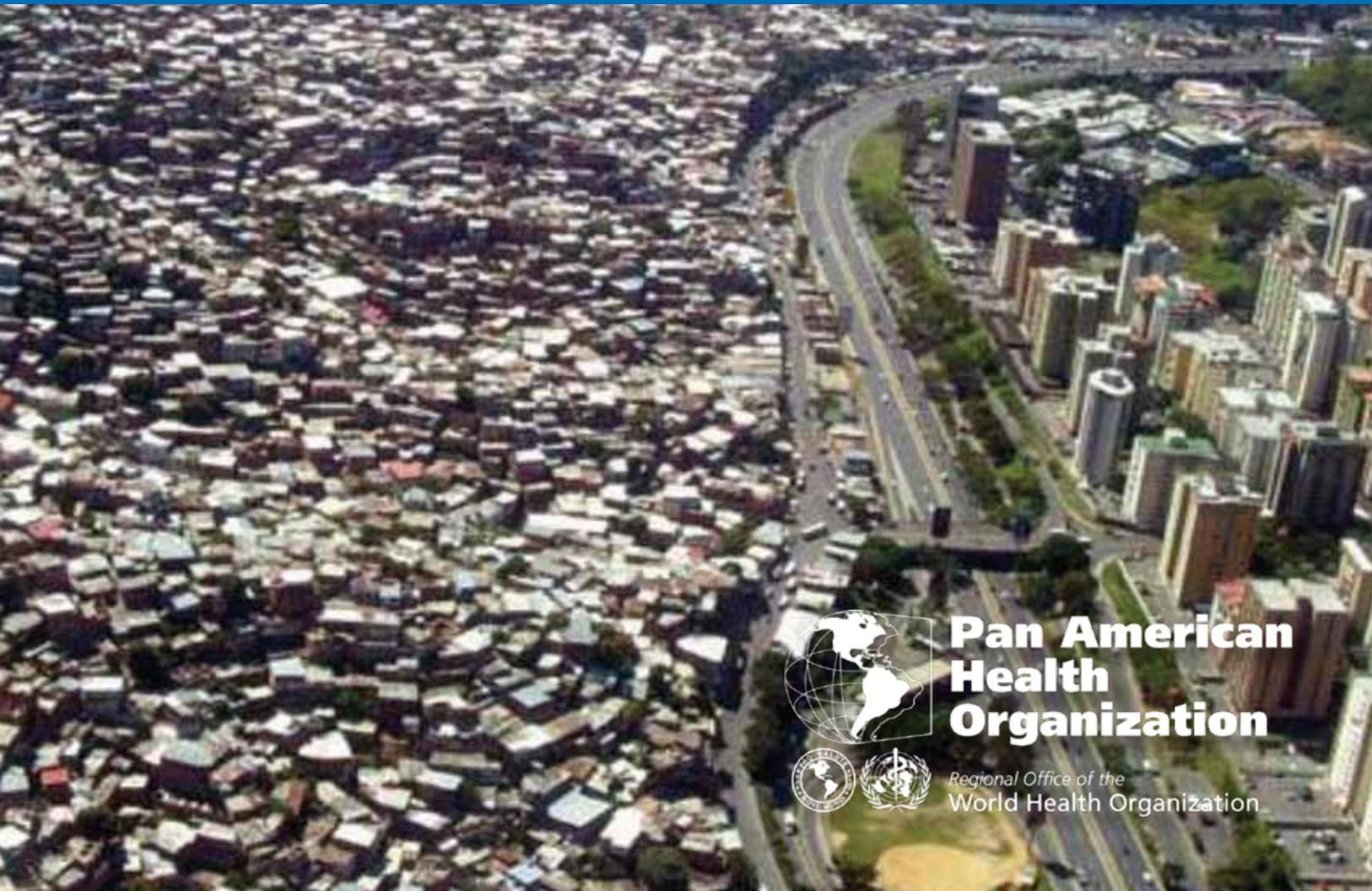


PAN AMERICAN HEALTH ORGANIZATION / WORLD HEALTH ORGANIZATION

Trends and Achievements in Promoting Health and Equity in the Americas: Developments from 2003-2011



**Pan American
Health
Organization**



*Regional Office of the
World Health Organization*

PAN AMERICAN HEALTH ORGANIZATION / WORLD HEALTH ORGANIZATION

Trends and Achievements in Promoting Health and Equity in the Americas: Developments from 2003-2011

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I. Introduction



Since the First International Conference on Health Promotion took place in Ottawa, Canada, in 1986 and the publication of the Ottawa Charter for Health Promotion (WHO, 1986), health promotion has been increasingly utilized as a central public health strategy. Over the last three decades, governments and international organizations worldwide have significantly increased their investments in health promotion programs. Many countries have taken important steps to incorporate health promotion into their national policies and mainstream it into their public health practice in order to operationalize and implement its values and principles. While some countries have achieved significant advances with these efforts, others have encountered important challenges and obstacles (see discussions on later sections of this document). Global initiatives such as the Millennium Development Goals and Primary Health Care have also recognized health promotion as a central strategy to improve health and equity.

Increasingly, developing countries are adopting health promotion as an appropriate approach to address the social determinants of health, inequities and the challenges associated with the epidemiological transition from infections to chronic diseases, globalization and urbanization. Currently, 12 countries in the Region have developed national health promotion policies and plans (Brazil, Canada, Chile, Costa Rica, Cuba, Dominican Republic, Ecuador, Guyana, México, Peru, Trinidad and Tobago, and the United States). Many countries and cities have implemented health policies aimed at decreasing risk factors and diseases, as well as policies applied to other sectors and that focus on the social determinants of health. Other countries have established national policies that combine improvements in health with addressing social and economic conditions of the population.

For many countries in the Americas, the arguments as well as the five strategies included in the Ottawa Charter constitute the core of their public health agenda. However, this has not happened without challenges. The Ottawa Charter's focus on "health for all" in the spirit outlined in the Alma-Ata Declaration on Primary Health Care (1978), implies a shift away from the traditional, hegemonic biomedical paradigm that is the basis of most public health systems. The five "areas of action" defined in the Ottawa Charter for health promotion interventions¹ go beyond the traditional emphasis on healthy lifestyles or changes in individual behaviors. Health promotion is seen as a strategy for social change.

¹ These areas are: establishment of healthy public policies; creation of healthy settings; strengthening of community action; promotion of personal skills; and reorientation of health services.

Increasingly, developing countries are adopting health promotion as an appropriate approach to address the social determinants of health, inequities and the challenges associated with the epidemiological transition from infections to chronic diseases, globalization and urbanization

Countries of the Region have attempted to engage in a variety of transformative processes to create the necessary structure, conditions and commitments for effective and sustainable health promotion. While important progress has been made, the majority of these efforts has mainly focused on changing lifestyles and individual behaviors and/or has acted on specific settings (schools, municipalities, etc.). As a result, they have fallen short of stimulating the structural and organizational changes required for effective and sustainable health promotion. Many of these experiences have not been institutionalized, often because the political component of health promotion is not addressed or it is weakly developed. Countries such as Chile and Brazil are an exception, since many of their policies and plans effectively incorporate health promotion principles and values at their core. All these experiences highlight the critical challenges that still need to be addressed in the Region.

The Pan American Health Organization/World Health Organization (PAHO/WHO) has played a key role in the development of health promotion in the Region. Throughout the years, PAHO and WHO have provided consistent leadership and stewardship on health promotion worldwide, and have been pivotal in shaping the concept, strategies and policies that have been implemented by their Member States. The WHO Report on Primary Health Care (WHO, 2008a) and the recent report on Health Systems Financing (WHO, 2010a) both stress health promotion as a key component for providing health care and highlight it as a real opportunity for increasing health coverage and saving costs.

By consistently promoting a broader concept of health as basis for human development and improved quality of life, PAHO has engaged many countries in the Region in adopting the values and principles of health promotion and incorporating them into national political agendas. Countries like Mexico and Chile have been able to develop important integrated and intersectoral initiatives to address national priorities such as obesity and chronic non-communicable diseases. Nevertheless, in most cases, advances in health promotion have mostly happened within the health sector and have not been successful in creating bridges and establishing collaboration with other sectors. These are some of the challenges that remain to be addressed and that will be further discussed in this document.

II. Purpose



This document will review and analyze the major trends and developments in health promotion and equity in the Region of the Americas during the period of 2003-2011. It will highlight the main opportunities and challenges for health promotion in the Region; discuss major developments within PAHO and its Member States; illustrate how PAHO contributed to the development of health promotion in the Region; and point out the remaining gaps to be addressed. It will also make recommendations about how to move health promotion forward within the Organization and Member States, as well as on how to incorporate health promotion into public health and technical cooperation agendas in the Region.

III. Background

Health promotion has made great strides in the past few decades worldwide. From an approach focused on disease prevention in the 1970s, the concept has evolved and broadened

Health promotion has made great strides in the past few decades worldwide. From an approach focused on disease prevention in the 1970s, the concept has evolved and broadened. During the 1980s and 1990s practitioners recognized the need for complementary interventions (such as healthy public policies), to incorporate other sectors and to create healthy environments, in order to make health promotion initiatives effective and successful. In the past few years, the concept of the social determinants of health has been incorporated into the health promotion approach, as global movements of social change and the need to invest and strengthen leadership in health promotion have become more prominent. The series of PAHO Regional and WHO Global Conferences and High Level Meetings on Health Promotion and on Urban Health that have taken place throughout the years have generated important declarations that have defined key aspects of health promotion and that have been key to politically position health promotion in the international agenda (Table 1).

Table 1. Historical health promotion conferences, initiatives, and key concept; World Health Organization; by year.

Year	Conference	Concept
1978	Alma Ata Conference on Primary Health	Health promotion as a goal
1986	1st International Conference on Health Promotion: Ottawa Charter on Health Promotion	Functions/strategies of health promotion, as a field of knowledge and practice
1988	2nd International Conference on Health Promotion: Adelaide	Healthy public policies
1991	3rd International Conference on Health Promotion: Sundsvall	Healthy settings
1992	International Conference on Health Promotion in Santafe de Bogota, Colombia	Addressed regional issues related to violence and equity
1997	4th International Conference on Health Promotion: Jakarta	Building partnerships
2000	5th International Conference on Health Promotion: Mexico	Ministerial declaration: building action plans
2005	6th International Conference on Health Promotion: Bangkok	Health promotion in a globalized world
2005	Launching of the WHO Commission on the Social Determinants of Health	Equity and the social determinants of health
2009	7th Global Conference on Health Promotion: Nairobi	Closing the implementation gap in health and development through health promotion
2010	Kobe Call to Action from the Global Forum on Urbanization and Health and the Launching of the WHO-UN HABITAT Report: Hidden Cities: Unmasking and overcoming health inequities in urban settings	Urban health
2011	First Global Ministerial Conference on Healthy Lifestyles and Control of Noncommunicable Diseases	Healthy lifestyles and control of noncommunicable diseases
2011	Global Status Report on Noncommunicable Diseases 2010	Key report on the global burden of noncommunicable diseases, their risk factors and determinants
2011	Global Statement on the Social Determinants of Health	Health promotion and the social determinants of health

However, while specific events and declarations have played an important role in shaping the concept and path of health promotion in the Region, it is the characteristics of specific initiatives that have created an impact and strengthened health promotion at various levels and contexts. Advances in health promotion are also not the result of isolated initiatives and programs, but of the sum and synergy of all health promotion efforts.

IN THE AMERICAS

The Latin America and Caribbean (LAC) countries have a long tradition of social mobilization and community-driven movements to improve living conditions for their populations. Movements towards the adoption of health promotion approaches have been taking place in the Region for decades. Starting in the 1950s, the concept of local development took hold in many countries as a way to improve the quality of life primarily in rural areas. However, most of these initiatives still implemented a top-down approach and assumed that communities would accept the ideas and health priorities as defined by outsiders. By the 1970s, as community resistance mounted, new integrated community development strategies that focused on promoting more active community participation and greater access to health services were introduced with varied results.

