The Proceedings of A Symposium On

THE EFFECTIVENESS OF HEALTH PROMOTION: CANADIAN AND INTERNATIONAL PERSPECTIVES

June 17-19, 1996
University of Toronto

Edited by: Bernice Dookhan-Khan, Ph.D.

Proceedings of a Symposium on

THE EFFECTIVENESS OF HEALTH PROMOTION: CANADIAN AND INTERNATIONAL PERSPECTIVES

June 17-19, 1996
George Ignatieff Theatre,
University of Toronto
15, Devonshire Place
Toronto, Canada

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World Health Organization, Health Canada, Ontario Ministry of Health, Health Education Authority (England), City of Toronto Public Health Department, North York Community Health Promotion Research Unit

Proceedings Edited by: Bernice Dookhan-Khan, Ph.D.

Symposium Chair - Irving Rootman

Symposium Coordinator - Bernice Dookhan-Khan

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FOREWORD

The following are the proceedings of the Symposium on the Effectiveness of Health Promotion held at the University of Toronto from June 17-19, 1996 as one of the events to celebrate the designation of our Centre as a World Health Organization Collaborating Centre.

When we embarked on the planning in January of this year, we realized that we were being ambitious. Not only was five and a half months a very short time in which to plan such an international event, but we had decided to cover **all** of the Action Areas of the Ottawa Charter rather than one or two--a daunting assignment, to say the least!

Thus, it was not surprising that there were some tensions and disappointments at the event itself. In particular, tensions between the academic and practitioner communities over the topic of effectiveness became apparent, perhaps exacerbated by some of the recent cutbacks in services affecting some of our colleagues. There was also some disappointment expressed regarding the strength and amount of evidence presented on the effectiveness of health promotion. In fact, in my closing remarks (**Appendix D**) I expressed such disappointment myself.

At that time, I was challenged by John Raeburn, one of the presenters who suggested that when I reviewed the papers more carefully, I would find more evidence in support of the effectiveness of health promotion then I might have anticipated. Indeed, when I did so following the Symposium, I was pleasantly surprised at the convincing case that could be built **(Appendix I)**. Nevertheless, I stand by my conclusion that we all have more to do to assemble and disseminate the evidence regarding the effectiveness of health promotion and that the Symposium should be seen as a beginning in this international effort, which must involve strong and genuine partnerships between academics and practitioners.

All of us interested in health promotion must take up this challenge in our own way. In the case of our Centre, we plan to establish a committee from among those who attended the Symposium and others who are interested to follow up on the concerns and recommendations that emerged during the stimulating two days that we spent together. But publication allows a much wider dissemination and also puts in the hands of participants and others the papers they heard, so we are also planning to make the fruits of the Symposium widely available as quickly as possible.

To the latter end, we have already put the abstracts from the Symposium on our World Wide Web Site (http://www.utoronto.ca/chp/) and the complete presentations, along with videos will soon be available through ParticipACTION (40 Dundas

Street West, Suite 200, Toronto M5G 2C2). We are also preparing a Synthesis which will bring together evidence from the presentations and other sources in a manner that will be helpful to those who are attempting to make the case for health promotion to policy makers. In addition, we intend to continue to pursue the topic of effectiveness as an area of priority for our Centre.

I hope that those of you who read these proceedings will feel inspired to contribute as well and to interest your colleagues in doing so. To this end, feel free to share them with others either by making copies or by referring them to our Web Site which will contain them shortly.

Finally, I'd like to close by thanking Bernice Khan who edited the proceedings and Nancy Hamilton and Colleen Stanton who reviewed them. My gratitude to all of the others acknowledged in **Appendix H** stands and is even greater now than it was at the time.

Dr. Irving Rootman,
Director, Centre for Health Promotion and
WHO Collaborating Centre in Health Promotion
University of Toronto

August 1, 1996

SUMMARY OF SYMPOSIUM

PURPOSE

The purpose of the Symposium was to synthesize and communicate evidence regarding the effectiveness of health promotion to practitioners, policy-makers, and researchers in health and other health-determining sectors.

OBJECTIVES

Its objectives were:

(a) to assemble, assess and synthesize international evidence from industrialized countries regarding the effectiveness of health promotion; and

(b) to communicate this knowledge to practitioners, policy-makers and researchers in health and other health-determining sectors.

ORGANIZATION AND PLANNING

The planning committee, who was comprised of representatives from the Centre for Health Promotion, the Provincial Ministry of Health, the Federal Ministry of Health and local community groups **(see Appendix G),** decided to use the Ottawa Charter for Health Promotion as the organising framework for the Symposium. Since this was a Canadian event, the committee thought that we should at least have a Canadian as well as an international perspective on each of the five action areas of the Charter. The **definition of effectiveness** offered to the presenters for consideration as they prepared their papers for the Symposium was:

> *The extent to which an initiative was able to achieve its objective or to produce short term, intermediate or long term positive outcomes.*

PROGRAMME

The Symposium programme **(see Appendix B)** combined several features:

- On all three days, both Canadian and non-Canadian speakers **(Appendix H)** with knowledge and expertise on the Effectiveness of Health Promotion covered both theoretical and practical topics. The first five presentations sessions were designed to review the evidence on the effectiveness of health promotion in relation to the five Action Areas of the Ottawa Charter and each session was followed by a thirty minute plenary. It was envisioned that the

two presentations would complement each other, thus enabling us to have a fairly comprehensive view of the evidence in relation to the particular topic being presented. The sixth presentation session addressed the perspectives of policy-makers and practitioners. One additional evening session was held in the form of an Open Public Forum to discuss the topic, "Is Health Promotion a Good Investment?" Summaries of papers presented can be seen in **Appendix C**.

- Small Group Sessions provided an opportunity for participants **(Appendix F)** to discuss the ideas and other materials presented on the Effectiveness of Health Promotion. For the small group meetings, participants were randomly assigned into six groups. Each group was to discuss two of the presentations (one per meeting); each group meeting lasted one hour; and each group was assigned a facilitator and recorder. All of the participants were provided with summaries of all the presentations before the first session of the Symposium.

- The Centre's Affiliated Units mounted an exhibit based on the five Action Areas of the Ottawa Charter showing many of the materials, programmes, and research undertaken. Participants viewed the exhibit during the break and lunch periods. A list of exhibitors can be seen in **Appendix E**.

- The last session of the programme included concluding remarks **(see Appendix D)** and acknowledgements **(see Appendix H)**.

SUMMARY OF KEY DISCUSSION POINTS

A summary of the key discussion points, relating to the effectiveness of health promotion, which emerged from the plenary sessions and the small group meetings is as follows:

Key Discussion Points From Plenary Sessions According To Each Theme (Summary/Abstract of Papers in Appendix C):

Healthy Public Policy

- In order to influence policy-makers, be armed with information on the current situation and comparisons with elsewhere; collect reliable information on the health situations and try to look at the health impact of different policies.

- To determine the health impact relative to equity, it is important to assess what impact the policy is having on health of the most disadvantaged

sections of the population, not only what impact it is having on the population as a whole.

- Provide a data base on effective healthy public policies by accumulating research studies in one location and make same available and accessible for practitioners to use when advocating for equity in public health.

Supportive Environments

- The gender equity issue need to be resolved so that women will be acknowledged for their contribution in this area; that their voices will be heard; and also that they will be treated fairly in the allocation of funding.

