Health Promotion: Concepts and Practices

A key issue paper focusing on the relevance for international cooperation

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Abbreviations

CAH	Community Action for Health
CCM	Country Coordinating Mechanism
Coof	Cooperation Office
FOPH	Swiss Federal Office of Public Health
GFATM	Global Fund to Fight AIDS, TB and Malaria
HIA	Health Impact Assessment
HP	Health Promotion
HPH	Health Promotion Hospital
ICPD	International Conference on Population and Development
ICT	Information and Communication Technology
IDUs	Injecting Drug Users
IFC	Individuals, Families and Communities
INHPF	International Network for Health Promotion Foundations
IUHPE	International Union for Health Promotion and Education
MDG	Millennium Development Goal
MPS	Making Pregnancy Safer
NGO	Non-Governmental Organisation
PAHO	Pan American Health Organisation
PCA	Participatory Community Assessment
Q&A	Questions and Answers
SCIH	Swiss Centre for International Health
SDC	Swiss Agency for Development and Cooperation
SECO	State Secretariat for Economic Affairs
Sida	Swedish International Development Cooperation Agency
SRH	Sexual and Reproductive Health
SWAp	Sector Wide Approach
Swiss TPH	Swiss Tropical and Public Health Institute
TB	Tuberculosis
VHC	Village Health Committee
WHO	World Health Organization

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Executive Summary

Today's health promotion (HP) concept was adopted at the First International Conference on HP in Ottawa in 1986 and further developed since in a sequence of international conferences and by many stakeholder groups. The concept focuses around five main action areas:

1. **Build Healthy Public Policy**
2. **Create Supportive Environments**
3. **Strengthen Community Actions**
4. **Develop Personal Skills**
5. **Re-orient Health Services**

The HP agenda is rooted in the socio- ecological concept of the determinants of health and has a strong equity focus. The concept proposes to widen up the traditional bio-medical vision of health to one that includes also bio-psychological dimensions and addresses the determinants of health. HP is closely linked to and complements other relevant concepts, such as the *right to health*, *health literacy*, *empowerment* and *resilience*, as well as *community health* and *primary health care*. "Prevention" and "health promotion" are complementary but not identical concepts. While "prevention" has usually a disease specific, pathogenetic focus and is oriented towards avoiding risks, the "health promotion" concept is based on a so-called salutogenetic thinking and aims at mobilising resources and potentials for good health through a usually multi-sectoral approach. "Health education" can be understood as one of many health promotion strategies.

Each of the five action areas is further explained and practical examples are given that illustrate how each area could translate at the implementation level. While overall the "Ottawa Charter" is still driving current thinking and action, main efforts since 1986 focused on developing a "whole of government approach" to ensure that other sectors' policies integrate the public health agenda; strengthening inter-sectoral collaboration and partnership to promote health; linking the health promotion agenda to globalisation and the social determinant of health gender; or mainstreaming of HP, to name just a few. In the last five years, intensive efforts were also made to make the concept more relevant to the needs of people and authorities in less developed country contexts. Major remaining challenges today include questions related to monitoring and evaluation, the lack of professional HP practitioners and infrastructure, as well as a frequently lacking commitment of decision makers to allocate the necessary attention and resources to the field of HP.

HP is a concept which is of high relevance to resource poor countries as it uses a very holistic development approach and addresses many of the social, environmental, cultural, and systems related aspects of the determinants of health. Empowering communities, individuals and families lies at the heart of this agenda. Depending on the specific needs in a given context, HP can provide solutions for any setting and complement other necessary initiatives such as the health system strengthening efforts. To show what this means in practice, two case studies (chapter 2) and six concrete examples (chapter 3) from various contexts (least developed countries, transition countries, a vulnerable population in a high resource country) are further elaborated. Some experts postulate that for Sub Saharan Africa the HP agenda would be a more relevant concept to help drive development efforts than the rather narrow Millennium Development Goals, which are limited to a selected set of more donor defined goals. While approaches based on the HP concept have been successfully developed in some African countries, the crucial importance of an enabling political system which favours bottom up development and promotes civil rights and empowerment of the most vulnerable, has led to these approaches coming up and disappearing with changing political powers.

For operationalising the concept in an African context, the full HP agenda needs to be integrated and adopted by both the public and the private systems, and should no longer be considered as something for NGOs and civil society, only. In addition, it is of crucial importance to contextualise approaches and interventions. A regionalised African approach to HP will have distinguishing features that will be likely to include a strong focus on the incorporation of cultural, religious and spiritual factors, and an emphasis on community. Resources for HP do not only include financial and human resources. Local assets and the social capital of the community should be considered as equally important resources for HP. It is felt that the most important contribution of the African context to HP could be the positioning of the community at the centre of health and development.

Advocacy for professionalisation in HP should also include the development of capacity for healthy public policies using a whole of government approach. In that respect, Sub-Saharan Africa could benefit from the experience generated by the HIV response, which successfully piloted and developed the principle of multi-sectoral collaboration.

The Swiss Agency for Development and Cooperation, SDC, is well placed to play a strong advocacy role in cooperation with partner countries and development partners based on its history as a former donor to WHO HP, the practical experiences generated through SDC funded projects, and considering the values underpinning its cooperation activities, of which many are at the core of the HP agenda. Particularly at the country level, where SDC works with various sectors, the multi-sectoral dimension of HP could be taken into consideration when developing cooperation programmes. In partner countries SDC is also well positioned to help ensure inclusion of civil society as an important force in main stakeholder forums.

Main institutional actors that can provide guidance and collaborative support for health promotion approaches in developing and transition countries include, amongst many others:
- The World Health Organisation
- The International Union for Health Promotion and Education
- The International Network of Health Promotion Foundations
- Health Promotion Switzerland

Introduction and Methodology

Health promotion (HP) is not a new topic for the Swiss Agency for Development and Cooperation (SDC). The "SDC Health Policy 2003-2010" was much inspired by the HP agenda. The policy refers to the determinants of health and addresses health promotion priorities such as the empowerment of civil society and users of health services. Prior to 2006 SDC financially supported the World Health Organisation's (WHO) efforts and activities in the field of health promotion. SDC was represented at the 2005 Bangkok health promotion conference. Its donor relationship with WHO HP came to an end when WHO requested that all donors move their funding to core contributions without earmarking to specific departments. While health education is part of most SDC supported projects, a more comprehensive health promotion approach was then developed with SDC support in projects such as the Kyrgyzstan Community Action for Health (CAH) project described in Chapter 3 of this document, the Swiss-Ukrainian[1] and Swiss-Romanian perinatal health[2] projects, the Family Medicine Programme[3] in Bosnia Herzegovina, and many others.

Switzerland's foundation for health promotion, "Health Promotion Switzerland", which has a primarily national mandate, is an internationally recognised player driving the development of the concept and its application, as explained in Chapter 5.

In 2010, SDC mandated experts from the Swiss TPH to develop this paper for two main reasons. Tanzania, an important partner country of SDC, is currently drafting a health promotion strategy with the support of WHO, following the development of a non-communicable disease strategy. The Tanzania Cooperation Office (Coof) would like to support this process by contributing to the capacity building of its own staff and the counterparts at various levels around the health promotion concept, and its application in an African context. At the same time, the SDC health network, which is composed of SDC staff at headquarters and at field level, aims at strengthening the capacity of its members in this area and update the knowledge on recent developments.

This paper will therefore briefly introduce the concept of HP and its link to other similar concepts. The underlying theoretical models of behaviour and social development are not elaborated on, as they are well described elsewhere. To make the paper practically relevant to those working in the field, the more theoretical first chapter will be followed by an analysis of the relevance of HP for health systems in developing countries which includes a practical case study developed for this paper. This is followed by showcasing a selection of diverse, pragmatic, good practice examples from various continents Chapter 4 is then dedicated to the Sub-Saharan African region and some recommendations to SDC. Chapter 5 presents a brief "who is who" in HP to give an idea of possible partners for collaboration. At the end of the paper are references of the documents used for the development of this publication and recommended for reading, along with a list of WHO HP focal point contacts in each region.

Methodology: The authors have used a mix of methodologies to develop this document. Our own experience in advising SDC in the field of HP over the years and implementing some of their projects with strong health promotion components complemented the internet based literature search for peer reviewed publications and grey literature. In addition, we led in-depth telephone interviews with three key experts. We would like to acknowledge their valuable contributions to chapters 1.2., 4 and 5 and warmly thank them for generously taking time and openly sharing their knowledge and experience.
- **Gauden Galea**, former Coordinator, Health Promotion, WHO
- **Annie Portela**, Technical Officer, Health Promotion, Dept. of Making Pregnancy Safer (MPS), WHO
- **Ursel Broesskamp**, Head, International Affairs Foundations Health Promotion Switzerland

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1 http://www.swisstph.ch/services/swiss-centre-for-international-health/portfolio/experience-health-technology-and-telemedicine/ukraine.html
2 http://www.swisstph.ch/scih-cd/roneonat
3 http://www.partnershipsinhealth.ch/A%20-%20Publications/Factsheets/Expanding%20Family%20Medicine%20Practice.pdf

1. Health Promotion: the Concepts

1.1 The Health Promotion Concept as Outlined in the Ottawa Charter

The health promotion concept as it is understood today was first internationally adopted during the famous **Ottawa Conference** in **1986**. The work in Ottawa built on previous commitments, such as the goals of "**Health for All**" (**1977**) and the International Conference on Primary Health Care in **Alma Ata (1978)**. The HP concept was also strongly influenced by an intense debate around **inter-sectoral action for health** and emerged at the time of a move to the "**New Public Health**"[4]. Before Ottawa, behavioural models of health focused on individual risk taking and applied a very medical approach (diagnostic leading to prescription) to solving health problems of populations.

For the field of HP, the Ottawa conference and the adopted Charter is to be understood as *the* milestone. It introduced a true paradigm shift in thinking about public health - comparable to the meaning of the International Conference on Population and Development (ICPD) that took place in Cairo in 1994 and led to a paradigm shift in the field of sexual and reproductive health.