Since the 1980s, the LAC countries have experienced major democratization and decentralization processes that significantly re-shaped their social, political, cultural and economic profiles. This has affected health systems in the Region differently. On the one hand, neoliberal policies centered on free market principles have influenced the development of health systems in some countries; these, in general, generated policies and programs that were incompatible with health promotion principles and values. On the other hand, decentralization processes that took place in various degrees in the Region have also resulted in a territorial redistribution of power and resources through political-administrative reforms. This resulted in greater autonomy, decentralized decision-making power, 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.

Concomitant with health sector reforms that took place during the 1980s and 1990s, a series of strategies were put into place by countries in the Region aimed at improving health by incorporating more equitable, sustainable, participatory and health-promoting approaches. In the early 1980s, countries in the Region made a commitment to implement the Primary Health Care (PHC) Strategy,

with a focus on community participation and improving access to health care for the most vulnerable population groups. By 1986, renewed emphasis was placed on Strengthening Local Health Systems (known as “SILOS”), as a viable strategy to tackle health priorities among the most vulnerable populations. The SILOS strategy was characterized by a focus on decentralization and local development in order to contribute to sustainable democratization, social participation and social justice processes.

By the 1990s, health promotion had surfaced as a major strategy in the Region; one that fit the complex health profile of its countries, with feasible proposals for integrated health and human development. Health promotion recuperated the importance of the social setting as a central element to achieve true equity by incorporating a positive concept of health and recognizing people as active participants in the process. In this context, interest in preventive and educational activities quickly spread throughout the Region, and particular emphasis was placed on promoting healthy lifestyles, with the creation of environments and conditions to support them; and greater importance was also placed on the importance of strengthening the social construction of health and the centrality of community participation in order to achieve better health (PAHO/WHO 1999).



BOX 1. The Continuity and Sustainability of Health Promotion Processes in the Americas: An Ongoing Challenge

Despite great advances, the development of health promotion in the Region has been uneven. In some countries such as Argentina, Brazil, Chile, Cuba, Guyana, Mexico, Peru, and Trinidad and Tobago, very dynamic processes have taken place, ones that reflect PAHO's active technical cooperation strategy in these countries at certain periods as well as political commitment from high levels of national leadership. This has stimulated the incorporation and development of health promotion within the agenda, structure and functioning of many Ministries of Health and among local governments. Examples include the creation of health promotion directorates and programs and the establishment of networks such as Healthy Municipalities, Health-Promoting Schools, and Health-Promoting Universities.

Nevertheless, over time, many of these initiatives were not sustainable. This can be attributed to various factors, but most importantly, to changes in leadership and personnel, both in the PAHO offices and public institutions, which led to the removal of key people that were committed to health promotion development. One example is that of Venezuela, where support for health promotion was strong at the beginning 1990s, that in turn led to the development of a strong healthy municipalities network. However, changes in the government and in the national PAHO office affected the continuity of the initiative and resulted in its termination a few years later. In Peru, the lack of support from the PAHO office led to a partial dismantling of some of the country's health promotion networks, but with a new administration and PAHO Focal Point this initiative is being rejuvenated.

Political context and timing can affect the continuity of many health promotion initiatives in the Region. Election periods and political transitions often cause delays (if not termination) of initiatives, shortage and/or changes in personnel and funds, and great uncertainty about the future of the initiatives. Constant advocacy about health promotion's purpose and benefits, and the establishment of strong coalitions and support bases among all stakeholders (universities, NGOs, etc.) can be an effective strategy to provide continuity and sustainability to health promotion initiatives during these transitional periods.

Lack of support from key personnel at key institutions can result in major delays or isolation of health promotion initiatives, or threaten their continuity. Various factors account for this resistance, such as lack of proper understanding about health promotion processes and their benefits, inadequate health promotion technical capacities among staff, concerns related to the time it takes for health promotion to show results, difficulties related to how to assess health promotion effectiveness and the usefulness of the data generated, biases against work that emphasizes community empowerment, and challenges inherent in working with rigid and bureaucratic institutions that do not facilitate intersectoral collaboration and that emphasize the production of specific results in a short period of time.

High turnover of key personnel in key institutions can be particularly disruptive as it creates challenges for the continuity of activities and for effective intersectoral collaboration. Such changes require work plans to be reorganized and cause delays as new people need to be integrated into the initiatives and be brought up to speed with their activities and partners. In some cases, it results in the withdrawal of that institution from the activities, temporarily or permanently. However, in some cases, changes in key staff can be positive and lead to greater involvement of committees and provide renewed direction to the initiative and its staff.

During the 2000s, increased emphasis was placed on including health promotion in the national and political agenda of the countries as well as addressing the social determinants of health. PAHO/WHO organized three Regional Health Promotion Forums in Chile (2002), Brazil (2005) and New York (2010), aimed at showcasing the achievements of countries in the Region in the development of national health promotion strategies and policies and improving technical cooperation with its Member States. During this decade, more importance was given to health promotion as a viable approach to be incorporated into health sector reforms and strategies such as Primary Health Care and Universal Coverage.

Overall, the Region has experienced powerful social movements that have generated many lessons and achievements, many of them related to health promotion, yet not exclusively. Nowadays, the Region faces new social, political and economic challenges such as globalization, the recent economic crisis, policies related to migration, and emerging diseases. There is also growing awareness about the challenges related to urbanization, climate change, human security and the burden of chronic diseases. These pose new questions for health promotion practice and have fueled the discussion on how health promotion could contribute to these important issues.

FROM 2005 TO 2011: A DYNAMIC PLATFORM FOR ACTION

The last six years have been particularly fruitful in the field of health promotion. Both the world and the Region have engaged in a series of dynamic processes that have placed health promotion in a privileged position among national authorities, academics, policy-makers and practitioners. Some of the major global and Regional highlights include:

The Bangkok Charter (WHO, 2005)

Acknowledging the reality of a new century faced with an increasingly fast globalization process, and the need to improve capacities in health promotion, this Charter ratified health promotion as an essential public health function that could contribute to efforts that address communicable and non-communicable diseases as well as other health challenges. The Charter identified as critical challenges new patterns of consumption and communication, marketing, increasing inequities within and between countries, environmental changes and urbanization. It also highlighted current opportunities for health promotion, as well as the need for policy coherence and to address the Millennium Development Goals. In order to close the implementation gap, several strategies were identified including investment in advocacy, policies and infrastructure, capacity building, standards and regulations, and the establishment of alliances.

The Charter also highlighted the stewardship role of the Ministries of Health.

Rio's Second Regional Forum on Health Promotion (PAHO/WHO, 2006a)

This Forum highlighted the evidence, as assessed by PAHO, of health promotion achievements. It analyzed human resources and organizational situations within the Ministries of Health, professional programs, and the different developments in the Region.

The PAHO resolution on Health Promotion (PAHO/WHO, 2006b)

Following the Bangkok Charter, PAHO's Directing Council passed a Resolution on Health Promotion which strongly supported the stewardship role of the Ministry of Health and asked other multilateral agencies to promote similar actions with other sectors.

Report of the WHO Commission on the Social Determinants of Health: Closing the Gap in a Generation (WHO, 2008b)

In 2005, the Director General of WHO established the Commission on the Social Determinants of Health (SDH). By clearly identifying the role of health determinants in the health outcomes of the population, this Commission developed a set of knowledge networks that worked together to assess the state of the world's

economy, environment, gender rights, human rights, priority health conditions and urban health. The results were described in a landmark report (WHO, 2008b) that called for *Closing the Gap in a Generation* and addressing the social gradient. In 2008 Brazil published its report on the SDH (CNDSS, 2008) and Canada's Public Health Agency's Annual Report (PHAC 2008) assessed the conditions of the SDH in the country. Subsequently, Chile integrated its policies around the principles of the SDH and it started a process of programmatic reform of its programs and initiatives. Other countries such as Argentina and Costa Rica reorganized their public services to incorporate the SDH approach as well. Most recently, as part of the United States reform process, the SDH have been considered within its strategic developments.

The WHO World Health Report on Primary Health Care (PHC): Now more than ever (WHO, 2008a)

On the 30th anniversary of the Alma-Ata Conference, and now within a radically different global political context, this report addresses the strengthening of PHC through four sets of Primary Health Care reforms: "(a) reforms that ensure that health systems contribute to health equity, social justice and the end of exclusion, primarily by moving towards universal access and social health protection – universal coverage reforms; (b) reforms that reorganize health services as primary care, i.e. around people's needs and

expectations, so as to make them more socially relevant and more responsive to the changing world while producing better outcomes – service delivery reforms; (c) reforms that secure healthier communities, by integrating public health actions with primary care and by pursuing healthy public policies across sectors – public policy reforms; (d) reforms that replace disproportionate reliance on command and control on one hand, and laissez-faire disengagement of the state on the other, with the inclusive, participatory, negotiation-based leadership required by the complexity of contemporary health systems – leadership reforms."

The Nairobi Call to Action for Closing the Implementation Gap in Health Promotion (WHO, 2008c)

An intervention-oriented document, and the product of the 7th Global Conference on Health Promotion, it declares that *"developing and developed countries are facing a surge of preventable diseases that threatens to undermine their future economic development. Five urgent responsibilities for governments and stakeholders [are then developed]: strengthening leadership and the workforce, mainstreaming health promotion, empowering communities and individuals, engaging participatory processes and building and applying knowledge."*

The Health in All Policies Conferences of 2010

In light of the numerous recent key statements and reports calling for intersectorial work on health, as was recommended by the Alma-Ata Declaration and the Ottawa Charter, and given the difficulty in implementing such approaches by the Ministries of Health, a European Union Report on Health in All Policies was issued (Finland Ministry of Social Affairs, 2006). More recently WHO convened three consultative conferences to move this agenda forward (WHO, 2010b; WHO 2010c; Government of South Australia, 2010). These consultations resulted in a call for a new role for the health sector: working in partnership, reaching out with a new set of tools including broader health information systems, effective integration of communities and other participatory processes, and applying the Public Health Lens² and Health Impact Assessment methods.

WHO's 2010 World Health Day on Urbanism and Healthy Living

Building on a growing awareness of the urbanization megatrend and realizing that the majority of

² The Public Health Lens is the inclusion of the population dimension more than individual behavior as an influence on people's health, and the approach to their determinants through interventions of other sectors considering the health consequences of their policies (Frohlich KL., Potvin L. 1999).

the world's population now lives in cities, activities for World Health Day 2010 included a review of the implications of urbanization on the health agenda. This was previously assessed by the Commission on the Social Determinants of Health's Knowledge Network on Urban Health (WHO Kobe, 2007), and it was accompanied by a report by the Global Research Network on Urban Health Equity (GRNUHE), a Rockefeller Foundation-supported project. During PAHO's 50th Directing Council (2010), the Ministers of Health discussed its implications, and identified the need for a Regional strategy, plan of action and resolution to be discussed in PAHO's Executive Committee in June 2011 and Presented to its 51st Directing Council in September 2011.

PAHO's Second Forum on Urban Health and Third Forum on Health Promotion in 2010

As part of the activities for World Health Day 2010, dedicated to "Urbanism and Healthy Living," PAHO organized the joint Second Regional Forum on Urban Health and *Third Regional Forum on Health Promotion* that took place in October 2010 in New York. The Second Regional Urban Health Forum aimed to improve urban health in the Americas through the strengthening of strategies that promote health in urban settings in this Region. The *Third Regional Health Promotion Forum* aimed to strengthen the current role of health promotion in the Americas and its contribution to improving urban health in this Region.

