfortable, and relatively straightforward to build. It is also, for the audiences most health promotion platforms are trying to serve, often the wrong choice. A caregiver trying to navigate a loved one's new diagnosis does not want to browse and search. A teacher who has had a hard week does not want to filter down overwhelming options to get to what they need. A clinician squeezed into a two-minute window between patients does not want to hunt for a resource. They want to be the site to guide them directly to what they need urgently.

Funnelled navigation begins by asking who the visitor is, and uses that answer to progressively narrow the experience toward what is most likely to be relevant. It requires the organization to have made prior decisions about who its primary audiences are and what those audiences most need, decisions that precede any technical design work. The best-performing site in the environmental scan used a multi-step interactive feature that identified the visitor's role, their specific area of concern, and the kind of support they were looking for, before presenting any resources at all. The visitor arrived at content having been accompanied through a brief, personalized pathway rather than having been left to find their own way through a catalogue.

This approach requires discipline. It means accepting that not everything the organization has produced will be equally prominent, and that some content will be deprioritized in service of a cleaner, more directed experience for the visitor most likely to arrive. That is a difficult organizational concession to make, particularly in institutions where content production is itself a measure of value.

While these two philosophies represent distinct operational styles observed during our scan, they are much more than mere layout choices. The architecture an organization selects serves as the primary mechanism for either utilizing or undermining an Affective Lens perspective at the point of entry.

## The Affective Lens as Architectural Principle

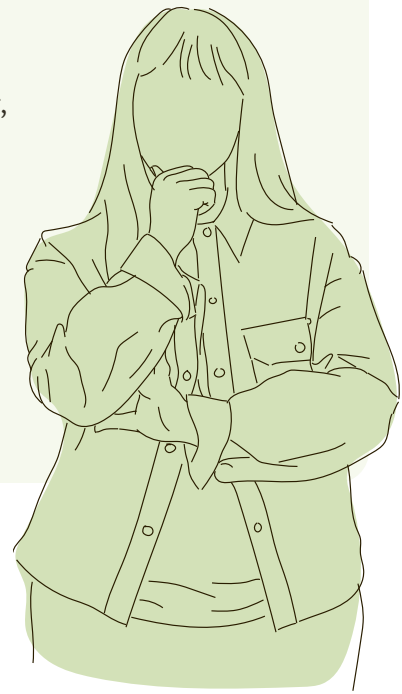
What our extensive environmental scan confirmed is that the Affective Lens is not a perspective applied to a platform after the fundamental design decisions have been made. It is not a matter of choosing warmer photography or more empathic copy. It is an architectural principle that shapes the most basic decisions: what goes on the homepage and what does not, how many navigation options are offered and how they are sequenced, what the first question the site asks a visitor actually is.

None of the five shortlisted sites arrived at their design through a conventional content-first planning process. Each had started from a clear and specific understanding of who their primary visitor was, what that person was likely to be experiencing when they arrived, and what the site needed to communicate before anything else. The content, in each case, was substantial and carefully produced. But it was organized in service of the visitor's experience of being met for who they were, not in service of the organization's interest in demonstrating what it had built.

This distinction is easier to state than it is to institutionalize, particularly in publicly funded environments where accountability tends to be measured in outputs rather than in the quality of the moment when a caregiver or professional in distress finds exactly what they needed and feels, for the first time in weeks, that someone understands their situation.

## Questions Worth Asking About Your Own Platform

- If you look at your homepage without reading a single word of its content, what does the visual structure communicate? Does it say 'we have a great deal to offer' or does it say 'we know who you are and we have been expecting you'?
- Has your organization made an explicit decision about who the primary visitor to your platform is? Not the full range of people who might conceivably visit, but the specific person you have designed the first experience for?
- How much blank space is on your homepage? And if the answer is 'not much', is that a deliberate decision or simply what happened when the content was added?
- When a visitor arrives on your platform's homepage, what is the first question the site asks them? And if it does not ask them anything, what does it say instead?
- Could a visitor who arrives overwhelmed and uncertain find their way to something genuinely useful within thirty seconds, without reading any navigation labels carefully or making more than two decisions?



# 5. A Sanctuary or a Departure Lounge?

In one form or another, the *resource library*, that is so common across publicly funded health promotion platforms, functions less as a learning environment and more as a sophisticated set of bookmarks. The organization has identified good external content, organized it into categories, applied filters, and presented it to visitors as a curated collection. The intention is to save users the work of finding credible sources themselves. It is a generous impulse, but it creates a set of problems that most teams have not fully reckoned with.

Content ownership, and specifically the question of how much of what is on your platform was produced by your organization and how much was sourced from elsewhere, is one of the more consequential strategic questions in digital health promotion. The question rarely receives the sustained attention it deserves, because the pressures that lead to heavy curation are real and the consequences are slow to become visible - at which point the library has grown considerably and the path back is not straightforward.

## The Capacity Logic and Its Limits

The case for curation is not difficult to make. Producing original content is resource-intensive. It requires clinical expertise, editorial oversight, design capacity, and ongoing maintenance as evidence and guidelines change. A team of five people cannot produce everything their users might need. Curating quality external material seems like a reasonable complement to what can be produced internally, and in limited measure it is.

The difficulty arises when curation becomes the primary mode of content provision rather than a supplement to it. In one platform assessed during our research, the resource library was predominantly composed of links to external sites. Visitors who followed those links left the platform. Many did not return. The organization had, in effect, built a departure lounge, a well-organized space whose primary function was to send visitors somewhere else.

From an Organizational Lens perspective this looks like service delivery, but from an Affective Lens perspective it is something more troubling. The visitor who arrived anxious or uncertain, who needed to feel accompanied through a process of finding support, has been handed a list of addresses and left to navigate from there.

## What Happens After the Click Away?

The research found that once a visitor followed an external link from a health promotion platform, the platform lost meaningful contact with them. It could not track what happened next. It could not assess whether the destination was useful, current, or appropriately pitched for the visitor's level of understanding. If the external resource was poorly designed, confusing, or simply not what the visitor needed, the experience registered as a failure of the *referring* platform in the visitor's mind, not of the destination.

This is not a trivial problem for organizations whose core purpose is to bridge the health literacy gap. Take any common scenario: a person looking for guidance on managing a physical condition, or a caregiver searching for guidance on mental health support. If they click through to an external resource that turns out to be dated, dense, or written for a medical audience rather than a layperson (or vice-versa), they will close the tab in frustration. They have had a negative experience with your platform, and they are likely to simply not return.

The research also noted a structural measurement problem. Because external links were not being tracked through analytics tools, there was no reliable data on what proportion of visitors were following those links, which external destinations were actually being used, or what the return rate looked like. The platform was operating largely blind to a significant portion of its users' journeys. Installing proper external link tracking is not technically complex. It is, however, routinely overlooked, and without it the curation model cannot be meaningfully evaluated.