The concept is driven by the concern for **equity in health** and calls for true participation of **individuals, families and communities** as key actors in improving a population's health. Any proposed solutions should be adapted to the local needs. To improve health - in its biological, psychological and social dimensions - it is, however, not enough to focus on people's behaviour, or on users or providers of health services. The HP concept is deeply rooted in the more socio-ecological concept of the **determinants of health**, where the individual (with the individual determinants of genetic/hereditary factors, sex and age) adopts health related behaviours and leads a lifestyle, influenced by social and community networks and wider socio-economic aspects, the physical environment (food, water, home, workplace, etc.), and cultural and environmental conditions. Social services, such as health, education, or water and sanitation, are important, but overall, to be seen as pieces in a much wider puzzle of factors that determine a persons' or a group's health. Other prerequisites for health include, among other things, food, income, a stable ecosystem, shelter, and social justice. The HP concept encompasses all these dimensions when acting on behalf of the health of people and populations.
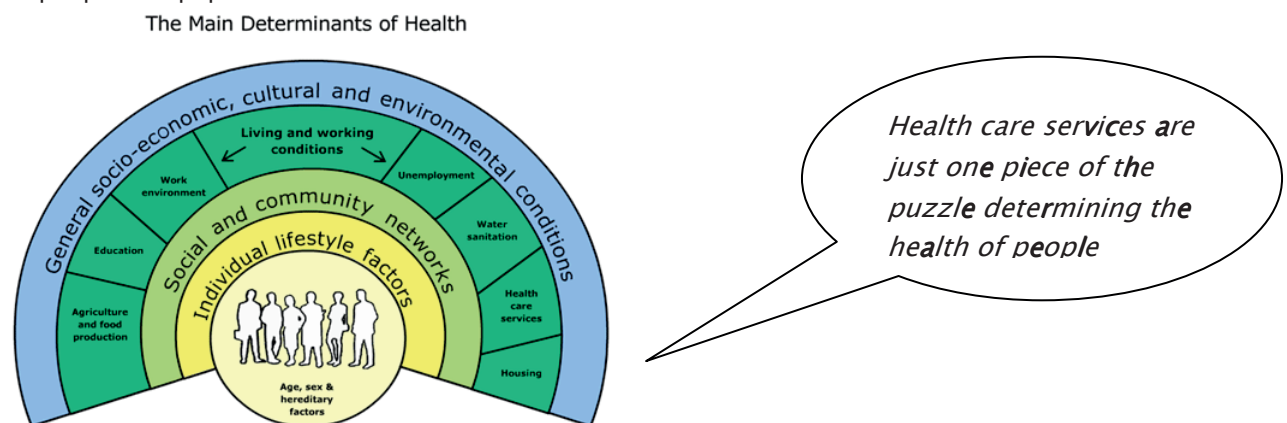
Figure 1: The main determinants of health, Dahlgren and Whitehead, 1991

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[4] **New Public Health**: based on a socio-ecological view of health, complementing the "Old Pubic Health" which focused on disease control through technical disciplines such as biomedicine, sanitation, quarantine, etc., "New Public Health" is much more concerned with the interplay between wealth/poverty, social well being, education and health, social capital and health. The "New Public Health" concept originated in the more affluent parts of the world where the classical public health threats, such as major communicable disease outbreaks, have been brought under control. It served as a reference in developing HIV prevention campaigns in countries like Switzerland. "New" and "Old" Public Health should not be understood as one replacing the other, but rather as complementary approaches to public health.

Health Promotion was defined in the Ottawa Charter as: **"a process of enabling people and groups to increase control over, and to improve, their health and quality of life."** The concept emphasizes the positive and active role played by individuals and groups to improve health, and the wide array of influences on health. It understands health as "*a resource for everyday life, not the objective of living. Health is a positive concept emphasising social and personal resources, as well as physical capacities. Therefore, health promotion is not just the responsibility of the health sector, but goes beyond healthy life-styles to well-being.*" (Ottawa Charter). The focus is thus, on well-being and not on morbidity or mortality.

What's the difference between prevention, health promotion and health education

It is important to distinguish between the concepts of "prevention" and "health promotion". The two concepts share a common goal: to improve population health. They need to be understood as complementary approaches to tackling public health issues in a population. The historical term "illness prevention" dates back to the 19th century discussion around social hygiene and population health. Prevention has a **pathogenetic focus** (concentrated on illness and disease, with close links to the medical and biological sciences) and aims at avoiding illness and diagnosable conditions through reducing or eliminating **risk** factors which determine ill health. Prevention may take place at an individual level (e.g., breast cancer screening) or at a population level (e.g., chlorination of water sources). Prevention (primary, secondary and tertiary) includes interventions such as anti-smoking campaigns based on health education, screening for disorders and illnesses, or treating high blood pressure to avoid complications - just to name some examples. However, prevention does not focus solely on the individual, but takes a community or population perspective. The lead for prevention campaigns often lies with the health sector.

The much younger concept of "health promotion", on the other hand, uses a **salutogenetic** approach (focusing on health and factors that maintain or lead to good health) with a **multi-sectoral** philosophy, involving not only the public health sciences, but also economic, political, cultural and social sectors. Compared to the "strategy of risk avoidance" as used in prevention, health promotion uses a **"strategy of promotion"** based on **resources and potentials for good health**. Health promotion strategies are **not limited to a specific health problem (usually not disease specific), nor to a specific set of behaviours**.

"**Health education**" is one of many possibly strategies, to pass on information in a prevention or health promotion programme. According to WHO[5], health education is any combination of learning experiences designed to help individuals and communities improve their health, by increasing their knowledge or influencing their attitudes.

Box 1: The difference between health promotion, prevention and health education

☞ This distinction between health promotion and prevention is helpful for conceptualising various complementary strategies to improving a population's health. In reality, however, they **cannot - and should not - be separated.** Many approaches, particularly in developing country contexts, do use a combined approach to reduce risk and promote health (see also explanation in WHO HP Glossary).

To operationalise HP, the Ottawa Charter, highlights five main areas for action:

6. **Build Healthy Public Policy**
7. **Create Supportive Environments**
8. **Strengthen Community Actions**
9. **Develop Personal Skills**
10. **Re-orient Health Services**

Figure 2: The five health promotion action areas, WHO 1986

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[5] http://www.who.int/topics/health_education/en/

☞ To achieve its full strength, a health promotion approach would **need to develop concurrent strategies that address as many action areas as possible.**

Below, each action area is further elaborated as described in the Ottawa Charter. The selected examples do not, by any means, represent a comprehensive list of possible actions. The need for multi-sectoral collaboration becomes obvious as no one sector can achieve this alone.

1.1.1 Build Healthy Public Policy

"Health promotion… puts health on the agenda of policy makers in **all sectors** and at all levels of the system, directing them to be aware of the health consequences of their decisions and to accept their responsibilities for health. Health promotion policy combines diverse but complementary approaches including **legislation, fiscal measures, taxation and organizational change**. It is coordinated action that leads to health, income and social policies that foster greater equity. Joint action contributes to ensuring safer and healthier goods and services, **healthier public services**, and cleaner, more enjoyable environments. Health promotion policy requires the identification and ways of removing obstacles to the adoption of healthy public policies in non-health sectors, "In the pursuit of healthy public policy, government sectors concerned with **agriculture, trade, education, industry, and communications** need to take into account health as an essential factor when formulating policy. These sectors should be accountable for the health consequences of their policy decisions." Recently, the term "**health in all policies**" has been more frequently used, meaning that all other sectors' policies should be planned or reviewed in terms of their impact on health. Health should also be integrated in overall economic and social development policies to act on the social determinants of health. Annex 1 shows a useful checklist that helps to apply an HP view when developing national plans. The so-called **"whole of government approach"**[6] that emerged after Ottawa stresses the importance of inter-sectoral collaboration to ensure healthy public policy.

Selected examples of measures to build healthy public policies:
- Fiscal taxes on products such as alcohol or cigarettes (e.g., to encourage healthy behaviour and make access more difficult (especially for groups like young people) and to raise funds for other preventive and curative measures of diseases associated with tobacco or alcohol)
- Mandatory wearing of seat belts (cars) or helmets (motorcycles) to reduce morbidity and mortality related to street accidents
- Legal banning of smoking from public places, such as restaurants, hospitals, trains, etc.
- Food and drug controls to ensure the safety of foods (at the levels of production, storage and distribution, labelling of products and sale) and quality of medicine (e.g., control of counterfeits).
- Mandatory sports lessons by making them part of the school curriculum
- Establish national health equity surveillance systems and assess health equity impact of policies and plans

1.1.2 Create Supportive Environments

"The inextricable **links between people and their environment** constitutes the basis for a socio-ecological approach to health. ... The conservation of natural resources throughout the world should be emphasized as a global responsibility. Changing patterns of life, work and leisure have a significant impact on health. … Health promotion generates living and working conditions that are safe, stimulating, satisfying and enjoyable. Systematic assessment of the health impact of a rapidly

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[6] In Switzerland and elsewhere the term "whole of government" is often used for inter-departmental coordination (e.g. between SDC, SECO, SFOPH, etc) mechanisms for global development and other policies. In health promotion, the notion "whole of government" focuses more on an inter-sectoral/multisectoral approach that would also involve civil society and other actors, such as the private sector.

changing environment - particularly in areas of **technology, work, energy production and urbanization** - is essential and must be followed by action to ensure positive benefits to the health of the public. The protection of natural and built environments and the conservation of natural resources must be addressed in any health promotion strategy." This area of action calls for an **inter-sectoral response**.

Selected examples to create supportive environments:

- Implementing vector control strategies, such as aerial and household spraying, water and sanitation programmes, air quality control measures, including indoor air quality
- Regulating the construction of polluting industries far from population centres
- Making the promotion of health a requirement for good corporate practice and make work places healthier (e.g., making helmets available to construction workers, introducing maximum driving hours for lorry drivers, taking measures to prevent needle sticks in health services, etc.)
- Building speed bumps on roads leading through residential areas to prevent street accidents involving children, the elderly and handicapped

1.1.3 Strengthen Community Actions: Community Empowerment

"Health promotion works through concrete and effective community action in setting priorities, making decisions, planning strategies and implementing them to achieve better health. At the heart of this process is the **empowerment of communities** - their **ownership and control** of their own endeavours and destinies. Community development draws on existing human and material resources in the community to **enhance self-help and social support**, and to develop flexible systems for **strengthening public participation** in and direction of health matters. This requires full and continuous access to information, learning opportunities for health, as well as funding support".

An important concept of this action area is the so-called "**settings approach**". The Ottawa Charter declared that, "Health is created and lived by people within the settings of their everyday life; where they learn, work, play and love." HP programmes try to reach and engage people in their own settings that may be **formal** (schools/universities, workplaces, hospitals, prisons, etc.), **geographical** with social ties (communities, cities, islands, districts, islands, etc.) or **informal** (virtual communities, market places bars, street corners, etc.).

Selected examples to strengthen community actions:

- Self help groups and community organised services for people living with HIV or AIDS
- Former tuberculosis (TB) patients creating health education committees to hold debates about TB, thereby reducing the stigma linked to TB
- Community initiative pooling funds for increasing access to cash to pay for transport to health facilities with skilled birth care
- Healthy school, healthy city, health promoting hospital, health promoting workplace, healthy market place and other setting oriented approaches

1.1.4 Develop Personal Skills: Individual Empowerment

"Health promotion supports personal and social development through **providing information, education for health**, and **enhancing life skills**. By so doing, it increases the options available to people to exercise more control over their own health and environments, and to make choices conducive to good health. … This has to be facilitated in **school, home, work and community**

settings. Action is required through educational, professional, commercial and voluntary bodies and within the institutions themselves."

A more recent concept that is closely related to this action area is **health literacy** (see below under 1.3.3).

