Advancing Health Promotion in the Americas

Lessons from 15 Case Studies

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Executive Summary

How to decrease inequities in health is one of the biggest challenges facing the countries of the Americas, given the enormous social, economic, political, climatic and ethnic variations present in the Region. As the interest in health promotion (HP) has grown worldwide, addressing its impact on population health has become a priority in many countries. As a result, HP has been increasingly utilized as a central strategy in community development initiatives.

Since 2007, The PAHO Working Group on Health Promotion Effectiveness has developed the *Guide to Document Health Promotion Initiatives* as a resource to support countries in the Americas in their efforts to document health promotion initiatives. This report provides an analysis of key lessons learned from 15 case studies completed with the *Guide*. It identifies characteristics, issues and themes that were common in the implementation of health promotion programs and initiatives implemented in different socio, cultural and economic contexts, with various levels of resources and complex political-administrative frameworks. It also attempts to identify and analyze the various mechanisms, processes, and tools used by these initiatives to support health promotion action. It is expected that this report will help guide future action to implement health promotion approaches to improve quality of life for the people of the Americas.

The review of these case studies suggests that there is no single set of contextual characteristics that was absolutely necessary to support HP action. However, some characteristics appeared to facilitate the development and implementation of strategies (for example, working with an organized community). The lack of some factors (such as national or institutional commitment to health promotion) could be compensated for by a strong emphasis on others (such as sustained public participation and broad intersectoral collaboration at the local level).

The case studies outlined key characteristics of the policy environment that played a central role in their initiatives. These included the type of political leadership at key levels of governments; political systems and processes in place; key policies (economic, education, labor, housing, etc.); the existence of previous initiatives and frameworks that focused on health promotion and its related themes; strong political and legal frameworks in place, particularly at the national level; level of fragmentation among service providers and sectors; low technical capacity in HP of key personnel from key institutions; existence of good models and experiences; level of community organization and engagement; pre-existing structures in the community (such as community organizations, committees, etc.); existence of strong national networks; evolving social and economic context; institutional policies and structures; shifting government and international agencies' priorities; countries' characteristics; strength and characteristic of social networks; cultural and social norms; presence of committed and energetic individuals; fully engaged local authorities and policymakers; rapid and unplanned urban growth; dependency on the public sector.

The case studies also strongly emphasized the importance of involving local authorities and policymakers in HP initiatives, however demonstrated the difficulty of maintaining their accountability and participation over time. Also emphasized was the centrality of community participation and empowerment for the successful planning, implementation and sustainability of HP initiatives. Participation promoted a paradigm shift in the population (recognition of rights to health and quality of life; expectation from treatment-oriented health services to models based on HP) and generated greater capacity for critical analysis and dialogue, increased access to services and elimination of barriers.

Intersectoral collaboration, that took place at various levels, played an important role in all the case studies reported. Alliances were formed with a wide array of sectors and stakeholders such as governments, health care service providers, NGOs, faith-based and community organizations, among others. Some weaker alliances were reported with the private sector. Some case studies reported challenges due to the "compartmentalized" structure of international and other high level organizations, making it difficult for them to deal with issues that were intertwined in the community context. The case studies also reported various attempts to strengthen and develop healthy public policies with different degrees of success while others reported on the challenges faced to develop sustainable and healthy public policies.

Among the main challenges reported are included delays caused by political transitions and constant changes of government at various levels; high turnover of personnel in key institutions; lack of support from critical stakeholders; resistance by local authorities, personnel in key institutions, program managers, consumers, and other key partners; limited capacity to document, monitor and evaluate HP initiatives; limited funding; power sharing; and working with institutions with rigid and bureaucratic structures.

Main lessons learned from these experiences include the need to form a strong coalition among all sectors of society to strengthen and sustain the HP initiatives during periods of political transition; the importance of working with institutions in order to open communication channels, explore new modes of intersectoral collaboration, and regularize processes and methodologies within their work plans and programs; the need to maintain strong, sustained and dynamic leadership both

from individuals and institutions at the local and national levels; the need to promote community organization while providing support, guidance and establishing links to those with real decision making power in local government; the importance of sharing power in order to establish successful intersectoral collaboration; the potential for success of ground-up processes at the local level; the need to invest and promote systematic evaluation of HP actions; and the importance of developing policies to improve the sustainability and institutionalization of HP practices, methods and strategies.

Acronyms/Abbreviations

HMC	Healthy Municipalities, Cities and Communities Strategy
HP	Health Promotion
HPS	Health-promoting Schools
MOE	Ministry of Education
MOH	Ministry of Health
PAHO/WHO	Pan American Health Organization/World Health Organization
PHAC	Public Health Agency of Canada
SDH	Social Determinants of Health
WG	PAHO's Working Group on the Evaluation of the Effectiveness of Health Promotion

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Introduction

How to decrease inequities in health is one of the biggest challenges facing the countries of the Americas, given the enormous social, economic, political, climatic and ethnic variations present in the Region. While significant advances have taken place in many countries in the past few years, the Region is still one of the most unequal in terms of wealth and health.

Despite evidence that suggests that inequalities in health result from the unequal distribution of resources, power and opportunities, the greatest share of the resources for health in the Americas continues to be invested in health care alone. Policies and interventions in the Region have traditionally focused on disease prevention and treatment, as opposed to the promotion of factors that create and sustain health and development. However, as the interest in health promotion (HP) has grown worldwide, addressing its impact on population health has become a priority in many countries. As a result, in the past few years, the Region has experienced an increase in policies and activities that incorporate a health promotion approach and that recognize, strengthen, and utilize a population's capacities, assets and resources to improve its own health.

Over the last 3 decades, health promotion has been increasingly utilized as a central strategy in community development initiatives, and governments and international organizations worldwide have significantly increased their investments in health

promotion programs and policies. From a focus on disease prevention in the 1970s, the concept of health promotion has evolved and broadened to incorporate various sectors and stakeholders, to reinforce the need for healthy public policies and to create healthy environments. In the past few years, the concept of "social determinants of health" (SDH) has been incorporated into health promotion, following worldwide calls for social change, for more equitable guarantees of health and development, and the need to invest and strengthen leadership and capacities in health promotion.

Concomitantly, since the 1980's, the countries of the Americas, particularly Latin America and the Caribbean, have experienced major democratization and decentralization processes that significantly re-shaped their social, political, cultural and economic profiles. These processes have resulted in a territorial redistribution of power and resources through political-administrative reforms and greater autonomy for decision-making and control of resources at the local level. Consequently, the concept of local and regional governments as facilitators of community participation and the mobilization of local resources and capacities have been greatly strengthened. By the 1990's, health promotion surfaced as a major strategy in the Region with viable proposals to address integral health and human development challenges while taking into account the complex health profile of its countries.

Nowadays, while health promotion is widely considered to be a successful approach to mobilize intersectoral efforts around health goals and to improve health at the local level, the evidence base and generalization of its accomplishments remains unclear. Health promotion practitioners have long highlighted the need to develop appropriate methods, indicators, and frameworks that can measure change in such multifaceted and evolving contexts, in order to help governments, decision makers and policy makers, understand the benefits of investing in health promotion approaches. Health promotion interventions tend to be complex, context-dependent, occur at different levels of decision-making (i.e. local, subnational and national) and in diverse settings and groups. They employ multiple strategies, are often large in scope, work with extended timeframes, require many resources (Judd et al, 2001) and flexibility to adapt to a continuously changing environment. Existing evaluation tools and methodologies usually do not appropriately capture changes in essential health promoting factors, they are often not suitable for application in the community context in which these interventions are carried out and, in most cases, do not provide insights into the multiplying effect of working with various levels of decision-making and action in a coordinated manner.

The evidence base for health promotion overemphasizes data related to health status outcomes and individual behavior change, to the detriment of evidence related to capacity building, community participation and empowerment, and the benefits of addressing the broader social determinants of health in an intersectoral manner. This can lead to stakeholders drawing inadequate conclusions related to health promotion as a feasible approach to improve community and population health and to the development of policies and programs based on evidence that defines communities and individuals in negative terms, greatly disregarding existing positive and health-promoting factors (Morgan and Ziglio, 2007).

In an attempt to address these gaps, in 1999 the Pan American Health Organization/ World Health Organization (PAHO/WHO) established a Working Group (WG) on the Evaluation of the Effectiveness of Health Promotion, comprised of evaluation experts from leading institutions in the Americas working on issues related to health promotion, evaluation and local development. The WG was comprised of people from governmental, non-governmental and academic sectors from various countries in the hemisphere, including Argentina, Brazil, Canada, Chile, Colombia, Ecuador, and the United States. Over the years, the WG has developed various materials to help guide HP evaluation efforts and contribute to the development of better HP policies and programs.

Since 2007, The PAHO WG has developed and field tested the *PAHO Guide to Document Health Promotion Initiatives* as a resource to support countries in the Americas in their efforts to document their health promotion initiatives. The expectation is that if many experiences are documented in the same way, capturing the same kind of information that is not normally captured, it will provide an opportunity to collective make statements about the effectiveness of health promotion interventions. The members of the PAHO Working Group have field-tested the Guide in a variety of contexts in the Americas, including Spanish, English and Portuguese-speaking countries. It is expected that the application of the Guide will expand available information about process, outcomes and impact achieved through health promotion initiatives in the Region. The application of the Guide can also provide the opportunity to share experiences and make recommendations on how to best aggregate and analyze health promotion information to apply the results to improve health promotion policies and programs in the Region.

This report provides an analysis of key lessons learned from 15 case studies completed during the field test of the *PAHO Guide to Document Health Promotion Initiatives*. Specifically, this paper identifies characteristics, issues and themes that were common in the implementation of health promotion programs and initiatives implemented in different socio, cultural and economic contexts, with various levels of resources and complex political-administrative frameworks. It also attempts to identify and analyze the various mechanisms, processes, and tools used by these initiatives to support health promotion action. It is expected that this report will help guide future action to implement health promotion approaches to improve quality of life for the people of the Americas.

