The Global health promotion conference in Nairobi 2009 is the 7th in order. It also completes the global dimension by being held in Africa. Previous conferences were held in:

1986 in Ottawa, Canada,

1988 in Adelaide, Australia “Building health public policy”,

1991 in Sundsvall, Sweden “Supportive environments,

1997 in Jakarta, Indonesia “New players for a new era”,

2000 in Mexico City, Mexico “Bridging the equity gap”, and

2005 in Bangkok, Thailand “Policy and Partnership for Action: addressing the determinants of health”

**KEY MESSAGE:**

Health promotion is **essential** to effectively address the current global public health challenges.

All public health policies and programmes should incorporate a health promotion component if we are to successfully reduce the burden of priority public health problems and the inequities related to ill health.
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EXECUTIVE SUMMARY

PART I: HEALTH PROMOTION AND GLOBAL HEALTH

THE GLOBAL HEALTH CRISIS

Global health is facing unprecedented challenges. The forces that are driving progress - globalization of markets, ease of travel, urbanization, and technological innovation, also are capable of creating conditions that increase vulnerability to poor health. The inexorable growth of noncommunicable diseases, re-emergence of infectious diseases and threat of pandemics, rapid urbanization, and climate change all pose immense challenges for global health and threaten attainment of the internationally agreed development goals. In addition, the burden of ill-health is increasingly distributed inequitably, both within and across countries, leading the Commission on Social Determinants of Health to conclude that "Social injustice is killing people on a grand scale". In the face of these challenges, the attainment of both good health and health equity depends on a comprehensive approach that empowers individuals and communities, fosters leadership for public health, and promotes intersectoral action to build healthy public policies and to create sustainable health systems. These elements form the foundation of health promotion.

HEALTH PROMOTION: A RESPONSE TO GLOBAL HEALTH CHALLENGES

Health promotion, “the process of enabling people to increase control over the determinants of health and thereby improve their health”, focuses not just on individual knowledge and behavior change, but also community capacity building and empowerment, and policy change.

From the Ottawa Conference (1986) through to the sixth global conference in Bangkok (2005), the understanding of health promotion has grown and sufficient evidence and experience accumulated to enable an integrated and cost-effective response to the current global health challenges.

Since the Ottawa Charter, the world has changed. Globalization and its attendant phenomena have shifted the nature of public health challenges. The 2005 Bangkok Charter, ‘Health Promotion in a Globalized World’, arose as a response the changing nature of public health. This Charter called for policy coherence, increased investment and a commitment to health promotion across all of government, the development community, civil society and the private sector.

Global health urgently needs to apply the body of evidence-based health promotion policies, practices and evidence to addressing the current challenges to good health. The processes of health promotion hold the potential to reduce social inequity, to contribute to the attainment of internationally agreed development goals, and to reduce the burden of newly recognized epidemics of noncommunicable conditions, the emergence of new infections, and to the health effects of disruption of ecosystems and climate change.

As new challenges come to the fore in public health, so do the opportunities for the promotion of health. Health is gaining prominence in foreign policy and global development, acquiring greater attention in global security and diplomacy. The concept of “health in all policies” begins to embrace “health in foreign policy”. The recent UN resolution (2009) on this theme provides further entry points to advance the global health
promotion agenda across these wide-ranging policy areas. Health promotion is particularly relevant in the areas of global health diplomacy and the rights-based approach to health.

CURRENT MANDATES:
A number of mandates represent powerful policy levers that the health promotion community needs to strategically utilize. The health promotion community is being asked to:

- **Strengthen health promotion approaches on the Social Determinants of Health and through Primary Health Care**

  Recently there have been a number of pivotal World Health Assembly Resolutions, that signal a clear mandate to strengthen health promotion approaches. In May 2009, the WHA passed three pivotal resolutions on Primary Health Care, the social determinants of health and climate change that demonstrate the cross-cutting role of health promotion.

- **Help accelerate progress towards achieving the Millennium Development Goals**

  The MDGs provide the highest legitimacy to compel the health community to mainstream health promotion. Progress in attaining the MDGs thus far is mixed. Neither the poverty goal nor the health goals be fully met by 2015. Directing health promotion interventions towards achieving the MDGs and scaling up efforts on NCD prevention have the potential to markedly propel attainment of these development goals.

- **Provide practical solutions to achieving health literacy, and working across sectors for health, as a development priority.**

  In July 2009, the UN Economic and Social Council (ECOSOC) devoted a segment of its annual session to health. The major outcome was a Ministerial Declaration, in which health promotion and disease prevention repeatedly were highlighted as development priorities. Specific attention was paid to health literacy, multisectoral and interministerial approaches, and the importance of tackling social determinants of health. This Declaration requires health promotion to expand its global platform to areas outside of but related to health, within the UN and its relevant special agencies.

PART II: FROM OPPORTUNITY TO REALITY - CLOSING THE IMPLEMENTATION GAPS

Despite the requirement to bring health promotion into the mainstream of public health policy and practice, in reality it has yet to be fully integrated into health policy making and programme implementation. Health promotion should be incorporated into all public health programmes and integrated into health policy implementation, and not be implemented as a fragmented and isolated programme area.
ADDRESSING THE IMPLEMENTATION GAPS

In the effort to make the most of what health promotion has to offer, and to fully integrate it into the health and development effort, there must be synergy between the evidence-base, policy and practice (Best Practice: IUHPE-FHI 2005).

Critical implementation gaps exist in relation to each of these areas. These three gaps are:

**Evidence is not implemented in practice**

Knowledge and evidence that exists on the effectiveness of health promotion strategies is not being sufficiently applied. The design and implementation of global health programmes should be informed by health promotion evidence base.

**Evidence on health impact is not applied to public policy**

Health should be integrated across broader economic and social development policies in order to act on social determinants of health. Health promotion approaches should be incorporated into these policies to ensure successful implementation, and to realise health promotion’s role in policy making to achieve equity in health.
Countries have insufficient capacity to put health promotion into practice

Well-performing health systems should have the capacity to promote health, with competent human resources and sustainably funded structures. Health systems should invest in sustainable capacity and infrastructures for health promotion.

These gaps threaten and limit the realization of public health goals. The health promotion community and their allies worldwide must firmly establish health promotion’s presence at the interface between policy, evidence and practice.

PART III: TAKING ACTION - IMPLEMENTING HEALTH PROMOTION STRATEGIES

Drawing from the action areas of the Ottawa Charter, the health promotion strategy presented here consists of five domains: individual empowerment, community empowerment, health systems strengthening, intersectoral action and building capacity for health promotion. These may be considered the basic building blocks for implementing health promotion. While each block may be usefully applied as a sole strategy, their effects will be greater when they are implemented in a coordinated and integrated fashion.

1. Individual Empowerment - Health Literacy and Health Behaviour

Health literacy is central to “empowerment”. A health literate and empowered individual is enabled to choose healthy lifestyle behaviours as well as being enabled to act on (individually or collectively) the social, political, economic and environmental determinants of health. Health literacy has been defined as the cognitive and social skills which determine the motivation and ability of individuals to gain access to, understand and use information in ways which promote and maintain good health. Health literacy goes beyond a narrow concept of health education and individual behaviour-oriented communication, and addresses the environmental, political and social factors that determine health. Health education is achieved through methods that go beyond information diffusion and entail interaction, participation and critical analysis. Such health education leads to health literacy, leading to personal and social benefit, such as by enabling effective community action, by enabling decision-making at the individual and collective levels, and by contributing to the development of social capital.

This approach also recognizes the issue of power and how power relations affect access to information and its use. Health literacy promotes empowerment, which in turn is vital for achieving the internationally agreed health and development goals as well as the emerging threats such as from the pandemic influenza, climate change and non-communicable diseases.

The facilitation of individual empowerment can occur in two ways: one-on-one facilitation in the health care setting and through community and population channels including social marketing and the use of information and communication technologies. Regular monitoring and evaluation can assess the impact as well as the reach of empowerment strategies. There are two pathways for the measurement of empowerment: 1) the processes by which it is generated and; 2) its effects in improving health and reducing health disparities.
2. Community Empowerment

Community empowerment refers to the process of enabling communities to increase control over their lives. Community empowerment is more than the involvement, participation or engagement of communities. It implies community ownership and action that explicitly aims at social and political change. Community empowerment is a process of re-negotiating power in order to gain more control. Community empowerment necessarily addresses the social, cultural, political and economic determinants that underpin health, and seeks to build partnerships with other sectors in finding solutions. Integrated community-based health promotion approaches can be applied to people, places and health issues.

The settings based approach is one such integrated approach which creates empowerment and action in multiple sectors. Settings based approaches provide an ‘entry point’ and can be implemented in micro to macro settings. Applying the settings approach simultaneously at multiple levels increases success.

Community empowerment is consistent with the social action objective of health promotion, and should occur alongside efforts in policy advocacy and interventions. There is a relationship between empowerment and health outcomes and it is important to be aware of barriers as well as enablers of community empowerment. Communities bring a holistic perspective which more naturally leads to a multi-sectoral approach. NGOs and civil society organisations are well placed to bridge between top-down and bottom up approaches. Interventions that work are those that are planned and based on a solid theoretical understanding of community organization whereby a community-based integrated approach is applied to people places and health issues.

Participation and partnership is another core element of an integrated community-based approach to empowerment. Participation can occur at different levels represented along a ladder of increasing engagement and it is when the higher levels of “citizen power” are facilitate that the best empowerment occurs. Involving communities in monitoring and evaluation can be further empowering in itself. Healthy development can be achieved when community empowerment is met with health system strengthening, health in all policies and a greater capacity for health promotion.

3. Strengthening Health Systems

Health promotion and health systems are inextricably linked. Health systems should be oriented toward keeping people well. Health promotion can be applied systematically at both the national and programme levels during planning, implementation and evaluation phases. It would foster universal reach with equitable access to essential products and technology, a well-performing workforce, mechanisms for community participation, appropriate financing, a well-functioning information system, and good leadership and governance.

Health promotion closely aligns with and reinforces efforts to reform health systems, based on based on social justice and people-centred care. Bringing health promotion into health systems supports reforms of primary health care including: creating universal access (including universal access to prevention), ensuring health care is people-centred and based on expectations and needs of people, providing healthy public policies, as well inclusive and participatory leadership.
4. Partnerships and Intersectoral Action

A 'whole of government' approach to health works closely with other sectors such as finance, education, agriculture, environment, housing and transport to examine how their policies can help achieve their own objective while also improving health. Intersectoral action can also arise from the community level via advocating for policy change and participatory activities influencing a whole of government approach. Intersectoral action was a fundamental tenet of the Alma Ata Declaration, and is one the four pillars of Primary Health Care. It also forms a basic premise of the recommendations of the Commission on the Social Determinants of Health, and is essential if we are to achieve health equity.

Establish health as a whole of government responsibility involves: creating governance for cross-sectoral activity; developing new policy and performance reporting approaches which are appropriate to the whole of government, and; effectively recruiting and sustaining a range of partners. Using tools including participatory budgeting, the law, health impact assessments and accountability and performance reporting systems will ensure intersectoral action is effective and health promoting.

5. Building Capacity for Health Promotion

Sustained health promotion requires institutionalizing health promotion practice into the day to day routines of organizations and systems. Investment in health promotion infrastructure and capacity is a necessary precondition for re-orienting health systems. System changes that are required include creating sustainable health promotion financing, developing a skilled health promotion workforce, having skilled leadership, developing monitoring, evaluation and performance management systems, and developing effective organisational and partnership arrangements.

There is strong need to build leadership capacity to spearhead the process of institutionalizing health promotion. Also needed are innovative ideas on sustainable financing and to create effective health promotion organizational forms. The successful delivery of health promotion outcomes also depends on workforce capacity, so there is a need to identify competencies, develop curricula and to strengthen capacity for training for health promotion leadership in countries.

Countries differ widely in their capacity for health promotion. A capacity assessment will identify which parts of the system require attention. A dialogue-based process with stakeholders, using capacity mapping tools, can provide the initial basis for prioritising areas for capacity development and form the basis of continuous quality improvement.
**MOVING FORWARD**

Mainstreaming health promotion, and realising the full potential health that promotion approaches offer, requires that:

- Interventions/programmes make use of the range of health promotion action areas, and reflect evidence on effectiveness.

  This includes assessing whether the mix of health promotion interventions being used have adequately incorporated the core health promotion building blocks, and whether some areas for action are being over- or under-emphasized.

- Health promotion considerations feature in all health system decision making

  Incorporating health promotion in all aspects of health system decision-making represents true mainstreaming. Mainstreaming health promotion into health system may occur in an opportunistic manner as well as through systematic processes. Through legislating and financing, in particular, governments can provide the mandate necessary for health promotion to be effectively mainstreamed.

- There is appropriate scaling up of interventions/programmes.

  Significant impact on population health promotion, requires soundly designed interventions but also requires sufficient coverage and, where appropriate, targeting of disadvantaged groups. This means that health promotion efforts will need to move beyond a focus on individuals and through time-limited projects, to a sustained effort which is integrated into health services and other social institutions (such as schools or the workforce).

**THE TIME HAS COME**

The mandates, commitments and expectations of health promotion must move beyond rhetoric into reality. The gaps between evidence for health promotion, policy and practice must be closed within and between countries, and must be backed by sustainable investment and action.
THE GLOBAL HEALTH CRISIS

Global health is facing unprecedented challenges.

The forces that are driving progress---globalization of markets, ease of travel, urbanization, technological innovation---also are capable of creating conditions that increase vulnerability to poor health. The growing interdependence of national economies makes trade more efficient, but at the same time, it increases the risk that a financial crisis in one country threatens the viability of other economies in general and the financing of health systems in particular. Globalization facilitates moving people and resources around the world to meet needs. Unfortunately, pathogens, toxins and unhealthy lifestyles are hitchhiking along, leading to the re-emergence of infectious diseases, the inexorable growth of noncommunicable diseases, and an increase in food safety concerns. Modern transport propagates the spread of infectious agents, leading to pandemics. Rapid urbanization as a global phenomenon exerts tremendous pressures on the environment and disrupts the ecological balance, promoting the emergence of new pathogens, pollution and climate change. The stresses associated with urbanization also exacerbate problems of injury, violence, substance abuse and poor mental health.

These new challenges compound the problems many countries still have in the attainment of the internationally agreed development goals.

Moreover, globalization and urbanization do not guarantee the equitable distribution of resources for good health. Groups of people that lack the skills, capital and networks to succeed in a globalized and urbanized economy are increasingly marginalized, while those who are able to take advantage of the opportunities afforded by this setting have access to extraordinary levels of resources and wealth. Thus, the burden of ill-health is increasingly distributed inequitably, both within and across countries, leading the Commission on Social Determinants of Health to conclude that “Social injustice is killing people on a grand scale” (CDSH, 2008). In the face of these new challenges, the attainment of both good health and health equity depends on a comprehensive approach that empowers individuals and communities, fosters leadership for public health, and promotes intersectoral action to build healthy public policies and to create sustainable health systems. Coincidentally, these elements form the foundation of health promotion.

THE EVOLUTION OF HEALTH PROMOTION TO BETTER RESPOND TO GLOBAL HEALTH CHALLENGES

Given the current global health challenges, health promotion has never been timelier, or more needed. Over the period from the Ottawa Conference (1986) through to the sixth global conference in Bangkok (2005), health promotion has grown as a discipline and accumulated sufficient evidence and experience to respond to the current global health challenges in an integrative and cost-effective manner, establishing it as an essential component of any attempt to address the global health crises.

Health promotion is frequently defined as being “a process of enabling people to increase control over and improve their health and its determinants.” Since the 1986 Ottawa Charter, health promotion has evolved from focusing primarily on individual knowledge and
behavior change to community capacity building and empowerment, and policy change. The transformation of social institutions and systems for better health is the *sine qua non* of health promotion.

The Ottawa Charter established a global mandate for health promotion to advocate for good health as a major socioeconomic and personal resource, enable people to achieve their highest health potential and mediate across all sectors in society for coordinated actions to improve health. It articulated the concept of health as a multisectoral responsibility, requiring both policy and population approaches, and touched on health's relationship to issues such as security, socio-economic status and social justice and equity, foreshadowing the social determinants of health model. The Charter also set action areas for health promotion, specifically:

1. **Building healthy public policy**;
2. **Creating supportive environments**;
3. **Strengthening community action for health**;
4. **Developing personal skills to enable better health**; and
5. **Re-orienting health services to expand beyond clinical services**.