> *Authority and trust are properties of the source, not the content. A library of external links does not inherit the credibility of the institution that assembled it.*

## The Clinician Preference Gap

Our research included a survey of practising clinicians, examining their awareness of, and referral behaviour toward, publicly funded health literacy resources. The findings illuminate a gap worth understanding carefully, because it has direct implications for how the content ownership question should be approached.

While this specific inquiry focused on mental health, the results highlight a universal standard for institutional trust. When asked about their preferences, 82% of clinician respondents indicated that it was important for mental health information to be generated, owned, and managed by the publicly-funded health authority, with half of those respondents rating this as either very or extremely important. The reasoning was consistent: institutional authorship carries a level of clinical accountability and quality assurance that curated external links could not ensure. Clinicians prefer and put more stock in content that an institution has produced and stood behind.

Their actual referral behaviour, however, told a different story. Despite this stated preference, clinicians were more often directing patients to external sites, including in some cases, resources designed for clinical providers rather than for the general public or families. The gap between what clinicians said they valued and what they actually recommended was not a matter of bad faith. More simply, they were not aware of what had been produced internally, or were not confident enough in the platform's navigational clarity to direct a patient there reliably.

This finding has two implications. The first is that internal content production is worth investing in, because the people who refer patients value it when they know it exists. The second is that producing good internal content is insufficient if clinicians cannot easily find it, evaluate its relevance for a specific patient, and recommend it with confidence.

## The Quality Signal in External Links

One finding from our environmental scan brings this design gap into sharp, quantitative focus. Researchers assessed the visual presentation of external resources recommended within a publicly funded platform's resource library and found that just over half had a dated appearance. When the same researchers then looked at the external sites that clinicians were independently recommending to patients, over 70% had a current, professionally maintained look and feel.

This gap suggests something about how resource libraries accumulate over time. Links are added when the resource is identified as credible and clinically relevant. They are rarely reviewed for continued currency, design quality, or whether the site remains maintained. A resource that was excellent three years ago may have aged poorly while remaining in the library unchallenged. The library grows without being adequately pruned.

## What the Best-Performing Platforms Do Differently

This operational discipline directly reflects a core characteristic shared by the five exemplary platforms from our environmental scan. They produced their own material and did not, in any significant measure, curate external resources. Jigsaw.ie's entire online content offering consisted of internally produced articles and direct human connection. Kooth.com owned and managed 100% of its content with the exception of a single page listing partner organizations. Understood.org's resources were internally authored throughout.

These were deliberate strategic decisions, made on the basis of a clear understanding that the design consistency, editorial coherence, and integrity of tone of a platform that depends on controlling what appeared within it. Each external link is a another small surrender of that control, and when external links constitute the majority of a library's content, the coherence of the platform as an experience begins to fragment.

The Connective Lens observation here is also worth noting. A platform composed largely of links to other organizations cannot build a sense of community or shared identity around its content. There is no voice, no consistent perspective, no accumulating relationship between the platform and its visitor. The visitor is always being redirected. The platform remains in their experience a transit point rather than a destination.

## A Note on the Less Is More Principle

To understand this critical need for curation, it is worth looking at a specific scenario from our user testing. A participant seeking ADHD resources filtered for a parent audience was met with a wall of twenty-four separate results. Twenty-four results, each with a brief description of content but without guidance on why a particular resource was being suggested, what level of prior knowledge it assumed, or how long it would take to engage with, is not a useful experience for someone already overwhelmed. It may demonstrate the library's comprehensiveness, but it is not at the service of the visitor.

The best-performing platforms in the environmental scan made consistent and deliberate decisions to offer fewer things and make each of them work exceptionally well. That discipline is considerably harder to maintain in an institutional context where adding a new resource is easy and removing an existing one requires someone to make an active decision. The default, in most organizations, is accumulation. Reversing it requires a different set of organizational conversations than the ones most health promotion teams are currently having.

## Questions Worth Asking About Your Own Platform

- What proportion of your platform's content was produced internally, and what proportion consists of links to external resources? Is there a deliberate strategic rationale for that balance, or has it evolved organically over time?
- When a visitor follows an external link from your platform, do you know what happens next? Is external link tracking in place, and when were the destination sites last reviewed for currency and quality?
- Do your clinicians know what you have produced internally? Is there a mechanism that makes it easy for them to identify a specific internally produced resource and recommend it to a patient with confidence?
- If you filter your own resource library for your most common visitor type and their most frequently searched topic, how many results appear? And is that a number someone with limited time and attention can usefully navigate?
- When did you last remove something from your resource library? And if the answer is never, or not recently, what would it take to make that a regular part of how the library is maintained?

# 6. Designing for the Affective State of Your Audience

Most health promotion platforms are designed around a picture of their audience that is, at best, incomplete. The picture is built from demographics, from clinical needs assessments, from survey data about what topics people say they want more information on. It captures what people identify as their informational needs. It rarely captures what they bring with them when they arrive.

The distinction matters more than it might initially appear. A person's capacity to engage with new information, to absorb it, retain it, and do something useful with it, is not a fixed property. It varies significantly depending on their internal state at the moment of encounter. A parent who is managing a recent diagnosis for their child, navigating a school system that does not fully understand the condition, worrying about the implications for the family, and running on interrupted sleep, is not in the same cognitive and emotional condition as the calm, information-seeking adult that most general platform design implicitly assumes. A teacher who has spent a morning managing a classroom with three or four students in acute distress, who reaches the end of their professional resources before the lunch bell, and who feels professionally isolated in a role that nobody outside the classroom fully understands, is also not that person. And a clinician squeezed into a two-minute window between patients, operating under the relentless pressure of a packed clinic schedule while trying to track down a reliable resource to hand to a distressed family, is equally far from that idealized profile.

These are the people most health promotion platforms are built for but they are largely designed as though they were for someone else completely.

## The Affective Snapshot Methodology

To see how this framework functions in practice, it is worth examining a specific application of the affective snapshot methodology introduced in Chapter 3. As part of a needs analysis for a program to raise awareness around techniques to help manage and thrive with ADHD, we convened two small focus groups. Our purpose was not to compile a list of features, but to capture the internal affective states of the two primary user groups: parents of children with mental health conditions, and teachers supporting students with complex needs. The methodology was deliberately open-ended. Questioning was adaptive rather than directive. The aim was not to establish what participants wanted from a platform, but to understand the emotional and cognitive context they inhabited, the internal conditions they would bring with them to any learning situation.

Group A was composed of teachers and principals describing their own emotional states and those they observed in colleagues. Group B was composed of clinical psychologists describing the emotional states they observed in the parents they supported through family therapy and group training. Using clinicians as proxies for the parent group allowed for a degree of reflective distance that direct interviews with parents would not have produced in the same way, and the psychologists' accounts carried the accumulated weight of many individual cases rather than one person's single experience.

