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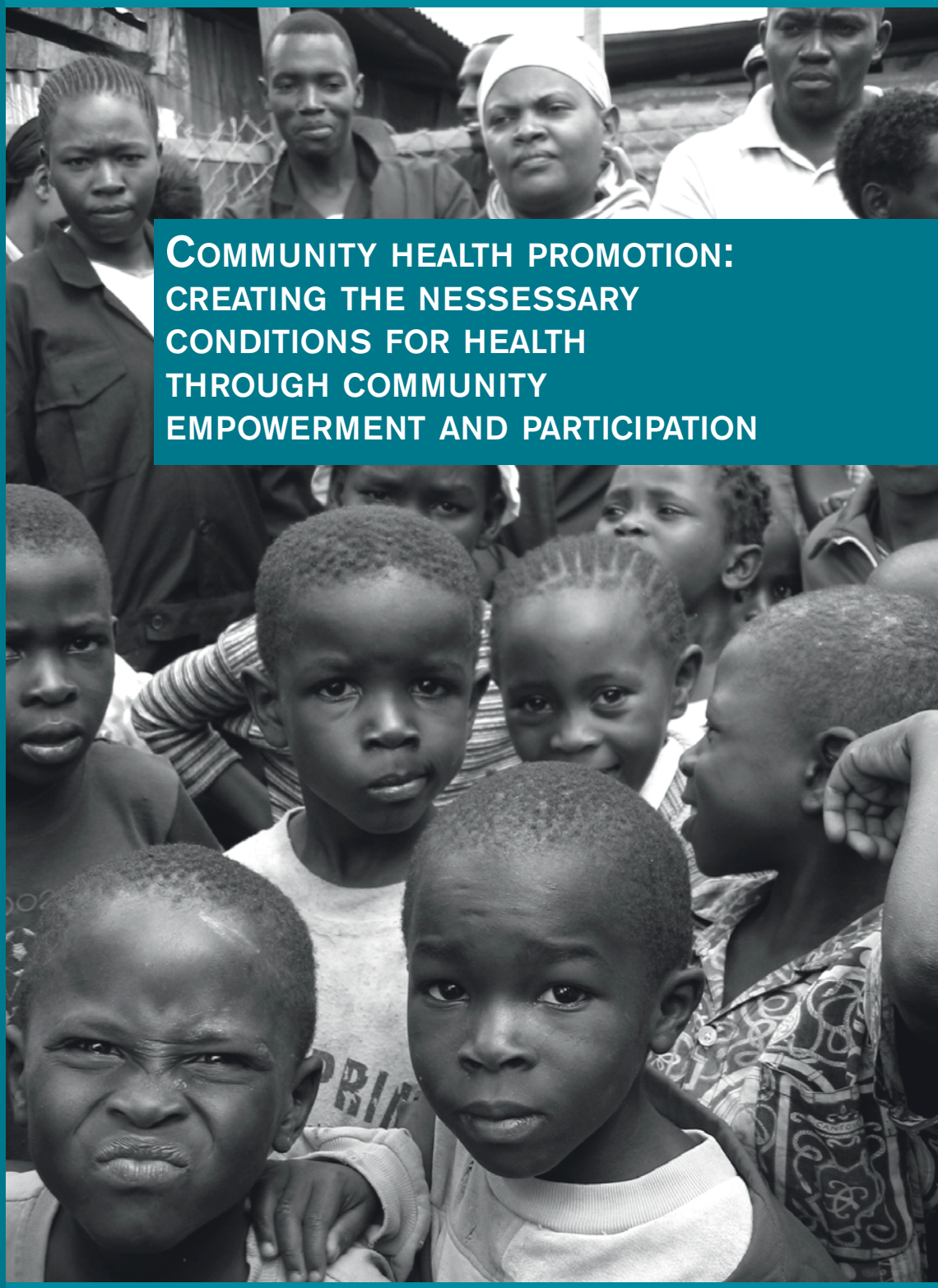

Community health promotion: creating the nessessary conditions for health through community empowerment and participation

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Promotion & Education

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Community Health Promotion – a step further

Sania Nishtar[1,2]

This themed issue of *Promotion & Education* has received financial support from the United States'Centers for Disease Control and Prevention (CDC), an Agency of the Department of Health and Human Services, under the Cooperative Agreement Number U50/CCU021856 on Global Health Promotion and Health Education Initiatives. The ideas expressed in the articles are those of the authors and do not necessarily represent those of the CDC and the IUHPE.

Community health promotion is of strategic significance in contemporary health systems. The overarching context of this stems from the inability of most countries with mixed health systems to deliver health as a public good; this coupled with the emerging role of the market in health and resource constraints at the social sector level, particularly in the developing countries, necessitate a visible role of the communities in health promotion in order to achieve the equity objective in health. However, in contrast to its significance, community health promotion remains a poorly understood concept, which makes it difficult to advocate it to policy makers. These considerations therefore led the Global Consortium on Community Heath Promotion, after its creation in 2003 as a collaborative initiative of the US Centers for Disease Control and Prevention (CDC) and the International Union for Health Promotion and Education (IUHPE) to focus on bringing clarity to concepts and norms as a starting point for the scope of its work; and it is within this context, and as a step in this direction, that this special issue has built further on the Statement of the Consortium (Nishtar et al., 2006).

The issue covers many aspects of community health promotion from the elaboration of its interface with the principles of equity and considerations of population health to spot-lighting a series of case-studies to enable a better understanding of what community health promotion involves and how participatory empowering methodologies can be used to harness community assets and why. In addition, the issue also features articles of practical relevance with respect to assisting countries and practitioners to examine whether their general activities in specific projects meet current standards of good community health promotion practice, and providing guidance on participatory evaluation.

The Consortium's Statement on which this issue further builds, defines community health promotion as a *participatory empowering equity focused process – one that regards community participation as being essential to every stage of health promoting actions as well as one that leverages community assets and knowledge to create the necessary conditions for health*. However, as outlined by Rice in this issue (2007; p.), not all health promoting policies and actions conform to this definition. The author uses lessons learnt from the application of participatory evaluation methodologies to Healthy Municipalities, Cities and Communities (HMC) Initiatives in selected countries of the Americas to highlight the point showing that most HMC initiatives had not appropriately taken into account key health promotion principles, such as intersectoral collaboration and community participation. The article by Baum delves deeper into the issue enabling an understanding of the implications of not doing so by referring to the Ottawa Charter-galvanised health promoting policies and actions in Australia (2007; p.); these have led to a significant impact at the population level across a range of health outcomes, but have remained unsuccessful in addressing inequities and reducing the existing gradients. Such experiences underscore the need to design health promotion policies and actions with a strong equity lens, and it is here that the need to combine top-down political commitment and policy action with bottom-up action from communities and civil society groups referred to by Baum in her article as the 'Nutcracker effect for health equity', assumes importance.

Understanding the role of the communities is therefore critical to health promotion. Within this context, a number of case studies have been featured in this special issue from diverse developing country backgrounds to showcase relevant approaches. Each study used a structured format to highlight both the intervention as well as the lessons that can be extrapolated from the experience for wider application. Weaknesses in their design and evaluation methodologies notwithstanding, the case studies yield important process-related lessons.

Firstly, the collective message emphasises the importance of understanding the entire process of community project management and its instruments. Foremost is the need to engage all development actors in a locally-suited participatory model for planning and governance; these include local government bodies, NGOs, international development partners, formally established community organizations, local leadership and inter-community federations. Participatory governance with a role, both for the public sector as well as the communities is relevant not only to the sustainability of grass roots initiatives, but also enables transferring successful social technologies to other settings and the adoption and integration of programmes as public policies.

Secondly, the case studies bring to the forefront many considerations that should be taken into account while structuring community initiatives; these include garnering participation and ownership at all steps; ensuring that voices are heard; fostering a sense of cohesion; ensuring that lessons learnt are factored into decision making; allowing for flexibility with program design so that it can be shaped by locally relevant evidence as it emerges during the course of interventions; encouraging self-management and social control; using culturally appropriate and locally validated tools of intervention and paying due attention to the empowerment of women in decision-making. These are regarded as being important to the sustainability of grass roots interventions in general. More specifically, however, these also enable overcoming religious, cultural and ancestral barriers to accessing healthcare as is shown by the case study from the Solomon Islands (MacLaren & Kekeubata, 2007; p.); in addition, they can also assist in fostering the empowerment of the most isolated and difficult to access groups, as is shown by the example of the forest peoples, or the *'caboclos'*, in Brazil who live in rural, often isolated and difficult to access areas of the Amazon (Scannavino & Anastácio, 2007; p.).

Thirdly, most examples highlight the need for intersectoral action within the larger framework of social sector development rather than within the domain of healthcare. Examples of health interven-

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tions cited herein have garnered support from across various sectors such as housing, education, youth services, and food security agencies rather than conventional health systems to improve health outcomes. A local perspective within an intersectoral scope can also flag locally specific opportunities for health promotion; for example, the case history from Orissa shows that disaster proneness is one of the strongest determinants of death and disability in the cited region of India; the predictability of disaster in this area therefore warrants institutional capacity strengthening for relief and rehabilitation operations rather than the traditional public health interventions (Mukhopadhyay, 2007; p.).

And *finally* the case studies allude to the potential value of networking both globally in terms of promoting values of equity and social justice in health by facilitating sharing of experiences across countries, as in the case of EQUINET (Loewenson, 2007; p.) as well as enhancing peoples'power over their health and well-being in local community settings as was shown for the 'Graniators'in Australia (Sullivan et al. p.).

The articles featured herein yield useful lessons for fostering community health promotion. Evidence of the effectiveness of such initiatives underscores the need to move beyond pilot and demonstration projects to mainstream the participation and role of communities for improving health across a range of outcomes (IUHPE, 2000). This necessitates a range of complex interdependent actions and requires going beyond increasing the voice of communities and frontline health workers to strengthening the social policy fabric, shaping social welfare and health financing arrangements and moulding the regulatory environment within country settings. Within the health sector, this also necessitates a number of other overarching measures, such as, redistributing health budgets from tertiary care to prevention and health promotion, and addressing budgetary and health personnel deployment imbalances in favour of rural, informal urban and primary care infrastructure and services. Existing and evolving public health programmes present an opportunity, where prevention, control and health promotion can be integrated as was shown for the non-communicable diseases initiative in Pakistan (Ronis & Nishtar, 2007; p.).

However, sustainable engagement of communities in mainstream healthcare is most feasible in countries with systems of governance which involve decentralization of administrative and political power to the lowest administrative units, such as municipalities. These structures have institutional mandate and responsibility for engaging communities and channeling inputs by development actors to local development plans. The local government perspective can also enable the tying in of health interventions to over-arching development goals, cross-linking these with initiatives for livelihood support, education, savings and credit, given that these are critical to the process of development in general at the grass roots level.

Spurring action at a social sector level within countries along these lines is a prerogative of state institutions; however, multilateral development initiatives such as the WHO's Commission on the Social Determinants of Health can provide an impetus particularly through WHO's leverage in more than 190 countries to encourage governments to make public policy choices organized around the active participation and involvement of communities as outlined in these approaches. A strong state and public sector in health is important to improve population health equitably – both by delivering public good as well as regulating the private market and the role of communities can be critical to the success of both.

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Reducing social inequalities in health: public health, community health or health promotion?

Valéry Ridde[1]

Abstract: While the Consortium on'Community Health Promotion'is suggesting a definition of this new concept to qualify health practices, this article questions the relevance of introducing such a concept since no one has yet succeeded in really differentiating the three existing processes: public health, community health, and health promotion. Based on a literature review and an analysis of the range of practices, these three concepts can be distinguished in terms of their processes and their goals. Public health and community health share a common objective, to improve the health of the population. In order to achieve this objective, public health uses a technocratic process whereas community health uses a participatory one. Health promotion, on the other hand, aims to reduce social inequalities in health through an empowerment process. However, this is only a theoretical definition since, in practice, health promotion professionals tend to easily forget this objective. Three arguments should incite health promoters to become the leading voices in the fight against social inequalities in health. The first two arguments are based on the ineffectiveness of the approaches that characterize public health and community health, which focus on the health system and health education, to reduce social inequalities in health. The third argument in favour of health promotion is more political in nature because there is not sufficient evidence of its effectiveness since the work in this area is relatively recent. Those responsible for health promotion must engage in planning to reduce social inequalities in health and must ensure they have the means to assess the effectiveness of any actions taken. (*Promotion & Education,* 2007, (2): pp)

Key words: social inequalities in health, public health, community health, health promotion, definition

Key Points

- **Health promotion's objective to reduce health inequalities and the process of empowerment distinguish it from public health and community health.**
- **Health promotion professionals must engage in planning to reduce social inequalities in health and ensure they have the means to assess their effectiveness.**

There has been much debate around the definition of health practices. Some authors have referred to vague and fluctuating definitions (Gagnon & Bergeron, 1999, p. 257), whereas others have managed to turn this controversy into a research area in and of itself (Fassin, 2000a). According to Bourdieu (2001), it is perfectly normal for scientists working in the same field of knowledge to be in perpetual disagreement. Traditionally, a dichotomy persists in expert opinion discourse between public health and community health, with the former being considered older than the latter. Health promotion emerged more recently, carrying a formal status since 1986. Additionally, three expressions are commonly employed to describe health interventions: public health, community health, and health promotion.

Upon being invited to contribute to this special issue on community health promotion, the author's immediate reactions were two-fold. First of all, there was a desire to discover how the Consortium managed to define this new concept. The answer can be found at the beginning of this issue, although the communiqué issued by the Consortium at the beginning of 2006 (Nishtar et al., 2006) still leaves one perplexed[i], and makes the present article all the more pertinent. Secondly, the author questioned the relevance of introducing a new definition for health interventions, since no one has yet really succeeded in defining the three processes that already exist. Introducing a new concept without having ever really succeeded in clarifying older ones puts us at risk of being subjected to critics'accusations, branded as 'windbags' (Fassin, 2000a, p.71). It can also lead to more confusion than clarification, as was the case in Canada when the term 'population health'first appeared. The objective of this article is, therefore, to attempt to differentiate the three types of health practices generally encountered in the literature and in the field, in order to situate the term 'community health promotion'and demonstrate that health promotion must take the lead in the fight against social inequalities in health.

An attempt to differentiate practicies:

Following the example of Rootman et al. (2001), it was considered useful when attempting to establish definitions to distinguish between the process and the goal of a practice. Examples drawn from the author's personal experiences and knowledge of Canadian, French, and African practices are used to support the arguments presented here.

End Goal:

Public health and community health generally share a common goal: improving the health status of people, taken as a group and not individually. Many examples could be given of public policies from around the world that share this objective. Curiously, and since it is rare enough to merit specific attention, the first health policy of Quebec

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Table 1. **Attempt to differentiate public health, community health, and health promotion**

	Process	End Goal
Public health	Technocratic	Improve population health
Community health	Participatory	
Health promotion	Empowerment	Reduce social inequalities in health

Source: Author

had a similar goal; however, it was framed negatively: the policy proposed 19 objectives to *"reduce health problems"* (Ministère de la santé et des services sociaux, 1992). This was later revised based on national public health priorities to *"make substantial gains in health matters"* (Ministère de la Santé et des Services sociaux, 1997), which serves as a reminder of the debate on the 'positive' versus the 'negative' definitions of the concept of health.

The definition traditionally found in public health training manuals follows Winslow's proposal from 1920 and defines public health as the art and science of promoting health, preventing disease and prolonging life (Fournier, 2003). This article, however, advocates a definition that goes beyond the famous three 'Ps'and focuses more on process than on the goals of promotion, prevention and protection, which were the foundation of public health priorities in Quebec from 1997 to 2002. Thus, more in-depth reflection on the teleological level is needed in order to understand the ultimate purpose of health promotion activities. A real paradigm shift is boldly proposed by affirming that health promotion seeks not only to improve the health of the population, but above all to reduce the gaps in the health status among population subgroups. Indeed, the Ottawa Charter states that, *"Health promotion focuses on achieving equity in health. Health promotion action aims at reducing differences in current health status"* (OMS, 1986). This paradigm shift also makes it possible to differentiate health promotion from previous endeavours to establish definitions, since Conill and O'Neill (1984) proposed the objective of community health to be the *improvement in the health status of the population*, making no mention of social inequalities in health. This distinction seems essential, since most interventions that do not specifically aim at reducing disparities almost always end up aggravating them, even when the goal of improving the health of the population is achieved (Fassin, 2000b, p. 33). This was the case for the residents of Montreal (Lessard, 2003). Adopting this definition means questioning beliefs, which are a central notion in the Khunian concept of a paradigm. Health promotion is thus conceived as an undertaking whose ultimate purpose is social change. If a new *'new public health'* (Horton, 1998) needs to be created in order to achieve this, then so be it. Perhaps this may not be necessary, as will be explained below, since the Ottawa Charter of the *new public health* already contains the objective of reducing inequalities.

Process:

In contrast to the view of Conill and O'Neill (1984) who believe that community health can have two poles, one technocratic and the other participative, the author maintains that these two poles actually constitute the distinction between the implementation process in public health and the one in community health. The process of implementing public health interventions seems to correspond to a technocratic top-down approach. If public health stakeholders agree with their counterparts in community health on, for example, encouraging individuals to change their lifestyles or behaviour, the former will use more coercion than the latter in attempting to achieve this change. Terms such as 'risk factor'and its corollary 'victim blaming'(Lupton, 1995) are characteristic of public health, where the health system, health education and prevention are the biggest budget recipients. In France, the history of public health (Abenhaim, 2003), as well as the quarrels about the creation of the National Institute for Prevention and Health Education (INPES), and the recent legislation in 2004 on public health, are all very indicative of this approach, which is centred on prevention and the health care system, and is run by a centralized or decentralized administration. Epidemiology and an evidence-based approach are the cardinal tools of public health, with physicians occupying a central place in the system. There are some authors who directly refer to the work of Weber and even maintain that the only authority really known to public health is rational-legal, based on law (Jaffré & Olivier de Sardan, 1999, p. 364). Regardless of whether this is representative of the history of public health, Fassin's analysis (2006) of the "double model of constraint and normalization, authoritarian control and moralizing intervention» in South Africa is the technocratic process paragon since «on many occasions public health has served the racist political project of South African authorities" (p.211). In Africa, health promotion is a relatively unknown concept (Nyamwaya, 2005); public health has the monopoly on words and practices for numerous reasons which would take too long to explain here (Ridde & Seck, 2006).

Community health practitioners, on the other hand, place population participation at the centre of their interventions and the emic point of view is supported. Certain health centres in the United States were pioneers in community medicine practices in North America in the 1960s (Lefkowitz, 2007), as were those of social medicine in certain health centres in South Africa in the 1940s (Fassin, 2006). There is recognition of the relationships between certain individual practices and the triggering of particular pathologies. At the same time, emphasis is placed on understanding the social and structural conditions that can give rise to such practices. Members of the community participate in defining the problem, finding solutions and implementing them. Epidemiology and statistical tools are not ignored, but they are not the only methods used, and the epistemological approach is more constructivist. Planning models using this triangulation of methods (Green & Kreuter, 1999), such as the model applied in Quebec from 1980-90 (Bergeron & Gagnon, 1994), and the one in Belgium (Bantuelle et al., 1998), are good examples of the community health process.

Health promotion interventions are based directly on the approach outlined in the Ottawa Charter. Actors thus attempt to implement a process that provides populations with the means to ensure greater control over and improve their own health (OMS, 1986). This is the concept of 'empowerment', which is a guiding value in health promotion but will not be discussed here for reasons of space[ii]. Empowerment actions and interventions appear to produce highly effective results in health improvement (Wallerstein, 2006). Evidently, this approach has its critics; in Lupton's view (Lupton, 1995, p.60), the rhetoric of empowerment serves to obscure public health professionals'investment and interventions by persuading certain groups to develop their competencies and exercise control over their lives.

The attempt to differentiate these three types of practice is summarized in Table 1-again, this is only an attempt. The distinctions must not be perceived as being set in stone and these characteristics are only highlighted *a priori* in order to force the

Table 2. **Inequalities in the use of the health system and mortality in Manitoba, Canada**

Indicators	1986	1996
Number of days in hospital	1.40	1.38
Admission rate to hospital	1.31	1.32
Mortality rate from all causes	1.21	1.42
Pre-mature mortality rate	1.39	1.85

Source: Adapted from Ross et al. (2005)

traits necessary for creating a Weberian ideal type.

Health promotion must address social inequalities in health[3]

In 1988, the Director General of the WHO was already concerned that, *"public health has lost its original link to social justice, social change and social reform"* (Hancock, Labonte et al., 1999). Twenty years later, this fact remains the same. Furthermore, health promotion must recover its original role and challenge social inequalities in health. Stakeholders need to understand that health planning is not simply a technical exercise, but can also be a tool for bringing about social change. This responsibility for action and advocacy must be entrusted to those in the field of health promotion. Besides the fact that public health practice, which is several centuries old, has not been able to eliminate the inequalities in health[4] that persist to this day (Mackenbach, 2005) – and which have been measured statistically ever since the 17th Century – three arguments, among others, may be used to support this case. The first two arguments are based on the ineffectiveness of the approaches that characterize public health and community health, i.e. actions generally centred on the health system and health education, for which effects are now well-known. The last argument in favour of health promotion is more political in nature since there is not yet sufficient evidence of its effectiveness, due to the fact that work in this area is very recent (Hills, Carroll et al., 2004).

The Health System:

For a very long time, and even today, people have believed that the health system is able to improve the health of the population and reduce disparities in mortality rates among sub-groups. The former French Minister of Health thought that the duty of public health basically involved nothing more than modernizing the organization of health services (Mattei, 2002). Section 2 of the Public Health Act, promulgated in France in 2004, states that the reduction of inequalities in health may be achieved through health promotion and by developing access to care and to diagnostics throughout the country, which no doubt explains why 97% of the health budget is allocated to the care system (Abenhaim, 2003). Budget allocation is not any better in Quebec. The expression 'health promotion'only appears in French legislation twice: in the above-mentioned section and as a reminder of the mission of the INPES; the latter mention, however, has not resulted in the word 'prevention'being replaced by'promotion'in the name of this public entity. According to French researchers, health policy essentially views the reduction of social inequalities in health in France from the angle of primary access to care (Pascal, Abbey-Huguenin et al., 2006, p.118).

Nevertheless, numerous studies have shown that if the health system and medicine can have an effect on the health of *individuals needing care*, they have no or very little effect on *population health.* Due to lack of space, this subject cannot be developed here, but readers are referred to the classic references on the topic (McKinlay & McKinlay, 1977; Ashton et Seymour, 1988). Furthermore, the health system and medicine can also have harmful effects on the health of individuals. In France alone, it is estimated that 18,000 people die each year from the side effects of medication (Abenhaim, 2003). In the United States, medical errors cause 98,000 deaths annually (Institute of Medicine, 2000).

Given the limited evidence of the health system's effects on the population, what evidence is there that the system reduces social inequalities in health? Although work on this topic is rare, recent research carried out in the province of Manitoba in Canada sheds some light on the subject. As is the case elsewhere in Canada, the health system in Manitoba is largely funded and administered by the public sector. A study on the data of the hospital use from 1986 to 1996 seems to show an equitable health system usage since the poorest, who *a priori* have the greatest needs, spent 40% more days in hospital and represented 30% more of hospital admissions than the richest. This difference in use, which favoured the poorest, remained constant over a period of ten years. However, examining the disparities in mortality rates for this same period shows that, not only does the situation remain unfavourable for the poorest, but the gap has widened to their detriment (Table 2). In other words, although health system usage has been equitable (in terms of need, rare evidence contradicts the «inverse care law»), social inequalities in health have not been reduced. There was also evidence that a 40% reduction in hospital beds has had no effect on population mortality indicators.

