Abstracts

The Effectiveness of Health promotion: Canadian and International Perspectives, June 17-19, Toronto, Ontario, Canada

THE EFFECTIVENESS OF COMMUNITY ACTION IN HEALTH PROMOTION: A RESEARCH PERSPECTIVE

by Marie Boutilier, Ph.D, North York Community Health Promotion Research unit, Department of Behavioural Science, University of Toronto

Abstract

Within the community there are multiple perspectives on community health promotion and the effectiveness of community action. This paper outlines community health promotion as a "practice" within four "arenas": health and social services, community activism, policy, and research. Adopting the Ottawa Charter's vision of empowerment and community development as key to community action, the features of an empowering practice are reviewed. Research is described as a practice to be held up to examination as empowering, similar to other practices which adopt a community action strategy. The possibility for research as an empowering practice is considered within the context of two research approaches: positivist and interpretive/constructionist, with reviews of studies within each approach. The dilemmas which researchers face in adopting an approach which supports community action are outlined as issues of effectiveness and accountability. Key questions are: 1) how can researchers adopt an empowering practice to strengthen community action? and 2) within the accountability and effectiveness web, how can researchers acknowledge and honour the community's perspective in health promotion?

Effectiveness, accountability and community action in health promotion: implications for an empowering research

I began my remarks by outlining four perspectives, or arenas of practice, that converge on the community in the name of health promotion: health and social services, policy, research, and community activism. Reviewing empowerment and community development as core elements of community action, and the features of empowering practice, my earlier questions were: 1) how can researchers adopt an empowering practice to strengthen community action?; and, 2) within the accountability and effectiveness web, how can researchers acknowledge and honour the community's perspective and agenda in health promotion? Similar to the other questions posed by this symposium, there are no simple answers.

1) Empowering research practice

Our experience in NYCHPRU leads to some observations. First, we do not claim achievement of a feat such as an empowering practice. A key element of our research however, in keeping with the Charter's guidance on community action and the approach of action research, has been the early involvement of community members as partners. The presence of partners with multiple perspectives also facilitates the reflexive posture of the critical social science perspective recently suggested by Eakin and her colleagues (1996), in that each step of the research can be questioned actively from a community perspective. Reflexivity in research echoes the "reflective practice" (Schon, 1983) which is at the core of practice-based action research.

Second, related to methods, we have found that community participants have a high expectation that any method that is used will be sound, demonstrate rigour and that methods will be appropriate to the objectives of the research. Community residents and health and social service practitioners have endeavoured to ensure that our collaborations will be in some sense generalizable and useful to others. In developing a research agenda, then, they may well look for outcome measures rather than interpretive understandings, and we adopt such methods as suit the needs of the research question (Mason and Boutilier, 1995; Boutilier, Cressman, Scarcello, et al., 1995; Boutilier, Mason, Rootman, et al., 1995; Boutilier, Mason and Rootman, 1996; Boutilier, Badgley, Sage, Marz, forthcoming).

2) Accountability, effectiveness and the politics of community research

In the complex settings of the community and the "institutions of research", key questions are, to whom are we accountable? Who will measure our effectiveness? The criteria will vary according to who poses the questions. In assessing our effectiveness and accountability, research practice is similar to other health promotion practices in that we must also assess our impact on those social relationships in which we intervene. Researchers seeking to adopt an empowering practice in community action, then, are confronted with a dilemma. The institution of research includes government funders whose influence is mediated by a peer review process. Review panels usually include researchers who practice within a conventional positivist stance, and expect that health promotion researchers will adopt the social planning approach similar to the demonstration projects reviewed earlier, with health issues and research questions well articulated before approaching the community. Review panels do not include members of communities with whom an empowering health promotion practice would seek to work, that is, people who are often of low education and income, women, youth, and elderly, or the practitioners who work with these communities and who are themselves thus lowered in status and political power by association (Reuschemeyer, 1986; Abbott, 1988). Thus to obtain funding researchers must priorize the funders' criteria of effectiveness and accountability, although they may or may not match those of the community and/or practitioners (Fawcett, 1989).