Overview of Case Studies

The set of 15 case studies was selected from a total of 17 case studies completed during this effort. The selection was based on the completeness and usefulness of the data provided by each case study. The 15 case studies represent a mix of experiences from high, middle and low income countries in the Americas with varied social, economic, cultural and political contexts (See Table 1). The case studies were implemented at different levels, national or local, and targeted a variety of population groups. Most case studies were implemented using the community or municipality as a setting, but also reported were cases that focused on schools and the workplace. Reports on the origins of the initiatives (reason for starting the initiative) were also varied and included:

- Political interest in the issue at stake resulting from popular demand, re-election, or pressure from community and international organizations. This was the case of Guarulhos, Brazil, in which high popular demand for health services resulted in renewed attention to health issues by political candidates seeking re-election.
- Problems affecting a particular population or a specific setting. Examples include violence and obesity among school-aged children (Mexico), and documented health disparities among minorities (Kansas City, Missouri, USA).
- Availability of funding (governmental or from other organizations) to develop

initiatives focusing on a particular issue or population. A request for proposals by an organization for communities to participate in a nationwide initiative to address health disparities sparked the establishment of the Kansas City Chronic Disease Coalition, in the USA.

- Response to an event or initiative at a national or regional level that catalyzed action such as the creation of national committees, or formal commitment at the national level. In Paraguay, for example, the initiative was launched based on an agreement between PAHO/WHO and the Ministry of Health (MOH) to strengthen political and legal frameworks related to health promotion and the Healthy Municipalities, Cities and Communities (HMC) Strategy. In Canada, the initiative to work with the Inuit population developed out of the establishment of a Commission on Aboriginal People.

- By the initiative of a community leader or organization to generate action or respond to an unmet need. That was the case in Uruguay, in which a community activist catalyzed action to implement policies and actions to promote a Tobacco-Free workplace, and the case of Indiana, USA, in which a group of community organizations came together to generate action to improve the community's quality of life.

- In response to an unmet need. In Fortaleza, Brazil, community organizations got together to provide services to at-risk families in a community that did not receive public attention to address their needs.

However, the analysis of the case studies had some important limitations. These case studies often represented the perspective of one person or group of persons from one sector (for example, Ministry of Health) who applied the Guide. It would have been interesting to include the perspective of other actors who participated in the initiatives. The tone of the case studies was often positive, as opposed to critical, and there was no opportunity to determine what, if any, opposing views existed. Each case study was completed by a different author and, therefore, there was some variation on how the information was presented. In addition, some case studies had the advantage of being completed with the help of a facilitator who had been trained in the use of the PAHO Guide, while others were not offered any kind of guidance or support.

Table 1. Overview of Case Studies

Name of the Experience	Country	Level of Implementation	Setting	Target Population/ Groups
Community Mental Health Initiative	**Brasil (Fortaleza)**	Local	Community	General population
Participatory Health	**Brazil (Guarulhos)**	Local	Community	General population
Inuit/Tutarvingar	**Canada**	Local	Community	Inuit population
Faces, Voices and Places	**Costa Rica (Cantón Corredores)**	Local	Municipality	General population
Health Promoting Schools Program	**Guyana**	National	Schools	School-age children
Health-promoting schools	**Mexico**	National and local	Schools	School-age children
Healthy Municipalities, Cities and Communities	**Paraguay**	National	Municipalities	General Population
National Wellness Program	**St Vincent and the Grenadines**	National	Community	General population
Home Help for the Elderly Program	**St. Vincent and the Grenadines**	National	Community	Elderly
Early detection of breast cancer	**Uruguay**	Local	Community	Women
Promotion of Cardiovascular Health	**Uruguay**	Local	Community	General population
Smoke-free building initiative	**Uruguay**	Local	Workplace	Staff and visitors
Smoke-free workplace	**Uruguay**	Local	Workplace	Staff and visitors
Crooked Creek Quality of Life Initiative	**USA (Indiana)**	Local	Community	General Population
Kansas City Chronic Disease Coalition	**USA (Kansas City)**	Local	Community	Latino and African-American

Key Health Promotion Components and Mechanisms

The importance of context

It is widely recognized that context is a fundamental dimension for health promotion practice and evaluation (Poland, Frohlich, Cargo, 2008). A specific context might enable significant health promotion action that in a different context or at a different time might be unsuccessful. However, given the complexities involved in mapping and evaluating contextual factors, they are not routinely integrated or appropriately accounted for in the design or evaluation of most health promotion programs. There are questions about the theoretical and methodological frameworks that should be used to understand how the context matters in HP programs and policies, and practitioners report not having the time or the skills to empirically document them. Given the central importance of context to better reposition HP programs and policies, the *PAHO Guide to Document HP Initiatives* focused mainly on trying to unveil the most important factors associated with the implementation of the case studies examined during this effort. The case studies described a broad array of initiatives at local, regional and national levels

in a variety of political, social and economic contexts. In each initiative, context created the landscape within which HP actions were initiated and carried out. The success of the various tools and/or methodologies used by these initiatives depended greatly on the context in which it was implemented.

The case studies outlined some key characteristics of the policy environment that played a central role in their initiatives. These included the type of political leadership at key levels of governments, political systems and processes in place, key policies (economic, education, labor, housing, etc.), and the existence of previous initiatives and frameworks that focused on health promotion and its related themes such as SDH, intersectoral work, etc. For example, in Paraguay, decentralization processes and the reorganization of health services at the national level offered a window of opportunity for action to improve health at the local level, which in turn lead to the successful launching of the Healthy Municipalities, Cities and Communities Strategy in municipalities across the country. In Uruguay, a paradigm shift that took place within the health sector to move from a treatment-oriented approach to a health-promotion perspective created the opportunity for the development of new programs and policies, resulting in increased availability of funding and resources, and catalyzing action for HP initiatives across the country.

Other micro and macro-contextual factors described in the case studies included:

- The existence of strong political and legal frameworks, particularly at the national level, greatly facilitated the planning, implementation and sustainability of HP programs. This was the case in Paraguay, where well defined operational frameworks, strategies and norms coming from the Ministry of Health helped to guide and facilitate the development of concrete and sustained activities at the local level. In Mexico, the fact that the HMC and Health-promoting Schools (HPS) initiatives were integrated into the MOH's public health strategies with a focus on municipalities as a strategic setting for HP actions, helped initiatives to focus on marginalized and vulnerable populations, and to channel resources, knowledge and services to these groups and locations. As a result, some of the schools participating in the initiative were certified as Healthy Schools under the MOH's program, strengthening the link between health services and schools.
- The level of fragmentation among service providers and sectors, along with low technical capacity in HP of key personnel from key institutions was an important barrier in many of these initiatives, especially to adequately document and evaluate their efforts.
- It was important to have good models and experiences on which to build the initiatives. The experience of Brazil demonstrated that working with a community that had experience with participatory approaches greatly facilitated the implementation of the "Participatory Health" initiative. The case study reported that due to its organization, and to a culture of empowerment and participation, the community was able to fully and actively participate in and contribute to all phases of the initiative. In Paraguay, the existence of a well-documented and successful HP experience in the municipality of Atyrá facilitated and encouraged its replication in other municipalities.
- The level of community organization and engagement was crucial in determining the quality of the participation in the initiative. In Costa Rica, previous initiatives implemented to promote sustainable development have contributed to strengthening community organization and empowerment. As a result, the community was familiar with management tools and was capable of organizing and implementing community projects. In addition, pre-existing structures in the community (such as community organizations, committees, etc.) was reported as a facilitating factor in the planning and implementation of HP initiatives.
- The existence of strong national networks (such as HMC) provided important support and leadership to initiatives taking place at the local level. This was the case in Paraguay, where the establishment of a National HMC Network helped to orient the development of strategies and plans of action at the local level.
- An evolving social and economic context can affect HP initiatives at various stages and

require constant revision and adaptation of strategies, activities and use of resources. In Uruguay and Paraguay, for example, the recent economic crisis led to an increase in poverty and an increase in demand for services and programs offered by the initiatives.

- Institutional policies and structures affected the implementation of HP initiatives. In Guyana, the difficulties faced to coordinate activities between the Ministry of Health and the Ministry of Education led to the creation of a school health unit that is responsible for coordinating activities within each ministry and sharing information with the other ministry through a small committee.

- The shifting priorities of governments and other agencies affected access to funding and influenced national and local policies and agendas. This negatively affected the experience with the HMC initiative in Paraguay, when key partners of the initiative redirected their actions towards other issues and initiatives. In Mexico, national partners that had initially supported the initiative restricted their funding for HP initiatives in subsequent years. This created problems to give continuity to activities and to support the work of the research teams involved. In Canada, changing governments led to questions about the renewal of funds.

- The characteristics of the country, its society and population, affected HP programs differently. For example, in small countries such as Saint Vincent and the Grenadines, programs were easier to implement since activities could be scaled down. Other countries like Canada, reported difficulties to reach populations such as the Inuit that live in remote and hard to reach places. In Guyana, increased focus had to be placed on working with hard to reach regions and remote locations where key staff was unwilling to go due to lack of suitable accommodation.

- The strength and characteristic of social networks in place contributed to the success of some initiatives. In Mexico, the level of social cohesion found in a particular community was described as the determinant of success for the initiative implemented in a school setting. The same initiative when implemented in schools in other less cohesive communities did not achieve the same results. In Kansas City, USA, the wide social network of the person hired as program manager helped the initiative to connect to active neighborhood groups and organizations that became a core of the strategy that was implemented.

- Cultural and social norms had to be taken into account during the planning and implementation of the activities. In Saint Vincent and the Grenadines, the initiative to improve home care for an elderly population had to adapt its strategies and activities due to the fact that males, in general, were not expected to be involved in activities such as helping with care for elderly people.

- Involving committed and energetic individuals was reported as critical in some of the case studies. These individuals were able to mobilize partners and resources, advocate for and raise awareness of important issues, and maintain the momentum of the initiative during difficult times.

- Many of the case studies highlighted the importance of fully engaging local authorities and policymakers in HP initiatives. Their participation and commitment was an important factor in determining the success and sustainability of various of the initiatives reported. This will be discussed in more detail in the next section.

- Rapid and unplanned urban growth related to migration from rural areas posed a constant challenge in the case study from Fortaleza, Brazil. The incoming population was generally poor and more vulnerable to social problems (prostitution, drug trafficking, etc.) and other problems related to a sudden rupture in its way of life, values and traditions.

- Dependency on the public sector created some challenges and unrealistic expectations in the target population. In the case of Fortaleza, Brazil, while national programs supplemented much needed income for poor families, the case study emphasized the importance of building capacity in the population in order to decrease its dependency on such programs and to be able reintegrate into productive networks.