Health Education:

The second argument concerns the impossibility for health education alone to successfully reduce social inequalities in health. Raising this issue is especially crucial for France and the United States, where health education continues to play a dominant role in overall health strategies (O'Neill & Stirling, 2007). Developing interventions that reduce inequalities in health would be no mean feat, and it could even be claimed that this would constitute a logical contradiction. Rose (1985) explains the importance for prevention activities to target the population as a whole rather than just high-risk groups. He maintains that when a risk factor is normally distributed in a population, reducing its influence will bring about greater change in the general health status of the population than if interventions are solely directed at high-risk groups. Conversely, to complicate matters even further, it is a known fact that when interventions targeting harmful health behaviours are directed at the population as a whole, these interventions appear to have a much greater impact on the most favoured social groups (Whitehead, 1995), thus contributing to increasing inequalities. Some specialists transpose Rose's propositions to social inequalities in health (Douglas & Scott-Samuel, 2001; Marmot, 2001). For these experts, the determinants of individual differences are dissimilar from the determinants of disparities among population sub-groups. Targeting interventions to increase average life expectancy or to reduce disparities therefore remains tricky. Based largely on English research findings, Paquet and Tellier (2003) affirm that, even if the whole population adopted healthy lifestyle habits, overall life expectancy would increase, but the health gradient among social classes would still persist. In summary, on the one hand, in order for health education to be effective, it is better to act on the population as a whole in order to improve overall population health; this, however, carries the risk of increasing inequalities. On the other hand, interventions targeted directly at individuals or certain sub-groups, rather than at the overall population, can provoke increased feelings

of exclusion and there are high risks of stigmatization.

Health Promotion:

The third argument for reducing social inequalities in health through health promotion is more political in nature than the two preceding arguments. The argument is inextricably linked to the commitment of stakeholders working in the field of health promotion. The ineffectiveness of public health and community health in reducing disparities in health can be partly explained by the fact that neither one has been willing to take up this challenge, whereas the new public health has boasted of its novel approach in taking all health determinants into consideration. Fassin argues about the existing difficulty getting beyond the rhetoric and refers somewhat harshly to windbags who do nothing (2000). According to Gepkens and Gunning-Schepers (1996), interventions which were meant to reduce inequalities in health tended to be based more on the traditional and reductionist approaches of health education than on newer proposals of holistic action based on the five pillars of health promotion. Now, almost twenty years later, health promotion must reclaim its original role and become a catalyst for raising questions about the permanence and invisibility of social inequalities in health, at least in France, claims Drulhe (2000). It appears that this moral and ethical necessity is not yet really being taken seriously (De Koninck & Fassin, 2004; Ridde, 2004a, 2004b; Bernier, 2006). This would explain why public health and community health still take precedence over health promotion, as is evidenced by the call for experts of the French Public Health High Commission, which excludes specialists in health promotion.

Why should health promotion bear the burden of redressing inequalities in health instead of public health or community health? Simply because the field of health promotion has judiciously ensured that it has a charter which includes this objective, whereas the other two fields do not. In the 1978 Declaration of Alma-Ata, inequalities in health were formally acknowledged, but their reduction was not an essential objective: *"Attainment of the highest possible level of health"* (Section 1) was affirmed, but not the reduction of inequalities in health (WHO, 1978). In contrast, the Ottawa Charter affirms that, *"Health promotion action aims at reducing differences in current health status"* (OMS, 1986). This requires implementation of a process of equity and social justice, one of the six principles underlying health promotion initiatives (Rootman, Goodstadt et al., 2001). One of the documents produced by WHO Europe, as part of the preliminary reflections on the Ottawa Charter, clearly stipulates that reducing inequalities is an integral objective of health promotion. A European task force recently studied the question of health promotion interventions that are effective in reducing health inequalities, taking for granted that this is the role of health promotion (VIG & ENHPA, 2001).

Attributing this role to health promotion appears to correspond to its mandate of social change and strengthening citizen power to take action on the determinants of health, especially when it is conceded that health inequalities are the result of social and political structures. However, this does not mean that health promotion *activities* must *all* be held responsible for reducing disparities in health; that is not an easy task. Through advocacy and the capacity to influence healthy public policy, health promotion must take leadership to advance equity in health.

Conclusion:

This attempt at differentiating the three types of practice serves to underline the vital role of health promotion in reducing social inequalities in health through the cardinal value of social justice and the use of empowerment as a fundamental process. From a practical point of view, this means that questions need to be raised in two areas. Firstly, health promotion planners must now examine the objectives they set to ensure these objectives are not aimed only at improving the overall health of the population. At best, this only replicates inequalities and, at worst, it exacerbates them. Secondly, once the objective has been reviewed and the actions initiated, there is a need to gather and evaluate the evidence of their effectiveness in reducing social inequalities in health; this will in result open new theoretical, conceptual, and practical fields of work (Ridde, Delormier et al., 2007).

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Lessons learned from the application of a participatory evaluation methodology to Healthy Municipalities, Cities and Communities Initiatives in selected countries of the Americas

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Abstract: Health promotion has made significant strides in the past few decades in the Americas. Creating a healthy and supportive setting, also known as the settings approach, continues to be one of the most widely used health promotion strategies. Interest in evaluating the effectiveness of these strategies has been increasing greatly in the past few years. Participatory evaluation holds great promise for helping to generate this evidence and promote understanding of the factors that affect, positively or negatively, the advances of health promotion in the Region. During 2004-2006, a Participatory Evaluation methodology was introduced into several countries in the Americas through formal trainings conducted by the Pan American Health Organization (PAHO) in collaboration with country partners. This article summarizes the main lessons learned from the application of the participatory evaluation methodology in various countries in Latin America and the Caribbean. Factors affecting the evaluation of the initiatives were identified at multiple levels (individuals, community, organizational, political, economic, etc.). Specific issues that were addressed included the political context, turnover of personnel in key institutions, concerns related to the effectiveness of participatory processes, and the existence of strong and sustained leadership at the country level. These factors are intertwined and affect each other in very complex ways, a fact that was reflected in the municipalities'experiences with participatory evaluation. Challenges included the ability to secure resources for the evaluation, the time needed to conclude the process, and working in an intersectoral manner. However, participating municipalities reported that the process of implementing a participatory evaluation and working with various stakeholders had an empowering effect: communities and stakeholders were more willing and interested in participating in health promotion initiatives in a sustained manner; alliances and intersectoral collaboration were strengthened; communication channels were opened; and municipalities were stimulated to review their planning and implementation processes in order to more appropriately incorporate health promotion principles. The article concludes with recommendations to improve the planning and implementation process of participatory evaluation efforts. (*Promotion & Education,* 2007, (2): pp)

Key words: health promotion, healthy municipalities, communities, participatory evaluation

Résumé en français à la page #. Resumen en español en la página #.

The First International Conference on Health Promotion in Ottawa, Canada, in 1986 produced what has since become known as the Ottawa Charter for Health Promotion (PAHO/WHO, 1986). Since then the health promotion strategy is accepted and utilized as a central element in community development processes. As a result, in the last 3 decades, governments and international organizations have significantly increased their investments in health promotion programs.

The concept of health promotion has shifted from a focus on disease prevention in the 1970s, to the recognition of the need for complementary interventions (such as healthy public policies), to incorporate other sectors, and to create healthy environments in the 1980s and 90s. In the past few years, the concept of health promotion has broadened to include the determinants of health, global movements of social change and the need to invest and strengthen leadership in health promotion.

Health promotion today focuses on addressing the multiple determinants of health. These determinants are both within individuals'control (such as personal practices and behaviors and accessing services), as well as outside it (such as physical and social environments, education, income and social status, housing, access to food, social support networks, and working conditions, etc.). These determinants do not act in isolation of each other, but rather interact in very complex ways.

Creating a healthy and supportive setting, also known as the settings approach, continues to be one of the most widely used health promotion strategies. The healthy settings approach is based on the premises that determinants of poverty and equity, and their influence on health, can be addressed through creating sustainable public policies and laws, developing supportive environments, building public-private partnerships, strengthening networks, mobilizing means of communication, and promoting an active role of municipal and local governments in health promotion and development.

The Healthy Municipalities, Cities and Communities (HMC) Strategy

The HMC movement is an example of the application of health promotion principles at the local level. The Pan American Health Organization (PAHO) developed and introduced the HMC Strategy in the 1990s to improve and promote local health and development in the countries of the Americas. This Strategy is being actively implemented in 17 of the 38 countries of the Americas.

An HMC is one that ensures continuous improvements in the conditions that affect the health and wellbeing of its members. This is achieved by facilitating joint action among local authorities, community members and key stakeholders towards improving their living conditions and quality of life. More than just addressing the consequences of disease, the HMC Strategy focuses on the determinants of health, and supports the processes that enable community members to take control over their own health and quality of life, and to participate in the development of an HMC (PAHO, 2002).

HMC is based on the premises that (1) various systems and structures governing social, economic, civil and political conditions, as well as physical environments, can impact individuals' and communities' health; and that (2) health is inherently linked to individuals'capacity to act in the community and society to which they

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belong. HMC strives to create a synergy between two premises: promoting individual actions and societies that respond supportively. The ultimate goal is to support processes that enable people to take control over their own health while improving equity, social participation, accountability and responsive local governance.

Evaluating Healthy Municipalities, Cities and Communities (HMC) Strategy

The evaluation of health promotion strategies such as HMC has been recognized by the international community as necessary in order to strengthen the capacity of institutions and communities to promote measures that are coherent with the needs and priorities of the population. Thanks to the HMC Strategy, countries of the Americas have gained considerable experience with innovative ways of translating health promotion into local action. However, there is little documentation about these experiences and even less about the results achieved.

Health promotion strategies, such as HMC, generate real benefits for people and their environment. It is of particular importance to be able to show these benefits to decision-makers so that they will be willing and motivated to set aside resources to support health promotion programs and activities. The evaluation offers many opportunities to create and disseminate evidence that demonstrates strengths, weaknesses, consequences, and impacts resulting from the development and implementation of these strategies.

The evaluation of these initiatives will also provide stakeholders with the opportunity to better know their community and its resources, and to reflect on the progress of their efforts. This will, in turn, support better design and management of health promotion initiatives in the context of community health resources, as well as create accountability related to what has been proposed and redirect efforts when needed. Given the intersectoral and interdisciplinary nature of health promotion, it is also expected that the evaluation process will create opportunities for collaboration among sectors, improve multidisciplinary dialogue and strengthen participatory efforts within HMCs.

The participatory evaluation of HMC initiatives

In very simple terms, evaluation means collection, analysis, interpretation and reporting of information, and using the results for decision-making. Like health promotion, in the past few decades, the concept of evaluation has also greatly evolved. The goal of evaluating health promotion strategies shifted from the evaluation and monitoring of projects and interventions, to more complex, thematic and interdisciplinary evaluations.

The implementation of health promotion programs highlighted the need for more flexible and participatory evaluations; ones that reflected health promotion principles as well as the complexity of local development and participatory experiences. This new approach required multiple measures and methods in order to evaluate changes in areas such as governance, social participation, social impact, equity, sustainability, etc.

Instead of judging the success or failure of an intervention or a project, this new approach focused on understanding local realities and on continuous learning. Evaluation, hence, shifted from something done by «outsiders» to a collaborative and participatory endeavor.

It is in this context that the concept of participatory evaluation develops. In a participatory evaluation, the key stakeholders are involved in all phases of the process, including the design, implementation, management, interpretation, and decision-making about the evaluation and its results. A participatory evaluation implies more than the application of participatory techniques to conventional approaches and methodologies for monitoring and evaluation. It requires:

- Participation of key stakeholders on all phases of the process.
- Negotiation and consensus about what to evaluate and how results will be interpreted and utilized.
- Continuous learning that results in capacity building and incorporation of lessons learned in the decision-making process.
- Flexibility to adapt to a continuously changing environment.

Participatory evaluation is considered to be the most appropriate methodology in the context of HMC initiatives because it reflects the principles of the HMC strategy, recognizes the complexities of HMC as a local development initiative, and facilitates the development of capacities, learning and empowerment. As such, participatory evaluation stimulates autonomy and community self-determination as it allows communities to improve their ability to resolve their own problems (PAHO, 2006).

It is expected that the implementation of a participatory evaluation will create opportunities and give voice to a broader range of stakeholders, encouraging them to take ownership of the evaluation process. When conducted in a truly participatory manner, this type of evaluation promotes accountability and motivates continuous and active participation from all stakeholders. Processes that are based on the commitment and dedication of all stakeholders are likely to create a sense of common interest among those involved and to produce positive changes in their community.

However, the participatory evaluation methodology presents some challenges. As with most collaborative and participatory endeavors, participatory evaluation can be time-consuming, since the process requires bringing together and building consensus among people from various backgrounds, sectors, institutions and groups, that often bring to the table different, if not conflicting, needs, agendas and interests. This emphasizes a need to clarify roles, responsibilities and the evaluation objectives and processes. The participatory evaluation also requires leadership from people with strong facilitation skills as well as people with openness to collaborate, to listen and to take into consideration their colleagues' perspectives, needs and interests. Because it is an open and flexible process, participatory evaluation has no predetermined plan. As a result, this approach may be perceived as less effective and objective and can be unsettling to those who are used to working with traditional evaluation settings.

PAHO's participatory evaluation initiative

In 1999, PAHO established a Healthy Municipalities Evaluation Working Group, comprised of evaluation experts from various international institutions. The Working Group agreed that specific evaluation tools, frameworks and evidence of effectiveness were needed to support health promotion and similar initiatives. Building upon these recommendations, the Evaluation Working Group has developed a series of evaluation tools, among them, a *Participatory Evaluation Guide for Healthy Municipalities, Cities and Communities.*

The Guide provides recommendations on evaluation processes and tools, as well as a mechanism to showcase and document the rich, extensive, and varied experiences and results related to the HMC Strategy. It offers an evaluation framework that incorporates essential HMC and health promotion elements such as intersectoral collaboration, social participation, capacity building, community capacity, among others. The methodology allows for the documentation and analysis of changes and accomplishments in terms of process, outcomes and results, and guides users on how to act on the results to improve their HMC initiative.

During 2004-2006, the Participatory Evaluation Guide was introduced into several

countries in the Americas through formal trainings conducted by PAHO in collaboration with country partners. Participants in these trainings included staff from the Ministry of Health (MOH) and other key ministries (such as education) at the national as well as state levels; representatives from NGOs, universities, and funding agencies; health workers; municipal staff and authorities; community organizations and members. Following the trainings, several communities in various countries of the Americas applied the participatory evaluation methodology to their HMC initiatives. Follow-up questionnaires were sent to workshop participants every 4 months during 2005-2006 to collect information about the activities taking place as a result of the training received. During this period, countries also submitted reports to PAHO and/or published their experiences with the application of the participatory evaluation methodology.

Lessons learned from the application of the Participatory Evaluation Methodology

This section presents the main lessons learned from the application of the participatory evaluation methodology in Brazil, Dominican Republic, Honduras, Mexico, Peru and Trinidad and Tobago. This information was compiled from reports submitted by the countries to PAHO and from the follow-up questionnaires completed by workshop participants.

1. Take into account the political context and timing

Given the strong emphasis of initiatives such as HMC on the active involvement of local authorities and the public sector, the political context and timing was by far the most important factor affecting the implementation of participatory evaluation in the participating countries. Election periods and political transitions often caused major delays (if not termination) of initiatives, shortage/change of personnel and funds, and great uncertainty about the future of the initiatives, and their evaluation.

In Honduras, for example, plans to conduct participatory evaluations that were incorporated into the municipalities'strategic plans for 2006, were suspended after the local elections and the political changes that took place in that year. Many of the people spearheading the process were removed from their posts. Workshops in the participatory evaluation methodology in municipalities were also suspended due to administrative problems in State Health Secretariats caused by this political transition and the turnover of key personnel.

The political timing of the application of the Participatory Evaluation Guide in the Campinas Region of the State of São Paulo, Brazil, was also reported as «sensitive», since it occurred right before elections. This generated uncertainty about who would still be present to follow-up on the initiatives, or even if initiatives would be continued (Sperandio et al. 2006).

The experience in the Dominican Republic underscores this difficulty. Even though plans were in place to conduct the participatory evaluation in 10 municipalities during 2006, local elections took place resulting in significant changes of municipal authorities and staff. As a result, efforts had to be redirected to introduce and seek support for the HMC initiative and the participatory evaluation from the newly elected and re-elected officials.

These moments of political/administrative transitions can have considerable impact on the work being conducted at the community level. It causes delays and losses (including financial) since the time necessary to explain and get agreement on the continuation of programs can be lengthy. This has consequences for the evaluation of programs under implementation, but especially for programs conducted by previous administration that do not continue under the new one.

These experiences demonstrate that the transitory nature of local and national political contexts can weaken programs and public policies, particularly when there is a change in political parties. This emphasizes the need to form a strong coalition among all sectors of society to strengthen and sustain the HMC initiative and their evaluation (Sperandio et al, 2006). Having a strong and broad base of support can provide continuity and sustainability to HMC initiatives and their evaluation during these transitional periods.

2. Aim for a truly intersectorial process

Incorporating a variety of local partners (MOH, NGOs, universities, community members and community-based organizations, etc.) was important for the sustainability of the HMC initiative and its participatory evaluation in the countries. It is crucial, however, to get buy-in from the main stakeholders in order to begin and sustain the implementation of the participatory evaluation methodology. Lack of support from critical stakeholders, such as municipal program managers or key personnel at public institutions can seriously deter or isolate the advancement of the initiative.

In the experience of Vila Paciencia, in the State of Rio de Janeiro, Brazil, it was difficult to coordinate the activities with the public sector, due to the communities'«historical social isolation and lack of citizenship rights», which was marked by «structural oppression and violence.» (Becker et al., 2006). As a result, it was not possible to include a representative from the public sector in the evaluation process, given its demonstrated lack of interest in the community. In addition, a weak community organization could not ensure that the community had a voice and, as a result, formal participation from the community association was weak. Even though this did not impede the conduct of the participatory evaluation by other stakeholders involved in the community (NGOs, universities, etc.), it kept the process isolated from the broader community context since it was unclear whether the evaluation results and conclusions would be taken into consideration by all relevant stakeholders.

However, as the Vila Paciencia experience reported, the implementation of a participatory evaluation methodology forced the group to confront these difficulties and to reflect on possible courses of action: «the participatory evaluation's emphasis on intersectorial collaboration contributed greatly to understanding local politics and the role of different actors (public, private, community, etc.), thereby providing a reference for discussions and decision-making.» (Becker et al, 2006)

Upon realizing the above, the group decided to create a new intersectoral group focused on the construction of a new community kitchen. The new group includes representatives from the local public sector (municipal education and social development, state's social assistance), as well as community members. The weak community participation also required concerted efforts focused on the process of getting the community organized. The new actors have demonstrated interest in participating in the evaluation process. It is expected that working on the evaluation will help to strengthen the work of the new intersectoral group and favor the sustainability of the Vila Paciencia initiative (Becker et al, 2006).

3. Conducting a participatory evaluation takes time, but it is worth it

All countries reported that the participatory evaluation process was lengthy and time consuming due to various factors. It is necessary to bring together and guarantee the buy-in from people from various backgrounds, sectors and interests. These people bring to the table different perspectives and paradigms. They often come from institutions and organizations with rigid and bureaucratic structures and work cultures.

As it happens in processes that emphasize community and multi-sector participation, the various levels of knowledge and lit-

eracy among those involved have to be taken into account. Experiences in Brazil, Peru, Dominican Republic and Trinidad and Tobago all noticed that different levels of education among the community leaders was a challenge to implementing the evaluation.

It is important to recognize the time needed for institutions, organizations and individuals to adapt and accept a new methodology and paradigm that can greatly change how they function and work, such as a participatory evaluation. In many cases, given the appropriate time and stimulation, people become motivated and apply dedicated efforts to implementing these new programs and methodologies.

For example, the participatory methodology was new to most of the health secretariats of the participating municipalities. This often generated an internal movement across public institutions to discuss the new concepts and assess degree of agreement among staff in order to incorporate the new methodology into existing programs, with particular emphasis on intersectorial collaboration and guaranteeing social participation in actions and decision-making processes. This is a slow process as it needs to take place through meetings, forums and discussion groups, and requires linking various levels of administration, breaking existing paradigms, and dealing with individual and collective resistance (Sperandio, 2006).

Respecting the time needed to achieve this acceptance in public institutions and among their staff was critical in order to put in place programs that were consistent with the communities'expectations, making optimal use of resources, adopting approaches that were more consistent with health promotion practices, and improving personal motivation among public staff and other stakeholders.

This initial process also served as an opportunity to strengthen alliances and trust among participants and their institutions (for example, municipal managers, representatives from the community and NGOs). As reported by the experience of communities in the Northeast of Brazil, these new alliances "encouraged an innovative way to promote local empowerment and equity." (De Sá et al., 2006)

Since preparing for and using participatory processes takes time in order to work effectively and even longer to demonstrate results, often, due to political pressures and impending changes in government, countries will bring in evaluators external to the community to conduct an outside and non-participatory evaluation. Although this produces useful information and results, it does not have the same empowering and long-lasting impact of the more participatory processes. It also does not guarantee that the information collected and analyzed and the lessons learned will be shared with the community.

4. Set aside resources for the evaluation

Lack of sufficient resources have in many cases limited or interrupted the participatory evaluation process. The allocation of scarce community resources to conduct a participatory evaluation was a common problem. This was often the result of a general lack of understanding about the effectiveness and the usefulness of the results generated on the part of program managers and others responsible for funding and budget.

This underscores the importance of continuously educating and raising awareness of the importance of health promotion in promoting equity and better health for all, and the need to establish adequate funding and structures for its evaluation. This includes the need to educate stakeholders on the benefits and the appropriateness of participatory evaluation in producing key information for decision-making at all levels.

Analysis of previous international experience supports the allocation of a minimum of 10% of total program resources to ensure the development and implementation of evaluation in health promotion (PAHO, 2005). It is important to advocate for the establishment of a fund for health promotion evaluation from the initial planning stages of any initiative (PAHO, 2005).

5. Reach consensus on the definition of key concept

It was common for the participating countries and the stakeholders to report a general lack of understanding about the concept of health promotion (often considered an approach to disease prevention) and the participatory evaluation methodology. This can have a direct impact on the planning of the evaluation since how people understand key concepts will shape the design, data collection, analysis and presentation of results of the evaluation.

There were also doubts about the benefits of conducting a participatory evaluation, mostly related to the time it takes to conduct the process and the usefulness of the data it will produce. As a result, it was not uncommon to face resistance by those in key institutions in applying a participatory evaluation methodology that, as they understood it, did not emphasize results and project evaluation.

It is important to address these concerns and take into account the challenges faced by stakeholders coming from institutions with rigid and bureaucratic structures, that very often do not have a policy to coordinate with other institutions or to work in an intersectorial manner, and who are often unwilling to share information.

6. Address concerns related to participatory processes

Concerns about working with the community also came up in some instances, often in the form of fears of receiving negative comments about and prejudice against actions taken with "too much" input from community members. Representatives from public sectors in some cases were apprehensive that the process would generate "unrealistic demands" on the part of community members or negative criticisms. This was particularly true of communities that were not well represented, in which, traditionally, programs and approaches were implemented from the top-down and truly representative and participatory mechanisms for community participation were scarce or non-existent. Often efforts had to be re-directed at organizing the community, and raising awareness about the real meaning of "participation" among the stakeholders.

7. Institutional context and individual factors

Working with institutions with rigid and bureaucratic structures was also reported as a major challenge for those engaged in conducting a participatory evaluation. Main complaints included lack of institutional support or excessive bureaucracy, lack of coordination among public sector institutions, strict guidelines regarding the use of funds, and conflicts between the different actors involved (federal, state, municipal).

Personal and professional interests, low technical capacity of personnel, and concerns that participatory evaluation would only lead to a heavier workload that would not necessarily translate into «benefits» for their immediate work also affected people's interest in investing in the process.

Of all challenges, the high turnover of personnel at all levels and institutions was by far the most disruptive and difficult to deal with since it could seriously impair the continuity, feedback and appropriate application of the participatory methodology. Brazil, Peru, Mexico and Trinidad and Tobago all indicated the difficulties faced when changes took place of key personnel (particularly within the Ministry of Health) involved with the health promotion initiatives and their evaluation. Public sector personnel are frequently transferred to another State or unit/program within their institutions and it is often the case that in

their new posts they are no longer in a position to follow through with the initiatives for which they were previously responsible.