Since the Ottawa Charter, globalization and its attendant phenomena have shifted the nature of public health challenges. These have spurred a transition in the nature and scope of health promotion, as documented by conference outcomes from Adelaide, Australia (1988), Sundsvall, Sweden (1991), Jakarta, Indonesia (1997) and Mexico City Mexico (2000). The new concept of healthy public policy was delineated in the Adelaide conference. The importance of supportive environments conducive to health and the links with sustainable development were established in the Sundsvall statement. Tackling inequalities in health was set as an overall priority and the 'settings approach' was further elaborated and endorsed. In Jakarta, with a majority of participants from the developing world, the discussion focused on issues related to globalization and the potential advantages and controversies around public-private partnerships. In Mexico City, 'Bridging the gap' a high-level political commitment to health promotion and the equity perspective, positioned health promotion on the regional and global political agenda.
The 2005 Bangkok Charter, 'Health Promotion in a Globalized World' (World Health Organization: Bangkok Charter, 2007), identified major challenges, actions and commitments needed to address the determinants of health in a globalized world by engaging the stakeholders critical to achieving health for all. This Charter gave new direction to health promotion by calling for policy coherence, increased investment and partnering across governments, international organizations, civil society and the private sector to work towards four key commitments to make the promotion of health:

1. Central to the global development agenda;
2. A core responsibility for all of government;
3. A key focus of communities and civil society; and,
4. A requirement for good corporate practice.

Health promotion has a history of over 20 years of assessing, re-inventing and re-aligning itself to better respond to the shifting health challenges in today's world. The accumulated body of theory, practice, policy and evidence has been gradually built up through commitment and participation. By practicing its own values and beliefs the credibility of health promotion stands strong. By engaging with an increasing number of allies, a critical mass of stakeholders has been achieved.

Global health urgently needs to apply the body of evidence-based health promotion policies, practices and evidence developed over the past twenty years in addressing the current challenges to good health. Health promotion is vital to:

- **COUNTER THE EMERGENCE OF NONCOMMUNICABLE DISEASES (NCD), INJURY, AND MENTAL DISORDERS.** These are growing at epidemic rates, especially in low and middle income countries. They cause over 60 per cent of the world's mortality, and lead the rankings in terms of preventable death and disability. Ironically, health systems often lack the mechanisms for sustainable funding of health promotion to prevent and counter NCD, injuries and mental disorders, even as they buckle under the growing burden from these conditions.

- **ADDRESS THE EMERGENCE AND RE-EMERGENCE OF INFECTIOUS DISEASES.** Disruptions to ecosystems and climate change are provoking the emergence of new infectious diseases and the re-emergence of diseases previously thought to be under control. Widespread migration and the ease of global travel have facilitated the global spread of communicable diseases and heightened the possibility of pandemics. While medical technology holds much promise, clinical solutions must be complemented by health promotion strategies to change behaviours, communicate risks and mobilise communities to reduce the risk for exposure to infectious agents. Health promotion action addressing the environmental and social determinants of these diseases will be critically important to their prevention and amelioration but will require a multi-sectoral approach through effective partnerships within and across countries.

- **ATTAIN THE INTERNATIONALLY AGREED HEALTH DEVELOPMENT GOALS:** The global development agenda embodied in the Millennium Development Goals (MDGs) includes targets that address specific diseases like malaria, tuberculosis, HIV/AIDS and broader health issues like under-nutrition, reproductive, maternal and child health, and water and sanitation. In a broader sense, all MDGs are health related, since poverty reduction, education, food and environment are determinants of health. Conversely,
health is essential to development. The MDGs recognize the complex and pivotal interrelationship of health and human development (WHO 2003). The urgent need is for the MDGs to be met, and health promotion has specific expertise that can accelerate the progress towards attainment.

- TACKLE THE ISSUE OF INEQUITIES IN HEALTH. The Social Determinants of Health model (CSDH 2006) recognizes that within a particular socio-political context, structural (i.e. sex, ethnicity, income, education, etc.) and intermediary (living conditions, working conditions, health behaviours, etc.) determinants of health can lead to differential health status by creating social inequity and giving rise to differential exposures and vulnerabilities. In turn, differences in health and well-being can aggravate socioeconomic inequalities, by adversely impacting on an individual’s capacity to work, for example. The health system is an intermediate social determinant of health itself, capable of impacting on differential exposures and vulnerabilities by facilitating equitable access to services as well as through the promotion of intersectoral action to improve health status. Implicit in this model is the acknowledgement that interventions to improve the health of a population must go beyond health and address the social, political, economic and cultural determinants that give rise to inequity and differences in health status. Health promotion, through its holistic and intersectoral approach, provides the vehicle for public health to address social determinants.

CURRENT MANDATES AND OPPORTUNITIES:
A large and growing body of health and development policies highlights a range of mandates and opportunities for health promotion to add value to the global health and development agenda.

HEALTH PROMOTION'S RELEVANCE ACROSS DIVERSE PUBLIC HEALTH AREAS

World Health Assembly (WHA) resolutions in diverse areas of work in public health consistently recognise the crucial role of health promotion across varied public health programmes. In May 2009, the WHA passed three pivotal resolutions on Primary Health Care, the social determinants of health and climate change that demonstrate the cross-cutting role of health promotion.

The resolution on the renewal of Primary Health Care (PHC) (World Health Assembly, 2009), called upon the Director-General:

‘...to prepare implementation plans for the four broad policy directions:

1. Dealing with inequalities by moving towards universal coverage;

2. Putting people at the centre of service delivery;

3. Multisectoral action and health in all policies;

4. Inclusive leadership and effective governors for health; to ensure that these plans span the work of the entire Organization, and to report on these plans through the

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Executive Board to the Sixty-third World Health Assembly and subsequently on progress every two years thereafter.”

These policy directions are encompassed within health promotion.

The report by the WHO Commission on Social Determinants of Health, ‘Closing the gap in one generation’ (CDSH, 2008) resulted in a resolution urging Member States:

“...to tackle the health inequities within and across countries through political commitment on the main principles of “closing the gap in a generation” as a national concern, as is appropriate, and to coordinate and manage intersectoral action for health in order to mainstream health equity in all policies, where appropriate, by using health and health equity impact assessment tools.”

Further, an explicit reference to health promotion was made in urging Member States:

“... to consider developing and strengthening universal and comprehensive social protection policies, including health promotion, disease prevention and health.”

Likewise, the resolution on climate change by the Executive Board (ref EB124/R5) endorsed a WHO work plan built upon health promotion approaches to strengthen health systems to cope with climate change health threats.

At the regional level, Member States have taken the essential role of health promotion in the different public health programme areas a step further through the elucidation of implementation strategies that clearly delineate the application of health promotion approaches in converting WHA resolutions into concrete actions within countries.

A good example is ‘Gaining Health’, the European strategy for the prevention and control of NCDs. It demonstrates the complementary nature of health promotion and health systems strengthening in NCD prevention and control throughout a range of strategies from addressing the underlying risk factors for NCD to upgrading health services to respond to clinical disease. It “marries” two conceptual frameworks: the Bangkok Charter for health promotion and the global health systems framework (World Health Organization Regional Office for Europe, 2006a)
The recognition by the WHA, which represents the political will of the highest governance body of the WHO, of health promotion’s crucial role in all areas of public health represents a powerful policy lever. The health promotion community needs to strategically utilize the political leverage from these WHA resolutions to drive health promotion into the mainstream of public health practice.

BEYOND PUBLIC HEALTH: HEALTH PROMOTION AND HUMAN DEVELOPMENT

Beyond the World Health Assembly resolutions, there are opportunities that represent entry points whereby health promotion can be aligned and integrated into a wider policy context.

THE MILLENNIUM DEVELOPMENT GOALS

The integral role of health in human development is validated by the Millennium Development Goals (MDGs). This set of eight goals embodies the commitment made by 189 countries in 2000 to sustainable human development (United Nations Millennium Declaration 2000). Three are direct health goals on reducing child mortality, improving maternal health and combating HIV/AIDS, malaria and other diseases. The remaining five embrace conditions that determine health on a broader context. Thus, the MDGs provide the highest legitimacy to compel the health community to mainstream health promotion.

Directing health promotion interventions towards achieving the MDGs has the potential to markedly propel attainment of these development goals. Thus far, progress in attaining the MDGs is mixed. The poorest countries have not benefited from the economic and social development that other countries have experienced. The goals addressing poverty and health likely will not be met fully by 2015. Better funding for health and strengthened health systems could potentially contribute towards reducing the shortfall. Health promotion can make a significant difference, through its advocacy role for prevention,
comprehensive capacity building for health and by promoting health literacy. (See case example in Part IV).

**MOBILIZING THE UN SYSTEM FOR HEALTH – WORKING ACROSS SECTORS FOR HEALTH AS A DEVELOPMENT PRIORITY**

In July 2009, the UN Economic and Social Council (ECOSOC) issued a Ministerial Declaration, (UN ECOSOC, 2009) that was noteworthy because:

- Health promotion and disease prevention repeatedly were highlighted as development priorities. The Declaration acknowledged outright the correlation between health and poverty. In addition to the internationally agreed health goals on maternal and child mortality, HIV/AIDS, malaria, tuberculosis and other severe infectious diseases, the Declaration recognized the adverse impact of chronic diseases (like cardiovascular diseases, cancer, diabetes, respiratory diseases), impaired mental health, injuries and road accidents, and poor sexual and reproductive health on development. A call for urgent action to implement the WHO Global Strategy for the Prevention and Control of NCD was explicitly endorsed.

- Specific attention was paid to health literacy, “seen as an important factor in ensuring significant health outcomes,” with a call for appropriate action plans to promote health literacy.

- Multisectoral and interministerial\(^2\) approaches in formulating national policies were designated as crucial in order to promote and protect health.

- The importance of tackling social determinants\(^3\) of health was emphasized. Likewise, the recommendations and conclusions from the WHO Commission on Social Determinants of Health (CSDH) were supported. Primary health care was given strong attention and the Declaration of Alma Ata was recalled. Comprehensive PHC services were defined to include health promotion and universal access to disease prevention, curative and palliative care according to needs.

This Declaration, by officially endorsing the key strategies that define health promotion as integral to socio-economic development, offers unique opportunities to expand the global platform for health promotion to areas outside of but related to health, within the UN and its relevant special agencies.

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\(^2\) Interministerial in this context mean that functions are established and institutionalized between ministries to share concerns about public health and to find solutions, where relevant ministries contribute to tackle the issues according to their remit on factors determining health

\(^3\) The notion of health determinants was acknowledged in a Discussion document on the Concept and Principles of Health Promotion held in Copenhagen in July 1984, stating that ‘health promotion is directed towards action on the determinants or causes of health’
GLOBAL GOVERNANCE FOR HEALTH: ENTRY POINTS FOR HEALTH PROMOTION

Health has always been a global concern. However, only recently has it garnered sufficient attention to merit its inclusion on the high-level global political agenda. As health gains prominence in foreign policy and global development, it is acquiring greater attention in global security and diplomacy. This further enhances the opportunities to apply health promotion interventions across the broader global policy platform.

The term global governance is fairly new, but it is already well recognised. Within the UN system, the United Nations Development Programme (UNDP) defined it in 1997 as ‘the exercise of political economic and administrative authority in the management of a country’s affairs at all levels’ (United Nations Development Programme, 1997). Depending on whether governance is seen, whether as a theory, a dynamic outcome, or a structure, there are valid applications for health promotion.

The Oslo Ministerial Declaration on Global Health, started in 2006 by Ministers of Foreign Affairs from Brazil, France, Indonesia, Norway, Senegal, South Africa and Thailand, set a milestone by linking health and security. The recent UN resolution 2009 on health in foreign policy provides further entry points to advance the global health promotion agenda across these wide-ranging policy areas. Health promotion is particularly relevant in the areas of global health diplomacy and the rights-based approach to health.

GLOBAL HEALTH DIPLOMACY

Global health diplomacy brings together the disciplines of public health, international affairs, management, law and economics and focuses on negotiations that shape and manage the global policy environment for health. Health promotion could play a significant role in global health diplomacy. The health promotion community needs to articulate, advocate and establish health promotion as an essential component of this field of global health governance, particularly in the areas of promoting health literacy and community empowerment and mobilization.

THE RIGHTS BASED APPROACH TO HEALTH

Public health is underpinned by a humanitarian perspective. The ‘right to the highest attainable standard of health’ was already articulated in the constitution of WHO in 1946, and later in the Declaration of Alma Ata from 1978. Health as a human right was further reaffirmed officially in two Covenants, which serve as binding international law for those countries who have ratified them. The two are the International Covenant on Civil and Political Rights (ICCPR, 1966), and the International Covenant on Economic, Social and Cultural Rights (ICESCR, 1966), primarily through Article 12. The notion of health as a

4The term ‘governance’ is used in different meanings: (1) a theory that helps policy analyst’s to understand the relationship between state and society, (2) a dynamic outcome: the complex process of steering, coordinating and goal –setting by means of which societies are governed nowadays; and (3) a structure that is the mixed system of hierarchies, networks and communities involved in the delivery of broad services to citizens in modern society. (extracted from background document to WHO Regional Committee for Europe, RC 59 14-17 September 2009, ‘Governance of health in the WHO European region’)
human right is referred to as ‘the Rights based approach to health’. But in today’s world, the persistence of war, torture, discrimination, violence and denial of basic health services impede the full realization of health as a fundamental human right. Health promotion in its advocacy role is clearly relevant to the rights based approach to health.

HEALTH PROMOTION AND NATIONAL GOVERNANCE

Some countries, such as Sweden have embarked on an integrative approach between health and other areas of governance. These examples highlight entry points at the national level, grounded on the confluence of health policy and other areas of national governance, whereby health promotion can play a significant role in promoting policy coherence across all government sectors.

THE EXAMPLE OF SWEDEN

In Sweden the 'Riksdag' (Parliament) in 2003 adopted the bill 'Shared Responsibility – Sweden's Policy for Global development'. Unlike the policies from Switzerland and the UK, which had a special focus on health, the Swedish policy is a comprehensive one with health as one of several foci. In the current iteration of the policy, valid from 2008, six areas are given priority and attached to each of them are three objectives. One of the six areas concerns health directly by addressing communicable diseases and other health threats. The three objectives are geared at 1) Sustainable health systems, 2) Early warning and control measures, and 3) Health promotion and disease prevention. Other areas related to health are linked to human rights like sexual and reproductive health rights and trafficking, migration and protection for refugees, as well as climate change. The implementation of the policy rests with all concerned Ministries and the state agencies under their domain as part of their regular mandate.
Health promotion is well-positioned to address today's global health challenges. The policy background establishes its relevance to both global health and, insofar as health is central to development, to the global development agenda. As a dynamic discipline, it is continuously evolving to respond to emerging issues. In the years since the Ottawa Charter, it has gathered a considerable body of evidence for what works when transforming social institutions and systems for better health.

Despite the opportunities to bring health promotion into the mainstream of public health policy and practice, in reality it has yet to be fully integrated into health policy making and programme implementation. It remains inadequately resourced and is relegated a lower priority in political decision-making. Ideally, health promotion should be incorporated into all public health programmes and integrated into health policy implementation, but it remains a fragmented and isolated programme area. Health promotion must transition from a vertical programme into a truly cross-cutting area of work that touches on every public health policy and programme.

**SCALING UP TO CLOSE THE IMPLEMENTATION GAPS**

For health promotion to ultimately achieve full integration into public health policy and programmes, it must be scaled up. In particular, three areas of critical importance require a concentration of scale-up efforts:

1. Linking health promotion to Primary Health Care (PHC) and the social determinants of health;
2. Solidifying health promotion’s role in policy making to achieve equity in health; and,
3. Increasing investments in sustainable capacity and infrastructures for health promotion.

**LINKING HEALTH PROMOTION TO PRIMARY HEALTH CARE, AND SOCIAL DETERMINANTS OF HEALTH**

Recognition of the social determinants of health and the failure of current health systems to address global health inequities has prompted resurgence in interest in Primary Health Care (PHC). In the World Health Report 2008, "Primary Health Care: Now More than Ever," WHO describes how PHC can serve as the unifying element to reform and strengthen health systems for more equitable and more efficient health care delivery.

WHO recommends that countries make health system and health development decisions guided by four broad, interlinked policy directions. These four represent core primary health care principles. Health promotion is fundamental to each one of these principles.

1. **Universal coverage**: Health equity, solidarity and social inclusion, which only can be achieved by universal coverage reforms that span the entire range of health services, from health promotion and disease prevention to clinical health care services.
2. *Putting people at the centre:* People-centred care requires a partnership model whereby individuals and communities fully engage with the public health community and participate in making health care decisions. Health promotion skills in engendering individual and community empowerment, promoting participatory care and fostering health literacy are fundamental to achieving this.

3. *Public policies for the public’s health:* Much of what impacts health broadly lies outside the influence of the health sector. Trade, environment, education and other sectoral policies all have their impact on health, and yet little attention is generally paid to decisions in these ministries that influence health. A "health in all policies" approach needs to be integrated broadly throughout governments. To accomplish this, the public health community should apply health promotion's strategies in advocacy and achieving intersectoral partnerships for policy change.