The review of these case studies suggests that there is no single set of contextual characteristics that was absolutely necessary to support HP action. However, some characteristics appear to facilitate the development and implementation of strategies (for example, working with an

organized community). The lack of some factors (such as national or institutional commitment to health promotion) could be compensated for by a strong emphasis on others (such as sustained public participation and broad intersectoral collaboration at the local level).

The case studies also highlighted major difficulties in documenting contextual factors and a weak understanding of the importance of context and its impact on HP initiatives. The lack of appropriate indicators or guidance on what to document in terms of context also posed a significant barrier. Partially due to these difficulties, it was not possible to make inferences about the influence of context on the initiatives and vice versa, and to compare and analyze contextual factors across the case studies.

The importance of the local level

Experiences from the last two decades in the Region demonstrate that the local level, represented by regional or local governments, plays a critical role in the successful implementation of HP actions, particularly when other assets that are present at the local level (community, individual, environmental, etc.) are mobilized and strengthened. Local authorities are responsible for establishing policies for a specific territory and population (PAHO/WHO, 1999), and therefore they have greater capacity to mobilize and integrate the action of the various sectors and actors present at the local level. Additionally, they can place health as a priority on their political agendas and are strategically positioned to better adapt health programs and policies to the specific social, cultural and ethnic context of their communities.

Local governments and communities in the Americas have demonstrated increasingly stronger motivation and social, political and technical commitment to initiatives aimed at promoting sustainable local development and improving living conditions of their populations, particularly those that make use of community capacity, resources and potential; foster self-reliance; improve coping abilities; and raise individual and community self-esteem. Experience indicates that the decentralization of decision-making power to the local level and the sharing of power, responsibilities, knowledge and resources to implement and consolidate HP programs, is an effective and sustainable public health strategy.

The case studies presented here strongly emphasized the importance of involving local authorities and policymakers in all phases of the initiative. In the experience of Guarulhos, Brazil, the participation and commitment from the city's mayor in all phases of the initiative and in the regional meetings facilitated the "Participatory Health Project" to be transformed into a cross-cutting management tool in health planning and evaluation in the municipality. In the same experience, the active involvement of elected officials in the public fora resulted in the development of a series of healthy public policies. The project has priority on the municipality's public health agenda, and during public assemblies (consultations with the community to define priorities), all staff, local authorities and members of municipal health committees are relieved of their other duties in order to fully participate in the process.

In Paraguay, the HMC Strategy contributed to repositioning local authorities in their communities and connected them with national and international initiatives and organizations (through participation in meetings and exchange of experiences), increasing their credibility among the population and improving their technical and management capacities. In Costa Rica, the active engagement of the community in the initiative has resulted in greater commitment from the mayor and the MOH to the initiative. As a result, an office has been created within the municipality's structure to manage the initiative, establishing a direct relationship between community representatives, local authorities and the initiative. The case studies, however, demonstrated the difficulty of maintaining accountability and the participation of local authorities over time.

Emphasized in the case studies was the importance of participation of local authorities or their representatives in committees and meetings, since that allowed for a closer connection between the municipality and the problems expressed by the community, the latter of which pressured local authorities to make clear commitments. In Mexico, the initiative was able to gain commitment of local authorities to develop policies and regulations to control the selling of foods within and in proximity to schools. Nevertheless, in the same initiative it was reported that there were some difficulties in engaging authorities at the State level to have them assume their share of responsibility in maintaining these policies and regulations forward.

Community empowerment and participation

All case studies emphasized the centrality of community participation and empowerment for the successful planning, implementation and sustainability of HP initiatives. Many case studies found that participation lead to co-responsibility and a shift from community "placing demands" to increased leadership and involvement to deal with the root causes, promote local development and generate public policies. Participation promoted a paradigm shift in the population (recognition of rights to health and quality of life; expectation from treatment-oriented health services to models based on HP) and generated greater capacity for critical analysis and dialogue, increased access to services and elimination of barriers.

The experience of Guarulhos, Brazil, showed the importance of using various participatory approaches simultaneously (such as participatory budgeting) and the creation of a database of public demands as a basis for planning of health actions. According to this case study, participation "created an irreversible and independent process of empowerment that sustained the initiative independent of political changes." The case studies described that, over time, the Health Management Councils that were developed through the framework of the initiative changed from discussing complaints to debating questions related to healthy public policies. This, in turn, resulted in stronger and more autonomous decisions and actions taken by the councils. Popular ownership of health issues promoted new behavior within the population as well, causing it to move away from simply demanding services to demonstrating a better understanding of how systems work and proposing feasible ideas. For example, the community now understood the logic of providing services in smaller health facilities rather than focusing on increasing the number of larger hospitals to serve the population.

In Paraguay, working alongside the community helped with the identification of the population's most heartfelt problems, shifting the planning of the initiative to be based on those issues. In the long run, it also helped the community to intervene in the development of public policies that affected its quality of life. The case study described a perceived changed in how participation took place over time, with an increase in the protagonist role of community members and organizations, who assumed the leadership for various actions. A critical dialogue with local actors was established to search for adequate solutions to address critical issues. Participation in the initiative also contributed to the population shifting from an expectation of a paternalistic state to the recognition of its rights to health and its responsibilities in creating and sustaining its own health.

In Guyana and Uruguay, the initiatives were able to help reduce isolation of some groups such as the elderly by encouraging their active participation and involvement. In Tala, Uruguay, this resulted in the rise of various new community leaders in different population groups. In Guarulhos, Brazil, the initiative helped with the identification and development of leadership within the population and health workers, and, as a result, most of the new leaders were elected to be part of municipal councils and committees or to attend official events and conferences.

Community participation was also key to mobilizing and changing the role of women in some of the countries. In Costa Rica, women greatly contributed to raising awareness and mobilizing men and families to actively participate in the health promotion process. In Mexico, mothers formed a health committee to follow-up on referrals of children to the community health center, and they became actively engaged in the dissemination of health information in the schools. The case studies pointed out that women's active participation in these initiatives allowed them to develop a leadership role that was traditionally carried out by men; they achieved greater self-reliance and influence in the community. Through these processes women became agents of change in their own communities and they became an integral part of the sustainability of the initiatives.

While most case studies described the use of participatory approaches with varying degrees of implementation during the different phases of the initiatives, many reported difficulties in maintaining the level of participation beyond the planning stage. Some studies also reported difficulties in engaging the poorest and most vulnerable population groups who were "occupied with their own survival."

Intersectoral collaboration

Intersectoral collaboration, that took place at various levels, played an important role in all the case studies reported. Alliances were formed with a wide array of sectors and stakeholders such as governments, health care service providers, NGOs, faith-based and community organizations, among others. Some weaker alliances were reported with the private sector. Participation of key groups often occurred through boards of directors or committees and inclusion of representatives from key stakeholders (churches, school staff, etc.).

Support from PAHO/WHO and other international agencies for the initiative was reported as critical for catalyzing and sustaining action and partners. In Costa Rica, support for the initiative by these organizations at the national level helped to attract interest from other organizations and initiatives and to bring attention to the issues and municipalities that were part of the HP initiative. However, some case studies reported challenges due to the "compartmentalized" structure of international and other high level organizations, making it difficult for them to deal with issues that were intertwined in the community context.

Stakeholder's participation in the case studies was reported as being a strength but also, at times, a challenge. While participation of various sectors was common at the planning stage of the initiatives, it was difficult to maintain the collaboration beyond the initial phase. Besides their input in the early stages of an initiative, it was important for partners to continually re-evaluate and adapt their roles; to be able to determine short, medium and long term gains related to their participation; and to be able to participate in decisions about appropriate entry points and strategies. In Guyana, lack of formal agreement among relevant stakeholders posed a challenge for their effective and sustained participation. It was important to identify specific responsibilities for each stakeholder and to establish a cross-sector program and budget that included current expenditures and the added value from other partners. In Guyana, intersectoral partnerships were also sustained through the establishment of formal Terms of Reference and Memorandum of Understandings.

Having well-defined objectives, mission, vision and expected results that linked to the interests and mandates of each partner facilitated their integration into the initiative and improved the functionality of the intersectoral collaboration. The development of a baseline that highlighted the relevant health and social determinants indicators (literacy, housing, water, sanitation, etc.) helped to captivate interest from a broad array of actors and raised awareness of the impact of other sectors' actions on health. It also helped to direct and implement actions

and strategies in a coordinated manner that maximized the use of resources. In Tala, Uruguay, active intersectoral collaboration helped with the development of one core strategy that integrated projects and initiatives lead by other participating sectors.

Many cases described how the health sector took the leadership in the coordination of the work. Ministries of Health and their municipal secretariats played an integrative technical and administrative role by mobilizing partners and resources, facilitating community participation, and building the capacity and skills of other stakeholders involved. This was in some cases justified by the fact that the health sector could provide the theoretical rationale and framework that demonstrated the complex influences of a diverse range of factors on population health.

It was important for initiatives to take into account the time, resources, knowledge and skills needed for effective intersectoral collaboration in health promotion. Resistance by staff in key institutions was common and mainly due to a lack of understanding of the concept and benefits of health promotion and its core mechanisms, such as community participation. Institutional bureaucracies and rigid structures limited the type of actions that could be taken and restricted the allocation of resources. However, given the appropriate time and attention, these issues were overcome. In Mexico, for example, the implementation of an initiative that proposed a holistic approach to health issues was met with resistance and required time and advocacy to be accepted. However, it resulted in the opening up of new lines of research related to the promotion of healthy lifestyles within the initiative's lead institution. This, in turn, resulted in the development of a broader research group within the institution to investigate other related issues.

Healthy Public Policies

The HP initiatives analyzed in this document reported various attempts to strengthen and develop healthy public policies with different degrees of success. In Guyana, for example, policies were developed at the national level to support school health promotion. These included policies related to school health, nutrition and HIV/AIDS. The demands of the Vision Screening Program, one of several programs within the initiative, resulted in the creation of a post in the Ministry of Education to expand and improve health care services to schools throughout Guyana. The initiative also resulted in the creation of a School Health Unit within the MOH and the MOE to support the development of protocols to ensure compliance with activities. Each ministry was required to provide funds for their area of responsibility (cross-program budgets). The Mexican experience was able to advance legislation on tobacco-free spaces and has established a link with municipal health secretariats to develop a policy to regulate the selling of food within and in close proximity to school. This latest initiative, however, has encountered many barriers. In Rivera, Uruguay, through the initiative of a community organizer, a working group was created to develop a Tobacco-free Workplace Policy within the City's Town Council. The policy was approved and implemented, making the municipality of Rivera the first one to be 100% Smoke-Free in the country.

