The Future of Health Promotion Programming

Glenn Laverack
Director, Health Promotion
Defining Health Promotion

- Ottawa Charter says ‘Health promotion is the process of enabling people to increase control over, and to improve, their health’. (WHO, 1986).

- The Bangkok Charter says ‘Health promotion is the process of enabling people to increase control over the determinants of health and thereby to improve their health.’ (WHO, 2005).
Defining Health Promotion

‘Health promotion represents a comprehensive social and political process, it not only embraces actions directed at strengthening skills and capabilities of individuals, but also action directed towards changing social, environmental and economic conditions’ (HP Glossary, WHO, 1998).

Irving Rootman et al (2001) A review of health promotion definitions found as the major discriminating feature ‘the extent to which it involves the process of empowering or enabling communities’.
Empowerment: The Means to Attaining Power

- Empowerment exists at different levels: individual, organisational, family and community.
- Community empowerment can be described as ‘a process by which disadvantaged people (a community of interest) work together to increase control over events that determine their lives’ (Werner, 1988).
- Social, environmental, economic, political.
The Continuum of Community Empowerment

1. Personal action
2. Small groups
3. Community organisations
4. Partnerships
5. Social & Political action

Interpreting Health Promotion

Health promotion is a set of principles centred on empowering people to take control of their health and its determinants.

Health promotion practice encompasses a range of communication, capacity building and politically orientated approaches set within a programme context. Practitioners use these approaches to help their clients to gain more power over the decisions and resources regarding their health (Laverack 2007, p 6).
Health Promotion Programming today

Has a bio-medical focus.
Relies on strategies of the behavioural sciences.
Has not come to terms with ‘empowerment’.
(Julika Loss and Marilyn Wise, 2007)

Largely employs health education modelling.
Funded through ‘top-down’ programming.
Is pre-packaged & professionally driven.
Is top-down, power-over and Zero-sum.
(Laverack 2004; 2007)
The Contradiction in Health Promotion

• Many health promoters continue to exert control over their clients through programming whilst at the same time use an emancipatory discourse (participation, empowerment etc) (Laverack, 1999).

The Reason

• To meet objectives, to complete within the timeframe, for quality assurance, control reporting and measurement.
Health Promotion has...

- Evolved from a bio-medical/health protection model for communicable diseases.
- Strategies that were led by psychologists and the behavioural sciences.
- Developed into a lifestyle model to ‘promote health’ for Non Communicable Diseases.
- Found it difficult to marry empowerment and government style programming.

- The challenges of Globalisation, the ‘health revolution’ and the determinants of health.

(Kickbusch, 2002).
Two Ideal Types of Programming

‘Top down’
- By far the most common form of programming.
- Lifestyle and behavioural.
- Short time-frame.
- Target individual change.
- Agency/professionally managed (pre-packaged).
- Goals identified by agent.

‘Bottom up’
- Goals chosen on basis of unmet needs.
- Longer time-frame.
- Community capacity building.
- Empowerment.
- Community ‘ownership’.
- Unpredictable.
Does Top-Down Programming Work?

- Evidence of Modest Success.
- Addressed a specific problem.
- Did not address broader determinants.
- Problem defined by an outside agent.
- Lacked community engagement & motivation.

- ‘Experts’ do not want to relinquish control.
- Trust is a missing ingredient.
The Saskatoon ‘In Motion’ Programme

- A 3-5 year plan to increase physical activity in urban and rural communities in Canada.
- Used public awareness, education and motivational strategies targeting individuals for behaviour change.

✓ In Saskatoon 57% people surveyed said that they had seen, heard or read about the ‘in motion’ programme.
✓ 18% surveyed said that the ‘in motion’ messages had led to them definitely thinking more about physical activity.

? Overall, 49% had no change in physical activity, 30% said they had become more active, but 14% had become less active & 7% unsure (SRHA, 2005).
? What about the low socio-economic, adolescents, indigenous people and ethnic minority groups?
Does Bottom-Up Programming Work?

- Alcohol & Substance Abuse Prevention Program (USA)
- The Tenderloin Seniors Organizing Program (USA).
- Werribee Residents Against Toxic Waste (Australia).

The success criteria were:
- Successful because they delivered on a small scale.
- Committed to an empowering approach.
- Had a flexible timeframe.
- Directly addressed community concerns.
- Had mechanisms to manage conflict.
What Challenges lie Ahead?
1. Local Health profiles.
   - Address local concerns and needs.

2. Government Health profiles.
   - Address national health agendas.

   - Address global considerations.
Tracking Local Health Profiles

- Community safety.
- Anti-social behaviours.
- Shabby environment.
- Unemployment/low income.
  (Liew, 2007).

- Public transport.
- Housing standards & Heating.
- Social exclusion.
- Preparedness for extreme local weather events.
Tracking Government Health Profiles

- Obesity (Exercise & Diet).
- Cancers (Skin).
- Violence & Injury (Domestic violence and abuse).
- Dangerous Consumptions (Gambling, Alcohol, Drugs, smoking).
- National Security.