An observation drawn from the NYCHPRU experience is that in the interests of effectiveness and publicly-funded "good investments", health researchers are increasingly encouraged to link with health practitioners and community groups (rather than conduct esoteric non-applied research in the mythical ivory tower). Such thinking underlies the Ontario Health System Linked Research Units Grants program which has funded NYCHPRU. The grant allowed for the structure to be put in place, with a general research agenda rather than specific questions. Starting with a structure of research, rather than an issue-specific grant, allowed us to link with practitioners and community members within health promotion foci, but before we had specific health issues or research questions in mind (Rootman and Allison, 1993). This allowed for the formulation of methods that encourage community participation in line with the Ottawa Charter vision of community action. While we must still seek peer-reviewed funds, we have been allowed the time to establish community and practice relationships in formulating proposals, and have then met with some success in obtaining peer-reviewed grants (Badgley, et al., 1994; Jackson, et al., 1995). I would suggest that this model be considered by others seeking to encourage research-community collaborations in community action in health promotion.

As a last word, I emphasize the multiple understandings of effectiveness, and the complex web of accountability and its implications for how we formulate and answer our questions. It appears that we must continue to consider, negotiate, and contest, both collectively and as individual practitioners, the questions raised by Green and Raeburn in 1988, "Health promotion: What is it? What will it become?", and, "who will control health promotion?". Further, in recognition of the director who challenged researchers to find a "centre of the universe" beyond the university, we might pose the questions, "in whose interest is research formulated and conducted?" and "to whom is health promotion accountable?"

Building Healthy Public Policy

Prepared by Rick Edwards, Ph.D., University of Toronto

Summary

This paper begins by situating the question of health promotion effectiveness in a political and professional context. I show that the ways of obtaining an answer to the question may be biased by the prevailing norms of the context. I provide an overview of methods of economic evaluation of health activities to demonstrate the variety of ways in which the question, "Is health promotion a good investment?", might be answered. Cost-effectiveness analysis is common in the health field, but is appropriate primarily to head-to-head comparisons of alternative treatments for specific ailments. Cost-benefit analysis is more suited to intersectoral comparisons of benefit, but deals with health outcomes only as they are translated into a common currency. Cost-benefit analysis does have the advantage of broadening the scope of analysis, suiting it also to the wide range of benefits to which health promotion contributes. I show that none of these methods is value-free; all require judgement on the boundaries of analysis and the weighting to assign to considerations of equity.

I then consider healthy public policy per se. I propose that the concept itself is one of the recent incarnations of Hygeia, and that its effectiveness as an idea would require a specific kind of historical study. This is not examined in detail, although I refer to examples in which the healthy public policy has played an important political-philosophical function.

More specifically, I present a range of public policies from the four priority action areas identified at the Adelaide Conference on Healthy Public Policy in 1988: women's health; food and nutrition; alcohol; and environment. I use this last category to refer to "big picture" healthy public policies, discussing income redistribution as an example of an explicit social equity healthy public policy and then using the Healthy Cities project as an example of a whole system intervention exemplifying healthy public policy principles. Policy for the provision of early childhood support is mentioned because of the strong evidence that it prevents a wide range of possible ills over the long term.

The results show mixed success for policies to promote health. Strong evidence of effect is found for alcohol policies intended to reduce consumption and for the early childhood policies, but the effectiveness of even these policies is compromised by the essential political and value-laden nature of their implementation. The effectiveness of healthy public policies, therefore, cannot be understood independently of their political context, my original point in situating the questions of health promotion effectiveness in its political and professional context. Quite apart from any definitive answer to the question of the effectiveness of specific health promoting public policies, however, I conclude that, if the concept of healthy public policy did not exist, we would have to invent it in order to convey the social vision of health.

Communities and the Development of Personal Health Skills Among Youth: Synthesis of Minnesota Experiences in preventing Alcohol Use and Heart Disease

by John R. Finnegan Jr., Ph.D., and Cheryl L. Perry, Ph.D., Division of Epidemiology, School of Public Health, University of Minnesota

Abstract

This paper reviews and synthesizes a program of research aimed at youth health promotion and disease prevention. Specifically, the paper summarizes lessons learned about prevention and the development of personal health skills among youth in the Upper Midwest United States (Minnesota, North and South Dakota) in reduction of future heart disease risk and delay in the onset of alcohol use. Epidemiologic studies show that the earlier the onset of alcohol use among children and adolescents, the greater the likelihood of proximal serious injury and death and more distal serious problems and impairment as youth pass into adulthood. Moreover, epidemiologic studies reveal that serious risk of heart disease in later adulthood begins in childhood and adolescence through risk behaviours including smoking, high-fat diets, and sedentary living. Success in prevention with children and adolescents reduces mortality, morbidity and associated social costs both in the short-run (immediate risk of injury or death) and in the long-term (later adult mortality and morbidity). Successful prevention with adolescents and children is therefore an important investment with immediate and long-term impact on quality of life and social and health care costs.