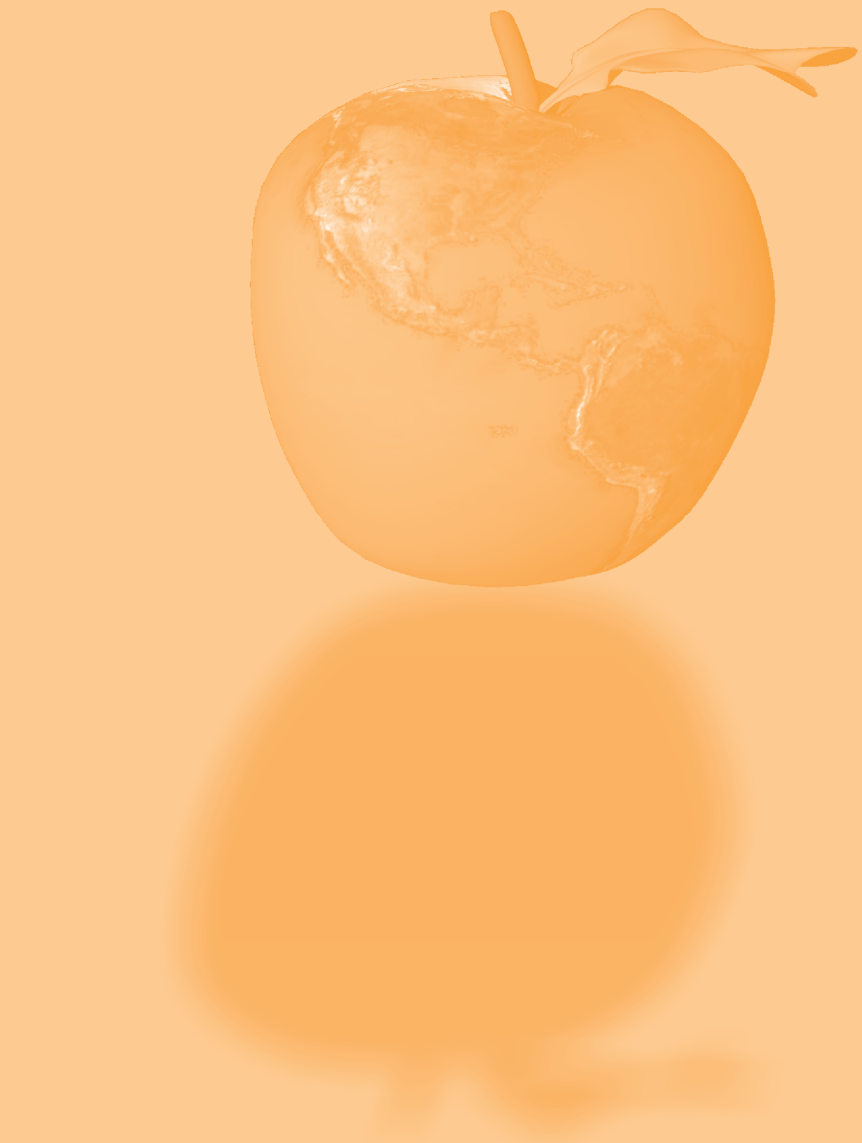
Other case studies reported on the challenges faced to develop sustainable and healthy public policies. The Paraguayan experience described that, even though the initiative was able to have some influence on policies at the local level, it lacked sustainability due to constant political and structural changes in the key public institutions that, in turn, resulted in delays or termination of initiatives and processes. Costa Rica described a similar experience, and emphasized the necessity to develop a legal framework for health promotion within the Ministry of Health and Education that was independent of the constant changes in

the political arena and that guaranteed the commitment of other sectors to collaborate with HP efforts.

Sustainability

In the case studies some issues were described that either facilitated or hindered the sustainability of the initiatives:

- In the experience of Guarulhos, Brazil, the importance of meaningful community participation and empowerment was emphasized as a central mechanism to promote sustainability. According to that case study, due to the active participation of the community, "the project became irreversible and permanent in the social sphere", and as a result, it became "independent of any government strategy, policy or management."
- The experiences in Brazil (Guarulhos), Guyana and USA (Indiana) indicated the importance of creating permanent structures (units within institutions, staff position, etc.) related to the project to help guarantee its continuation, institutionalization and sustainability. In the case of Indiana, USA, for example, the initial coalition that was formed to promote community action was later transformed into a nonprofit development corporation, capable of attracting public resources for affordable housing for the community of Crooked Creek.
- In Paraguay, the commitment of the community and of the initiative's technical staff was described as factors positively affecting the sustainability. However, that was overshadowed by the lack of political support from higher levels.
- Having a strong and broad base of partners involved with the initiative at the local and national levels also improved sustainability and continuity of activities during periods of political transition.



Main Challenges and Barriers for HP Action

One of the main challenges faced by the HP initiatives analyzed was the delay and rupture caused by the political transition periods (elections) and constant changes of government at various levels. These transition periods caused significant delays due to the need to re-orient new authorities and key staff members, guarantee their support for the initiatives, and reaffirm alliances and commitments made by previous administrations. They also caused uncertainty among other key partners about the continuity of and support for the initiative.

High turnover of personnel in key institutions created challenges for the continuity of activities and for effective intersectoral collaboration. These changes required work plans to be reorganized and caused delays as new people needed to be integrated into the initiatives and be brought up to speed with its activities and partners. Paraguay reported serious delays caused by changes of staff in key public institutions due to retirement or rotations. In Guyana, a change in the initiative's focal point in the MOE resulted in the position remaining open for an extended period of time and the temporary withdrawal of that institution from the activities. However, as reported by the case study in Kansas, USA, changes in key staff can also be positive and lead to greater involvement of committees and provide renewed direction to the initiative and its staff.

Lack of support from critical stakeholders, such as municipal authorities or key personnel in public institutions can deter or isolate the advancement of the initiative. In Mexico, the lack of links between the Health-promoting School Initiative and other community organizations or actors was a serious limitation, since it created difficulties to promote broader environmental changes outside the school setting. As a result, the case study reported that the new knowledge and skills taught in the schools did not translate into improved behaviors outside the schools. In Costa Rica, inconsistent participation from some institutions resulted in low commitment from people and institutions and little follow-up of activities in the community.

The case studies reported encountering resistance by local authorities, personnel in key institutions, program managers, consumers, and other key partners. The experience of Guarulhos, Brazil, reported encountering most of its barriers internally, among the program's users and managers. The experience of Kansas, USA, reported major resistances to engaging Native Americans, which was one of the targeted populations, into the program. In most cases, this resistance was related to a lack of understanding about health promotion and its benefits, skepticism about participatory approaches, and limited understanding of the relationship between the actions of other sectors and health. The development of a baseline that highlights the most relevant determinants of health (housing, literacy, etc.) was reported as a useful tool to link the mandates of sectors and local authorities to issues being addressed by the initiative. Active promotion of cultural integration across racial, ethnic, and age groups was also emphasized as central to reduce resistance among key target groups.

Many case studies conveyed difficulties in documenting, monitoring and evaluating HP initiatives. There was limited technical capacity to document HP interventions, especially questions related to contexts; others reported on the challenge to reconstructing changes that happened overtime due to changes/non-availability of actors involved in the initiative and emphasized the need to plan and start documenting HP initiatives from the beginning so that all HP elements are considered. Those initiatives that conducted some documentation and evaluation of their efforts raised questions about how to adequately correlate the contribution of the initiative to changes observed in the community, organizations, health behaviors and outcomes.

Limited funding appeared to be an important barrier in most initiatives; there was a need to continuously seek funding. However, initiatives reported a general lack of skills for grant writing and fundraising. Finding adequate funding and keeping programs operational are a continuous concern. Some initiatives reported that as communities and groups understood their rights, received outside influence, and became aware of future possibilities or of their current problems, the demands and expectations for services and programs increased and it became more difficult to meet all the expressed needs (such as more frequent health screenings or services, on-going continuing education, etc.). The use of mini-grants also required meeting complicated government requirements and internal fiscal management, which resulted in stressed relationships among participating organizations.

All countries reported that the HP process was lengthy and time consuming. It required bringing together and guaranteeing the buy-in from people from various backgrounds, sectors and interests, and who brought to the table different perspectives and paradigms. They often represented institutions and organizations with rigid and bureaucratic structures and work cultures. Respecting the time needed to achieve this acceptance in public institutions and among their staff was critical in order to put in place programs that were consistent with the communities' expectations, making optimal use of resources, adopting approaches that were more consistent with health promotion practices, and improving personal motivation among public staff and other stakeholders. The experience of Mexico described the need to work with key staff in their institutions

in order to achieve acceptance of holistic approaches to health promotion as opposed to focusing on specific issues in isolation (tobacco, nutrition, etc.).

Sharing responsibilities, power and leadership adequately among all partners also created conflicts in some case studies. In Kansas, USA, leadership responsibilities were not distributed beyond key staff and this created a barrier to full participation by other members of the coalition. In other cases, the co-management of resources generated conflicts due to low trust and credibility among the partners involved.

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

Main Lessons

These experiences demonstrate that the transitory nature of local and national political contexts can weaken programs and public policies, particularly when there is a change in political parties. This emphasizes the need to form a strong coalition among all sectors of society to strengthen and sustain the HP initiatives during these transitional periods.

Despite the difficulties of working with institutions with rigid and bureaucratic structures, the experiences suggested that such collaboration has helped to open communication channels with other levels and sectors, resulted in an improved organizational climate and opened a space for exploring new modes of intersectoral collaboration. Working with institutions also offered the opportunity to regularize processes and methodologies within their work plans, programs, etc. Given institutions' far-reaching structure and linkages with other groups and institutions, this has the potential to promote and support the implementation of health promotion activities, its evaluation and the allocation of resources for these priorities.