In Trinidad and Tobago, for example, a series of training workshops in participatory evaluation were planned for MOH/ Regional Health Authorities staff and community members but had to be postponed due to limitations caused by institutional changes. This activity is suspended until further notice, until other national counterparts are assigned by the MOH. Changes in key personnel were also responsible for the cancellation of participatory evaluation workshops in Honduras.

On the positive side of working with institutions, the experience in Peru reported that the process of participatory evaluation has opened channels of communication with other levels and sectors providing valuable inputs into the annual evaluation of the Ministry of Health. This has resulted in an improved organizational climate and opened a space for exploring new modes of intersectoral collaboration (Red de Municipios Saludables del Peru, 2004).

Working with institutions also offers the opportunity to regularize processes and methodologies within their work plans, programs, etc. Given institutions' far-reaching structure and linkages with other groups and institutions, this has the potential to promote and support the implementation of health promotion activities, its evaluation and the allocation of resources for these priorities. Another example is that of the San Marco University, a public institution in Lima, Peru. The participatory evaluation methodology was incorporated into the curriculum of their health promotion certificate program, which provides the opportunity to build capacities and increase technical knowledge among professionals working in the field.

8. Strong leadership is central to the sustainability of the evaluation initiative

A common determinant of successful experiences with the participatory evaluation in the countries was the existence of strong, sustained and dynamic leadership to take the process forward. Active commitment and engagement from institutions both at the local and national levels is key to the success of the initiative, as is collaborative work among these institutions.

The role of national and regional HMC networks can be central in these efforts, giving their potential far-reaching connections to municipalities throughout a country or region, as well as their connection with key stakeholders that can support the evaluation process. Gaining the support and working through national and regional HMC networks greatly supported the advancement and sustainability of the evaluation initiative in countries such as Brazil and Peru. In Peru, the AMARES Project, a program supported by the European Union, the Peruvian Network of Healthy Municipalities and 7 regional Peruvian networks are collaboratively developing a database of baseline data which, in turn is generating a great deal of baseline data that will be critical to support evaluation efforts in the future.

9. Conducting a participatory evaluation can be an empowering process by itself

There was an empowering effect of applying a participatory methodology – communities and stakeholders were more willing and interested in participating and maintaining this participation. The process of planning and implementing a participatory evaluation provided a very rich opportunity to discuss, exchange and reflect on countries' experiences with the HMC Strategy.

Most countries reported that these planning discussions brought to light the various interpretations that participants gave to health promotion concepts and principles. Participants quickly realized the implications of these differences for the planning and implementation of the evaluation methodology and the importance of reaching consensus among the group members. This resulted in a productive and positive dialogue among participants to reach consensus on the various concepts and principles utilized in their evaluation processes.

This process also stimulated participants to take into account different aspects of health promotion that had been overlooked in previous evaluation efforts. This brought up a "difficulty" since many realized that their HMC programs were not taking into account some of the health promotion principles (for example, programs were not intersectoral). This is stimulating many municipalities to review their planning and implementation processes in order to more appropriately incorporate health promotion principles.

Conclusions

Health promotion has made significant strides in the past few decades in the Americas. Interest in evaluating its effectiveness has been increasing greatly in the past few years. Participatory evaluation holds great promise for helping to generate this evidence and promote understanding of the factors that affect, positively or negatively, the advances of health promotion in the Region.

The experiences described in this article highlight some of the various challenges posed by the complex and multidimensional local and national contexts in which the participatory evaluation is introduced. Factors affecting the success of evaluation initiatives were identified at all levels of reality (individuals, community, organizational, political, economic, etc.). It is also important to take into account that these factors are intertwined and affect each other in very complex ways. This was reflected in the municipalities' experiences in applying the participatory evaluation.

Even though the development of the Participatory Evaluation Guide happened as a direct response to requests from countries implementing the HMC Strategy, once the methodology was made available and was applied in such initiatives, the majority of countries realized they «were not ready» to implement such an innovative approach to evaluation. This was mainly due to their realization that their HMC and health promotion programs and initiatives had not appropriately taken into account key health promotion principles (such as intersectorial collaboration or community participation).

This was an important contribution that the application of the participatory evaluation made to these initiatives: it shed light on the gaps in their efforts and forced those involved to confront the problems and reflect on how to address them. As a result, the majority of community groups and institutions involved in this initiative perceived the need to re-examine and thereby reorient their planning and implementation processes in order to effectively apply the participatory evaluation methodology in the future. Thus, engaging in the participatory evaluation process has served as a catalyst to generate intersectoral and participatory processes essential to the development of HMC initiatives.

All countries involved in this evaluation initiative reported that the process of engaging in participatory evaluation was highly motivating and revitalizing, concretely allowing those involved to evaluate their actions more consistently, stimulating interest in the issue of evaluation and in-depth reflection on activities. The experience strengthened capacities among those involved, generated commitment to promote health promotion principles, strengthened alliances among key stakeholders, and emphasized the potential of the participatory evaluation as a decision-making tool. These experiences demonstrate that supporting the implementation of participatory evaluation initiatives has the potential to contribute to the advancement of health promotion in the countries of the Americas.

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Aparajita Orissa

Alok Mukhopadhyay[1]

Abstract: Following the 1999 cyclone, which devastated important areas in the state of Orissa, India, the Voluntary Health Association of India (VHAI) established *Aparajita* as the long-term aid and reconstruction programme. Aparajita aims at empowering the local community and building their capacity to recover from devastation and prepare for future natural disasters. The programme operates in three main areas of the state: Jagatsinghpur, Kendrapara and Puri. After an assessment study of the damage and the communities'socio-economic and health status, *Aparajita* focused its interventions on livelihood support, infrastructure development, capacity building, savings and credit, and health interventions. This programme has served to establish the basis of a disaster management process, which includes two main components, preparedness and relief. Given the number of natural adversities in India, there is a need to both empower the communities in the management process, as well as influence government to support and institutionalise initiatives like Aparajita. (*Promotion & Education,* 2007, (2): pp)

Key words: capacity building, disaster management, India

Who we are?

Aparajita can be described as a civil society response to the devastating cyclone in Orissa, India, which occurred on October 29, 1999, and completely shattered the rhythm of people's lives. More than 15 million people in 10 districts of Orissa were said to be affected with around a million houses damaged. The aftermath not only revealed the extent of damages in terms of material and human loss but also the inadequacies of individuals, communities and administration vis-a-vis disaster preparedness. A number of individuals and institutions came together under aegis of the Voluntary Health Association of India (VHAI) to provide relief to the cyclone affected people of Orissa. VHAI did not have disaster relief or mitigation in its original mandate, but to turn its back on people's misery and distress was not an acceptable option. Hence VHAI's response to the tragedy was instantaneous and spontaneous.

After three initial weeks of emergency relief and medical assistance by VHAI, *Aparajita* came into being as VHAI's response to the perceived need of long term rehabilitation.

The word «Aparajita» means the woman with the indomitable spirit. It aptly describes the unconquerable spirit of the people who have survived the calamity.

What do we want to achieve?

The main thrust of the rehabilitation has been to strengthen the capacity of the affected community and to minimize their vulnerability to future emergencies.

VHAI recognizes the intrinsic connection between disasters and development. The disaster traumatically brought to focus all the basic problems of the region. The cyclone reduced all issues to their fundamental level and highlighted the inherent weaknesses of the coastal areas of Orissa, i.e. poverty, underdevelopment and poor disaster preparedness.

What are we doing?

After providing the basic relief, the teams stayed on in the affected areas to make an assessment of the needs of the people and identify key partners for long term relief and rehabilitation work. It was decided to focus operations in 3 blocks, in Jagatsinghpur, Kendrapara and Puri districts.

How are we doing it?

Micro-planning exercises, complete damage assessment and vulnerability mapping were done in the target areas to appraise and determine the needs of the community.

Aparajita initially started with three blocks with 15 gram panchayats[1] (G.Ps) which later on expanded to 79 G.Ps in June 2001. The main areas of intervention were:

- ***Livelihood support*** – Cash for work programmes, kitchen garden and agricultural support; fisher folk and post harvest support and artisan rehabilitation, such as, providing raw materials, tools, training and economic support to vulnerable women artisans for micro-enterprise such as pottery and bamboo basket making, mat and palm leaf weaving, handlooms.
- ***Infrastructure Development***—restoration and renovation of individual housing, repair of village infrastructure, including schools, roads, community buildings etc.
- ***Capacity Building***—training of trainers, training of health workers, training of traditional birth attendants and training relevant to treatment in camps.
- ***Savings and credit***— support to self help groups in dry fish, lime production, mat weaving, bamboo crafts, basket making and vegetable growing.
- ***Health Interventions***—first aid and curative health services for common ailments, safe drinking water and sanitation, awareness generation on preventive health aspects, care of pregnant and nursing mothers and referral linkages.

Right from the outset, the main thrust of the programme was to include the community perspective in the development and implementation of the program; this enabled community ownership of the program and contributed to its sustainability With the help of micro planning and baseline survey, the target areas were assessed, beneficiaries were identified, groups and marketing linkages were formed and with community participation, activities and interventions were planned and carried out systematically.

Project implementation was assisted by a number of committees:

- *Project Coordination Committee*
- *Village Committees*
- *Advisory Committee*
- *Technical Support Committee*

Due to timely and effective implementation of the programme, various health and development interventions, starting from 1999 till date, have been carried out successfully; these are outlined in Table 1.

Aparajita activities were monitored centrally as well as at the field level. Once a month direct monitoring by VHAI's Chief Executive and his team was done through visits to the operational blocks followed by regular staff meetings where team findings, achievements and constraints were discussed and inputs were provided. The core team members undertook Field monitoring through field visits at least once a week to each of the field offices and respective villages. Field officers also send their reports on a regular basis. A field office was set up

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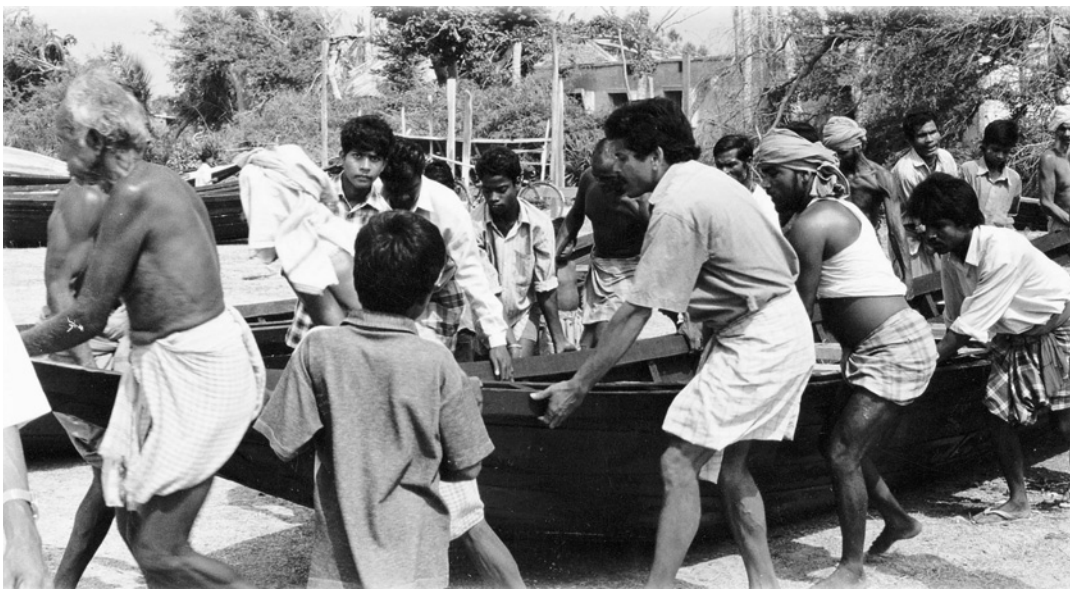


Local population working together on reconctruction efforts following the cyclone in Orissa

in Bhubaneshwar, which is the State Capital. Setting up the field office there facilitated interaction at various levels.

What are we learning?

The super cyclone sparked many questions for introspection in terms of disaster management. Disaster preparedness and relief are two separate components of the disaster management process, i.e. mitigation, preparedness, response and recovery. While disaster preparedness highlights a continuous planning process and focuses on general principals; disaster response operates with certain end objectives in mind that emerge from the situation resulting from actual realization of the disaster.

Good disaster management must recognize correctly the difference between agent and response-generated needs and demands. There are problems created by the disaster itself, and others generated by the effort of organizing a response. In Orissa's case many agencies ended up with unorganized relief activities. Doling out free materials even when the immediate need was gone and providing much more than the minimum wages prescribed by the government crippled people's initiative to stand on their own. VHAI from the very beginning considered immediate and humanitarian relief as an interim phase. VHAI did not use very special or extremely qualified professionals. It did not provide huge amount of resources. Consequently the training is now sustainable with some inputs from the government and some from community and some from us.

How will we know we are making a difference?

India faces a number of disasters every year; a concerted effort to gather evidence from these unfortunate events and the subsequent processes, could enable the country to develop an insight into disaster management, which could then be used to build institutional capacity. For example, in the cases of cyclone-prone areas, the simplest measure for disaster preparedness can include the construction of cyclone shelters for storing safe drinking water and other essential lifesavers and measures can be taken to make housing cyclone-resistant. Such measures can assist with reducing suffering, morbidity and mortality. However, as opposed to this, disasters fade rapidly from public memory and the Diaspora of expertise is uncoordinated with no institutional linkage. There is an urgent need to take existing evidence into account and institutionalize experiences; the Orissa project can be useful in gaining policy insights into community health promotion in a particular disaster setting, from which lessons should be extrapolated.

1. Gram Panchayats are local government bodies at the village level in India. A ram Panchayat can be set in villages with a population of more than five hundred.

Table 1. **Health and development interventions 1999 to date.**

Name of block	**Astarang**	**Mahakalpara**	**Erasama**	**Total**
Activities	**No.of beneficiaries**	**No.of beneficiaries**	**No.of beneficiaries**	**No.of beneficiaries**
Livelihood Support				
Kitchen Garden	2230	2400	3760	8390
Individual Support	106	205	100	511
Boats and Nets	425	1255	580	2260
Infrastructural Development				
School Renovated	5	5	6	16
House Renovated	109	305	188	602
Pond Desilting,Desalination	11	2	12	25
No. of book banks	48	12	24	84
Capacity Building				
TBA Training	20	24	15	59
Training of health worker	64	25	23	112
Training of Woman Group, Literacy etc	160	28	42	230
Total No. of People Supported	17,752	10,614	18,455	46821

Shehjar Khoj

Alok Mukhopadhyay[1]

Abstract: Turmoil and conflict whether social or political in nature, affects every constituent of the society. No social fabric is strong enough to resist the undercurrents and dissatisfaction manifested violently or otherwise. The conflict in Kashmir is one such phenomenon. Realizing the need for effective health interventions in Kashmir, the Voluntary Health Association of India (VHAI) started Shehjar Khoj project in 1999. The project, among other, aims at promoting social justice and equity in the provision of health services and improvement of the health status for all, with emphasis on the less privileged. The project currently operates in four districts and has implemented numerous interventions, which involved training, motivating and encouraging active participation of the community, including village opinion makers and health workers. Understanding people's cultural and ideological beliefs has been a critical factor in enabling the development of locally suited programmes, and therefore the project's success. (*Promotion & Education,* 2007, (2): pp)

Key words: conflict, capacity building, India

Résumé en français à la page #. Resumen en español en la página #.

Who we are?

Shehjar Khoj is a project established by the Voluntary Health Association of India in Kashmir since 1999 with the aim of improving health interventions. When turmoil and conflict began in Kashmir, there was a collective numbness to respond, generated by fear and unpredictability. Turmoil and conflict of any type and of any kind - social or political - affects every constituent of the society. No social fabric is strong enough to resist the undercurrents of conflict; the resultant issues manifest themselves in many ways ranging from dissatisfaction to violence.

It was envisaged that the situation in Kashmir would gradually lead to poorer health outcomes particularly with state's reluctance in enhancing the public medical facilities in the far off and remote areas and streamlining the functioning of this sector.[1] It was within this context that *Shehjar Khoj* developed a response to this growing crisis. The word *Khoj* stands for «Quest» or «Search»; Prefixed to Khoj, the word *Shehjar* means «Shade». *It aims to define the «Shade of Health Awareness and Health Facilities» that Khoj project strives to provide to the people of Kashmir against the scorching heat of poverty, negligence and disease.*

What do we want to achieve?

Shehjar Khoj has the following aims and objectives:

- Promotion of social justice, equality and human rights in the provision and distribution of health services for all, with an emphasis on the less privileged.
- Strengthening people's health movement in the state.
- Advocating congenial policies and programmes, aimed at improving the health status and quality of life of the people.

What are we doing?

In order to develop and achieve the ambitious aims and objectives of the programme, the following strategies are implemented:

- Initiating innovative grass root level sustainable health and development.
- Taking action in some of the least developed pockets of the state.
- Capacity building of voluntary agencies through non-formal orientation training and awareness building programmes.
- Influencing policies and programmes for a cost-effective, preventive, promotional and economically sustainable health care system in the state.

How are we doing it?

District Budgam was chosen as the first area of operation. In consultation with the district administration, five villages of Tehsil Chadoora with a population of over 9,000 were identified. Work commenced in these districts in 1999 by training local dais (traditional birth attendants) and educating girls in community health, hygiene and sanitation. Inspired by the success of *Shehjar project, another project Shadab was started in Wakharwan, a cluster of villages in Pulwama district* over 2000-01.By September 2004, project activities were extended to another five villages of Khan Sahib Block of Budgam district under the banner of *Khoj Project.*

The following activities were conducted in preparation for the interventions:

- Meeting district administration, health and education personnel to discuss plans and activities, areas of operation, and modes of implementation.
- Establishment of Village Development Committees (VDCs) constituted by reputable local villagers in order to enhance the role of stakeholders in community programmes, thus enhancing the acceptability of programs.
- Identification of Village Health Workers (VHWs) and leveraging their potential to disseminate health information and deliver certain health care services.
- Conducting baseline surveys[2] to ascertain existing socio-economic conditions and health status in selected villages. The survey revealed that there was a serious lack of health facilities with no antenatal and post-natal arrangements, poor sanitation, low literacy rates[3] and a special need for mental health programmes.

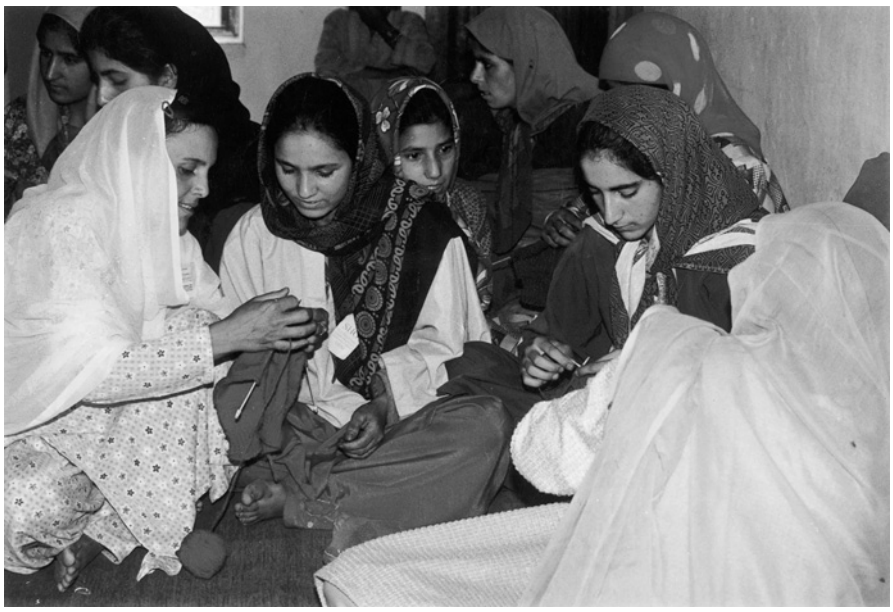
Subsequently, the following interventions were implemented:

- Building capacity of traditional birth attendants (TBAs) in modern methods and techniques of delivery and reproductive health; distribution of *Dai's kit*[4] to conduct safe deliveries and the establishment of a monthly training and review programme at Shehjar OPD clinic.
- Providing health services via house-to-house visits, setting up of outpatient facilities and sub-centers. Shehjar introduced the yellow prescription card for its outdoor patients; the card is widely recognized by all the hospitals in the valley and allows patients access for referral.
- Organising mass health camps for providing free treatment and medicines to patients with trained VHWs, TBAs and supervisors assigned to monitor each patient for follow up.
- Organising Self Help Groups (SHGs) for families involved in arts and crafts through income generation and assisting with the establishment of Thrift and Credit societies[5], which facilitate the dissemination of health care information.
- Expert counseling, monitoring and treatment facilities for people with mental and psychological problems.

1. Chief Executive Officer, Voluntary Health Association of India. Correspondence to: vhai@vsnl.com

Notwithstanding the turmoil and the subsequent devastation caused by the October 8, 2005 earthquake, several steps have been taken to ensure sustainability of the project.

VHAI in collaboration with State Voluntary Health Associations (SVHAs) through a Project Advisory committee has been involved in this project at several levels - conceptualizing, monitoring and training. The Programme Coordinator is mandated with overall planning, monitoring and implementation at the village level; the Medical officer is made incharge of health services and capacity building of field staff; and the Supervisor guides grass root level workers like VHWs, TBAs and volunteers in the implementation and monitoring processes. An award in honor of ***Sonjoy Gose*** –well-known social activist who died in Assam– was conferred by the Government of India to *Shehjar Khoj* project in recognition of its efforts.



Training village women in Kashmir through the Shehjar Khoj project

What are we learning?

During the turmoil, men became the victims of their male identity, as a result of the direct association with their counterparts in the struggle. The woman suffered foremost, on the pretext of their female identity as mothers, sisters or wives; suffering the emotional and financial repercussions of the phenomenon. In such situation of fear and turbulence the first casualty is always loss of trust and community spirit. In order to achieve its aims and objectives, every programme has had to build rapport and deep understanding of community's psyche to fill up its wounds and provide culturally appropriate responses.

How will we know we are making a difference?

Shehjar Khoj firmly stands on the concept of community motivation through the creation of a "chain" of ever increasing volunteers from the grass-root level. In Kashmir, *Shehjar Khoj* has overcome the orthodox and conservative attitudes of people, while it managed the sociopolitical conflict, which had created «ideologically opposite groups» amongst the population. The team spirit, community motivation and participation garnered by the project are the key to its success to improve access to health and the health status of the population, which needs to be maintained by the project in the future. However over the long term, it is also imperative to sustain, improvise and expand the project targets and areas of operation.

Table 1. **Shehjar Khoj Project District Budgam**

Project activities	Beneficiaries covered 2000-05	Beneficiaries covered 2005-06	Total 2000-06
No. of patients examined and treated	10,927	1729	12656
No. of ANCs examined and treated	923	129	1052
No of ANCs (high risk) cases referred	112	15	127
Immunization of Children	2642	723	3365
Village meetings for health awareness	232	60	292
Health Education Training for VHWs\TBAs	521	57	578
No. of SHGs formed	14	14	28
Children treated in School Health Programme	1317	648	1965
Total	16,688	3375	20,063

Annexure 1. **Baseline Data (1999-2000) Findings**

Name of the village	Literacy Rate			Sex Ratio (per 1000 male persons)
	Male	Female	Total	
Zoohama	62.23	35.20	49.01	958
Dadompora	46.40	24.54	36.04	901
Hanjoora	65.32	37.73	51.90	947
Surayar	42.18	23.11	32.92	844
Nowhar	43.23	19.35	32.11	880

1. Editorial in The Greater Kashmir, June 13, 2001.
2. *Baseline Survey was conducted in 5 villages of Shehjar Project by the project team comprising of Traditional Birth Attendants and Village Health Workers (VHWs) to ascertain the existing health scenario for the reference year 1999-2000. Besides providing information about basic population and other vital statistics of the villages, the survey facilitated the project team in getting familiar with the villagers.*
3. See Annexure - 1
4. Dai's kit is used by Trained Birth Attendants in home delivery. The kit contains a soap piece, gauze piece, disposable gloves, sterilized razor blade (cord cutting instrument) and clean cord ties.
5. A cooperative society that makes loans to its members at low interest rates.