Selected examples to develop personal skills:

- Life skill education in schools (that could include sexual and reproductive health and HIV, gender roles, communication skills, entrepreneurial skills, etc.), supporting young people as social change agents
- ICT (Information and Communication technology for Health), e.g., reaching a target group via facebook, an interactive website, blogs, etc., to share culturally sensitive information or do online training
- Training of volunteers, often patients themselves, to empower others
- Training of peer educators to promote behaviour change in harder to reach groups with higher risk behaviour such as sex workers, injecting drug users, and men who have sex with men
- Innovative chronic disease self management programmes
- Empowering men to challenge conventional masculinity concepts in relation to risk taking, not seeking help and late use of health services

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1.1.5   Re-orient Health Services

"The responsibility for health promotion in health services is shared among individuals, community groups, health professionals, health service institutions and governments. They must work together towards a health care system which contributes to the pursuit of good health. The role of the health sector must move increasingly in a health promotion direction, beyond its responsibility for providing clinical and curative services. Health services need to embrace an expanded mandate which is sensitive to, and respects cultural needs. This mandate should **support the needs of individuals and communities for a healthier life, and open channels between the health sector and broader social, political, economic and physical environmental components**."

The re-orientation of health services is linked to the **health system strengthening efforts**.

Selected examples to re-orient health services:

- Offering a culturally appropriate care delivery model in health facilities, including the use of the local language to increase effectiveness of skilled birth care
- Turning healthcare institutions into health promoting settings. 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[7]:
  - Care processes 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
  - 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, information to support consent and informed choices, and respectful treatment

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[7] Source: A primer for mainstreaming health promotion, 2009 (*see list of references*)

An HPH will consider the potential barriers for patients, their families, and the community to health learning, exercising choices and making informed decisions. These include health literacy, out-of-pocket costs, access issues, and personal circumstances. The 2009 primer for mainstreaming health promotion, from which this information stems, also includes a section on building health promoting health systems (pg 51 ff).

1.2 Main Developments Since Ottawa

Since Ottawa, the health promotion agenda was further developed and supported by a series of international conferences. (*Links to the conferences and related documents are given at the end of the document in the list of references.*) In addition to these conferences, the International Union for Health Promotion and Education (IUHPE) has organised a series of international conferences pooling a wider range of stakeholders - also from the non-governmental organisations. The IUHPE's 20th conference[8] was held in 2010 in Geneva with a thematic focus on health, equity and sustainable development.

Main International Conferences on Health Promotion since 1986

1986: Ottawa Charter for Health Promotion

1988: Adelaide "Building health public policy"

1991: Sundsvall Supportive Environments for Health

1997: Jakarta Leading HP into the 21st Century- "New players for a new era"

2000: Mexico, "Bridging the equity gap"

2005: Bangkok Charter for HP in a Globalised World

2009: Nairobi "Promoting health and development: closing the implementation gap"

2013: planned for Helsinki "Health in all policies"

Box 2: The sequence of the main International Conferences on Health Promotion since 1986

Each of the subsequent conferences to the Ottawa conference basically highlighted one of the action areas, and deepened and further developed the understanding and sharing of experiences around the five action areas. The three key informants to this publication (Gauden, Portela and Broesskamp) confirm that the **five action areas are still a valid concept** to frame today's HP approaches. Attempts were made to improve the taxonomy, and the use of terminology has shifted slightly, but the basic understanding is still the same (e.g., the term community empowerment is today often used for "community action for health", or "individual empowerment", rather than "individual skills for health"). In

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[8] http://www.iuhpeconference.net/

addition, "re-orienting health services" is linked to the health systems strengthening agenda. As mentioned, it was also recognised that for sound healthy public policies, a **"whole of government approach" / "health in all policies"** is needed that involves **inter-sectoral collaboration and cooperation and** relies on a foundation of **partnership**. The whole of government approach can be motivated when all sectors understand the co-benefits of improved population health. In recent years, the concept of "health impact assessment" (**HIA**) emerged out of this line of thinking. Health Impact Assessment is a means of assessing the health impacts of policies, plans and projects in diverse economic sectors using quantitative, qualitative and participatory techniques[9].

Over the years, **gender** has been embraced as one of the key equity principles forming a social determinant of health. The Bangkok conference in 2005 introduced a special focus on the effects, challenges and opportunities that increasing **globalisation** brings in relation to HP. As a result of the efforts to fully embed HP into systems, programmes and sectors (the term **mainstreaming** is also used) is that HP activities can lose visibility (e.g., tobacco control, accident prevention, etc.). The defenders of the mainstreaming approach propose that all actors should wear a "health promotion lens" and that basic HP principles should be understood by all.

> **Remaining major challenges common to both the developed world and resource poor countries:**
> - Difficulty identifying suitable short and medium term indicators for measuring progress and health promotion effectiveness resulting in a (still) small body of evidence on effectiveness and cost-effectiveness of health promotion
> - Lack of professionalisation of practitioners, lack of HP infrastructure
> - Distortion of resource allocation to biomedical and curative strategies rather than holistic HP approaches and prevention
> - Limited political willingness (health authority collaboration with other sectors which may be reluctant to consider health in their priority setting; empowerment challenges the existing power structure)
> - Economic interests, and power of the health care business and other lobby groups (e.g., tobacco and/or alcohol producers)

As mentioned, monitoring and evaluation of health promotion remains a challenge, as the effects of HP often take long time to become evident. The World Health Organisation, in collaboration with the International Union for Health Promotion and Education has launched the Global Programme on Health Promotion Effectiveness to enhance the evidence base around HP[10]. The list of references in the back of this document highlights a recent publication (Amuyunzu-Nyamongo and Nyamawa, 2010) that is dedicated to the question of the Evidence of Health Promotion Effectiveness in Africa.

Health Promotion Switzerland has developed a useful framework for outcome classification in HP and prevention, which, with some adaptation, may also be very useful for low resource contexts (see annex 2).

Another remaining challenge is to make the health promotion concept - which is well developed for use in high income countries - relevant to resource limited countries and settings. Until the Bangkok conference in 2005, this remained a largely unanswered question. Thailand, a country in transition, showcased an impressive HP approach driven by high commitment of the government and the various actors. It was mainly during the 2009 Nairobi conference, when the HP concept was scrutinised from the view of the least developed countries.

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[9] http://www.who.int/hia/en/
[10] http://www.who.int/healthpromotion/areas/gphpe/en/index.html

While the HP agenda passed a phase of slight hibernation in the, formerly leading, WHO, the topic seems to be undergoing revitalisation. The WHO is currently working on a systematic review of evidence on health outcomes of HP approaches and collaborates with twenty thematic experts. The publication is planned for summer 2011.

1.3 The Link to Other Concepts

The strong rooting of the HP idea within the concept of **determinants of health** has been elaborated on above. There are, however, many other concepts of relevance to HP. The "Health Promotion Glossary" (see list of reference) may help to provide more clarity on the multitude of terms used. The following section shows, a bit more depth, how selected concepts are linked with the ideas of HP.

1.3.1 Equity

Today, it is an undisputed fact that health is unequally distributed between and within populations. It is important to realise the importance of systematic differences in exposure to health hazards and risk conditions in the population, which for some groups mean poorer chances of achieving full health potentials as a result of life circumstances. Inequity and inequalities are wrongly often used interchangeably. If a person lives longer, or suffers less sickness or disability than another, then inequalities in health status exist but not necessarily as a result of inequity. These differences may not have arisen from living conditions, but from genetic predispositions, personal lifestyle choices or particular accidents. However, if differences in health status result from different living conditions (such as reduced access to nutritious foods, inadequate housing, lack of access to appropriate health care, lower income levels and frequent periods of prolonged unemployment), then inequalities in health status are the result of social inequities[11]. As mentioned, the HP concept is rooted in the aim to promote health for all and contribute to more equity in health. While achieving complete equality in health status is an unrealistic goal, even in an ideal world, more equitable and fair access to opportunities and supportive environments in favour of health is the goal that needs to be pursued when developing a health promotion approach. **Gender** inequalities are of particular concern in many societies. While **sex** is, per se, considered a **determinant of health,** gender is an important determinant of **risk taking in health** as well as **use of health services**. In addition, gender is increasingly important for understanding how men and women respond to health promotion programmes and interventions, and analyse their outcomes (Keleher, 2004).

1.3.2 Right to Health

Both the concept of "right to health" and the HP concept base their logic on the determinants and essential prerequisites for health, and have a lot in common. The right to health contains "freedoms" and "entitlements", including the freedom of discrimination and the right that "services, goods and facilities must be available, accessible, acceptable and of good quality." Both concepts stress the importance of the right of "participation". One could say that the concept of HP helps to translate the right to health into practice, and that the human rights approach is an important principle shaping the thinking in HP.

1.3.3 Health Literacy, Empowerment, Resilience

HP is a process directed towards enabling people to become active in shaping their own health ("develop personal skills"), thus, exerting control over the determinants of health and for positive change, by, with, and for people as individuals or groups. To be able to take such an active role, people and groups need to be ***empowered***[12]***.*** Power roles between providers and users need to change and people have to have access to information, services and skills-building. When the empowerment becomes effective at the level of the individual, the person shall become "health literate", meaning that a person/community has the skills to access, understand, and use information

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[11] Adapted from http://www.health.vic.gov.au/healthpromotion/what_is/determinants.htm

[12] Empowerment is an emancipation process in which the disadvantaged are empowered to exercise their rights, obtain access to resources and participate actively in the process of shaping society and making decisions. (SDC 2004)

for health. **Health literacy** can be achieved to various extents - reaching from a basic level of understanding information provided, to complex levels of actively seeking information and knowledge from various sources, and combining this information into a personal picture on which to base action. So health literacy means more than being able to read a pamphlet. Health literacy is a key outcome from health education, which is one of the HP strategies. While health literacy looks at individuals or communities, the concept of HP is much broader and encompasses all the dimensions explained above. "**Resilience**", a newer concept used in health and HP, refers to the ability of an individual or a group to "thrive, mature, and increase competence in the face of adverse circumstances" (Gordon 1995). Using a resilience-oriented approach therefore, means looking at resources and coping mechanisms that people draw upon to avoid risk or cope with stress and adversities, and focus on how these abilities can be strengthened. **Promoting resilience, health literacy and the empowerment of individuals, families and communities** are therefore all to be understood as integral strategic elements for the wider goal of HP.

1.3.4   Community Health and Primary Health Care

Community health, community action for health (see also definition in WHO HP glossary) or community based health are similar concepts that aim at promoting access of communities to appropriate services for health, but at the same time look at the community as actors in shaping the health of their populations through getting involved in HP, prevention and managing/shaping the services that are offered to them. As mentioned above, "strengthening community action" for health is one of the five key action areas for HP, since communities are understood as part of the health system in the wider sense. For a comprehensive HP strategy, the community action would be complemented with programmes targeting the individual, and policy level actions and interventions that address the determinants of health.