A common determinant of success in these HP experiences was the existence of strong, sustained and dynamic leadership to move the process forward. Active commitment and engagement from individuals and institutions both at the local and national levels was key to the success of the HP initiatives, as was collaborative work among these institutions. The role of

national and regional networks can be an asset in these efforts, in light of their potential far-reaching connections to municipalities, institutions and key stakeholders throughout a country or region.

Community organization and participation is critical but they do not come about on their own. They require support, guidance and the establishment of links to those with real decision making power in local government. In cases where community groups are not fully equipped with the skills and competence to effectively participate in HP initiatives, systems must be put into place to build their capacity to ensure that they are able to play a meaningful role. Investing time and resources to organize the community (establish a community group, non-profits, etc.) can go a long way to mobilizing resources, engaging new partners and creating new connections with other local, regional and national organizations. It also raises the community's or municipality's profile which in turn can result in more visibility and resources.

Successful intersectoral collaboration requires the sharing of power. One common model of intersectoral participation involved convening a multi-sector community-based group or forum to define and act on local health priorities. The creation of committees, boards, or other entities to formalize and institutionalize power sharing was helpful. These should be in place from the very beginning of the initiative. Given HP's emphasis on addressing the SDH, intersectoral strategies have a better chance of being successful when taking place within cultures, organizations and governments that have a tradition or experience of working collaboratively. In some countries, the complexity of government structures and bureaucracy, as well as a complex policy environment, worked against the development of successful strategies and more comprehensive planning at higher levels. Public participation, empowerment of marginalized groups at the local level, and strong alliances with non-government organizations facilitated intersectoral collaboration, possibly because these groups were less likely to bring a sectoral-based perspective to the issues at stake.

While HP action can be initiated from the top-down, such approaches have limited capacity to influence key SDH if initiatives are not supported by comprehensive, ground-up processes at the local level. Initiatives in which community stakeholders share control over the process and are able to meaningfully participate in that process, showed significant potential for success.

In the case studies analyzed there was a relative lack of systematic evaluation of HP actions. At the same time, almost all of the case studies reported positive outcomes that were thought to be attributable their HP initiatives. The experience indicates that initiatives should define from the beginning how each phase will be documented, evaluated and the how data will be analyzed. This includes defining how core HP mechanisms and indicators will be incorporated and followed. Building a track record of the initiatives' successes and achievements increases credibility and access to decision-makers.

The development and adoption of policies can significantly improve the sustainability and institutionalization of HP practices, methods and strategies. This requires increased efforts to understand, advocate for and promote the benefits and effectiveness of HP actions as a means to improve population health.

Conclusion

Health promotion has made significant strides in the past few decades in the Americas. The breadth and variety of the 15 case studies across many cultures, countries and levels of development demonstrate the increasing importance attached to HP in the Region. Interest in evaluating its effectiveness and understanding the factors that affect, positively or negatively, the advances of health promotion in the Region, has increased greatly in the past few years. The analysis of the 15 case studies offers another step in the efforts to learn more about how HP has taken place in the countries of the Americas, and to understand some of the practical implications and challenges that have arisen from the many ways in which HP initiatives have been structured and organized.

The experiences described in this report highlighted some of the various challenges posed by the complex and multidimensional local and national contexts in which HP was implemented. Factors affecting the success of initiatives were identified at all levels of reality (individuals, community, organizational, political, economic, etc.). These factors were intertwined and affected each other in very complex ways.

The analysis is consistent with one of the key assumptions of HP practitioners and researchers: that the broader socio-cultural, political and economic context for decision-making has a significant impact on how issues are framed and how intersectoral approaches are used to address those issues.

The diversity of the contexts represented in the case studies resulted in each initiative approaching HP differently. While the existence of a supportive environment in which to plan and implement policies and programs was helpful, HP action experienced some success even in environments which were unstable and less supportive of this kind of work. While contextual factors can often act as an obstacle, they can also stimulate new and innovative opportunities.

All case studies reported that the process of engaging in HP initiatives was highly motivating and revitalizing, stimulating interest in and in-depth reflection on priority issues. The experiences strengthened capacities among those involved, generated commitment to promote health promotion principles, strengthened alliances among key stakeholders, and emphasized the potential of health promotion as a viable approach to improve the health and quality of life of the countries of the Americas.

However, due to the complexities inherent in building the evidence-base of the effectiveness of these initiatives, it is essential to create opportunities for mutual learning, exchange of experiences and the pro-active identification and dissemination of evidence and "good practices", taking into account the complexity of communities and decision-making processes. These would be valuable to assist funders, policymakers, practitioners and communities in linking the success of specific programs and policies to broader contextual, economic, environmental and social issues. It can also help with the development of rational strategies for health promotion that can be understood by policy and decision makers and applied to policies and interventions at the national and local levels. In order for that to happen, it is important to articulate the definition of success and effectiveness in health promotion initiatives, and redefine the criteria to judge the data generated in these efforts in order to improve programs and policies aimed at improving community health and reducing health inequalities.

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Brief Summaries of Case Studies

Lessons from

15

Case Studies

Case 1

Collaborative Action for Community Change and Risk Reduction for Chronic Disease and Health Disparities in *Kansas City, Missouri (USA)*

The Kansas City-Chronic Disease Coalition began in 2000 in Kansas City, Missouri, in response to two events: 1) the Centers for Disease Control and Prevention (CDC) request for proposals for the Racial and Ethnic Approaches to Community Health (REACH) 2010, and 2) minority health status assessments released by two organizations that highlighted significant health disparities among African-American and Latino residents of Kansas City.

This urban area was characterized by high rates of poverty and few opportunities to engage in healthy behaviors. The Coalition is comprised of health, community and neighborhood organizations; faith communities, business, as well as residents of Kansas City. Over time, the Coalition included Native Americans as one of its target populations; however efforts to reach that population never came to fruition.

The Coalition's mission is to improve health outcomes for diabetes and cardiovascular diseases (CVD) by promoting access to quality care, healthy environments, and lifestyles through integrated, affordable, culturally sensitive, and accountable community-based health care and prevention services. It proposes five interrelated phases: a) collaborative planning and capacity building; b) targeted action and intervention; c) community and system changes; d) widespread behavior change; e) improving community health outcomes.

The Coalition developed a comprehensive action plan that proposed 86 community changes. Through its "Pick Six" program it also provided resources to key partners to support the implementation of six action plan items (e.g., six new or modified programs, policies or practices). Resources included grants, technical support, and program materials.

The Coalition facilitated about 675 community changes between 2001 and 2007. Some examples include: modified clinic operating hours to increase access, adoption of clinical care guidelines, inclusion of health information in neighborhood newsletters, use of church facilities for physical activity, and the development of walking clubs or paths. Findings from the participatory evaluation suggest that the Coalition was an effective catalyst for environmental changes to reduce health disparities related to CVD and diabetes.

Some of the Coalition's important assets were the wide social network of the first project manager and the development of relationships with a large number of community organizations. However, challenges in implementing mini-grants, including complicated government requirements and internal fiscal management, stressed the relationships that had been established with these organizations. Limited involvement and participation from Latinos (one of the target populations) was also a barrier.

Between 2001 and 2007, the Coalition received large grants as part of the CDC's REACH 2010 Initiative. A new five-year grant received in 2008 allows for the continuation of this successful initiative and may permit more sustained efforts to address health disparities, with the main adjustment to be made being to develop an effective strategy to engage the Latino community in the initiative.

Case 2

Home Help for the Elderly Program *St. Vincent & the Grenadines*

The Home Help for the Elderly Program, an initiative of the government of St. Vincent & the Grenadines implemented by the Ministry of Social Development, began in August 2002 to improve care and

support to elderly population. The initiative intended to benefit persons 60 years and over, those who were isolated and shut in homes, and those with special needs. It included 92 homecare helpers, 2 supervisors, and 1 case worker and it received support from a local church.

The initiative's mission was to create a supportive environment and a sense of belonging for the elderly while also raising their self-esteem and attending to their basic health and social/emotional needs. It proposed a holistic approach, in which the elderly were assisted with health care and other needs, while the providers were taught about the elderly way of life and how to care for them. The services were provided at no cost to the recipient.

St. Vincent & the Grenadines' Red Cross provided training in first aid for home helpers. Nurses provided general nursing care and supervised the trainees during their internship. The Ministry of Health provided officers to assist with the training program. Due to the involvement and support of the Ministries, all areas of the country are covered.

Currently, 450 elderly are benefitting from the Initiative, and it is considered to be a cost cutting measure for the government, since it would be more costly if the government were to provide institutional care for this population. Social indicators have changed; community and family response to the elderly has also improved. The elderly reported feeling a sense of comfort and security, and their family members felt comforted knowing that they were being taken care of.

There has been a greater utilization of the health care facilities within districts. The elderly have begun paying more attention to diet and nutrition. Policymakers have gained a better understanding of the profile of the elderly in their society. The training programs have also been a source of employment for the caregivers.

However, there was a lack of male involvement in the project (as home helpers), limited financial and human resources, limited equipment and material, and lack of support from the private sector. Ensuring that the true beneficiaries had access to the program has been a continuous challenge, as well as, ensuring that political interference was kept to a minimum. The Initiative also had no formal documentation and evaluation system.

The initiative contributed to positive changes for the elderly population in St. Vincent & the Grenadines. As the initiative is in the implementation and maintenance stage, evaluation must be considered and this must be an ongoing process. A source to sustain the initiative must also be considered as reliance has been solely on the government.

Case 3

National Wellness Program
St. Vincent & the Grenadines

Starting in 2006, the Department of Physical Education and Sports in the Ministry of Social Development of St. Vincent & the Grenadines launched the National Wellness Program which was implemented through community groups and institutions. Other participating organizations/ institutions included the Ministry of Health & the Environment, Homes for the Aged (Thompson Home, Golden Age Homes), Her Majesty's Prison, and other community groups in various districts. The initiative was meant to benefit the general population; specifically, individuals who were involved with the participating organizations/institutions.

As chronic non-communicable diseases are a pressing and major problem in St. Vincent & the Grenadines, accounting for 80% of deaths in the country, the initiative's mission was to sensitize participants about healthy lifestyles and the benefits of participating in regular physical activity. One of the primary aims of this initiative was to change the belief that health is only important when individuals are not well and to make people be more proactive when it comes to their health.