These Forums served to identify areas for future collaboration among PAHO, its key partners and its Member States, in order to improve current public policies and practices that relate to promoting health in urban settings.

PAHO's Directing Council resolutions in 2010

The 50th Directing Council passed several resolutions with implications for health promotion: one on Strengthening the Framework Convention on Tobacco Control (PAHO/WHO, 2010a), a second one on public health and the consumption of drugs (PAHO/WHO, 2010b), a third one on health and human security (PAHO/WHO 2010c), and a fourth one on the health competencies for primary health care personnel (PAHO/WHO, 2010d). The evidence discussed during and the commitments that emerged from the 50th Directing Council's Roundtable Discussions on Urbanization and Healthy Living, examined the challenges posed to the practice of health promotion in the Region, and especially within the reality provided by the city as a defining setting (PAHO/WHO 2010e). The Ministers of Health and their delegations recommended the preparation of a preliminary Regional strategy and plan of action on urban health that outlines the policies that should be adopted to guide sector activities in order to adapt health services and take effective action in the face of urban health challenges. The Directing Council asked PAHO to take action in: producing evidence,

awareness raising, mobilizing resources, fostering partnerships, adapting and developing capacities, strengthening urban services, and encouraging the application of specific methods of assessment (such as Health Impact Assessment and Health Equity Impact Assessment) in order to influence the incorporation of health, health promotion and health equity into all urban policies. Member States noted that action needed to be taken by local and national governments to mainstream health equity, to actively promote the participation of citizens and key stakeholders, to assess health equity, to develop baseline data on urban health and keep it updated regularly, making it accessible, and to facilitate exchange of information between cities, governments, and countries to learn best practices in the field of urban health.

The WHO Global Forum on Urbanization and Health in 2010

The WHO Centre for Health Development organized the Global Forum on Urbanization and Health from 15 – 17 November in Kobe, Japan (www.gfuh.org). The Global Forum marked the culmination of the World Health Organization 2010 campaign on urbanization and health and a series of global events and initiatives, including World Health Day 2010 on the theme of urban health and the launch of the WHO/UN-HABITAT global report entitled *Hidden Cities: unmasking and overcoming health inequities in urban settings* (<http://www.hiddencities.org>). In an

unprecedented demonstration of global collaboration, over 300 city and national leaders from more than 80 countries around the world came together for the Forum, to compare approaches and ideas and commit to policies to improve the health of city dwellers. The Forum endorsed a landmark *Kobe Call to Action* which provides government leaders, mayors and city policy makers with a framework for action to promote health and health equity across all urban public policies.

Capacity mapping exercise (PAHO/WHO, 2007–11)
“Promoting Health in the Americas: A review of Progress on Implementing Health Promotion”

For the first time an exercise was conducted to establish an overview of the health promotion situation in the Americas. As part of a worldwide effort to identify the development of health promotion, it assessed the capacities of human resources, information technology, healthy public policies structures, healthy environments, financing, capacity building, education, communication, intersectorial action, national plans, organizational positioning, and integration into public health programs.

All the events described above set the stage for more effectively facing the challenges of health promotion and current public health priorities. Nevertheless, while these international events, initiatives and documents are important advances

and provide key frameworks, they have not necessarily translated into action and have not guaranteed their adoption and implementation by countries. This remains one central challenge for technical cooperation in the Region that will be further discussed in this document.

**HEALTH PROMOTION
DEVELOPMENT WITHIN
PAHO**

The year of 2003 marked a clear institutional shift for health promotion within the Pan American Health Organization/World Health Organization. During this year, as part of an institutional restructuring process, health promotion went from being an isolated program or a strategy utilized to articulate programs to a cross-cutting theme that was expected to be weaved into the planning and work of all programs within the Organization. This transitional moment involved an evaluation of existing programs and strategic exercises to understand how health promotion could be incorporated into them. The Second Health Promotion Forum that took place in Rio de Janeiro, Brazil in 2005 also marked an important hallmark for health promotion in PAHO/WHO, as it focused on how to implement policies and to mainstream health promotion across the Region. During this time, discussions started to focus on how to consolidate health promotion with the emerging Urban Health Initiative

and how health promotion tools and methods could contribute to improve urban health.

Starting in 2007, the operational aspects of health promotion gained strength, at the same time that the issue of human security started to emerge and take shape within the institution. In order to advance the mainstreaming process, and based upon the mandate outlined in the Health Agenda for the Americas 2008-2012, six cross-cutting priority issues (CCP), one of which being health promotion³, were incorporated into the Organization’s strategic plans. This required that in the development of all PAHO work plans and initiatives, an indication be made of which of the six CCPs would be incorporated, and it included tools in its operational manual for planning on how to do this. PAHO has also evaluated its biannual work plans to ensure that health promotion, as well as the other five CCPs, are adequately incorporated (see discussion about the achievements and challenges of this process in the section “Mainstreaming Health Promotion”).

PAHO has also helped to advance health promotion by incorporating it into many of its strategies and initiatives, such as Primary Health Care; Universal Coverage; Faces, Voices and Places; Urban Health Initiatives; Healthy Settings; Integrated Management of Childhood Illnesses (IMCI); among others. As a result

³ The remaining CCPs were gender, ethnicity, human rights, social protection and primary health care.

of all these activities and processes, many aspects of health promotion became more clearly defined and consolidated within the Organization; nevertheless some important gaps still remained (see discussion under “Mainstreaming Health Promotion”). Equally important were the launching of World Reports on Violence and Road Safety⁴ and global initiatives such as the Global Strategy on Diet, Physical Activity and Health⁵. Although they address very specific issues, they do so by adopting an

integrated and intersectoral approach that highlights and emphasizes health promotion strategies and values.

By 2010, a series of Organizational, Regional and worldwide events placed health promotion in a privileged position to be considered as a strong and key strategy to help improve the health and quality of life of the people of the Americas (Directing Council, Roundtable, World Health Day 2010, etc.). An appropriate approach was firmly consolidated to work in conjunction

with emerging issues such as climate change, human security, urban health, and chronic non-communicable diseases. Within PAHO, a new place was created for health promotion; one that has clearly defined roles and is expected to strengthen the Institution’s response to other topics and programs in the Region (see “Mainstreaming Health Promotion” for a more in-depth discussion of the difficulties and challenges to be addressed).

⁴ http://www.who.int/violence_injury_prevention/road_safety_status/2009/en/index.html

⁵ <http://www.who.int/hpr/gs.reference.group.shtml>

IV. Key Trends in Health Promotion in the Region

The development of healthy settings (municipalities, schools, workplaces, housing, etc.) has been one of the strategies most widely applied in Latin America and the Caribbean

ATTENTION TO THE SOCIAL DETERMINANTS OF HEALTH

Nowadays, the need to address the social determinants of health is widely accepted. The WHO Commission on Social Determinants of Health, established in 2005, and its related knowledge networks, helped to more fully define the causes underlying health disparities: (a) differential power and influence associated with income inequality, and social and economic status, (b) differential exposures to stress, environmental toxins, and other adverse conditions, and (c) differential consequences associated with discrimination and unequal access to services (WHO, 2008b). Widespread awareness of this idea is important since it has helped build consensus on the need to take action and where to intervene on broader conditions that affect these and related unequal outcomes.

As a concept and set of practical strategies, health promotion remains as the more comprehensive approach to address the major health challenges faced by developing and developed nations and that are associated with the social determinants of health. It

incorporates actions directed at macro determinants of health, that are outside the immediate control of individuals (social, economic and environmental conditions) and those that are within the more immediate control of individuals, such as healthy behaviors.

In recent years, many countries in the Americas have put greater emphasis on the social determinants of health. As a result, the countries of the Region have seen an increase in policies and activities that include addressing health determinants to reduce health inequalities, and which recognize, strengthen, and use people's capacities and resources to improve their own health (see Box 2). The development of healthy settings (municipalities, schools, workplaces, housing, etc.) has been one of the strategies most widely applied in Latin America and the Caribbean (see section "Creation of Healthy Settings" for more details).

Prior to the *World Health Assembly Resolution on Reducing Health Inequities through Action on the Social Determinants of Health* (WHA 62.14) (WHA 2009), PAHO's Directing Council approved a series of important resolutions and documents that helped to shape and orient

its Member States' responses to these issues. These include in 2001, Resolution CD43.R11 on Health Promotion in the Americas (PAHO/WHO, 2006b) and Resolution CD43.R15 on Health, Drinking Water and Sanitation in Sustainable Human Development, in 2004 Resolution CD45.R3 on Millennium Development Goals and Health Targets, and in 2006 Resolution CD47.R20 on Health Promotion: Achievements and Aspirations contained in the Ottawa and Bangkok Charters.

PAHO has also played a significant role in disseminating information and providing technical cooperation and guidelines to its Member States on the topic (See Box 2 and Box 3). A key challenge is knowing how to intervene effectively; there is little information about what combinations of environmental and policy approaches make a difference in reducing health disparities. Another critical challenge is developing an evidence base for what works in influencing these mechanisms to achieve improvements in population health and health equity.

The Secretariat of the Pan American Health Organization has a constitutional responsibility to



BOX 2. Regional Initiatives to Address Health Determinants

In 2006, Brazil created a National Commission on the Social Determinants of Health (CNDSS). This intersectoral commission works to produce and disseminate information on the relationships between the social determinants of health (SDH) and health status, to improve policy and program design, integrate the issue of the SDH and the consequences of inequalities into the education of health professionals, and mobilize civil society to increase interest in the relationship between health and living conditions (CNDSS, 2008).

Likewise, in 2007, the Ministry of Health of Argentina established the Secretariat of Health Determinants and Research, which works to integrate strategies for responding to health problems and facilitating the implementation of National Programs in the country (Red de Municipios Argentina, 2010).

In 2008, Chile created the Secretariat of Social Determinants of Health in the Ministry of Health, which produced regional SDH assessments and held health forums to analyze the SDH at national and regional levels. This experience enabled the development of intervention proposals with joint public participation (Health Forums: Challenges and Citizen Proposals) (Ministry of Health of Chile, 2010).

The current governance model being used by Costa Rica's Ministry of Health is centered on the need to influence the social determinants of health to protect and improve the health of the population. To this end, the model is based upon a strategy of "moving from treatment of disease to the promotion of health", which is a fundamental shift in paradigm towards a culture of inclusiveness and equity in achieving a better quality of life and wellbeing.

PAHO/WHO also leads a series of Regional initiatives that include a SDH approach; for example, the Healthy Municipalities, Cities, and Communities Initiative; Health-Promoting Schools; "Faces, Voices, and Places"; and efforts to renew primary health care.

BOX 3: PAHO's Open e-course on the Social Determinants of Health and the Development of Public Policies

This free and open virtual course was developed by PAHO/WHO with the goal of raising awareness, disseminating knowledge and promoting reflection about the social determinants of health in order to promote changes in the health agenda of the countries of the Region and improve social justice and human rights. The course aims at generating a broader and more critical perspective about the social determinants of health by facilitating comprehension of its key concepts and interventions. The content included is based on evidence-based material on the social determinants of health as well as the products from the WHO Commission on the Social Determinants of Health.

The course was developed for staff at PAHO/WHO and Ministries of Health in Member States who are responsible for the formulation of policies, plans and programs related to the social determinants of health. Furthermore, through collaboration with other country-based initiatives and academic institutions, a broader audience has been reached. As such, this initiative is helping to strengthen personnel and institutions on a variety of levels throughout the Region.