What the sessions produced turned out to be more than a needs analysis. It was something more granular and more useful for platform design and helped form a picture of the inner landscape that these visitors carry with them, often invisibly, into every encounter with a health promotion resource.

## What the Teachers Described

The focus group was convened specifically in the context of professional development around child and youth neurodiversity and mental health, the kind of complex territory that digital health promotion platforms for educators frequently set out to address. What emerged was striking in several respects, and not primarily for the reasons that might be expected. The most prominent theme was not, as had been presumed, workload, though workload featured throughout. It was a particular kind of overwhelm with a cumulative, compounding quality. Teachers described classrooms where three or four

students were simultaneously experiencing significant mental health difficulties. Managing those students while attempting to teach the rest of the class created a sustained state of cognitive and emotional demand that did not lift at the end of the school day. The exhaustion, as multiple participants described it, crept into every aspect of their lives.

Alongside this was a pervasive sense of professional inadequacy. Teachers described knowing that a student needed a kind of support they did not have the training or the time to provide, and feeling the weight of that gap acutely. Several described a specific dread such as arriving at school in the morning already anticipating which student would destabilize the day, and feeling something close to relief on days when that student was absent.

The social dimension was also consistently present. Teachers described feeling professionally isolated, unsure whether what they were experiencing was normal, reluctant to raise it with colleagues or management for fear of appearing unable to cope. The isolation was compounded by the sense that people outside the classroom, including parents, school leadership, and health professionals, did not have an accurate picture of what the classroom day actually involved.

What teachers said they wanted from professional development was telling. They wanted practically applicable strategies they could use the following morning, content that was quickly digestible given their time constraints, and above all a sense of being seen and supported rather than simply informed. They wanted to feel connected to a community of people in similar situations. They wanted, as one participant put it, to know they were not alone in this.

> *The capacity to absorb new information is not a fixed property of the learner. It varies with their internal state at the moment of encounter. Platform design that ignores this is not neutral. It is a design choice with measurable consequences.*

## What the Clinical Psychologists Described

The picture that emerged from the clinical psychologist group was equally specific, and contained several findings that a standard parent needs assessment would be unlikely to produce.

Parents of children with mental health conditions, as described by the psychologists who worked with them regularly, were frequently operating under a form of ambiguity that was itself a significant source of distress. They were often unable to clearly distinguish between what was a parenting challenge and what was a neurological or clinical one. This ambiguity produced a particular kind of guilt, a background sense that if they were more consistent, more patient, more skilled as parents, the situation would improve. The possibility that their child's difficulties had a brain-based origin, that the child was not choosing difficult behaviour but experiencing it, was for many parents both a relief and a further source of grief.

The social dimension for parents had a different character than for teachers, but was no less significant. Parents described a form of isolation rooted in shame and the perception of judgement from other parents, from the school system, and occasionally from extended family. They wanted techniques and strategies, but what they described wanting first was to feel less alone, less judged, and more confident that they were not the cause of their child's difficulties.

The psychologists noted a consistent pattern in how parents arrived to group sessions. The parents were guarded, uncertain whether this was a space that would understand their situation, and watchful for signs of judgement. The sessions that produced the most engagement and the most durable learning were consistently those that began by acknowledging the difficulty of the parents' position before introducing any content. The acknowledgement did not need to be extensive. It needed to be genuine and specific enough to signal that the facilitator, or in a digital context - the platform, knew who was in the room.

## Why This Changes the Design Brief

The snapshots via an affective lens provide findings that have implications that go well beyond tone of voice or the warmth of a homepage image. They change the design brief at a fundamental level.

A parent arriving on a health literacy platform in the state described above is not primarily looking to acquire information. They are looking to feel less alone, to have their difficulty recognized, and to find something that gives them a sense of agency over a situation that frequently feels unmanageable. Information is useful to them, but only once that prior need has been, at minimum, acknowledged. A platform that moves immediately to content, presenting resources without first establishing that it understands who has arrived and what that person is likely to be experiencing, is addressing the informational need while missing the affective one. And when the affective need is unmet, the information does not land with the same force, is less likely to be retained, and is considerably less likely to be acted upon.

Learning theory supports this. What concerns an audience determines what they will remember. Personalization in a meaningful sense is not about showing someone content tagged to their job role or their child's diagnosis. It is about demonstrating an understanding of what occupies their attention, what they are afraid of, and what they are trying to do. Content that speaks to those concerns is retained. Content that does not is processed and forgotten, if it is processed at all.

The feedback gathered from participants in a well-designed digital health program in the research set illustrates this directly. Parents who completed the program described not just having learned new strategies, but having had a shift in how they understood their child's experience. One participant wrote that the program had helped them realize their child could not simply *choose* to behave differently, and that this realization had changed how they responded to the challenges of parenting. Another described knowing that they were not alone as the most significant thing the program had given them. These are not merely informational outcomes, they are affective ones, and they are the outcomes that produce durable change.

## The Design Gap

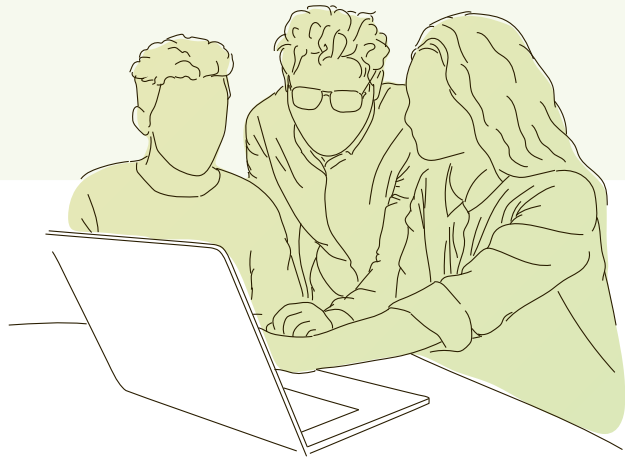
An environmental scan of 27 publicly available online mental health resources we conducted mapped the format types in use across those platforms against the four-lens framework. The finding was unambiguous: the overwhelming majority of resources indicated an Activity Lens orientation. They were articles, videos, toolkits, and archived webinars. The Affective Lens was rarely utilized at all: almost nothing in the landscape was designed to meet the visitor's inner state before presenting content. The Connective Lens fared no better, with peer support options either difficult to find or absent entirely.

This is not a finding about individual platforms making poor decisions, but rather a sector-wide default that reflects the assumptions embedded in conventional adult education: that the learner is ready to engage, that information is what they need, and that providing it well is sufficient. The affective snapshot data suggests that for the audiences most health promotion platforms are trying to serve, these assumptions are systematically wrong in ways that have direct consequences for impact.