Reorienting Health Services through Community Health Promotion in Kwaio, Solomon Islands.

David MacLaren[1] and Esau Kekeubata[2]

Abstract: When ethnic minorities adhere to cultural practices which mark them as unique, structural impediments within health services can deny access and significantly add to the burden of disease. This is particularly pertinent if the development of health services is not done in partnership with all population groups in the area. This is the case at Atoifi Hospital, which structure prevents certain Kwaio people (Solomon Islands) from receiving benefits of hospital services and maintaining cultural beliefs at the same time. A Participatory Action Research process was used to collaboratively work with health service providers and community groups to review the situation, design and build a health facility with both medically and culturally appropriate policies and procedures. The Participatory Action Research process of collectively looking, thinking, planning and acting towards reorienting health services to become more culturally appropriate at Atoifi was the first time leaders, from both the community and hospital, had collectively sat together in a mutually respectful way to discuss community health promotion initiatives. The project was complete in 2006 with collaboration and dialogue between both groups proving vital to its success. Numerous indicators are present that the culturally appropriate health facility is making a difference, not only in terms of the hospital usage by all, but also for the feeling of "community ownership." (*Promotion & Education,* 2007, (2): pp)

Key words: dialogue, minority groups, participatory action research, culturally appropriate

Who are we?

The Kwaio people are one of the 12 language groups on the island of Malaita, Solomon Islands. This group is unique given that almost half of the ten thousand Kwaio people uphold traditional ways of life in the tropical rainforest clad mountains and retain customary religious beliefs and ancestral culture. This is in contrast to 95% of their fellow Solomon Islanders who have accepted Christianity. Health services in Kwaio were established in the 1950s and 1960s by the colonial government and Christian churches; these failed to incorporate local understanding or concepts of health in planning, policy or the delivery of curative or preventive services. Little changed for almost four decades. As a result, Kwaio people faced a stark choice when in need of health services – relinquish fundamental precepts of Kwaio culture and religion by accessing health services or remain true to Kwaio beliefs and stay away. Many continue to choose the latter.

This is of particular concern at Atoifi Hospital, established by a Christian Church in 1965 with no Kwaio participation in planning or policy development. Hospital services are delivered in a single building which includes a two-story section. Maternity services are delivered within the building. This causes problems for many Kwaio who consider the entire building a woman's area and taboo for men to enter. In addition, the two story section allows women to be physically above men – an anathema in Kwaio culture. Thus to enter the building contravenes fundamental precepts of Kwaio culture, causing the spirits of the ancestors to allow misfortune or illness to befall the individual or their family. The implication is not only for clinical curative services, but preventative services including antenatal services, immunization and other community health initiatives. Atoifi is one of the best equipped and most respected providers of health services in the Solomon Islands with people traveling from across the country to utilize the services it provides. The Kwaio do not experience the benefits of having arguably the most respected health service on their land. Because Atoifi is the primary provider of curative and preventative health services for Kwaio, the exclusion they face causes inequalities in health and creates antagonism between the community and Atoifi's service providers.

Since the establishment of Atoifi Hospital, Kwaio community leaders have wanted access to services at the hospital through means that do not cause cultural offence or require the relinquishment of ancestral values. However, because of the colonial and Christian paradigm, which has informed the attitude and practice of many of the hospital administrators and deemed Kwaio who retained ancestral culture and religion as 'backward', 'primitive'and 'heathen', requests were not taken seriously. In 2000 we (the two authors, a community health worker, born and raised in the Kwaio mountains, and the current chairman of the Kwaio *Fadanga*, i.e. the Kwaio Council of Chiefs, and an Australian public health researcher having worked with Atoifi and the Kwaio since 1992) worked with community groups to document a list of barriers faced by Kwaio wishing to access health services at Atoifi[1]. This was written in English, the language used by hospital administrators as most do not speak Kwaio language. The list was presented to administrators with a recommendation from the community that a facility be established at Atoifi Hospital specifically for Kwaio people unable to access mainstream services. Administrators agreed to pursue a facility on the hospital campus specifically for Kwaio unable to access mainstream services. In 2002, a Participatory Action Research process began, facilitated by the authors, with the community and hospital staff to collaboratively review the situation, design and build the facility and create relevant policy and procedures.

How are we doing it?

A group named the Atoifi Support Committee comprising community and hospital leaders was formed to discuss community health issues and plan for the future. The group acted as a conduit for information from the community to hospital leaders and from the hospital to community leaders. The culturally appropriate facility was conceptualized, designed and driven forward by members of the Atoifi Support Committee through 2002 with technical assistance provided by external agencies. The process of collectively conceptualizing, planning and implementing plans to develop a culturally appropriate health service at Atoifi was the first time leaders from both the community and hospital had collectively sat together in a mutually respectful way to discuss community health promotion initiatives for the future. A series of parallel meetings were facilitated by the authors with community groups and hospital staff to inform the planning process and provide feedback. This participatory process was respectful of all social, cultural and religious knowledge and responsive to new knowl-

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edge created through the process. This process was occurring through a particularly tumultuous time in Solomon Islands history. The years 1998-2003 saw civil unrest between the peoples of Malaita and Gudalcanal Islands known as the 'Ethnic Tension'. This included the overthrown of the democratically elected government in June 2000 by rebel elements of the Royal Solomon Islands Police and a militant group called the Malaita Eagle Force. This resulted in the crumbling of law and order and almost total collapse of government services, including health services. Being a non-government health service, Atoifi was one of the only hospitals in the country offering full services. In Early 2003 just months before the Pacific Islands Forum initiated the Regional Assistance Mission to Solomon Islands (RAMSI), a multinational force made up of Australian, New Zealand and Pacific Island military and police got involved to re-establish law and order and the machinery of government violence, which also affected Atoifi. In May 2003, the Australian business manager of the hospital was murdered. This caused most of the staff to flee the hospital campus, where most resided. This resulted in a near collapse of the organization and new projects, including the culturally appropriate health facility, were postponed until the situation stabilized.

Given the community engagement strategies used in the PAR process, the authors were requested and participated in the process to facilitate dialogue between church and hospital administrators and community groups to address the uncertain and volatile situation. In late 2004, after staff returned, a RAMSI police post was established at Atoifi and some stability returned and the process to establish the culturally appropriate facility was re-started. Plans were made and construction began in 2005. All building materials were either donated directly by community members or purchased from community contributions. Two buildings were constructed of local materials, one for the general community and one for women's services (including antenatal services). They were officially opened in June 2006. Both are now used by Kwaio without causing cultural offence or relinquishing religious beliefs.

What are we learning?

Numerous lessons have been learned through the Participatory Action Research Process, which resulted in culturally appropriate health services for the Kwaio at Atoifi Hospital. One of the key lessons was the importance of *participation*. It was only through participation and dialogue that hospital administration and community leaders had mutual understandings of important issues to each group. Prior to this project there was no process through which community leaders and hospital administration could engage in meaningful dialogue. The result of which was historical mistrust, suspicion, stereotyping and misinformed assumptions. Through the process of engaging in meaningful dialogue as equals working towards a common goal, both groups became aware of the social, cultural, spiritual and economic complexities the other faced in planning health services. Underpinning this participation was the importance of *flexibility*. To be flexible, both in terms of the approach adopted and the response to unexpected events allowed the project to continue through a dynamic and volatile period of history. Having the capacity to *deal with complexity* allowed all involved to acknowledge, respond, value and incorporate complex changes in the project rather than trying to 'control'them. This enabled the project to ultimately come to fruition. We learned that if the project was truly community owned and driven it would be able to adapt to complex and dynamic social, cultural, political, religious and economic situations. This required periodic halts in progress, but was critical to the project's long term successes. The role of the *researcher/facilitator being a catalyst* was also an invaluable lesson learned. Although this community health promotion project was run as a Participatory Action Research project in collaboration with an Australian public health researcher, the researcher always saw himself as a facilitator of the change process, rather than an external 'expert'directing the project. Researchers involved always strove for the process to be *with* and *by* persons, not *on* or *to* them. Being true to this process allowed the responsibility for the project's successes and sustainability to lie with the hospital and community, not the researcher/facilitator. A final major lesson learned throughout the project was the *importance of local leadership*. The reality of a culturally appropriate health facility would never have been realized without visionary leadership in the Kwaio Council of Chiefs. As community leaders they exemplified how oppressed peoples can articulate the situations of oppression in which they live and take actions to transform such oppressive situations.

How will we know we are making a difference?

Change at several levels show that the culturally appropriate health facility is indeed making a difference. Firstly, the Kwaio people are using the facility. Prior to the official opening in June 2006, a senior chief who was ill sought treatment at the facility. He was admitted there for several weeks. This was a powerful signal of support by senior community leadership and opened the way for others to use the facility after its official opening. Subsequently, there has been ongoing 'community ownership'and a feeling of having a facility that is *'in and of Kwaio'*on the hospital campus for the first time. An outcome of this strong feeling of ownership by the community is that relatives of people admitted there are staying for several days, often sleeping in the facility, as is normal in a village setting - of course, this brings a new set of challenges for hospital administrators. The construction of the facility has created a feeling of partnership and goodwill between the community and hospital leadership and has stimulated ongoing debate for the need to provide more culturally appropriate health services for all sectors of the community that address the social and cultural determinants of health for all. This includes the limitations of such initiatives and change in policy and practice that is needed to reorient health services. Given the strong medical, religious and cultural

paradigms present, this will be an ongoing challenge. A doctoral thesis has been produced that outlines the intricate historical, political, cultural and religious contexts in which health services operate in Kwaio and a detailed description and analysis of the Participatory Action Research process and outcomes[2]. This document is being used as a basis for further collaboration and evaluation of the facility by Atoifi Hospital, Kwaio Council of Chiefs and university collaborators. A final indicator of the difference being made by this community health promotion project is the numerous requests the authors have received to present the process, experiences and reflections at local, national and international forums.

1 MacLaren, D. (2000) Kastom and Health: A Study of Indigenous Concepts of Custom, Health and Appropriate Health Care within Kwaio, Malaita, Solomon Islands.
2 MacLaren, D. (2006) Culturally Appropriate Health Care in Kwaio, Solomon Islands. An Action Research Response. PhD thesis. Griffith University.

The Graniators support group program

Emily Sullivan[1], Ilse Blignault[1], Aunt Shirley Duncan[2] and Lisa Jackson Pulver[1].

Abstract: Aboriginal grandmothers (grannies) in many communities throughout Australia are considered the backbone of the social structure. This is the case for the Murri1 Granies in a town in regional eastern Australia. Many of these women are also their grandchildren's primary caregivers and disciplinarians, and sometimes this role is detrimental to their own care and well-being. As a response to this stress, the local Aboriginal Medical Service (AMS), which includes a comprehensive primary health care facility, began promoting the program Relax to the Max to the Grannies as part of the holistic care they offer. Since these humble beginnings some three years ago, the group has grown to become the Graniators support group. In addition to their initial work of supporting each other, the group extended their field of action to the entire community to address social issues, particularly those around youth and children. To complement and strengthen their initiative, the Graniators partnered with other organizations in the community including the police, the municipal council, and the state government's department of housing, the local primary school, and a special youth service group. The program's evaluation has proved to be extremely positive in providing others in the community a clear and positive formula for driving change at a grass roots level. (*Promotion & Education,* 2007, (2): pp)

Key words: Aboriginal grandmothers, youth, partnership

Résumé en français à la page #. Resumen en español en la página #.

Who are we?

Murri Grannies (Aboriginal grandmothers) in a regional town in northern New South Wales are considered the backbone of the community. Many find themselves in the role of primary caregiver and disciplinarian to their grandchildren and great grandchildren, meeting their physical, financial and social needs. This is on top of their need to care for themselves. Nevertheless, they take on the role willingly because they want their grandchildren to thrive and to reach their full potential. Not surprisingly, the Grannies'own needs are often neglected and they become stressed and anxious.

In early 2004, the Counselor at the local Aboriginal Medical Service (AMS) noticed that many of the Murri Grannies who came to see her suffered from stress and anxiety associated with their care-giving role. Others were distressed by the lack of respect that Murri kids in the community showed them as elders. The Counselor talked about this with Aunt[1] Shirley, the Aboriginal Mental Health Worker at the AMS and a Grannie herself. Together, they initiated an eight-week program for the Grannies called *Relax to the Max*. It involved relaxation sessions and discussion on how to care for themselves mentally, emotionally and spiritually, as well as including a bit of pampering, such as a visit to the hair salon. The program had an overwhelmingly positive response and together, the Grannies with the Counselor and Aunt Shirley decided to start a support group for themselves.

The name given to the Support Group, 'the Granitators', was chosen as it identified the strength and determination of the Grannies. Led by Aunt- Shirley, the group decided to meet once a fortnight for about four hours, on an ongoing basis, providing a support network and social outlet for about 25 Murri Grannies in the local area.

What de we want to achieve?

The initial aim of the Group was for the Grannies to support each other in addressing the daily issues they faced. As time went on, the Grannies realised they had a common desire in wanting to reach out and to do something about the problems affecting their grandchildren, families and community. In early 2005 the Grannies visited the 'Linking In' project in another regional town that ran activities to support young people in the community. This was a significant event as it provided them with the motivation and inspiration to expand their own focus. From this point, the Graniators'aim grew to include assisting the community to address social issues, particularly around youth.

What are we doing?

Every second Tuesday, the Grannies meet at a place organised by the AMS. Aunt Shirley sometimes organises guest speakers and at other times invites the Grannies to follow the *Relax to the Max* tape. This meeting provides the Grannies with time-out to relax away from the grandkids, and a chance to reminisce about the old days on the Christian mission station together. Building friendships and trust amongst the group has been an important aspect of the

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2. Mental Health Team, Pius X Aboriginal Medical Service, Moree, NSW, Australia.

meeting as it has enabled the Grannies to share their stories and problems with each other and they now feel comfortable turning to one another to both offer and receive advice and support.

As well as partnering with the AMS, the Graniators have established partnerships with several organizations in the community including the police, the municipal council, and the state government department of housing, the local primary school, and a special youth service group. With the support of these organisations, they hold the *Brekkie Club* every weekday for up to 30 school children where the Grannies take it in turn to prepare breakfast. Once a month the Grannies assist the local police with a movie night for the families of the community. In addition, the Grannies are often invited to contribute to community activities such as the *Croc Eisteddfod* and *Carols by Candlelight*.

What are we learning?

At the end of 2005 the Graniators'program was formally evaluated as part of a larger project to provide on-site training and capacity-building for AMS staff in service planning and evaluation. Aunt Shirley and the Grannies were involved in the evaluation of their own project and in compiling the community report[2].

The evaluation documented positive changes in both the Grannies themselves and in the community. The Grannies have gained strength and confidence and act as new role models for the community. Several informants commented on the way the Graniators are raising the spirit of the community.

Many people have benefited from the Graniators'work. For example, the Grannies have built friendships and mutual support within the group, and formed new and positive relationships with the police. Kids from the *Brekkie Club* not only have a nutritious meal in the morning and get to school, but also now know they have more then one Granny to love them.

Most importantly, the Grannies have new learnings such as:

- The importance of the friendship and bond between them in achieving success out in the community and to their continuing as a support group for each other.
- The value of taking small steps and working within their own limits.
- The usefulness of having frequent and regular meetings where they focus on their initial aim of supporting each other to avoid 'burn out.'
- The worth of building partnerships within and outside the Murri community in the town and working together to achieve shared goals.
- The fact that challenges can be overcome. In facing the challenges, they have learnt new skills such as networking, and have grown stronger.

How will we know we are making a difference?

Thinking and talking about the issues and reflecting on what others said about the Graniators allowed the Grannies to see more clearly where they come from, how things are going, and how they might work more effectively in the future. The Grannies are proud of them, and are keen to share their success with others.

1. MacLaren, D. (2000) Kastom and Health: A Study of Indigenous Concepts of Custom, Health and Appropriate Health Care within Kwaio, Malaita, Solomon Islands.
2. MacLaren, D. (2006) Culturally Appropriate Health Care in Kwaio, Solomon Islands. An Action Research Response. PhD thesis. Griffith University.

Current health promotion practices in communities – Latin America

Motuca healthy municipality project: building together a better future

Rosilda Mendes[1] and Fabio Falvo[2]

Abstract: The Brazilian Ministry of Health in collaboration with the Municipality of Motuca and the School of Public Health at the University of Sao Paulo set up in 2002 the Motuca Healthy Municipality project with the aim of improving the population's health and quality of life. The project used a participatory and holistic approach, which addressed the social determinants and structural inequities, and called for strategies of community empowerment, social participation, intersectoral networking and good governance. All local and public actors from rural and urban areas were consulted and participated in the project to collect information on the living conditions and challenges to better well-being. This participatory methodology allowed in turn developing cultural and socially appropriate initiatives to improve local governance and standards of living on a long-term basis. Although there is still the challenge to maintain the momentum and reenergize the efforts, the project serves as a model for further efforts to evaluate the effectiveness of participatory intervention and research methodologies to promote health and well-being in communities. (*Promotion & Education,* 2007, (2): pp)

Key words: participatory methodology, empowerment, health promotion

Who we are?

Motuca Healthy Municipality project was set up in 2002 for a total duration of three ears by the Ministry of Health in collaboration with the Municipality of Motuca and the School of Public Health, University of Sao Paulo. The main objective was to create a new managing system with a participatory approach to improve the quality of life of the population.

The municipality of Motuca is located in the Northwest part of São Paulo State, Brazil covering an area of 230 square kilometers with a total population of 3,872 inhabitants. According to the Brazilian Institute of Geography and Statistics (IBGE), the population increased by 12.47% during the period 1993-2000... Majority of the population (63%) lives in the urban areas, where social and commercial services are available and small industries exist. Four groups of settled-out landless people represent 37% of the population. This high population in the rural area is different from the rest of Brazil where, in general, usually only 18% of the population lives rurally. In the 1980's the regional government allotted ownership of government-owned land to these people, which is where they now grow sugar cane and other agricultural products.

1. CEPEDOC Healthy Municipalities, Faculty of Public Health, São Paolo University, São Paulo, Brazil
2. Secretary of Health, Motuca, São Paulo, Brazil

The economy of the municipality is based on a large local sugar cane processing plant. In the period between March and November each year the processing plant also employs 1440 local workers. Cultivation of oranges and the production of carnauba wax contribute to the local economy as well. Additionally, there is a factory which produces hand-woven carpets and rugs.

In terms of health, the main strategy for strengthening primary health care is the Health Family Program, which is run by the State of São Paulo in collaboration with the Federal Ministry of Health. The municipality provides other primary health care services in addition to this and takes responsibility for transporting patients in need for advanced care to a neighboring city - Araraquara, which is 40 kilometers away.

What did we want to achieve?

In its broadest definition, this project encompassed a holistic approach which addressed the social determinants and structural inequities, and called for strategies of community empowerment, social participation, intersectoral networking, and good governance. Through interactions between government and civic representatives, policies and social conditions, which promote good governance at a local level, were constructed. Technical and educational cooperation created an enabling environment in which all the participants focused on the needs of the future.

How did we do it?

Participatory governance strategies were created in order to involve different social actors. Initially, four workshops called *Oficinas de Sensibilização* - two in the urban area and two in the rural area- were conducted; based on these workshops, a collective vision for the city was developed: «our city nowadays» and «our city in the future». Collecting and analyzing the information from these groups allowed a better understanding of the potential for and barriers to local governance to improve the standard of living on a long term basis. Secondly, a *Healthy Municipality Committee was established with representation from* the professional community, decisions makers and community members. A participatory approach was used to integrate the local committee in order to create a common vision for the city and to involve the settled-out landless people, previously excluded from local policies.

Other methods included recognizing the historical context of the city. More than 500 historical photos were exhibited in a local community center; in addition, community thematic maps were created for the rural and urban areas, representing environmental, housing, economic, recreational, and public services aspects. Through these the broad dimensions of the city were elaborated. For instance, it enabled an understanding of distribution of illiteracy, which contrary to popular belief, was in the urban areas. Currently, the *Committee* is prioritizing problems and defining participatory evaluation.

What did we learn?

To-date, three Municipality Conferences have been held with the overall objective of presenting the process-related findings and other related information to the population, specifically, and to other cities in the region, in general.

This process has examined different interests and abilities that shape political agendas, and the possibility of creating alliances and networks to strengthen local governance to improve living conditions. The challenge now is to reenergize these efforts, to think through the problems together focusing on improving polices and institutions that better serve the needs and interests of the population. Empowerment of the groups can be considered the greatest lesson learned.

How do we know we can make difference?

This Project serves as a model for further efforts to evaluate methodologies in participatory intervention and research. Process and outcome data are necessary in order to establish the effectiveness of health promotion initiatives. The question of who conducts the evaluation is important. It must include all the social actors. Linking intervention in the planning, implementation and evaluation can be useful to contribute to the capacity to promote health and ensure continuation of the intervention. It means we have established a way to better understand the facilitators and barriers in the initiative, and to better plan for sustainability of efforts within changing political contexts.

Empowered women from rural areas of Bolivia promote community development

Roxana Ríos[1], Catón Olmedo[2], and Luis Fernández[3]

Abstract: The United States Agency for Development in Bolivia (USAID/Bolivia) created in 2002 PROSALUD- Partners for Development Project (PfD) with the aim of improving the population's well-being. The project used three components: small grant scheme, technical assistance and database system management. Through the small grants scheme, the PfD supported a Community Participation Strategy (CPS) project over a three year period. The project involved the rural areas of six Bolivian departments and sub urban areas of three Bolivian cities. The main objective was to increase health service utilization with a particular emphasis on empowerment of women, strengthening of local organizations and increasing the demand for health services. Women from both the urban and rural areas, and from different indigenous groups, were trained in project management, health promotion, reproductive health and family planning, advocacy and community participation. Participatory methodologies have allowed empowering women in decision making and capacity building throughout the entire project process. The experience shows that it is important to work with formally established grass-root community organizations and strengthen leadership within them. Additionally, the sub-projects demonstrated that interventions are more successful when promoters speak and write native languages, women are more motivated and empowered, projects are designed to be responsive to daily necessities identified by the communities and health services are culturally suitable. A preliminary evaluation, in both quantitative and qualitative terms, shows an overall improvement in health knowledge and practice, and utilization of health services. (*Promotion & Education,* 2007, (2): pp)

Key words: empowerment, participatory methodology, women

Résumé en français à la page #. Resumen en español en la página #.

What is this initiative about?

The United States Agency for International Development in Bolivia (USAID/Bolivia) created a Health Project in September 2002, with the overall aim of improving the health of the Bolivian population to be implemented by PROSALUD, a Bolivian NGO who is being working in the health sector since 1986. The project is entitled Partners for Development (PfD), which comprises three components: small grants, technical assistance, and management of data base systems. The small grants component was designed to benefit the public sector, NGO's and Grass-root Community Organizations through a competitive process.

In the beginning (2003), USAID/Bolivia through the Integral Health Project PROSIN, and since 2005 through the PfD via its small grants component, supported a Community Participation Strategy (CPS) project over a three year period (April 2003 – June 2006) in 35 municipalities as follows:

	Number of interventions	
Department	Rural Municipalities	Sub-urban
Beni	3	1
Chuquisaca	5	
La Paz	11	
Pando	1	1
Potosí	9	
Tarija	3	1

The project was led by a psychologist with expertise in working with communities and was implemented by 15 nurses. The project aims to increase health service utilization with a particular emphasis on empowerment of women, strengthening of local organizations and increasing the healthy practices and demand for health services. The total contribution to this project by USAID/PfD was US $ 280,000.

What is the approach used?

The Community Participation Strategy has been implemented in the first stage through 73 community based educational sub-projects including basic project managerial training to selected women, some office furniture and materials, basic kitchen tools for community based organizations and equipment for strengthening health services.