Access to the course (currently only available in Spanish): <http://dds-dispositivoglobal.ops.org.ar/curso/>

report to the Pan American Sanitary Conference on health conditions and trends in the Region. Such is the principal purpose of the 2012 edition of *Health in the Americas* that is currently under preparation. The objective of this analysis is to provide an updated and comprehensive presentation of the health situation throughout the hemisphere generally and specifically in the countries and territories of the Americas, and it describes and analyzes the progress, constraints, and challenges of PAHO Member States in their efforts to improve the health of the peoples of the Region. It is also worth noting that the overarching theme in the 2012 version will be that of equity and a specific chapter will be written on the determinants of health within the region of the Americas. This is an important demonstration of the importance both PAHO and its Member States are giving to the issues of equity and the social determinants of health.

DEVELOPMENT OF HEALTHY PUBLIC POLICIES AND “HEALTH IN ALL POLICIES” AND HEALTH EQUITY IN ALL POLICIES

Globally, public policies have a major influence on the determinants of health and well-being. Policies influence the distribution of power and resources at the global, national and local levels, which in turn shape the conditions in which people grow, live and work – the social

determinants of health (Kickbusch, McCann, Sherbon, 2008). Such decisions made by governments and other institutions across sectors can have both positive and negative implications for patterns of health and social inequalities.

The importance of public policy within global health promotion has been formally recognized at least since the development of the Ottawa Charter in 1986, which identified building Healthy Public Policy as one of five health promotion action areas. Since then, the development of healthy public policies has emerged as a key health promotion strategy.

Health promotion provides an important framework to advocate for policies that support the creation of health-supportive environments. It is a technical and political approach to working across sectors, fostering empowerment and improving quality of life. In the Region of the Americas, health promotion has demonstrated success in addressing difficult social issues while promoting citizen engagement and participation, as well as social accountability (See Box 5).

Growing recognition that population health cannot be sustained by narrowly focusing on the financing and distribution of medical services, has led many policymakers and stakeholders to propose more comprehensive and integrated strategies that foster health in all policies (HiAP). Many countries have already come to recognize the importance of incorporating health promotion and disease prevention

into their health reform processes and engaged in a broad range of policy changes such as regulation of alcohol and tobacco products, expansion of healthier transportation systems (bicycle paths, pedestrian-friendly roads and pathways), improvements of water and air quality, expansion of primary health care services, improvements of nutrition programs, etc. This new focus on HiAP has helped to shift the emphasis away from individual lifestyles and single diseases to the broader determinants and actions that impact population health. Within the framework of the social determinants of health, the goal is to achieve health equity in all policies and as such, instruments have been developed and their use promoted to help with this achievement. PAHO has led capacity-building activities for the application of Urban HEART, Health Impact Assessment and Health Equity Impact Assessment to facilitate the introduction of this process in selected cities and countries of the Region (see Box 4).

Nevertheless, while HiAP resonates with decision-makers and stakeholders throughout the Region, it is a politically challenging strategy. It requires the mobilization and coordination of a variety of sectors, federal agencies, academic institutions, NGOs, and the private sector. It also rests on the commitment of leadership from the top to set the required frameworks for action. Such policies need to be more fully implemented and evaluated; actions related to the



BOX 4: PAHO's Capacity Building in Urban Health Metrics (Urban HEART and Health Impact Assessment)



In May 2011, a workshop was held in Bogota, Colombia, for 21 countries and 23 cities from Latin America and the Caribbean to train eighty participants in the urban health metrics instrument of Urban HEART (Health Equity Assessment and Response Tool) and Health Impact Assessment/Health Equity Impact Assessment (HIA/HEIA). The workshop was designed to build collaboration, a common language and long term relationships within each country by inviting representatives from the national level (Ministries of Health), the local/city level where a pilot will be conducted, and an academic institution. Those attending the workshop included key decision makers and leaders at the national and local levels.

The Urban HEART tool aims at providing policy and decision makers at national and local levels a tool to (a) use existing databases from multiple sectors to identify and analyze inequities in health among people living in various parts of cities and who belong to different socioeconomic, age and ethnic groups, (b) identify priorities, and (c) facilitate decisions about which viable and effective strategies, interventions and actions might be used to reduce these inequities in health. The Health Impact Assessment tool is a prospective approach that helps to estimate what might be the impact on health and health equity from implementing specific policies, programs and projects, no matter what sector might be the focus (be it transportation, urban design, education, food security, etc.).

The workshop was facilitated by staff from the WHO Kobe Center for Health Development and from the Centre for Health Equity Training, Research and Evaluation (CHETRE) which is part of the University of New South Wales Research Centre for Primary Health Care and Equity. The latter also provides leadership for the International Union for Health Promotion and Education (IUHPE) Global Working Group on HIAs.

To illustrate the state of the art on designing city policies based on health criteria, a panel was invited to discuss the Urban Design Guidelines of New York City, with an intersectoral team that presented the approach and accomplishments to date on their published guidelines.

Participants came from the following countries and cities: Argentina, Belize, Bolivia, Brazil, Chile, Colombia (Bogota, Cali and Medellin), Costa Rica, Cuba, Dominican Republic, El Salvador, Guatemala, Honduras, Guyana, Jamaica, Mexico, Nicaragua, Paraguay, Peru, Surinam, Trinidad and Tobago, and Uruguay. All teams presented follow-up plans for putting into practice these instruments and the majority of them plan to conduct capacity and institutional building activities upon their return home. It is expected that this will help to ensure the application of these instruments, a concrete and directed initiative to address the social determinants of health, and some evidence of the effectiveness of intersectoral strategies and actions in the future.

social determinants of health, their surveillance, evaluation and related methodological issues pose important challenges that need to be addressed collaboratively. Lastly, these policies also need to be linked with the appropriate infrastructure, resources and strategies that will allow for true intersectoral collaboration and social change.

Although intersectoral collaboration has been highlighted as a key strategy to foster HiAP, it will

require not only that the health sector increases its cooperation with other sectors, industry and nongovernmental organizations, but also that other sectors and stakeholders take health, health equity and the wellbeing of the population into account in the development of their own policies. One key factor to enable such processes to take place is to foster health and wellbeing as common values across all sectors. To facilitate these efforts, government initiatives

need to foster collaboration, innovation and synergies for cross-cutting action and programs. Ministries of Health can play a key role in this effort by bringing the “health perspective” into the policy discussion. However, this requires strengthening the capacity of the health sector to advocate for this approach and to adequately present the relevant evidence to influence the policy development process (See Box 6).

BOX 5. Examples of successful healthy public policies in the Americas

Regional policies to control alcohol

In 2008, drunk-driving laws in Brazil were modified to considerably decrease the legal limit of blood alcohol allowed for driving (known as “zero tolerance”) (Law 11.705/08).

After the implementation of a local ordinance that prohibited the sale of alcoholic beverages after 11:00 pm, the city of Diadema, Brazil observed a 30% decrease in homicides and a significant decrease in reports of domestic violence (Dualibi et al., 2007).

In Costa Rica, marketing of alcoholic beverages has been severely restricted and approval was required by an independent council (WHO global alcohol database, <http://apps.who.int/globalatlas/default.asp>).

Adoption of the WHO Framework Convention on Tobacco Control

In 2005, WHO developed the WHO Framework Convention on Tobacco Control as a response to control the global tobacco epidemic. Its goals were to protect the population against the health, social, economic and environmental consequences of tobacco consumption and exposure to second-hand smoke, with a series of policy measures to be applied by the States. These measures included increases in price and taxes applied to tobacco products, protections against exposures to tobacco smoke, inclusion of health warning on cigarette packages, prohibition of marketing of tobacco products, and access to tobacco-cessation programs. As of May 2010⁶, 168 countries worldwide had ratified this framework, among them 27 countries in the Region of the Americas.

Although most countries have initiated the implementation of the Framework at the national level, this process in the Region has been unequal. While some countries have adopted and successfully implemented measures to control tobacco, these are not often compatible with the guidelines in the Framework. Seven countries have approved national legislation that prohibits smoking in public spaces and workplaces (Colombia, Guatemala, Panama, Paraguay, Peru, Trinidad and Tobago, and Uruguay). Other countries such as Argentina, Brazil and Mexico, have national and/or subnational (state, province, city) policies that only partly reach the population. Nevertheless, it is important to highlight that of the 100 main cities of the world declared “100% Free of Tobacco Smoke”, 12 are located in Latin America and the Caribbean.

⁶ 20 May 2010. See http://www.who.int/fctc/signatories_parties/en/index.html for an updated list of countries that have signed up to the Framework.



BOX 6. Initiatives to Improve Intersectoral Action on Health

Health Equity in All Urban Policies: A report on the Expert Consultation on Intersectoral Action (ISA) in the Prevention of Noncommunicable Conditions (Kobe, Japan, 2009)

In order to identify mechanisms to help policy-makers trigger effective intersectoral action, a group of public health practitioners, policy-makers, academics and WHO representatives from different disciplines gathered in Kobe, Japan at the WHO Centre for Health Development in June 2009. Experiences from 20 countries were analyzed on topics such as tobacco control, nutrition, urban planning, health impact assessment and human rights. The resulting report contains a set of practical recommendations for policy-makers on how to trigger intersectoral action and technical guidance to Member States on effective mechanisms to achieve “Health in All Policies”. The need for high-level “political commitment” and adaptation of the policies to the local political, economic, cultural and social contexts was recognized as crucial for success (WHO Kobe, 2009).

WHO Policy Maker Resource Group on the Social Determinants of Health

In January 2010, the First Meeting of the WHO Policy Maker Resource Group on Social Determinants of Health took place in Viña del Mar, Chile, under the theme of “Intersectoral Action to Tackle the Social Determinants of Health and the Role of Evaluation.” The meeting aimed at bringing together an inter-disciplinary group of experts and country actors to explore how to take forward the evaluation of intersectoral processes and approaches geared towards supporting governance for health equity. It was organized by WHO, PAHO, the Public Health Agency of Canada (PHAC) and the Government of Chile. This meeting helped to shape the first steps toward a conceptual mapping of evaluation theories and methods critical to intersectoral action and processes, as well as recommendations on the practical steps to be taken by WHO to take forward the agenda on evaluation of intersectoral processes for health (World Health Organization Policy Maker Resource Group on Social Determinants of Health, 2010).

CREATION OF HEALTHY SETTINGS

The creation of healthy and supportive settings (municipalities, schools, workplaces, housing, universities, etc.), also known as the settings approach, has been one of the most used and successful health promotion strategies implemented in the Americas in

the past decades. The settings approach is based on the belief that determinants of poverty and equity, and their influence on health, can be addressed through: the creation of sustainable public policies and laws; the development of supportive environments; the establishment of multisectoral alliances and partnerships; the strengthening of networks; and the promotion of

active participation of communities and local governments in health promotion and development.

The Healthy Municipalities, Cities and Communities Strategy

PAHO developed and introduced the Healthy Municipalities, Cities and Communities Strategy (HMC) in the mid 1980s with the

goal of promoting local health and development by ensuring continuous improvements in the underlying conditions that affect the health and well-being of community members. The HMC Strategy is based on the premises that (1) various systems and structures governing social, economic, civil and political conditions, as well as the physical environment, can impact an individual's and a community's health; and that (2) health is inherently linked to an individual's capacity to act in the community and society to which he/she belongs. This is achieved by promoting social participation, accountability and responsive local governance and facilitating joint action among local authorities, community members and other key stakeholders.

In the last decade, the Healthy Municipalities, Cities, and Communities (HMC) movement has grown substantially in the Region. In addition to the HMC Network of the Americas, countries such as Argentina, Brazil, Canada, Chile, Costa Rica, Cuba, El Salvador, Mexico, Paraguay, Peru, and the United States have established national and/or regional networks, and have included healthy settings initiatives in their political agendas. Currently, 18 of the 35 countries and 3 territories of the Americas are involved in the HMC Strategy.