The platforms that perform best, as the environmental scan showed, are those that have organized their design around a genuine understanding of their visitor's inner state. They do not begin with what they have to offer. They begin with who is arriving and what that person is likely to be carrying.

## Questions Worth Asking About Your Own Platform

- When did your organization last gather qualitative data specifically about the emotional and cognitive state of your primary user group, not their informational needs, but the internal context they bring to any learning encounter?
- If you read your platform's homepage aloud to a parent in the state described in this chapter, at what point would they feel recognized? At what point would they feel that the platform understood not just their topic area but their situation?
- What proportion of your platform's content addresses the affective dimension of your audience's experience, their isolation, their self-doubt, or their need to feel that what they are dealing with is understood? And how is that content positioned relative to informational resources?
- In the programs or courses your organization has produced, where does acknowledgement of the difficulty of the learner's situation appear? Is it present at all, and if so, is it near the beginning where it can do the most work, or buried somewhere in the middle?
- And when you measure the impact of what your platform produces, what outcomes are you looking for? Are any of them affective ones?



# 7. Avoiding the Smorgasbord

Navigation tends to be treated as a late-stage technical problem in the development of health promotion platforms. Once the content is planned, once the information architecture is sketched, then the question of how users will move through it is handed to a web developer to resolve - often being pointed to an example site itself developed with via a heavy Organizational perspective.

The result is a site structure that is functional without necessarily being considered, one that organizes content in a way that makes sense from the inside of the organization, but may communicate something quite different to a visitor arriving from the outside.

Our research found that navigational architecture is one of the most consequential decisions a health promotion platform makes. More than determining whether users can technically find content, it communicates, before a single resource has been opened, what assumptions the platform is making about who is visiting and what they are affectively capable of when they arrive.

Navigation, in other words, is an affective statement as much as a structural one. And most health promotion platforms are making that statement in a way they do not fully intend.

## The Smorgasbord Default

To understand why the navigational approach dictates a platform's success, we must examine how the smorgasbord model functions as a default setting. This broad presentation of available content, organized by topic or content type, relies on an expectation that visitors will scan, select, and self-direct their way to what they need. The model is familiar because it is the default architecture of the web as most organizations have learned to build it. It reflects the Organizational Lens view of a site, one that is comprehensive, categorized, and accessible to anyone with sufficient patience to work through it.

The difficulty, as the research made clear, is that patience and self-direction are precisely the capacities most likely to be compromised in the people most health promotion platforms are trying to reach. A parent managing a child's recent diagnosis, a teacher already at capacity before the school day begins, does not arrive on a platform in a state that supports methodical menu navigation. They arrive looking for a signal that the site knows why they came and can take them somewhere useful quickly. The smorgasbord offers them a display case and invites them to browse.

Our comparative data brings this operational tension into clear view. One publicly funded mental health platform had a homepage carrying more navigational options, both visible and scroll-accessible, than all of the five shortlisted best-practice sites combined. The options were well-organized and logically categorized. They were also, for a visitor in a heightened emotional state, overwhelming. The 60% bounce rate we observed across that platform stands as a direct behavioural reflection of this structural layout.

> *Navigation architecture should not be a technical decision made after the content is planned. It is a fundamental design decision that encodes the organization's assumptions about its visitor. Those assumptions are worth making explicit before they are built in.*

## Funnelled Navigation and What It Requires

Funnelled navigation begins from a different premise entirely. Rather than presenting the visitor with the full range of what is available and inviting them to self-select, it asks the visitor a question first. Who are you? What are you dealing with? What kind of support are you looking for? The answer to that question narrows the experience progressively, so that what the visitor encounters is not a comprehensive catalogue but a curated path through the content most likely to be relevant to their specific situation.

We see the operational power of this approach in the interactive sentence-completion features utilized by platforms like Understood.org. By walking the visitor gracefully through a multi-step sequence: identifying their role (parent, educator, patient), specifying the area of difficulty, and refining the type of support they were seeking, the architecture prevents cognitive gridlock. By the end of that sequence, the visitor had not browsed a menu. They had been accompanied to a starting point that had been selected for them, and the selection had been made on the basis of information the visitor had provided about their own situation.

Foundry (foundrybc.ca), the youth mental health platform included in the scan, had built a similar principle into its Pathways feature: a structured navigation tool that guided visitors through a set of choices before presenting content. The implementation had technical inconsistencies at the time of the research, and the introductory video explaining how the feature worked was underdeveloped relative to the quality of the rest of the site. But the underlying logic was sound and, when the feature worked as intended, produced a meaningfully different experience than open-ended menu navigation.

What funnelled navigation requires, and this is why most organizations do not build it, is that prior decisions have been made before any technical work begins. The organization must have decided who its primary visitor is, what that person is most likely to need, and what sequence of questions will most efficiently connect them to it. These are strategic and design decisions, not technical ones, and they cannot be delegated to a developer at the point of build.

## The Number of Options Problem

This principle becomes highly visible when examining the comparative count of navigational options across the shortlisted sites and the platforms being assessed. The count covered all links and options visible on the homepage, both above and below the initial view, that a visitor could use to access information.

The five best-practice sites shared a striking characteristic: their homepage navigation was, by any measure, minimal. Jigsaw.ie offered two primary pathways. Kooth.com kept its navigation to a small number of clearly defined options. Understood.org's primary navigation was essentially the interactive question sequence, with organizational information reduced to a single small icon. The principle was consistent across all five with fewer options, each made to work exceptionally well for the intended visitor.

The contrast with the platforms under review was marked. One site presented visitors with enough navigational options across its homepage that counting them required a systematic scroll. The intention was comprehensiveness but the effect, particularly for a visitor not already familiar with the site's structure, was a kind of visual noise that made orienting difficult. Every additional option added to a menu is, from the visitor's perspective, a small additional cognitive demand. For a visitor already operating under load, those demands accumulate rapidly.

## Navigation as an Affective Statement

The choice between smorgasbord and funnelled navigation is, at its core, a choice about what the organization believes its visitor is capable of when they arrive. Smorgasbord navigation implicitly assumes a capable, self-directed adult who knows what they are looking for and has the cognitive resources to find it. Funnelled navigation implicitly assumes a visitor who may be uncertain, overwhelmed, or emotionally compromised, and who will benefit from being guided rather than left to navigate independently.

In the context of health promotion and literacy platforms, where the majority of visitors are either managing a health challenge themselves or supporting someone who is, the second assumption is considerably more accurate than the first. Far more than a technical nuance, it is an act of institutional empathy, a practical expression of the organization's stated commitment to meeting people where they are.

The gap between what health promotion organizations say about their mission and what their navigation architecture communicates to visitors is, in many cases, substantial. Closing that gap requires the people making strategic decisions about platform development to understand that navigation is not a downstream implementation detail. It is one of the primary ways a platform expresses what it believes about the people it was built to serve.