4. *Accountable leadership:* In order to succeed with future health systems reforms, competent, responsive and reliable leadership is necessary. Health promotion captures some of the key values and mindset required of effective health leadership.

The revival in interest in PHC stems in large part from the work of the Commission on Social Determinants of Health (CSDH), whose work clearly demonstrated the strong influence of social factors on health status, and ultimately, on health inequities. The Commission’s recommendations point the way forward for efforts to achieve global health equity. Health promotion approaches provide a feasible means to operationalize the Commission’s recommendations. For instance, the “Healthy Settings” initiative is a practical mechanism to tackle various social determinants of health while providing opportunities for community empowerment.

Member States have endorsed the increased attention to the revival of Primary Health Care and action on the social determinants of health through WHA resolutions in May 2009.

**POLICY MAKING FOR EQUITY IN HEALTH**

The notion of health equity was already implied by the WHA resolution in 1977, and captured in the slogan “Health for all”. It was further elaborated at the Alma Ata conference the year after and underpinned the concept of Primary Health Care (PHC) on the principles of “solidarity, equity and social justice”.

Ten principles for policy action for health equity are:

1. Policies should strive to level up, not level down.

2. The three main approaches to reducing social inequities in health are interdependent and should build on each other:
   a. Focus on poverty;

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5 Common terms in this context are (in)equity and (in)equality. They are not identical, but in some languages there is only one word for graded, usually socio-economic, differences between population groups. Implicit is the connotation that these differences are not fair, nor just. In this text, the terms are used interchangeably, with the notion that such health differences are unfair and unjust.
b. Narrow the health divide; and,

c. Reduce social inequities throughout the whole population.

3. Population health policies should have the dual purpose of promoting gains in health and reducing health inequities.

4. Actions should be concerned with tackling the social determinants of health inequities.

5. Stated policy intentions are not enough. The possibility of action doing harm must be monitored.

6. Select appropriate tools to measure the extent of inequities and the progress towards equity goals.

7. Make concerted efforts to give voice to the voiceless.

8. Whatever possible, social inequities in health should be described and analysed separately for men and women.

9. Relate differences in health by ethnic background or geography to socioeconomic background.

10. Health systems should be built on equity principles.

From (Whitehead, M & Dahlgren, Göran, 2007)

These policies need to address the full span of health determinants, from the root (distal) causes like poverty, to immediate exposures, like tobacco, alcohol, diet and exercise. To be effective, policies to reduce health inequities should be organised in a hierarchy to comprehensively deal with:

1. The macro policy environment, that influences economic growth strategies, income inequalities, and poverty (absolute and relative);

2. Multi sectoral actions, requiring the engagement of various sectors of government, like education, working environment, primary health care and health systems;

3. Social and community inclusion policies, like social networks; and,

4. Lifestyle, covering the interface of lifestyles as structurally determined and individually chosen, like tobacco, alcohol, nutrition and physical activity.

But principles must be accompanied by strategies that operationalize the policies and permit implementation through definitive action to reduce health inequities. These strategies can be grouped into:

1. Integrated determinants of health strategies

2. Disease-specific strategies

3. Settings based strategies

4. Population group strategies
From (Whitehead, M. & Dahlgren, Göran, 2007)

Recent findings demonstrate positive impacts from interventions tackling the wider social determinants of health (e.g. in the fields of housing and employment) to reduce health inequalities (Bambra, C et al., 2009).

Health promotion will be positioned, in this conference, as an essential, effective approach in policy making for health equity. The particular contribution from health promotion is in identifying and focusing policy action on relevant social determinants to address health inequalities.

MONEY TALKS – ECONOMICS AND INVESTMENT IN HEALTH

A large body of evidence has accrued that irrefutably demonstrates how a healthy population is essential for economic development. The World Bank in its 1993 Development Report concluded that the best strategy to ensure unhampered development in developing countries was to invest in the health of young girls and women, which invariably leads to improved population health (The World Bank, 1993). The World Economic Forum has developed a model that depicts how the rise in chronic diseases represents the greatest risk to global economic development (Global Risks 2009: A World Economic Forum Report, 2009). Thus, investing in health, in general, and in health promotion, in particular, is a valid strategy to ensure economic prosperity.

Investing to reduce health inequities is also a smart economic move. The economic implications of health inequities have been estimated for the European Union (EU). The results are striking. Due to health inequities the average life expectancy at birth for men and women in the 25 EU Member States is shortened by nearly 2 years (1,84). The expected average life expectancy in good health is reduced by more than 5 years (5,14) due to health inequalities. The economic loss is calculated to 141 billion euros, or 1,4 per cent of the GDP. Calculated as a ‘consumption good’, meaning how health contributes to people’s happiness or satisfaction in life, the estimate is 9,5 per cent of the GDP, corresponding to an economic cost of 1,000 billion euros (Mackenbach, J P, Meerding, JW, & Kunst, A E, 2007).

Given the demonstrated economic benefits of investing in health, and in reducing health inequities, one would expect a significant amount of spending for health, at least from richer countries. However, the OECD Health Project revealed that the average allocation by the 30 richest countries in the world to keep people healthy was 5 per cent of their health budgets. Among developing countries, the allocation is much lower. This situation highlights the dissonance between theory and evidence, on one hand, and actual practice, on the other. Health promotion needs to scale up advocacy efforts to channel greater investments towards the discipline, supporting capacity building and sustainable infrastructures for health promotion to ensure healthy populations and unencumbered economic growth.
In the effort to fully integrate health promotion into the health and development effort, three critical implementation gaps exist. These are:

1. **THE EFFECTIVE APPLICATION OF HEALTH PROMOTION EVIDENCE**
   
   Health promotion is essential for the attainment of goals in areas of priority public health concern. The design and implementation of global health programmes should be informed by health promotion evidence base.

2. **THE INTEGRATION OF HEALTH INTO ALL POLICIES**
   
   Health should be integrated into sectoral policies as well as overall economic and social development policies in order to act on social determinants of health; health promotion approaches should be incorporated into these policies to ensure successful implementation.

3. **THE DEVELOPMENT OF HEALTH PROMOTION CAPACITY**
   
   Well-performing health systems should have the capacity to promote health sustainably, through health promotion, with competent human resources and sustainably funded structures.

These gaps pose challenges to the health promotion community and their allies worldwide to firmly establish health promotion’s presence at the interface between policy, evidence and practice.

**ADDRESSING THE IMPLEMENTATION GAPS**

**ADDRESSING GAP 1: APPLYING EVIDENCE OF HEALTH PROMOTION EFFECTIVENESS**

A health promotion lens can be applied to all health policies and programmes and should be integrated into health policy development as well as implementation planning.
All health policies should include an implementation plan, where the following items are addressed:

- Sustaining political commitment – which are ideological barriers and with what interval shall the policy be renewed?
- Addressing and commissioning responsible actors – how can concerned sectors be identified and engaged, and how can mutual understanding and commitments be established to ensure multi sectoral coherence?
- Skilled management structure(s) and professional staff – do these already exist, and do they match the structure of the policy?
- Adequate human and monetary resources – what is needed and what is available? What types of competencies and capacities are needed? How can funds be raised and by whom?
- Measuring what happens and why – How can progress be monitored, and reported?

At the programmatic level, health promotion evidence can be incorporated into programme guidelines. The programme planning process will be the time when the guidelines are adapted to suit the context of the population or community of concern. Adequate resources will be required to ensure sufficient population coverage. Training on implementation of guidelines will be necessary to assure that programmes are delivered appropriately and effectively. Monitoring systems should be put in place to track whether the programmes are having any impacts. Furthermore, investment should be made in programme evaluation, so that the evidence base is continually updated. These aspects are elaborated upon in Part III, on Implementing Health Promotion strategies and further illustrated in Part IV on Application of the Health Promotion Toolbox.

ADDRESSING GAP 2: INTEGRATING HEALTH INTO ALL POLICIES

There are some elements that seem to be more critical than others when moving from a superficial approach to integrating health into social policies towards more comprehensive, contextually adapted and politically approved policies involving different parties and stakeholders.

1. Integrating health promotion when developing comprehensive health and social policies and programmes

   This “principle” was already spelled out in 1984 in the “Yellow paper” ... (quotation + ref) and further articulated in the Adelaide recommendations from the 2nd international health promotion Conference in Australia 1988. ... (quotation + ref) Some policies from Finland, United Kingdom, the Netherlands, New Zealand and other, mostly western, countries integrate health promotion elements. However, real-world examples reflecting full integration of health promotion into public health and social policies and programmes are rare.

2. Reducing inequalities and covering the life span including the demographic transition.

   Population ageing is a worldwide phenomenon, with major implications on demands for health care, social services and the economy as a whole. Reducing health inequalities will require policies that promote health and prevent ill-health at every stage of life, rather than focusing predominantly on children and younger people.

3. Setting qualitative and quantitative targets
Opinions and practices vary about the types of targets in health policy. Some claim that qualitative targets that are process-oriented (improved health, better quality care, etc.) are more practical and realistic. Others believe that quantitative targets offer more transparency and accountability. For policies that impact on health, likely both types of targets are necessary, and should be set and agreed upon from the outset.

4. **Settings**

People live their lives in the various settings: neighbourhoods in cities or villages, schools, workplaces, community centres, recreational areas, and others. These settings offer favourable opportunities to integrate health promoting actions into settings-based policies.

5. **Measurements**

The importance of measuring outcomes and impacts was reinforced by the present WHO Director-General, who stated, “We must never forget: evidence has great strategic and persuasive power at the policy level”. The Commission on Social Determinants of Health (WHO Commission on Social Determinants of Health, 2008) also emphasized the importance of measurement as one of its three overarching recommendations.

Garnering compelling evidence requires strategic and smartly managed monitoring and evaluation systems. In this field health promotion has a deficit gap to fill. The Commission provides useful guidance, where systematic monitoring, training and research in health promotion can play a significant role. Some of the most relevant recommendations for health promotion include:

1. Establishment of national health equity surveillance systems. Such a minimum system should include:
   a. Health outcomes by mortality data e.g., infant and maternal mortality, and morbidity data for at least three major national problems like diabetes, HIV, under nutrition and self-rated mental and physical health;
   b. Measures of inequity stratified by sex, at least two social markers like education, income, ethnicity, a regional marker (urban/rural), one summary measure of absolute health inequities between social groups and when applicable good quality health data on indigenous people.

2. WHO to steward the creation of a global health equity surveillance system;

3. Research funding bodies to create a dedicated budget for the generation and sharing of evidence on social determinants of health, including health equity intervention research;

4. Training and education on the social determinants of health to be made mandatory for training medical and health professionals, as well as non-medical professionals and the general public; and,

5. Governments to build capacity for health equity impact assessment among policy-makers and planners across government departments. One example is the Rapid Equity Focussed Impact Assessment developed in New South Wales, Australia, where concrete recommendations for improving equity were formulated.
All these recommendations are highly applicable to different aspects of health promotion and also refer to the development of health promotion benchmarks and indicators as set out in the Bangkok Charter.

**ADDRESSING GAP 3: CREATING COHERENT INFRASTRUCTURES AND DEVELOPING HEALTH PROMOTION CAPACITY**

Building capacity and infrastructures for health promotion is a long-term process. Achieving a critical mass of health promotion professionals requires a long term human resource strategy. A weak link in strengthening health promotion capacity is the lack of robust infrastructures for the discipline. Without sustainable infrastructure, there is limited capacity to deliver on expected outcomes. Key aspects that require attention are:

**POLICY AND GOVERNANCE – NATIONAL/REGIONAL/LOCAL CONNECTION**

Most countries operate at different geographical governance levels, from national, sub-national/regional/provincial, to local governance units, each with specific authority and competence. In most cases all governance levels are involved in population health. Health promotion policies can be effective only if there is coherence around central values and principles at all governance levels. At the same time, policies need to have some flexibility built in for adaptations to the context at various levels.

**FINANCING**

Any discipline requires adequate financial resources to accomplish its mission. The unique nature of health promotion, on one hand being a public health programme normally within the Ministry of Health, and on the other being an ‘approach’ within other sectors in society, makes adequate funding challenging. Increasingly, health promotion as an institutional entity is being subsumed as organisational units in the public sector, or foundations under the non-for-profit umbrella with different forms of governance.

Three main sources of financing are most common: general tax revenues, earmarked “sin” taxes (e.g. revenues from tobacco and alcohol sales, and/or gambling), and insurance funding. There is a general agreement that overall, resources for health promotion are increasing but continuity and adequacy of funding in relation to goals and tasks remain uncertain. When mainstreaming health promotion, rational judgements about funding to ensure allocation of adequate and sustainable resources will be needed.

Within the health sector, innovative strategies are needed to protect health promotion from “losing out” to the politically charged demands for acute healthcare services. However, majority of financial and other resources for health promotion could potentially derive from outside the health sector, through budgets for education, employment and work environment, housing, roads and transport, environmental protection, among others. The challenge is how to locate and channel the resources within these non-health sectors towards improvement of people’s health through health promotion’s intersectoral approaches.

**SUPPORT MECHANISMS – KNOWLEDGE MANAGEMENT**

Modern technology and the advent of Internet communications offer opportunities to streamline knowledge management and expedite communications. The demand for better efficiency in health promotion requires judicious allocation of responsibilities for knowledge management and information dissemination to institutions which have the requisite competence and infrastructure. These institutions can serve as the centre of
knowledge and communication “hubs,” relieving local and regional units of the burden of building their own data and communications systems.

**TRAINING & SKILLS DEVELOPMENT**

Health promotion training, both for health professionals and professionals in other sectors is a cornerstone for the broad approach to improving health in today’s societies. Establishing training and capacity building programmes requires collaboration with universities, colleges, professional organisations and NGO’s. Healthcare practitioners and health promotion practitioners should be trained in advocacy and social mobilisation skills.
PART III: TAKING ACTION: IMPLEMENTING HEALTH PROMOTION STRATEGIES

Health promotion contributes to good health outcomes through empowering individuals and communities to make healthy choices and take healthy actions. Empowerment has been shown to be particularly effective pathway to health improvement for disadvantaged populations (World Health Organization Regional Office for Europe, 2006b). The enhancement of health literacy and the empowerment of communities depend, on the support from health programmes, and on the environment created by public policies. Thus, intersectoral action and health system strengthening are integral to individual and community empowerment. The effectiveness of these strategies depends, in turn, on institutionalizing health promotion capacity.

ADOPTING THE HEALTH PROMOTION LENS

The aims of health promotion are achieved by using participatory approaches to working with individuals, communities and institutions that build on their strengths and assets and recognizing that many factors lying outside individual control affect health (PAHO, 2008). These principles can be built into all aspects of health policy and programme planning, delivery and evaluation, and assist with mainstreaming health promotion in the health system.

A health promotion lens represents a systematic approach that can be adopted within health policies and programmes, and across the health system, to incorporate health promotion principles and practices into all parts of the system. It helps to strengthen the appropriateness, effect and sustainability of health programmes by placing greater emphasis on incorporating an understanding of the social, cultural, political, environmental and economic conditions and structures that affect the lives, and health, of individuals and communities. By recognizing the importance of context, health promotion provides the evidence base for how to tailor intervention strategies in diverse settings, and what key partnerships need to be formed at the community and policy levels, in order to improve health at the individual and population levels.

As seen in Figure 1, the health promotion lens provides both a checklist of principles:

- Address determinants (risks & assets)
- Focus on equity & rights
- Adopt multiple strategies & settings
- Support participation & empowerment
- Connect levels & partners
The principle of adopting multiple strategies specifically translates as the health promotion strategy presented in the next section (individual empowerment, community empowerment, health systems strengthening, intersectoral action and building capacity for health promotion) represents an essential aspect of an integrated approach for mainstreaming health promotion. These may be considered the basic building blocks for implementing health promotion. While each strategy may be usefully applied as a sole strategy, their effects will be greater when they are implemented in a coordinated and integrated fashion (World Health Organization, 1997). Together, they constitute a strengthening of the health system’s capacity to adopt and implement intersectoral, population-based, participatory, context-sensitive and multifaceted strategies to achieve better health conditions and status in the entire population, particularly to those most marginalized (PAHO, 2008).

**BUILDING BLOCKS FOR CLOSING THE IMPLEMENTATION GAP**

Closing the health promotion implementation gap requires practical action. Our understanding about the complex relationships between the social determinants of health points to the need for action at different levels – individuals, communities, regions, nations. Our understanding about working with communities, particularly vulnerable populations, point to the importance of creating conditions that enable people to take control over their health. The lessons of health promotion over the past two decades point to the importance of coordinated strategies.
1. INDIVIDUAL EMPOWERMENT - HEALTH LITERACY AND HEALTH BEHAVIOUR

Core to individual empowerment is health literacy. Health Literacy (Kickbusch, 2001; Nutbeam, 2000; Nutbeam & Kickbusch, 2000) has been defined as the cognitive and social skills which determine the motivation and ability of individuals to gain access to, understand and use information in ways which promote and maintain good health. Health Literacy goes beyond a narrow concept of health education and individual behaviour-oriented communication, and addresses the environmental, political and social factors that determine health. Health education is achieved therefore, through methods that go beyond information diffusion and entail interaction, participation and critical analysis. Such health education leads to health literacy, leading to personal and social benefit, such as by enabling effective community action, by enabling decision-making at the individual and collective levels, and by contributing to the development of social capital.