Creating Healthy Environments

by Bo J A Haglund, Karolinska Institute, Dept of Public Health Sciences, Sweden

Abstract

Since the Ottawa conference in 1986 the concept of Supportive Environments for Health (SE) has evolved as a key strategy for health promotion work. The concept of Supportive Environments has been used in rehabilitation work for some time and its importance for physical or mental recovery for individuals is evident. But in the evolution of the new public health SE has acquired a new meaning. At the Ottawa Conference an ecological dimension was added to the health concept. Although the concept of SE was coined at the Ottawa conference it was at the Sundvall Conference in 1991 it was given a practical definition. The uniqueness of the Sundsvall conference was in the merging of issues of public health with environment, e.g. as presented in the "Our Commmon Future". This was then an important theme in Agenda 21. One of the major outcome of the conference was a handbook for creating SE called "We Can Do It!" In contrast to the prevailing and increasing amount of litterature using a hierarcy of evidenc to assess the effectiveness of means and results of medical and other health care practices, the handbook summarizes about thousand global case studies and experiences, and presents 171 "stories" as the basis for strategies for good health promotion praxis. This presentation take its starting point in theses stories and present the Health Promotion Strategy Analysis Model (Helpsam), providing a tool for analysing and planning health promotion as well as presenting seven common key strategies for health promotion. Setting specific strategies for health promotion such as education, work, transport and energy, housing and physical environments, food and agriculture, and social support leads up to a formula for succesful health promotion. Finally, the Supportive Environment Actions Model (SESAME) present a staged planning model for health promotion work. This model has also formed the basis for a "20 - Key Items for Health Promotion Actions" questionnaire used to systematize knowledge and experiences on creating Supportive Environments for Health.

In Summary

Thus supportive environments is one of the crucial means of promoting health. The words signify that health cannot be seen in a vacuum; it is determined to a great extent by environmental conditions. Environments are not just the visible structures and services surrounding us but have spiritual, social, cultural, economic, political and ideological dimensions as well. Furthermore, all these different facets of life are interwoven and inseparable. Influencing one will affect changes in the others, for better or for worse. But if a healthy societal development is to be maintained , the environment must be targeted for change. This is what is known as sustainable development, a term introduced in the Brundtland Report "Our Common Future" in 1987.

The focus of Sundsvall was on action - long overdue - to improve public health by creating Supportive Environments. The links between health and the physical environment have long been recognized, but inadequately addressed. Now, our old paradigm of ignoring pollution and waste has broken down. There is no away to throw things anymore. But we are still searching for that qualitative jump which allows for a synthesis between the social and physical dimensions of our environment, the individual and collective dimensions of our health, and the local and global dimensions of our action. Increasingly too, we realize

that the environment, as it affects health, includes social, cultural, economic and political aspects. If the goal of health for all is to be attained, the total environment must be supportive of health development. Only an enlightened, healthy and involved community can make this happen.

The goal of creating supportive environments for health has far-reaching implications for individuals and institutions throughout society. Building alliances is one of the key elements of health promotion and a central political concern - alliances across sectors, across disciplines, across professions and across organizations.

Environmental conditions represent a threat to health, and so do behavioural and lifestyle issues. Medical research provides a basis for identifying health problems. But to define strategies for health promotion and learn more about the processes involved, contributions from the social sciences are necessary.

One of the most important challenges is inequality itself. The contrasts between rich and poor countries and between regions within countries are large, and in some fields even expanding in terms of resources and health.

By and large, the prerequisites for environmental protection and sustainable development are the same as for health, namely: peace, education, food, income, a stable eco-system, maintainable resources, a supportive social network, social justice and equity. To this list we should like to add: DEMOCRACY.

Conversely, war and poverty are the worst threats to both health and the environment. Next comes depletion of natural resources, through exploitation and misuse, mainly by the industrialized countries.

We bear a heavier responsibility for the future of the planet and its peoples than any other generation. Scientifically, we know better and we have the technological and institutional experience necessary to do better. The population issue also has a direct bearing on the public health-environment connection. Culturally acceptable family planning programmes and radically improved access to various birth control methods is an absolute necessity. In many societies, women are grossly disadvantaged and their skills and resources largely untapped. Education of women and girls should be radically increased.