> **Primary Health Care as Defined in Alma Ata Aims at:**
> - Reducing exclusion and social disparities in health (universal coverage reforms)
> - Organizing health services around people's needs and expectations (service delivery reforms)
> - Integrating health into all sectors (public policy reforms)
> - Pursuing collaborative models of policy dialogue (leadership reforms)
> - Increasing stakeholder participation
>
> Again, all very similar to the HP concept, but focusing only on the primary level of care, while an HP approach would look beyond the service level also at the meso and macro level of the system

In conclusion, Health Promotion offers a very appropriate framework to integrate different concepts and help translate them systematically into reality.

1.4   Main Approaches for Health Promotion

The primary goal of HP is to offer holistic processes that will support individuals in practicing healthy behaviours. While people may understand the need to improve their health habits, often they lack necessary resources, such as having the means to buy healthier foods, access to services that correspond to their needs, or their government may allocate the resources for health to strengthening clinical services only, not realising the importance of public policy for the health of the population. **A HP approach therefore, would be one that addresses an issue at several levels - individual, family/group, community and political/social/economical,** thus **addressing several of the five action areas at all levels of the determinants of health.**
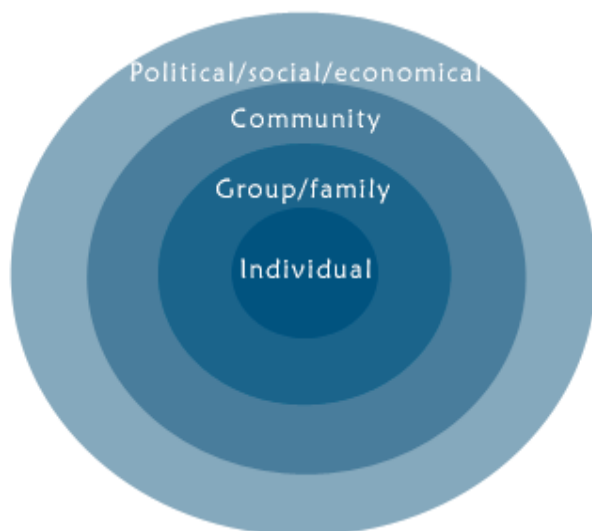
Figure 4: Determinants of health. Source: Victorian Government Health Information

Typically, HP approaches work in so-called "settings" as further explained in chapter 1.1.3. Approaches for HP have been classified in various ways by different schools of thought. While in earlier times, educational approaches based on a biomedical understanding of health resulted in top down educational approaches driven by experts, over time, the focus has shifted to include approaches that work at the level of the environmental, economic and social determinants of health, complemented by systems thinking and the aim to work in partnership across various sectors of governments, as well as between government and non-government actors. Today, the concept presented in the Primer developed for the Nairobi Health Promotion Conference in 2009, represents the understanding of the objectives, the type of interventions and the mechanisms that can be used for health promotion. The idea is not that HP is replacing the biomedical curative model, but HP should be understood as complementary with the overall aim to promote people's health.
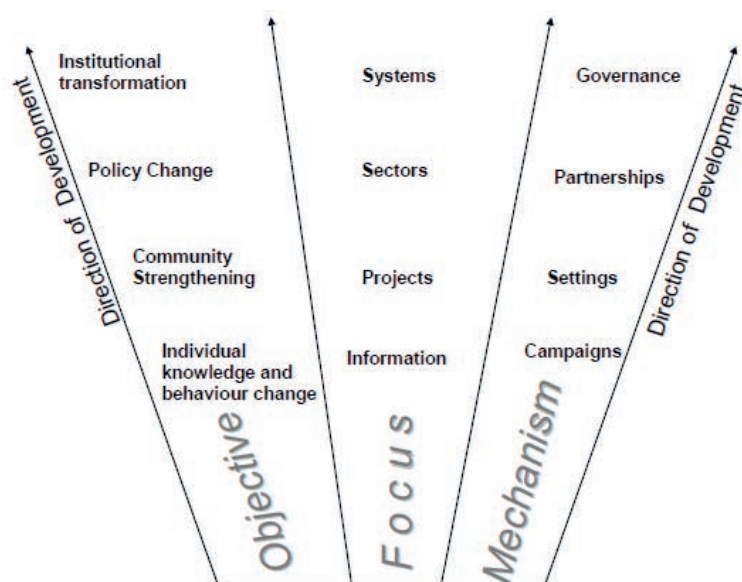
Figure 5: Objectives, focus and mechanisms of health promotion. Source: A Primer for Mainstreaming Health Promotion, 2009

The types of activities for continuous quality improvement in promoting health are well summarised in the following web.
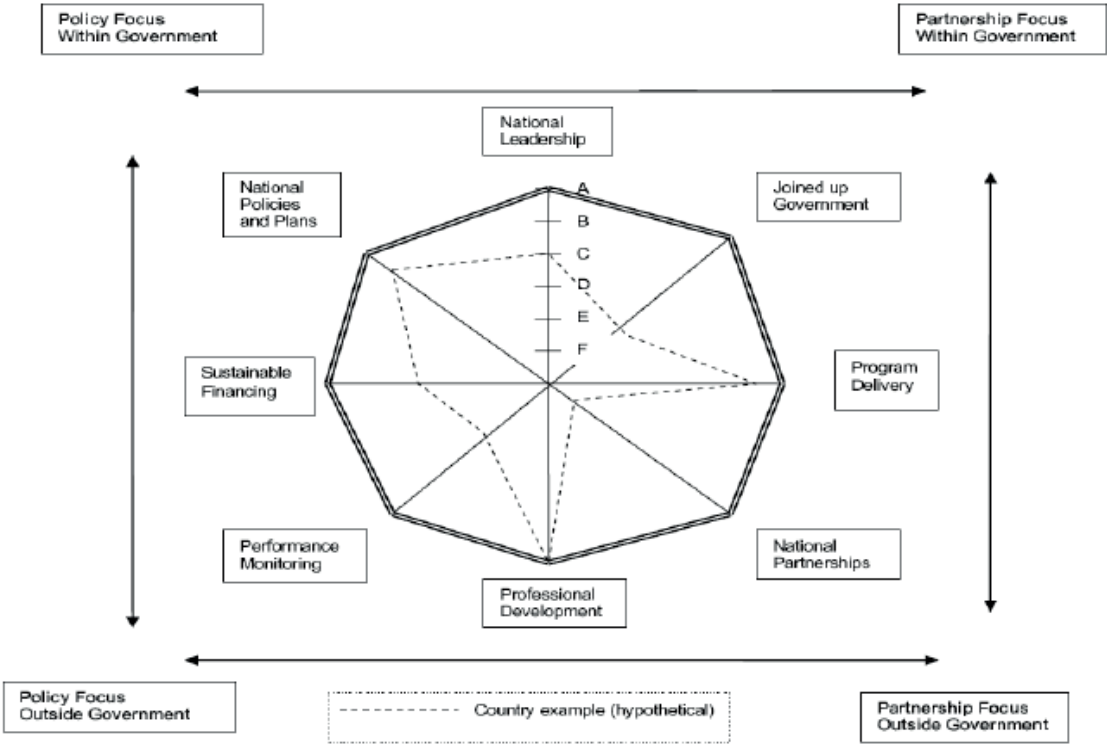
Figure 6: Continuous quality improvement. Source: A Primer for Mainstreaming Health Promotion, 2009

2 Relevance for Health Systems in Less Developed Countries

Promoting, preserving and re-establishing health is the core function of a health system. The question is how far a complex and systemic view as the one proposed by the health promotion community is needed to improve population health. The view that the observed lack of significant progress on crucial population health indicators in Sub-Sahara Africa has much to do with the fact that most efforts have gone into strengthening health systems, but hardly any into addressing the wider determinants of health is becoming more widely debated (see e.g. Houéto 2008 or Sanders et al 2008).

Amuyunzu-Nyamongo and Nyamawa (see list of references) "recommend the recognition of the HP approach as a leading process in the health systems". HP most definitely plays an important complementary role in health system strengthening efforts, but health authorities and health providers in less developed countries may find all these concepts somewhat confusing and theoretical. Not working in an ideal world, they are faced with many problems exacerbated by greatly constrained resources. They might see HP as a luxury for developed nations who have solved their own fundamental problems and feel overwhelmed by the idea of "having to solve all problems at the same time". In addition, health authorities might feel challenged by the HP concept and fear a loss of power when adopting a true HP approach. HP is also frequently misunderstood as adding a little bit of health education to what is being done anyhow, as talking to the community about health or telling people to

stop unhealthy behaviour. Sometimes, as is the case in the new Tanzanian strategy for non communicable diseases[13], HP is also taken to mean primary prevention, which does not reflect the added value of the comprehensive concept. However, also in contexts where resources are limited, following an HP approach can offer more effective ways to tackle major health problems by pulling many forces together and sharing responsibility with others. This can also mean that the needed resources could be pooled from various budgets and sources. Also, HP capacities developed to tackle *one* health problem can constitute an entry point to the process of solving *another* health or development problem in a given community or setting. The approach would be based on the understanding that the causes of any one health problem are multi-factorial and interrelated. HP is considered "multi-tiered" because it involves various levels of society to help address a health problem. Taking a health promoting lens for the health sector could mean that as part of the generic activities of all health programmes, special attention is given to the main components of the HP agenda.

GENERIC ACTIVITIES OF ALL HEALTH PROGRAMMES:

1. Situational analysis
2. Programme planning
3. Policy advocacy
4. Knowledge for action
5. Monitoring & evaluation

HEALTH PROMOTION LENS:

- Address determinants (risks & assets)
- Focus on equity & rights
- Adopt multiple strategies & settings
- Support participation & empowerment
- Connect levels & partners
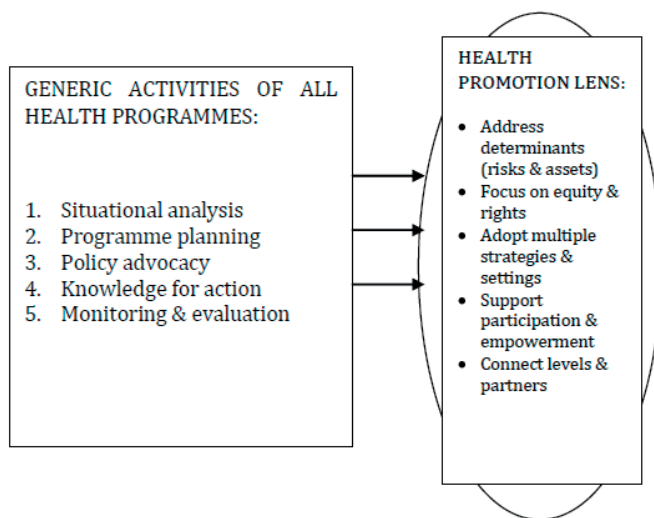
SOURCE: ADAPTED FROM PAHO 2008 DRAFT

Figure 7: The health promotion lens. Source: A Primer for Mainstreaming Health Promotion, 2009

While the health sector is encouraged to take a lead role in enabling a holistic health promotion approach and facilitating partnerships across various sectors of government, and with actors outside of government, one major blocking factor has often been the tradition of dominance of the health sector, and health workers' feeling of superiority when dealing with other people's health. Adopting a truly health promoting attitude in the spirit of the Ottawa Charter would entail a shift, or sharing of power and responsibility that acknowledges that people are at the centre of change in health, and that non health sector stakeholders and actors have to join the partnership of actors to orchestrate successful health promotion. Engaging with communities or setting healthy policies that address the determinants of health are often not traditional strengths that fall into the core mandate of the health sector and highlight the need for partnership.