This approach also recognizes the issue of power and how power relations affect access to information and its use. Health Literacy promotes empowerment, which in turn is vital for achieving the internationally agreed health and development goals as well as the emerging threats such as from the pandemic influenza, climate change and non-communicable diseases.

2. COMMUNITY EMPOWERMENT

Community empowerment refers to the process of enabling communities to increase control over their lives. Community empowerment is more than the involvement, participation or engagement of communities. It implies community ownership and action that explicitly aims at social and political change. Community empowerment is a process of re-negotiating power in order to gain more control. Community empowerment necessarily addresses the social, cultural, political and economic determinants that underpin health, and seeks to build partnerships with other sectors in finding solutions. Integrated community-based health promotion approaches can be applied to people, places and health issues. The settings based approach is one such integrated approach which creates empowerment and action in multiple sectors.

3. STRENGTHENING HEALTH SYSTEMS

Health promotion and health systems are inextricably linked (WHO, 2007). Applying a health promotion lens the national and health programme level can ensure a system that focuses on keeping people well. It would foster universal reach with equitable access to essential products and technology, a well-performing workforce, mechanisms for community participation, appropriate financing, a well-functioning information system, and good leadership and governance.

Health promotion closely aligns with and reinforces efforts in bringing in health systems reforms based on social justice and people-centred care. Bringing health promotion into health systems supports reforms of primary health care that ensure universal coverage and thereby equitable access to health services for all people. Service delivery reforms that ensure health care is people-centred and based on expectations and needs of people are vital for effective health promotion, just as much as are healthy public policies, and inclusive and participatory leadership.
4. PARTNERSHIPS AND INTERSECTORAL ACTION

The health of populations is determined not by health sector activities alone but by social and economic factors, and hence by the policies and actions beyond the mandate of the health sector. It is thus important for the health sector to work in collaboration with other sectors to raise awareness of the co-benefits of acting together for people-centred policies that promote health.

The concept of ‘intersectoral action’ for health was subject to a technical discussion at the World Health Assembly in 1986. The focus was on how to promote health as a development goal framed by an equity perspective. The sectors of main concern were:

- Agriculture – food and nutrition
- Education and culture – information and life patterns
- Environment – water, sanitation habitat and industry

Among the recommendations were ‘that Member States should take action to ensure that national strategies for health for all developed and implemented as an integral part of an equity-oriented development strategy’. Also ‘Member States should develop and strengthen their institutional mechanisms and decision-making processes to ensure that the health sector collaborates with other sectors in determining how their policies affect health ...” (Intersectoral Action for Health, World Health Organization). A resolution was adopted, ‘Recognizing that factors which influence health are found in all major sector of development’ (ref WHA39.22)

A ‘whole of government’ approach to health works closely with other sectors such as finance, education, agriculture, environment, housing and transport to examine how their policies can help achieve their own objective while also improving health (Stahl, Wismar, Ollila, Lahtinen, & Leppo, 2006). Intersectoral action can also arise from the community level via advocating for policy change and participatory activities influencing a whole of government approach. Intersectoral action was a fundamental tenet of the Alma Ata Declaration, and is one the four pillars of Primary Health Care as laid out in WHO’s 2008 World Health Report (World Health Organization, 2008). It also forms a basic premise of the recommendations of the Commission on the Social Determinants of Health (CDSH, 2008).

5. BUILDING CAPACITY FOR HEALTH PROMOTION

Sustained health promotion requires institutionalizing it. This means ensuring that health promotion is integrated into the building blocks of financial and human resource planning, knowledge management, partnership building, and capacity for effective implementation (“HPF International Network of Health Promotion Foundations,” n.d.). This process requires leadership that understands the interconnectedness of causes, can strike strategic relationships across sectors, can advocate and mobilize sustained financing and catalyze systemic change in health related policies and infrastructure needed to be built. It entails having wide knowledge complemented by a repertoire of personal attributes. There is strong need to build leadership capacity to spearhead the process of institutionalizing health promotion. Leadership is needed to generate innovative ideas on sustainable financing and to create effective health promotion organizational forms. The successful delivery of health promotion outcomes also depends on workforce capacity, so there is a need to identify competencies (Barry, Allegrante, Lamarre, Auld, & Taub, 2009; Galway
Consensus Conference, 2009), develop curricula and to strengthen capacity for training for health promotion leadership in countries ("ProLead: Health Promotion Leadership and Management Development Programme," n.d.). Countries differ widely in their capacity for health promotion and this needs to be addressed in most developing countries.
OPERATIONALISING THE BUILDING BLOCKS

1. INDIVIDUAL EMPOWERMENT: HEALTH LITERACY AND HEALTH BEHAVIOUR

Health literacy is critical to individual empowerment. Individual empowerment provides the means for an individual to make healthy choices, but it also provides a means to negotiate and demand changes in their environment that are obscuring their healthy choices. Individual empowerment can be both facilitated by health promoters and by health care practitioners.

- Health promoters can affect individual empowerment by using specific strategies at individual, community and population levels.
- Health care practitioners have a unique opportunity to incorporate health promoting strategies which empower individuals in their one-on-one consultations. Health care has a strong tradition of being disease focused without considering the person as a whole and that their health is a complex interplay of physical, social, economic, cultural and environmental factors (World Health Organization, 2007). It is recognized that healthcare reform should move towards a holistic approach and that the health care practitioner should form a full and equal partnership with the individual in order to optimize health and so that the health care system is a people-centred one (World Health Organization, 2007).

A CONCEPT AND AN OUTCOME: POWER AND HEALTH LITERACY

At the social level, empowerment has an explicit purpose to bring about social and political change, both by developing skills as well as having an increased sense of political awareness (Laverack, 2007). "Enabling" empowerment implies that people cannot "be empowered" by others; they can only empower themselves by acquiring more powers of different forms (Labonté & Laverack, 2008). It assumes that people are their own assets, and the role of the external agent is to catalyze, facilitate or "accompany" the community in acquiring power.

At the individual level, empowerment enables a person to participate in and be health literate within the realms of their ecological and cultural contextual influences of their community (Zimmerman, 1990). This then leads to the power to be able to gain more control of resources or decision-making that is not only positive for their own health and life, but also for that of their wider community. The concept of an individual’s power as suggested in the term “individual empowerment” is not the power whereby one person becomes more powerful than another. It means that as one person gains, everyone else around them also gains. An empowered individual is likely to participate in social action and advocacy as well as perform as a positive health role model thus benefiting not only themselves but those in their wider community. An empowered individual has power from within, reflecting higher feelings of personal value and a sense of individual control. This
sense of value and control results in participation, psychological power (Zimmerman, Israel, Schulz, & Checkoway, 1992) as well as a sense of community. These components of empowerment are linked and are also linked to community empowerment.

As there is a relationship between empowerment and health outcomes (Laverack, 2006), the level of power from within may be associated with and reinforced by the observed "social gradient of health" (Marmot, Rose, Shipley, & Hamilton, 1978). That is, the more socioeconomically disadvantaged you are, the less feelings of personal value, individual control and sense of community you have; and the worse your health. Although the structural determinants are critically important, it is also known that individuals can become more powerful without necessarily gaining control over material resources (Laverack, 2007). This gain of power may be brought about by increasing health literacy.

Critical to individual empowerment is health literacy. Within empowerment, health literacy does not simply encompass the ability to read information, make appointments and understand a health problem. Health literacy requires that there is an "achievement of a level of knowledge, personal skills and confidence to take action to improve personal and community health by changing personal lifestyles and living conditions" (UN ECOSOC, 2009). Also integral to health literacy is having skills to contribute meaningfully to social organization and social advocacy. Health literacy results in individuals being able to navigate the health system, engage in self care and participate in community action for health. Health literacy has been shown to be a fundamental strategy in accelerating the achievement of internationally agreed health development goals (UN ECOSOC, 2009). For example, this has been demonstrated particularly in the context of literacy for women and its positive effects on childhood mortality (Save the Children, 2000). Health literacy has also proved to have positive effects on addressing non-communicable conditions (UN ECOSOC, 2009). For example, increased health literacy is has been shown to increase health status of older populations, faced with co-morbidities of chronic conditions (Cho, Lee, Arozullah, & Crittenden, 2008). Education fosters development and thus health literacy should also be linked with development.

**AN INTERVENTION STRATEGY:**

The key lesson from health promotion successes is that single focused, short-term communication campaigns are not sufficient for sustained health improvement. Nor are knowledge-based information and communication programmes and materials sufficient to sustain behaviour change.

Individual empowerment as an intervention has emerged in recent decades as a strategy to improve self management of individuals with chronic conditions, improve use of health services and improve mental health. These have included participation in support groups, educational programmes, empowerment of the caregiver and a reorientation of health services to provide advocacy and support for the patient to make decisions about their health. Furthermore, interventions to empower youths, people at risk of HIV/AIDS and women have proven successful in strengthening self and collective efficacy, stronger group bonding, formation of sustainable groups, addressing gender inequities, increasing participation in social action and actual policy changes. Specific to women’s empowerment, interventions that have integrated with the economic, education and/or political sectors have resulted in greater empowerment, autonomy and authority. All of these empowerment outcomes lead to better health outcomes (World Health Organization Regional Office for Europe, 2006b). As human behaviour both influences and is influenced by multiple factors in the social environment, to achieve the most success, approaches to promote change need
The approaches that have worked at the individual level:

A central premise of facilitating one-on-one “individual empowerment” is the ability of the facilitator (health practitioner or community worker) not to exert power-over, as is the traditional practitioner-patient relationship, but to instead transfer power, for example by initiating discussion with specific communication techniques and providing resources. There has been particular effort recently to encourage medical consultations to provide interventions that increase an individual’s health literacy (Adams et al., 2009). However this transformative empowerment can only occur if the individual is a willing participant as empowerment can only come from within – thus strategies which result in the individual being willing to take positive action on their own determinants of health in partnership with the facilitator are needed.

Further to discovering approaches that work for empowerment, the people-centred approach recognizes the need to address the individual’s family and community in the broader context of their environment at the same time as empowering them to achieve good health (World Health Organization, 2007). It is also equally important to consider the support and enabling features that will allow the facilitator and the broader healthcare system to be holistic, compassionate and empowering.

Approaches that have worked are based on sound theories and models of health literacy, empowerment and human behaviour, as they provide a tool for moving beyond intuition, in order to design, implement and evaluate health promotion interventions (Glanz et al., 2005; Nutbeam & E. Harris, 1998). It is most beneficial to draw on more than one theoretical framework to match the multiple levels of the programme response being planned (Nutbeam & E. Harris, 1998). Theoretical frameworks that have been incorporated into people-centred models include:

- The stages of change (or transtheoretical) model which recognises that individuals experience a dynamic process of change, namely, pre-contemplation, contemplation, preparation, action, maintenance and termination.

- The theory of reasoned action incorporates the notion that behavioural intentions are influenced both by attitudes towards the behaviours and by the subjective norms of the behaviours. The theory of planned behaviour extends this to a third influence, that of perceived behavioural control (particularly the perception of the environment on behavioural control)

- The social cognitive (or learning) theory is one of the most robust theories as it describes a dynamic, ongoing process in which personal factors, environmental factors, and human behaviour exert influence upon each other. This theory emphasizes the construct of “self-efficacy” whereby the person has a sense of agency to act even when faced with obstacles. It considers how self-efficacy, environmental, and individual factors impact behaviour and thus emphasizes the need for strategies directed at social systems that support these (Bandura, 2004).

Strategies that have worked are supported by these behaviour change models. Specific measures that reflect people-centred models of health care (World Health Organization, 2007) all recognize that all health care should encompass individual empowerment. These measures include:
• Actively engaging patients and families in decision making, education and information provision. Activities may include written as well as verbal communication as decision aides, interactive health education through the web (Murray, Burns, Tai, Lai, & Nazareth, 2005), and access to health records.

• Motivational interviewing- a well known method of health counselling, supported by systematic reviews to be effective for self management of chronic disease (Rubak, 2005).

• Recognising the potential role of volunteers – often “patients” themselves, who can be trained to facilitate the empowerment of others (World Health Organization, 2007).

• Using indigenous knowledge and peers from the community to improve outreach to hard to reach groups (Brindis, Geierstanger, Wilcox, McCarter, & Hubbard, 2005; Hays, Rebchook, & Kegeles, 2003; Kim, Koniak-Griffin, Flaskerud, & Guarnero, 2004; Rekart, 2005; Rompay et al., 2008; Ussher, Kirsten, & Sandoval, 2006). For example, programmes to reduce harm for community sex workers utilize peer education is an essential component of success, results in empowering women to negotiate for condom use.

• Supporting individuals as social change advocates. This has shown to be particularly useful for youths (Chinman & Linney, 1998; Holden, 2004).

• Using all levels of health workers including the use of empowered lay health workers (World Health Organization Regional Office for Europe, 2006b).

• Using communication techniques which are culturally sensitive and non-hierarchical

• Innovative chronic disease self management programmes. These are being adopted most notably in developed countries (Zwar et al., 2006) but are particularly urgent for developing countries (World Health Organization, 2002). Activities within the programmes may include support, education and activity groups; opportunities for individual as well as caregiver empowerment; creating partnerships between the individual and practitioner to allow for joint decision making, for example to formulate care plans and for goal setting.

A health system which is realigned to enable these approaches will result in a health promoting system conducive to empowering individuals.

**APPROACHES THAT HAVE WORKED AT THE COMMUNITY AND POPULATION LEVELS:**

Individual empowerment is facilitated by strategies that empower at the community level and reciprocally, community empowerment is facilitated by empowering the individuals within the community. The theory of “community organization” thus informs on community empowerment and will be expanded on in the following track. For this track, it becomes important to understand theoretical frameworks that inform on strategies that improve the reach of health information to all members of a population, and include:

• **Diffusion of innovations** is “the process by which an innovation is communicated through certain channels over time among the members of a social system” (Rogers, 1995). To be effective it requires the use of both informal and formal communication channels as well as a variety of different strategies in different settings – thus increasing the chance of institutionalizing innovations (or messages).

• **Communication theory.** In public health this represents an ecological perspective at multi-levels which may include tailored messages at the individual level. Targeted messages at the group level, social marketing at the community level and media advocacy at the policy level (Bernhardt, 2004).
Social marketing has been shown to be an effective planning model in health promotion practice (Armstrong Schellenberg et al., 2001). Social marketing is the “application of commercial marketing technologies to the analysis, planning, execution and evaluation of programmes designed to influence the voluntary behaviour of target audiences in order to improve their personal welfare and that of society” (Andreasen, 1995). The four “Ps” (product, price, promotion and placement) of commercial marketing can be translated in health promotion as the “social proposition” (creating an appropriate image to the target audience), “costs” (the real or perceived costs and benefits of advocated actions for different population sub-groups), “communication” (the channel of communication i.e. leaflets, media, sponsorship etc) and “accessibility” (the ability to successfully market to hard to reach populations).

In order for mass communication to be successful, it is the collaboration across sectors which can create the enabling conditions. Where there are mechanisms and processes whereby local government work in collaboration with members of the community to: identify health issues of community concern, determine responsibility and suggest improvements; the devised solutions often require input from outside of the health sector. An example where successful individual empowerment needs non-health sector collaboration is the use of micro-enterprises for women who identify as their core reason for lack of power (and thus lack of health) as being their lack of control of finances.

Partnerships between health and non-health sectors to enhance the success of communication strategies to foster individual empowerment and health literacy may include partnering with: the education sector, community based organizations, the business sector, and traditional and mass media to name a few.
INDIVIDUAL EMPOWERMENT

In summary, individual empowerment enables a person to participate in and be health literate within their own community. This leads to better health outcomes for the individuals and positively influences the health of their broader community. The concept of power is important to understand, not as power over the other but as a mutual process of gain. Furthermore, empowerment to address the determinants of health can occur without gaining control over material resources.

Health literacy is critical to empowerment and encompasses knowledge skills and confidence to take action.

Individual empowerment has been shown to benefit population health via various forms of approaches at the health care level as well as at the community and population levels. These strategies are most successful when they are based on sound theoretical frameworks.

Finally, the measurement of individual empowerment is necessary in order to inform strategies and to inform where strategies need to be altered. Individual empowerment is a key component of health promotion and should be integrated as one of the multifaceted approaches into the principles first detailed in the Ottawa Charter for health promotion.