- Sometimes people can be provided with low cost solutions for environmental problems. For example, the "C.A.N. DO" programme is specifically designed to educate people and provide them with very low cost, if any cost, to the solutions.

- Institutional health promotion programmes in Sweden are organized around the holistic setting approach and this approach has been accepted widely using all the different kinds of environments and also including health promotion activities. During the last six months, two studies have been implemented in Sweden and Norway to try to grasp this method.

- There has been a shift in Sweden in terms of approaches and strategies for addressing psychosocial determinants of health. For example, in occupational health, the main focus is no longer only the old physical environment but it includes more depending on societal changes and issues/problems that arise.

Community Action

- Empowerment indicates a certain degree of democracy and it seems to be a real prerequisite for sustainable community development and health promotion but no government wants democracy.

- Community participation and social mobilization are key factors when building partnerships with the community in both empowering research and practice and empowering community development. It is a very slow process that involves much facilitation and negotiation and most public funding agencies are impatient with this process.

Building Personal Skills

- With the rapid development of information, there is a lot to learn and presently, CYBERISLE is trying to build a website model with a complex mixture of fun, active learning and high participation. After this model is developed, it will be disseminated and an impact evaluation carried out through a multiyear study.

- Although community-based research seems difficult and sometimes complex, Project Northland demonstrated a synergistic effect by using community strategies to accomplish much more through the use of community task forces thus strengthening community action.

- Socio-economic status should not be a determinant for access to education and communication and people from all socio-economic levels should be treated equally to overall exposure and access to information, opportunities and interactions.

Reorienting Health Services

- One of the greatest barriers to implementing any orientation of health services is the culture of institutions and health professionals who need to pay attention to the broader health issues (daycare, staffing, waste disposal, etc.) in their own health practices and their own working environments. Presently, there are several WHO projects on health promoting hospitals using a healthy cities approach.

- Although there has been a lot of discussion and rhetoric around reorienting health services toward health promotion, there is evidence that the budget to accomplish this goal is still very minimal.

- Management style in the health services is a crucial factor in reorienting health services and the Action Areas in the Ottawa Charter are actually the principles of good management as well.

Perspectives of Practitioners and Policy-makers

- Through workshops, health promoters and community health workers are taught storytelling and given a few tools to help them begin to consolidate some of their own experiences into stories but people probably learn how to use stories effectively by telling them.

- Telling stories to decision-makers to justify that health promotion should continue has proven to be difficult even with the best definitions and right

combination of storytellers.

- Health promotion is often regarded as a tool box for achieving something else in which policy-makers, particularly politicians are interested.

- A set of indicators to determine knowledge, attitudes and behaviours have been devised over a period of time and these indicators are monitored through annual survey data.

- From a political perspective, the whole notion of "effectiveness" is value-laden depending on the rationale and the timing.

- Funding will be approved if the evidence of effectiveness of health promotion is strong enough in making a case for the work to be done, if a participatory approach is used.

- Credit needs to be given to the successes in health promotion and in order for this to be done, one should focus on intermediate health promotion activities which later lead to direct measurable health outcomes.

Key Discussion Points From Small Group Meetings

When reviewing the notes from the small group meetings, several key points were discussed which have been categorized under three major headings: Issues, Concerns and Recommendations for Action.

Issues

- How can you continue to build bridges as the economic system continues to break down? You can have a number of supportive environments, and methods for analyzing them, but how do you make bridges to the larger economic and political systems.

- The process of practitioners and academics working together is extremely difficult, comparable to working with the community.

- We are limited by a narrow vision of outcomes (i.e. medical and disease prevention models).

- Should outcome of health promotion be quality of life?

- The present cuts in social services directly impacts health spending.

- Always a concern to address issues of injustice; want less patchwork; want to work on what causes inequity.

- Have allowed ourselves to be evaluated by standards that are inappropriate; traditional ways do not fit with work, therefore, we fail. We need to establish our own identity.

- How to bring new partnerships and build bridges to private sector?

- Perhaps the speakers do not have the answers either, it is clear that it is very difficult to evaluate health promotion.

- Surprised at all the models/frameworks for evaluation - at the community level these models are not always applicable and are very difficult to put into place.

- It is difficult to form a coherent picture of health promotion.

- What demands does the field want to make on researchers and academics? What is the role for academics in health promotion? For example, practitioners need help from academics to develop evaluation tools; a framework; need to work in partnership so it is a coherent framework and we can approach policy makers.

Concerns

- We are often talking about regions, localities, communities, but what is a community? Communities are not just geographically bound - may be issue-related, disempowered. How does the voice of the disempowered get heard?

- Systemic barrier/access and equity issues underlie many of the presentations in the last two days.

- Any research? Much of the research has been done in community development and effectiveness has been proven. But where are the community development stories?

- We need to recognize that the community, academics, politicians, practitioners all have a role in evaluating the effectiveness of health promotion.

- Centre for Health Promotion has developed a (policy) technical resource , resource manual in response to DHC's need to help in district health

development.

- Need for the Ministry to share outcomes and effective programmes.

- Need for a general framework for health promotion evaluation to bring consistency to field.

- Need a "review and dissemination" function for new written materials related to research and practice dissemination - through electronic media; workshops; associations; and working groups

- Need different model - need to get past description to case studies of evaluation and political use of evaluation. Not new programme stories, but evaluation methods, analysis and use.

- Desire to promote health promotion and therefore, nervous to be public with evaluation, changes in methods, etc.. We need critical analysis; don't reframe our data. Acknowledge use of "wrong" evaluation tool.

- Should pro-actively step back and focus on what needs to be done; if government money is not there, how do we create it? Discussion regarding alternate funding; where systemic advocacy fits into what's left; American vs Canadian models...keep working to protect infrastructure.

- Need to hear more from practitioners about their stories and concerns re: effectiveness. It was recognized that there is already a considerable body of experience out there. We should tap into this existing knowledge base.

- Question arose: 'Effectiveness for whom? and to whom are we accountable? It was pointed out that these questions need to be considered prior to implementing a project.

- There is a lot of turf wars and silo-building and there is little partnership between the different groups, e.g. education, parks and recreation. Teachers are being taught to do smoking prevention in the schools, when this was the role of the public health nurses.

- Sometimes you have the goals but not the method on how you will evaluate the effectiveness of health promotion.

Recommendations for Action

- Develop a set of evaluation models, pilot them, edit them, augment them.

- Need a clearinghouse for effectiveness data, research in both print and media formats.

- Develop a framework of effectiveness that can be applied to different projects using the health promotion framework from the Ottawa Charter for comparability, sharing, translation.

- Provide an annotated bibliography on community action, effectiveness study that have been done that are transferable.

- Use venues like health promotion summer schools to bring all groups together; figure out incentive to bring all to table, e.g. invite key people to speak and inform colleagues.

- Evaluation is a powerful tool which has not been used sufficiently. There is a tendency for practitioners to see academics as solving these problems. There is a need to move evaluation from professionals to the community.

- Create dialogues very early in the project where agendas become overt and this involves building trust and mutual respect, listening and negotiation.

- Focus on community strengths/capacity and not just liabilities/problems when looking at the future of health promotion; and collectively think of what can be done to "shape the future" rather than be affected by the "shape."