Some of the main ideas of the Ottawa Charter have been promoted in the frame of the HIV and AIDS response. Particularly in the Sub Saharan African context, health promotion approaches should build on the achievements and lessons learned from the AIDS response.

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[13]

http://www.ktl.fi/portal/english/research__people___programs/health_promotion_and_chronic_disease_prevention/projects/training_seminar/ncd_seminar/ncd_seminar_materials/ncd_seminar_15-19.3.2010/ see 16.3. 15:45, slide 13

Relevant Experience Gained from the AIDS Response:
- Continuous analysis of the determinants of the epidemic
- Empowerment of people living with HIV and their involvement in self-help groups
- Empowerment of civil society organisations and giving them a role as stakeholders in the policy dialogue (e.g., CCM of the GFATM)
- Importance of community empowerment (for prevention, home based care and treatment
- Multi-sectoral approach
- Legal changes (e.g., legality of access to syringes for IDUs, or distribution of condoms)
- Etc…

2.1 The Added Value of Using a Health Promotion Lens: two Case Studies from Sub-Saharan Africa

The following two case studies illustrate what the added value of using an HP lens could look like when addressing a health problem at district level.

2.1.1 Case study: Using a HP approach to HIV prevention in schools

Health problem to be addressed: a district in an Eastern African country is faced with the fact that many young people become HIV infected, and many girls drop out of school because of unwanted, early pregnancies.

A traditional approach to address these issues could be:
- The Ministry of education or health starts an HIV prevention programme for young people in schools. The programme is designed by experts.
- A health worker visits schools periodically to teach female students about abstaining from sex and screens them for pregnancies.
- Girls who fall pregnant are expelled from school to discourage others from engaging in premarital sex.
- Midwifes are trained on contraception counselling for adolescents.

These actions are useful; however, they are fragmented and developed independently of each other. They are also very provider/expert driven and do not actively involve young people, their families or the community. They are only focused on the symptomatic problem, without taking into account possible causes. For all these reasons, they are likely not to have much impact on the health situation of adolescents.

A health promotion oriented approach could involve the following process:

A. Invite participation, establish evidence base and adapt to local culture
In a first step, the situation and the needs of various stakeholders are comprehensively analyzed. With support and guidance from professionals, such as youth workers, health professionals, social workers and teachers, youth groups conduct a needs assessment with their peers and elaborate on suggestions for possible solutions. At the community level, focus group discussions with parents, key opinion leaders and service providers are organized.

Underlying problems that might be identified may include, amongst others:
- Young people believe that sexual relations are a necessary element of a loving relationship between girls and boys
- The misconception that girls refusing sex do so to tease and should be forced into having sex

- Young people have no access to condoms (too expensive, not allowed to be seen with them - facing punishment by parents and expulsion from school, etc.)
- Young people have not learned how to negotiate the use of a condom
- Children discussing issues related to sexuality with their parents is taboo
- Young girls are coerced into sex or are pulled into sexual activities by the "sugar daddy" phenomenon
- Religious leaders condemn today's youth for their immoral behaviour
- Most young people have unprotected sexual relations and therefore, sexually transmitted infections spread rapidly
- Young mothers disappear from the community, as they are expelled from schools and their family

B. Develop personal skills

Based on the situation analysis done, gender sensitive and comprehensive life skills education and peer education is introduced in schools, as well as for out of school youth - both girls and boys. These programmes would also address gender roles and stereotypes, concepts of masculinity, gender based violence, etc.

C. Create supportive environments

Courses for parents on how to talk with youth within the family environment about sexuality are offered; as part of a social marketing campaign, a rural radio programme, that works with sensitized opinion leaders (e.g., religious leaders, traditional chiefs, presidents of women's associations, etc.), launches a public debate; teachers are sensitized on the rights of students and that comprehensive sex education does not lead to more and earlier sexual activities; taking an active role in supporting and training peer educators.

D. Strengthen community action

The community explores how far the lost tradition of 'initiation', which included sexuality education and the construction of positive role models in the community, could be revived in a modern manner leaving behind potentially harmful components, such as female genital mutilation. The community supports a self help group for teenage mothers who learn about their health and link it to opportunities of vocational training. In the frame of a peer education programme, teenage mothers visit schools to sensitise their peers on the realities of how it *can* be (see the example of the "aunties" programme[14]).

E. Re-orient health services

Health services would be re-oriented to become more youth friendly, involving adolescents, parents and the community in their design. Health workers would be sensitized to the needs of adolescents and non-discriminatory treatment of clients. Opening hours would be re-discussed to make services more youth friendly, and the question of when parental consent is needed for prescribing contraceptives to minors would be solved involving all stakeholders.

F. Healthy public policy

Expulsion of pregnant girls from schools, as well as the expulsion of students found with a condom in school is based on a tradition and not on a country law or school policy. School authorities and heads of schools are informed of this by the Ministry of Education. The government introduces a policy of tax exemption and subsidizes condoms to make them more accessible for all and affordable for young people. Laws are introduced to penalize gender-based violence and sex with minors. The police are trained to enforce these laws and work with communities on creating the necessary awareness.

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[14] http://www2.gtz.de/dokumente/bib/gtz2008-0156en-aunties.pdf

G. Multi-sectoral coordination and collaboration, working in partnership

It is clear that not all of this can be done by one group of actors or within the health sector alone. For some of the interventions, the health sector would take the lead, coordinating closely with other sectors, such as education, politicians, police, the community, etc. For other activities where the Ministry of Education, the Ministry of Youth, the Ministry of Finance, local government, civil society organizations or non-governmental organisations (NGOs) have the lead, the health sector would play roles in the fields of advocacy, raising awareness, building skills, facilitating and supporting, being responsive to needs, coordinating processes, etc. Such a health promoting approach would be understood as a shared responsibility.

2.1.2 Case study: Using a HP approach in malaria control

Health problem to be addressed: a community in Benin is faced with high under five malaria related mortality despite many efforts at the international and the national level to control and prevent malaria. This case study is based on a real intervention (small scale, community level) which took place between 2005 and 2007 and is documented in the book of Amuyunzu and Nyamwaya (2010).

The traditional approach taken to address this issue could include:
- Free distribution of insecticide-treated bednets through the National Malaria Control Programme
- Making adequate malaria treatment accessible at the health facilities through the National Malaria Control Programme

These actions are important and useful, however, they are provider/expert driven and do not actively involve the mothers, families and communities. Therefore, they carry the risk that they are not "used" by these key decision makers for child health and that the planned impact will be much less than expected.

The HP oriented approach of this community based intervention involved the following process[15]:

A. Invite participation, establish evidence base and adapt response to local culture

In a first step, health priority problems were identified and described at community level. Village leaders, notables and the whole community participated in a general assembly of the village. This led to the planning and implementation of a baseline study about the cause of fever in children. In a feedback session on the results of the base-line study the various health or non-health factors of fever, in connection with the realities of the village, were presented and problems to be resolved for a coordinated approach in the fight against fever are discussed. The aim of this step was to ccreate a general community understanding of the causes of fever in children. The main problems identified were reformulated according to the community's understanding and based on locally available means. The problems were then prioritized according to the weight placed on them by the community members. In addition, the community members discussed the availability of resources necessary for solving the identified problems as well as the potential collaboration with health and non-health professionals. This process then led to the development of an action plan and the set-up of a steering committee which took the lead regarding the implementation of the identified activities. During the whole implementation phase the steering committee linked with the community and held periodic village meetings.

Underlying problems that were identified included:

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[15] the case description in a summary based on the chapter: Health Promotion as a contribution to effective malaria control: an analytical case study; David Houeto and Alain Deccahe

- although available at home, the freely distributed insecticide treated bednets are not used because their need is not understood
- the mothers do not perceive fever as a typical symptom for malaria, but as a common and banal sign of infection which can be managed by self medication and does not require recourse to healthcare
- severe malaria, in the form of convulsions, coma and severe anaemia is associated with witchcraft or bewitchment, influencing the care seeking behaviour
- the mothers and families do not have money available to seek health care

Based on the situational analysis, the **eight main actions** for change were defined to be:
- **early home treatment of child fevers by mothers**
- **use of insecticide treated bed nets**
- **parents' income improvement**
- **setting up a micro- insurance scheme for health**
- **environmental cleanliness and creation of mosquito-free habitat**
- **systematic schooling of children and adult literacy**

B. Develop personal skills

Based on the results of the baseline study, trainings were organised to train mothers about appropriate early home treatment of child fever. These trainings led to mothers establishing their criteria for the selection of community health workers and shaping the approach in collaboration with health professionals (e.g. re-packaging of the treatment dose in reconditioned sachets).

In addition, the community agreed to systematically school children and promote adult literacy to contribute to behaviour change.

At the end of the intervention a significant gain in knowledge and healthier practice could be observed. Community skills for communication and negotiation as well as adequately treating child fever are said to have been strengthened.

C. Create supportive environments

Income generating activities were introduced to improve parents' income such as for example the installation of grain mills for processing corn, beans and other cereals as well as cassava. Contacts to the International Institute of Tropical Agriculture were made to improve agricultural practices.

In addition, a micro-insurance scheme for health was set up, with an membership fee (0.2 US$) and a monthly contribution (o.4 US$) per household, covering 100% of care at the community and district health care level.

D. Strengthen community action

Community members adopted a new model of habitat with appropriate measures to maintain their environment clean. The chief of the village ensured the model's use for the building of new houses.

The steering committee committed itself to supervising a quarterly de-worming programme through the micro-insurance scheme, in order to reduce children's susceptibility to fever according to the belief in the village.

During the intervention period, some 80% of the community members participated in the various activities.

E. Re-orient health services

The mothers identified a community health worker as the nearest source of health care. The supply of medicines and prices were managed by the steering committee.

F. Healthy public policies

The Ministry of Health subsidized the cost of insecticide treated bednets. In addition, the government supported the elimination of adult illiteracy and the systematic schooling of children.

The impact evaluation at the end of the intervention not only showed clear gains in community knowledge, skills and practice, but also improvements in health status (reduced prevalence of fever, severe cases of fever and malaria mortality).

In summary, the process was based on the following principles:
- No action was taken without considering the local context of the intervention community
- The issue approached was a priority for the intervention community
- Participation, through giving voice to the community to take all the possible and suitable actions for fever control, was effectively done
- Health professionals played a guiding role as resource persons and proposed actions for community consideration
- The use of multiple strategies for actions that addressed various aspects of the community's life without limiting them to the health sector
- Confidence by the community in the intervention played the role of "motivator" that increased the members' self esteem

3 Health Promotion in Practice

For a better understanding, some selected good practice examples are presented to show how the main areas for action can be translated into practice. Furthermore, the reader is referred to the 2009 toolkit for mainstreaming HP. The toolkit elaborates on the concept in relation to 12 priority health topics and gives a wealth of topic-related good practice examples.