The world community sometimes acts slowly. People at the local level can influence their situation more directly and often more swiftly. Empowering individuals, local authorities and groups is crucial. Health is not only, and perhaps not even primarily, the concern of doctors and nurses. It is political, a question of influence, power and resources.

Change won't come easy. Advocating community participation means initiating a process of decentralization. Such a process will be a fundamental challenge in the face of the steady concentration of political and economic power in the hands of small elites. Sundsvall highlighted such concrete efforts!

A Story/Dialogue Method for Health Promotion Knowledge Development and Evaluation

by Ronald Labonte, University of Toronto, and Joan Feather, University of Saskatchewan

Summary

Health promotion, as a contemporary concept and practice derived from many disciplines and their diverse theoretical roots (MacDonald 1990), suffers an ongoing identity crisis. What is it or, more specifically, what does it attempt to achieve? For many practitioners health promotion is essentially disease prevention achieved through changes in lifestyle behaviours (NYCPHRU 1993, Labonte 1988/89). For others, health promotion works on unhealthy living conditions, the **Ottawa Charter for Health Promotion**'s prerequisites of "peace, shelter, education, food, income, a stable eco-system, sustainable resources, social justice and equity" (World Health Organization 1986). More recently, academics and practitioners have turned their attention to changes in social dynamics that are thought to influence both sets of outcomes, such as empowerment and community capacity (SPHE/CDC 1994, Wallerstein 1992, Labonte 1993).

Disagreements over what health promotion should accomplish spill over to how it should account for its effects. Are improvements in morbidity and mortality rates the "bottom line," especially in a tight fiscal environment where "evidence-based decision-making" is the new rhetoric driving government health "investments" (Federal, Provincial and Territorial Advisory Committee on Population Health 1994, Health Australia 1995, Labonte 1995)? Or is health promotion concerned primarily with people's subjective experiences of "positive health" (Antonovsky 1980, Labonte 1993) or quality of life (Renwick, Brown and Nagler 1996)? Or are these more distal outcomes, questions for health promotion research to sort through, while programs should demonstrate that they have achieved proximate changes in lifestyles, empowerment or community capacity? And, if the latter, through what practice means, what specific programs or activities?

One of the difficulties in answering these questions is determining whether some theory(ies) exist for health promotion, which surfaces a strained relationship between practice and theory (Buchanan 1994, Labonte and Robertson 1996). Practitioners often complain that they want less theory and talk, and more practical advice and action (Feather and Labonte 1995). Academics, whose practice in the world is theory and talk, often take solace in sociologist, Kurt Lewin's, aphorism that "there's nothing so practical as a good theory." The tension may have less to do with theory as a reasonably argued and defensible explanation of practice, than with how abstract theory is often imposed upon practice (Buchanan 1994) with little regard for the contingency of day to day life (Kelly et al 1993, Labonte 1996a). As MacDonald (1990) argues, health promotion theory should be, and is being, built from practice. The resolution to the theory/practice friction may be to stand Lewin's aphorism on its head by recognizing that "there's nothing so theoretical as a good practice." The issue then becomes one of working with practitioners and community group members to research and theorize their own work, for the intent of improving their own actions towards more clearly stated goals.

But once there is agreement over goals, how are they to be evaluated? Health promotion practice exists primarily within health institutions whose underpinning explanatory framework for health, and its determinants, is biomedical (Labonte 1995). This explanatory framework, in turn, rests on the knowledge assumptions of "conventional" or positivist science (Guba and Lincoln 1989, Labonte and

Robertson 1996), which attempts to understand complex relations by reducing them to specific variables that can be subjected to experimental manipulations. Research or evaluation emphasizes "objectivity" through use of randomized control or quasi-experimental designs, quantitative data and repeat intervention trials. While an important source of knowledge for health promotion practice, the conventional method often runs into difficulties when it is used to study people and their relationships, which are not as pliable to manipulation as are drug effects on cells:

* Making people subjects of researchers' questions rather than subjects of their own lives.

  Surveys are a common way of studying people in their day to day lives and are often used in program evaluations. But sometimes surveys are experienced by people (especially poorer people) as intrusive and intimidating (NYCHPRU 1993). Detailed technical surveys have led to people dropping out of health promotion programs or complaining that their own concerns were not being listened to (Kort 1990, Labonte 1993, Goodman, Steckler, Hoover, and Schwartz 1993).