Even though there was no formal monitoring or evaluation system in place, the expansion of the program to other communities has been a positive indication that changes are coming about. Communities reported a heightened awareness about physical activity and expressed an interest in getting involved with the program. There was greater utilization of community resources (e.g. the community centers and recreational sites) and health care facilities within the districts. Positive behavior change was demonstrated by the population's increased level of physical activity.

The case study reported some challenges such as a lack of male involvement in the project, limited financial and human resources, limited equipment and material, and lack of support from the private sector. In addition, the change in the location for some of the activities has hindered the involvement of some participants. Adequate funding will need to be acquired from other sources.

Case 4

Inuit Tutarvingat (Inuit Centre at NAHO)

Ottawa, Ontario, Canada

The Inuit Tutarvingat Initiative began in 2000 in response to the Royal Commission on Aboriginal Peoples (RCAP). Participating organizations and institutions included the Metis Centre, First Nations Centre, and the Communications Unit. The Initiative is intended to benefit the Inuit population, which has the poorest health status in the country of Canada. Policy makers, government workers, and the general public are the target audiences for the Initiative.

The main focus of the Initiative is to promote practices that will restore a healthy Inuit lifestyle and improve the health status of the Inuit population through research and dissemination of research results, education and awareness raising, human resource development and sharing information on Inuit-specific health policies and practices. The Initiative seeks these changes at the level of individuals, organizations, community and society.

The Initiative has 5 objectives: 1) improve and promote Inuit health through knowledge-based activities; 2) promote understanding of health issues affecting the Inuit population; 3) facilitate and promote research and develop research partnerships; 4) foster participation of the Inuit population in the delivery of healthcare; 5) affirm and protect Inuit traditional healing practices.

Change in the Inuit community has been difficult to capture as the population is greatly dispersed. Also, because no formal monitoring or evaluation system is in place yet, it is difficult to measure change and results. Very little ethnic data is collected so it is hard to tell how Inuits in general are benefitting. Some products and resources target specialized audiences but the uptake and impact of those resources are not known. Organizational level changes have, however, made going for smaller grants easier for staff.

Some challenges faced by the Initiative include difficulty in the retention of Inuit workers, long upstream population health challenges, and changing governments leading to questions regarding the continuity of funding.

Although evidence of effectiveness has yet to be determined due to a lack of formal monitoring and evaluation the Initiative seems to be headed in the right direction. According to the Initiative, communications have been reaching the target audience, the Centre has gained visibility, and resources/partnerships have been established. However, the Initiative needs to focus on fewer issues with longer and more comprehensive projects and to strengthen partnerships with health and education sectors and to develop target materials. Performance monitoring and evaluation must also be developed and improved.

Case 5

Health-Promoting Schools Initiative *Guyana*

The Health Promoting Schools Initiative began in 2002 in Guyana to address the growing health and social problems that are related to lifestyles and behavior in the country. Lead organizations included the Guyana Ministry of Health, Guyana Ministry of Education, and the Pan American Health Organization (Guyana). Participating organizations included the Caribbean Council for the Blind, the Ministry of Human Services & Social Security, the Cheddie Jagan Dental Clinic, the Ptolemy Reid Rehabilitation Center, Money Gram, the Ministry of Agriculture, the Ministry of Culture and Youth and Sport, Voluntary Service Organizations (VSO), the Linden Economic Advancement Program (LEAP), the Peace Corps, the Guyana Red Cross, Women Across Difference, the World Bank, and the St. Sidwells Anglican Church.

The Initiative was implemented in nurseries, primary and secondary schools along with the respective communities in which the schools were located. Target groups included Parent-Teacher Associations, Community Improvement Advisory Committees, and school-age children of all levels.

The Initiative aims to create supportive environments that encourage positive change through education and skills training among the various target groups. The mission is 'to create and maintain the capacity of school communities to build health into all aspects of life at the school and improve the health of children, teachers, parents, guardians and other members of the school community. The Initiative is facilitating primary health services and schools to work together, improving their ability to detect and offer assistance to children and young people in a timely fashion, detaining and preventing the adoption of risky behaviors, such as smoking, consumption of alcoholic beverages, substance abuse, early and risky sexual practices, and early unwanted pregnancy. Technical support was provided by PAHO and the MOH. The PTA provided the human resources and several international agencies provided financial resources.

According to the Initiative, achievements and results of the Health-Promoting Schools Initiative cannot be described due to the lack of formal monitoring or evaluation systems in place to routinely collect the data that would be needed to substantiate any claims. However, the communities involved have reported some behavioral changes among parents and children.

Challenges varied in the different stages of the Initiative. In the planning stage, there were a lack of formal agreements among relevant stakeholders, a lack of adequate funding, and a lack of skilled human resources. During the implementation stage, there was a lack of formal monitoring systems to track progress and a lack of effective communication strategies to communicate to the public about the initiative and to ensure effective communication among stakeholders.

The effort will continue to be sustained through the School Health Units within the Ministries of Health and Education. Both of these units are responsible for coordinating the activities within each ministry and sharing that information with the other ministry through a small committee.

Case 6

Crooked Creek Quality of Life Initiative (CC QOLI): A Community Development Experience in *Indianapolis, Indiana, USA*

Authors: Alicia Chadwick with Crooked Creek Northwest Community Development Corporation, Helen W. Lands with Fay Biccard Glick Neighborhood Center at Crooked Creek, Mary Beth Riner with Indiana University

School of Nursing, and Marty Rugh with St. Vincent Health.

The purpose of this initiative was to improve the quality of life of residents of a geographically defined neighborhood in an urban mid-western city in the United States. An advisory board provided oversight for a comprehensive assessment conducted by nursing students and that was used for developing a proposal that funded an advisory group appointed by the mayor of the city. Using the PAHO Healthy Municipalities, Cities and Communities model, diverse sectors of the community collaborated to address the conditions responsible for health and well-being. Organizations involved included a hospital, social service agency, housing development agency and university.

The goals of the CC QOLI were to improve the quality of life of Crooked Creek residents through: revitalization of built environments (commercial and community buildings, housing, roads, sidewalks, etc.); new collaborations among health, education and social service organizations; and resident engagement in community improvement. Among the initiatives implemented to achieve these goals were: investments in a housing program for low and moderate income residents; construction of a Family Pavilion to address the civic, social, intergenerational, cultural, and recreational needs of Crooked Creek individuals and families; and a School Health Program for area students.

The Fay Biccard Glick Family Pavilion at Crooked Creek was constructed and now provides a wonderful space for community gatherings, youth and family activities, recreation and an affordable venue for wedding receptions, family reunions, graduation ceremonies, open houses and religious services. The School Health Program moved healthcare delivery beyond traditional hospital walls, and is now part of a broader vision to build healthier communities. School corporations have adopted healthier school policies and are able to address chronic issues of asthma, obesity and absenteeism. Investments in Housing have resulted in completion of three congregate living homes for 12 disabled residents—the most recent using "green" building practices, costly repairs to the homes of 33 elderly homeowners, education of 60 potential homebuyers about the home buying process, and down payment assistance for 12 first-time buyers who purchased homes in Crooked Creek.

The Family Pavilion project experienced some difficulties such as having the contractor walked off the job midway through the project resulting in an eight month delay and cost overruns. Another contractor had to be hired and additional funds were raised in order to complete the project. The School Health Program became more complex when partners realized that the unique nature of each school required interventions to be tailored for each particular school's student population. The Investments in Housing program found the cost of projects were sustainable only to the degree that the organization continued to successfully compete for public and private funds to underwrite projects.

Some of the lessons learned across initiatives included: 1) Collaboration makes individual organizations stronger—a new organization without a track record benefits from partnering with an established organization, which gives others "permission" to be supportive. Established organizations benefit from the energy and entrepreneurial aspects of start-ups. 2) Having a good plan based on good data is crucial to securing funding and support. 3) Program operators need to ensure senior that leaders (senior executives and board members) stay informed and engaged over time in order to sustain initiatives over the long-term, otherwise they risk being replaced by the next new (and not necessarily better) thing.

Case 7

Health through Participation: the experience of Guarulhos, *São Paulo, Brazil*

Authors: Rosilda Mendes, Paulo Fernando Capucci, Douglas Brandalise, Emilia Broide.

The initiative is taking place in Guarulhos, Sao Paulo, as one of the strategies to deal with problems related to health and living conditions with the aims of promoting and enhancing popular participation and establishing a channel of communication for including popular demands into the development of health policies. The priority project *Health Through Participation* works through promoting local Forums that are open to the public and that are held every two years. Between 2005 and 2007, a total of 37 Forums were held, bringing together 5,700 representatives of local communities, health professionals, health managers, NGO´s, churches, etc.

The initiative's main objective is to increase the population's control over health care and management of public policies related to health, as well as to assist in determining the state of health in specific areas at the lowest possible level of division of local urban space. It began in 2005 with the *Health Through Participation* Forums held in twenty-two areas of the city in conjunction with the Participatory Budget Forums. In 2007, the *Health through Participation* Plenary Sessions were held in each of the Health Districts which had been organized as the basis for health management. Since the first Plenary Sessions, approximately 1300 representatives have been elected to comprise local Health Councils for the 65 Basic Health Units, hospitals, and specialized health centres in the municipality. By the end of 2009 14 Forums will be held.

The local Health Councils have broadened their scope of action from acting on local health issues to broader social issues. Action, therefore, has become geared to local day-to-day issues affecting the communities. The Project has led to a change in health policy and related areas of municipal administration. The resulting focus of the discussions on public health policy has been publicly credited to the initiative. Improvements were registered at Basic Health Units with regards to the quality of the care given. In addition, there has been a significant advance in identifying more specific health demands on the part of the population. The fact that the public has taken control of health issues has generated a new trend within the population, with popular complaints giving way to specific proposals for change and greater support from the health sector. The public now understands, for example, the logic of investing in primary care through the Basic Health Units rather than in a greater number of large hospitals. There have been positive changes related to the establishment of mechanisms for participation involving many local actors. However, the Councils have tended to have a certain cliquishness which has hindered fuller social participation.

Among the lessons learned from this experience is the need to guarantee support from local government in order to successfully increase social participation and to improve the planning of activities in order to ensure that the project's sustainability can be maintained. Budgeting is central to supporting the permanent activities required for the Project, as it is fairly complex and involves many players. What is most important for the Project is that it should not stand apart from local activities and politics. It therefore needs to be open-ended.