Examples have been selected based on the following criteria:
1. Developing or transition country context, or targeted vulnerable minority groups
2. Address all or several of the main action areas for HP
3. Participatory and empowering approach
4. Demonstrated effectiveness
5. Innovation
6. Multi-level and multi-sectoral collaboration
7. Transferability

3.1 Community Action for Health in Kyrgyzstan[16]

A good example of a successful health promotion approach is the **Community Action for Health (CAH)** programme in Kyrgyzstan. CAH is a partnership between communities in rural areas of Kyrgyzstan, represented by voluntary Village Health Committees (VHCs), and the governmental health system of the country. The partnership aims at enabling rural communities to act on their own for improvement of health in their villages, and at strengthening the capacity of the governmental health system to work in partnership with village communities for improving health.

CAH is part of the Kyrgyz national health reform programme ("Manas Taalimi") and was initiated in 2001 by a project **funded by SDC** and implemented by the Swiss Red Cross. Following the inclusion into the health reform, the Swedish International Development Cooperation Agency (Sida) and USAID joined SDC in supporting CAH and its extension throughout the country. CAH has different building

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[16] **Source**: Community Action for Health in Kyrgyzstan. Accessed at http://www.cah.kg/en/home/

blocks. The process of collaboration with communities starts with an analysis of health priorities by the population in each village facilitated by staff from the primary health care sector. The project provides the health workers with preliminary training on how to do the assessment. As part of the process the community elects members for the VHC. The VHCs work without remuneration but receive technical support from governmental HP and primary health care staff. The collaboration builds on a partnership approach and aims at building organizational capacity to help the VHCs become an independent civil society organization. The VHC are trained to implement so-called 'health actions' in their villages to address the health problems which were prioritized by the communities, as well as other issues of public health concern.

Up to now, health actions have covered a broad range of topics, such as promotion of iodised salt, control of brucellosis, promotion of good nutrition, hygiene education, curbing of alcohol abuse, hypertension control, sexual and reproductive health, and many others. Outcomes of these health actions include, for example, a decrease in goitre prevalence among school children, and a decrease in alcohol consumption through research and awareness of the financial and social costs of alcohol in the communities and a sustained health action to introduce "new traditions" around alcohol. Another example includes a health action which was developed in 2008 for education on sexual and reproductive health (SRH) of adolescents in schools. Currently, this collaboration includes over 1400 VHCs, covering about 2.5 million people and further expansion is planned.

CAH addresses several of the main action areas for health promotion, such as **strengthening community actions**, **developing personal skills**, and **creating supportive environments**. As being part of the national health reform programme, CAH also addresses the **reorientation of health services**.

3.2   South Africa's Successful Tobacco Control Measures[17]

In the fight against tobacco use, the classic strategy includes activities such as banning advertising, clean indoor air policies, restrictions on sales to minors, an effective education programme, and tax increases. According to international literature, tax increases are to the most effective strategy. Study results indicate that young people and the poor are more responsive to cigarette price changes than older and more affluent people.

In just one decade, South Africa has been able to significantly reduce the tobacco consumption of its population. The tobacco control policy involves two important pillars: legislation on one side and tax increases on the other. In 1993, South Africa introduced a law that prohibited smoking in public transport and introduced health warnings. This law was amended in 1999 by banning tobacco advertising and sponsorship, prohibiting smoking in all public places - including work places, and banning the sale of tobacco to minors. These amendments supported the creation of an environment where smoking was increasingly regarded as socially unacceptable. Since 1997, there has been a 50% excise[18] tax on the retail price of cigarettes. The results of these HP efforts are remarkable, causing a more than 40% decrease in cigarette consumption since 1991: decreased smoking prevalence among young people from 23% in 1993 to 19% in 2000, among low-income earners from 31% to 25%, among black South Africans from 28% to 23%, and among males from 51% to 44%. Notably, despite the reduction in tobacco consumption, government revenue has increased through the increase in excise tax.

A deciding factor explaining South Africa's success in tobacco control has been the strong political will of the Ministry of Health and NGOs to challenge vested interests of the tobacco industry. In addition,

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[17] **Source**: Van Walbeek C. Tobacco Excise Taxation in South Africa. WHO publication. Accessed at http://www.who.int/tobacco/training/success_stories/en/best_practices_south_africa_taxation.pdf
[18] An **excise tax** is an inland tax on the production or sale, as opposed to customs duties which taxes on importation.

the country is able to contain cigarette smuggling within reasonable limits. This is of importance because international experience shows that smuggling erodes the benefits of higher taxes. This example of a successful health promotion approach is mainly based on the area of building a **healthy public policy** and **creating supportive environments**.

3.3 Mexico's Conditional Cash Transfer Programme[19]

PROGRESA (Programa de Educacion, Salud y Alimentacion), founded in 1997, is an innovative Mexican programme that works with cash transfer to poor rural households, on the condition that their children attend school and their family visits local health centres regularly. The programme is based on a change in the poverty reduction strategy of the Mexican government, ending the universal "tortilla" subsidies that benefited the whole population, to favour programmes that targeted the poor, involve co-responsibility by the beneficiaries, and promote long-term behavioural change.

PROGRESA provides bi-monthly cash transfers to households with children in school. The amounts increase with school grade level in order to compensate for hypothetical lost earnings from child labour, and to improve retention of children at the secondary level. Transfers are higher for girls than for boys attending the secondary school level to encourage female enrolment.

PROGRESA also provides free basic health care to beneficiaries including prenatal care for pregnant women, growth monitoring of babies, nutritional supplements for children, monetary grants for purchasing food, and education on hygiene, nutrition and reproductive health. These benefits are connected to conditions such as regular visits to the health centres, attendance at educational sessions, and helping to maintain schools and clinics.

Evaluations have shown that PROGRESA raised school enrolment rates, increased attendance at health clinics and reduced morbidity among beneficiary children aged 0 to 2 years. In addition, a randomized effectiveness study also showed that PROGRESA is associated with better growth and lower rates of anaemia in low-income rural infants and children.

PROGRESA is a HP approach based on a **healthy public policy**, leading to the creation of a **supportive environment** (better nutritional status), the development of **personal skills** (education on hygiene, nutrition and reproductive health) and **empowerment of individuals and communities.** It also engages in **re-orienting health services** by focusing mainly on reducing access barriers to services.

3.4 "Diabetes and My Nation" – Empowering Marginalised Populations in Canada[20]

Diabetes and My Nation, a non-profit foundation formed by a group of First Nations elders, aims at improving the health outcomes of Aboriginal people living with diabetes and other chronic diseases through a holistic approach that integrates traditional healing and traditional learning methods, with modern medicine and advanced technology. The model consists of various integrated programs focusing on health prevention and health management among the target group, such as (1) promoting diabetes management and prevention, (2) developing culturally appropriate education materials and programs, (3) building bridges between Aboriginal communities and healthcare services, (4)

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[19] **Source:** Wodon Q et al. Mexico's PROGRESA: Innovative targeting, gender focus and impact on social welfare. En Breve – World Bank – January 2003; and Rivera JA et al. Impact of the Mexican program for education, health, and nutrition (Progresa) on rates of growth and anemia in infants and young children: a randomized effectiveness study. JAMA. 2004 June 2;291(21):2563-70. Abstract accessible at http://www.ncbi.nlm.nih.gov/pubmed/15173147

[20] **Source**: Diabetes and My Nation Foundation. Accessed at http://www.dmnf.org/foundation.html, and Munro M. Unique diabetes program has big impact on B.C. First Nation. Edmonton Journal. Accessible at http://www.edmontonjournal.com/life/Unique+diabetes+program+impact+First+Nation/2120542/story.html

establishing community based physical activity and nutrition initiatives, and (5) promoting research in the field of traditional healing and diabetes management.

An evaluation has demonstrated that a successful program, integrating all aspects that affect the person with diabetes, from motivation to social support with constant monitoring by the health care professionals, can achieve considerable reduction in diabetes clinical parameters such as a reduction of the haemoglobin A1c marker in the blood, lipids, blood pressure, etc. These clinical parameters are known to be linked to renal impairment, cardiovascular disease, other disabilities and hospitalization costs. Of high interest is the finding that there seems to be a spill-over effect, as an improvement in the health of the community as a whole took place - also in those who did not participate in the intense program. The care of First Nations people significantly improved as compared to the care of people in the adjacent community of non-First Nations people. The entire community demonstrated a remarkable understanding and awareness of the risks of the disease and of risk reduction methods.

"Diabetes and My Nation" focuses on **strengthening community action for health**, but also addresses other areas of HP, namely **create supportive environments**, **develop personal skills**, and **re-orient health services** by making them centred around users' needs, and culturally more appropriate and accessible.

3.5 Strengthening Maternal and Newborn Health: Implementation of the IFC Framework in El Salvador[21]

The WHO IFC framework aims to empower Individuals, Families and Communities to increase control over maternal and newborn health, and to improve access to quality health services. The IFC framework has been developed with contributions from many actors and is currently implemented in countries in all regions, including Sub-Saharan Africa.

El Salvador adopted the generic WHO IFC framework for their context and started pilot programmes in two zones with high maternal mortality. Local IFC committees were established with the director of health services, community leaders, and representatives from the education, transportation and law enforcement sectors. The committee, with support from the national IFC committee, then identified issues related to maternal and newborn health taking into account various perspectives. An essential process was the Participatory Community Assessment (PCA). Several roundtable meetings were held with different stakeholders, such as women of reproductive age, mothers, grandmothers, mothers-in-law, male partners, healthcare providers, community leaders and institutional stakeholders. These meetings were followed by a multi-stakeholder roundtable with representatives of earlier roundtables. During these meetings a range of possible short- and long-term solutions to priority problems were identified. Proposed solutions included health education strategies for maternal and newborn health, increased involvement of teachers, schools and community leaders, ensuring visits by skilled healthcare providers for maternity care, transport schemes, road repairs, the role of men supporting their wives/partners for improved health care, etc. Based on the identified solutions, an action plan was developed by the local committee with support from national and district levels. The plan was implemented in collaboration with local actors and led to an increase in uptake of antenatal care services and more births attended by skilled health professionals. Within the health services, visits by gynaecologists from the tertiary hospital increased, and men's clubs were established aiming at increased awareness of danger signs and increased support for women. The health services reported an increase in men attending antenatal care services with their partners. In addition, the police started

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to assist by transporting women in labour and with newborns as emergencies. This led to zero maternal deaths being reported in the two intervention zones in 2008.

This HP approach addresses not only the strengthening of **community actions**. Depending on the developed action plan, it can also address the creation of **supportive environments**, the **development of personal skills** and the **reorientation of health services**.