- Pull together the tremendous amount of existing knowledge about initiatives and successes and make this accessible and available to all interested.

- Look at integration of strategies, both in evaluation and research just as they are integrated in community work/health promotion practice.

- Produce an evaluation framework that includes each of the five health promotion strategies, that includes possible tools like storytelling, case stories and illustrations, potential interim measures, and a list of sources used, resources available through the Centre, with an annotated bibliography for further work.

- Organize a one-day workshop/seminar and share what has gone on here for inspiration and hope.

PRODUCTS FROM THE SYMPOSIUM

The following items will be produced:

- **A book or monograph** consisting of the edited versions of the papers and the commentaries on the papers based on the work in this Symposium. This could be published by the European Office of the World Health Organization, just prior to the Fourth International Conference on Health Promotion so that it could be used as a resource at that Conference.

- A **background paper** for the Fourth International Conference on health promotion to be held in Indonesia which will be based on the Monograph and all the other products.

- A set of 8 **video-tapes** of all the sessions through ParticipACTION to those interested.

- A set of **Proceedings** which will be sent out to all participants within a month of the conclusion of the Symposium.

- All of the **edited papers** will be made available to those in the field through ParticipACTION within the next two months.

- A **synthesis paper** of the key elements of the Symposium and other summaries.

REFLECTIONS

Reflections and comments, to sum up the three-day symposium, were very encouraging with regards to the effectiveness of health promotion and this has left us with much food for thought. Here are a few reflections and comments from participants:

> *...you have actually demonstrated that you are really ready and willing to tackle the big issues in health. You are willing to ask the questions and you have actually demonstrated during this week that you have the methods to address the questions, because you are using multi-disciplinary approaches, you are crossing professionals, you have found ways of allowing local people's views to be represented and acted upon...*
>
> *...It seems to me that the same old issues that occurred ten years are coming up, in particular, evaluation. In 1986, I helped put together a universal evaluation system for community-based health promotion and this got totally lost in the system but it was the same old issues ten years ago which are presently being discussed. What I feel has happened now, is that community development and empowerment really seems to have become more the centre of gravity for health promotion than they were ten years ago. Health promotion has moved on and it is forming itself around the empowerment notion that community is now the buzz word. I think that this is an interesting historical moment and this conference has really addressed the whole feeling of international health promotion and it is looking very healthy.*
>
> *...each of us in each portion of the field has done incredible work and has made incredible progress. We are sitting here in the mid 1990's with a group of less than 150 people talking about one of the most powerful concepts in the world today, wondering how we are going to fund it so we don't get blown off the map. There is something wrong with that picture.*
>
> *I would like to leave you with a pioneering analogy. Christopher Columbus set off not knowing where he was going. When he got there he had absolutely no idea where he was. When he got back, he had no idea where he had been and he did all of that on somebody else's money. But at least he knew where he started from. Ten years ago, we didn't know where we were starting from and I think we do now. Increasingly, we know where we are going; we do increasingly have the tools to know where we will have been; and when we get back, we will be able to (in a few years time) justify the use of the money we would have had.*

APPENDIX A

INTRODUCTORY REMARKS AND OPENING OF SYMPOSIUM

(The following are excerpts of remarks by Dr. Irving Rootman, Director of the Centre for Health Promotion; and Dr. Desmond O'Byrne, Head of Health Promotion and Education at the World Health Organization.)

Irving Rootman:

On behalf of the WHO Collaborating Centre in Health Promotion, University of Toronto and on behalf of the planning committee, I would like to welcome you to this Symposium on the "Effectiveness of Health Promotion."

We are absolutely delighted to see you because when we had our first planning committee meeting in January 1996, some skeptics said that it was impossible to organize this in six months so the fact that you are here, the fact that we have a programme of excellent presenters suggest to me that we have actually been successful in organizing it and it is reassuring to have you all with us. We have had some interesting time over the last six months putting this programme together and I think that it reflects the best thoughts of the group assembled it. I promise you some very interesting experiences over the next three days.

We see ourselves going through three phases in this initiative. The first phase was developing the Symposium, the second phase takes place over the next three days of the Symposium (which involves approximately 150 persons) and phase three will involve the rest of the world.

This Symposium is important not only for those of us who are assembled here today, but also for others who are outside this room who hopefully will benefit from the materials that are presented and from our own thinking. I see all of us as partners working towards producing something that will be of interest not only to Canadians but to people globally. In addition, we are not just engaged in a 3-day Symposium here but what we are also doing, is really contributing to the larger ends of Health for All throughout the world so I think that you should be pleased that you are part of this and we hope that you will work with us to make it a success.

Desmond O'Byrne:

I am very happy to have this opportunity to link in with this very important Symposium. In 1986, we had the Ottawa Conference and you are actually using

the five action areas of the Ottawa Charter. Well, ten years on, it is time that we take stock because it is a critical world and a changing world since the time of 1986. The outcome of this Symposium is critical in the overall process of what we are doing in the World Health Organization in evaluating what works and what does not work and what our goals and priorities should be as we move into the twenty-first century.

In order to put it in context, W.H.O. has developed a five-year action plan on leading health promotion into the twenty-first century. Part of that action plan is taking stock and evaluating the previous ten years, what works and what doesn't; and what alliances and strategies we must develop as we look into the future world of the twenty-first century.

What you are doing is really important and will fit into, not only a Canadian perspective but a global perspective and I think that it is only right that your newly designated WHO Collaborating Centre should actually be seen as continuing to this global effort. The Fourth International Conference on Health Promotion will be held in Jakarta in Indonesia from the 21-25 July, 1997 and the title is "New Players for a New Era: Leading Health Promotion into the Twenty-First Century." I must hasten to add that the new players does not exclude old players.

I would like to say that the first draft of the conceptual framework for the Fourth International Conference was done by Dr. Irving Rootman about one and a half years ago and it's fundamentally the same even though there has been several different versions.

The three main objectives of the conference are:

(a) to review and evaluate the impact of health promotion specifically since the Ottawa Charter;
(b) to identify innovative strategies to achieve success in health promotion, not within a narrow health education or a wider health promotion perspective but we are trying to see where we can learn even from other areas what are the most effective alliances and strategies we can bring into our armory and into our approaches;
(c) to facilitate the development of partnerships to meet global challenges.

The process of preparation for the Fourth International Conference is divided into three main tracks to follow. The first track is the review and evaluation track into which obviously, your work and deliberations will feed. We can try, by drawing from the methods and the strategies of this Symposium and others, set ourselves in a strategic position to bend the trends more favourably and the new partnership track, of course, is by moving outside our traditional fields into unchartered waters

bringing in the private sector to work with us.

I think that in Ontario and in Canada, you have been leading the way in health promotion since Lallonde; ten years later, you had the Ottawa Charter Conference and now ten years later, we are looking to you here in Ontario and to the new collaborating centre and the whole network of centres that you have here, together with other countries to help to give that lead not only for yourselves in Canada but in fact you can link out and other countries can learn and benefit. So that Health for All is not just a slogan, but people will have healthier and more fulfilling lives. Thank you very much and every success to you in your Symposium.