EMERGING STRATEGIES USING INFORMATION AND COMMUNICATION TECHNOLOGIES (ICTS):

With the advancement of ICTs, the internet and mobile devices are fast becoming dominating forms. Internet access means access to health information online, electronic learning (eLearning), the use of text messaging, and the evolution of web-based communities such as online social networks. Even in developing countries, these forms of ICT are emerging rapidly, although their quality and usability are not always reliable. Mobile devices including mobile phones, Personal Digital Assistants (PDAs), laptops, wireless and satellite communications are also becoming particularly useful in remote communities and warrant as a significant strategy for individual empowerment. Careful scaling up of appropriate network services is paramount for the future particularly for underserved populations. Services should be regulated and maintained so that individuals not only have access to reliable ICTs, but so that materials are targeted and adapted for appropriate use of the information – particularly for those most disadvantaged. Effective partnerships between health and ICT services will facilitate this.

MONITORING PROGRESS:

There are two pathways for the measurement of empowerment: 1) the processes by which it is generated and; 2) its effects in improving health and reducing health disparities (World Health Organization Regional Office for Europe, 2006b).

Baselines, indicators and benchmarks at the individual and community levels are important to inform action and report on progress. The contextual differences between individuals and communities, however means that a single set of valid and reliable measures is unrealistic. Different levels of development, different languages, different customs and cultures mean that the way in which people define, perceive and manage health and illness will be highly varied between individuals, communities and countries. Nonetheless, measuring levels of health literacy as well as the impacts of health literacy will inform how interventions should be focused and how they need to be altered to improve success.

It is unrealistic to expect individual health status changes to occur in short time frames and due to the complex causal relationships between individual empowerment and health outcomes, process measures are more useful.
These may include:

- reported increase in self-esteem or confidence
- reported satisfaction with healthcare experience
- reported increase in sense of “control” and sense of “community”
- reported increase in self-management practices (such as blood glucose monitoring)
- participation in support, activity or education groups
- Knowledge, attitude, practices and belief (KAPB) questionnaires

For the community and mass communication strategies, it is important to assess the reach to underserved groups as well as the impact of messages: efficient use of time and resources and the programmes costs and benefits.

Monitoring and evaluating the effects on health and health disparity as a result of empowerment strategies can be done at a population level in more longitudinal time frames. Population groups where individual empowerment interventions have occurred over time can be compared with matched populations where these interventions have not occurred. This could be used as an advocacy tool to support individual empowerment interventions.

## 2. COMMUNITY EMPOWERMENT

Disease-focused, one-on-one approach to healthcare is insufficient to address the broader determinants of an individual’s health. If the social, political, economic and environmental determinants of health are to be addressed, then healthcare programmes need to incorporate the social action objective of health promotion (i.e. mobilise communities, governments and businesses to address the social determinants of health in order to improve health equity, reduce the health impact of poverty, and strengthen community capacity. For social action to occur, community empowerment through integrated community-based health promotion interventions should occur alongside specific efforts in policy advocacy and policy interventions. This is because “well organized and empowered communities are highly effective in determining their own health and are capable of making governments and the private sector accountable for the health consequences of their policies and practices” (World Health Organization: Bangkok Charter, 2007).

**AS A CONCEPT AND WHAT MAKES IT WORK:**

Communities are groups of people that may or may not be spatially connected, but who share common interests, concerns or identities. Communities may be local, national, international or even global in nature and may have either specific or broad interests. Community empowerment is a synergistic interaction between individual empowerment, organizational empowerment and broader social and political actions to bring about an outcome of a change in public policy, legislation or culture (Laverack, 2007). Globalization adds another dimension to the process of community empowerment. In today’s world, the local and global are inextricably linked. Action on one cannot ignore the influence of or impact on the other. Community empowerment recognizes and strategically acts upon this inter-linkage and ensures that power is shared at both local and global levels.

Theoretical models which are broadly considered “community organization models” emphasise community assessed and owned participation processes, and contain theories
including that of “social systems”, “social networks” and “social support” (Glanz et al., 2005). Community organization models can be classified as three different (possibly overlapping) types (Rothman, 2001):

- Community (locality) development is process orientated and aims to build cohesion, consensus and capacity of communities
- Social planning is task orientated utilisers experts to solve community problems
- Social action is both process and task orientated and aims to increase community capacity to be their own experts to solving social injustices.

It is social action models which stress empowerment as core to communities expanding their power from within to bring about desired social change. As described in the previous track, there is a relationship between empowerment (and thus bringing about social change) and health outcomes (Laverack, 2006). As a process, community empowerment forms a five point continuum representing progressively more organized and broadly-based forms of social and collective action including: personal action; small mutual groups; community organizations; partnerships; social and political action (Laverack, 2007). Although seemingly linear, the process is actually dynamic and complex. Facilitators of community empowerment must also work with all levels, and all sectors, both public and private. As well as health promotion practitioners, key facilitators have been identified to include local opinion leaders (i.e. village chiefs, traditional healers, religious leaders), lay health workers and social movements, political will (i.e. governments that sponsor or mandate mass mobilizations) combined with the use of culturally based and culturally competent interventions (World Health Organization Regional Office for Europe, 2006b). Effective leadership that promotes participatory decision-making as well as oversight may be the most important characteristic of successful empowerment (World Health Organization Regional Office for Europe, 2006b).

As well as being aware of the enablers of community empowerment it is equally important to know what may serve as barriers. These have been shown to include (adapted from World Health Organization Regional Office for Europe 2006 (World Health Organization Regional Office for Europe, 2006b):

- Weak leadership in empowerment programmes – for example, when intended leaders are not trained in their specific leadership purposes, are not remunerated or supported adequately, this leads to inconsistent motivation
- Cultural and structural barriers including unequal power dynamics – for example, marginalized groups such as youth, women or injection drug users find it difficult to achieve collective action.
- Bureaucracy – for example rules and regulations such as inadequate funding allocations to disadvantaged groups
- Political barriers including authoritarian regimes – for example civil society organizations may be banned or discouraged
- High social stratification – for example when status of community health workers within the community is not addressed, their role in mobilizing community empowerment is extremely limited,
A history of poor experience of participation in government or top-down implementation – for example where participation programmes are not viewed as a mutual learning process, obstacles in implementation may be dealt with without discussion with community members.

Racism and lack of representativeness in participating members – for example, where there is institutionalized racism, the socially excluded groups are less likely to view local community organisations or networks as representative of their interests or needs.

Lack of management, organization and resource mobilization expertise or conditions supporting participation – for example, where participation is organized whereby community members become no more than informants.

Strong networks of non-government organizations (NGOs) and civil society organizations (CSOs) are often at the forefront of working with the hard to reach populations, being the interface and bridge, supporting individuals and communities to act on health as well as advocating for policy solutions. Communities are more likely to bring a non-silo approach to issues and thus are better able to initiate intersectoral collaboration to address health in all policies (PHAC & WHO, 2008).

**AS AN INTERVENTION:**

The interventions that have resulted in community empowerment have included participation, the formation of community based organizations, effective local leadership, resource mobilization, creative ways of the community asking “why” (i.e. photovoice), community assessment of problems, linking different communities with common needs (Laverack, 2006), use of outside agents and programme management. Combinations of these approaches are likely to result in effective community empowerment.

Laverack (Laverack & Wallerstein, 2001) provides the key questions to consider in planning for community empowerment:

- Who is the community in a programme context?
- What factors influence community empowerment?
- Are we measuring community empowerment as a process or an outcome?
- How can we build capacity as a part of the programme approach?
- How can we promote empowerment beyond attempts to measure it?
- How does the approach influence stakeholder roles and responsibilities?

**THE APPROACHES THAT HAVE WORKED:**

Communities can dramatically improve their health when they have the necessary knowledge, tools, skills, and support to identify and implement sustainable, low-cost interventions. Typically, social action in health promotion adopts a community-based integrated approach to people, places, and health issues. The “entry points” where these interventions act, however, remain diverse – for example they can enter from a population, setting, or social determinants perspective.

Integrated community-based health promotion approaches may enter from a diverse range of entry points and may include:
Disadvantaged populations - For example slum dwellers, Indigenous people

Specific social determinants – For example Social exclusion and Gender

Emerging global challenges – For example climate change and threatening pandemics

Macro- and micro settings – For example healthy cities, healthy schools, healthy marketplaces

**SETTINGS APPROACH**

The settings approach has demonstrated to be a key ecological, whole systems approach recognizing the complex contextual factors of social systems (Dooris et al., 2007). It recognizes that key stakeholders within and outside the government and the health sector must be involved in order to address the skills needed to act on the social determinants of health. The ‘settings approach’ to health promotion has been one organised approach which provides a demonstration of integrated community-based health promotion. They can be implemented as micro-setting interventions (such as health promoting schools, health promoting workplaces, healthy marketplaces, etc), targeted at particular populations (such as youth, older people, women, etc), and these strategies can be reinforced with macro-level interventions (i.e. healthy cities) addressing the community's concern as a whole. The settings approach can be applied simultaneously at multiple levels, for instance, within the context of urbanization, a healthy city may be coupled with multiple micro-setting interventions. Such strategies have been shown to support efforts to empower individuals and communities for community action in multiple sectors.

The community empowerment approach implicit in the settings approach has benefits beyond the health sector as it enhances the community's capacity to participate in public policy-making and to enhance government and institutional accountability. An empowered community can initiate action to address their own health and other concerns and advocate for health and other policies.

The integrated community-based health promotion approach gives emphasis to the need for participation and partnership, including at the governance level. For example, integrated approaches which have worked include those where community citizens themselves have been facilitated to develop their own mechanisms of participatory governance. This has resulted in the persuasion of local authorities to collaborate and form partnerships that can address basic rights and services for the citizens (Barten, Mitlin, Mulholland, Hardoy, & Stern, 2007). Formation of coordination structures at community level is important for all phases of a programme – from undertaking situational analysis, to developing a consensus-based strategic plan, to monitoring implementation processes and outcomes.

**PARTICIPATORY APPROACHES**

Participation is a core element of empowerment – and participatory processes can be incorporated into health services (in programme delivery, services planning, governance) or in community organizations and broader policy and governance processes. Participation can occur at different levels represented along a ladder of increasing engagement – as outlined in Table 1. Without meaningful participation, the aims of capacity building and empowerment will not be achieved. It is at the highest levels on the ladder where consumers have an opportunity to affect outcomes and control processes and hence possess “citizen power”. It is necessary to create mechanisms for (and a culture of) consultation and
participation, joint planning of activities and shared ownership of outcomes. Furthermore, community-owned discussion and debate results in increased knowledge and awareness, and a higher level of critical thinking. Critical thinking enables communities to understand the interplay of forces operating on their lives, and helps them take their own decisions.

**TABLE 1: LADDER OF PARTICIPATION**

<table>
<thead>
<tr>
<th>Level on the ladder</th>
<th>Description</th>
<th>Type of participation</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Manipulation</td>
<td>Non-participation</td>
</tr>
<tr>
<td>2.</td>
<td>Therapy (power holders can ‘educate’ or ‘cure’)</td>
<td>Non-participation</td>
</tr>
<tr>
<td>3.</td>
<td>Informing</td>
<td>Tokenism</td>
</tr>
<tr>
<td>4.</td>
<td>Consultation (those without power can hear and be heard, but lack the power to ensure their views are heeded)</td>
<td>Tokenism</td>
</tr>
<tr>
<td>5.</td>
<td>Placation (some level of consumer influence – government may give in to some demands, or may include representatives in decision making)</td>
<td>Tokenism</td>
</tr>
<tr>
<td>6.</td>
<td>Partnership (consumers can negotiate with power holders and engage in trade-offs)</td>
<td>Citizen power</td>
</tr>
<tr>
<td>7.</td>
<td>Delegated power</td>
<td>Citizen power</td>
</tr>
<tr>
<td>8.</td>
<td>Citizen control</td>
<td>Citizen power</td>
</tr>
</tbody>
</table>

Source: (Arnstein, 1969)
Participation may be initiated by an organization or it may be initiated by the community. Whoever it is initiated by however, it is the community perspective that should structure the issue so that citizen control is more likely, and to minimize problems with definitions, language, and framing (Gregory, 2007). The actual techniques for the participation process will be dependent on local context and therefore to present exact methodology would be inappropriate. However different techniques will mean that communities will participate in different ways and can influence the quality of the outcome. Using a variety of techniques will result in more effective participation, particular with minority and vulnerable groups (NHMRC, 2006). There will always be community members who will not want to participate, which means that those who do, need to be strategically chosen to represent the whole community.

Participatory processes make up the base of empowerment. However participation alone is insufficient if strategies do not also build capacity of community organizations and individuals in decision-making and advocacy (World Health Organization Regional Office for Europe, 2006b).
MONITORING PROGRESS:

Community empowerment is an important health promotion outcome. As with individual empowerment, there are two pathways for monitoring progress in community empowerment: 1) the process by which it is generated and 2) its effects in improving health and reducing health disparities (World Health Organization Regional Office for Europe, 2006b). Measuring empowerment can be an empowering process in itself. With a clear theoretical understanding of the concepts pertaining to community empowerment (Glanz et al., 2005; Nutbeam & E. Harris, 1998) this can provide a means to designing a methodology which can be used to inform strategies to maximize health promotion outcomes (Glanz et al., 2005). Finding direct causal links between community empowerment strategies and health outcomes is difficult and context specific, however measuring process outcomes that are sensitive to the immediate actions is more useful.

Nutbeam (Nutbeam, 1996) suggests that social mobilization - the observable actions and influences that social groups have had on particular health environments or healthy lifestyles, can be used as a health promotion outcome and thus an outcome for community empowerment. Another way to measure empowerment is to measure community participation. The World Bank has identified four characteristics to ensure that participation is empowering; peoples access to information on public health issues, their inclusion in decision-making, local organizational capacity to make demands on institutions and governing structures and accountability of institutions to the public (World Health Organization Regional Office for Europe, 2006b).

Laverack (Laverack, 2006) asserts that an understanding and the measurement of multiple levels and domains which will give the most accurate picture of empowerment and allow the ability to link it to health outcomes. For an accurate picture of outcomes of community empowerment interventions indicators should be collected from multiple levels and domains and over time. A single outcome such as an improved health outcome, operating in such an open system is necessarily due to many other processes including empowerment.
Therefore linking health outcomes with multiple domains of the process of empowerment and may include (Adapted from Laverack, 2006):

- Level of participation
- Formation of community organizations
- Level of local leadership
- Resource mobilized
- Community driven creative activities that have occurred
- Level of community assessment of problems
- The establishment of partnerships between communities with common needs,
- The use of outside agents
- Level of programme management

3. HEALTH SYSTEMS STRENGTHENING

It is now widely accepted that health outcomes can be better secured when health systems are functioning effectively (World Health Organization, 2007). But how well are health programmes and health systems geared towards keeping people well?

Health programmes can do better by using a health promotion lens and supporting community action, individual health skills, and advocacy for policy action. Health systems can also change the ways in which the work is done and funding is allocated in order to strengthen their orientation to prevention and health promotion. Healthcare institutions can also become health promoting settings.

THE HEALTH PROMOTION LENS: AT THE LEVEL OF NATIONAL PLANNING

A systematic approach at the national level to ensuring health promotion is embedded into all parts of the health system would entail the re-visiting of national health plans with a health promotion lens. Some of the key elements to consider, for each step of the planning process, are outlined in Table 2.