* Assuming that numbers are "hard," "objective" data, while people's stories of their own lives are "soft," "subjective" opinions.

  At a recent meeting, a conventional health researcher asked: Does health promotion accept evidence-based arguments, or is it concerned with stakeholders' opinions? This presented the classic dichotomy between evidence as what could be expressed statistically, and opinion as what remained verbal. But people's opinions (their stories) are also evidence, just as statistical evidence originates as researchers' opinion (why study **x** and not **y**?) and conclude as researchers' opinion (the "discussion" or interpretation of the social significance of the findings).

* Interpreting the findings using assumptions that may not be shared by the research subjects.

  One attempt to measure community capacity (Eng and Parker 1994) includes questions about people's participation in local political decision-making. Researchers believed that more participation meant a more capable community. In one case the health promotion work led to less participation. Did this mean the community was now less capable? Community leaders later explained that, as poorer groups became more capable in demanding participation, local politicians felt threatened and attempted to shut them out. The poorer groups became involved in a struggle to gain greater voice. Community leaders believed this struggle was part of the process of becoming a more capable community. Interpretations of research findings take on more meaning when they include the people who are researched (Labonte 1996a).

There is growing argument in the practice and research communities that abstract theory and conventional science norms are insufficient to make sense of what health promotion is, and how its effects should be evaluated (Baum 1995, Labonte and Robertson 1996, Fawcett et al 1995, Dixon 1995, Dixon and Sindhall 1994). Yet there are important counter-challenges from the research community, and particularly its conventional adherents, that health promotion practice is more ideological than theoretical, little more than a series of normative claims rarely subjected to rigorous study. Health promoter's own practice narratives rarely go deeper than the "first we did this, then we did this, and here's the slides of smiling participants" that characterize conference presentations. These program descriptions often fail to analyze how or why the content of the programs were

chosen, how their actions promote health, what are the key generalizable lessons learned and how the program results will affect future practice, that is, they are undertheorized.

This article describes a "story/dialogue method" that attempts to bridge the chasm between descriptive stories and rigorous explanation, and so point towards accountability norms that are more in keeping with what health promotion practice attempts to accomplish. The method was developed in a partnership between practitioners and researchers who were frustrated equally with researchers whose methods and assumptions often do not fit the "reality" of practice, and with practitioners who risk losing resources for their work or having inappropriate evaluation methodologies foisted upon them by failing to articulate better practice-based theory. The article begins with a discussion of the history and theoretical underpinnings of the story/dialogue method. The method is then described and illustrated with examples of the several uses to which it has already been put. (To date, over 1,000 practititioners have participated in thirteen different applications of the method.) The article concludes with a discussion of its strengths and weaknesses, and its particular relevance to health promotion evaluation.

Health Care Reforms: Reorientating or Disorientated?

by Professor Richard Parish, Sheffield Hallam University

The Ottawa Carter established a clear framework for health promotion development and delivery. Reorienting health services formed one of the five key dimensions of this framework. Which received widespread international endorsement.

The Charter also highlighted the need for change to be facilitated, and emphasised the important process issues of mediation, advocacy and enabling. Many viewed the health services as being the catalyst for change, but the evidence from subsequent health promotion case studies indicates that the health sector is failing to fulfil the role of change agent. Indeed, far from being supportive, the health professions are often a major barrier to health promotion development.

And yet the health sector could be enormously influential in stimulating action in each of the other Ottawa Charter areas: creating an environment supportive of health; developing personal skill; engaging the community as a resource for health development; and forcing health on to the agenda of all government departments by not allowing it to be relegated just as an issue for the ministry of health. However, the health services have yet to acknowledge in practice that health is created or harmed largely by influences outwith the delivery of health care itself. A far sighted health sector will have to extend its influence beyond the traditional boundaries of service delivery if it is serious about promoting the health of future generations.

That said, there is much that can also be done within the health system itself. The advent of health care reform, with the consequential emphasis on prioritization, value for money and explicit contract specifications, provides a golden opportunity to review the possibilities for health promotion within the delivery of health care itself.

This paper will consider the possibilities for a reorientated health sector in terms of both internal change and external influence.

How effective is strengthening community action as a strategy for health promotion? An empowerment/community development perspective.

by John Raeburn, Head, Behavioural Science, University of Auckland

Summary Conclusions

Note: Presenters were asked a series of questions for this summary. I have repeated the questions here with slight adaptation, and have tried to respond to each - a little difficult around this topic.