3.6 Healthy City Project in Dar es Salaam, Tanzania[22]

The healthy city concept translates the settings approach of health promotion to the needs of municipalities and uses a socio-environmental model of health. It aims to place health issues on the urban development agenda. Healthy city projects were first implemented in developed countries, but in the late 1990s they also started in developing countries. From 1995 to 1999 WHO with funding from the Dutch Government via UNDP's Local Initiative Facility for Urban Environment (LIFE) supported healthy city projects in various countries, among others also in Dar es Salaam, Tanzania.

To develop the Dar es Salaam project a consultation was held with participants from central and local government sectors including all departments of the City Commission and relevant ministries, NGOs, CBOs, WHO and other partner agencies. Issues addressed were topics such as development context, environment profile, housing and health, food safety, school health, water, sanitation and health and others. During the consultation key problems encountered by the city were discussed and possible solutions were defined. The resulting document was considered a form of city health plan. One of the resulting intersectoral collaborations was focusing on the improvement of water and sanitation facilities in Buguruni market where there was no system for regular collection and disposal of waste, the existing sanitation system was inadequate and water supply to the market irregular. The markets were identified as the origin of epidemic outbreaks, e.g. cholera.

Selected findings from the evaluation are presented below in the box. This is a good example to show that by using a settings approach, the scope of a health promotion intervention can be limited to a feasible dimension. On the other hand, the evaluation raises critical questions regarding threats to the sustainability of such initiatives when they are donor driven and not responding to expressed local needs.

Box 16. Sustaining a settings approach in Dar-es-Salaam

Improvements in the Buguruni market involved key stakeholders from the outset in that the 'market task force' consisted of members of the market association. There was little HCP money available for implementing healthy market activities identified by the task force so they raised additional finances by (a) developing strategic and operational plans with categorized, budgeted prioritised activities for presenting to possible donors and (b) by requesting funds from various donors. The structure of the healthy market plan enabled the donors to make small but important contributions towards the development of a healthy market. Sixty five food vendors from Buguruni market were trained by the HCP. Some of them were trained as trainers who later trained over 1,500 street food vendors from across the city. Food handling and cooking standards were developed by the market task force and monitors were selected from amongst the trained market vendors who were assigned the job of ensuring that standards were maintained. Thermometers have been provided to food vendors of the market to ensure food is cooked to the required temperature. A self-financing mechanism was developed whereby the improved water and sanitation facilities developed in the market place had user fees and all resulting savings have been invested towards further development of the market. Thus sustainability is enhanced although no data is available on whether user fees are being collected and used effectively.

Box 3: Healthy Cities in Action- an evaluation of WHO/UNDP LIFE Healthy City Projects in 5 countries, 2002

This HP approach addresses the setting approach of creating **supportive environments**. It strengthens **community actions and the development of personal skills**.

4 Relevance for Sub-Saharan Africa and SDC: Q&A

Q: How relevant is the Health Promotion concept for Africa?
A: In the early years after Ottawa, the health promotion agenda was mainly picked up by stakeholders working in the field of chronic disease and accident prevention in the more developed world. No African country was among the participants and signatories at the Ottawa Conference[23]. This led to the erroneous impression that HP was something for the rich and had to do with promoting physical activity, combating smoking or overweightness. The concept seemed of not much relevance to developing countries. Following independence, African countries engaged in the Bamako Primary Health Care initiative and were busy setting up curative systems and combating the spread of epidemic diseases. Even though the Primary Health Care concept shares some common principles with the HP concept, essential areas of the latter are missing, notably the focus on determinants of health beyond the health sector, the call for multi-sectoral collaboration or healthy public policy.

Like the industrialised nations, transition countries were soon faced with a high burden of chronic diseases and more readily welcomed HP approaches. This was not the case in Sub-Saharan Africa where the concept was long perceived as an imported one with not much relevance to the real needs of the continent. For a long time, HP in Sub-Saharan Africa was dominated by the biomedical and behavioural approaches, using a disease specific approach controlled by the health sector. After African countries had gained independence, over decades a very narrow understanding of HP was applied ("health education" in Anglophone countries, and "information, éducation et communication" (IEC) in Francophone countries), based on the reasoning that ignorance was a significant obstacle to development and engagement of people in healthy behaviour. We know today that efforts to create knowledge, without addressing skills and an enabling environment, do not lead to behaviour change. This explains why these narrow approaches did not show the expected results.

In 2001, the WHO Regional Office for Africa formally recognised the importance of HP in addressing the major health problems of the region. Houéto (2008), in his publication, cites Katz, who questions whether for Africa, the HP agenda would not offer a more relevant framework than the Millennium Development Goals (MDGs). Several experts are strongly convinced that the African region would be the one needing the HP concept most. The authors of the Sanders et al paper (2008) would very much agree with this view point. This cannot happen, however, without contextualising the concept properly and making it relevant for Africa.

Q: Why did Health Promotion not develop quicker in Sub Saharan Africa? Is there progress?
A: Health promotion is a rather new concept for Sub Saharan Africa. The three country case studies (Mozambique, Zimbabwe and South Africa) described in Sanders et al 2008 show that progress, in terms of developing an HP approach in a country, is not a linear function in one direction, but that achievements can be reversed again, depending on the political system in power, the economic context or factors such as conflicts and wars. There is a very clear interdependence of the type of government with how far a holistic HP approach is being promoted in a country. A rather high level of democratisation is needed to allow true participation, community empowerment and shift of power to happen. For repressive governments the Ottawa agenda is certainly a threatening one, explaining why such regimes, when coming to power, have stopped programmes that had been established.
The question how far Africa has made progress in HP is discussed controversially. While Sanders et al and Houéto in their publications paint a rather pessimistic picture, David Nyamwaya (2003) stresses in

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[23] http://www.phac-aspc.gc.ca/ph-sp/docs/charter-chartre/index-eng.php

his article that "*over the last 20 years there has been a significant acceleration in the development of health promotion in Africa*". While this is certainly true on paper (in 2001 a regional HP strategy was adopted), and resulted in the drafting of some HP strategies, this has rarely been translated into tangible programmes which would have addressed several of the five action areas.

The situation was also influenced by the international development community who strongly pushed agendas related to the control of communicable diseases and focused on "quick wins". This culminated in the adoption of the MDGs as the global targets towards which to measure progress in health.

Q: How can the concept become meaningful in an African context?

A: For operationalising the concept, the full HP agenda, including community participation, empowerment, and the strengthening of health literacy and skills needs to be integrated and adopted by the public and private systems, and should no longer be considered as something for NGOs and civil society. For this, capacity has to be built among African stakeholders and decision makers to allow them to make use of the integrating potential of the HP framework within their health systems. They need to be in a position to conduct research that will help develop locally relevant HP approaches based on local evidence. According to Houeto and Luwaga the "vital steps that define HP are: interventions are based on "best practices" approach; grounded on theory; based on sound intervention/research design; ethically appropriate; based on an evaluation framework with details analysis and dissemination plans".

A regionalised African approach to HP will have distinguishing features that will be likely to include a strong focus on the incorporation of cultural, religious and spiritual factors, and an emphasis on community. Advocacy for professionalisation in HP should also include the development of capacity for healthy public policies using a whole of government approach. In that respect, Sub-Saharan Africa could benefit from the experience generated by the HIV response, which successfully piloted and developed the principle of multi-sectoral collaboration. Currently promoted efforts for health system strengthening can be enriched by re-orienting health services in view of the Ottawa agenda. The most important gap in terms of HP in the region is the lack of approaches that work on the wider determinants of health. Here, the international community would need to play a more supportive role in developing relevant approaches in partnership.

A recent publication by Mary Amuyunzu-Nyamongo and David Nyamawa (2010) is dedicated to the question of evidence of **Health Promotion Effectiveness in Africa** and can give further information on what works and what doesn't. The authors stress that it is absolutely crucial to contextualise approaches. Context, for the case of this region, has to encompass the issues of culture and religion, alongside with health promotion infrastructure, capacity, economic development, socio-cultural factors and the policy environment, amongst others. It is also suggested to link the discussion around health promotion effectiveness to the issue of resources. "Resources in the context of HP effectiveness are more broadly defined as going beyond financial resources or workforce capacity, but include the local assets and social capital of the community in which the interventions are carried out."

In the view of the authors, "perhaps the most important contribution of the African context to HP is the positioning of the community at the centre of health and development."

Q: How relevant is health promotion for SDC when working with partner countries? What could be SDC's comparative advantage?

A: HP is a relevant concept for SDC's cooperation in health and the overall goal to improve health of the poor and most vulnerable as part of their livelihood and wellbeing improvement by addressing root causes of ill health. SDC is well placed to play a strong advocacy role in cooperation with partner countries and development partners based on its history as a former donor to WHO HP, the practical experiences generated through SDC funded projects, and considering the values underpinning its

cooperation activities, of which, many are at the core of the HP agenda (e.g., human rights, gender equality, equity, participation and ownership, etc). Particularly at the country level, where SDC works with various sectors, the multi-sectoral dimension of HP could be taken into consideration when developing responses in inter-sectoral cooperation. Making HP an agenda of a sectoral health approach should be avoided. Having established contacts with various sectors in the countries, this comparative advantage of SDC could be used to foster dialogue towards a whole of government approach. SDC is also well positioned in partner countries to help ensure inclusion of civil society as an important force in main stakeholder forums (building on the experience with the SWAp). Finally, HP efforts in Sub-Saharan Africa, including best practice cases, outcome evaluations and failures, need to be documented and monitored to contribute to sharing experiences and developing a regional HP approach. Investments in HP are no "quick wins" with an immediate return on investment. Long term commitments are necessary. Investments into this field, however, should be understood as a "MUST" - as part of the package of interventions for poverty reduction and the sustainable improvement of the health of the poorest.