PAHO has actively promoted and strengthened the Strategy throughout the Region. It has established a *Healthy Municipalities,*

Cities and Communities Evaluation Working Group comprised of experts from leading institutions in the Region. This group has developed a series of guides and tools aimed at orienting national and local governments in the planning, implementation and evaluation of HMC initiatives (see Box 7). PAHO has also spearheaded the *Executive Committee of the Healthy Municipalities, Cities and Communities Strategy* that has met regularly to discuss issues related to HMC initiatives throughout the Region and to develop guidelines and by-laws to orient HMC strategies. PAHO maintains an active listserv of the Healthy Municipalities, Cities and Communities Network that serves as a platform for the exchange of experiences and information about the Strategy. In addition, the *Newsletter of the Healthy Municipalities, Cities and Communities Network* is published electronically on a quarterly basis with relevant articles related to health promotion and the HMC Strategy in the Americas. For more information about all the resources described above, see the section on "Resources".

Health-Promoting Universities

The concept of Health-Promoting Universities refers to higher education institutions that have developed an organizational structure that incorporates health promotion values and principles; such structure is supported by political and institutional

commitment to foster and sustain these values and principles. The institutional policy of a Health-Promoting University should clearly contain the following elements: development of by-laws and policies that foster healthy settings; activities related to capacity building in health promotion; promotion of health promotion research and evaluation; activities to improve health education, health literacy and health communication; creation of links with preventive services and primary health care; advocacy for health promotion within the university community; investments in community outreach; and creation of links with other institutions and sectors (Arroyo, 2009).

The Health-Promoting Universities Movement has gained strength in the Region both with public and private institutions of higher education, mostly as a result of the work conducted by the Health-Promoting Universities Networks that have been established in various countries. A series of International Conferences of Health-Promoting Universities have also been central to more clearly define the Initiative's framework and field of action, as well as to promote it in Latin America and the Caribbean. These events have taken place in Chile (2003), Canada (2005), Mexico (2007) and Spain (2009); the next one will take place in Costa Rica (2011).

PAHO/WHO and the PAHO/WHO Collaborating Center for Training and Research in Health Promotion



BOX 7. Reorienting the Healthy Municipalities, Cities and Communities Strategy in the Americas

Between 2008 and 2009, PAHO and ISALUD Universidad de Argentina conducted a Regional survey of Healthy Municipalities, Cities and Communities that included 12 countries: Argentina, Brazil, Canada, Colombia, Chile, Costa Rica, Cuba, Honduras, Mexico, Paraguay, Peru and Uruguay (Meresman et.al, 2010).

The results highlighted the current status of HMCs in the Region and contributed key information to reposition the Strategy at a Regional level as it related to: (1) the conceptual framework and HMC strategies and tools; (2) issues related to implementation processes (scale, legal frameworks, capacity and infrastructure); (3) associated strategies and participatory processes as the central thread for citizenship empowerment and governance; (4) the importance of monitoring and evaluating the impact of HMCs on the health and quality of life of the population; and (5) the need to develop a strategic research and capacity-building agenda.

The results of the Regional survey also brought out some new and key elements to strengthen the discussion and analysis of achievements and challenges and to reorient the HMC Strategy in the Region. **The main conclusions of the survey included the following:**

- It is important to strengthen the identity of HMCs in order to allow for a new generation of concepts and tools that will renew its tenets and update its methodologies and approaches.
- This should be accompanied by the development of public policies that promote networks that can support these expansion processes, stimulate horizontal cooperation, and value the uniqueness and diversity of HMCs.
- It is important to promote better linkages between the “healthy” and the “productive.” There needs to be increased and better linkages between HMCs and social, productive and income-generating initiatives (i.e. housing and social inclusion initiatives at the local level).
- The key factors that strengthen and improve HMC implementation processes are: (a) institutionalization of the Strategy, (b) stability of technical teams, (c) the existence of legal-institutional frameworks, (d) the existence of multi-stakeholder and multi-institutional management committees, (e) adoption of tools to improve intersectoral collaboration, (f) staff permanently assigned for collaborative work, (g) staff with coordination and management competencies, and (h) integrated and available financial resources.
- HMCs should contribute to the expansion of new forms of social participation (development of virtual networks and e-governance models), by incorporating them into empowerment and governance improvement processes, and, as such, transforming them into effective tools to promote citizenship ownership.
- Alliance-building strategies should foster new societies that are capable of serving more dynamic actors and sectors: culture, youth, academic organizations, businesses and productive organizations.
- It is important to develop a continuous training and capacity-building plan for professionals involved with HMC initiatives, that emphasizes new themes (social determinants of health, local development), incorporates specific tools according to levels of responsibility, and that strengthens coordination and management abilities.
- Among the priorities for research, the survey highlighted the need to establish a permanent research agenda and mobilize already existing technical capacities, such as by creating National Councils that include researchers from a variety of disciplines.



BOX 8. The “University for Health Initiative” of the Santiago de Cuba Medical Sciences University

The University for Health Initiative was launched in Cuba in 1996, as a result of the first National Meeting on Universities for Health organized that same year in Santiago de Cuba. Initially, the strategy was incorporated into the national “Healthy Municipalities” Movement.

During the first phase of the initiative, a series of activities were developed to improve the internal settings of the universities and to promote healthy lifestyles among faculty and students. Actions also focused on promoting university extension projects that involved the local community. One example was the “Sleep without Mosquitoes” project developed by the Santiago de Cuba’s School of Medicine in collaboration with the Quebecen Trois-Revieres University of Quebec, Canada, which focused on educating health promoters in environmental health to support dengue-prevention efforts.

In the past few years, the Santiago de Cuba Medical University, has implemented a series of activities developed within the framework of the Universities for Health Initiative. These include:

- Development and promotion of physical activities among students, staff and the local community. The “Race for Health” is celebrated every November 18th as part of “Sports Day”.
- Establishment of “Tobacco smoke-free spaces” within the university and enforcement of the Ministry of Health’s directive that prohibits the sale of alcoholic beverages and alcohol on university campuses.
- Promotion of recreational and cultural activities that are smoke and alcohol free.
- Organization of educational activities to increase environmental awareness and knowledge, such as the annual MediEco event that creates a space for the exchange of experiences to address environmental issues affecting local communities.
- Inclusion of sex education classes in the curriculum of health science majors.
- Development of activities to combat substance abuse, such as the annual “Say NO to drugs” event organized in collaboration with various university departments.

For 2011 the University has established a series of goals related to the University for Health Initiative. These include increasing health promotion and disease prevention activities geared for the university community and its surrounding community. Two related projects are “Learn and Prevent” and “Healthy Smile”, both of which aim to promote healthy behaviors among students and faculty.

and Health Education of the University of Puerto Rico, have strongly supported the Regional HPU Initiative by helping to organize a Regional technical working group and documenting best practices and experiences in the Region.

Healthy Housing Strategy

The concept of Healthy Housing was first defined by a WHO Expert Commission in 1987 (WHO, 1987). In 1993, PAHO/WHO launched a Regional Initiative for Healthy Housing; this initiative has since promoted coordinated actions to protect populations most vulnerable to housing risks in the neediest areas and has contributed to integrated local development of the communities in the Region (PAHO/WHO, 2006c).

The Inter-American Network for Healthy Housing, created in 1995, spearheads a series of educational and research projects at the national level, some of them in coordination with PAHO/WHO. Seven General Meetings have been held since 1997 and up to 18 Latin American countries have been involved in activities related to the Inter-American Network for Healthy Housing (PAHO/WHO, 2006c). The Network has contributed to the production of scientific literature on the topic (Guzmán R. et al, 2006; Barceló C, 2008; Rojas et al., 2009). It has also supported capacity-building efforts through Master's degrees on Health and Housing, workshops, and face-to-face and distance learning training

for more than 5,000 people in the Region. Courses on educational and outreach topics such as postgraduate courses in Bioclimatic Architecture, Basic Sanitation and Housing Hygiene, Avian Flu and Housing, Housing and Vectors were offered for free to more than 19 countries. Two PAHO/WHO Collaborating Centers are involved with Network activities (WHO CC for Health in Housing /INHEM in Havana, Cuba; WHO CC for Research on Health and Housing in Buffalo, N.Y.). The National Institute for Hygiene, Epidemiology and Microbiology in Havana, Cuba, has had responsibility for the Executive Secretariat of the Network since 2002.

The PAHO Healthy Housing Strategy requires strong political commitment, solid technical and intercultural experience, ongoing intersectoral collaboration, a multidisciplinary approach, and a high level of community participation and action. One effective mechanism to foster the adoption and implementation of the Strategy in the Region is the establishment of intersectoral and multidisciplinary National Healthy Housing Networks; these could be associated with the Inter-American Network for Healthy Housing in order to promote the exchange of information and technology and increased awareness and capacities.

Health-Promoting Schools

A health-promoting school is one that constantly strengthens its

capacity as a healthy setting for living, learning and working. It engages health and education officials, teachers, teachers' unions, students, parents, health providers and community leaders in efforts to make the school a healthy place.

The PAHO Health-Promoting Schools Initiative in the Americas has three main components: comprehensive school health education, including life skills training; healthy and supportive environments and surroundings; and adequate health and nutrition services. It has also established and maintained the Latin American Network of Health-Promoting Schools, which provides an opportunity for the exchange of knowledge, ideas, resources, and experiences.

Global School-Based Student Health Survey (GSHS)

The GSHS is part of a global surveillance system designed to provide accurate data to periodically monitor the prevalence of important health risk behaviors and protective factors among students 13 to 15 years of age. The GSHS is a relatively low-cost survey which uses a self-administered questionnaire to obtain data from a representative sample of students. Countries implementing the GSHS receive technical assistance from PAHO/WHO and the United States Centers for Disease Control and Prevention (CDC). The key topics addressed by the survey are: alcohol and other drug use;

dietary behaviors; hygiene; mental health; physical activity; protective factors; respondent demographics; sexual behaviors that contribute to HIV infection, other STIs, and unintended pregnancy; tobacco use; violence and unintentional injuries.

PROMOTING LOCAL DEVELOPMENT AND SOCIAL PARTICIPATION

Health promotion represents a comprehensive social and political process. It not only embraces actions geared toward strengthening the skills and capabilities of individuals, but also actions to change social, environmental, and economic conditions so as to alleviate their impact on public and individual health. As such, strengthening local development, community mobilization and participation has been the cornerstone of health promotion.

The participation fostered by health promotion is broad and applies to all situations and levels of individual and collective experience. Direct participation in planning, implementation, and evaluation of public policies instills respect for developing new knowledge for changing the social determinants of health and dealing with inequities. The key role of social participation in health promotion is linked to a commitment to social justice as well as to empowerment, partnership building, and the creation of settings conducive to the implementation of actions that bring different social sectors together.

Promoting local development and community participation has long been a central goal for PAHO. Throughout the years, PAHO's strategies in this area have focused on approaches aimed at: fostering community mobilization and empowerment for decision-making, improving good governance, and promoting the creation of environments aimed at increasing an individual's control over his/her life. Some of the key strategies promoted by PAHO include: the development of healthy settings; strengthening networks; participatory budgeting; promoting local development; and working with local authorities.