TABLE 2: HEALTH PROMOTION CHECKLIST FOR NATIONAL PLANS

<table>
<thead>
<tr>
<th>HEALTH PROMOTION LENS CHECKLIST FOR NATIONAL PLANS</th>
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</thead>
<tbody>
<tr>
<td>1. Situational analysis</td>
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<td></td>
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<tr>
<td>HEALTH PROMOTION LENS CHECKLIST FOR NATIONAL PLANS</td>
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<tr>
<td>---------------------------------------------------</td>
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<tr>
<td><strong>2. Determining priorities, objectives and outcomes</strong></td>
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<tr>
<td>Have communities been involved in identifying needs prioritising health issues, and drawing up a national health promotion strategy?</td>
</tr>
<tr>
<td>What community assets can be mobilised to create better health?</td>
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<tr>
<td><strong>3. Selecting intervention strategies</strong></td>
</tr>
<tr>
<td>Has the Ottawa and Bangkok Charters been applied?</td>
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<tr>
<td>Have all partners been identified and been involved in intervention planning?</td>
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<tr>
<td>Are the interventions informed by evidence and applied in local context?</td>
</tr>
<tr>
<td>Has the potential for health promotion been identified in all aspects of health services delivery, alongside treatment and care?</td>
</tr>
<tr>
<td>Has the role of primary health care and traditional medicine been described?</td>
</tr>
<tr>
<td><strong>4. Implementation</strong></td>
</tr>
<tr>
<td>Has a comprehensive strategy for health improvement been published or is readily accessible to the public?</td>
</tr>
<tr>
<td>Have sufficient resources been allocated to ensure appropriate targeting and programme coverage?</td>
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<tr>
<td>Is there a human resources strategy in place?</td>
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<tr>
<td>Have capacity strengthening been incorporated into implementation plans?</td>
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<tr>
<td>Are there clear organizational arrangements for the co-ordination, management and evaluation of health promotion on a whole-system basis?</td>
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<tr>
<td>Are there clear arrangements for engaging non-health sectors?</td>
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<tr>
<td>Are there arrangements for governance and accountability?</td>
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<tr>
<td>Does the health system recognize its responsibility as an employer to promote the health of its employees?</td>
</tr>
</tbody>
</table>
### HEALTH PROMOTION LENS CHECKLIST FOR NATIONAL PLANS

<table>
<thead>
<tr>
<th>5. Monitoring &amp; evaluation</th>
<th>Have indicators which reflect health promotion action and health improvement been adopted amongst Key Performance Indicators for health system performance?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Have appropriate indicators and tracking systems been developed to monitor health literacy, social participation, risk factors, social determinants, service access and output, and policy measures?</td>
</tr>
<tr>
<td></td>
<td>Has a social process of monitoring and learning been instituted?</td>
</tr>
<tr>
<td></td>
<td>Are there arrangements for equity audits to ensure the most disadvantaged are benefiting?</td>
</tr>
<tr>
<td></td>
<td>Are the arrangements for monitoring and evaluation to be in the public domain?</td>
</tr>
</tbody>
</table>

Source: Adapted from PAHO/Mexico Conference (PAHO/WHO, 2000) and Parish and Mittelmark (Parish & Mittelmark, 2005)

### AT THE PROGRAMME LEVEL:

Adopting the health promotion lens for all health programmes means the key features of health promotion can be applied to all aspects of health programme planning, delivery, and evaluation. However, the effective application of the lens does require a sound understanding of the social determinants related to the specific health condition being addressed, and the attitudes and behaviours of the relevant population groups and communities.

The planning of health promotion action within each health programme area entails: 1) assessment of key risk factors and social determinants and their distribution in populations, 2) the assessment of evidence about potentially effective interventions and how they might be applied to the relevant population and community context, and 3) the adoption of appropriated tailored and scaled intervention strategies.
For instance, at the situation analysis for programme planning, the specific information required include (adapted from PAHO (PAHO, 2008) draft):

- Is there data on determinants of health, features of context, and influence of non-health sectors?
- Is there information broken down by gender, ethnicity, and socioeconomic groups?
- Is there data on community capacity to act?
- Is there data on strengths and assets of individuals and communities?
- What is the community’s view about the problems and solutions?

These questions are also applicable to assessing the evidence base for potentially effective interventions. Health promotion action should be tailored to the contexts, values, knowledge and actions of individuals and communities, and as such, can assist with adapting health programmes to foster individual and community ownership and sustainable health behaviour change. This means that the evidence base for interventions must be scrutinized to consider the conditions under which effective delivery can occur and desired outcomes can be achieved for particular populations and communities. Interventions must be considered from the viewpoint of: political acceptability, social acceptability, availability of essential resources for implementation, organizational expertise and capacity for implementation (Buffett, Ciliska, & Thomas, 2007).

The health promotion lens offers particular principles that can be built into the programme planning process. These are particularly important in designed appropriately tailored intervention strategies. These principles are (adapted from PAHO (PAHO, 2008) draft):

- Involve health promotion personnel and examine health promotion evidence
- Focus on groups with the most disadvantage and understand the contexts for their health choices and actions
- Community participation in planning enhances understanding of the problem, adaption of intervention strategies, and feasibility of implementation
- Set goals and objectives around engagement and empowerment and develop strategies that build on existing individual and community values, attitudes, and practices
- Use the Ottawa and Bangkok Charters as a checklist and adopt strategies at many levels, from individual to community to policy level, working in a unified way
- Work holistically in a setting, wherever possible
- Involve the community in monitoring and evaluation

For implementation planning, it is necessary to ensure financial and human resources required are available, along with the policy mandate and organizational capacity required. In addition, it is important to consider:

- how to coordinate the strategies being implemented by different actors and at different levels,
- how to ensure the targeting is right, coverage is sufficient, and the programme will be in place for sufficient length of time,
- how to support the use of participatory evaluation method, and collect indicators which relate to determinants, empowerment, and equity of outcomes, and
- how partnerships will be formed and community leadership roles developed so the programme and its outcomes are sustainable.
**BUILDING HEALTH PROMOTING HEALTHCARE SETTINGS**

Healthcare settings can be transformed to health promoting environments. A health promotion hospital (HPH) is one which “constantly strives to strengthen its capacity to promote health in a holistic manner. It uses infrastructure, technical expertise, and know-how to promote health of patients, relatives, staff and management and the community in a holistic manner” (Lin et al., 2005). In practical terms, a HPH adopts an integrated set of initiatives such as:

1. Design care processes so they can be responsive to the needs of patients and their families, taking into account culture, social norms, physical and mental capacities, health care skills, health aspirations, domestic resources and circumstances;

2. A charter of patients’ rights, prepared through a consultation process with patient representative groups, which addresses such issues as protection of privacy, consultation about treatment options, providing information to support consent and informed choices, and respectful treatment;

3. Routine patient satisfactory surveys in the spirit of a learning organization, and use the feedback from patients and their families to identify what is being done well or could be improved, and to guide action;

4. Health education services relevant to the users, through a variety of activities, information media and channels (including integrating into the care process), to foster well-being or support self-management of health concerns with confidence and skills;

5. Patient health and welfare support services, such as counseling for patients and families, support groups, self-care training, so to enable patients and families to deal with health conditions and associated anxieties; and,

6. Amenities that can enhance the experience of using hospitals, such as shops, cafeterias, quiet spaces for spiritual reflection, hygienic restroom, storage spaces for people who travel long distances, or facilities for people caring for family members.

A HPH will consider the potential barriers for patients, their families, and the community to health learning, exercising choice and acting on information. These include health literacy, out-of-pocket costs, access issues, and personal circumstances.

**BUILDING HEALTH PROMOTING HEALTH SYSTEMS**

The operational mainstreaming of health promotion into all health programmes can be effected through adoption of health promotion strategies into programme guidelines. To support day-to-day work, mechanisms should be adopted for ongoing collaboration between health promotion specialists and various health programme managers and health services providers. Joined development and use of shared guidelines, with delivery by the same providers, are practical mechanisms to ensure efficient coordination (Atun, Bennett, & Duran, 2008).

The renewal of primary health care, however, calls for universal coverage and people-centred health care, and not just a benefit package of selective preventive services (World Health Organization, 2008). Additionally, the WPRO policy framework for People-centred Health Care calls for action in four domains: informed and empowered patients and
communities, competent and responsive healthcare practitioners, efficient and benevolent health care organizations, and supportive and humanitarian health systems. Health promoting healthcare settings can be instigated in hospitals, in primary care organizations, and other health facilities through those who champion people-centred health care. The success and sustainability of these initiatives will depend more on efforts in health system strengthening, with health promotion as a core component.

Given the shared concerns between health promotion, disease prevention, and disease management programmes – including common health conditions, common behavioural risk factors, common social determinants, and issues of health care access (Martin-Misener & Valaitis, 2008), collaboration across programmes is possible not only in specific programme delivery activities but also at the system level, such as policy, funding, information systems.

Most fundamental to good health and access to preventive care is universal access to primary health care. The removal of user fees is particularly important measure to address inequities in healthcare access (World Health Organization, 2008). User fees have been introduced in many countries as a means of raising revenue, but these led to decreased access, particularly for the poorest and most vulnerable populations. The reliance on user fees can be replaced with well planned “pre-payment” and “pooling” systems, using a combination of public, private, external and domestic sources. Achieving universal access through combining different insurance schemes (including those of community, cooperative, employer-based and other private schemes) is critical measure for ensuring appropriate access to prevention (World Health Organization, 2008).

Purchasing of health services is one approach to increase the focus on, and resources, for health promotion in health systems (World Health Organization, 2007; National Preventative Health Taskforce, 2008).

- Fee-for-service, although generally seen as not an ideal way to pay for health care, can be used to motivate primary care providers to offer brief interventions, such as counselling around tobacco, alcohol, diet, physical activity, or even to implement empowerment strategies.
- Performance-related payments, which can also have the risk of inappropriate over-servicing, can also be used to reward providers to offer health promotion programmes, such as lifestyle-related programmes or community action programmes.
- Capitation payment for providers is a way of extending service coverage to population groups who might otherwise not have adequate access, but it does require the health system to have strong health promotion capabilities if population health is to be improved.
- Elimination (or at worst reduction) of user charges for preventive services is another way to ensure poor and vulnerable population groups have access to needed healthcare. It is most crucial for preventative service charges to be eliminated as the user often 'feels' the least immediate benefit from these.
- Consumers can be given financial incentives to improve their health behaviour. Reduced insurance premiums and co-payments or no-claim bonus could be linked to changed behaviour (such as quitting or not taking up smoking).

As any incentive payment systems have risks, and purchasing systems need to be underpinned by a sound monitoring system and mechanisms for stimulating improvements should performance be disappointing.
The trend towards performance-based funding is demonstrating that it is possible to adopt a ‘diagonal approach’, where incentives are provided to focus on outcomes and reward achievements, based on agreed country ownership of targets and implementation (Low-Beer, Afkhami, & Komatsu, 2007). The ‘diagonal’ approach to health system strengthening can help address health system bottlenecks by addressing policy and capacity issues, without losing sight of the monitoring of health outcomes (World Health Organization, 2007).

Non-payment incentives at the individual level can also increase the focus on health promoting health systems. For example, incentives may include; health promotion training opportunities; health promotion reporting requirements; less service time allocated to treatment based interventions and more to health promoting services; health promotion mentoring and supervision; and integration of health promotion into performance management.

The Tallinn Charter 2008 (Health Systems for Health and Wealth) identified key actions for more efficient and effective delivery of health services. These are important platforms for supporting a stronger health promotion presence within the health system:

- integration of targeted disease-specific programmes into existing structures and services in order to achieve better and more sustainable outcomes;
- a holistic and coordinated approach to health promotion, disease prevention and integrated disease management programmes,
- redistribution of financial resources to meet health needs and reduce financial barriers to services,
- financing incentives to improve health system performance,
- better balance in resource allocation between health care, disease prevention and health promotion,
- monitoring and evaluation of health system performance with stakeholders at all levels of governance.
MONITORING PROGRESS:

WHO has suggested that health system performance measurement focus on impact on health and health equity, its responsiveness to healthcare users, and the fairness of financing arrangements (World Health Organization, 2000). While access and equity in relation to healthcare and health financing clearly can have important impact on health status, whether a health system is health promoting depends the extent to which it incorporates action on social determinants of health in its activities, ranging from the clinical encounter to organizational and workforce arrangements, to working with and being accountable to the community, to advocating for change. The measurement of health inequities at national and local levels can show the disparities in the social determinants of health and can be used as a measure of how well a health promoting health system is performing. Health inequities invariably exist in smaller geographical regions and can be significantly masked by larger area and country measures. Thus incorporating local monitoring whether as indicators, qualitative measures and rapid assessment is vital. Inequity measurements will vary depending on the type of measure used as well as the choice of populations across which comparisons are made (Anand, Diderichsen, Evans, Shkolnikov, & Wirth, 2001). Thus, depending on context specificity appropriate measures could include:

- access/reach of health programmes such as measures of health seeking behaviour – a health equity measure.
- Focus group consultations with community representatives to ascertain their perception of health system responsiveness – a responsiveness to healthcare users measure
- the amount paid in user fees (or the prevention of financial hardship due to catastrophic illness) between identified inequitable groups – a fairness of financing arrangement measure

Creation of a contextual checklist at programme level incorporating the aspects of a health promoting health system (as an addition to national level checklists as per table 2) should be continually reflected upon to assess progress. “Citizen panels and juries” (Parish & Mittelmark, 2005) can provide a transparent and participatory approach to this type of monitoring and can ensure governments are continually made accountable for sustaining health promoting initiatives in health systems.
4. INTERSECTORAL ACTION

"Intersectoral action" (for health) refers to actions affecting health outcomes undertaken by sectors outside the health sector, possibly, but not necessarily, in collaboration with the health sector" (PAHO/WHO, 2000). The health promotion lens calls for attention being placed on social action and public policy as fundamental measures to address social determinants of health and the achievement of health equity. Health promotion strategies operationalise two critical principles of primary health care reform: intersectoral action and health in all policies, and inclusive leadership and effective governance for health.

WHY IS INTERSECTORAL ACTION ESSENTIAL AND HOW TO MAKE IT HAPPEN?

The priority health issues faced by countries and communities share common social determinants of health. These are best tackled together, as changes in each social determinant can contribute to multiple health objectives. Because of the inter-related nature of the social determinants (e.g. poverty and social exclusion), some policy measures (e.g. poverty alleviation) may also effect changes in several social determinants (e.g. poverty alleviation leads to social inclusion).

Stewardship for the health of the community requires the formulation of strategic policy direction, ensuring good regulations and their implementation, and using sound information for decision-making (World Health Organization, 2000). The stewardship role of government points to not only a responsibility for the well-being of citizens, but also the possibility of achieving policy coherence for action on shared problems that impact on health as well as other aspects of society, economy, and environment. The development of healthy public policy is a function of government stewardship – i.e. adopting public policy measures which create the enabling conditions for individuals and communities to make healthy decisions.

Getting sectors to work together, through achievement of co-benefits, is fundamental to addressing the 'causes of the causes' which result in poor health. Policy action is essential, but top-down national action is often insufficient. Effective system leverage means not only having a cross-sectoral policy framework at the government level, but also support for local actions which can transform the lives of people in communities. Better support of communities to act intersectorally and to hold government and other institutions accountable is a key to influencing change at the public policy level.

The key steps in effecting intersectoral action as an approach to healthy public policy development will vary according to specific policy context and institutional arrangement within a country, but they can be summarized generally as:

1. establish health as a whole of government issue – this may require shifting the debate and reframing the problems from a government perspective
2. creating governance structures to reinforce cross-sectoral workings
3. developing new approaches appropriate for the whole of government, including using a range of new tools and mechanisms for policy development and for performance reporting
4. recruiting a range of partners to help – and putting emphasis on co-benefits
GETTING STARTED: RE-FRAMING HEALTH AS A WHOLE OF GOVERNMENT ISSUE

While the health sector may be interested in a whole of government approach to address the key risks for health, governments may also benefit from such an approach. By working across sectors, fragmented programmatic efforts can be consolidated, limited resources can be pooled and scaled up, costs and benefits are shared across sectors, and collaborative efforts can be results-focused.

For the health sector, however, it is important to recognize that other sectors have imperatives different from health. Thus, building a case for intersectoral action should be framed in a broad way to allow a variety of sectors to “find a place” rather than framed as other sectors working with health as health is not “taking over” (PHAC & WHO, 2008). It is critical, therefore, to focus on the shared concerns and describe the problem so that non-health sectors can relate to it. It is also useful to acknowledge the limitations of previous approaches based on health sector action alone. Inter- and multi-sectoral action may in fact be considered slightly differently, and be used to encourage non-health sector autonomy. Inter-sectoral may consider that the health sector is the initiator and may take a lead role, however, multi-sectoral considers that the interaction results in autonomy in the non-health sector, thus encouraging a win-win situation and is the ultimate goal of collaboration.

DEFINE COMMON CAUSE: FOCUS ON SOCIAL DETERMINANTS AS WELL AS EQUITY

Health conditions and risks are not evenly distributed. Disadvantaged communities experience the clustering of risk conditions and health problems, often as the consequence of political and economic decision making which do not incorporate health equity considerations.

Equity issues can be brought into all aspects of programme planning, delivery and evaluation (VicHealth, 2008). Equity of access (cultural, financial, physical barriers to services), equity of opportunity (influences of education, employment, locality), and equity of impacts and outcomes (for different population groups) should be considered and reflected in all programmes. Equity issues can thus also be brought into the centre of intersectoral action, as a focus for ‘health in all policies’.

Some specific strategies that can support the development of new understandings and ways of framing issues include:

- Create fora for public and civil society participation
- Provide opportunities for researchers to showcase key findings
- Use political champions to advocate for intersectoral action
- Build on international involvement and leadership
- Build consensus via shared gatherings
- Build on concerns about using resources efficiently
IDENTIFY CONCRETE ACTIONS:

It is important to look for solutions, not just point to the problems. A health promotion lens applied to policy action would aim to achieve 'health in all policies' – i.e. the incorporation of health-related action in all public policies. This would entail some combination of the following actions (adapted from PAHO 2008 draft):

- Focus on the role of all social and economic institutions in creating health
- Look for solutions that can achieve co-benefits across policy sectors
- Advocate for policies which strengthen community assets
- Monitor the impact of non-health sector policies on health
- Address the equity impact of non-health sector policies
- Develop governance arrangements that ensure ongoing partnerships and collaboration across policy sectors
- Use international treaties, conventions, and declarations
- Advocate for access to information and continued participation in decision-making, particularly for marginalised populations

National approaches will have limited effect if they are not supported by local efforts (PHAC & WHO, 2008). Community or local action is also essential for successful health promotion and many examples exist of community action resulting in positive changes in the social determinants of health in very poor settings - although the success of these is reliant on sound policy frameworks (Blas et al., 2008). Community action to drive intersectoral action is more likely to be able to be inclusive of those most marginalized. Local action can also inspire changes to policies and regulations. Intersectoral action is most effective when it occurs at several levels simultaneously, while incorporating an understanding the complexity of institutional arrangements in government (PHAC & WHO, 2008).