1. Is this kind of health promotion a good investment? What is the evidence, and how reliable and valid is it?

The evidence presented in this paper suggests that it works in a general sense, and does so in a fundamental way on an enduring basis. However, the term "investment" implies "cost-benefit". Are the dollars spent well? is the implication of this question. The answer to that depends on what one is looking for. What are the benefits sought? Less heart disease? Less cancer? Fewer people addicted? Less AIDS? Better mental health? Better quality of life? "Good health" as defined by politicians?...by epidemiologists?...by the people themselves? I believe that if a generic approach to health and quality of life is what is being looked for, then the approach outlined is the approach of choice - it deals with all these things at a very fundamental level. It provides an general infrastructure to enhancing health in an holistic sense, and also facilitates the development of specific health initiatives, as so many developing country projects have shown.

In general, ECD is "cheap" for health systems. The best projects are those which are virtually self-funding. One professional - if required at all - can mobilize and support a whole community, which can then raise its own finances.

2. What are the key ingredients that make this kind of health promotion work?

First, there needs to be a clear conceptual understanding of the enterprise, and an embracing of the strong values base out of which it comes. In particular, there needs to be an embodied understanding of what working in an empowerment way means, and what community development truly means in an operational sense.

Second, the use of a systems based planning model is important. In particular, all action needs to be based on needs/wishes assessment.

Third, the principle of community control needs to be observed.

Fourth, there need to be adequate resources for whatever is done, with those resources under the control of the community as much as possible.

Fifth, evaluation is a critical part of the enterprise, especially evaluation based on goal attainment. Any research needs to be owned and controlled by the community.

Sixth, any professional involvement needs to be as facilitator and support, not as controller or self-appointed advocate.

Seventh, a negotiating, cooperative approach is generally to be preferred to a confrontational or conflictual one.

3. How effective are various strategies for promoting health on their own and in combinations? Please use the language of the Ottawa Charter.

Clearly, this approach arises principally out of the community action stream, and fulfils the rhetoric of that stream. But clearly all the other streams apply too - we need supportive policy, the social/physical environment is a crucial dimension, people's skills are being enhanced, and health and social services need to adapt to the realities of this approach.

Within the community action stream, however, it is difficult to see how this approach can effectively be broken down into smaller parts. It is quintessentially an holistic and generic way of working, and should retain this "whole" ethos.

4. What methods are most appropriate for evaluating the effectiveness of this kind of health promotion?

This is best done in the context of a planning model, with an emphasis on goal-attainment information, triangulated with various other indices and data sources. These involve both quantitative and qualitative information. The ownership of the evaluative processes is by the community itself, and these processes can definitely be called "participatory". There is also a critical dimension, in that there is constant analysis of where the endeavour is going, where it sits in the scheme of things, whether it is doing its work in the best possible way, and what should be done to improve things.

5. What are the gaps in current knowledge? How can these gaps be filled and what are other possibilities for action? Please identify three action steps to close the most critical gaps in knowledge.

In one way, there are no significant gaps in knowledge here - ECD is an old and well-established way of working, and we know it works in general terms. What is missing is for the professional, academic and bureaucratic establishment to appreciate its value, and for systematic demonstration projects with an evaluative component. Three suggested action steps are as follows:

1. To determine the current status of ECD as it is understood by professionals, academics and policy makers, and to determine their areas of lack of knowledge, and what barriers exist to its wider implementation.

2. To clarify exactly what it is that "health promotion" is trying to achieve in terms of outcome goals, and what values/processes are consensually agreed on, and then to determine how ECD fits into this framework.

3. To encourage researchers and funding bodies to focus on ECD as an area in its own right, and to set up demonstration projects in a health promotion context (since ECD can operate in other contexts such as economic development and environmental protection) to demonstrate its efficacy directly, and to develop optimal modern models for its application.

One final priority: ECD is still not well understood by most health promotion workers, although most accept its value. A priority in the knowledge development area is to encourage educational bodies to address this area more explicitly in health promotion worker training schemes, so that it can be more deliberately applied.

Person-Centred Health Promotion

by Harvey A. Skinner, Ph.D. and Kim L. Bercovitz, Ph.D., Department of Behavioural Science, University of Toronto

The development of personal skills through lifelong learning is one of the five central components of the Ottawa Charter for Health Promotion (1986). Whereas the other four components are conceptualized and take action at community and population levels, the development of Personal Skills is located at the individual level. The goal is to enhance life skills and options that will enable individuals to exercise more control over their own health, including their physical, social, and economic environments. In this paper, we review conceptual developments and research on Personal Skills. The primary focus is on what motivates health behaviour and the processes of change.