APPENDIX B

SYMPOSIUM PROGRAMME

A Symposium on
The Effectiveness of Health Promotion:
Canadian and International Perspectives

Monday, June 17 - Wednesday, 19, 1996

George Ignatieff Theatre, University of Toronto
15 Devonshire Place, Toronto, Canada

Funded by:
World Health Organization, Health Canada, Ontario Ministry of Health, Health Education Authority (England), City of Toronto Public Health Department, North York Community Health Promotion Research Unit

Please note:
All sessions will be held in the George Ignatieff Theatre unless otherwise indicated.

Day 1	Monday, June 17, 1996	
1:00 - 1:30 p.m.	**Opening of Symposium** **Introductory Remarks**	Irving Rootman, Centre for Health Promotion Canada Desmond O'Byrne, WHO, Switzerland
1:30 - 3:00 p.m.	**"Healthy Public Policy"** *Session Chair:* Giorgio Solimano, CORSAPS, Chile	Rick Edwards, University of Toronto, Canada Margaret Whitehead, King's Fund Policy Institute, England
3:00 - 3:30 p.m.	**Break/Posters/Exhibits**	
3:30 - 5:00 p.m.	**"Supportive Environments"** *Session Chair:* Beth Savan, University of Toronto, Canada	Bo J.A. Haglund, Karolinska Institute, Sweden Bruce Small, Green-Eclipse Inc., Canada
5:00 - 5:30 p.m.	**Meeting of Small Groups**	

Day 1	Monday, June 17, 1996	Evening Session
7:00 - 9:00 p.m.	**Open Public Forum:** **"Is Health Promotion a Good Investment?** *Panel Moderator:* Lisa Priest, Health Policy Reporter, Toronto Star, Canada *To be held at:* J.J.R. MacLeod Auditorium, Medical Sciences Building, Room #2158	*Panel Members:* Joan Feather, University of Saskatchewan, Canada Nancy Kotani, Canadian Public Health Association, Canada Richard Parish, Sheffield Hallam University, England John Raeburn, University of Auckland, New Zealand Bruce Small, Green-Eclipse Inc., Canada

Day 2	Tuesday, June 18, 1996

9:00 - 10:30 a.m.	**"Community Action"** *Session Chair:* Suzanne Jackson, NYCHPRU, Canada	John Raeburn, University of Auckland, New Zealand Marie Boutilier, University of Toronto, Canada
10:30 - 11:00 a.m.	**Break/Posters/Exhibits**	
11:00 - 12:00 p.m.	**Meeting of Small Groups**	
12:00 - 1:00 p.m.	**Lunch**	
1:00 - 2:30 p.m.	**"Building Personal Skills"** *Session Chair*: Liz Jonson, City of Toronto Health Department, Canada	Harvey Skinner, University of Toronto, Canada John Finnegan, University of Minnesota, U.S.A.
2:30 - 3:00 p.m.	**Break/Posters/Exhibits**	
3:00 - 4:30 p.m.	**"Reorienting Health Services"** *Session Chair:* John Hastings, Canadian Public Health Association, Canada	Joy Johnson, University of British Columbia, Canada Richard Parish, Sheffield Hallam University, England
4:30 - 5:30 p.m.	**Feedback from Small Groups**	
5:30 - 7:00 p.m.	**Reception** *To be held at:* Massey College, 4 Devonshire Place	

Day 3 Wednesday, June 19, 1996

9:00 - 10:30 a.m.	**"Effectiveness of Health Promotion: Perspectives of Policy-makers and Practitioners"** *Session Chair:* Michael Goodstadt, Centre for Health Promotion, Canada	Ron Labonte, University of Toronto, Canada Nick Doyle, Health Education Authority, London, England Lavada Pinder, Ontario Ministry of Health, Canada
10:30 - 11:00 a.m.	**Break/Posters/Exhibits**	
11:00 - 12:00 p.m.	**Meeting of Small Groups**	
12:00 - 1:00 p.m.	**Lunch**	

1:00 - 3:00 p.m.	**Synthesis and Closing Remarks** *Session Chair:* Irving Rootman, Centre for Health Promotion and WHO Collaborating Centre, Canada	Pam Gillies, Health Education Authority, London, England Tariq Bhatti, Health Canada, Canada

APPENDIX C

ABSTRACTS/SUMMARIES OF PAPERS PRESENTED

BUILDING HEALTHY PUBLIC POLICY

Rick Edwards, Ph.D., University of Toronto, Canada

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.

CONCLUSIONS

- No systematic health impact assessment of policy exists.
- Effectiveness evaluations have hidden assumptions.
- Specific policies affect public behaviour, but their health impact difficult to determine.
- The process and content are still necessary.

EFFECTIVENESS OF HEALTHY PUBLIC POLICY

Margaret Whitehead, Ph.D., Visiting Fellow, King's Fund Policy Institute, England

SUMMARY

Healthy public policy encompasses legislation, fiscal measures, taxation and organizational change. It is characterized 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 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 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.

CREATING HEALTHY ENVIRONMENTS

Bo J. A. Haglund, M.D., Karolinska Institute, 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 Common 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 literature using a hierarchy of evidence 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 successful 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.

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!

CREATING SUPPORTIVE ENVIRONMENTS

Bruce M. Small, P.Eng., Green-Eclipse Incorporated, Canada

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?"

W. H. O.

=

WHO?

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

Marie Boutilier, Ph.D., University of Toronto, Canada

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?"

HOW EFFECTIVE IS STRENGTHENING COMMUNITY ACTION AS A STRATEGY FOR HEALTH PROMOTION? AN EMPOWERMENT/COMMUNITY DEVELOPMENT PERSPECTIVE.

John Raeburn, Ph.D., University of Auckland, New Zealand

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 fulfills 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.

Definitions used in this context (taken from overhead transparency):

"Health Promotion":
The process of attaining via empowerment, self-determined positive health/mental health/ quality of life goals.
"Empowerment":
Processes of individual strength, building and self determination involving both psychological and structural dimensions.
"Community Development":
The gradual but proactive transformation of a whole locality-based community to strength, cohesion, and high quality of life for all.
"Empowering Community Development": Community Development where empowerment and community control are paramount issues.

COMMUNITIES AND THE DEVELOPMENT OF PERSONAL HEALTH SKILLS AMONG YOUTH: SYNTHESIS OF MINNESOTA EXPERIENCES IN PREVENTING ALCOHOL USE AND HEART DISEASE

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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.

Lessons learned *(taken from overhead transparency)*

- Prevention must be sustained, long-term.
- Programs should actualize children's and adolescents leadership, self-determination
- Prevention requires continuing support and commitment of communities, schools.
- Prevention messages must be consistent and complementary.
- Programs must be aimed at the domains environment, personally and behavioural attributes
  - Reduce "Supply" as well as "Demand"

PERSON-CENTRED HEALTH PROMOTION

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INTRODUCTION

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.

REORIENTING HEALTH SERVICES: FROM RHETORIC TO REALITY

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SUMMARY

One of the fundamental strategies recognized in the Ottawa Charter is the reorientation of health services. This was one of five strategies considered vital for major progress in health promotion. It is important to note that this strategy is the last to be mentioned in the charter. When discussing health improvements, we tend to first consider the role of health services. Yet, a true reorientation of health services cannot occur until the first four strategies described in the charter are at least partially enacted. This is the case because health services, particularly in North America and Europe are powerful, extensive, complicated systems not easily re-directed and reorientation is unlikely to occur in any real way until strengthened and empowered communities demand a different way of doing business in health care.