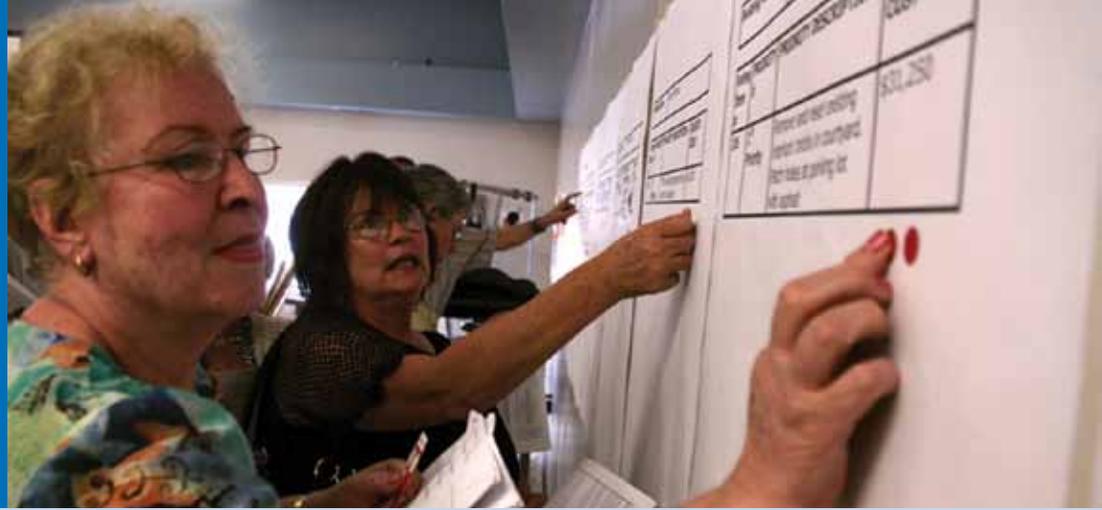
Social Participation and Decision-Making Processes

In order to be properly addressed, the social determinants of health need to be understood from a multisectoral perspective; one that includes the active participation of all sectors of society (public, private, and civil society) in decision-making processes as well as in mechanisms for planning, management, monitoring, and evaluation of policies and programs so these will reflect the conditions, interests, and strengths of the entire population.

Many cities in the Americas exclude a large portion of their inhabitants, namely the poor, from the process of decision-making, as elites or interest groups dominate the process. As a result, policies and programs do not take into account the social conditions and

health determinants that affect large segments of the population, and collaboration with civil society and NGOs that work on a specific health issue may be ineffective. The consequence for the health sector is that services are not coordinated and tend to focus only on disease treatment rather than on broader determinants of health. One important gap to be addressed in the Region is the need to strengthen formal channels for participation within the various government institutions in order to promote citizen and community participation and empowerment.

From 2005 to 2006, PAHO implemented the project Local Observatories of Participatory Budgeting and Public Health in Latin American Cities, with the purpose of supporting the development of innovative policies in local public health administration by studying participatory budgeting experiences and their specific impact on the promotion of public health in some cities in the Region. It was expected that documenting these processes and promoting observatories to monitor their future activities would yield better managerial practices in these cities, as well as the dissemination of information about their achievements and results with other cities interested in learning and applying innovative local management tools in their own contexts, with special emphasis on health promotion. Following the protocol developed by PAHO, case studies of participatory budgeting



BOX 9. Participatory Budgeting Experiences in the Americas

Between 2005 and 2009 in Guarulhos, São Paulo, Brazil, a total of 51 Health through Participation Forums were held to establish a channel of communication for including popular demands into the development of health policies. This led to a series of plenary sessions and the election of approximately 1,300 representatives to comprise Local Health Councils that have become directly involved in urban decision-making and have reportedly improved the health sector's response to community complaints and proposals for change.

In Pasto, Colombia, members of the community had the opportunity to express opinions and vote on the allocation of local public monies, present their needs and demands, discuss alternatives, select priorities, and, finally, monitor implementation of the projects, oversee expenditures, and verify outcomes. As a result, there was an increase in resources allocated to health services, drinking water and sanitation systems improved, the subject of sexual and reproductive health was added to courses for young people, and schools added environmental care to their curricula and began offering school lunches (Guerrero, 2006).

in the public health arena were conducted in four cities: Cotacachi (Ecuador), Guarulhos (Brazil), Pasto (Colombia) and Villa el Salvador (Peru) (See Box 9).

Working with local authorities

Since the 1980s, the majority of the countries in the Americas have, in various degrees, gone through decentralization processes that resulted in a redistribution of power, decision-making autonomy, and resource control by local authorities. As a result, the concept of regional and local governments as facilitators of community participation, mobilization of resources and capacity-building at the local level, has been strengthened.

These experiences demonstrated that the local level can facilitate the development of conditions to successfully implement health promotion and improve social participation. With increased capacity to act, local governments have also demonstrated greater motivation and social, technical and political commitment to initiatives aimed at improving the living conditions of the population.

Local authorities are responsible for establishing policies for a specific territory and population (PAHO/WHO, 1999); as such they enjoy a greater capacity to influence mobilization and integration of actions and resources of other local stakeholders. They can also place health at the top of their

political agendas, and adapt their policies and programs to the local, cultural and ethnic context of their communities. Therefore, local governments are in a privileged position to implement programs based on decentralized and participatory models.

This goes hand-in-hand with a variety of strategies promoted by PAHO/WHO that focus on improving equity, democracy and sustainable development, such as health promotion; primary health care; and healthy municipalities, cities and communities. Thanks to PAHO's efforts and technical cooperation, many countries of the Region have applied one or more of these strategies successfully. These experiences have demonstrated the

effectiveness of approaches that incorporate an integrated concept of health and that place the local level as a central element in community development processes. One such experience was the project on Integrated Malaria Control without the use of DDT (see Box 10).

EXPANSION OF A HEALTH PROMOTION EVIDENCE BASE

While health promotion is widely considered to be a successful approach to mobilize efforts around health goals and to improve health at the local level, the creation of an evidence base and the generalization of accomplishments to various settings and contexts remains a challenge. Currently, there is little consensus on the methods and recommendations for assessing the effectiveness of health promotion programs and policies.

While there is strong pressure to generate evidence of the effectiveness of health promotion interventions, the current medical framework commonly used to define “evidence” is based on methods that are not necessarily suitable for health promotion practices. Additionally, as health promotion initiatives frequently and most successfully use a variety of approaches and strategies simultaneously, it is difficult to attribute positive outcomes to just one of them. Finally, it is more difficult to identify what was prevented - what never took place,

than it is to show the results of diagnosis and treatment of health problems that already exist.

This can lead to stakeholders drawing inappropriate and/or negative conclusions related to health promotion as a viable approach to improve community and population health. Since health promotion initiatives are usually focused on creating impacts that may take years to show results, politicians who need to show their effectiveness in the short term are often reluctant to invest in these initiatives. Accordingly, it is important to document the short and medium term outcomes that result from health promotion initiatives and demonstrate their relationship to potential long term impacts.

While most practitioners and decision-makers emphasize the need for a conceptually sound evidence base for health promotion, the current methods and strategies used to build that evidence often do not correspond with the community context in which they are applied. As a result, the evidence base for health promotion often overemphasizes data related to health status outcomes and individual behavior change. This is to the detriment of producing evidence related to capacity building (community, institutional, individual) and the benefits of addressing the broader social determinants of health. Therefore, the advancement of health promotion as an effective model to improve health and reduce inequalities requires an adapted and balanced evidence base.

In an attempt to address these issues, the World Health Organization (WHO) and the International Union for Health Promotion and Education (IUHPE) have established the Global Program on Health Promotion Effectiveness⁷. This multi-partner initiative aims to raise the standards of health promoting policy-making and practice worldwide by: reviewing and building evidence of effectiveness in terms of health, social, economic and political impacts; translating evidence for policy makers, teachers, practitioners, researchers; and stimulating debate on the nature of evidence of effectiveness. It focuses on the principles, models and methods that relate to the best health promotion practice, taking regional and cultural diversity into consideration.

To contribute to this worldwide initiative, PAHO has established a Regional Working Group on the Evaluation of Health Promotion Effectiveness. This group is comprised of leading experts and institutions from governmental, non-governmental and academic sectors from various countries in the hemisphere. It has contributed to the creation of guides, tools, and resources to support implementation of health promotion in the Region and promote documentation, evaluation and analysis that produces evidence for improving the quality of and going to scale with health promotion initiatives, policies and programs (see boxes 11, 12 and 13).

⁷ <http://www.who.int/healthpromotion/areas/gphpe/en/index.html>



BOX 10. “Regional Program of Action and Demonstration of Sustainable Alternatives to DDT for Malaria Vector Control in Mexico and Central America”: municipal governments as strategic health assets

From 2003 to 2008, the DDT-UNEP-GEF Project, carried out in Mexico and Central America, consisted of developing pilot programs using an alternative model of comprehensive control of the malaria vector without the use of DDT, based on a successful Mexican experience and adapted to specific ecosystems.

In 2002, a 63% reduction in malaria incidence was seen in demonstration sites with high rates of malaria transmission, accompanied by an 86.2% reduction in Plasmodium falciparum cases. In addition, institutional capacities were developed in the countries for control of the disease without the use of any type of insecticide through a sustained program of epidemiological and entomological surveillance, social participation, participatory planning, and environmental management measures using primarily an environmental care approach.

Community participation and the incorporation of municipal governments was the key strategy applied. It was the first time in the sub-region that municipal governments were successfully incorporated into local activities to combat malaria, a responsibility that was traditionally considered to be under the purview of the Ministry of Health’s mandate.

The participating municipal governments contributed to the success of this initiative by financing important infrastructure projects such as bridges, basic sanitation systems, and recovering of river banks; they provided materials, supplies and personnel to assist in community cleaning brigades; they created permanent committees or staff positions (with proper resources allocated) to address issues related to malaria; they established and enforced policies aimed at improving environmental management (such as proper waste disposal); and they advocated for and promoted this model at national and international levels.

Another great achievement of this project was the identification and training of community leaders to serve as a link between the community and the project’s technical personnel. Community leaders assisted in the coordination of local activities, which in turn resulted in an increase of up to 63% of community health agents in the pilot communities.

In this project, municipal governments demonstrated their capacity to act as agents of change. They achieved this through the development and implementation of public policies and innovative management mechanisms that produced sustainable changes in the social, cultural and physical structures of their communities in order to prevent and control malaria. They successfully mobilized actors, sectors and resources which resulted in better coordination of activities and more rational use of resources. The project also resulted in increased knowledge and improved skills among the population related to the malaria-vector lifecycle and its control. The population demonstrated improved community environmental management (i.e. proper waste disposal), changes in attitudes and behaviors (improved personal hygiene), greater sense of responsibility about their and their families’ health (i.e. keeping their properties clean), and less dependency on the public sector for the implementation of malaria control strategies (i.e. organizing and participating in cleaning brigades independently of the presence of the health department technical teams).

This experience demonstrated that municipal governments can play a key role in the implementation of health promotion strategies. They are in a privileged position to act upon a variety of factors and levels, and to create the appropriate settings for the successful implementation and sustainability of such initiatives. They are also able to place health and health promotion on the local political agenda and to generate momentum for the discussion and resolution of community issues and problems without the creation of new or parallel structures. This indicates that municipal governments can be an important health asset, and that their incorporation into health promotion initiatives can be an effective and sustainable strategy.