## The Post-Content Check-In

One navigational feature observed in the best-practice sites that is almost entirely absent from the platforms we examined is the post-content check-in: a prompt, appearing after a visitor has been directed to a specific topic or resource, that asks whether their needs have been met and offers a pathway to further help if they have not.

This feature is small in implementation and significant in effect. It extends the affective logic of funnelled navigation beyond the arrival moment into the content experience itself. It signals to the visitor that the site is not simply a delivery mechanism for information but an ongoing presence that is interested in whether the information was useful. It also, practically, creates a mechanism for feedback and impact assessment that most platforms currently lack.

## Questions Worth Asking About Your Own Platform

- If you count the total number of navigational options on your platform's homepage, including those accessible by scrolling, how many are there? And is that number a deliberate strategic decision, or simply what accumulated as content was added?
- Does your navigation ask the visitor a question before presenting content, or does it present content and expect the visitor to find their own starting point?
- If you had to describe the implicit assumption your navigation architecture makes about the visitor's state when they arrive, what would that assumption be? Is it consistent with what the affective snapshot research suggests about your actual audience?
- At what point in your platform's development was navigation discussed? Was it a strategic decision made before content was planned, or a technical problem solved after the content structure had already been established?
- And does your platform check in with visitors after directing them to content, to find out whether what they found was useful? If not, how do you currently know whether it was?



# 8. The Costs of Cutting Connectivity

The Connective Lens is the most consistently neglected of the four lenses in digital health promotion. This is not because the people building these platforms do not value community, peer exchange, and shared discovery. In most cases they do, and it appears in the planning documents and the initial project briefs. It tends to disappear before the platform launches, and it disappears for structural reasons that have very little to do with its perceived value.

Understanding why this happens, and what the consequences are, requires looking at how digital health promotion projects are typically funded and what that funding structure rewards. It also requires looking honestly at what the research evidence says about the role of connection in whether health promotion actually works.

## What the Connective Lens Actually Covers

The Connective Lens encompasses dialogue and shared discovery: the conversations, forums, peer interactions, and community structures through which individuals locate common ground and find that others share their experience. In a health promotion context this includes discussion forums, moderated community groups, peer support networks, live facilitated sessions, communities of practice for clinicians, and any mechanism that allows one participant's discovery to become available to others.

It is worth being clear about what the Connective Lens is not. A social media channel is not, in itself, a connective structure. One publicly funded mental health platform we examined had maintained an active Facebook presence, publishing approximately 140 posts over a six-month period. Those posts had generated five comments in total. The channel generated reach in the broadcast sense. It did not generate connection. The distinction matters: reach is an Organizational Lens metric. Genuine dialogue is a Connective Lens one, and the two are not the same thing.

Similarly, a lecture-format webinar, even a live one, sits primarily within the Activity Lens. The format positions participants as recipients of information rather than contributors to a shared inquiry. The connective potential of a live session is largely unrealized when the design does not make active dialogue central to the format.

## The Funding Structure Problem

The structural explanation for why connective elements are consistently cut from digital health promotion projects is relatively straightforward, and our research named it directly. Digital health promotion is almost always funded on a project-by-project basis: a defined deliverable, a defined timeline, a defined budget. The deliverable is typically a product, a platform, a course, a resource suite and the budget is calibrated to the cost of producing that product.

Connective elements, by their nature, are not products but ongoing processes. A discussion forum requires moderation, a community of practice requires facilitation. A peer support network requires someone to manage it, seed conversations, address distress signals, and maintain the conditions under which genuine dialogue can occur. The problem, given the nature of project-based funding in the sector, is that they are not one-time costs. They are recurring commitments, and recurring commitments do not fit easily into project-based funding envelopes.

The consequence is predictable. Connective features appear in the planning phase, where they are enthusiastically endorsed as essential to the platform's mission. As the budget is tightened and the scope is negotiated, they are deferred to a future phase of development and a vicious circle ensues.

That future phase rarely arrives with its own dedicated funding, because the argument for it has to be made from scratch for approval within a subsequent funding cycle. And that argument will lack the support of evidence of impact from a connective element that was never built in the first place.

> *The ongoing human cost of sustaining connective learning sits outside the boundary of what project-based funding is designed to cover. This is a structural problem, not a values problem. But the result, for the user, is the same.*

## What Users Consistently Say They Want

One of the more striking consistencies across our research was the gap between what health promotion platforms offer in terms of connection and what the users of those platforms say they are looking for.

In our affective snapshot focus groups, both teachers and parent groups identified the desire for community as one of their most significant unmet needs. As our investigation into their inner landscapes illustrated, teachers longed to feel professionally connected and supported, eager to know that others were dealing with similar challenges and had found approaches that worked. Similarly, parents expressed a vital need to connect with peers in comparable situations, seeking to reduce the isolation that accompanies supporting a loved one with complex needs and to access the kind of practical wisdom that only comes from shared lived experience.

The user experience observation sessions produced a consistent finding of the same kind. When participants were asked directly what they felt was missing from the platforms they had navigated, forums and live chat options appeared repeatedly. What they wanted was somewhere between a resource library and a crisis line: a space to talk, to ask questions that were not emergencies, and to hear from others who had been in similar situations. That space did not exist on the platforms they were using. It was technically simple to achieve, but securing resources for *ongoing* staffing capacity to maintain them was structurally ruled out by term-limited project procurement.

## What Connective Design Actually Looks Like

The best examples of connective design in health promotion tend to be found either in platforms that manage to make community central from the outset, or in programs that structure their delivery around peer exchange rather than content broadcast.

Kooth.com was the most instructive example from our environmental scans. Despite being a mental health platform built primarily for young people, with no links to external social media, it was designed from the ground up as a social environment. Its core features, a moderated forum, a live chat function, a shared articles section, and a journal tool, were mutually reinforcing: content encountered in one context could generate a conversation in another, and peer interaction was built into the navigation rather than added as an optional feature. Community *is* the primary offering, not a supplemental feature.

In the clinical provider education context, the Project Echo approach offers a well-evidenced model of connective learning that has been adopted internationally. Originally developed at the University of New Mexico, the model structures learning around expert-guided, peer group case-study sessions in which practitioners present real cases from their practice, receive input from a specialist hub, and engage in facilitated discussion with peers facing comparable challenges. The format is explicitly designed to build communities of practice rather than simply transfer knowledge, and its particular effectiveness in reaching clinicians in rural and isolated communities makes it especially relevant for the Canadian health promotion context.

One publicly funded clinical support program we examined had developed its own adaptation of the Project Echo format, used alongside a resource library and a suite of micro-learning tools. The Connective Lens contribution of this program was its most distinctive feature and, by the evidence available, its most impactful one. However, the capacity constraints that came with its growth pointed directly to the need for a scalable connective infrastructure that the format alone could not fully provide.