Currently in Canada there are a number of emerging trends and forces that may facilitate progress in the reorientation of health services. These trends include economic necessity, the era of health care reform, current decentralization of health services and a growing body of evidence that suggests existing medical services do not provide once anticipated health outcomes.

In Canada, there are a number of stellar initiatives that demonstrate the ways health systems can be reoriented. Many of these successes have occurred outside the health system. It is not clear if these successes can be systemized. Indeed the evidence suggests that attempts to reorient health systems may produce paradoxical effects. The paper concludes by considering these such paradoxes.

The first paradox to be considered arises when community oriented health services that are meant to serve a community impede or stifle community development. A second paradox occurs when attempts to systematize "effective" interventions renders these interventions ineffective. The third paradox concerns the way in which the tenets of health promotion and the strategies of the Charter have helped to reinvigorate the existing health care system. The challenge of the future is to develop knowledge and design strategies that will help us manage these paradoxical effects so that positive outcomes are achieved.

HEALTH CARE REFORMS: REORIENTATING OR DISORIENTATED?

Richard Parish, Ph.D., Sheffield Hallam University, England

SUMMARY

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 emphasized 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.

CONCLUSION

We live in a period of health reform where there is increasing demand on health services and limited resource in which to meet that demand that health promotion

actually offers, a cost-effective way of improving health for the future.

So my own view of the role of health services, in health promotion, is that they do need to **Invest** their time and energy in undertaking health impact analysis on behalf of the community, so they need to invest in policies; they need to; they need to **Reflect** on the real influences upon health; they need to have a **Vision** for what the future of health care system might look like if it is to address those influences upon health; there needs to be a greater emphasis on **Research** and evaluation in health promotion and all **Organisational** development. The health services need to be more **Outward** looking, they need to **Train** the health professionals in such a way that they are more geared in delivering health promotion and have the necessary skills and indeed, then those health professionals can then **Mediate** and manage all the processes of health promotion to achieve the goals that would have been set. They need to engage in more **Analysis** and have the action programmes to follow through and that means equipping people with the necessary **Negotiating** skills.

When taking all these things, **I**nvestment, **R**eflection, **V**ision, **R**esearch, **O**rganisational development, **O**utward looking, **T**raining, **M**ediation, **A**nalysis and **N**egotiation, you can see **the model that we are tribulating is the model that exist here with this Centre for Health Promotion in Toronto** as is reflected in this diagram below:

I nvestment (in policies for health)
R eflect on the real influence upon health
V ision for the future

R esearch and evaluation strategy
O rganisational development
O utward looking
T raining
M ediate and mange
A nalysis and action
N egotiating strategies (the win-win solutions)

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

Ronald Labonte, Ph.D., and Joan Feather, Ph.D.,
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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 practitioners 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.

EFFECTIVE POLICY-MAKING

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SUMMARY

Policy-makers say they want evidence on the effectiveness of health promotion programmes. Health promotion practitioners rightly give a high priority to evaluating their work and are anxious to show its positive impact. However, we sometimes neglect the possibility that policy-makers may often be more interested in evidence of effective policy-making by health promotion agencies than in evidence about particular interventions. I will develop this theme by commenting on:

- the diversity of policy-makers;
- the process of policy-making in government and in thet health service;
- policy-making in health promotion agencies;
- the interaction between policy-makers and health promotion agencies;
- what counts as evidence of effective health promotion policy-making.

Policy-makers

Policy-makers are not a homogenous group sharing a common view of what counts as evidence. There are policy-makers at all levels within the health field:

- in national and local government;
- at the national and local levels of the health system;
- in professional associations and self-regulatory organisations, watchdog bodies, accrediting agencies, research funding agencies, etc.;
- at the supranational level - in UN agencies and in bodies with a powerful indirect influence on health such as the World Bank;
- in non-governmental organisations.

There are distinctions within the ranks of policy-makers. At the top of these

various hierarchies are elected politicians, elected or appointed officeholders, supervisory boards and so on. They are served by civil servants or professional officers and advisers. Outside them are clusters of unofficial policy advisers, think-tanks and lobbyists. Beyond these are opinion formers in the media and public opinion in general.

Policy-making in government and the health services

We have to be mindful of the broader, government-created, policy context. For example, among the major influences on the development of health policy in the United Kingdom are:

- Economic policy, especially the government's commitment to cutting personal taxes and reducing public expenditure, thus an all-pervasive concern with efficiency and value for money.

- Broad themes that inform government policy on public services as a whole, such as:

    - Competition is the best way of ensuring consumer satisfaction and value for money. 'Internal markets' produce competition.

    - Public services should be managed as businesses and according to a business management philosophy.

    - New forms of accountability to the public based on gathering and publishing comparative information about service performance.

- Existing health policies, which reflect the government's economic philosophy and the above broad themes, particularly the internal market of purchases and providers split and the concern for evidence-based medicine.

- The politics of the National Health Service, which remains a high profile party-political battleground.

- 'Stories' - not only powerful case studies disseminated through the media but also the problems experienced by MP's constituents and revealed in their 'surgeries' and post-bags.

- The last of these influences -stories- may have greater influencce on policy than scientifically collected evidence. Often they fuel the prejudices of politicians, and if, for example, they are about support for a section of the population regarded in the tabloid press as undeserving, they can damage

health promotion efforts. On the other hand, panics about drugs or the behaviour of young people have forced politicians to turn to health promotion approaches as the only practical way of 'doing something'.

Policy-making in health promotion agencies

An analytic approach

The Health Education Authority uses, broadly, the following approach:

- We assess the significance of the public health problem, using data from epidemiology, the social sciences and medical research.
- We look at the climate of opinion around the problem, taking into account data about public perceptions and the political context.
- We consider whether there is scope for using the health promotion approach to tackle the problem.
- We look for evidence that health promotion could have an impact.

Health promotion impact

We gather evidence of health promotion impact from:

- Our own needs assessment research.
- Evaluations of past Health Education Authority programmes.
- Our own and others' surveys of knowledge, attitudes and behaviour, and from our own tracking of health promotion indicators.[1]
- Our own systematic effectiveness reviews.[2]

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[1]See, for example, Bridgewood A, Malbon G, Lader D, Matheson J, *Health in England 1995 - What people know, what people think, what people do,* HEA/Office for National Statistics, 1996.

[2]The HEA has a programme of systematic reviews of the international literature on the effectiveness of health promotion. So far, the following have been published by the NHS Centre for reviews and Dissemination at the University of York as part of its *Effective Health Care Bulletin series:* Review of effectiveness of health promotion interventions to prevent accidents in older people (EHC Bulletin v.2(4); Accident prevention in young people (EHC Bulletin v.2(5)). The following are forthcoming: Health promotion interventions for the prevention of coronary heart disease and stroke in older people; Review of effectiveness of health promotion interventions: young people and alcohol misuse; Substance abuse in young people;Mental health promotion.

- Literature searches.
- Expert panels.