However, to understand the behaviour of individuals, one must examine the context in which health behaviour occurs. This context is comprised of personal, social, environmental and institutional factors (Winett, King and Altman, 1989). Although the location of our analysis is on individual health behaviour, we do this within a broader systems perspective. This approach, termed the Person-Centred Health Promotion model (Figure 1), is adapted from Romeder (1990). In this model, the Person's capacity for self-care and behaviour change is influenced by Others (mutual aid, family, peer group), by assistance from Professionals (care, counselling), by access to information that is timely and pertinent to the individual, as well as by the Environment (physical, social, economic, political).

The Person-Centred model, provides a framework for examining progress over the past decade in the development of Personal Skills. The specific aims of this paper are:

1. To review three conceptual models for understanding motivation and the processes of health behaviour change,

2. To examine the growing literature on self-change,

3. To discuss characteristics of self-help/mutual support groups and what is known about their effectiveness,

4. To examine evidence on the effectiveness of professional assistance, including brief interventions for smoking cessation and problem drinkers,

5. To look at the innovative possibilities of using information technology (e.g., Internet) for health promotion: "telehealth".

Summary

There is an impressive body of research supporting the effectiveness of brief interventions by health practitioners. Moreover, the majority of adults visit a health practitioner each year and generally are expecting their practitioners to inquire about and give assistance for health behaviour concerns (Skinner, 1993; Wallace and Haines, 1984). Nevertheless, practitioners are not routinely raising health risk behaviours with patients and generally are not optimistic about their ability to intervene

effectively (Lewis et al., 1991), **despite** the evidence on practitioner effectiveness.

These findings beg the question of "Who is hiding from whom?" The situation is analogous to a game of hide and seek, where both patients and health practitioners are "hiding" from each other.

DRAFT

Creating Supportive Environments - A Canadian Perspective

by Bruce M. Small, P.Eng., Green-Eclipse Incorporated, Goodwood, Ontario

Abstract

The author bases his analysis on a review of the 1987 publication "Healthier Environments for Canadians", using it as a reference point for progress towards healthier environments over the last decade. He concludes that with a few notable exceptions, described herein, there has been little progress towards, and in fact much regression from, the visions of healthier environments conceived nine years ago. The review notes that one common thread among successful developments during the period was the presence of specific individuals who acted as driving forces for the visions they pursued. The author concludes that health promotion is a good investment, but that we may need to stop ignoring the fact that specific individual people who are highly motivated to be sources of action are the key ingredient in effective health promotion, independent of specific methods and techniques.

Is Health Promotion a Good Investment?

Is health promotion a good investment? While it can be argued that health promotion has not produced the massive environmental changes that have been hoped for, it still appears to be a necessary activity if we are ultimately to counter negative forces and foster healthier environments for all.

What strategies work? In Canada, strong initiative by specific individuals who act as a driving force appears to be a common factor among those areas where progress was made in environmental health. This would suggest that we consider a "disease model" of health promotion, i.e. that our goal is to *infect* people with the concept that health is a good idea and that it can be achieved, and to encourage them to become a source of initiative, either for others or themselves.

How do we evaluate it? A rule of thumb might be that an effective health promotion campaign increases the number of people taking personal initiative towards good health in themselves or for others. In addition, we must of course also look at health outcomes.
How do we do it? Initiative is a function which usually requires much more than mere information and is a major step beyond empowerment. Personal human contact with others who have *"caught the bug"* seems to be an essential ingredient. Identifying and funding such individuals, encouraging them, and helping them circulate freely to inspire others, would appear to be a good investment.

What else needs to be done to create healthier environments? The 1987 report *Healthier Environments for Canadians* stands without need for revision as a continuing map of areas requiring action. If single issues within it were to be highlighted, it remains true that on the physical side, reduction of pollution both indoors and outdoors is a key, untapped leverage point for reducing illness and health costs in our society. On the psychological and social side, we face a massive cleanup and personal support project throughout our societies in order to undo the damage

occasioned by both the recent recession and the government and industrial measures adopted in its wake. Neither of these measures is likely without major progress towards valuing all individuals in our society.