BOX 11. Tools, Resources and Guides developed by the PAHO Working Group on HMC Evaluation and the PAHO Working Group on the Evaluation of Health Promotion Effectiveness

The Mayor's Guide to Improve Quality of Life: This kit, available in English, French, Portuguese and Spanish, was developed to support mayors and local authorities in the implementation of health promotion activities at the local level through the adoption of the Healthy Municipalities, Cities and Communities Strategy. It provides guidance on how to place health promotion on the local political agenda, build and strengthen intersectoral alliances in order to improve social and health conditions of the population, create healthy public policies, maintain healthy environments, and promote healthy lifestyles. The Mayor's Guide includes: guidelines for implementing and evaluating HMC initiatives; examples of good practices; copies of international agreements, declarations, and conventions; lists of additional resources; and Health Topic Fact Sheets. (http://www.bvsde.ops-oms.org/bvsacd/cd63/MCS_Guiaeng/MCS_Guiaeng.html -English version)

Healthy Municipalities, Cities and Communities: Evaluation Recommendations for Policymakers in the Americas: This concise Guide, available in English and Spanish, offers specific recommendation for policy-makers, local authorities and practitioners on how to incorporate health promotion evaluation into policy and program development. (http://www.bvsde.paho.org/bvsdemu/fulltext/MC_Recommendation.pdf - English version)

Roadmap to Contribute to the Achievement of the Millennium Development Goals: This document, available in English and Spanish, presents methodological orientations for the inclusion of the MDGs in local development plans with a focus on the social determinants of health. It orients users on the development of local action plans that support the implementation of the healthy-settings approach based on the principles and phases of implementation of the HMC Strategy. It also discusses each MDG and its implications for local governments, along with some examples of experiences implemented in the Region. The Road Map includes orientation for incorporating the MDGs into local development plans, with the objective of facilitating participatory municipal management and support and implementation of healthy settings. (<http://www.bvsde.paho.org/bvsdemu/fulltext/roadgoals/roadgoals.html>)

Participatory Evaluation Guide for Healthy Municipalities, Cities and Communities: This guide, available in English and Spanish, provides guidance and tools to HMCs to evaluate their own efforts and contribute to the evidence base of the Strategy's effectiveness. It provides recommendations on evaluation processes and tools, as well as mechanisms to showcase the results. The Guide presents an evaluation framework that incorporates essential health promotion values and orients users through a step-by-step process to design and implement a participatory evaluation of their HMC initiatives. It has an extensive list of possible indicators for measuring and evaluating a myriad of aspects of the HMC Strategy. (<http://www.bvsde.paho.org/bvsdemu/fulltext/guiaevaleng/guiaevaleng.html>)

Guide to Economic Evaluation of Health Promotion: This Guide, available in English and Spanish, provides step-by-step orientation on how to conduct an economic evaluation of health promotion interventions. It is written especially for health promotion practitioners and policy makers. It assumes no prior knowledge of health economics. It aims at introducing non-economists to some of the language, tools and insights required to ensure the fidelity of the evaluation. The Guide is also useful to those in charge of financing, implementing and evaluating health promotion interventions or to people interested in advocating for health promotion strategies, by giving them access to the empirical literature on economic evaluation. (<http://www.bvsde.paho.org/bvsacd/cd65/finalecoeva.pdf>)

Guide for Documenting Health Promotion Initiatives: This Guide, available in English and Spanish, proposes a simple, standard format to support the documentation of health promotion initiatives. It is composed of a 7-part questionnaire and is accompanied by detailed guidelines that orient the users on how to complete it. It is available in Spanish and English. Currently efforts are underway to construct an online platform and database based on the Guide (See Box 12). An adapted format of the Guide was also used as a basis for The First Hispano-American and Inter-American Contest of Best Practices in Urbanism and Health (See Box 14).



BOX 12. Creating a Health Promotion Initiatives Database

The enhancement of health promotion effectiveness is one of the key issues to which PAHO has long been committed. While starting and supporting health promotion initiatives in the Americas, PAHO has identified three prominent obstacles that hinder the further improvement of their practice:

1. Health promotion initiatives are difficult to document;
2. The complexity of health promotion initiatives makes it hard to link causes and effects; and
3. Much of the promising work in developing countries/communities is never documented.

In addition, practitioners of and participants in health promotion initiatives in the Americas ought to be better connected as a community, where organizations and individuals alike could be most empowered to share best practices, enhance recognition, raise funds, and engage the local public - the end beneficiaries of various health promotion initiatives.

In light of these issues, the PAHO Working Group on the Evaluation of Health Promotion Effectiveness has developed the Guide for Documenting Health Promotion Initiatives. The Guide and its guidelines are currently available in a down-loadable format from the PAHO SDE Virtual Library and the PAHO website (<http://devserver.paho.org/hpd/>). An electronic platform has been constructed that permits users to fill out the Guide online while consulting the related guidelines. Once posted, these experiences will feed into an open, searchable database of health promotion experiences. Ultimately, the goal of this initiative is to create, manage, and improve an information and communications technology (ICT)-backed platform/database, which is functional for and widely-used by all practitioners of health promotion initiatives worldwide.

It is expected that this online platform and database will enable users to, as a community, share contacts and resources for research and practice, connect with each other at all levels and among various countries, empower each other and the general public in health promotion, and improve understanding, recognition, funding and eventually effectiveness of health promotion. The more experiences put into the database, the richer will be the basis for drawing conclusions about health promotion effectiveness. Additionally, as the Guide focuses its user on the importance and value of context in the results achieved, this information will be useful for going to scale with and replicating successful experiences.

BOX 13. PAHO's Initiative to Document Health Promotion Experiences

A PAHO review of 15 health promotion case studies identified the mechanisms, processes, and tools used to support health promotion activities in the Region (PAHO/WHO, 2011). The key characteristics that supported health promotion included committed political leadership in key levels of government; initiatives and frameworks focused on health promotion and related subjects; strong political and legal frameworks, particularly at the national level; a high level of community organization and participation; attention to cultural and social norms; and the presence of local authorities and those responsible for policies, fully integrated into the process. The review also emphasized the central role of intersectoral collaboration, community participation, and decision-making power for planning, implementation, and sustainability of initiatives.

The document is available in the following four languages:

English http://new.paho.org/hq/dmdocuments/hp-15case_en_v4.pdf

Spanish http://new.paho.org/hq/dmdocuments/hp-15case_sp_v3.pdf

Portuguese http://new.paho.org/hq/dmdocuments/hp-15case_por_v3.pdf

French http://new.paho.org/hq/dmdocuments/hp-15case_fr_v3.pdf

FOCUS ON HEALTHY URBANIZATION

In 2008, for the first time in history, the United Nations reported that more than half the human population was living in urban areas, and this proportion is expected to rise to 70% by 2050 (UNFPA, 2007). The majority of urban dwellers will live in cities in Asia, Africa, and Latin America - in countries that are becoming ever more impoverished relative to the industrialized countries (Stephens, 2000). Latin America and the Caribbean (LAC) is the most urbanized area in the developing world, with 77% of its population already living in cities. It is estimated that the Region of the Americas will continue to urbanize in the coming two decades, when the urban proportion will rise as high as 85%.

Urbanization is more than a demographic issue; it is also a megatrend and a process. Its origins are the perceived benefits of urban life, which are present in all countries, but particularly in developing countries. Urbanization needs to be considered within a macroeconomic context that encompasses various social, economic and political factors. Managing sustainably and equitably in urban environments will be one of the greatest challenges in the upcoming decades. While the Region has been advancing in this regard, with fewer people living in poverty and an increased literacy rate and life expectancy, the evidence tends to average out the

large inequalities within countries and within cities (PAHO/WHO, 2007). Health promotion has been increasingly recognized as a key strategy to help improve conditions in urban settings.

PAHO's Urban Health Initiative



PAHO's Urban Health Initiative dates back to 2005, when a technical meeting was organized in Santiago, Chile, with the goal of defining PAHO's strategic framework for technical cooperation in urban health. The exercise involved activities such as the preparation of concept papers, case studies, a project to support urban innovation, and a consultative meeting. In preparation for these discussions, PAHO funded the development of Urban Health Profiles of the cities of Asunción (Paraguay), Buenos Aires (Argentina), Guarulhos (Brazil), Lima (Peru), Managua (Nicaragua), Mexico City (Mexico), Montevideo

(Uruguay), and Rosario (Argentina). In April 2007, a Preliminary Urban Health Forum was held at PAHO Headquarters in Washington, D.C., in which the participants outlined the most important elements of PAHO's new conceptual framework and proposed a plan of action in urban health.

These events culminated in the establishment in 2007 of the *PAHO Regional Urban Health Forum*. This Forum focuses on consolidating a conceptual and strategic framework for technical cooperation on urban health. It worked to promote and facilitate dialogue with internal and external partners to contribute to better health policies and programs based on public health scientific evidence. The first meeting of the Regional Urban Health Forum was held in 2007 in Mexico City. As part of the activities during World Health Day 2010, dedicated to "Urbanism and Healthy Living", PAHO organized the joint Second Regional Forum on Urban Health and Third Regional Forum on Health Promotion that took place in October 2010 in New York, with the purpose of improving technical cooperation and assistance to Member States and their cities on the issues of urban health and health promotion. Some of the key participants in these Forums were interviewed about their experiences and these videos can be found at the PAHO World Health Day 2010 Web site. http://new.paho.org/hq/index.php?option=com_content&task=view&id=2416&Itemid=1989



BOX 14. The First Hispano-American and Inter-American Contest of Best Practices in Urbanism and Health

During 2010, PAHO/WHO, in collaboration with PROINAPSA-UIS, the Spanish Cooperation Agency, EDC, EDEX, and the School of Public Health in Andaluza (Escuela Andaluza de Salud Pública) organized the first Hispano-American and Inter-American Contest on Best Practices in Urbanism and Health.

The objectives of the First Hispano-American and Inter-American Contest of Best Practices in Urbanism and Health were to: identify best practices in urban health in the Americas and Spain; create a portfolio of best practices on urbanism and health for the Region; and strengthen the horizontal cooperation among countries by means of exchange of experiences and lessons learned in urban health. Municipal governments, social groups, grassroots and non-governmental organizations (NGOs), and private organizations were encouraged to apply.

Over 130 submissions were received from 16 different countries. Part of the prize consisted of a national recognition by the PAHO office in the respective country. The winning experiences also had the opportunity to be filmed and broadcast at the Regional level and interviews with representatives of the top five winners are posted on the PAHO World Health Day 2010 Web site. The coordinator of each winner was invited to present their experiences in the Second Regional Forum on Urban Health and Third Health Promotion Forum that took place in New York City in October 2010.

The five best practices selected were:

1. Reduction of social, environmental and security vulnerability of the inhabitants of the city of Medellin through a strategy of shared responsibility and community involvement aimed at managing risk (Medellin, Colombia).
2. Promoting Healthy Work Environments in Informal Work Sites (ICU) (Bogota, Colombia).
3. Sustainable Mobility Plan (Buenos Aires, Argentina).
4. Comprehensive Tobacco Program of the City of Murcia (Murcia, Spain).
5. Environmental Sustainability through the Millennium Institution: Trasmilenio (Bogota, Colombia).

For additional information about the contest and the award winners consult the website: http://new.paho.org/hq/images/stories/AD/SDE/UH/informe_final_de_blanca_patricia1.pdf

INVESTMENTS IN CAPACITY BUILDING IN HEALTH PROMOTION

The work of health promotion in a world of changing conditions to improve health and wellbeing requires an array of competencies. The workforce, including those working in Ministries of Health and other sectors, often lack of core competences such as

building collaborative partnerships, leadership, advocacy, evaluation, and planning for change and sustainability.

Defining a set of core competencies for effective health promotion is an important step towards building and strengthening health promotion capacity at the individual, institutional, and systems levels (WHO, 2002). Multiple efforts have

been undertaken to define core competencies in the developed world by academic institutions and health agencies (Battel-Kirk, 2009; Hyndman, 2007; WHO, 2002). Efforts have also been made to transform sets of core competencies for the developing world (WHO, 2002). The 2009 Galway Consensus Conference Statement also identified the broad domains of core competencies (IUHPE 2009).

During the past 10 years, there has been increased use of technology to support learning and action in the field, with PAHO taking a leading role in the Region. PAHO has supported the development of a Virtual Public Health Library and has been instrumental in supporting the Collaborating Centre at the University of Kansas in translating and culturally-adapting the 7,000 page Spanish version of the Community Tool Box (<http://ctb.ku.edu/es>). PAHO also led the development of an online course for health promotion that is currently being adapted for use by Ministries of Health throughout the Americas (See Box 15). A remaining challenge is how to use emerging technologies to support implementation of models of change and to assure guidance for those facing the problems and challenges in this work.