Evidence for policy-makers

There are, therefore, many occasions on which policy-makers need evidence which engenders confidence in the ability of health promotion agencies to analyse problems in a compelling way and to provide a coherent approach to tackling them. Such evidence is made up of:

- Coherent analysis
- Well-funded policy
- Credible strategy
- Appropriate programmes
- Defined outputs and outcomes (which often will not be morbidity and mortality outcomes)
- An evaluation plan

How Policy Makers within Government view Health Promotion Effectiveness: A Personal Perspective

Lavada Pinder

SUMMARY

In most areas, governments are coming on strong these days with the question "What difference is health promotion making?" This question makes it essential to examine the context in which it is being asked and go on to try to figure out what the question really means. Furthermore, there are many reasons in the current environment that make government's policy decisions more difficult than ever before:

- Governments are continuing to try to resolve major social and economic problems in the face of growing public distrust and little confidence in government institutions.

- There is the trend to move away from government intervention -the federal government leaving it to the provinces, and the provinces leaving it to the municipalities.

- Values are shifting and, with it, social policy is changing. Universality has been replaced by targeting.

- Government is downsizing in terms of reduced staff and reduced budget.

- There is bottom line mentality. Business plans have become the new art form.

Where health promotion is concerned, this is not the friendliest of environments. Health promotion continues to be viewed as an important but puzzling element of the health system or, at least, as a worthwhile strategy. Bureaucrats within the government are facing several challenges including:

- Frequently, they are still fighting myths that health promotion is an euphemism for social marketing, pamphlets, posters, physical jerks and spiritual addresses.

- They are struggling to provide a clear comprehensive coherent picture of health promotion - what it is, how it works, and what it has and can achieve.

- They are trying to reconcile health promotion values and strategies with the prevalent thinking.

The question, "Is health promotion making a difference" can be answered in several

ways:

- From the **pioneer** approach, sometimes the response focusses on the complexity of health promotion, difficulty in its participatory nature in setting objectives, problem of attributability, etc.

- From the **state of the art approach,** sometimes the response is drawn from the literature and cites examples from projects and pilots around the world.

- From the "**gutsy**" approach, sometimes the response gets right down to it and describes local programmes as partnerships at the community level.

Regardless of what route we take in responding to the question, what we are dealing with is accountability on two levels - activity and outcome. Every project, no matter how small, must be evaluated, and we should have the most basic counts of activities (number of products, events, workshops, participants). The links between activities and outcome have to be made in order to answer the big question from any perspective.

There has been a tendency to consider every programme, project and activity to be unique and to require a unique evaluation. Under the legitimate guise of community ownership and innovation, we have enjoyed reinventing the wheel. The result is that it is exceptionally difficult to provide information across programmes. The information is all vertical and usually defies meta analysis.

We have not settled on basic information and evaluation frameworks, and maintained them over time. We have not developed a set of indicators, tools, and models that can be universally applied. It is only recently that a health promotion outcome model dealing with health promotion action in terms of inputs and clear definitions of intermediate and long-term health promotion outcomes is gaining wide acceptance.

There needs to be a mechanism to facilitate intersectoral action and coordination within governments, with other governments and with the voluntary and private sectors. They need to be established with the idea of institutionalization in mind.

There needs to be stable sources of multidisciplinary expertise to continue to develop the determinants of health framework, add to the evidence, study the policy process, develop tools for policy analysis, engage in policy analysis and health impact assessments, prepare case studies and outline policy options.

There needs to be multisectoral partnerships at national, provincial and local levels to stimulate and encourage public awareness, dialogue and take on coherent, ongoing, well-planned, targeted programmes to advocate health promoting policies.

Finally there needs to be public understanding and support to balance the preoccupation with health care and the continuing perception that health is dependent on the availability of treatment services. I believe that considerable and valuable energy has been devoted to debates related to establishing or maintaining position. Initially, it was the effort to establish preeminence over health education, more recently, there has been the apparent need to clarify our identity vis a vis population health.

In conclusion, I believe that the current demands on health promotion will, in the long run, prove useful. I believe that this is a turning point for the field when it will have to become more rigorous not narrower. There is nothing wrong with being held accountable for public monies in a way that makes sense to those the people have selected. (Remember that in Tommy Douglas' Saskatchewan, it was always the policy to be "fiscally conservative and socially progressive" - these ideas are not mutually exclusive).

APPENDIX D

CONCLUDING REMARKS

(The following are excerpts of remarks by Dr. Irving Rootman, Director, WHO Collaborating Centre for Health Promotion)

I just want to bring us back to the theme of the Symposium, "Effectiveness of Health Promotion." While I think that we had some fantastic presentations in the last three days, I have to admit that at core, I am somewhat disappointed in terms of the amount of evidence that actually came forward in terms of supporting health promotion to people who are making decisions about the allocation of money. In fact, if you add up all the pieces that we have put together this week, it does not really amount to as being able to make very strong statements in support of health promotion. In addition, I would argue that a stronger statement was made in support of health promotion, last week, at the Conference in Montreal. Even though, no tangible evidence was produced to back up the statement, it was a very strong statement. Basically it was said that there is abundant evidence of the effectiveness, cost-effectiveness and cost-benefits of individually oriented health promotion interventions approaches but less evidence in terms of the effectiveness of community-based interventions.

What we have achieved from the last few days reflects where we are in the field of health promotion but I guess that is the reality of it. It means, I think, that it is very difficult to pull this information together and some of it doesn't even exist at this point. To me, this is a spur to continued work to be able to systematically, on an ongoing basis, pull the information together that is really needed in order to support our ongoing activities. Therefore, I feel that this should be an incentive for us not to give up the ghost on this one Symposium. This Symposium is just a start and we were probably too ambitious. However, I think that we do have the basis for going forward.

In moving our activities forward, my anticipation is that we will be looking at some of the recommendations that have come out of the small group sessions, the plenary sessions and the closing session. Our intention is not just to limit ourselves to our initial narrow focus but to broaden it in terms of trying to incorporate some of the ideas that were presented over the last three days.

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1. Addiction Research Foundation - Workplace Programme
2. City of Toronto - Department of Public Health
3. City of Toronto - Healthy City Project
4. Donwood Institute
5. Environmental Protection Office - City of Toronto, Dept. of Public Health
6. Green-Eclipse Incorporated
7. Health Canada - Ontario Regional Office
8. Health Communication Unit
9. Hospital for Sick Children
10. Metropolitan Toronto District Health Council
11. North York Public Health Department
12. North York Community Health Promotion Research Unit
13. Ontario Prevention Clearing House
14. Ontario Tobacco Research Unit
15. ParticipACTION
16. Quality of Life
17. Regional Women's Research Unit Health Programme, Women's College Hospital
18. SAFE KIDS Canada
19. Self-Help Resource Centre of Greater Toronto
20. Urban Health Initiative, The Wellesley Hospital

21. YMCA of Greater Toronto

APPENDIX F

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APPENDIX G

SUMMARY OF EVALUATION REPORT

Methodology

In order to evaluate the symposium a questionnaire was developed and distributed to all participants in their information package. The purpose of the evaluation was to elicit as much feedback as possible on the symposium to assist organizers with future symposiums.

Planning committee members estimate that between 100 and 120 people participated in the symposium. 27 (23%-26%) participants handed in an evaluation form. The low response rate and probable self selection bias must be considered when interpreting the results. It is possible that participants who took the time to complete an evaluation form may have been more disappointed or more satisfied with the symposium or specific presentations compared to all other participants. This self selection bias becomes more problematic due to the low response rate. Because of these limitations the evaluation results cannot be generalized to the opinions and perceptions of all participants at the symposium.