RESHAPING GOVERNANCE AND PUBLIC POLICY:

Governance provides a pathway to address the social determinants of health (CDSH, 2008). Governance typically involves making decisions about policy tools to be adopted, such as legislative provisions, creation of organizations with mandated functions and authority, inter-organizational partnerships, financing and provision of services and programmes, processes that enable representation by the community/consumer sector. It necessarily touches on political interests as well as community and business sector interests, and thus involves network management processes.

GOVERNANCE MECHANISMS

Governance structures and processes are interrelated with policy responses. Governance mechanisms oversee decision making in regards to the development of a policy or course of action and the implementation of the decision(s). Governance mechanisms that can be adopted for intersectoral action across government include: ministerial committees, cross-government planning, common legislative frameworks, common policy development and assessment tools, shared targets across portfolios, and common reporting indicators.

Governance is, however, not an activity limited to government, but one that defined the relationship between government and other stakeholders outside of government, including business and civil society. Participatory governance can take multiple forms, with differing levels of stakeholder engagement: community representation on committees, public
reporting on policy outcomes, public consultations or hearings for proposed policies, delegation of community service obligations to community organizations or to public/private partnerships. The most common initial step towards good governance – i.e. accountable and transparent decision-making – is by establishing mechanisms for participation in policy development and review.

There are, however, some trade-offs and decisions which need to be made in design participatory governance, to balance efficiency of process, effectiveness of participation, and extent of involvement: (Adapted from (Gregory, 2007))

- The level of participation (as described by Arnstein's (1969/2003) ladder)
- The purpose of the participation
- Who initiates the participation
- Who participates
- At what stage participation occurs
- What types of decisions communities can contribute to
- Whether members want to participate
- Choices about participation techniques

These choices should made taking into account the contexts for participation.

It is important to recognize that governance and policy are in themselves structural determinants of health that shape the socioeconomic and political context of a country. As such, they also influence inequities between individuals and communities in relation to social position and living conditions. Therefore more equitable governance arrangements and policy responses will result in equity improvements in relation to social position and daily living conditions (CDSH, 2008). Likewise, action focused solely on daily living conditions and social position can achieve health equity outcomes limited by the equitable nature (or not) by the socioeconomic political context.

**ADVOCATING FOR POLICY CHANGE**

Acting on appropriate designs of policy interventions is not a matter of technocratic planning by government, but a consequence of negotiated process between stakeholders across sectors, and between civil society and government.

The health sector plays an important role through evidence-informed advocacy. Strong network of NGOs/CSOs and empowered communities, linked with health sector interests, can form effective policy advocacy coalition. Advocacy depends on presenting compelling arguments that convey a sense of urgency for action. It requires presenting decision-makers with proposed actions that are irresistible. Advocacy efforts need planning. The key steps include:

1. Researching the issue – what is the nature and magnitude of the problem? How is the problem distributed across communities and populations? What solutions are possible, and at what cost? Who benefits?
2. Knowing the target audience – what is the entry point (or issue of interest) for decision-makers? For the community? For the media? For other stakeholders?
4. Deciding on the advocacy approach – What is more effective at this stage – public media campaign? Lobby in the corridors of power? Presenting evidence (of problem and solution) to bureaucrats?
5. Deciding on key messages and key audiences – consider how to align the interest of the target audience, the desired outcomes, and the advocacy approach.

6. Making contacts and assessing the climate for change – do homework on who are the key people to talk to and how receptive they are to talking. Explore how amenable decision-makers are to potential changes in legislation and policy.

7. Building constituency and building alliances – make sure potential allies are supportive and will undertake coordinated action.

It is important to recognise and work with the factors that shape political decision-making, i.e. understand the context for policy-making.

TOOLS AND MECHANISMS: NEW APPROACHES FOR WHOLE OF GOVERNMENT ACTION

A range of policy tools may be adopted to support health in all policies. Working with existing institutions and policy levers are more likely to be effective for mainstreaming health promotion, rather than separate programmatic funding or time-limited projects (PHAC & WHO, 2008). Governance processes (i.e., whole-of-government and inclusive of civil society) may be supported through such tools as health impact statements and mandatory reporting on health status and equity which allows the potential health and equity impacts of policies to be identified. Citizen participation in policy development, such as through participatory budgeting, would bring the community yet closer to policy ownership if not community empowerment.

PARTICIPATORY BUDGETING

Participatory budgeting recognizes that citizens “own” the public budget and must actively monitor government spending, scrutinizing how much is spent and on what, as well as the process through which these decisions are made. Without adequate funding, legal and policy frameworks cannot reduce health inequities. With active awareness of budgetary issues, the relationship between civil society and the government transforms from a hierarchical one, to a transparent, inclusive and horizontal one (IIMMHR, 2009). Civil society recognition of government budget systems that are not transparent, may still identify a mismatch between what is allocated, what is released and what is spent which can provide a platform for accountability advocacy.

The process of participatory budgeting has included:

- Analyzing a government’s spending trends over a period of time
- Understanding who among the population is prioritized to fulfil government equity obligations
- Tracking outlays to outcomes by seeking to understand not only how much has been allocated and spent, but also what outcomes are delivered.
- Using budget data to supplement socio-economic indicators for poor health

For example, in Porto Alegre, Brazil, citizens have been trained to participate and meet twice a year to settle budgetary issues. Civil participation has resulted in priority budgeting towards garbage collection, piped water supply, sanitation and drainage, and education. Porto Alegre now has the highest standard of living and the highest life expectancy of any Brazilian metropolitan centre (Knowledge Network on Urban Settings, 2007). Participatory budgeting thus provides essential support for evidence-based advocacy that is necessary to push governments to allocate and spend on the right priorities (IIMMHR, 2009)
USING THE LAW:

If governments have the stewardship role, along with coercive powers, then laws are important tools for assuring the conditions for people to be healthy. Indeed the Bangkok charter (World Health Organization: Bangkok Charter, 2007) specifies a need to “regulate and legislate to ensure a high level of protection from harm and enable equal opportunity for health and well-being for all people”. Contemporary thinking about public health law suggests that laws are useful as policy instruments for health promotion, through the range of incentives, rewards, and sanctions they provide for society. Examples of how law – as expression of government’s coercive powers - can be used support intersectoral action and as health promotion interventions include (Gostin, 2004):

- Power to tax and spend – inducements or disincentives for behaviour, funding of programmes
- Power to alter the informational environment – assist with making choices (labelling, warnings)
- Power to alter the built environment – protect from hazards and support lifestyles (planning and zoning, recreation, toxic waste management)
- Power to alter the socioeconomic environment – effect social policy objectives (redistribution)
- Direct regulation of persons – protect workers, consumers and population generally
- Indirect regulation through tort system – civil litigation (environmental damage, hazardous products)
- Deregulation – decriminalization

USING HEALTH IMPACT ASSESSMENT (HIA) AS A TOOL FOR POLICY CHANGE:

Health impact assessment (HIA) is a useful tool to help raise awareness of health and equity issues across all sectors, assisting affected communities to participate, and thereby support decision-making in choosing between options and optimising overall outcomes of decisions (Kemm, Parry, Palmer, & (Eds)., 2004). HIA uses “a combination of procedures, methods, and tools by which a policy, programme or project may be judged as to its potential effects on the health of a population and the distribution of those effects within the population” (Nordic School of Public Health, 2000; WHO, 1999). HIA is different from other decision aides (Mindell & Joffe, 2003) in its focus on complex interventions or policy and their diverse effects on determinants of health, requiring evidence on the reversibility of adverse factors damaging to health, involving diversity of evidence (disciplines, study designs, sources of information), and involving a broad range of stakeholders.

HIAs can be particularly useful for addressing health inequalities and social determinants through the technical analyses required to:

- Estimate the prevalence of health determinants on which the proposed policy/programme may impact
- Check the current distribution of these determinants on population sub-groups and the extent of their contribution to health inequalities
- Estimate the effect of the policy/programme on the prevalence of these determinants for different populations
- Estimate the effect of changes in the prevalence of these determinants in population group on health inequalities.
Additionally, HIA is a process involving participation from, and accountability back to, affected communities. As such, it is both a tool for promoting ‘health in all policies’ as well as a tool to support community empowerment and action.

**USING ACCOUNTABILITY AND PERFORMANCE REPORTING:**

Common levers used by governments for policy implementation are: legislation and regulation, grants and subsidies, service delivery, guaranteeing rights, setting market conditions, and information and education. Monitoring and evaluation of their impacts and outcomes – for health and for equity – is a critical component of an accountability system.

Report cards are used as a monitoring system as a proactive approach to evaluating the effects of existing or changing policies (Simmes, Blaszcak, Kurtin, Bowen, & Ross, 2000; Weir, d’Entremont, Stalker, Kurji, & Robinson, 2009). They can be used to evaluate the health effects of all policies. Report cards use a timely and reliable set of indicators which may be generated through community to national level intersectoral consultation, which will result in a broad set of social indicators that impact on health. Report cards are necessarily succinct, to the point and this translates to maximum impact to the reader. A report card is a tool that can be used to provide evidence based advocacy to empower communities to influence intersectoral action. For example in the United States, women’s health report cards have shown the progress (or lack of) of women’s health status and have included indicators of employment wage gaps between men and women and high school completion rates for example. Findings from the report cards are an avenue to prompt advocacy for action into other sectors in the aim of improving women’s health and well-being (National Women's Law Center and Oregon Health and Science University, 2007).

League tables are a related approach as they attempt to evaluate activities or institutions by ranking simultaneously cost-effectiveness, maximum health gain and maximum health equity (Fox-Rushby, Mills, & Walker, 2001). They should be used in conjunction with other performance measures due to difficulties in consistent methodologies to evaluate such a wide range of activities – particularly if these activities span multi-sectors. Nonetheless, given that tackling the social determinants of health addresses multiple risk factors and health outcomes, using a league tables across sectors would potentially show the cost effectiveness with maximum health gain and provide evidence to inform were resources should be prioritized.
DEVELOPING PARTNERSHIPS

Effective intersectoral action relies on a foundation of partnership. Building partnerships is not just about being nice to people or being inclusive for all. It is a strategic activity and should be based on sound analysis - of shared problems and shared solutions.

A checklist for partnership in health promotion at the organizational level, for government agencies and non-government organizations, can serve as the starting point for intersectoral action as well as a continuing frame of reference to foster continued partnerships (VicHealth):

1. Determine the need – is there common interest and complementary capacity, is there a clear goal, is there shared understanding and commitment, is there willingness to share ideas/resources/influence
2. Choosing partners – is there interdependence in the core business, is there a history of good relations, does the coalition bring added prestige and value, do partners bring new information and skills
3. Making sure partnerships work – is there managerial support, are the roles and responsibilities clearly defined and understood, are the communication and decision-making processes simple
4. Planning collaborative action – is there participatory decision-making system, are all partners involved in priority-setting
5. Implementing collaborative action – can common processes be standardized to make reporting and communication simple, is collaboration and reciprocity rewarded, is the time involved recognised, is there a regular opportunity for informal contact
6. Minimising the barriers for partnership – is there a core group of people continually involved, are there formal structures for information sharing and resolving disputes, can alternative views be expressed
7. Reflecting on and continuing the partnership – are there processes for recognising and celebrating collective achievements, can outcomes of collective work be demonstrated, are resources available, is there a process for reviewing membership in a partnership

INTERSECTORAL ACTION

In summary, intersectoral action for health is essential for the achievement of co-benefits, fundamental to addressing the 'causes of the causes' of poor health. Intersectoral action needs both good governance (and the adoption of effective public policy measures) as well as effective community assessment and action. Reframing health as a 'whole of government' issue will assist in engaging other sectors to define common causes and to identify concrete actions.

Reshaping governance can provide a pathway via a network of management processes. It is imperative to establish effective partnerships with diverse sectors through participatory governance, having evidence that can inform multiple stakeholders about their contributions and to advocate for policy change, adopting a systematic approach to resourcing and to implementation, and being outcome oriented.

Policy tools can include participatory budgeting approaches, using law, using HIAs and using accountability and performance reporting processes. These alongside strategic development of partnerships (including with the private sector), can all drive towards the production of co-benefits.
Partnerships provide a basis for joint learning – to share good practices, as well as lessons for the future. Partnerships also depend on mutual accountability. So having a process for refreshing and renewing partnerships is important – and having a focus on shared problems and desired outcomes will help ensure that partnerships remain relevant and productive. The *partnerships analysis tool* used by the Victorian Health Promotion Foundation (VicHealth) explores the necessity and the value of the partnership and facilitates the design of a visual map representing the current nature of the partnerships, as well as providing a checklist to provide feedback and to suggest areas that need further support or change.

### MONITORING PROGRESS:

Intersectoral action is a process, albeit it with desired outcomes related to changes in the social determinants of health, with intermediate measures being related to relevant areas of policy action. Thus, it is hard to identify a simple causal chain which links a health promotion action to changes in health status (Nutbeam, 1996). Furthermore, monitoring progress on outcomes is necessarily specific to context. Nonetheless, process indicators are possible, particularly those that are most sensitive to the immediate impact of intersectoral actions.

Measures that are immediate reflections of intersectoral action could include (Adapted from Nutbeam, 1996):

- Change in public policy and organizational practice
- Changes in mandates for participatory governance and budgeting
- Development of effective partnerships between organizations
- Changes in law and regulation
- Changes in organizational structures, funding and resource allocation

The setting of country level *targets* such as for those on health inequalities (such as in life expectancy and infant mortality) has been proposed (PHAC & WHO, 2008) although the identification of the causal links between targets and intersectoral action requires more research.

## 5. BUILDING CAPACITY FOR HEALTH PROMOTION

Successful health promotion interventions are underpinned by a comprehensive range of infrastructure supports, including well-developed policy, inter-sectoral partnerships, political commitment and clear direction, information about the nature and extent of health problems, quality research, workforce development and training, evaluation of progress, and developing the capacity of the health sector to promote health.

Health promotion capacity varies across countries. Evidence collected across countries (and presented at the 6th Global Conference on Health Promotion in 2005 in Bangkok) point to countries with higher levels of health promotion capacity also achieving higher levels of development (as indicated by the Human Development Index). In developing countries, closing the health promotion capacity gap and institutionalizing health promotion in health systems is a particularly urgent task.
Typical path of health promotion development in health systems consists of: 1) developmental phase (pilots in a few locations), 2) standardization phase (compiling principles into guidelines, 3) expansion phase (diffusion lessons and models), 4) institutionalization phase (integrating principles and practices into health, social, and political institutions).

However, institutionalizing health promotion means not only incorporating health promotion within all programmes and delivering them to scale. It is characterised by the ‘built-in-ness’ of programmes and approaches within organizations and systems (Goodman, McLeroy, Steckler, & Hoyle, 1993). Institutionalization requires the day-to-day routines of organizations and systems, such as resource allocation, knowledge management, planning, and partnership development, to reflect an orientation to health improvement. The orientation would be seen through organizational goals, governance, programmes, and resource management systems (Ravindran & Kelkar-Khambete, 2008).

As such, implementation and institutionalization fundamentally requires behaviour change on the part of actors and organizations. It entails moving from a focus on provider and institutional interests and activities to a focus on people and communities, a concern for equitable health outcomes, and ensuring management actions support quality programme delivery for these ends. It also means assuring the continued replenishment of system infrastructure and capacity to achieve effective delivery, to engage in intersectoral action, and to facilitate empowerment of individuals and communities.

Effective health promotion on the ground depends on having 1) evidence-based strategies which are appropriately applied to context, 2) adequate delivery infrastructure, and 3) appropriate implementation plans and skills (Lin & Fawkes, 2007), as can be seen in Box 1 below.

**ENHANCE SYSTEM CAPACITY FOR HEALTH PROMOTION**

Institutionalizing health promotion means having a knowledge management system to apply evidence in context, having financial and human resources (infrastructure) for programme delivery and action, and having the implementation capacity (including monitoring and evaluation) to deliver according to intervention specification.

Typically, health promotion infrastructure and capacity are weak within health systems. Major system changes required usually relate to financing, workforce development, M&E systems, partnership arrangements, and political mandates.