Case 8

Healthy Schools Initiative in the Departments of Asunción, Central, Misiones, Itapúa y Cordillera. *Paraguay*

Author(s): Health Promotion Directorate–Ministry of Public Health and Social Wellbeing.

The Healthy Schools Initiative started in Paraguay in the decade of 1990, spearheaded by the Ministry of Health with the support of the Pan American Health Organization. The objective was to promote health in the school setting and the integral development of boys and girls within the educational community.

In 2000, a pilot project was implemented in 17 schools distributed throughout urban, peri-urban and rural areas of the Departments of Central, Cordillera y Misiones. At each selected school a Management Committee comprised of school authorities, parents, students, local authorities and representatives of organizations and local institutions was formed. The 17 schools focused their action on four areas: primary health care, infrastructure, training, and participatory projects. Although this effort started with great impetus, it was not possible to sustain it overtime. However, it created a fertile ground that allowed some initiatives to be maintained within the framework of Healthy Schools and at times it catalyzed the beginning of new processes.

In October 2008, the authorities of the new government re-launched the Healthy Schools initiative, in a joint project between the Ministries of Health and Education. A data assessment was conducted to jointly analyze and generate a consensus on the criteria for accreditation. Strategic partnerships were established with organizations such as the program VIDA (cardiovascular disease prevention), and with international agencies such as UNICEF, UNDP and UNFPA. Actions undertaken at this stage have emphasized a strong and consistent interest of all stakeholders. It should be pointed out that the Ministry of Education and Culture has modified the "Technical High School Education in Health" curriculum, reorienting it toward health promotion, and thereby contributing to the process of implementing the Healthy Schools Initiatives.

One of the challenges of this initiative has been that numerous experiences in school health describe themselves as a Healthy Schools or `Health-promoting Schools` yet there are no uniform criteria established for its designation. These experiences are promoted by different sectors: the municipality, health districts, local government, and the education community. The current objective is to unify the Strategy by developing criteria for accreditation that guides institutions in the development of lines of action, complemented by a monitoring system. The current goal is to develop a unified strategy at 40 selected schools in 5 Regions. A baseline will be developed, along with a system for continuous and systematic data collection and analysis.

Some difficulties included (1) limited resources and the dispersion of efforts of the Health Promotion Directorate, which made it difficult to carry out a sustained process and (2) the lack of coordination within the Ministry of Health's programs that hindered integrated action based on common objectives.

Lessons learned included the need for systematic data collection and analysis, dissemination of information among the main stakeholders so that results are assessed, and the need for community empowerment (local governments and other social actors) in order to avoid processes to remain inconclusive.

To facilitate the collective construction of Healthy Schools will help social actors to identify protective factors and stimulate effective responses. Responsibility should be assumed mainly by governmental institutions, linking efforts with other institutions working in this area. The Healthy Schools Strategy creates an opportunity for the school setting to be transformed into a space that fosters the social production of health.

Case 9

Promotion of Healthy Settings and Lifestyles at Primary Schools of Four Mexican States

Mexico

Authors: Luz Arenas Monreal, Pastor Bonilla Fernández, Cristina Caballero García, Elba Abril, Héctor Hernández P., Sofía Cuevas B.

In 2006 the National Institute of Public Health (INSP) of Mexico initiated the project *Promotion of Healthy Settings in Primary Schools* in four Mexican States, in collaboration with the Health Services of the States of Guerrero and Jalisco, the Center for Research on Food and Development, and public schools of the states of Morelos, Jalisco, Guerrero, and Sonora. This project was financed by the National Science and Technology Board. It used an integrated approach to improve physical, emotional and social environment for school-aged children and addressed problems affecting this population such as overweight, obesity, addictions, environmental degradation, and family and social violence.

Initially, focus groups were conducted with teachers of the four States to help identify health determinants (living, work, and education conditions; physical environment; psychosocial factors; social and family support networks; etc.) that affected the populations in the areas where the initiative would take place. The main characteristics found among the families of the schoolchildren were: low social class, low educational level among parents, poverty, and migration to the United States. In the first phase, baseline measurement data were collected: weight/age, weight/height, age/height, prevalence of caries and smoking with the following results: coexistence of malnutrition and overweight or obesity among children of all participating schools, high prevalence of cavities, and a significant percentage of children who currently smoke and/or consume alcoholic beverages.

In the second phase, educational interventions were carried out in topics such as: self-esteem and the culture of peace, environmental protection and care, smoking prevention, and nutrition and hygiene. As a result, increases were observed in knowledge related to healthy food and hygiene as well as improvements in skills related to waste separation and care of natural resources. Teachers reported a decrease in violence and an increase in the use of more peaceful ways of resolving conflicts among schoolchildren. Two health committees were formed: one of children and another of parents. Links were established between the schools and local health centers to facilitate the children's access to services.

The children had difficulty in applying outside of the school setting what they had learned through the initiative, which highlighted the limitations of school-centered initiatives that do not include the community as a whole. There were also difficulties in influencing agencies responsible for the development of public policies (sale of healthy food in schools and its vicinity) in the States of Guerrero and Morelos. In the States of Jalisco and Sonora, where regulations of food sale within the schools were already in place, the initiative managed to raise awareness of families about healthy food consumption.

This project contributed to the inclusion of more integrated health promotion approaches to initiatives taken by the INSP, such as promoting the establishment of a research group on Promotion of Healthy Lifestyles.

Case 10

The Community Mental Health Movement of Bom Jardim, Fortaleza

Brazil

The Community Mental Health Movement of Bom Jardim, in Fortaleza, Brazil aims to provide services to people with various types of mental illnesses in order

to improve their integration into the community and promote individual, group and social empowerment. It is implemented in 22 community centers of 5 neighborhoods located in the "Greater Bom Jardim" area of the municipality of Fortaleza. The initiative focuses on vulnerable, at-risk families, living in extreme poverty. This population is characterized by a low level of education, unemployment, lack of opportunities and low self-esteem.

The initiative started when local church leadership and missionaries working in the region formed a volunteer group to provide shelter and counseling to the population that at that time did not have any access to mental health services. Initially, efforts to include the local government were fruitless. However, with a change of government in 2005, the initiative gained more recognition and momentum, which resulted in the establishments of alliances and an increased flow of resources to expand actions and services. Some of the stakeholders currently involved in the initiative include local and state health departments, indigenous populations, local universities, the private sector, NGOs working with delinquent youth and the PETI Program (Program to Eradicate Child Labor).

The initiative incorporated various strategies to achieve its goals. Community therapy groups were established, as well as other groups aimed at facilitating personal therapeutic processes within collective actions (bio-dance, therapy through art, self-esteem support groups, etc.). Massotherapy, reiki, breathing and relaxation workshops and sessions were offered. Theater and music events were scheduled in public places as a way to the community to take ownership of places that had been dominated by drug trafficking and violence. Various cultural and arts activities were offered, free of charge, to all community members (music, language, painting and theater classes). A community garden and pharmacy were established and professional training was offered to young people. Lastly, efforts were put in place to integrate people with mental illnesses into these activities in order to support a process to decrease stigma attached to mental health problems and to support de-institutionalization of these patients.

Positive outcomes have been reported from this initiative. The general community attitude towards dealing with underserved populations has shifted from a personal to a collective and social perspective. The community's identity has improved, with those living in Bom Jardim showing pride in their neighborhood, when prior to the initiative they would describe it as ugly and violent. A network has been established to help community members to take better care of themselves. New links have been established with other stakeholders working in the community and with the private sector. Community youth have reported greater motivation to attain a higher education level and stigma related to psychological problems has decreased. The initiative has also received national recognition and various national and regional awards.

Some of the challenges included changes in government that created delays and uncertainty about the initiative's continuity, difficulty to maintain and increase resources as the initiative expanded, and resistance from other institutions to collaborate with the initiative's activities.

There is considerable social stigma attached mental illnesses, especially when it is related to underserved and poor populations. This experience demonstrated the viability of empowering, improving social capital and expanding therapeutic and educational activities for these populations. It also promoted a new ways of viewing mental health issues that was inclusive and transformative.

Case 11

Faces, Voices and Places initiative in the municipality of *Corredores, Costa Rica*

The Faces, Voices and Places (FVP) initiative in Corredores,

Costa Rica, started in 2006 as part of a larger initiative that was launched in 1998 to improve food security and nutrition in the region. In Corredores, the initiative also focused on water and sanitation. It involved the Ministry of Health, municipal government, local schools, Paso Canoas market, the Association of Rural Aqueducts, INCAP/PAHO, local health services, community groups, and the local Food Security Committee. A FVP office was established in the municipality to facilitate coordination, implementation and follow-up of activities. The community organization in place allowed for a greater commitment from all those involved to work collaboratively.

The Initiative worked with women, indigenous populations and children in various projects such as food cultivation and bread-making. Schoolchildren were involved in the design and implementation of recycling programs within schools. A community garden was established in two indigenous communities with food production aimed at providing for the population and for sale. Training and resources were offered to those working with solid waste disposal (gloves, appropriate attire) and a local committee of solid waste disposal workers was establish to improve capacity and give more dignity to this important job that contributed to local development and environmental sustainability.

The initiative promoted greater awareness of issues related to food security and nutrition, not only at a household level but also at community level. Infant mortality rates have decreased in Corredores since the beginning of this initiative, which was attributed to increased population awareness and education. All mothers now receive prenatal care regardless of their social situation. A higher level of community empowerment was also observed, with members demonstrating more confidence to identify problems and jointly discuss solutions. Health professionals also reported feeling more motivated to work with the community.

Working within the framework of the FVP initiative helped to attract national attention to this region of the country, resulting in higher commitment and resources available to work with these vulnerable communities and populations. Working with issues related to food security, water and sanitation also helped to identify and have an influence on other issues important to the community, such as environmental degradation and intra-family violence. As a result, the initiative shifted towards a focus on the determinants of health, bringing together various institutions and sectors and highlighting their roles in community wellbeing.

Lack of good management at the national level and among some of the institutions involved was highlighted as a significant challenge. Lack of follow-up from technical personnel at the national level, mostly caused by the remote location of the municipality caused some difficulties. The high level of children dropping out of school to work in the fields also hindered the success of the initiative although there were some efforts by school directors to keep children in schools.