Each sub-project comprises two five-day workshops to train women health promoters as cascade trainers. Then, the health promoters replicate the knowledge in 19 sessions three hours each to the women in community workshops. The training is related to reproductive health and family planning in the following themes: contraception, pregnancy and delivery, sexual organs infections, women reproductive and sexual rights, self-esteem among others. Women from indigenous cultures, like Aymara[1], Quechua[2] and others were involved in this process.

As an output, 219 women from community based organizations have been trained in basic project management; another 1080 women have been trained as health promoters, which in cascade replicated what have learned to about 30,000 women of the communities who have received training in reproductive health and family planning (RH/FP).

In relation of the educative materials, the ones developed by the NGO ***"Manuela Ramos*** (Lima, Perú)**"** served as the tools of intervention for this project; these were adapted to the local setting and validated.

In the second stage, as three new sub-projects, the Community Participation Strategy trained the women health promoters, in different but related themes as a continuation of first stage, including leadership, negotiation, small projects management, advocacy, and community participation.

As another result, six active networks of women health promoters have been established as well as committees of sexual and reproductive rights defenders were established; these networks and committees gained insight into community needs, negotiated community requests with respective municipalities'governments and developed conjoint action plans for quality of health services improvement.

Success history: *The women health promoters'network of sub-urban area in Bermejo, Tarija (38,000 people municipality) negotiated with the local Municipal Government in November 2005, the young people orientation center implementation, which is giving today orientation in RH/PF in coordination with local health services. In average, every month*

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around 80 young people seek the services of the orientation center. In addition, women health promoters offer orientation in contraception and sexual/reproductive rights to the post delivery women at local hospital services.

After the project conclusion, the promoters of the CPS, are also raising funds from different donors for the implementation of new local development projects. This can be stated as another result like "local capacity built".

How are we doing this?

This project employs participatory methodologies for the empowerment of women in decision making and builds their capabilities in the whole project process: from problem analysis and identification to the design and implementation of local solutions. Specific areas of focus include: situational analysis, communities'selection for intervention, self diagnosis, project proposal elaboration, management and evaluation. This enables an understanding of the whole process of community project management and its instruments.

What are we learning?

Implementation of the project has enabled an understanding of community health promotion in a specific setting. The experience shows that it is important to work with formally established community based organizations and strengthen leadership within them. The results of such an intervention are directly proportional to the capacity of the promoters; however, better results can be gained if promoters speak and write native languages, when motivation amongst women is higher, when subprojects are designed to be responsive to day to day necessities identified by communities, when health services are culturally suitable and with the participation of Grass-root Community Organizations, particularly women have better relations in terms of negotiations with local authorities.

How do we know we are making the difference?

A quantitative, qualitative and cost related study to evaluate the effectiveness and empowerment of CPS was conducted in the 2005. Results of the qualitative component of the study showed an increase in ante natal care, PAP screening and family planning methods provision, and decrease in the gap between the health services and communities, having in mind the sexual and reproductive women rights. Results also showed that the local authorities were more likely to provide financial support to implement the process. In addition a visible change was observed in knowledge, attitude and practice of couples with respect to negotiating for and exercising human/reproductive rights.

The quantitative component of the evaluation yielded the following results:

Effectiveness average of 37%[3], with the following variables: 73.5% of the woman showed willingness to use RH services, 11% women accepted and used family planning methods (FP), 11.8% assisted ante natal care and delivery services, 27.6% reported gender equity relationships with their couples, and 55.8% reported gender and family relations without violence.

Empowerment average of 31.4% with the following variables: 50.9% realized healthy practices, 39% had knowledge about prevention of intra-family violence, 27.6% referred to improving communication with their couples; in addition, the demand for RH services have increased by 9.7% in relation to previous year (2004).

The average training cost in this project per woman was US $ 24.

Implications for broader application

The two phases of the CPS strategy include training (including the selection of project intervention areas), advocacy and local activities and consolidation; the latter also includes strategies to establish financial sustainability. Consolidation of the RH/FP component of the program also provides an opportunity to integrate other elements such as environmental interventions. The methodology has shown modest success in Bolivia and can be adapted to other settings, with careful attention to specific characteristics of each country such as cultural and working practices, health services accessibility, and the regulatory environment.

1. The **Aymara** are a native ethnic group in the Andes and Altiplano regions of South America; about 2.3 million live in Bolivia, Peru, Northern Chile, and Northeastern Argentina (in particular in Salta Province). They lived in the region for many centuries before becoming a subject people of the Inca, and later of the Spanish in the 16th century. (Wikipedia, free internet encyclopedia).
2. **Quechua** (Runa Simi; Kichwa in Ecuador) is a Native American language of South America. It was the language of the Inca Empire, and is today spoken in various dialects by some 10 million people (Quechuas) throughout South America, including Peru, South-western Bolivia, southern Colombia and Ecuador, north-western Argentina and northern Chile. It is the most widely spoken of all the languages of the Indigenous peoples of the Americas. (Wikipedia, free internet encyclopedia).
3. By means of Net Aggregation Method:
   % Effectiveness = ((% measured in ex post evaluation - % base line) / (100 - % base line)*100.

Promoting health and happiness in the Brazilian Amazon

Caetano Scannavino[1] and Rui Anastácio[1]

Abstract: With the motto«Health, happiness of the body. Happiness, health of the soul», the Health and Happiness Project (PSA) works to promote integrated and sustainable community development in parts of the Brazilian Amazon. PSA grew out of local workers'personal experience in collaborating with communities and the need for sustainable actions for their future development. It was established as a not-for-profit organization in 1987. PSA started off by implementing strategies that would increase the health status of the population, which was identified as the biggest challenge, to then extend to other areas of development. Education, training and community participation were key elements of the project's actions, which included basic sanitation, reproductive health and child health, technical assistance in agricultural practices and youth empowerment through communications, among others. Once the health structure was established, the work moved on to new priorities related to education, economic production, protection of the environment and community management in the medium and long terms. The project's success has helped to institutionalize the practices and today it reaches a total of approximately 5,000 families distributed across 150 rural communities in the mid- and low-Amazon region. (*Promotion & Education,* 2007, (2): pp)

Key words: health promotion, community health, development

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Who we are?

We hear much about the Amazon and its natural resources, but little is said of its inhabitants, especially the forest peoples, the majority of which are 'caboclos'– descendents of Indians who live in rural, often isolated and difficult to access areas.

These people partly subsist on hunting, fishing, the collection of forest products, growing manioc and other regional crops, but no longer manage to guarantee their own subsistence due to the impacts of deforestation in the Amazon.

Amthough public services offered by respective municipalities are improving, there still appears to be a major shortfall. This is evidenced by some of the key social sector indicators of the region; 60% of the population is under 18 years of age, of which only 7.5% manage to complete secondary education. Health is one of the key challenges in the social sector domain at the community level. Preventable diseases lead to significant mortality and morbidity due gaps in the delivery of primary health care services (Gusmao, 2002). Infant mortality is high and Infant deaths account for 15.7% of all deaths in the community; this is reflective of regional health disparities in Brazil given that this is almost double the national average of 8% (Gusmao, 2002). The majority of these deaths are the result of preventable diarrhoeas or infectious diseases.

The population lives in a region extremely rich in natural resources,; however at the same time, they suffer from increasing impoverishment. This is mostly due to the lack of investment in the population's own potential. However, these groups still maintain a strong sense of community, solidarity and self initiative and are able to effectively mobilize and work together to resolve their own problems, if and when given the opportunity.

The Health and Happiness Project (PSA) was created in 1987, taking the local reality of these populations as a starting point, the project is grounded in the belief that a critical component of safeguarding the Amazon, relates to guaranteeing living conditions for the forest peoples. PSA is a not-for-profit organisation, which works to promote integrated and sustainable community development in riverside locations on the banks of the rivers Tapajós, Amazonas and Arapiuns in the West of Pará, Brazil.

PSA further built on the work of a medical doctor and an art-educator who had experience working with riverside communities in the municipality of Santarém between 1984 and 1985. They created a non-governmental organisation, PSA, to guarantee the continuity of the actions in a broader and more independent manner and without party-political connections.

In 1987 cooperation agreements secured by BNDES- Banco Nacional de Desenvolvimento Econômico e Social, from Federal Government, which permitted the work to commence with 16 pilot communities. The Participatory Planning highlighted health as one of the biggest challenges and from here, the other programmes of the Health and Happiness Project were developed.

How are we achieving our aim?

Education and community participation were key elements of the project's actions and brought immediate results for the whole population, taking advantage of resources from the region itself. Community leaders, health workers, traditional midwives, rural producers, women, teachers, children and young people built their capacity through training to become trainers. The project invested in basic sanitation (chlorine, filters, toilets, wells and adapted water systems). Community events promoting the health of the children, with three-monthly vaccination campaigns were initiated. Rural farmers received technical assistance to increase the availability of food stuffs produced using agro-ecological practices. Groups of women were involved in activities to promote reproductive health and combat malnutrition with the consumption of local plants of high nutritional value. In the schools, teachers and children participated in health and ecology work-

Mobile Health Unit (Abaré): monthly visits to the communities to promote primary health care for 2.500 families in the municipalities of Santarém, Belterra and Aveiro, a consortium between PSA and the Municipal Councils.

1. Projeto Saúde & Alegria, Brazil. Correspondence to Caetano Scannavino, Project Coordinator: Rua Mendonça Furtado, 3979, Santarém-PA, Cep 68040-050, Brazil. (psa@saudeealegria.org.br)

shops. A communication network was developed with the youth, where they were trained as reporters allowing them to produce, exchange and disseminate educational materials via community newspapers, radios and videos.

The project tries to take a positive in-take on promoting health, instead of disease-oriented, which is where the term «happiness» comes into play in the organization's name. As a main strategy when visiting communities, team members and community members use the Great Mocorongo Circus. The representations of the circus include music, poetry, educational and cultural sketches to promote healthy behaviors, such as, breast feeding, the use of oral re-hydration therapy and hygiene, among other.

What are we learning?

These simple and culturally appropriate education methods had a very positive impact on the communities, who not only began to change their health practices, but also became more stimulated to actively participate and influence other areas of their development. Once the health structure was established, the work could move on to new priorities related to education, economic production, protection of the environment and community management in the medium and long terms. PSA with the community's involvement in the planning and implementation created integrated development programs, as shown in Figure 1.

How do we know we are making a difference?

The lessons learned made it possible to develop exemplar and culturally-adapted social development technologies, which are low in cost, high in impact and replicable in other regions and contexts. Consequently, in 1999, PSA started to gradually increase the communities it worked in.

Mocorongo Grand Circus: a small mambembe traveling theatre presented by rural residents with music, poetry, educational and cultural skits, communicating the content in the communities'own language

Faced with a larger scale program, certain principles for successful project development were established, i.e.:

- working in partnership with government bodies and other existing development actors to transfer social technologies;
- programmes are readapted in order to be integrated as public policies;
- training trainers is prioritized;
- the concept of territorial communities is reinforced to encourage self-management and social control, focusing on strengthening inter-community federations.

As reflected in Figure 2, over the years it has been possible to significantly improve the quality of life indicators in partner communities, according to comparative data between areas served and those not served by PSA (Souza Lemos, 2000.)

At present, PSA works directly in three municipalities – Santarém, Belterra and Aveiro – reaching a total of approximately 5,000 families distributed across 150 rural communities in the mid- and low-Amazon region. PSA is also increasingly consulted by governmental and non-governmental bodies, from the Amazon and beyond, to provide advice on the replication of its experiences.

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Mocoronga network: youth's communication initiative for education- radio communications and programmes and internet access points

Figure 1. **Integrated Development Model**

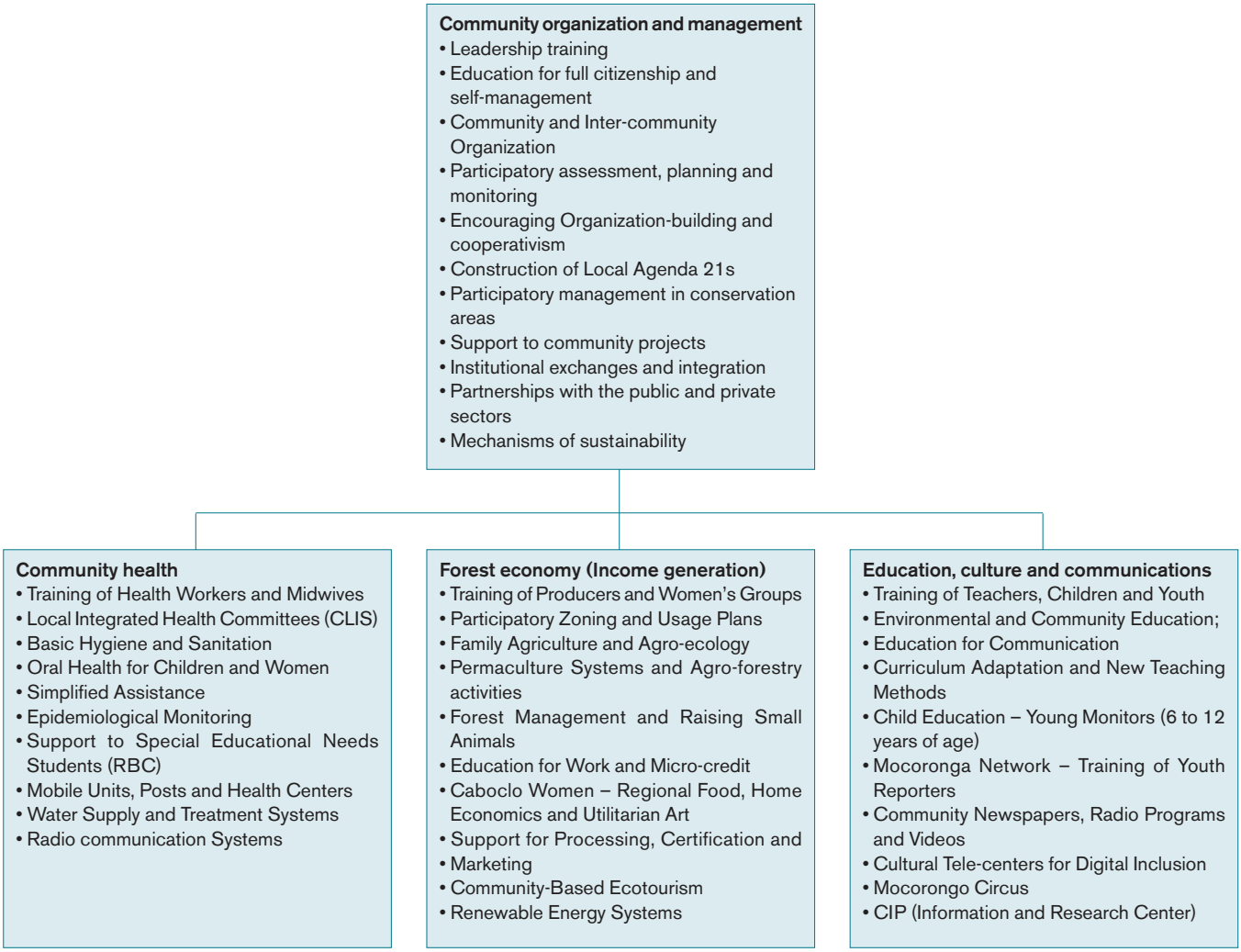

Figure 2. **Quality of life indicators**

Advocacy for appropriate health policy and effective governance of health system

Alok Mukhopadhyay[1]

Abstract: Health policies supported by sustained advocacy efforts need to continually grow and develop to respond to the increasing pressures of macro-economic policies of globalization, liberalization and privatization. VHAI, the largest network of voluntary agencies in health sector is playing a critical role at both macro and micro levels. Its health advocacy efforts emerge from the grassroots with an understanding of their health and development problems as well as the strategies adopted to address them. The process, of strengthening an upward mobilization of information, towards formulation of an effective health policy, is backed by serious macro research on various policy dimensions of health, done by the Independent Commission on Health and Development in India (ICDHI), set up in 1995 by VHAI. These key policy documents, prepared are both reflective and prescriptive and are presented to the highest state authorities along with a discussion at various levels with varies groups. One of the recent successes was at getting the giant tobacco companies withdrew from Cricket sponsorship with an association in the formulation of comprehensive Bill by the Union Government to prevent this in future. Various well-researched policy documents have been put together by the organisation based on its micro and macro level work and persistent advocacy. Appropriate public health and development policies with their effective implementation are the cornerstones to realize the fundamental values of Ala Ata. The health care system needs to be removed from the current bio-medical model and closer to a socio-political and spiritual model where health care again becomes an organic part of community care as it once was in the traditional society. (*Promotion & Education,* 2007, (2): pp)

Key words: Global health advocacy; State health policies; Grassroots.

Over decades, the State has played a significant role in health sector. With the growing process of Globalization and the influence of New Economic Policy, there is tremendous pressure to replace this arrangement and put the social sector in market place. There can be little doubt that the greatest economic force now sweeping through the health care system worldwide is that of the market. Health is a vital human good and Medicare plays a key role in promoting it. Totally commercializing it even for the sake of choice and efficiency runs a potent risk of submitting it to the market-forces. The integrity of medicine itself is at stake. Thankfully for the poor in most developing countries the State still remains principal provider in Health Sector. We need to appreciate the importance of advocacy for peoplecentered health from this backdrop.

Health policies need to grow, develop and be continually creative to meet the changing needs of the situation. This underlines the importance of sustained advocacy on health policy, to ensure that it is peopleoriented and relevant. Viable options for health system must be technically feasible, consistent with public sector capacity, and capable of commanding sufficient social and political support to be sustainable. This is particularly true for the developing world, where a large section of the population does not have well-defined and strong enough platform to air their frustration against inadequate social policies.

VHAI, the largest network of voluntary agencies in health sector in a massive, complex and heterogeneous country like India, plays significant role in this area. A large section of the population of India is totally dependant on the Government health sector since they do not have the financial means to buy services from the market. Several studies conducted by us show that when the public health infrastructures do not work, the health expenditure becomes one of the major contributors for indebtedness of the poor.

In India, the state health policy is outdated. The critical services and facilities are getting frayed due to growing population, non-optimal use of existing facilities and increasing pressure of global financial institutions for dilution of the role of Public Care and to abandon holistic, people-centered community health care and to replace it with a selective «magic bullet» oriented health care. The situation is further complicated by the fact that the large private sector usually does not provide quality services at a reasonable cost. Outreach of the voluntary sector is limited due to absence of more enabling atmosphere. We, therefore, felt that it is important to work towards a new Health Policy to respond to the current situation adequately.

Plans and policy options should be guided by an ambitious vision of what should be accomplished, but they must also be informed by the realities of the present. Despite the rhetorical vision of a health system with a universal, vertically integrated, publicly provided system, India has not provided funds to make that vision a reality. Raising additional government finance has its own complexities. Any policy that proposes a significant expansion in the low level of publicly mobilized resources devoted to health needs to provide an explicit proposal for how the additional costs will be financed.

These realties are not immutable. They can be changed through institutional reforms and strong political commitment, but one cannot simply assume that they will disappear. Ultimately changing the shape of the health system depends on political decisions made at national, state and local levels. An explicit approach to policy formulation and implementation must ensure that the health system is improving the health of all in an equitable, accountable and affordable manner. For developing an appropriate and sustainable health care system, the health policy must promote Government, Public and Private Partnerships; an inter-sectoral coordination along with the Decentralisation of the health system, tempered with effective supervision.

Our advocacy effort begins at the grassroots by not only trying to understand people's health & development problems, but to work with them to learn how to develop the alternative approach. This experience-based learning gives us very essential credibility to talk about important health issues with conviction. The knowledge about exciting innovations to address critical issues of health care being taken up in large metropolitan towns or institutions of developed countries reach all corners of the world within days, but similar effort at the remote rural areas of the developing countries hardly attracts anybody's attention.

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We feel that the process of strengthening upward mobilization of information is an important factor towards appropriate direction of an effective health policy. Experience of our grassroots effort is backed by serious macro research on various policy dimensions of health, involving respected professionals, academics, policy makers and activists. While preparing documents to influence the health policy, we not only rely on primary and secondary data, but they are usually backedup by focused group discussions with stakeholders and public hearings of beneficiaries and roundtable with concerned professional groups.

We keep the major political parties, key officials and the media fully informed about the endeavour and often they are invited to participate in some of these events. The documents finalized through this participatory process are not just critique of health policies, but are prescriptive. We clearly outline viable solutions to the major public health problems and document examples of successful micro experiences. This elaborate and rigorous process provides the alternative policy documents legitimacy and the desired credibility. Preparation of key policy document is cornerstone of a successful advocacy effort. We ensure that the policy document is formally presented to the highest possible authority of the land. Our policy document for an alternative health policy was presented to the Prime Minister and the President in an elaborate function widely covered by the media. This was followed by discussion with elected representatives of various political parties and Parliamentary Standing Committee on Health. These high profile events create an overall empathetic atmosphere for policy change.

Often the groups working on policy matters loose their steam by sheer demand of preparing the policy document. It is important to ensure that sufficient finance and human resources are available for advocacy related work. Persistent and dogged follow-up is key «mantra» in advocacy.

During our recent successful work for a comprehensive bill to debar tobacco companies from sponsoring sports, we received tremendous support from Cricketers and Cricket Control Boards of other countries and sporting public. This was backed by our Public Interest Litigation against the Indian Cricket Control Board in the High Court. Eventually the giant tobacco company withdrew from the sports sponsorship due to our dogged advocacy and the successful Public Interest Litigation. The Government is now drafting a comprehensive Bill to prevent this in the future. We are playing an active role in the finalization of the content of this Bill. Similarly, the revised Health Policy is in the final stage of redrafting with substantial input from the report produced by us. We are also Members of the Steering Committee for drafting the New Health Policy.

We should remember that adoption of an appropriate public policy by the Government is not an end by itself because the major task of effective implementation of the policy is an equally important issue. Advocacy groups have to play dynamic role of monitoring the implementation of the public policy closely, particularly in the initial years. Our grassroots level projects play a very important role of providing us feedback on the effectiveness of the implementation process at the grassroots. The feedback is regularly conveyed to the authorities to enable them to fine-tune the mechanism of implementation.

The importance of urgent and sustained global advocacy for restoration of fundamental values of Alma Ata – people-centered, holistic and sustainable health care cannot be overstressed. The challenge to health in the new millennium will be to recognize that in no country in the world the private sector has been the answer to health problem of the population. Even in the United States, forty seven percent of the population is without health insurance coverage. Secondly, there is an imperative need to acknowledge that health improvement is less an outcome of medical technology than of living standards. Health improvements based on narrow technical interventions are bound to be chimerical. Thirdly, the macroeconomic policies of globalization, liberalization and privatization, which are increasing the exploitation of low-income countries and communities around the globe, have had profoundly deleterious effects. Finally, it is simply not true that we do not have resources to pay for health for all. It is estimated that the cost of providing basic health care to be world's population will amount to 25 billion dollars. This is about what Western Europe spends on cosmetics, and a fraction of the 400 billion dollars that the world spends on armaments annually.

We obviously need a new paradigm of health care far removed from the current bio-medical model and closer to a socio-political and spiritual model. Currently, health care has become a commodity that can be bought and sold in the market; it is no longer an organic part of community care as it once was in traditional society. The 'germ theory'needs to be replaced by a model where the human being is regarded as central and helped to regenerate a sense of well-being and fitness in his or her life situation. Interestingly, most of the traditional systems approach health from this holistic perspective.

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Cracking the nut of health equity: top down and bottom up pressure for action on the social determinants of health.

Fran Baum[1]

Abstract: The Commission on the Social Determinants of Health was established to advise on ways in which understanding of the social determinants of health can affect practical action to improve population health equitably. This paper considers the factors that are necessary to encourage governments to adopt policies that aim at doing this. It argues that knowledge, while essential, is insufficient. Governments need a commitment to the values of fairness and justice and an ability to cope with the complexity of responding to social determinants beyond exhorting individuals to change their behaviour. The role of civil society is crucial in advocating for governments to do this. The presence of linking social capital is also crucial to creating a social and political environment in which fairness is promoted. A case study of the poor health status of the Aboriginal peoples in Australia is used to illustrate the importance of social capital. (*Promotion & Education,* 2007, (2): pp)

Key words: Social determinants of health, linking social capital, Aboriginal health.