## The Shared Cost Solution

We proposed a practical response to the structural funding problem. If connective elements cannot be sustainably funded within individual project budgets, the solution is to fund them across projects through a shared infrastructure that sits at the organizational level rather than the project level.

This means maintaining a small core team with ongoing responsibility for community management, forum moderation, engagement support, and the facilitation of peer learning across multiple projects simultaneously. The costs of this team are distributed across all projects that benefit from its work, rather than being borne by any single project budget. Each individual project becomes a contributor to a shared connective infrastructure rather than being required to independently justify and fund the connective elements it needs.

This is how media organizations manage editorial teams, how clinical services manage supervision structures, and how continuing professional development programs manage their facilitation capacity. It is, however, relatively uncommon in publicly funded digital health promotion, where the project-by-project funding logic creates strong incentives against the kind of sustained investment in human infrastructure that connective learning requires.

## A Note on What Webinars Could Be

The lecture-format webinar is the most common concession to connective learning in health promotion, and it is worth being honest about its limitations. A presentation delivered live via video conference, followed by a brief question-and-answer period, provides the format of dialogue without most of its substance. Participants remain in the role of audience rather than contributors.

This is not an argument against webinars. It is an argument for using them differently. The research identified a flipped webinar model as considerably more effective for connective purposes: participants complete the didactic content independently in advance, and the live session is used entirely for discussion, case-based exploration, and peer exchange. The preparation

burden on the presenter decreases. The connective value of the session increases substantially. The format becomes genuinely built through a Connective Lens rather than simply designed via the Activity Lens with a chat function add-on.

## Questions Worth Asking About Your Own Platform

- When your organization's last digital project was planned, at what point did connective elements appear in the scope? And at what point did they disappear from it?
- What connective infrastructure currently exists across your organization's digital portfolio? Is there a team or a function with ongoing responsibility for community, moderation, and peer engagement, or does each project handle this independently when it handles it at all?
- When your users have told you what is missing from your platforms, how often has connection appeared in their answers? And how has your organization responded to that finding?
- Are the webinars your organization runs designed primarily to transfer information, or to build the kind of ongoing community that reduces isolation and increases the practical impact of what people learn?
- And is there a funding argument your organization could make for a shared connective infrastructure, one that spans projects rather than being confined to any single one? What evidence would you need to make that argument credibly?

# 9. When Your Ecosystem Becomes a Maze

Most digital health promotion ecosystems do not start out as mazes. They begin as a single platform, or perhaps two, serving a reasonably well-defined purpose. Over time, as programs expand, as new funding is secured, as different teams develop different initiatives, new sites are added. Each addition is logical in isolation. Collectively they create something that no single person designed and that no visitor can easily navigate: a landscape of overlapping properties with inconsistent audience assumptions, competing navigation conventions, and no clear logic governing which visitor should go where.

Our research examined a publicly funded health literacy ecosystem in precisely this condition. The sites within it were individually well-intentioned and, in several cases, genuinely effective for their core audience. But the relationship between them had never been strategically defined. The result was confusion for visitors, confusion for the clinicians who were supposed to be referring patients across it, and a growing sense within the organization itself that the ecosystem had become harder to explain than it was to use.

This is not an unusual situation. It is, in our experience, the norm for any health promotion organization that has been building digital properties for more than five years without a governing ecosystem strategy.

## How Ecosystems Lose Their Shape

The process by which a coherent set of digital properties becomes an incoherent one is gradual and largely invisible while it is happening. Each individual decision is defensible. A new program is launched and given its own landing page, because the program has its own audience and its own tone. A second platform is developed with a different content management system, because a different team is managing it and they have different technical preferences. A resource library is built on one site that duplicates content already available on another, because the teams did not know about each other's work or did not think to consolidate.

The cumulative effect is a digital presence that reflects the organizational history of how health promotion was staffed and funded, rather than a coherent strategy about how visitors should be served. From the inside, each site makes sense because the team managing it knows its context. From the outside, a caregiver, a teacher, or a clinician trying to navigate the ecosystem encounters a landscape of apparently similar sites with subtly different purposes, inconsistent visual identities, and no reliable indication of which one is the right starting point for their specific need.

Our research found that clinicians were particularly affected by this confusion. When surveyed about their referral behaviour, clinicians showed a stated preference for directing patients to health authority-produced resources. Their actual behaviour, however, indicated that they were more often directing patients elsewhere, or not directing them at all. The ecosystem, as it stood, was not simple enough to refer confidently. A clinician who is not certain which platform to recommend will not make a recommendation, and that is a significant failure of the ecosystem's fundamental purpose.

> *An ecosystem that makes sense from the internal perspective of an organization is not necessarily one that makes sense from the outside. Managing the transitions between your websites is a core strategic responsibility.*

## The Audience Overlap Problem

One of the more specific findings in our ecosystem research was the degree to which audience definitions across the different sites had been allowed to blur. Each site had an intended primary audience. In practice, the content on each site frequently spoke to multiple audience groups without clearly distinguishing between them, and the navigation of each site invited visitors to self-identify in categories that did not map cleanly onto who was actually arriving.

The most instructive example of where this can go wrong was a platform where the resource library invited visitors to filter content by audience type, offering categories including youth, parents and caregivers, healthcare professionals, and school professionals. An audit of what appeared when a healthcare professional used that filter revealed that the results included resources clearly designed for parents, mixed in with materials intended for clinical audiences, with no clear indication of which was which. The taxonomy had been built to demonstrate *comprehensiveness* rather than to serve a specific visitor's specific need.

The same platform's front page carried a statement orienting visitors toward youth mental health. Below that statement, four audience-selection buttons invited visitors to identify themselves by role. The first button, labelled for youth and young adults, led to a page that opened with text addressed directly to parents and caregivers. The audience confusion was not in the content, which was in many cases excellent. It was in the navigational and taxonomic logic that was meant to connect the right content to the right person.

This kind of inconsistency accumulates over time as different people add content to a platform with slightly different assumptions about who the visitor is. Without a governing taxonomy and a defined primary audience, each addition makes sense to the person who made it and adds to the confusion of the person trying to use the result.

## The Multi-Login Deterrent

A further practical consequence of an unplanned ecosystem is the authentication problem. As multiple platforms proliferate, each with their own login requirements, users who might benefit from resources across the ecosystem are required to create and maintain separate accounts on each site. This is not a trivial friction for caregivers, teachers or clinicians who are already managing considerable complexity.

The research found that the prospect of multiple sign-ins was a genuine deterrent to cross-platform exploration, and that users who had registered on one platform rarely independently navigated to a related platform to access additional content. The ecosystem's collective resource, which was substantial, was effectively siloed by its own authentication architecture.

Resolving this requires either a single-sign-on system that works across properties, or a consolidation of platforms onto shared infrastructure where role-based permissions can serve different user groups from a single login. Both approaches are technically achievable. Both require the organizational decision to treat the ecosystem as a unified entity rather than a collection of independent projects, and that decision is harder than the technical implementation that follows from it.