By addressing various determinants of health, this initiative successfully improved the community's quality of life by empowering women to be more independent and to play a more proactive role at the individual, family and community level; improving access to and the quality of food; and improving family income. It helped to strengthen social cohesion and the community's capacity to organize itself and be involved in the solutions to their own problems. This experience highlights the importance of going beyond identifying the problems affecting a community, to also understanding their roots and the population's capacity to make decisions and act individually and collectively.

Case 12

Early Detection of Breast Cancer through Mobile Mammography Services
Uruguay

The Mobile Mammography Services, which is part of the Early Detection of Breast Cancer Program coordinated by the Honorary Commission to Fight Cancer, was launched in 2003 in four municipalities of the state of Colonia, Uruguay (Juan Lacaze, Colonia Valdense, Nueva Helvencia, and Rosario). It aimed at improving early detection of malignant tumors, as well at improving self-care and self breast exams among women in these municipalities. Mammography services were not available to women living in this remote area of the country prior to this initiative, which required them to travel to the state's capital for services. This disproportionately affected women from poorer sectors of the community.

Various local stakeholders were involved in the planning stage of the initiative through the establishment of a Local Committee in each of the municipalities selected. This Local Committee raised money to cover the costs of bringing the mobile clinic to the communities and to pay for the health professionals that were staffing it. Community members also offered to transport women who could not get to the mobile clinic on their own, either due to the distance or to having physical disabilities. Due to the limited availability of the mobile services in each community, the emphasis was primarily on women who were 40 years or older, who lived in poorer neighborhoods, and who did not have regular access to health services.

Of the approximately 10,500 women over 40 years old living in these municipalities, the initiative managed to conduct a mammogram on 5,392, which was around 51% of this population group. Demand for services was high. Even though 100% of the appointments available were scheduled, each municipality still had a long waiting list of users who would have liked to have been seen. As a result, two permanent mammogram machines were installed in two of the localities included in this initiative. Even though these services are now only available in private clinics, it came about as a result of the population's demands for services.

The initiative initially encountered some resistance. Some women were not well acquainted with mammography, which led them to be fearful and anxious of undergoing the examination. It was important to explain to them the science behind the exam and make sure they understood how beneficial it was to undergo. As a result, an informational campaign was created and delivered by local leaders through the media to address the main concerns of the population in regards to mammogram exams.

The initiative also successfully raised awareness of breast cancer through a continuous campaign aimed at improving women's knowledge about their bodies and their rights. Although this improved women's self care and awareness about breast cancer, it also created some challenges for the initiative to respond to the demand for services generated by this increased knowledge.

The municipalities included in this initiative had a high level of organization and community participation, which greatly contributed to the successful implementation and planning of the activities. Nevertheless, there were important rivalries among these sites, which created difficulties to establishing networks and collaborative links.

The initiative also resulted in the development of two important policies, one that allows women to take one day off per year to have a mammogram, and another one that offers free mammograms for women aged 40-59 every two years.

Case 13

Azucarlito "Free of Tobacco Smoke Workplace" Initiative in *Uruguay*

The Azucarlito "Smoke-free Building" was launched in 2002 as an initiative to maintain a smoke-free work environment in a sugar factory in Paysandú, Uruguay. It started in response to an interest expressed by the factory management and a group of employees to work in a free of tobacco smoke setting. An initial baseline determined that 10% of the factory's workers were smokers. Smoking cessation programs previously put in place to help staff quit the habit had not been effective.

Initially, activities aimed at improving knowledge about the negative consequences of smoking and the positive benefits of keeping spaces free of tobacco smoke. Also discussed were the distinctions between "active smokers" and "passive smokers." Groups were set up to discuss individual and collective responsibilities for everyone's health, which were facilitated by a doctor and a health promotion specialist. Smoking cessation support groups were established. Finally, a policy was implemented from the top management level declaring Azucarlito a "Smoke-free Workplace", and outlining sanctions that would be applied to those who did not abide by the new rules.

The initiative resulted in many staff members quitting smoking while others significantly reduced the number of cigarettes smoked per day. The initiative gained media attention, which promoted Azucarlito as the "First Free of Tobacco Smoke Workplace" in the country and motivated other organizations to launch their own "Free of Tobacco Smoke Workplace" initiatives.

Leadership and coordination from a community organizer from the Honorary Commission to Fight Cancer was central to the success of the Initiative along with broad participation and support from all levels within the company. The Azucarlito Company had an expressed commitment to protect its workers' health, which generated support from high levels of management within the company. Leadership from one manager in particular, who was an ex-smoker and who suffered serious health consequences as a result of his habit, was also highlighted as a crucial factor for the success of the experience. Workers also actively participated in all phases of the initiative. Some of the challenges included resistance to participating in the initiative's activities and programs from smokers within the company, particularly those in higher levels of management.

The Azucarlito "Smoke-Free" initiative established an important and innovative model for health promotion programs and policies in Uruguay. The experience received national recognition and was replicated in various institutions. It also served as a model for the development of the National Decree 268/05, which prohibits smoking in all enclosed spaces in the country as part of the National "100% Spaces Free of Tobacco Smoke" initiative.

Case 14

Making the Rivera Town Council a Free of Tobacco Smoke Workplace *Uruguay*

The "Rivera Town Council Free of Tobacco Smoke" Initiative was launched in 2004 with the aim of transforming the main building of the municipality of Rivera's Town Council into a workplace free of tobacco smoke. The initiative was designed and implemented by the Town Council's staff and a coordinator from the Honorary Commission to Fight Cancer. Collaboration also took place with the radio program "Entre Todos" ("Among all of us"), which helped to disseminate information about the initiative and its results to the general population.

Initially, a working group named "Grupo Pro Calidad de Vida" (Group of Quality of Life), comprised of staff and managers from various departments of the Town

Council was formed. They were given an office space with access to telephone, computer, printers and the Internet. The working group met regularly to discuss decisions and activities related to the Initiative. In the course of the Project, this group changed in line with the needs of the initiative's various tasks and phases. The group's diversity and the high level of commitment and participation from its members were highlighted as one of the main factors affecting the success of the initiative.

One of the main contributions from this group was the drafting of an internal policy regarding smoking in the workplace. This policy, once approved, led to the creation of areas designated for smoking and it transformed the Rivera Town Council into the first Town Council 100% Free of Tobacco Smoke in Uruguay. Smoking cessation programs were also implemented and made available to all staff. The initiative was officially recognized by the Mayor's office and the city's legislature approved a change in the municipal statute to support it. Involvement of the mayor in the activities increased during the course of the initiative. Local labor unions also supported the efforts.

An awareness campaign was developed to share information about the magnitude of the problem and the risks of first and second hand smoking to those working in the building. This was done through presentations and workshops with an oncologist and university professors, posters, stickers and other promotional materials such as mouse pads. Ashtrays were also placed in strategic places with reminders for people to deposit their cigarettes before entering the premises.

One of the initial challenges was the fact that tobacco smoke contamination at the workplace was not seen as a problem by staff, management and even health services. As awareness increased due to the Initiative's efforts, the issue began to be perceived as a problem that needed to be addressed. A positive effect was also noticed on the perception by the local health services staff about how tobacco smoke affected the population's health as a result of the Initiative. This led to the support of the health services to the initiative's activities and greater promotion of local public policies to combat tobacco smoke contamination in the workplace.

One important factor hindering the success of this Initiative was the lack of will by some staff members to discontinue smoking at work. The policy aimed at making smokers either quit their tobacco usage or limit their tobacco consumption to non-work related areas. However, it required intense and constant enforcement in order to significantly curtail the tobacco smoke contamination in the workplace.

The Initiative has been sustainable and it managed to maintain a good level of participation in order to secure the results obtained. The level of tobacco smoke contamination in the building has decreased along with the number of smokers among the staff. The non-smoking policy in the workplace is well established and respected. Currently, the working group is focusing on documenting the experience in order to better disseminate its results and lessons learned to the community and health professionals.

Case 15

Community Promotion, Prevention and Education for Cardiovascular Health in *Tala, Uruguay*

This community-based initiative, implemented since 2002 in the municipality of Tala, Canelones, aimed at promoting a better understanding of a holistic concept of health and to promoting the adoption of healthy lifestyles. It involved the local government, community organizations, public and private health services, rural and urban schools, local churches, the Honorary Commission for Cardiovascular Health, academia, sports organizations, health professionals, community health workers and community

leaders. Initially, a baseline was taken to assess the population's profile and the major problems affecting it. It demonstrated an aging population that suffered from a high prevalence of preventable conditions. These were mainly caused by changes in eating habits, sedentary lifestyle, alcoholism, smoking, high consumption of psychoactive drugs, and deterioration of social, economic and environmental conditions affecting cardiovascular health. Unemployment was particularly high, especially among the rural population. Health services focused almost exclusively on providing treatment, with very little promotion, prevention and education activities.

Activities included various activities such as a broad media campaign about the importance of healthy lifestyles, the incorporation of health teams in schools, the establishment of community groups and capacity-building activities. A series of projects sprung up from this initial effort (proper waste disposal, vector control, prevention of STDs, substance abuse and domestic violence, etc.), all under the same strategic line of action and with a focus on the most vulnerable population groups and those with specific cardiovascular risks (obesity, diabetes, addictions, etc.).

Some of the results observed included: increased awareness among health professionals regarding the importance of promoting healthy lifestyles and better understanding of health promotion strategies and mechanisms; greater acceptance of efforts conducted in a participatory manner and with the community; increased knowledge and healthy habits among adolescents and the elderly; greater participation and less isolation of the elderly population; better understanding of issues related to school health with the implementation of a more efficient follow-up and referral system; and the establishment of community health groups such as "Adultos en Movimiento" ("Adults in Movement") that works to prevent domestic violence.

One important factor supporting the Initiative was a change in the national government that took place in 2005. This led to an increase in technological developments and a greater emphasis on health issues in the media. It also led to a structural change in the health system, which now geared itself more towards health promotion and education, and strengthened primary health care strategies. This led to the inclusion of various social actors at the local level in the decision-making process, which greatly facilitated the planning and implementation of the initiative. This, in turn, generated greater interest and commitment on the part of the community with the Initiative.