Résumé en français à la page #. Resumen en español en la página #.

When the late Dr. Lee, Director General of the World Health Organisation, announced the formation of the Commission on the Social Determinants of Health at the World Health Assembly in May 2004 he commented:

> "*The goal is not an academic exercise, but to marshal scientific evidence as a lever for policy change—aiming toward practical uptake among policymakers and stakeholders in countries*"

This paper focuses on factors that are likely to encourage and initiate practical action on the social determinants of health inequities. It will include discussion of the need for both evidence and knowledge together with understanding and a commitment to equity. Consideration will be given to the importance of the «nutcracker» effect which describes the power of the combination of top down and bottom up action on health equity. The arguments articulated herein demonstrate that societies, which focus on *linking social capital* (as defined by Szreter & Woolcock(2004) and discussed in detail below) are more likely to be committed to and effective in taking action on the social determinants of health than those with low levels of linking social capital.

Powerful combination of evidence, knowledge, understanding and values

Knowledge and evidence are clearly important to achieving action on health equity. The CSDH has established a knowledge network on Evidence and Measurement. The first paper from this network (Kelly et al, 2006) argues strongly in favour of methodological pluralism and epistemological variability in approaches to studying the social determinants of health and health inequity. They note «Humans use different forms of knowing and different forms of knowledge for different purposes. There is no necessary hierarchy of knowledge involved until we need to discriminate on the basis of fitness to purpose» (Kelly et al, 2006 p. 8). An understanding of the complexity of factors that contribute to the social determinants requires an insight into many different disciplines and the use of a range of methods. However, the most useful qualitative research methodology involves interviews of key informants to ascertain ways in which social, economic and political structures shape individual experiences. For example longitudinal epidemiological studies that enable the determination of causal links between exposure to certain social and economic conditions and diseases or policy studies of the outcome of different systems of social welfare. Such knowledge is often context specific and contingent on political and economic circumstances. The complexities of this process and the broad range of knowledge on social determinants is often envisaged to be an impediment to the uptake of the knowledge in this area. Commenting on the challenging of getting knowledge to inform policy and practice, Speller (2001) used Stacey's (1996) Agreement & Certainty Matrix to demonstrate that health promotion and public health initiatives often fall into a zone of complexity that leads to uncertainty about what works and so consequently to a lack of agreement among policy makers and practitioners. Stacey stresses the need for non-linear and creative thinking when organisations are working at the edges of chaos and dealing with complex information to obviate issues emerging from lack of consensus. It is envisaged that such situations often arise when organizations attempt to address the social determinants of health. Thus it will take a particular combination of commitment to justice, understanding of complexity and the ability to lead organisations through the change necessary to cope effectively with complexity in order to lead to the actions, which the Commission envisages lending impetus to.

Evidence on health inequities has been available in many developed countries for sometime; however this has not ensured the institutionalization of remedial action. Most notably, the «Black Report» in the United Kingdom (Townsend and Davidson, 1992) was rejected by the incoming Thatcher Government despite the compelling information it presented on the existence of inequities and the possible reasons for their existence. This and many other examples show that while evidence on inequities is necessary it is certainly not sufficient to ensure action. Policy makers also need to know what can be done to reduce inequities and need to work from a values base that emphasises the pursuit of social justice as crucial to society. Knowing what is to be done requires coming to grips with the range of choices that lie inside and outside the health sector.

The international health promotion movement has come a long way in the past twenty years. In the 1970s and 1980s, behaviour change using pamphlets and marketing campaigns was the overriding tool of health promotion. Subsequently, the concept of health promotion was revolutionarized by the Ottawa Charter for Health Promotion (WHO, 1986), which established that while changing behaviours was indeed a crucial aim of health promotion, bringing change at that level involved a complex interplay of policy and strategy, creating supportive environments, encouraging community action and reorienting health services. The Ottawa Charter was instrumental in galva-

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nizing action in many countries. In Australia, for example impact at the population level was clearly evident and manifested itself as reduction in prevalence of smoking and smoking related morbidity, decrease in road accident-related fatalities, reduction in suicide rate and decline in the rate of skin cancer (Baum, 2002). Each of these has been achieved not through single measures but through a battery of self reinforcing measure. While these are significant public health gains, they have done little to address inequities and reduce the existing gradients. Here it is important to recognize that unless designed with a very strong equity lens, health promotion can act to increase the difference between groups rather than reduce them even if they improve population health as a whole. For example, there is evidence that people in higher socio-economic groups are more likely to be successful in quitting smoking (Osler and Prescott, 1998; Barbeau, Krieger, Soobader, 2004). In Australia over the period 1998-2004 while there has been a 9% decline in smoking among the lowest quintile the rate of change for the highest socio-economic quintile is 35% (see Table 1). A reasonable conclusion is that anti-smoking messages have been more successful with better off people and, at least temporarily, have increased inequality.

Further complicating our message is the fact that health inequities do not reflect a dichotomy between a disadvantaged group at the bottom of the social advantage pile and the rest sharing equal health status. The work of Sir Michael Marmot (Chair of the Commission on the Social Determinants of Health) and colleagues (see summary in Marmot, 2004) has shown that the distribution of health in communities is in the form of a gradient. This gradient is also illustrated in Table 1 where the percentage decline in smoking across socio-economic quintiles is in the form of a gradient from high to low. This has great significance for the strategies we adopt to bring about equity. The gradient in health suggests that we need population wide universalist strategies as well as those targeted at the most disadvantaged. Again this is a more complex argument to advocate to policy makers than the one which focuses on the need to target those at the bottom of the pile.

Taking action on the social determinants of health to reduce health inequity will also require politicians and policy makers to resist what Kickbusch (2006) has called «the doability of medicine». Modern medicine offers individuals considerable possibilities. But many of its interventions will not have a discernable impact on population health (as opposed to the health of a few individuals, usually towards the end of their life). Perhaps this is the hardest lesson for policy makers and politicians to grasp. Yet it is also the most important lesson to grasp if we are to have the understanding necessary to bring about a real determination to improve health across populations. Rose (1985) has set this lesson out most clearly. He points out that treating high risk or diseased individuals does not have much impact on population health levels overall, but changing a risk factor across a whole population by just a small (and often clinically insignificant) amount can have a great impact on the incidence of a disease or problem in the community. For example reducing salt intake in manufactured food by a small proportion across a population (at a level individuals would not notice) would reduce blood pressure levels and in time reduce death rates from cardio-vascular disease. Add to this the need to implement population-wide strategies in a way that is equitable and the extent of complexity of knowledge and concepts is considerable. Rose's message about population health is counter intuitive and the difficulties of grasping it effectively is, in all likelihood, the reason why we face challenges in shifting our health care system to a focus on prevention, health promotion and social determinants of health, despite so many WHO and Government sponsored reports that have called for this reorientation (Benezeval, 2003; Independent Inquiry into Inequalities in Health, 1998; Stahl et al, 2006; Stegeman and Costongs, 2003; WHO, 1978; WHO, 1986; Wilkinson and Marmot, 2003).

Understanding of Rose's dictums on preventive medicine are likely to be heeded more easily in those who have a more collective mind set rather than those more committed to a strong individualism. This fact was point out by Tesh (1988) when she pointed to the strong individualism that underpins public health policy in the United States. A strong ethos of individualism is likely to lead to victim blaming assumptions (Crawford, 1977). Such an attitude is obvious in the following comment by an Australian federal health minister, Tony Abbott (2005) on a television program on childhood obesity:

> "*No-one is in charge of what goes into my mouth except me. No one is in charge of what goes into kid's mouths except their parents. It is up to parents more than anyone else to take this matter in hand.....if their parents are foolish enough to feed their kids on a diet of Coca Cola and lollies well they should lift their game and lift it urgently*".

Tesh (1988) points out that the very research questions we ask are shaped by core values. Thus a focus on individualism would lead to questions about why individuals are over weight and explore their motivations while a more collective ideology would explore questions about why it is that obesity levels in all high income countries have increased in the past decade and consider what features of the society have encouraged this. The assumption that changing behaviour is about personal motivation is very common despite the evidence that people need supportive environments in which to make healthy choices and that pressures from social mores, advertising and constraints of health food availability are likely to have strong influences on the choices people are able to make (Baum, 2002). There are many factors that reinforce ideologies of individualism. These include the fact the ideology is less threatening to many vested interests, especially commercial interests, the philosophy of some political parties are grounded in a strong belief in the individual rights even when these are at the expense of the common good and the fact that protecting the rights of individuals has often been a guard against the excesses of totalitarian regimes. Consequently public health is often viewed as being aligned with a 'nanny state' that seeks extreme measures that restrict rights. This view has been voiced during campaigns to introduce tobacco control, enforce seat belt legislation, restrict the ownership of firearms, restrict the advertising of junk food and enforce sun protection in schools.

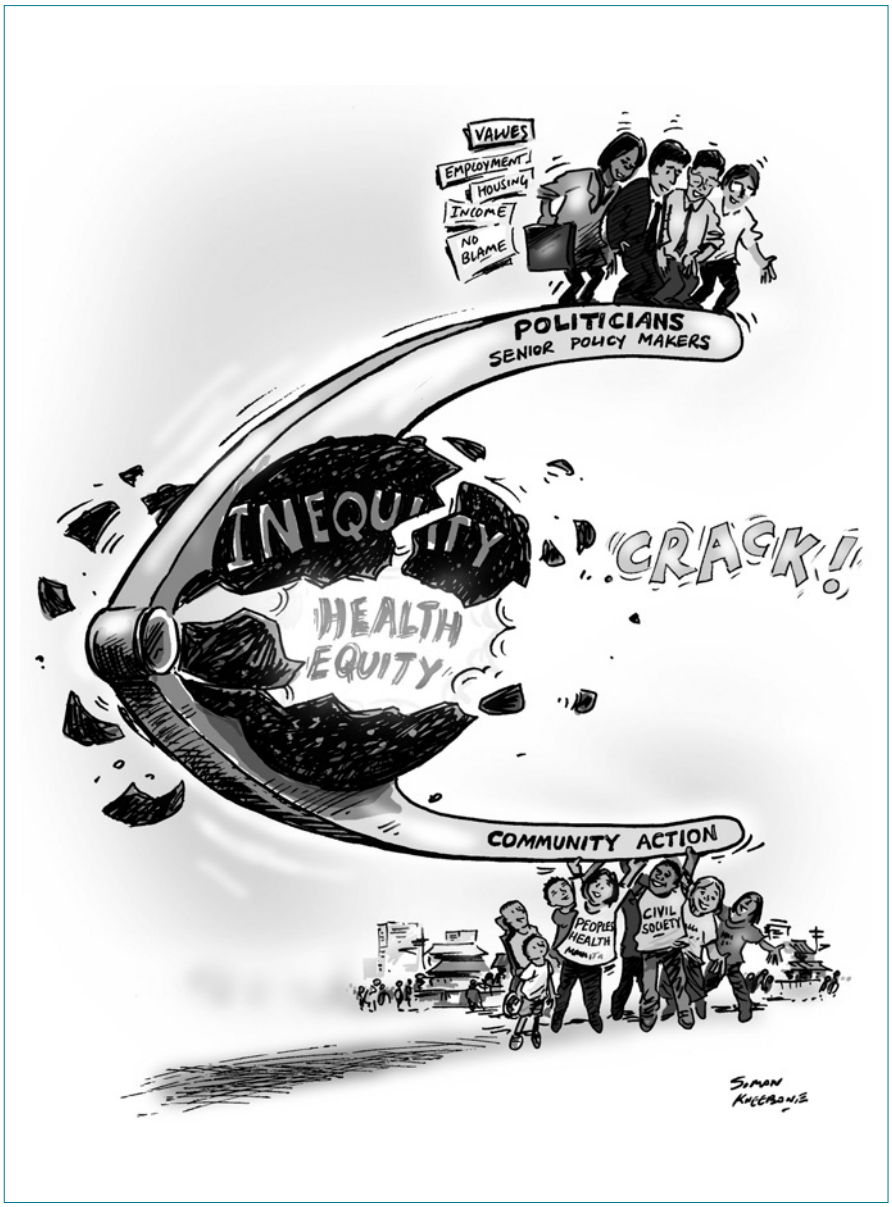
The fact that many of the determinants of health of health lay outside the formal health sector also complicates the tasks of implementing action on the social determinants of health. In the past twenty years the importance of cross sectoral action has

Table 1. **Percentage Smoking and Percentage change by five socio-economic quintiles Australia, 1998-2004**

	1998	2001	2004	% Change
1st Lowest	30.0	25.8	27.3	-9%
2nd	27.0	25.1	23.6	-13%
3rd	28.4	23.7	21.7	-16%
4th	25.8	23.6	18.2	-29%
5th Highest	23.1	18.4	15.1	-35%

Source: Data derived from Adhiknit and Summerhill, 2000; Australian Institute of Health and Welfare 2002 & 2005.

Figure 1: **The Nutcracker effect: top down and bottom up action for health equity**



been repeatedly reinforced and put into practice. Through the Healthy Cities projects, the need to integrate government initiatives in the intersectoral domains was demonstrated, particularly with reference to road injuries, substance abuse, and poverty (Ashton, 1992; Baum 2002; WHO, 2007).. European Union's current focus on 'Health in All Policies'is testimony to the acceptance of this message (Stahl et al, 2006). The crucial task now remains to ensure that this intersectoral action happens effectively and as a matter of course and is implemented with a strong focus on reducing equity.

The messages of modern health promotion then are complex. They involve understanding the factors that impact on population and the existence of a health gradient, the limitations of most medical therapy as a means to make significant improvement to population health, and understanding that while behaviour change is the aim of health promotion achieving this effectively is not about simply telling people to do so but in creating supportive environments which will require action from multiple agencies. The task of equity health promoters would be much easier if there were a simple message to pitch to politicians and senior policy makers. But the reality of the situation makes equity a hard nut to crack. The following section considers the social and political environments in which equity is more likely to make it to the policy agenda.

The "Nutcracker" Effect

The "nutcracker" effect is illustrated in Figure 1. It demonstrates the value of combining top down political commitment and policy action with bottom up action from communities and civil society groups. Government commitment to taking action on the social determinants of health equity is likely to result from a belief in social justice and an understanding of the complexities of health promotion as detailed in the previous section. If a government reflects a political commitment to individualism and is wary of a overly interventionist 'nanny state'then the pursuit of equity is unlikely to be on it's social policy agenda to any extent. In this situation it will be hard to find much pressure exerted on the top of the lever. Such was clearly the case in Thatcher's Britain. Action on health equity only resulted when Blair Labour Government was elected on a platform that included a strong commitment to pursuing equity. By contrast a government driven by a belief in social justice is likely to implement policies designed to reduce inequities; the Nordic welfare states have provided a strong example of such governments. A powerful influence on government's desire to be socially just is the pressure from the more socio-economically better off in a society to do so. The existence of this pressure has been described as linking social capital and is described in more detail below. The other crucial part of the nutcrackers effect is the bottom up action from civil society.

Civil society action

One way in which governments can be persuaded to take action is through bottom up pressure. This is a consequence of growing iniquities as a result of which communities prefer governments who state a commitment to reduce such inequities. Within this context, history provides numerous examples of the role of civil society in bringing about change. Outstanding examples are the suffragettes in ensuring votes for women; the civil rights movement in the USA in stopping sanctioned segregation; and the anti-apartheid movement in bringing democracy to South Africa; and the green movement in putting environmental issues on national and international agendas and the land rights movement in Australia. (See Burgmann, 2003 for a discussion of these various social change mouvement). In each case years of grass roots actions led to irresistible pressures for change. In recognition of the important role that the civil society may play in arguing for action on the social and economic determinants of health the Commission on the Social Determinants of Health has established a stream of work on the role of civil society which has involved many civil society players. The report from the June 2006 meeting of the Commission (Commission on the Social Determinants of Health, 2006)

notes that the Commissioners recognised the distinctive contribution of civil society in country level action on the social determinants of health including direct engagement with national governments and national commissions on social determinants such as those in Kenya and Brazil. They also noted the importance of mass mobilization such as the Indian People's Health Assembly and the crucial role of labour organisations and trade unions (Commission on the Social Determinants of Health, 2006, p. 22). Civil society groups may also play a major role as advocates of equity. Globally the People's Health Movement (PHM) has played such a role since its formation at the first People's Health Assembly. The movement has organized two People's Health Assemblies to date (intended as alternative World Health Assemblies) from which two key documents have emerged – the Peoples'Health Charter written in 2000 and the Cuenca Declaration (2005) (see PHM, 2006 for copies) have made powerful statements about the need to reduce global inequities. Many health promotion and public health associations around the world make similar calls. Locally community-based health promoters also play crucial advocacy roles for health equity. It can therefore be argued that collectively, civil society is a crucial to bring the bottom up political pressure to bear on politicians and policy makers so that they are willing to take action on health equity. Civil society can be oppositional to governments and in extreme situations can bring about social and political change by contributing pressure for a change of government. In other situations progressive civil society can work through advocacy and incremental change and will be opportunistic about chances to influence policy agenda.

Linking Social Capital

So far we have seen that bringing about action on health equity will reflect a complex mix of sufficient evidence, good understanding of what changes population health, a political elite committed to changes and active civil society pressure for that change. But we are still left with the question of how is it that some societies are more inclined towards taking action to reduce health inequities than others. Some clues can be found in the notion of linking social capital. Szreter & Woolcock(2004, p.655) define linking social capital as «norms of respect and networks of trusting relationships between people who are interacting across explicit, formal or institutionalised power or authority gradients in society». What does this mean in practice? A society high in linking social capital is likely to be characterised by the following features:

- High trust in formal institutions
- Fair and transparent public policy processes
- Commitment to redistribution by the better off people in society
- Commitment to activities of State (e.g. low taxation evasion)
- Opportunities for people from different groups to interact in a respectful manner

There are indications that many of these factors are declining rather than increasing. Trust in institutions has declined significantly in the past two decades in most countries where this is measured (Eckersley, 2004). While transparency and fairness are upheld as hallmarks of democracy in practice there have been significant challenges to this. The extent of commitment to redistribution varies around the world from the Nordic countries where it is high to others where taxation policy is moving away from redistribution, Australia and the US included (Stretton, 2005). Many corporations and very rich individuals seek to avoid tax and show little commitment to the country in which they operate, preferring to avoid tax whenever possible (Korten, 2006). A society high in linking social capital would have its richest corporate and individual citizens committed to supporting a strong taxation base. This base would make possible redistributive measures. In the Australian context Stretton (2005) has pointed out that under the conservative Menzies government in the 1950s the top margin tax rate was far higher than it is in Australia today. Finally, what opportunities are there for people to interact respectively across class and ethnic difference? The degree to which this can happen varies from society to society but in societies marked by considerable inequity it happens less. The consequence is that there are less common bonds and less understanding. Linking social capital implies that there is a sense of obligation from powerful institutions in society towards the less powerful. Bourdieu's (1986) conception of social capital makes it clear that the networks and reciprocities involved in exchanges most commonly work to the benefit of the already well-off and more powerful groups. They do this by giving people pathways by which they gain access to educational, cultural and employment opportunities. Policies aimed at reducing inequities should, as an aim, work towards ensuring that benefits that accrue to certain classes in society are made available to other less powerful and privileged groups as well, on the premise that a society that supports and encourages such policies is likely to be characterised by high linking social capital. The importance of this notion of linking social capital is best illustrated by a case example articulated herein, which focuses on a case study of the absence of linking social capital between Australian Aboriginal and non-Aboriginal peoples. The case shows how the absence of linking social capital can have profound impact on health and illustrates how the presence of strong linking social capital has the potential to encourage government commitment to equity. .

Australian case study of the lack of linking social capital

The case of the relationship between non-Indigenous Australians and Indigenous Australians illustrate the importance of the concept of linking social capital to the likelihood of effective intervention to reduce health inequity. Indigenous people in Australia have been described as second class citizens in Australia (Chesterman and Gilligan, 1997). In the early days of settlement there is solid evidence (Hunter 1993; Reynolds 1998) that they were subjected to considerable violence. In the twentieth century much Indigenous experience was shaped by the welfare policies purported to be in the best interests of Indigenous people. In fact, it controlled their lives to the extent that children were removed from their families and the law dictated who Indigenous people could and could not marry. The experience of the «stolen generation» has been well-documented in the Bringing Them Back Home Report (Human Rights and Equal Opportunity Commission 1997). It demonstrates the significant impact that these experiences have had on the health and well-being of the Indigenous people caught up in this shameful period of Australian history. Clearly one of the sequelae of these experiences is a legacy of deep mistrust that the Indigenous people have towards mainstream institutions of the non-Indigenous society such as the police, health and welfare systems and schools. Clearly, very little linking social capital was evident in this area.

Non-Indigenous Australians often project negative views of Indigenous Australians that reflect purely on their current behaviour and situation without taking into account the impact of the historical experience of Indigenous peoples. Indigenous people are far more excluded from the social and economic mainstream of Australian life than are other Australians (Trudgen 2000). They are also subjected to significant racism (Hunter, 1993) and live in a world which is dominated by invisible and largely unacknowledged assumptions of whiteness (for further details of concept of

'whiteness'see Riggs 2004; Fein et al. 1997). The history of Australia since the invasion by white people shows that a number of factors have worked to determine the health of the indigenous people; these include: the way society has been organized, the degree and nature of interaction between Indigenous and other Australians, the levels of trust between the two groups and the extent of care extended to Indigenous Australians by the wider society. Limited attempts have been made to bridging the social capital between Indigenous and non Indigenous Australians and therefore the scope for linking social capital to development has sadly been lacking in Australian society. This has led to the exclusion of the Australian Indigenous people from mainstream economic, educational and social life in Australia. Some insights into the likely impact of social exclusion on health can be gained from the recent literature debating the impact of income inequality across populations. Wilkinson (2005) has argued that a key determinant of population health outcomes is the extent to which societies distributed their income equally with more equal societies achieving higher population health outcomes. He theorised that part of the explanation for this pattern was that countries with less equal distribution of income also had lower levels of social capital. He argues that this link exists because unequal societies are characterized by individuals with increased anxiety and low social support institutions and by higher levels of violence and disrespect between citizens. His work has been strongly criticized for under playing the role of access to material factors (especially employment and housing) that underpin inequalities (see for example, Lynch et al 2000). However it gains support from the work of Michael Marmot and colleagues (Marmot et al. 1991; Brunner & Marmot 1999) who explain health status gradients in populations through the stress people experience from not being at the top of hierarchies and the consequent absence or loss of autonomy over one's life, working and neighbourhood environment. Applied to the experiences in the Australian context, it is evident that racism and economic inequity have led to lack of control on part of the indigenous people, over their life in terms of its direction, culture and traditional ways and the ownership of land. This has led to extreme stress for Indigenous peoples; Marmot's work indicates that it is likely to have a very significant impact on health. The situation principally results from the lack of supportive policies from mainstream Australia – the lack of linking social capital. Szreter and Woolcock (2004) argue that consideration of the relationship of the state in terms of the initiation and sustaining of networks, trust and social structures is crucial. They show, with illustrations from a case study from nineteenth century England, that states (local and central) can create and encourage the conditions in which linking social capital can operate. They can do this by ensuring that resources flow from more powerful to less powerful groups. Szreter and Woolcock's (2004) argument leads to the conclusion that greater linking social capital in Australia can lead to increased empathy about the dispossession suffered by Aboriginal people, and increase in the level of concern with respect to improving the material conditions and facilities and services available to Aboriginal people; this will contribute to advancing the common commitment to a goal of a society of mutually respecting citizens. While there have always been accounts of some sympathy and empathy and desire to link with Indigenous peoples from those more powerful, this has rarely been from other than a small minority (Reynolds, 1998).