## Two Models for Coherence

Our research identified two viable structural responses to the ecosystem fragmentation problem, both worth examining as general models.

The first is the meta-site model: a single landing property that functions as a gateway to the rest of the ecosystem, with no content of its own beyond what is needed to orient the visitor and direct them to the right destination. The meta-site carries a clear organizational identity, communicates the landscape of what is available, and uses funnelled navigation to identify the visitor's role and need before routing them to the appropriate platform. Each underlying platform retains its own identity and audience focus, but the meta-site resolves the entry point problem. A clinician who wants to refer a patient to the ecosystem has a single URL to offer.

The second model is the consolidated platform: a single site that serves multiple audience groups simultaneously through role-based permissions and personalized dashboards. A parent who logs in sees content relevant to parents. A clinician who logs in sees content relevant to clinicians. A teacher sees what is relevant to teachers. This model consolidates hosting, maintenance, authentication, and analytics in one place, reducing the organizational overhead of managing multiple separate properties and providing a unified picture of how the ecosystem is being used.

Both models require the prior strategic decision that the ecosystem as a whole serves a defined set of audiences with defined relationships to each other, and that those audience definitions should govern platform architecture rather than emerge from it. That decision needs to be made explicitly, by the right people, before any technical work begins.

## The Organizational Identity Question

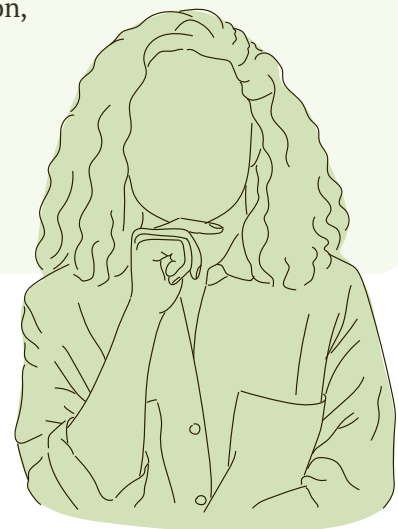
One issue that the ecosystem fragmentation problem tends to bring into view is the question of organizational identity. In a multi-site ecosystem where each platform has its own name, its own visual design, and its own voice, the question of whether the parent organization is visible to visitors at all becomes significant.

Our research found that the health authority behind the ecosystem under review had a high level of trust among clinicians and the general public when its role was known. The problem was that it was frequently not known. Visitors arrived on one of the ecosystem's sites via a search result or a clinician referral, engaged with the content, and left without being clearly aware of the institutional source of what they had accessed. The credibility and authority of the health authority, which were genuine and substantial, were not being transferred to the individual platforms in any reliable way.

A coherent ecosystem strategy, whether organized around a meta-site or a consolidated platform, provides the structural opportunity to make that institutional identity visible and consistent across everything a visitor encounters.

## Questions Worth Asking About Your Own Platform

- If you listed every digital property your organization currently maintains, including sites, microsites, program landing pages, and learning platforms, how many would there be? And is there a document somewhere that explains the intended relationship between them?
- Could a clinician who wanted to refer a patient to your organization's digital resources describe, in a single sentence, where to send them? If not, what is the consequence of that for your referral rates?
- When a visitor arrives on any one of your digital properties, is it clear to them what else exists in the ecosystem and how it relates to where they are?
- Does your ecosystem have a governing taxonomy for how content is categorized and audiences are defined, or has that taxonomy evolved organically as different teams have added content over time?
- And is there a person, or a function, in your organization whose role it is to look after the ecosystem as a whole, rather than just the individual properties within it?



# 10. Building an Ecosystem That Holds Together

The problems facing digital health promotion platforms are not, in most cases, problems of insufficient content, inadequate technology, or lack of clinical expertise. They are problems of orientation in terms of what the platform is primarily organized around, and whose experience that orientation serves.

The default orientation in the sector is outward and organizational. Platforms are built around what the institution has produced, what it needs to communicate, and what the funding cycle has made possible. The visitor's inner state, their navigational needs, and the sense of community that determines whether learning produces durable change are acknowledged in mission statements and neglected in platform architecture. The preceding chapters have examined, in some detail, what that neglect costs and where it comes from. This final chapter is about what to do instead.

## Why the Framework Needs to Come First

The decisions most consequential for a platform's eventual effectiveness are made very early in the project lifecycle, often before any learning design or empathic design expertise is in the room. Audience definitions, content taxonomies, navigational philosophy, and the scope of connective features are all substantially shaped by the initial project brief. Once that brief has been written, approved, and used to secure funding, meaningful revision is very difficult.

The four-lens framework is most valuable not as a diagnostic tool for platforms already built, though it serves that purpose, but as a planning instrument applied before any build begins. Used at the outset of a project, before clinical subject matter experts have defined the solution from their own frame of reference, it asks questions that conventional project planning does not ask. The result is a brief that encodes a fuller understanding of what the platform needs to do, for whom, and under what conditions. In our experience, project teams with no prior learning design background engage productively with the four-lens model within minutes. The concepts are not opaque. What they require is the organizational decision to treat them as primary.

## Starting with the Affective Lens

A platform planned from the Affective Lens begins with an honest inquiry into the inner state of its intended visitor. Not the broad demographic category, but the specific individual most likely to arrive: what is occupying their attention, what have they already tried, what would need to be true for this platform to feel relevant in the first thirty seconds of their visit?

The Affective Snapshot Methodology described in this guide is one practical mechanism for this. Focus groups with clinicians who work closely with the target audience, observed user sessions with real visitors, and persona work that goes beyond role and diagnosis to emotional context and motivational state all serve the same purpose: ensuring that the affective reality of the visitor shapes the design of the platform before any other consideration does.

In concrete terms, the Affective Lens governs homepage architecture before content is added to it. It determines the choice between smorgasbord and funnelled navigation. It shapes what the platform communicates in its first visual impression, how much text appears above the fold, and whether blank space is used deliberately or filled by reflex. Every design decision should be tested against it before being finalized. Most currently are not.

> *A platform that attends to all four lenses is not a more complicated platform but a more honest one. Built around what actually determines whether a visitor is helped, rather than around what is easiest to plan and measure.*

## When Content Follows Feeling

Once the Affective Lens has established who the visitor is and what they need to feel on arrival, the Activity Lens answers what resources, pathways, and tools will most effectively meet those needs. The content strategy follows from the affective strategy rather than preceding it. This resequencing matters more than it might appear.

When content is scoped after affective inquiry rather than before it, resources are developed to address specific needs rather than to demonstrate topical comprehensiveness. Internally produced content is prioritized over curated external links, because it carries institutional authority, maintains quality over time, and keeps the visitor within an experience the organization controls and can learn from. The quantity of content becomes a design variable: fewer, better-targeted resources, each made to work exceptionally well for a specific person in a specific situation, consistently outperform comprehensive libraries that place the navigational burden back on the visitor.