5 The "Who is Who" of Health Promotion

World Health Organisation (WHO)
The WHO has been instrumental in developing the HP agenda long before Ottawa. Unfortunately, to date, HP is still placed in the WHO's organigramme in the cluster "non-communicable diseases and mental health" under the department "chronic diseases and health promotion". This has certainly contributed to the widespread false understanding of HP as being something that has to do with chronic diseases and lifestyle problems of the richest nations. In comparison to earlier days, the HP agenda at the WHO has passed through a rather silent phase in the past few years. However, as mentioned in chapter 1.2., this weakness is now being addressed and the WHO, in particular the Pan American Health Organisation (PAHO), is active in mainstreaming HP in their overall activities. The WHO is now leading the organisation of the periodic international conferences on HP, the last one of which took place in Nairobi in 2009. *(In this document's list of references, contacts to the WHO HP focal persons in each regional office are provided.)*
www.who.int/healthpromotion/areas/en

The International Union for Health Promotion and Education (IUHPE)
The IUHPE is over half a century old and is a worldwide, independent and professional association of individuals and organisations committed to HP. Membership of the network is very diverse and range from government bodies, to universities and institutes, to NGOs and individuals across all continents working to advance public health through HP and health education. IUHPE works through various global thematic working groups and regional offices in all continents. Main fields of activities include advocacy and capacity strengthening for HP, training, communications and scientific activities. The network organises international conferences every three years, the last one in Geneva in 2010.
www.iuhpe.org

The International Network of Health Promotion Foundations (INHPF)
The INHPF was established in 1999 to enhance the performance of existing HP foundations, to assist the development of new foundations, and mentor and support these foundations. The mission of the Network is to strengthen the capacities of countries to promote population health through HP foundations at national and sub-national levels. Health Promotion Switzerland is one of the founding members of INHPF. Secretariat duties rotate between member organizations.
www.hpfoundations.net/about-us/joining-inhpf

Health Promotion Switzerland

Health Promotion Switzerland is a public, semi autonomous foundation. Originally established in 1989 as the "Swiss Foundation for Health Promotion", in 1998, it became "Foundation 19", as it was designed to implement Article 19 of the Swiss Federal Health Insurance Act. Switzerland has an interesting financing mechanism for HP. Most of the foundation's funds are generated via the mandatory health insurance contribution that each resident of Switzerland must subscribe to. In 2002, the foundation was renamed once again, finally becoming today's "Health Promotion Switzerland". According to the strategy 2007–2018, they have three main goals:

- Strengthening Health Promotion and Prevention in Switzerland and internationally through institutional coordination and networking ensured.
- Healthy Body Weight: Larger proportion of individuals with a healthy weight.
- Mental Health and Stress, focusing on workplace health promotion.

Through its leading role in the INHPF, the foundation is also involved in capacity building and peer support for HP at an international level. Health Promotion Switzerland participates in the annual meeting of INHPF and shares its experience with participating foundations, including those from low resource countries. Health Promotion Switzerland has no direct project activities in development cooperation.

www.gesundheitsfoerderung.ch/index.php?lang=e

Others

Of course there are many other global, regional, and numerous national actors and networks engaged in HP. A selection is listed below with active links leading to their website. Some are focusing on specific settings (schools, hospitals, cities, etc.), others on specific agendas, such as physical activity. Others have a more narrow focus on issues, such as equity or determinants of health, obviously all very much part of HP. The regional Equinet network, also supported by SDC, would be one such example.

- **International Francophone Network for Health Promotion (RéFIPS)**
  http://www.refips.org/
- **Global Advocacy for Physical Activity - Advocacy Council of ISPAH (GAPA)**
  http://www.globalpa.org.uk/
- **Global Consortium for the Advancement of Promotion and Prevention in Mental Health (G-CAPP)**
  http://www.gcappmentalhealth.org/Home.asp
- **HP-Source.net**
  http://www.hp-source.net/
- **International School Health Network (ISHN)**
  http://www.internationalschoolhealth.org/
- **The International Health Promoting Hospital Network**
  http://www.who-cc.dk/goals-and-purpose-of-the-hph-network
- **The Alliance for Healthy Cities**
  http://www.alliance-healthycities.com/htmls/about/index_about.html
- **Equinet**
  http://www.equinetafrica.org/
- **Health Action Partnership International (HAPI)**
  http://www.hapi.org.uk/
- **International Collaboration on Social Determinants of Health**
  http://www.equitychannel.net/

6 References to Further Information

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  http://www.who.int/hpr/NPH/docs/hp_glossary_en.pdf
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  http://www.who.int/healthpromotion/conferences/7gchp/documents/en/index5.html
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  http://www.who.int/healthpromotion/conferences/7gchp/documents/en/index6.html
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  http://www.who.int/healthpromotion/milestones/en/index.html

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- Houéto David. **La promotion de la santé en Afrique subsaharienne: état actuel des connaissances et besoins d'actions**. Promotion & Education 2008 (Suppl1); 15: 49

Links to the International Conferences

- **1986 Ottawa, Canada**
  http://www.who.int/healthpromotion/conferences/previous/ottawa/en/index.html
- **1988 Adelaide, Australia, "Building health public policy"**
  http://www.who.int/healthpromotion/conferences/previous/adelaide/en/index.html
- **1991 Sundsvall, Sweden, "Supportive environments"**
  http://www.who.int/healthpromotion/conferences/previous/sundsvall/en/index.html
- **1997 Jakarta, Indonesia, "New players for a new era"**
  http://www.who.int/healthpromotion/conferences/previous/jakarta/en/index.html
- **2000 Mexico City, Mexico, "Bridging the equity gap"**
  http://www.who.int/healthpromotion/conferences/previous/mexico/en/index.html
- **2005 Bangkok, Thailand, "Policy and Partnership for Action: addressing the determinants of health"**
  http://www.who.int/healthpromotion/conferences/6gchp/en/index.html
- **2009 Nairobi, Kenya, "Promoting health and development: closing the implementation gap"** http://www.who.int/healthpromotion/conferences/7gchp/en/index.html

Further Reading

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Contacts of Health Promotion Focal Persons in WHO Regional Offices

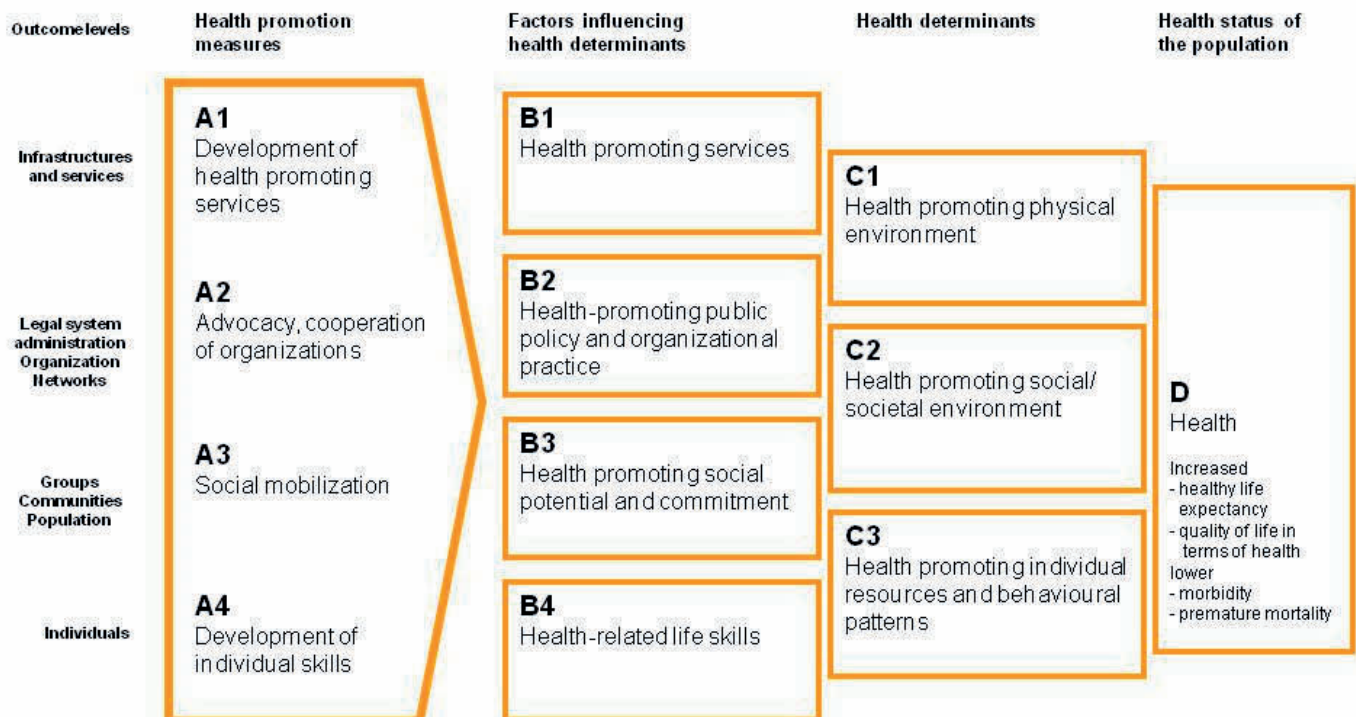| WHO Regional Office for Africa (AFRO)	WHO Regional Office for Europe (EURO)
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Annexes

Annex 1: Health Promotion Lens Checklist for National Plans

1. Situational analysis	What are the social and behavioural contexts that will shape the possibility of improved health? Do policy and legislation measures support health creation and equitable health delivery? What is the capacity of human and financial resources in the health system to promote health? Are there arrangements for impact assessments of the health system on the environment and economy?
2. Determining priorities, objectives and outcomes	Have communities been involved in identifying needs prioritising health issues, and drawing up a national health promotion strategy? What community assets can be mobilised to create better health?
3. Selecting intervention strategies	Has the Ottawa and Bangkok Charters been applied? Have all partners been identified and been involved in intervention planning? Are the interventions informed by evidence and applied in local context? Has the potential for health promotion been identified in all aspects of health services delivery, alongside treatment and care? Has the role of primary health care and traditional medicine been described?
4. Implementation	Has a comprehensive strategy for health improvement been published or is readily accessible to the public? Have sufficient resources been allocated to ensure appropriate targeting and programme coverage? Is there a human resources strategy in place? Have capacity strengthening been incorporated into implementation plans? Are there clear organizational arrangements for the co-ordination, management and evaluation of health promotion on a whole-system basis? Are there clear arrangements for engaging non-health sectors? Are there arrangements for governance and accountability? Does the health system recognize its responsibility as an employer to promote the health of its employees?
5. Monitoring & evaluation	Have indicators which reflect health promotion action and health improvement been adopted amongst Key Performance Indicators for health system performance? 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? Has a social process of monitoring and learning been instituted? Are there arrangements for equity audits to ensure the most disadvantaged are benefiting? Are the arrangements for monitoring and evaluation to be in the public domain?

Source: Adapted from PAHO/Mexico Conference (PAHO/WHO, 2000) and Parish and Mittelmark (Parish & Mittelmark, 2005) in "A Primer for Mainstreaming Health Promotion" prepared for the 2009 Nairobi Conference

Annex 2: Swiss Model for Outcome Classification in Health Promotion and Prevention

Gesundheitsförderung Schweiz
Promotion Santé Suisse
Promozione Salute Svizzera

Overview of the Swiss Model for Outcome Classification in Health Promotion and Prevention (SMOC)

Outcome levels	Health promotion measures	Factors influencing health determinants	Health determinants	Health status of the population
Infrastructures and services	**A1** Development of health promoting services	**B1** Health promoting services	**C1** Health promoting physical environment	
Legal system administration Organization Networks	**A2** Advocacy, cooperation of organizations	**B2** Health-promoting public policy and organizational practice	**C2** Health promoting social/ societal environment	**D** Health Increased - healthy life expectancy - quality of life in terms of health lower - morbidity - premature mortality
Groups Communities Population	**A3** Social mobilization	**B3** Health promoting social potential and commitment	**C3** Health promoting individual resources and behavioural patterns	
Individuals	**A4** Development of individual skills	**B4** Health-related life skills		

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