(Wanless, 2003)
Tracking Future Health Profiles
Tracking Global Health Profiles

- Climate Change.
- Extreme weather.
- Fossil Fuel consumption.
- Security (biological, radiological).
- Pandemics (bird Flu).
- Trade and employment.

(Wanless, 2003)
Future Health Programming

Global agenda: ie. reduce fossil fuel consumption.

Local needs: ie. security, improved environment and social inclusion.

Government agenda: ie. reduce obesity and increase exercise.
Keeping an Eye on the Private Sector

- The ‘Wellness Revolution’.
- $200 billion industry in USA in selling health.
- Vastly increasing need for health literacy about products and services.
- A widening gap between the healthy better off and the unhealthy poor.

(Kickbusch, 2002)

What are the opportunities for public – Private sector partnerships?
What will Programming Have to Look Like?
Health Promotion will need…

- a socio-political & environmental perspective.
- Innovative ways to engage all people.
- a focus on building community capacity towards action and empowerment.
- strategies that politicise communities, build networks and partnerships.
- appropriate professional competencies.
Health Promotion Programmes will...

1. Engage communities to share their priorities.
2. Create a ‘community-wedge’.
3. Have flexible funding and selection criteria.
4. Use parallel-tracking or similar methods.
5. Measure the process as well as outcomes.
6. Be creative to expand on successful community initiatives.
Engaging communities on NCDs

Provide resources for initiatives based on local needs - culturally appropriate and affordable.

- Green Gyms (Allotment Junkies) (UK).
- Creating virtual communities (USA).
- Walking (school) Buses (UK/Australia).
- School and community gardens (Canada).

Supportive environments and healthy public policy.

- Safer parks scheme (NZ).
- Community policing / street lighting (UK).

(Wharf-Higgins et al, 2007; CDC, 2006)
Creating a ‘Community Wedge’

- Mapping to identify community concerns.
- Prioritise to set a local profile.
- Share priorities.
- Building community capacity.
- Building community confidence.
Flexible Funding and Criteria means...

- Thinking outside the ‘health box’.

- Using a broader base for health selection criteria.

- Using funding in creative ways to engage people and build community capacities.

- Thinking of creative funding partnerships.
‘Bottom-up’ approaches can be deliberately accommodated within a ‘top-down’ programme context.

The programme becomes the means to an end to increase community capacity/empowerment.

How does the programme increase capacity in each ‘Domain’, where there is an agreed need for improvement?
Parallel-Tracking

**Programme design phase:** Identification of issues, appraisal and approval stage.

**Chronic Disease Prevention track**

**Obesity** (Exercise - Diet)

**Empowerment track**

Engaging and Enabling people to take control of their lives and health

**2. Programme Objectives.**

Improvements in the morbidity and mortality of the population.

**Empowerment objectives.**

What is the level of control and choice over health and life decisions?

**3. Strategic approach.**

Top-down approaches employing social marketing, health education and behavioural interventions.

**Strategic approach.**

Does the programme address local issues and build capacity?

**4. Management.**

Pre-packaged and controlled by an outside agent.

**Management**

How is the community involved in the delivery of the programme? What is the strategy for comm control?

**5. Evaluation**

Epidemiological data to demonstrate objectives.

**Evaluation**

Does the programme use participatory evaluation techniques-empowering?
Nine domains of empowerment

1) Stakeholder participation.
2) Problem assessment capacities.
3) Local leadership.
4) Resource mobilisation.
5) Organisational structures.
6) Links to other organisations and people.
7) Stakeholder ability to ‘ask why’.
8) Control over programme management.
9) Equitable relationship with outside agents.

(Laverack, 2001).
Measuring the Process

- Made during the timeframe of the programme.
- A participatory (self) assessment.
- Flexible and culturally appropriate.
- Builds capacity and is empowering.
- Ranks and quantifies the measurement.
- Visually represents the measurement.
Measuring the Process

- Participation
- Organisational structures
- Leadership
- Resource mobilisation
- Problem assessment
- External linkages
- SLLPC Project Management
- Critical Assessment

Pilot assessment vs 2003
Expanding on Successful Local Initiatives

The ‘Wedge’ is the community concern that acts as the starting point.

As a facilitated process of capacity building it can lead to communities:

- Discussing the ‘determinants’ of their health;
- Taking action on local issues;
- Taking action to bring about broader change (social, political, economic, environmental);
- Becoming more engaged in the control of the programme.
Practice Challenges

‘Understanding your ‘enabling’ role as the Health Promoter.

- Understanding the practical means of empowering people in whatever is your everyday work.

- Bridging state and civil society.
Glenn Laverack
Director, Health Promotion

PH: 64 9 373 7599 extn: 89472   EMAIL: g.laverack@auckland.ac.nz