Funding those individuals with the energy, enthusiasm and optimism to dare tackle problems of this order of magnitude, would appear to be an appropriate health promotion measure to bring such change about. If there would be a short way of remembering not to undervalue specific human beings in the health promotion loop, it would be by associating the well known W.H.O. (World Health Organization) with the simple question: "Who?".

The Effectiveness of Healthy Public Policy

by Margaret Whitehead, Visiting Fellow in Health Policy Analysis, King's Fund Policy Institute, London

Summary

Healthy public policy encompasses legislation, fiscal measures, taxation and organisational change. It is characterised by an explicit concern for health and equity in all areas of policy and an accountability for health impact. Policies have to be studied in their social context, taking into account the many interacting policies and influences occurring at the same time. To make sense of these interacting forces requires both quantitative and qualitative methodologies from a range of disciplines, and the intelligent use of "natural experiments". An essential component of any evaluation is an assessment of how a policy has been interpreted and implemented on the ground (as opposed to on paper), and any differential impact on different groups within the population. The methods and results of evaluations are illustrated with evidence on two specific policy questions: how effective is tobacco pricing policy? and is equity-oriented policy good for survival? The examples illustrate that a concern for health and equity can be placed on the agenda of policy-makers in different sectors, as originally envisaged in the Ottawa Charter, but there are gaps in knowledge which need to be addressed. Priorities for action include the development of better tools for health impact assessment, especially ones which take equity into consideration and incorporate the experience of people on the receiving end of policies. The process by which equity and health have been put on the agenda of policy-makers in different countries in worthy of closer study as a guide to building healthy public policy in the future.

Conclusions

These examples were chosen for two main purposes. Firstly, they illustrate some of the major evaluation issues raised at the beginning of the paper. In particular, policies have to be studied in their social context, along with all the other policy inputs and influences going on at the same time - often uncontrolled and sometimes unmeasurable To make sense of these interacting forces requires rigorous, but appropriate methodologies, to tease out the effect of specific policies, as they are applied, not just as they appear in official documents.

Secondly, and above all, these examples illustrate that a concern for health and equity can be placed on the agenda of policy-makers in different sectors, as originally envisaged in the Ottawa Charter. Evidence on the effectiveness of pricing policy in reducing tobacco consumption has been used successfully to convince some ministers of finance to use tax policy explicitly for health promoting purposes. Evidence of the positive and negative health consequences of macro-economic and social policies has convinced the World Bank, at least on paper, a) to acknowledge that some of the structural adjustment policies designed for countries in debt have had a deleterious effect on the chances of health of some of the most vulnerable sections of those populations, and b) to advocate equity-oriented economic policy and public health measures as good investments in health. These and other developments show that building healthy public policy is not utopian, as some commentators have suggested: it is possible and has actually happened in some cases. Of

course, such advances need to be put in perspective - there is a long way to go to put health on the agenda of major sectors and counter-productive developments are under-mining these efforts all the time. Nevertheless, a start has been made and real progress in some areas can be identified.

From experience so far, certain key ingredients help in encouraging the building of healthy public policy. Nothing can be achieved without the support of the public and their political representatives. In fact, in a democracy, policy would surely be considered unhealthy if imposed without the involvement of the people. An essential task is therefore to bring the issues out into the open, encouraging awareness and debate about the need to take health and equity into consideration and of the practical feasibility of doing so. This is greatly helped by the collection and presentation of:

- information on the current situation in a country and how this compares with elsewhere;
- some assessment, based on the best evidence available, of the health impact of policies under discussion;
- examples of successful policy implementation from elsewhere, undertaken by comparable localities or countries;
- feasible (costed) policy options for making improvements, which make sense for that specific country and its political climate.

There are many gaps in current knowledge which hinder the building of healthy public policy. Information systems are often not geared to collecting the most relevant data, particularly data differentiated by social group within populations. With some notable exceptions, the science of health impact assessment of policy is at an early stage and the tools available are still crude. How to study policies in their natural settings, with all the multiple interaction that that involves, is a continual challenge. We have only begun to tackle the issue of incorporating evidence form lay knowledge into the evaluation of existing policies and the building of new ones. And finally, there is the relative lack of tradition of policy analysis in health promotion on which to draw - even in intensely research fields such as smoking and health (Davis, 1995).

Priorities for action on these gaps include:

1. Concerted effort to improve routine information and monitoring systems to provide policy-relevant data.
2. The development of better tools for health impact assessment, especially ones which take equity into consideration and incorporate the experience of people at the receiving end of policies;
3. Studies of policy implementation and agenda setting.