The platforms that have understood this have not produced less. They have designed with more focus and discipline, and their users have found what they came for.

## The Connective Lens as Structural Commitment

The Connective Lens requires the most deliberate early intervention of the four, because it is the most vulnerable to being cut. The structural logic of project-based funding disadvantages connective features systematically: they are ongoing processes rather than deliverable products, and they require sustained human investment that does not fit neatly into finite budgets. Left to the default, they will be deferred. And they are almost always deferred.

Planning from the Connective Lens means making the case for community and peer exchange at the funding stage, before scope is fixed. It means presenting evidence that connective learning produces outcomes that content delivery alone cannot, particularly for audiences whose primary unmet need is to feel less isolated in their situation. It means proposing a shared organizational infrastructure for community facilitation across projects, so the cost is distributed rather than concentrated in any single budget line.

The format decisions matter too. A lecture webinar repositioned as a facilitated peer exchange requires less preparation from the presenter and delivers substantially more value to the participant. A discussion forum seeded with specific prompts drawn from real audience questions generates genuine dialogue where an open forum generates silence. These are learning-design decisions. They need learning design expertise behind them, not good intentions and a Zoom link.

## The Trap of Institutional Logic

The Organizational Lens is the lens most health promotion platforms have already mastered. Compliance requirements are met, mandated content is included, governance structures are in place, and reporting metrics are collected.

The problem is when organizational rigour becomes the organizing framework for the visitor experience. When it does, the platform makes sense from inside the institution and is bewildering from outside it. The Organizational Lens needs to be the foundation on which the other three lenses build, but like a foundation, it should be barely visible to the visitor as the dominant logic of what they encounter. An organization that has achieved this has built something genuinely difficult. It has also built something that works.

## The Project Story as a Planning Instrument

One recommendation from our research deserves particular emphasis as a concluding point, because it addresses a problem that sits upstream of everything else in this guide.

The decisions that most determine a platform's quality are made in the earliest conversations about what it should be. Those conversations are shaped by whoever is in the room: typically clinical subject matter experts, project managers, and organizational stakeholders working from a funding brief that specifies deliverables and timelines. The learning design and empathic design expertise that would bring the full four-lens perspective to those conversations is frequently absent, because it has not yet been engaged.

We refer to this as the project story: a deliberately crafted account of what the platform is intended to produce, anchored entirely to the practical difference it makes in a visitor's daily life. The project story is developed through affective snapshot work and design thinking process before any technical brief is written. It describes the visitor, their situation, and what success looks like from their perspective. It becomes the reference point against which every subsequent design decision is tested: does this navigation choice serve the person we described? Does this content format reach them in the state they will arrive in? Does this connective feature give them what they said they most needed?

A project story maintained as a living document through the development process is the mechanism by which the four-lens framework stays active after the initial planning phase. It is harder to maintain than a feature checklist. It is considerably more likely to produce a platform that does what it was built to do.

## The Pattern That Runs Through All of This

The nine sections that preceded this one have examined the patterns that characterize digital health promotion platforms that aren't working as well as they should:

- the resource library treated as a strategy,
- the analytics misread as a content problem,
- the consultation processes that reproduce existing models,
- the navigation that reflects organizational assumptions rather than visitor needs,
- the curation that undermines institutional authority, the affective state of audiences that platform design consistently underestimates,
- the connective dimension perpetually deferred, and
- the ecosystem fragmentation that leaves visitors and clinicians unable to navigate a landscape that grew without a governing logic.

What stood out in our research is that these aren't issues confined to isolated cases. They are structural features of a sector that has built its digital presence primarily through the Organizational and Activity Lenses, and that hasn't yet fully acted on what the Affective and Connective Lenses require.

Every one of the exemplary platforms we evaluated across our environmental scan, had all made the same foundational decision. They started with a specific, deeply researched understanding of who their visitor was and what that person needed to feel before engaging with anything the platform offered. Everything else followed from that.

That is a design philosophy, and it is available to any organization willing to ask the right questions before the build begins. The questions aren't complicated. What's complicated is creating the conditions in which those questions get asked at the right moment, by the right people, with sufficient authority to shape what gets built.

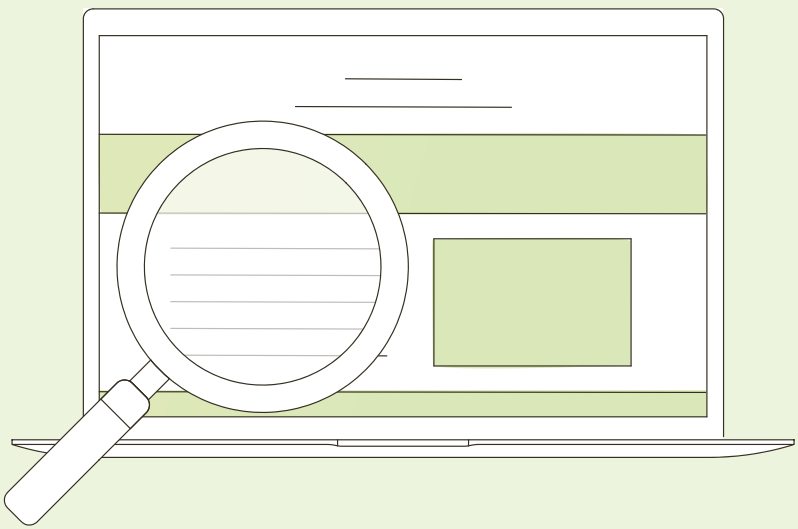
That's precisely the work the Learnbase team does. If the patterns described across this guide are recognizable in your organization's digital presence, and in our experience they usually are, we're here to help.

## So… what to do next?

Using the insights and perspectives shared in this book, we've built a quick *affective* snapshot tool that will give you some immediate feedback on how it might feel to first encounter your program's website and messaging.

**Just scan the QR code or use the link below.**

**https://learnbase.com/affective-site-snapshot**



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## The Author

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**If a parent of a child with a newly diagnosed condition, or a burnt-out health provider arrived on your website right now, how would their experience *feel*?**

Would they feel recognized, or would they be met with an overwhelming, menu of alternatives and info about your organization?

*A Field Guide to Affective Online Health Promotion* is a hands-on, practical manual built for immediate application by digital health practitioners, public health leaders, and design teams. Moving past abstract theory, standard analytics, and surface-level needs assessments, Learnbase founder Neil Hammond exposes 10 structural traps digital health platforms fall into, and provides an actionable four-lens framework needed to fix them today.

Stop building well intentioned filing systems. Use this guide to transform your platform into a responsive, high-impact digital health sanctuary.

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