Results

Of the people who completed an evaluation form there was representation from Public Health (3), volunteer sector (1), municipal government (2), provincial and federal government (3), the Health Promotion Branch (1) and Community Health Centres (4). Fourteen respondents indicated they represented another organization type.

Most work with the general population (74%), and with women (51%). Slightly less work with multi-cultural communities (44%) and depending on the target group anywhere from 15% to 30% indicated they worked with other specific target groups.

Most respondents have over 6 years of experience in the health promotion field (64%), 24% have 1 to 5 years and 12% have been in the field less than one year.

Satisfaction with Symposium

Most respondents were 'satisfied' (60%) or 'very satisfied' (24%) with the symposium overall and only 8% were dissatisfied. The majority (80%) also indicated they gained 'some' (60%) or a 'great deal' (20%) of knowledge about the effectiveness of health promotion. As well over 50% of the respondents found the workshop presentations, the people they met and the papers and other materials 'useful' and

another 30% to 44% found these items ‘very useful'.

Usefulness of the Information

The Effectiveness of Health Promotion: Perspectives of Policy-makers and Practitioners session (the questionnaire did not provide separate ratings for each presenter in this session) by far received the highest ratings for usefulness of the information (90% ‘good’ or ‘excellent’). Margaret Whitehead’s Healthy Public Policy session , both Harvey Skinner’s and John Finnegan’s Building Personal Skills session, the Supportive Environments session by Bruce Small, the Community Action session by John Raeburn and the Closing Remarks were given the highest ratings for usefulness of the information (over 70% ‘good’ or ‘excellent’). The usefulness of the information obtained in the meetings of small groups were rated by most respondents as ‘average’ to ‘good’.

Quality of the Presentations

The Effectiveness of Health Promotion: Perspectives of Policy-makers and Practitioners session was also rated highest for the quality of the presentation (94% ‘good’ or ‘excellent’). The Community Action by Raeburn, Supportive Environments by Small, Building Personal Skills by Skinner and the Closing Remarks also received high quality ratings of 80% or more ‘good’ or ‘excellent’.

Rating of Aspects of the Symposium

Respondents were asked to rate various aspects of the symposium including planning and promotion, length, logistics, meeting rooms, location, accessibility, accommodations, opportunities to network, and refreshments. Most of these aspects received positive ratings of ‘good’ to ‘excellent’ by over 70% of the respondents. The area indicating most room for improvement was with the planning and promotion of the symposium (42% ‘good’ or ‘excellent’, 27% ‘average’, 23% ‘fair’ and 8% ‘poor’). This questions includes two different variables, so it is impossible to separate opinions on the planning, from those on the promotion.

Things Liked Best About Symposium

A few comments were made about the things the respondents liked best about the symposium. The most often mentioned items included networking opportunities, international perspectives, and the presenters.

Things Liked the Least About the Symposium

A few comments were also made about the things the respondents liked the least. The most often mentioned comment was that there was insufficient data or evidence presented about the effectiveness of health promotion. Some commented that there was not enough time for networking and more emphasis should have been placed on practical applications. In addition four people commented that there were not enough handout materials and information to take home.

Recommendations for Changes

The most often metioned recommendation for change was to include more practitioner level input (10 comments), as well more advanced notice (4), more in-depth presentations (3), and have presentations available in written or video form.

APPENDIX H

ACKNOWLEDGEMENTS

The Centre for Health Promotion would like to thank all those who made this Symposium such an outstanding event, including all those who supported this effort through their attendance. Special thanks is extended to:

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Our Presenters and Speakers:

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APPENDIX I

Summary of Evidence on the Effectiveness of Health Promotion

Based on International Symposium
June 17-19, 1996
Centre for Health Promotion
University of Toronto

Introduction

A symposium was held at the University of Toronto from June 17-19, 1996 to consider evidence on the effectiveness of health promotion. It reviewed both Canadian and international evidence in relation to the five Action Areas or strategies for health promotion which were identified by the 1986 Ottawa Charter for Health Promotion: Building Healthy Public Policy; Creating Healthy Environments; Strengthening Community Action; Building Personal Skills; and Reorienting Health Services. Although evaluating health promotion initiatives is difficult because of their complexity and long-term nature, considerable evidence was presented supporting the conclusion that health promotion is in fact an effective approach to maintaining and improving the health of populations. This statement briefly summarizes the evidence that was presented in relation to each of the Ottawa Charter strategies. Subsequent publications will present the evidence in more detail as well as include additional evidence.

Building Healthy Public Policy

Healthy public policy encompasses legislation, fiscal measures, taxation and organizational change. It is characterized by an explicit concern for health and equity in all areas of policy and an accountability for health impact. Although it was noted that the effectiveness of healthy public policies cannot be understood independently of their political context, strong evidence of effect was presented for alcohol policies, tobacco policies, early childhood and equity-oriented policies.

With regard to alcohol policies, it was noted that policy measures to reduce the overall level of consumption, such as minimum age drinking laws, taxation and supply reduction have been demonstrated to be effective. It was also noted that higher tax rates on alcoholic beverages and laws and regulations governing physical availability of alcohol, along with a minimum legal drinking age are supported by strong evidence as measures to reduce traffic crashes. The evidence strongly suggests that a number of policies working together are most likely to be successful in reducing alcohol-related problems.

As for tobacco policies, evidence was presented that price changes have a significant effect on the prevalence of smoking. For example, studies in the United States have found that a 1% rise in price results in about a 0.3% reduction in smoking prevalence and a 0.1% reduction in the quantity smoked per adult. Evidence was also presented regarding the combined effects of a tobacco tax increase and a tobacco education program in California where the policy was associated with the tripling of the rate at which cigarette consumption was falling in California, an effect which was not observed in the rest of the United States. It was also noted that there was evidence that price changes have a greater impact on teenagers and low income adults than on older people and those with higher incomes. However, the additional hardship for poor people caused by cost increases and qualitative evidence that tobacco is used to make living in hardship more tolerable was brought to the attention of the symposium participants.

It was noted that there was a considerable amount of evidence that policies which support preventive preschool interventions with at risk families have consistently shown positive effects in terms of the reduction of health and social problems over the lifespan. For example, the Head Start Program was associated with a 27% increase in graduates, 21% reduction in arrests and 14% reduction in welfare recipients. Thus, from a policy perspective, money invested in early childhood prevention strategies (e.g. daycare/childhood enrichment) will give greater payoffs than money invested in later prevention efforts with the same groups.

Finally, with regard to equity-oriented policies, it has been found from studies in developing countries that although the average income of countries is associated with higher life expectancy, the main effects come through successful poverty reduction policies and increased spending on public health and social measures. A relationship between more equitable distribution of resources and better health has also been found in industrialized countries. For example, studies of industrialized countries have found that countries with smaller income inequalities, lower incidence of relative poverty, and high rates of universal family benefits have tended to have lower infant mortality rates.

Thus, it is clear from the evidence presented at the symposium that public policies are effective in improving the health of people, especially if they are linked to other supportive interventions.

Creating Supportive Environments

A number of examples of successful attempts to create supportive physical and social environments were presented at the symposium. They included: The Lung Association's "C.A.N. DO" program; The Envirodesic Certification program; product

trends; and healthy school initiatives.