**GETTING STARTED: CAPACITY ASSESSMENT AS BASIS FOR CAPACITY BUILDING**

Planning for institutionalization means not only incorporating health promotion strategies into health programmes, but also assuring the adequacy of health promotion capacity in the basic building blocks of the health system. A capacity analysis of the system is a useful step...
to looking at how institutionalization might be effected – i.e. in order to identify the shortfalls and weaknesses in the system (Lin & Fawkes, 2007). Such a capacity assessment might ask questions about:

- Governance arrangements – what is the nature of the mandate for health promotion, is there a designated person with authority for it, is equity in health part of the government’s policy vision, is there political and professional leadership, are there formal institutional linkages across sectors, is prioritization process evidence-based and transparent
- Policy environment – are there national policies and plans to address priority health issues, are legislative and regulatory frameworks in place that protect and promote health and are they being implemented, are policies and plans monitored and evaluated
- Delivery system structure and resources – is there an education/training system to produce a health workforce capable of delivering health promotion interventions, does the financing system provide enough resources and incentives for health promotion, are there inter-organizational relationship to enable coordinated delivery of health promotion strategies, are quality assurance and M&E systems in place to support effective delivery, is there investment in research or research translation

It is in the area of delivery system structure and resources that attention is often required to ensure the fundamental building block are in place to enable successful delivery of health promotion outcomes.

**SUSTAINABLE REVENUES**

Health promotion financing continues to represent a significantly small proportion of the health budget. Innovative ways of financing should be sought which enable health promotion finances to be stable, consistent, and independent of pressure from healthcare, while maintaining the interdependent relationship between them. Health promotion financing targets should be harmonised with those of health care financing:

- To be able to generate sufficient and sustainable resources.
- To ensure universal coverage of health promoting programmes and policies particularly to hard to reach groups in order to maximise "public good".
- To be allocated efficiently to maximise population health benefits by creating correct incentives to insurers, providers and consumers.

Financial resources can be used to expand programmes as well as to provide incentives for behaviour change. To institutionalize health promotion in health systems, key financing reforms can involve:

- additional revenue for health promotion (e.g. hypothecation through sin tax, social insurance, appropriation from health budget or treasury),
- expanding coverage of preventive services through affordability measures (e.g. reducing user charges),
- expanding the benefit package available, paying for performance (e.g. to encourage primary care providers to offer counselling and brief interventions, provide appropriate referrals).
Finding the best solution to sustainable financing is not always achieved from the outset. Ongoing exploration and lobbying of existing compatible structures and organisations as well as new innovative sources (hypothecated taxation, corporate partnerships and social insurance) will create multifaceted and innovative funding sources and is likely to ensure better sustainability.

SKILLED WORKFORCE

Health is a labour-intensive industry and skilled workforce is critical to the delivery of all health programmes, including health promotion. Workforce development requires attention to integrating health promotion into the training of the health workforce, for both basic qualifications and through continuing education. Examples of competencies required for health workers in community setting (adapted from Australia Industry Skills Council) are:

- work with the community to identify health needs
- plan a health promotion project
- establish and maintain community, government and business partnerships
- build community capacity for health
- undertake advocacy
- evaluate a health promotion project

At the same time, there is a need to develop specialist health promotion skills (such as health communications, community development, policy advocacy, partnership development), who will ultimately have the designated responsibilities for driving the health promotion effort. For such health promotion specialists, the core competencies have been proposed to be (Galway Consensus Conference Statement, 2008):

- **Catalysing change** – empowering individuals and communities to improve their health
- **Leadership** – provide strategic direction for building capacity, developing healthy public policy, mobilising resources
- **Assessment** – assess needs and assets in communities and systems that help understand the behavioural, cultural, social, environmental, and organizational determinants that promote or compromise health
- **Planning** – develop measurable goals and objectives in response to assessed needs and identify evidence-based and theoretically informed intervention strategies
- **Implementation** – carry out effective and efficient, cultural-sensitive, and ethical strategies to ensure the greatest possible improvement in health
- **Evaluation** – determine the effectiveness of health promotion programmes and policies
- **Advocacy** – advocate on behalf of individuals and communities to improve their health and well-being, and build their capacity for undertaking health promoting actions
- **Partnerships** – work collaboratively across disciplines, sectors, and partners to enhance the impact and sustainability of health promotion programmes and policies

Systems for continuing professional development is needed for both the general health workforce and for health promotion specialists. Organizational policies should reflect the institutionalization of health promotion into all practices. For example, if healthcare
practitioners (whether doctors, nurses or allied health professionals) are required to report time on healthcare interventions, they should be required to report on the incorporation of health promotion interventions (such as empowerment strategies). Time (as well as payment incentives where appropriate) should be allocated for this in order to provide better incentive for this. Furthermore, a larger number of health promotion workers with adequate salary incentives within organizations will ensure that a team approach for ensuring the mainstreaming of health promotion into organization is achieved. Relying on one single health promotion worker to oversee all health promotion activities only create “add-on” or tokenistic representation of health promotion.

ORGANIZATIONAL FORMS

The delivery of health promotion activities may come from diverse organizations. Typically, primary health care constitutes an important setting for health promotion activities. Community organizations, however, also play an important role in reaching diverse populations, and these may include schools, clubs and self-help groups, faith-based organizations, professional and business associations.

Community-based organizations require technical or professional support. Leadership for health promotion may come from government, academic institutions, professional associations, and other non-government bodies. Leadership may be expressed through individuals but it is usually important that organizational entities embody leadership roles. Typically, a national agency may be charged with ensuring the delivery of a minimum set of accessible and evidence-based prevention strategies, including health promotion. This would entail technical leadership in surveillance, intervention design, and evaluation research. It would also require a focus for intersectoral partnership and advocacy across sectors for appropriate policy development. What is most appropriate for individual country depends on specific contexts, however, typically, health promotion foundations and/or a unit within the ministry of health will have a leadership responsibility. The organizational location of the lead technical unit can facilitate or hinder effective exercise of leadership, however. If a unit is placed within an area dominated by a disease control imperative, health promotion is likely to provide more of a service function. If a unit is placed within a media or communications area, then health promotion work is likely to be skewed towards information and marketing. It is important to be aware of the potential pitfalls in order to ensure they can be addressed.

Establishing health promotion foundations which are autonomous or semi-autonomous from national government have shown to increase national health promotion capacity particularly through their ability to trial innovative projects away from potential government criticism. It is through the advocacy and leadership during the development of these organisations that have increased the visibility of health promotion among politicians, finance institutions, economists, and the general public. Success of the Health Promotion Foundations in the Western Pacific Region has been attributed to the continuity, timing and commitment in leadership, which has ensured that momentum for health promotion commitment is not lost (Brink, 2009).

In many countries, there will be units at national and state/provincial levels, if not lower levels as well. In such decentralised systems, it is important to have clearly defined roles and responsibilities, transparent arrangements for financing, and excellent coordination mechanisms. Different kinds of expertise may exist at all levels, and they should be drawn
upon, rather than solely relying on a single level or single organisation for expertise and leadership.

**INDIVIDUAL LEADERSHIP**

At the same time, the cultivation of individual leaders and leadership skills is needed – with leadership being defined as:

‘*interpersonal influence over and above the influence that stems from a person’s positional authority or legitimate power* and ‘*has the effect of influencing the activities of others toward some defined goal*’ (D. Campbell, Dardis, & K. Campbell, 2003)

The challenge for health promotion leadership is to build upon the standard organizational management requirements for leadership skills, and extend to new qualities and competencies related to the need to build partnerships, undertake intersectoral action, and empower communities – as can be seen in the following table.

<table>
<thead>
<tr>
<th>Leadership model</th>
<th>Organisational Management</th>
<th>New qualities and competencies for Health Promotion</th>
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</thead>
<tbody>
<tr>
<td>Individual:</td>
<td></td>
<td>Relational:</td>
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<td></td>
<td>Personal power</td>
<td>Commitments</td>
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<td></td>
<td>Knowledge</td>
<td>Mutual respect</td>
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<td></td>
<td>Trustworthiness</td>
<td>Trust</td>
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<td>Competence base</td>
<td>Intrapersonal</td>
<td>Interpersonal</td>
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<td>Skills</td>
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<td>Self-awareness:</td>
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<td>Social awareness:</td>
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<td>Emotional awareness</td>
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<td>Empathy</td>
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<td>Self-confidence</td>
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<td>Service orientation</td>
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<td>Accurate self-image</td>
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<td>Political awareness</td>
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<td>Self-regulation:</td>
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<td>Social skills:</td>
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<tr>
<td>Self control</td>
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<td>Building bonds</td>
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<tr>
<td>Trustworthiness</td>
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<td>Team orientation</td>
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<td>Personal responsibility</td>
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<td>Change catalyst</td>
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<td>Adaptability</td>
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<td>Conflict management</td>
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<td>Self motivation:</td>
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<tr>
<td>Initiative</td>
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<td>Commitment</td>
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<td>Optimism</td>
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KNOWLEDGE AND PERFORMANCE MANAGEMENT

The evidence base for health promotion draws particularly on interventional research and programme evaluation. A robust monitoring and evaluation (M&E) system is particularly important to ensure that health promotion strategies are continually adjusted and improved over time. M&E systems need to cover not only health outcomes, but also intermediate outcomes, and risk factors, including social determinants. At a minimum, tracking of key risk factors and health promotion outcomes for different population groups, in different geographical communities, is needed. Administrative reporting systems should also be in place so that the health promotion effort (both inputs and outputs) can be documented. Ideally, observatories can track system characteristics and activities as well as intermediate outcomes, including health promotion outcomes. Good monitoring systems should link with programme development, include both quantitative and qualitative indicators, and help point to issues which require further analysis. Core indicators may be developed to allow for benchmarking across comparable countries.

M&E should be seen not just as a stand-alone information system, but a social and learning process whereby relevant actors discuss the meaning and implications of the reporting. A knowledge management system requires bringing together programme managers, planners, community stakeholder to review monitoring outcomes, come to agreement about programme adjustments and new priorities, as well as to instigate further studies to understand better the factors which have contributed to or prevented successful programme implementation.

M&E should be integrated into the organizational and programme management process, such as being linked to continuous quality improvement (CQI) efforts. With regular cycles of feedback, managers, health service teams, and community organization representatives can make plans for improving their health promotion practices and the system supports that they need.

DOING A RAPID ASSESSMENT

The ‘spidergram’ below illustrates how health promotion capacity can be mapped visually, and can be a useful tool for undertaking a rapid assessment of health promotion capacity—whether at local or national levels. In such an assessment process, it is invaluable to bring together a range of stakeholders – including ministry of health and other relevant ministries (including Finance or Treasury), non-government organizations, academic institutions, healthcare providers, local government, etc. A rapid assessment built on processes which utilize dialogue would help foster consensus development amongst key stakeholders and support prioritization about how health promotion capacity might be further developed (Lin & Fawkes, 2007).
Securing sustainable infrastructure is a first step to securing health promotion capacity. To ensure that capacity is continuously improved means that adequacy and appropriateness of infrastructure investment should be regularly assessed. Equally important, however, is to ensure that enhanced capacity translates into a high-performance health promotion system. A process of continuous quality improvement should be developed, underpinned by both a monitoring system and a process for reflective practice. Such a ‘plan-do-study-act’ cycle can be used to assess both how well the health promotion building blocks (i.e. individual empowerment, community empowerment, health system strengthening, and intersectoral action) are in place as well as the specific elements of the health promotion infrastructure. See Figure 2 below.
FIGURE 2: CONTINUOUS QUALITY IMPROVEMENT

[Diagram showing arrows connecting steps: Improving Infrastructure, Developing Capacity, Enhancing Performance]
MOVING FORWARD

In order to incorporate health promotion into health systems it should be ensured that:

- all interventions/programmes reflect the principles of health promotion effectiveness;
- health promotion considerations are linked into all health system decision making and conditions exist that support diffusion of innovation;
- there is appropriate scaling up of interventions/programmes.

ASSESSING PROGRAMME EFFECTIVENESS

The development of health promotion theory and evidence base over the past two decades has propelled health promotion practice from a focus on individual knowledge and behavior, to community strengthening, and now increasing towards healthy public policy, and transformation of social systems. Recognising the importance of adopting multiple strategies, a starting point for closing the implementation gap is to assess the extent to which the major building blocks for health promotion action are being used comprehensively.

Using a ‘spidergram’ for rapid assessment of intervention effectiveness such as figure 1 can be adapted to programme level interventions. This would help point to whether the health promotion interventions have adequately incorporated the core health promotion building blocks, and whether some areas for action are being over- or under-emphasized.

LINKING TO HEALTH SYSTEM DECISION-MAKING

Incorporating health promotion in all aspects of health system decision-making represents true mainstreaming. Mainstreaming is an organizational/programmatic decision and represents change to the way businesses are customarily done. Mainstreaming health promotion into health system may occur in an opportunistic manner as well as through systematic processes. When change is being contemplated is the best time to look at how health promotion can become mainstreamed – i.e. when plans are being developed or revised, when budget planning and reviewing is happening, when legislative/regulatory reviews are occurring, when health sector reform is being contemplated, when regional plans are under development, when monitoring and performance management measures are being designed or revised.

Mainstreaming can also occur in systematic fashion. This requires understanding the political, organizational, and technical complexities that exist simultaneously in a health system. In a complex system, barriers to institutionalization may occur for multiple reasons, e.g. divergent perspectives of different stakeholders, absence of agreed roles and procedures, unclear policy mandate, lack of staff capacity, lack of technical support and training, insufficient community understanding and ownership, etc. A mainstream location
of responsibility is needed to oversee and negotiate these forces, and ensure the system building blocks are in place.

Diffusion of innovation theory suggests several factors being important to incorporation of new practices into existing systems (Greenhalgh, Robert, Macfarlane, Bate, & Kyriakidou, 2004):

1) System readiness – e.g. receptivity to change, presence of supporters, resource availability, time, monitoring and feedback can shape how quickly organizations adopt new practices,

2) key influences on implementation processes are leadership and management support, training, communication, tailoring activities to local needs, and external collaboration,

3) person attributes of adopters – opinion leaders who support change and are willing to take risks and try new approaches, and

4) Perception of innovation – the more people know about and understand the innovation, the more likely the adoption of new practice.

This means efforts towards institutionalization will require:

- designated leadership role to provide organizational support,
- cultivation of adopters and building of critical mass,
- incremental change to services and supporting health workers to change their practices,
- active communication within and outside the organization,
- system and process for monitoring and reporting back.

It also helps, in the early phase, to focus on a few key health issues or population groups.

Incorporating health promotion into health systems and policy processes on an ongoing basis ultimately requires governments to exercise political will, to regulate, legislate, invest, and demand agency coordination on specific issues and priorities. Through legislating and financing, in particular, governments can provide the mandate necessary for health promotion to be effectively mainstreamed.

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**SCALING UP**

Achieving significant health outcomes at the population level depends on: the effect size of intervention, the reach or penetration of intervention into population, and the sustainability of effect (Hawe, Noort, King, & Jordens, 1997).

If health promotion efforts are to achieve a significant impact at the population level, it will require not only soundly designed interventions but also sufficient coverage of the population, and with appropriate targeting. This means that health promotion efforts will need to move beyond a focus on individuals and through time-limited projects, to a sustained effort which is integrated into health services and other social institutions (such as schools or the workforce etc).
Scaling up specific programmatic interventions is a useful first step. It does not necessarily imply the same intervention being conducted in more places. It requires appropriate adaptation to different populations and communities, and sufficient resources to cover expanded numbers of people. It also requires recognition that population-level interventions that address social and behavioural norms, such as policy and legislation change, may be most effective.

The combination of scaling up health promotion interventions and integration of health promotion into existing institutions and services (be they health sector or other sectors) represent core strategies for meeting global health development challenges. However, the achievement of sustainable health outcomes will depend on: sufficient health promotion infrastructure and capacity to develop and implement effective programmes, community ownership of the programme in order to maintain and sustain change, and a shared problem-solving capacity between the health sector and the community to apply lessons from existing efforts in order to develop solutions for new health problems (Hawe et al., 1997).
The need for sustainable health promotion efforts, then, requires an orientation away from one-off campaigns and projects towards more focus on systemic change. The table and the diagram below depicts a continuum of choices, moving from small to large scale impact.

<table>
<thead>
<tr>
<th>Objective</th>
<th>Individual knowledge and behavior change</th>
<th>Community strengthening</th>
<th>Policy change</th>
<th>Institutional transformation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Focus</td>
<td>Information</td>
<td>Settings</td>
<td>Sectors</td>
<td>Systems</td>
</tr>
<tr>
<td>Mechanism</td>
<td>Campaigns</td>
<td>Projects</td>
<td>Partnerships</td>
<td>Governance</td>
</tr>
</tbody>
</table>

These are not mutually exclusive, but represent an essential pathway of health development, a course of evolution and action that has become both timely and urgent.
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