Theories on linking social capital suggest that it is most evident at times when networks and trust develop between groups. Over the last fifty years, the Australian history does suggest that there has been a growing movement in which Indigenous peoples in Australia have been able to assert their rights more than in the past (Burgmann, 1993). Their endeavours have been supported by non-Indigenous people as was seen in the referendum on constitutional rights for Indigenous peoples and during the reconciliation marches of 2000. The early 1990s held promise of being a period in which linking social capital between Indigenous and non-Indigenous Australians might take root, as evidenced by Prime Minister's Paul Keating's 1993 Redfern speech:

> *And, as I say, the starting point might be to recognise that the problem starts with us non-Aboriginal Australians. It begins, I think, with the act of recognition. Recognition that it was we who did the dispossessing. We took the traditional lands and smashed the traditional way of life. We brought the disasters. The alcohol. We committed the murders. We took the children from their mothers. We practised discrimination and exclusion. It was our ignorance and our prejudice. And our failure to imagine these things being done to us. With some noble exceptions, we failed to make the most basic human response and enter into their hearts and minds. We failed to ask - how would I feel if this were done to me?*
>
> *Paul Keating (then Prime Minister of Australia)– Redfern Speech December 1992*

This political will received strong support from an active reconciliation movement that reached a height with a reconciliation walk involving 250,000 Australians across Sydney Harbour Bridge in May 2000. But recent events with the promotion of more punitive policies suggest any linking social capital has been on the decline in recent years. Recent policy directions such as the imposition of «Shared Responsibility Agreements» which demand certain behaviours from Indigenous people as a condition for receiving social security benefits have acted to reduce the autonomy of Indigenous peoples and have been interpreted as a return to more paternalistic policy days (Collard et al 2005; Anderson, 2006). Our knowledge of the importance of *control* to *health status* (Marmot, 2004) suggests that policies should aim to encourage self-determination supported by resources that can make a difference. Linking social capital suggests a policy approach, which is trustful of communities, encourages them to do the right thing for their children and provides them with the infrastructure to create a health promoting environment.

Conclusion

This article has examined the factors that are important for encouraging practical action on social and economic factors that affect population health and health inequities. It has argued that knowledge is crucial but insufficient and that in order to crack the nut of inequity, practical action is needed both from governments as well as the civil society. Civil society is constituted by a rich array of groups, many of whom remain concerned about promoting justice at a local level and lobby and advocate for equity-oriented policies. Their actions can both encourage governments to take action as well as can develop popular constituencies to support action initiated by the government. Governments need to recognize that taking effective action would be reflective of their commitment to equity and justice and will enable them to deal with the complexity of evidence and devising complex responses. These responses need to be based on strategies that go beyond blaming individuals to those that focus on creating health and equity promoting environments. However, the exact process by which such commitment comes about differs from one context to another. Notwithstanding, it is likely to emanate from a society in which governments and their agencies have both the ability to deal with complex evidence and devise solutions that deal with this complexity leveraging social capital. This form of social capital ensures that the better off in a society are prepared to support and encourage action to improve the health in

a way that reduces inequity. Thus when the Commission on the Social Determinants of Health reports in May 2008 a crucial legacy will include improved knowledge on how action on social and economic determinants can be used by governments to improve population health equitably; examples of governments who are successfully taking such action; a strengthened civil society with a louder voice about the importance of this action and improved understanding of the processes (such as linking social capital) by which societies adopt fairness and justice as the basis of their social and health policies.

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Criteria and checkpoints for better community health promotion

Jan E. Ritchie[1]

Résumé en français à la page #. Resumen en español en la página #.

Members of the CDC and IUHPE Global Consortium on Community Health Promotion have been wrestling with two questions in their work together over the term of this Consortium. These questions are: 'How best can community health promotion practitioners check out whether their general activities and specific projects meet current standards of good community health promotion practice? And, where do practitioners start, whether working alone or in a team, in order to make certain they are working most effectively?'

To address these questions, the Consortium members decided to compile a simple list of criteria and checkpoints to assist practitioners in appraising their project activities step by step. Although this is definitely an early work-in-progress, we have decided to place the initial draft in the public domain so as to encourage practitioners to provide us with feedback since the list will only able to be verified after field-based testing of these suggested steps.

The values outlined in the Statement of the Global Consortium published in the previous edition of this journal (Nishtar et al, 2006), need to be read in conjunction with these criteria and checkpoints as these values form the foundation on which this list has been compiled. The most pertinent of these values and principles in relation to this checklist is the recognition that «community participation ... must drive every stage of health promoting actions» (Nishtar et al, 2006, p 7). The term 'community health promotion'refers here to health promotion action initiated *with* community members, *by* community members and *for* community members. Working in partnership with communities throughout all activities is the essence of good community health promotion.

Two existing works-in-progress have served to lay the foundations for this checklist and the Consortium gratefully acknowledges these contributions. The Centre for Community Health Promotion Research, University of Victoria, Canada has done some far-reaching work in developing a framework to assess the effectiveness of community health promotion interventions, and this Centre has been very generous in sharing their developing material with us. The Western Pacific Region of the World Health Organization has in recent years developed regional guidelines for implementing a Healthy Islands approach to promoting health (WHO WPRO, 2001), with a special focus on checking out progress in initiating and implementing community health promotion action. This development in particular has occurred through extensive consultation with communities across the Pacific island countries.

The criteria and checkpoints for community health promotion practice are here set out in two stages: Stage I: 'Getting Started'and Stage II: 'On the Go'. We hope that despite not yet being tested in the field, they can be refined with your feedback, and eventually offer real value to practitioners.

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Stage I: Getting Started

Criteria for initiating community health promotion action

As you begin

Invite the community to identify and prioritise the issues they want addressed by health promoting action.

- Outline the issue to be addressed
- State the population concerned
- Describe how the community context – physical environment, and/or social, cultural, political, economic or gender aspects – has influenced the issue in the first place
- Indicate source and amount of specific funding, if available.

'Starting': Collaborative Planning and Organisation

How does the community want to take this action forward?
Which other key persons have an interest or stake in addressing the nominated issue? How can they come to agree on appropriate action?
What is the goal of community health promotion action in this instance?
What strategies can be harnessed to meet this goal?
In partnership with the community, consider: What steps need to be taken to implement this action?

- Identify the issues important to the community in starting this action
- Identify key stakeholders, reflecting the full diversity of views and recognising the power different ones hold
- Provide opportunities for different views to be aired and discussed
- Plan discussions to work towards developing a common vision
- Document the shared vision
- With community, determine leader responsibilities
- Identify community leader
- With community, implement structures for relevant data collection and management
- With community, implement structures for regular forums for reflection on progress
- With community, determine health promotion goal to address this issue
- With community, determine health promotion strategies to meet this goal

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Checkpoints
Which immediate outcomes have you achieved in Stage 1?

- **Community mobilised?**
☐ Very well ☐ Well ☐ Somewhat ☐ Not well ☐ Not at all well
- **Relevant data sought?**
☐ Very well ☐ Well ☐ Somewhat ☐ Not well ☐ Not at all well
- **Collaborative partnerships initiated?**
☐ Very well ☐ Well ☐ Somewhat ☐ Not well ☐ Not at all well
- **Leader identified?**
☐ Yes ☐ No
- **Priorities identified?**
☐ Very well ☐ Well ☐ Somewhat ☐ Not well ☐ Not at all well
- **Goal determined?**
☐ Very well ☐ Well ☐ Somewhat ☐ Not well ☐ Not at all well
- **Strategies planned?**
☐ Very well ☐ Well ☐ Somewhat ☐ Not well ☐ Not at all well
- **Communities involved in all stages of planning?**
☐ Very well ☐ Well ☐ Somewhat ☐ Not well ☐ Not at all well
- **Initiating action able to be sustained?**
☐ Very well ☐ Well ☐ Somewhat ☐ Not well ☐ Not at all well
- **Plan able to be disseminated to others?**
☐ Very well ☐ Well ☐ Somewhat ☐ Not well ☐ Not at all well

Stage 2: 'On the Go'

Criteria for implementing community health promotion action

'Doing': Community organisation and action

Have mechanisms been put in place to engage the community at every stage?
Have key stakeholders adequate capability to implement strategies identified in Stage 1?
Has appropriate leadership evolved?
Have appropriate resources been mobilised for this implementation?
Is the process being monitored?

- Engage the community
- Confirm leadership
- Support key stakeholders with on-going training if required
- Mobilise resources for action
- Monitor the process of implementation

'Making Waves': Bringing about transformational change

Has community action led to wider a social understanding of health promotion?
Have stakeholders connected with champions from other sectors?
Has the community decided they want health promotion action to be publicised?
Has this health promotion action managed to positively influence wider public policy?
Has the development of a health promotion initiative in collaboration with the community led to the establishment of an evidence base for community health promotion action?

- Connect stakeholders with champions from other sectors
- Publicise this health promotion action
- Influence wider public policy by stakeholders
- Influence wider social understanding by community action
- Identify components of an evidence base for community health promotion action

Checkpoints
Which immediate outcomes have you achieved in Stage 2?

- **Communities involved in all stages of planning and implementing?**
☐ Very well ☐ Well ☐ Somewhat ☐ Not well ☐ Not at all well
Relevant data collected and used?
☐ Very well ☐ Well ☐ Somewhat ☐ Not well ☐ Not at all well
Collaborative partnerships cemented?
☐ Very well ☐ Well ☐ Somewhat ☐ Not well ☐ Not at all well
Leader confirmed and followed?
☐ Very well ☐ Well ☐ Somewhat ☐ Not well ☐ Not at all well
Priorities confirmed?
☐ Very well ☐ Well ☐ Somewhat ☐ Not well ☐ Not at all well
Goal confirmed?
☐ Very well ☐ Well ☐ Somewhat ☐ Not well ☐ Not at all well
Strategies confirmed and implemented?
☐ Very well ☐ Well ☐ Somewhat ☐ Not well ☐ Not at all well
Implementing action continuing to be sustained?
☐ Very well ☐ Well ☐ Somewhat ☐ Not well ☐ Not at all well
Plan able to be disseminated to others?
☐ Very well ☐ Well ☐ Somewhat ☐ Not well ☐ Not at all well

Community health promotion in Pakistan: a policy development perspective

K. A. Ronis[1] and S. Nishtar[2]

Abstract: Pakistan was one of the initial signatories to the Alma Ata Declaration in 1978, however, it was not until 2004 that the first policy dedicated solely to public health and health promotion was launched. The National Action Plan for Prevention and Control of Non-communicable Diseases and Health Promotion in Pakistan has gained a prominent place on the nation's health agenda competing for resources with traditional health policies that focus on treatment, cure and evolving technology.
From a health promotion perspective the action plan was unique in that it focused on the community setting through two major behavioral communication change initiatives – one through the media and the other by integrating non-communicable disease prevention into the work plan of the Lady Health Workers.
The development phase of this inaugural public health/health promotion policy follows closely the pathway of the Australian Policy Cycle and celebrates a comprehensive consultation process. Its strength comes from the tripartite partnership between the Government, the World Health Organization and a Non-Government Organization, Heartfile who lent impetus to the creation of the initiative. This public-private partnership greatly facilitated the process of policy development and continues to support research, implementation and evaluation.
This paper endeavors to analyze the development of the National Action Plan with a focus on community health promotion.
(*Promotion & Education,* 2007, (2): pp)

Key words: community health promotion, policy cycle, partnerships and non-government organizations

Résumé en français à la page #. Resumen en español en la página #.

Historical background to health promotion policies in Pakistan

In 1978, Pakistan became one of the initial signatories to the World Health Organization's (WHO) Alma Ata Conference which laid the foundation and target for *Health for All by the Year 2000* (WHO, 1978). One of the five principles to emerge from Alma Ata focuses on disease prevention, health promotion, and curative and rehabilitative services. Policies to address this principle in Pakistan did not appear until 1990 when the Pakistan Government launched its first *National Health Policy* (Ministry of Health, Government of Pakistan, 1990). From a public health and health promotion perspective this policy focused on school health services; family planning; nutrition programs; malaria control programs; control of communicable diseases (e.g. tuberculosis and infective hepatitis); sanitation and safe drinking water.

In 1997, the second *National Health Policy* (Ministry of Health, Government of Pakistan, 1997) was launched and health promotion and health education received a prominent place under priority health programs and non-communicable diseases such as cardiovascular disease, cancer and diabetes were highlighted for prevention and control measures. The focus for health promotion was «health education» and the five principles of the *Ottawa Charter for Health Promotion (WHO, 1986)* as a guiding framework per se were not alluded to.

The most recent *National Health Policy* (Ministry of Health, Government of Pakistan, 2001) was launched in 2001 and omits the prevention and control aspect of non-communicable diseases; it does not specifically refer to health promotion and in relation to public health the main goal is *...to create mass awareness in public health matters* with a major focus on the use of multi-media to disseminate information.

In 2003, a Pakistani non-government organization (NGO) by the name of *Heartfile* (http://heartfile.org) approached Pakistan's Ministry of Health and lobbied for the development (implementation and evaluation) of a public health/ health promotion policy that specifically addressed non-communicable diseases from a prevention and wellbeing perspective. A tripartite partnership was formed between the Ministry of Health, the World Health Organization and *Heartfile*, a unique combination of public-private sectors working together to support national health goals (Nishtar et al, 2005).

In 2004, the *National Action Plan for Prevention and Control of Non-communicable Diseases and Health Promotion in Pakistan* (NAP-NCD) (Ministry of Health, WHO and *Heartfile*, 2004) was launched and the first planning phase for implementation was initiated. This public health/health promotion policy is both a policy and an implementation document and is Pakistan's first national policy devoted specifically to the prevention and control of non-communicable diseases and health promotion and therefore is a milestone in public health/ health promotion policy development.

What policy development cycle did the NAP – NCD follow?

In the absence of a *Pakistani Policy Cycle* reference, the *Australian Policy Cycle* (Bridgman and Davis, 2004) has been utilized to analyze the development of the NAP – NCD policy as seen in figure 1.

Bridgman and Davis (2004) state that *much policy begins with* ***identifying issues*** and during the initial planning phase of the NAP - NCD, there was the identification that non-communicable diseases such as cardiovascular disease, lung disease, diabetes and cancer contribute significantly to the illness of the Pakistani population; secondly these diseases are very costly in their treatment (incurred on the health system) and thirdly, if there are significant numbers of people affected by morbidity then this affects the social and economic productivity of a nation (Heartfile, 2003a).

In addition to the identification of the impact that the afore mentioned diseases have on the Pakistani society they *do not feature prominently in Pakistan's National Health Policy and are not addressed in a prevention and control paradigm* (Heartfile, 2003a). According to Bridgman and Davis (2004) *sometimes an existing policy proves no longer effective and requires an overhaul....* and with this new public health/health promotion policy, *Heartfile* identified the fact that the current national health policy did not give due coverage of these non-communicable diseases and community health promotion therefore a new strategic framework was needed.

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Heartfile successfully identified the issues and put non-communicable diseases, prevention and community health promotion on the agenda for consideration by the Federal Government.

According to Bridgman and Davis (2004), ***policy analysis****, is often - though not always - the work of the public service, drawing on broader debates among specialists in a policy field.* In the development of the NAP - NCD, decision makers were provided with a situational analysis by *Heartfile* about the policy problem (i.e. non-communicable diseases and health promotion) so the decision makers could make an informed decision and provide information/data for debate. *Heartfile* provided a situational analysis due to their technical expertise in the area which examined programs and policies within Pakistan to review existing prevention and control related efforts and to identify gaps related to policy, implementation and research. The action plan was led by *Heartfile* until the time of its development and launch.

Policy analysis leads to *identification of appropriate* ***policy instruments*** (Bridgman and Davis (2004) and with this public health/health promotion policy, the instrument selected was a national action plan with an Integrated Framework for Action. The dual approach provided a guide for the policy maker and bureaucrat and was scientifically written to appeal to the public health/health promotion community.

Bridgman & Davis (2004) state that... *through* ***consultation****, policy proposals are improved, ideas tested and, appropriate, support gathered.* One of the major strengths in the development phase of the NAP - NCD is related to the wide consultation which started with the tripartite collaboration of the Ministry of Health, Government of Pakistan; WHO and *Heartfile*. In addition to the three main partners, other relevant players or actors were consulted, for example: the scientific community; public health practitioners; related organizations; other stakeholders, key leadership and staff.

In an Australian policy cycle context, the ***co-ordination*** element of the cycle requires discussions with treasury about available funding and to consider the relation between a new proposal (in this example the NAP - NCD) and overall government direction (in this example Pakistan's *National Health Policy)*. The development of the NAP – NCD was well situated within the overall direction of the government's health policy and availability of resources was discussed. *Heartfile* successfully lobbied the Ministry of Health to allocate funding to the action plan and transform it into a program.

The ***decision phase*** in the policy cycle means consideration by cabinet or other recognized authority and in this case a committee of the Ministry of Health and the Planning Commission had the mandate to take such a decision. According to Bridgman & Davis (2004)...***implementation*** *must follow, in which policy is given expression through legislation or a program, in pursuit of the goals agreed by ministers.* With the NAP - NCD an Integrated Framework for Action was included to prioritize and direct the implementation of the policy.

Under a formally approved Planning Commission 1 (PC 1) (Ministry of Health, Planning Commission, 2003) allocations have already been made to support two major community health promotion initiatives namely the media focused behavioral change communication strategy and a communication campaign at the grass roots level utilizing the Lady Health Workers of the National Program for Family Planning and Primary Health Care (2nd Goal) (Heartfile, Ministry of Health, WHO and 2004).

According to Bridgman and Davis (2004) ...***evaluation*** *is essential so government can gauge the effects of a policy and adjust or rethink policy design as appropriate.* Similarly, partners that have supported a policy development such as WHO and *Heartfile* also need to know the effectiveness of the policy and to assess the viability of continuing as a partner both in terms of time commitment and other resources (e.g. funding). In addition evaluation can help in redesigning or fine tuning community health promotion programs in response to process, impact and outcome evaluation findings.

In conclusion, the development of Pakistan's first *National Action Plan for Prevention and Control of Non-communicable Diseases and Health Promotion* adhered to a comprehensive and well planned policy cycle; its implementation in the community setting aimed at promoting health and well-being has been initiated and ongoing monitoring reports indicate a supportive public – private partnership approach.

Figure 1

Identify issues ⇨ policy analysis ⇨ policy instruments ⇨ consultation ⇨ co-ordination ⇨ decision ⇨ mplementation ⇨ evaluation ⇨ identify issues etc.

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From testimony to advocacy: a humanitarian NGO's experience

J. Ancien

Doctors of the World France (*Médecins du Monde,* MdM) is an international humanitarian aid NGO working to support access to health care to vulnerable populations of the world excluded from these services. MdM has fixed two strategies to «cure and give witness,» especially in light of the flagrant injustices lived by the populations they work with. Based on the need to improve the situation of these populations, and using the Anglo-Saxon model, the association wanted to take their strategy one step further by progressively developing advocacy actions in partnership with other organizations. This case study shows the different success obtained through advocacy actions in two campaigns: one against the World Bank's promotion of health systems'privatization in 1993 and another one for the increase in training of health care workers in the South in 2006.

A healthy park: the case of a prevention and community health promotion programme in a marginalised area in the Peruvian forest

E. Peñaherrera Sánchez and W. Palomino

The healthy park initiative is an example of a prevention and health promotion programme in a community affected by high levels of drug use. It was developed through a strategic partnership with local actors (such as community leaders and youth groups), public institutions (Health and Education Ministries and the local police) and private sector institutions (NGOs, local commerce). The community involvement was essential throughout the project''s entire process of design and implementation. Community members were empowered through direct responsibility for carrying out the project and its follow-up, through advocacy initiatives and financial accounting with the funding agency, the Belge Technical Cooperation group. The key programme outputs include the creation of a framework for community coexistence and a community development plan, which allowed not only to plan and distribute responsibilities among the neighbours for the park''s care and maintenance, but also to coordinate an increase in services and development opportunities with the local authorities.

Network of healthy communities of Rio de Janeiro – Brazil

Daniel Becker[1,2], Katia B. Edmundo[1], Wanda Guimarães[1], Maria S. Vasconcelos[1], Daniella Bonatto[1], Nilza R. Nunes[1] and Ana Paula Baptista[1]

Abstract: Poor communities in Rio de Janeiro, which are known as favelas, suffer from various problems related to poor housing, poverty, unemployment, violence and organized crime, and lack of access to basic services, such as health care and education. In order to tackle these determinants, and inspired by WHO's international Healthy Communities/Cities movement, the Network of Healthy Communities of Rio de Janeiro was formed in 2004. The Network is coordinated by the Center for Health Promotion (CEDAPS) and now includes more than 100 community groups and organizations in the state of Rio de Janeiro. Their aim is to promote health, community development and equity through community empowerment, participation, capacity building and advocacy. The paper describes the work that has been done since the Network's inception and the challenges which they face to reach their goals in the context of a country like Brazil. The Network represents an important landmark of how poor populations can organize themselves in a collective, participatory and constructive way to influence public policy and strive for better conditions of life in disadvantaged settings, like the favelas. (Promotion & Education, 2007, (2): pp)

Key words: poor communities, empowerment, health promotion, equity

Résumé en français à la page #. Resumen en español en la página #.

Background

The Network of Healthy Communities of Rio de Janeiro is a social initiative for promoting health and equity, especially through community development. The approach was inspired by the international Healthy Cities movement, which was launched in 2005 by 59 communities, with the support of the Dreyfus Health Foundation, the Brazilian Ministry of Health, the Rio de Janeiro Municipal Health Secretariat, the Pan-American Health Organization (PAHO), the Ford Foundation, several universities and NGOs.

Poor communities (*favelas*) in Rio de Janeiro suffer from serious problems, such as poor housing and environmental conditions, unemployment, lack of recreation and cultural life, and restricted access to basic services such as health and education. In addition, they are severely affected by violence from organized crime and the state police.

Public policies directed towards low-income communities in Brazil are scarce and almost always implemented without taking local needs into account; therefore, they fail to harness the potential of local talent. Residents have limited opportunities to participate and contribute to the development of these policies. As a result, the effectiveness, sustainability and ownership of social interventions are reduced.

It is thus crucial to increase opportunities for community participation in the development and implementation of social sector community projects. Networking of community groups can increase their collective political strength and enable them to operate autonomously. Networking can also enable the building of capacity in low-income communities thus enabling them to participate in decision-making relevant to programs that affect them.

Besides, poor communities have many untapped resources. These include: social networks, solidarity, celebration and culture, businesses, informal activities on education, recreation, religion, politics and much more. There are men and women that even in the midst of extreme poverty, violence and lack of services, break the isolation of their homes and become agents of a social action that benefits their communities. Capacity building and networking can strenghten this potential.

Given better opportunities to develop their skills and potentials, with better chances of interaction with the civil society and the state, community members can increase their contribution to the economic, social, and cultural development of their communities.

It was within the context of these realizations that the initial goals of the Network were formulated; these are to:

- strengthen and empower each community group through capacity building, planning and systematization of actions, meetings and exchange of experiences and opportunities;
- improve the collective power, to strengthen the capacity of communities to defend their right to health and to negotiate programs and public policies;
- increase social participation, so to influence local governance and open avenues for communities to become stakeholders in health (and other) public policies;
- increase visibility of positive actions in favelas, fighting prejudice and stigma.

The Network of Healthy Communities presently compromises 106 members - groups and associations that work for development and health promotion in poor communities in the State of Rio de Janeiro. According to a recent survey, the total population of those territories is over 1.4 million people. 68% of leaders are women, and 75% are African-Brazilian. 92% use their own resources (including personal finances) for their work. They engage in all kinds of forums and committees to obtain resources to their communities and to voice their problems and needs. Their work reaches directly 130,000 people and many more indirectly.

The Rio de Janeiro-based non-governmental organization Center for Health Promotion (Cedaps, 2007) acts as a technical and political reference for support, channeling its resources, projects, and institutional partnerships to the Network. Cedaps builds the capacity of organizations to plan strategically and develop local actions, helps them to produce educational material and activities, articulates integrated actions and events, promotes partnerships and strengthens the capacity to negotiate with the government and the private sector.

To reach these goals, CEDAPS uses an empowerment-oriented methodology, "Shared Construction of Solutions" (Cedaps, 2007), based on the Problem Solving for Better Health (PSBH) program, developed by the Dreyfus Health Foundation, based in New York, in more than 30 countries worldwide (Dreyfus Health Foundation, 2002)., and on additional elements from well known methodologies: Healthy Cities; Carlos Matus'Strategic Planning (Azevedo, 1992); Local Development (Becker et al.,

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2005), Paulo Freire's Popular Education (Freire, 2000) and others).