The "C.A.N. DO" program is a comprehensive public education and action program to address the problem of indoor air pollution. Now fully launched onto the Internet and the subject of Canada-wide discussions, the program is having a significant influence on the indoor product market, which is beginning to recognize environmental health problems.

The Envirodesic Certification program confers a certification mark on those builders, manufacturers and service providers whose buildings, products and services meet strict standards for Maximum Indoor Air Quality. As part of the program, low pollution homes for the general public as well as homes with custom health features for families with environmentally sensitive individuals are being produced.

With regard to product trends, there are now several product markets in which low emission alternatives are being produced by manufacturers. For example, low-odour paints, lower-emission flooring alternatives, low-indoor-pollution floor cleaning products and low-emission insulation materials are now being produced by mainstream manufacturers.

Finally, there has been a substantial increase in interest around the world in attempting to create healthier school environments. For example, the National Education Association in the United States has assembled and published, ***The Healthy School Handbook: Conquering the Sick Building Syndrome and Other Environmental Hazards In and Around Your School***. This publication, a collection of contributions from authors from both the United States and Canada, constitutes a credible source of evidence that indoor air quality in schools has been adversely affecting health and learning. Similarly, in Europe, the World Health Organization has experienced considerable success in introducing Health Promoting School projects in most European countries including those in Eastern Europe.

Thus, there is evidence that creating supportive environments is an approach which is gaining in popularity and that such environments can lead to improved health.

Strengthening Community Action

Substantial evidence was presented that Community Development which is a key approach to community action in health promotion, leads to positive health promotion outcomes. Seven sources of evidence were presented: From developing countries; from health education; from community psychology; from community-initiated western projects; from health agency funded projects; from mental health

primary prevention projects; and from components of the community development approach.

Dozens of examples of generic community development projects coming from the third world provide some of the strongest evidence for the efficacy of community development as a strategy, both for health outcomes and quality of life in general. One specific example comes from Lima Peru where citizens planted half a million trees, built 26 schools, 150 day care centres and 300 community kitchens and trained hundreds of door-to-door workers. Following these initiatives, literacy fell to 3% which is one of the lowest rates in Latin America and infant morality dropped to 40% below the national average.

Health education is an approach which has been used successfully for many decades in both developing and developed countries and there have been many well evaluated health education projects which demonstrate that this approach, either by itself or in combination with others such as community organization leads to positive outcomes. For example, a comprehensive substance abuse prevention program in San Juan, California which included community education, was associated with a 50% reduction in substance-related suspensions and reduced discipline problems.

Community psychology also supplies many examples of successful community development initiatives. One is a project in Modello and Homestead Gardens in Florida where there was a 60% reduction in severe child abuse, a drop from 80 to 0% in high school truancy, a 65% decrease in drug trafficking, 50% fewer problems in alcohol and drug use reported by parents and substantial drops in teenage pregnancy rates following a community development initiative.

An outstanding example of a community-initiated western project is the Alkali Lake experience in British Columbia where the local Indian Band changed its village life from almost universal alcohol abuse and attendant problems, to a vibrant, strong, alcohol free condition with a strong economic base.

There are also examples from health agency funded projects such as the federal government's Health Promotion Contribution which suggest that such initiatives can have an impact on the health of individuals and communities.

Some of the strongest evidence of the effectiveness of community development approaches comes from the mental health field. It was noted that Jack Pransky reviewed dozens of primary prevention programs finding that many of them showed substantial levels of success. For example, The Milwaukee Teen Initiative Program was associated with a 74% increase in grade point averages, 55% less school absenteeism and reduced theft and vandalism.

Finally, there is evidence from a variety of fields that some of the key elements thought to be operative in a Community Development approach are effective in a health promotion sense in their own right. These include initiatives focused on social support, personal control, network-building, community cohesiveness and peer programs. For example, a support group for children with divorced parents was associated with reduced school behaviour problems, reduced shyness and improved school learning.

Developing Personal Skills

Whereas the other four strategies in the Ottawa Charter are conceptualized and take action at community and population levels, the development of personal skills takes place 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.

Evidence was presented that projects to develop personal skills among children and adolescents were associated with a delay in the onset of alcohol use and in the reduction of cardiovascular disease risks. For example, a three year intervention consisting of school-based skills training, peer leadership, parental involvement and community-wide strategies in Minnesota appears to have been effective in reducing alcohol use, reducing the tendency to use alcohol, reducing the combination of alcohol and tobacco use, changing functional meanings of alcohol use, reducing peer norms and peer influences to drink, developing skills to reduce per influences and increasing parent child communication about alcohol-related issues. Similarly, a school-based cardiovascular program in the context of a community wide campaign appeared to lead to lower prevalence of smoking, healthier food choices and increased physical activity among females.

Evidence was also presented that brief interventions by health practitioners led to reduced smoking and alcohol use and increased physical activity among patients especially with booster phone calls.

Reorienting Health Services

Reorienting health services refers to assuming a new direction for such services. From the point of view of the Ottawa Charter for Health Promotion this means that health services must be shared, use a holistic approach, be culturally appropriate, be oriented beyond cure and care and foster research and education. Although in Canada and in other countries, we have not as yet been successful in reorienting health services, there are a number of developments and forces that may facilitate progress to this end.

For example, there are a number of cases where professionals and community members have established partnerships to develop new and innovative services. In British Columbia a pilot project of a nursing Centre on Vancouver Island has demonstrated that when a community is asked to be involved in the planning and organization of a service, a sense of ownership evolves.

An example of a holistic approach which is culturally appropriate is the First Nations Pap Test Clinic in Vancouver which was developed with community members using a participatory approach.

An example of an initiative going beyond care and cure is the Federal Government's project on Enhancing Preventive Services of Health Professionals which is working toward encouraging Canadian health professionals to incorporate health promotion and disease prevention strategies into their everyday work with the ultimate goal of rebalancing the system toward health promotion and disease prevention.

Finally, there are examples of changes in curricula of health professional schools toward health promotion as well as changes in research funding agency policies such as those of the Medical Research Council to permit support of health promotion research projects.

Thus, there are many examples of excellent pilot projects and community initiatives that have demonstrated how health services, at least on a small scale, can be reoriented. These projects however, in large part have been developed outside the existing health care system. As yet, we have not determined if the existing system can be reoriented and if these programs will remain effective if and when they become part of established health care delivery. It should also be noted that according to the person who prepared one of the background papers on reorienting health services for the symposium, "a true reorientation of health services cannot occur until the first four strategies described in the charter are at least partially enacted."

Conclusion

It is clear from this summary that there is substantial evidence that each of the five strategies of the Ottawa Charter is effective in maintaining and improving health. Initiatives focused on young people seem to be especially effective.

It is also clear from the presentations at the symposium that the positive and more substantial outcomes are likely to be achieved if more than one strategy is employed. That is, that the five strategies of the Ottawa Charter are synergistic and meant to be used in combination with one another.

Finally, it should be noted that health promotion as a scientific enterprise is still relatively young. As we gain more experience, more evidence of the effectiveness of health promotion interventions is likely to be produced. Notwithstanding this, at this point in time, there is a substantial body of evidence from research that has been completed that health promotion is extremely effective as an approach to improving the health of populations.

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APPENDIX J

Selected Review Articles on Effectiveness of Health Promotion

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