This social 'technology' creates an opportunity for the direct participation of community leaders and groups, enabling them to contribute in problem solving, through indigenously derived solutions that harness available resources and partnerships. This enables mobilization of the community and its resources and a network of social projects, with solutions that have the potential to generate direct impacts. The people who suffer with the problems become problem solvers, active stakeholder,. acting to change the social determinants of health. The collective construction systematizes and organizes local actions, promoting ownership and sustainability to the development process initiated.

Community-based interventions have contributed to tackling issues such as domestic and street violence, lack of cultural and sport activities, prevention of HIV/Aids and other infectious diseases, adolescent pregnancy, income generation, environmental and sanitation problems, smoking, hypertension and diabetes and community organization.

Meeting the challenges

A major challenge of the network is how to evaluate and demonstrate changes and benefits of such a program, which works with so many intangible variables; and therefore, systematizing and collecting these results is very important. Many of the member communities have been working with CEDAPS for more than 10 years to do so. Some of the results achieved at a process and output level are as follows:

- 13 HIV/Aids community managed Prevention Centers;
- Almost 400,000 condoms distributed every year;
- More than 1,200 educational events and activities yearly;
- Several health promotion activities developed by community leaders;
- Creation of innovative educational strategies and material;
- 700 adolescents in 11 communities have participated in education programs that promote autonomy, self-esteem, and social entrepreneurship; 80% of them express better understanding of citizenship, better self care, social responsibility, and better perspectives for the future;

Local development programs that engage residents since the diagnostics phase, creating integrated networks of community projects in health, environment, leisure, education, and income generation.

Another important challenge consists on broadening those results into the collective perspective of a network organization. In addition to strengthening local actions, it is also important to break the isolation and engage people in collective and solidarity actions. Some indicators reflect this empowerment process (Wallerstein, 2006), such as, the leaders, who:

- Learn to develop projects, to speak in public, to organize their actions and physical space;
- Establish partnerships, circulate in academic and political environments;
- Negotiate and co-manage social programs;
- Support the actions of their peers, disseminate information and opportunities, exchange experiences, get organized to fight for collective causes;
- Obtain media coverage and campaigns, gain visibility and break the segregation of favelas;
- Broaden their horizons, participating in forums, meetings, conferences, and councils.

A third challenge is to effectively increase social participation in public policies in a country like Brazil. In this area, changes have started to emerge. The Network is directly involved in partnerships with public policies, in Primary Health Care programs, the Pan-American Games in Rio de Janeiro, groups that fight social violence and others. In this regard, Cedaps is working to improve the Network capacities in advocacy and social control of public resources.

The forth challenge is sustainability. CEDAPS doesn't have a direct line of funding for the Network's activities, and it is struggling to obtain resources that allow for intensifying the collective and capacity building activities. In the long term, we expect that cooperation with public policy makers will help to sustain the program.

Finally, there is also the challenge of how to disseminate this experience and facilitate an exchange. CEDAPS is constantly seeking for such opportunities. As part of the Dreyfus Health Foundation's global PSBH community (with 30 countries), we plan to integrate other initiatives into an international network of communities. Cedaps has published several articles about the Network, it is co-creating the Brazilian Network of Healthy Communities and Municipalities, and has joined IUHPE's Global Consortium for Community Health Promotion and the Knowledge Network for Urban Settings of WHO's Commission for Social Determinants of Health. Our next goal is to participate in South-South cooperative programs.

Perspectives

The Network of Healthy Communities represents an important step in the ability of poor populations to obtain better public policies. Our work recognizes that there are community leaders and groups that strive for better conditions of life in favelas, and that their work must be reinforced.

The Network is demonstrating that an organized movement, created in a collective, participatory, and constructive way, can reinforce the effectiveness of each group, and create collective power for broader and more ambitious achievements. We hope that it will represent a landmark for health promotion in communities.

We all seek utopia – an integrated, equitable, and healthy city. As Mário Quintana, a Brazilian poet, used to say, «certain things cannot be achieved, but this is not a reason to give up seeking them». The Network of Healthy Communities wants utopia and works to achieve it.

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Development of Healthy Cities networks in Europe

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Abstract: The Healthy Cities network in Europe was inspired by the Ottawa Charter for Health Promotion when it was launched in 1987. The networking process was initiated by the WHO Regional Office for Europe, but developed its own dynamics in different European countries during a time marked by fundamental political transformations in many of the countries of Eastern Europe. The networks then connected with the 'Local Agenda 21' and the 'Sustainable Cities and Towns Campaign' to create a new and broader programmatic agenda at the local level. City Health Profiles and participatory policies, which can contribute to new forms of urban planning and local governance. In particular, the «Aalborg plus10 – commitments» of local governments in 2004 have the potential to inspire a new phase of participatory and sustainable policies at the level of local communities in Europe. However the extent to which these initiatives will influence the macro-politics of the European Union towards a proclaimed "Europe of Citizens" remains to be watched carefully during the coming years. (Promotion & Education, 2007, (2): pp)

Key words: healthy cities, Europe, sustainability

Résumé en français à la page #. Resumen en español en la página #.

The founding role of the WHO European Region

The Healthy Cities project was launched in Europe in 1987 by the WHO Regional Office for Europe. It was clearly inspired by the Ottawa Charter and the «Health for All» strategy. The public response revealed that the initiative was timely in a Europe, which was undergoing a political transition, especially in the East. Besides the organization of a formal WHO-led European Healthy Cities Network, which has so far implemented over four, 5-year phases of structured and goal-oriented collaborative activities with a limited number of especially committed cities, an open process of regional and national networking of interested cities and counties has also been stimulated.

The movement quickly spread and, after two years, in 1989, more than 350 cities in Europe had declared themselves members of a national healthy city network and many more expressed their interest in joining to address the public concerns related to urban health and living conditions. Today more than 1300 cities, districts and counties are members in more than 30 national networks; however the motivational impetus to these efforts is clearly on the decline and needs new political commitment to take this process successfully into the future.

During the last 20 years the importance of the urban dimension of living conditions and the key role of local governance for the planning of appropriate health services and and of sustainable living conditions has become widely recognized . The European region has experienced enormous political and constitutional changes during thelast 20 years . Between 1989 and 1996, 27 states in the eastern part of the Region adopted new constitutions with the overall trend to decentralize and democratize political processes. Municipal governments have been delegated more responsibility and autonomy to set priorities and decide policies in areas such as education, social services, health services, community care, environment, and health and urban planning.

During this process of change, a parallel process of dramatic decline of public financial resources took also place and imposed severe constraints for political initiatives at the local level. Under these circumstances, the development of activities at the local level and the organization of national networks varied considerably in the different countries and regions . The structure of national health systems, the existence or lack of supportive national and regional policy frameworks for «Health for All» or for sustainable development in the context of the Local Agenda 21, as well as the distribution of responsibilities and resources for service delivery between local governments, regional structures and the national governments, heavily influenced the potential for common actions.

During the first years of the European Healthy Cities network the WHO mainly helped to share information and to facilitate training and resource development for the networks. Later, in addition, it tried to strengthen the organizational and strategic capacity of the national networks and urged national governments to recognize them as important structures and players in urban and public health. Coordinators and political leaders from national healthy cities networks met regularly and cooperated directly with WHO in a special European forum for networks. An important achievement of this cooperation has been the adoption of a common set of minimal standards for a Healthy City and an action framework, which aspired to raise the professional standards of healthy cities activities in the different networks and their constituent cities.

As a new working method, city health profiles or health development plans were introduced. These techniques were originally developed by piloting within the WHO European Healthy Cities network. The profiles should provide a basis for a city to develop an intersectoral plan for joint actions with its partners derived from a quantitative and qualitative analysis of social, environmental and health data, as well as the actual experience of citizens. In some countries, member cities have undertaken population surveys with the aim of spotlighting community priorities and citizens' views on health and environmental development.

National institutes of public health, universities and other research organizations have become increasingly important partners for many networks, since they can secure a sound methodological approach for core tasks, such as the city health profile. National networks and the improvement of international communication have encouraged many cities to move away from a culture of organizing single events to a culture of producing strategic health plans, in which promoting health through intersectoral cooperation becomes an aim for all city departments. The employment of health promotion specialists at the municipal level has fostered these innovative processes in public bureaucracies.

Different surveys and assessments carried out in the European Region indicate that long-established healthy cities networks showed a clear potential to:

- provide a testing ground for new participatory health policies and citizen

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involvement;
- generate and disseminate knowledge and new ideas through cooperation, conferences, newsletters, websites and organizational development;
- promote best practices by setting standards, giving guidance and consultation, providing training and supporting the professional development of health promotion specialists;
- strengthen local capacities in adopting good governance approaches based on the principles of «Health for All» and the Local Agenda 21;
- inform national policy developments by condensing and advocating local needs.

Opening towards sustainable development and health in a global context

During the last 10 years a number of attempts have been made in Europe to link

the Healthy Cities networks with urban planning and sustainable local development initiatives.

The following principles were seen as key for healthy urban planning (Barton et al., 2003):
- Human health as a key facet of sustainable development
- Cooperation between planning and health agencies
- Cooperation between the public and the private sectors
- Community consultation and empowerment
- Political commitments at the highest level
- Health integrated plans and policies
- Health integration at all scales from macro to micro
- A comprehensive approach to determinants of health
- Evidence-based planning for health

WHO Regional Office for Europe has made healthy urban planning a core developmental theme of the fourth phase (2003-2007) of the European Healthy Cities Network.

Common programmes at the level of the European Union have been launched, which led in 1994 to the Sustainable Cities and Towns Campaign to integrate health into the broader sustainability discourse.

The national Healthy Cities networks in Europe rarely reached the level of common goal setting with regard to local policy development. The Sustainable Cities and Towns Campaign, conversely, initially obtained 80 European local authorities to sign up to the Aalborg Charter on 'European cities and towns towards sustainability'and committed themselves to its objectives. This document was then renewed in 2004 with the "Aalborg plus 10 – commitments" including a common vision that "cities and towns are inclusive, prosperous, creative and sustainable, and provide a good quality of life for all citizens and enable their participation in all aspects of urban life." (Aalborg Commitments, 2004) The amended document takes into account the challenges faced with globalization and the revolution in technology, as well as the other social, economic, environmental and political determinants; and underlines that working with all the spheres of government is central to combat the determinants.

The next European conference of the Sustainable Cities and Towns Campaign in Sevilla (Spain) in 2007 will reveal the extent to which the ambitious commitments laid out by the Charter have gained substantial support by the different European governments and the European Commission on the route towards a proclaimed "Europe of Citizens".

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EQUINET: Networking for equity in health in east and southern Africa

Rene Loewenson[1]

Abstract: This short report outlines the perspectives and motivations for the work of the Regional Network for Equity in Health in east and southern Africa (EQUINET). It presents key areas of work on health equity being implemented to strengthen the state and public sector in health, organised around the active participation and involvement of communities. This includes work on strengthening people's power for health, on increased fair financing; on retaining health workers and challenging trade policies that encroach on health. Such work faces challenges that can be met through increased regional networking to exchange experience, information and expertise, particularly given the demand for ìlearning by doingî. (*Promotion & Education,* 2007, (2): pp)

Key words: health equity; Africa; networks

Résumé en français à la page #. Resumen en español en la página #.

EQUINET was formed to promote and realize shared values of equity and social justice in health. It involves people working in government, civil society, research, Parliament and other institutions in east and southern Africa (ESA) (www.equinetafrica.org).

We have since 1998 used and supported research and policy analysis, held forums for skills development, analysis, dialogue, learning and engagement, strengthened networks and formed alliances towards achieving health equity. These activities jointly have contributed to an affirmative vision of the health systems that we would want to build to deliver on equity goals.

The lessons learned indicate that achieving equity, while demanding technical and public policy choices, is centred on a strong state and public sector in health, organised around the active participation and involvement of communities. As found in other regions, rising investment in health through the public sector is necessary to support the universal health systems and redistributional policies necessary for improved health outcomes (UNDP HDR 2003; EQUINET SC 2000).

Different areas of work in EQUINET thus feed into an understanding of how to achieve this, with research, capacity building, policy dialogue and information exchange to:

• Support the strengthening of **people's power for health,** including the power and ability that people have to make and implement choices over health inputs. Work in the network is informing parliamentary and civil society processes and building skills for participatory methods in health systems. EQUINET supported research highlights that public participation in health can have a positive impact on health outcomes and the performance of health systems, particularly when linked to mobilisation around collective action to realise social and economic rights (Loewenson et al 2005; Ngulube et al 2005; London 2004).

• Provide **increased fair, sustainable and equitable financing** for health at national, regional and global level. This includes exploring options for increasing resource mobilization through mechanisms that provide for universality (like taxes and social health insurance), and that protect households against the impoverishing effects of health costs. This complements work done on mechanisms for allocating public resources fairly between geographical areas, in reflection of health need (McIntyre et al 2005).

• **Ensure that health workers are valued, motivated and retained within our health systems.** Responding to the outflow of skilled health workers from public sector district health systems to high income countries, work is underway with the Regional health secretariat in east, central and southern Africa to review and support implementation of incentives to retain health workers and to identify and propose options to manage the costs and benefits of health worker migration. (EQUINET, TARSC, HST, UNAM 2006)

• **Challenge trade liberalization and encroachment on health**, through identifying ways of protecting health in trade agreements, and exploring how health systems can promote nutrition in ways that support household control of food production, particularly for women farmers (Bond 2006, Chopra 2005).

Challenges to equity actions

As in many networks, EQUINET faces challenges of communicating across different constituencies, and of spreading skills and capacities across the region in a context of under-resourced institutions facing multiple demands. While universal access to life-saving antiretroviral medicines (ART) is now recognized as a policy goal, treatment access is still affected by constraints within health systems. This calls for 'learning while doing' approaches that share knowledge and experience while implementing change (Makwiza et al 2005). We are challenged to learn not only about what measures and processes will enhance health equity, but also how to advance equity-oriented change in policy and practice in ways that strengthen local capabilities and autonomy.

> *"I learned that learning participatory approaches starts with three days and takes three decades"*
> Participant at an EQUINET training workshop, Tanzania 2006

We do this in a process of globalization that is unequal in its distribution of costs and benefits, weak in regulating and managing its social costs and promoting market led reforms within the health sector that widen inequalities in health (UN WCSDG 2004; EQUINET SC 2004) . As the health costs of such polarization visibly increase, so too does the gain from networking across countries to protect equity in health in the region.

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This article outlines work of institutions in EQUINET more fully described and published at . EQUINET is governed by a steering committee involving institutions leading work in the network in east and southern Africa, ie Training and Research Support Centre, Peoples Health Movement Tanzania ; Community Working Group on Health, University of Zimbabwe, CHESSORE, Centre for Health Policy Wits University, Health Economics Unit University of Cape Town, Tanesa Tanzania; Malawi Health Equity Network; ; Health Systems Trust, University of Namibia, University of Cape Town; University of Western Cape; Health Sciences Research Council South Africa and Southern and east African Trade and Information Negotiations Institute, Southern and east African association of parliamentary committees on health and REACH Trust Malawi.

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Global Equity Gauge Alliance

Antoinette Ntuli[1]

Abstract: The lack of attention to equity in health, health care and determinants of health is a burden to the attainment of good health in many countries. With this underlying problem as a basis, a series of meetings took place between 1999 and 2000, culminating in the creation the Global Equity Gauge Alliance (GEGA). GEGA is an international network of groups in developing countries, mainly Asia, Africa and Latin America, which develop projects designed to confront and mitigate inequities in health, know as Equity Gauges. Equity Gauges aim to contribute towards the sustained decline in inequities in both the broad sociopolitical determinants of health, as well as inequities in the health system. Their approach is based on three broad spheres of action, known as «pillars»: 1) measurement and monitoring, 2) advocacy, and 3) community empowerment. Through a series of examples from local or national level gauges, this paper showcases their work promoting the interaction between research and evidence based policy formulation and implementation, and the interaction between the community and policy makers. (*Promotion & Education,* 2007, (2): pp)

Key words: equity, determinants of health, empowerment

Résumé en français à la page #. Resumen en español en la página #.

The Global Equity Gauge Alliance (GEGA) is an international network of groups in developing countries that facilitate processes designed to confront and mitigate inequities in health. In 1999 and 2000, a series of meetings involving researchers and activist NGOs noted that, despite the 1978 Alma Ata Declaration, which emphasizes the importance of equity for the attainment of good health, inequities still, prevailed and continued to grow worldwide. The concern that few countries were giving adequate attention to measuring and monitoring equity in health, healthcare, and the underlying determinants of health, culminated in the establishment of an organized consortium of eleven (now grown to fifteen) health equity projects, called Equity Gauges, based in Asia, Africa and Latin America.

Equity Gauges focus on disparities that are unjust and unfair, and place health equity squarely within the larger framework of social justice. Their focus goes beyond the monitoring of inequities. Equity Gauges aim to contribute towards the sustained decline in inequities in both the broad sociopolitical determinants of health as well as inequities in the health system. On the understanding that socio-political and health inequities are mediated by differentials in power, the Equity Gauge strategy includes an explicit set of activities designed to empower those who are marginalised and disempowered as an essential element of improving health equity. This active approach to equity is supported through three broad spheres of action, called «pillars» of the Equity Gauge. The *Measurement and Monitoring* pillar is focused on monitoring and measuring population health, and identifying socioeconomic and other determinants at work; *advocacy* for pro-equity policy aims to motivate action by policy makers and to increase accountability; and, the *community empowerment* pillar aims to amplify the voices of marginalised communities and plays a critical role in creating a sustainable culture of expectation for equity in society.

Equity Gauge teams are varied in their membership and include representation from Ministries of Health, Education, Water and Sanitation, local governments, legislators, policy makers, community organisations, public and private research and policy institutions, universities, international NGOs and other social groups. These diverse groupings utilize the three pillar approach to formulate individual country or local area activities that promote the interaction between *research and evidence based policy formulation and implementation*, and interaction between the *community and policy makers.*

Research conducted by Equity Gauges has been influential in the inclusion of equity indicators in some national information data sets, has strengthened measurement capacities at country level, and has pointed to the need for regular monitoring of inequities in health. In South Africa, the Cape Town Equity Gauge demonstrated the unfair allocation of financial and human resources between health districts serving those who are rich and those serving poor communities in the metropolitan council and their work led to policy changes in human resource allocations. Need reference here

Some of the success of the Gauges has been attributed to the inclusion of political representatives and senior health managers in the steering committee of the project. The inclusion of parliamentarians as core Equity Gauge team members has promoted the use of research to assist them in monitoring the implementation of pro-equity policies. An additional benefit has been the strengthening of participating parliamentarians appreciation of the difference between «pro-poor» and «equity oriented» activities and policies.

Reliable and valid information gathered from the measurement process forms a strong basis for evidence based policy recommendations and raising of public awareness. Equity updates emanating from equity studies are disseminated through publications, newsletters, newspaper articles, conferences and seminars with policy makers and training workshops. The Chilean, Nairobi and Zambian Gauges have held Equity workshops for journalists to ensure that concepts of health equity filter into the public domain. These platforms provide advocacy opportunities in which the potential of evidence gathered locally for pro-equity policy development is demonstrated.

Evidence gathered by Gauges assists in identifying communities affected by unjust resource allocation. Equity Gauges collaborate with affected communities to make information available and accessible and to advocate for pro-equity changes. This collaborative and empowering effort has at times resulted in the development of the community's own monitoring processes and the recognition of the right of the community to participate in the planning, implementation and management of health and other social services.

The Pakistan Equity Gauge facilitated the process of understanding fairness in

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health and included participation of men and women from a rural district, health care providers from public service, NGOs, and elected representatives. In twenty three villages men and women conducted an equity analysis separately and prioritized disparities that would receive immediate attention. A joint workshop attended by villagers, local government, civil society and community members resulted in the development of an advocacy plan aimed at influencing stakeholders to work on the identified disparities.

In Zambia, a series of in-depth workshops at the local level involving community representatives and health workers led to joint action that improved the quality of care, strengthened skills for local monitoring and assessment, increased the communities' capacities to influence local decision making, and amplified community voices at national level.

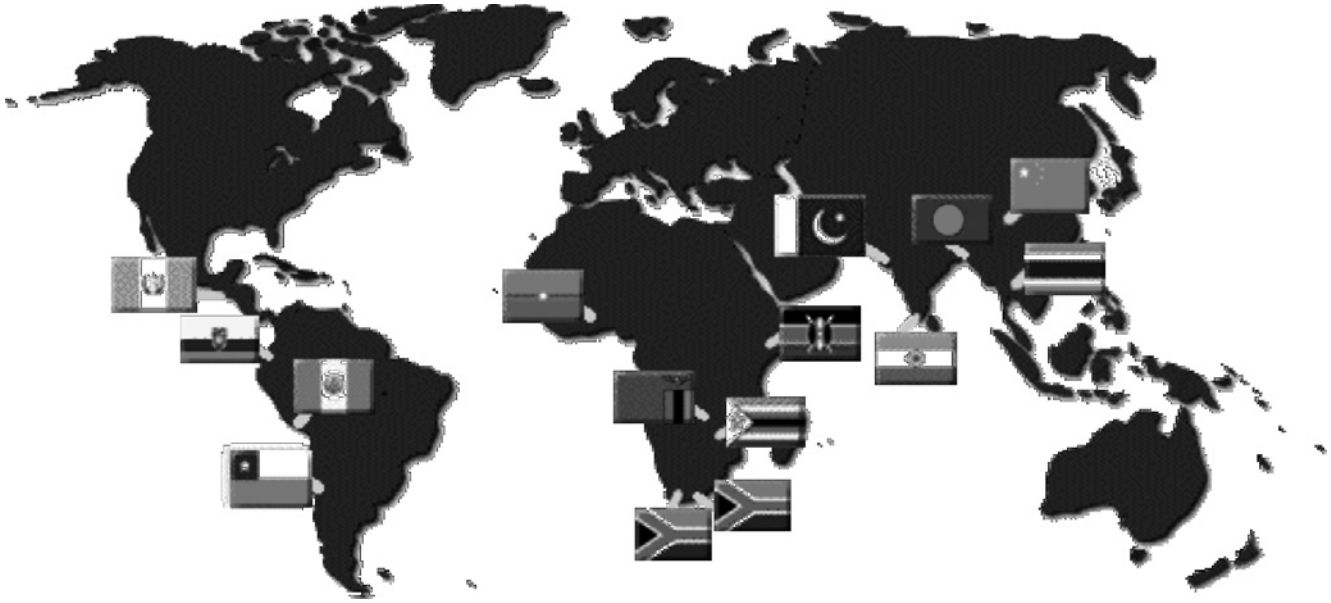
Many of the Equity Gauges originated in research and tertiary institutions with an «expert» role in research. This has proved to be a limiting factor for implementing the community empowerment pillar which requires specific sets of technical abilities and which can be time consuming. This challenge is being overcome through capacity development of the Gauges themselves and through collaboration with local organisations recognised for their expertise in community development.

GEGA has also been active at the global level. Concern with unjust international political and economic frameworks and policies has resulted in GEGA partnering with health activist organizations, including the People's Health Movement and Medact, to produce the Global Health Watch, evidence based analysis of the political economy of health and health care.

GEGA's shared vision and approach has benefited Alliance partners and has enabled:

- Sharing of lessons learnt and experiences between the different Gauges
- The creation of critical mass of experience to enable evaluation of the Equity Gauge strategy and to develop a proof of concept
- Sharing of skills and expertise between Gauges
- Country Location of Equity Gauges

Country Location of Equity Gauges



Showcasing networks – Abstract

The Quebec Healthy Cities and Towns Network: a powerful movement faced with new challenges

P. Simard

After twenty years serving its members, the Quebec Healthy Cities and Towns Network (QHCTN) faces several challenges. There are currently many changes being made in the local organization and the administration of services. The Network, through its capacity to mobilize the different municipalities, is the best placed to advocate and support a coordinated approach to government initiatives and also to encourage partnerships with other institutions (education, health, socio-economic) and communities. There is, nonetheless, a need to rethink its direct support to members, especially in terms of communication and networking among them.