PAHO's initiative to identify health promotion core competencies for the Americas

Initiatives to define core competencies in health promotion in the Americas were limited and incomplete. In order to close this gap, in 2007, the Sustainable Development and Environmental Health Area of PAHO/WHO, in partnership with FUNDESALUD, Colombia, and the University of Toronto, Canada, spearheaded a Regional initiative to identify training opportunities and define core competencies and standards for health promotion for the Region.

A Regional survey was carried out through a process of consultations that involved a broad group of individuals and organizations related to health promotion, working in different levels and countries in the Region.

Based on results of this initiative, a set of five core competencies were identified, with each set broken into component parts with recommendations as to what level of competency is required by different health promotion actors. *Health Promotion Core Competencies for the Americas* (Jackson, 2007) recognized that effective health promotion practice is not simply an accumulation of knowledge and skills. Rather, a broad range of skills and knowledge are transformed into health promotion practice when infused with the core values of health promotion and expressed in principled action. In other words, health promotion practice is about both what is done and how it is done when designing, implementing, and evaluating health promotion programs and policies. *Health Promotion Core Competencies for the Americas* can be used in the description and analysis of health issues; the identification, assessment and integration of evidence and theories; when decisions are made about the most appropriate course of action to promote health; and in the determination of job-related competencies required to implement and evaluate any specific course of action.

INTEGRATION OF HUMAN SECURITY AND HEALTH PROMOTION

Human security⁸ means protecting the fundamental freedoms of individuals: freedom from want, freedom from fear, and freedom to take action on one's own behalf. It means more than the mere absence of conflicts; rather, it stresses the need to create systems that give people the building blocks of survival, dignity, and livelihood (PAHO/WHO, 2010c).

Although not a new concept, interest in human security has resurfaced in the past few years worldwide. From a health promotion perspective, lack of human security has a disempowering effect – people feel victimized by the economy, unsafe labor conditions, insecurity related to their properties, lack of access to food, threats to physical safety and violence. In addition, lack of human security tends to generate a culture that tolerates insecurity (such as tolerance for violence

⁸ The broad vision of human security, shared by the Millennium Development Goals and the determinants of health, recognizes the interdependence of economic, political, social and cultural factors and views health as a multidimensional phenomenon, with good health depending on a series of factors and ill health having multiple consequences. It highlights the need to tackle the fundamental determinants of human health in order to promote healthy urban development and maximize the benefits of urban development (PAHO/WHO 2010g).



BOX 15. PAHO's Initiatives to Improve Capacities in Health Promotion

PAHO's Health Promotion Capacity Mapping Initiative. In 2001, as part of a worldwide WHO initiative, PAHO conducted a Regional survey to identify and assess health promotion organizational structures, competencies and resources in the various sectors at national, regional, and local levels as well as the Ministries of Health of its Member States. It also aimed at determining the capacity and responsiveness of health promotion policies, institutions, programs and practices at regional and national levels.

In response to this PAHO initiative, 27 Member States prepared reports on health promotion in their countries using guidelines provided by PAHO. Eight countries reported national action plans including health promotion activities or targets, and six other countries reported having national health promotion policy frameworks. Every participating Member State mentioned increasing investment in healthy policies, and most were implementing healthy settings initiatives. Almost all countries expressed a need to strengthen information and surveillance systems, and most were active participants in health promotion networks to share experiences and strengthen national and local capacities.

In 2010, follow-up questionnaires were sent out to Member States and the results are currently being analyzed. It is expected that the health promotion capacity mapping initiative will provide a baseline for the countries to see their progress and the current status of their systems and institutional capacities to promote health. This will support future planning and implementation of measures to strengthen and increase capacity in health promotion. It will also allow PAHO to analyze achievements, challenges and areas to reinforce the national cooperation strategy for each country and for the Region as a whole. UN Organizations such as UNDP, the Inter-American Development Bank, PAHO/WHO, and others can also gain insight as to where they might increase their investments in order to improve the social determinants of health and equity.

PAHO's Virtual Course on Health Promotion. The E-course "Health Promotion: concepts, tools and strategies" is a PAHO/WHO initiative to promote the integration of its cross-cutting priorities in the daily work of its staff, teams and programs. The course was developed based on current PAHO guidelines and policies. A team of experts from a variety of disciplines and countries worked collaboratively on developing the content. The course design was tailored to the needs of PAHO professional and administrative staff.

The course aims to strengthen the concept of health promotion within PAHO/WHO, by incorporating as a learning tool a series of videos and interviews with PAHO staff that perform a variety of roles within the Organization and who openly discuss their challenges related to the implementation of health promotion. The course lasts approximately 3:30 hours and it is divided into three main modules: introduction, key concepts and values, and tools and strategies.

PAHO's Virtual Libraries. The CIDSAUDE database was developed by the Center for Studies, Research and Documentation of Healthy Municipalities (CEPEDOC), in collaboration with PAHO/SDE, School of Public Health of the University of São Paulo, and BIREME (PAHO's Regional Public Health Library). Its objective is to collect and disseminate information about scientific literature related to health promotion and Healthy Municipalities, Cities and Communities in Latin America. Based on the CIDSAUDE experience, many countries in the Region are currently involved in a Regional initiative to develop their own virtual libraries and to identify and collect relevant materials to populate their databases (Argentina, Bolivia, Costa Rica, Dominican Republic, Honduras, Mexico, and Peru).

In addition, PAHO maintains the Virtual Library of Sustainable Development and Environmental Health that compiles and disseminates updated and evidence-based information and tools on issues such as health determinants, social policies, basic sanitation, health promotion, food security and nutrition, and climate change (www.bvsde.paho.org).

against children). This tolerance and disempowerment are also reflected in organizations and institutions, including those related to health.

Health Promotion and Human Security overlap as they both:

- Promote the empowerment of individuals and communities by focusing on strengthening individuals', families' and communities' assets with the goal of improving security and health. This "assets-strengthening" approach focuses on developing competencies, community organization, social participation and health-promoting social networks.
- Aim at building a culture of security that is reflected in behaviors as well as at physical and organizational structures (healthy settings and health and health equity in all policies).
- Promote the reorientation of health services – including the reorganization of Ministries of Health to primary health care services that address those determinants of human insecurity that affect the populations they serve.

In October 2010, PAHO's 50th Directing Council approved Resolution CD50.R16 on Health, Human Security and Wellbeing (PAHO/WHO, 2010c). This resolution urges Member States to continue to promote analysis of the concept of human security and its relationship with health, with a view to its incor-

poration into country health plans, pursuant to their national legislation, emphasizing coordination and multisectoral interagency participation to reflect the multidimensional aspects of such an approach. It also requests PAHO's Director to promote the concept of human security and its relationship with health within the organization and in relevant multilateral forums; support the development of policy guidelines and methodological tools for integrating the approach of human security into the Organization's programs and activities; and increase awareness for personnel in PAHO and the Member States of issues and approaches to addressing human security and its relationship to health.

IMPROVING THE LINKAGES BETWEEN HEALTH PROMOTION AND THE PREVENTION OF CHRONIC NON-COMMUNICABLE DISEASES

Chronic non-communicable diseases (CNCDs), such as cardiovascular diseases, cancer, diabetes, and chronic respiratory diseases, cause a significant burden of disease and death in the Americas. They account for 78% of deaths in the total population in the Region, and 19% of deaths in men and women under the age of 70. In addition, CNCDs account for 74% of disability-adjusted life years lost (WHO, 2004). If current trends persist, there could

be a considerable increase in the mortality rate from CNCDs; yet many non-communicable diseases are highly preventable.

The burden of non-communicable diseases does not affect all social groups in the same way. While non-communicable diseases were traditionally associated with wealth, current evidence suggests that the risk for some CNCDs is actually higher at lower socioeconomic levels (CARMEN network, 2010). The poor may have fewer resources to make lifestyle changes; they may also have less access to quality health services, including prevention, diagnostic services, treatment, and essential drugs. The burden of disease may also vary by gender and/or ethnic background, due to differential exposure to risk factors (such as air pollution or opportunities for physical activity) or differential experiences with health services.

Addressing CNCDs requires an integrated and intersectoral approach. It depends on interventions and policies to "improve the living environment, facilitate physical activity, reduce tobacco use and alcohol abuse, regulate access to hazardous products, provide information and education services for healthier lifestyles and make available sufficient and healthier dietary choices" (WHO, 2008d). In the past few years, there has been increased awareness about the need and pressure to incorporate health promotion into CNCD programs. PAHO has been involved in a series of initiatives aimed at improving

these linkages. PAHO's Member States have developed a Regional Strategy and Plan of Action to prevent and control chronic diseases and are implementing it through the CARMEN (Collaborative Action for Risk Factor Prevention and Effective Management of NCDs) Initiative (see Box 16 for more information).

During 2011 a series of high level meetings took place to discuss issues related to prevention and control of noncommunicable diseases. In April, WHO organized the First Global Ministerial Conference on Healthy Lifestyles and Noncommunicable Disease Control, in Moscow, that resulted in the Moscow Declaration. This declaration defines a series of actions to be taken by governments, ministries and the international community to address the challenges posed by NCDs, including strengthened and reoriented policies and programs that emphasize multisectoral action on the behavioral, environmental, social and economic factors. In preparation for the Moscow meeting, three Regional events took place. In March, a group of Latin American NGOs came together and established the Coalition for a Healthier Latin America for the prevention and control of NCDs⁹. In early April, in Uruguay, Ministries of Health and other health authorities from South America met to reaffirm their political commitment to the development and strengthening of public policies geared at addressing risk factors related to NCDs. A resolution¹⁰ was adopted by the IV Meeting of the

South American Council (UNASUR). Also in April, Ministries of Health of the Americas came together and prepared the "Ministerial Declaration for Prevention and Control of Non-Communicable Diseases"¹¹ in which they agree to take comprehensive and integrated action to combat NCDs and called for the definition of a Regional Plan of Action. The results of all these events will contribute to the High Level Meeting being organized at the United Nations General Assembly in September 2011.

INCORPORATING HEALTH PROMOTION INTO PRIMARY HEALTH CARE SYSTEMS

Countries across Latin America have engaged in major efforts to reform and restructure their health systems. Nevertheless, despite impressive gains in certain health indicators, millions of people continue to lack access to health care and other conditions essential for good health (PAHO, 2009). A 2003 PAHO report estimated that 47% of Latin America's population is excluded from needed services (PAHO & SIDA, 2003). In addition, health systems in the Americas are highly fragmented and costly, and have difficulty adjusting to changes in epidemiologic or demographic trends (PAHO, 2009).

Excessive fragmentation of the health system serves as a barrier to access and contributes to low quality services, low consumer satisfaction, increased costs, and an inefficient

use of resources. At the system level, it manifests itself as a lack of coordination between services and sites, duplication of services, underutilized capacity, and provision of services in inappropriate settings, such as hospitals. At the individual level, the fragmentation is experienced as difficulty with access to services, loss of continuity of care, poor fit between the services available and the needs of the user, and lack of adaptation to people's cultural preferences and/or gender (PAHO, 2010f).

WHO and PAHO recently called for a renewed focus on primary health care, drawing on the principles of the 1978 Alma-Ata Declaration that identified this approach as the key to attaining the goal of Health for All. Renewed Primary Health Care proposes a framework that: reflects the social-cultural, economic and political conditions of countries and communities; offers services that address the main community health issues from a health promotion, preventive, curative and rehabilitative perspective; promotes multisectoral collaboration for community development; encourages community and individual participation

⁹ Declaración latinoamericana frente a la emergencia sanitaria de las Enfermedades No Transmisibles (ENT). Marzo 2011 (Unpublished document)

¹⁰ http://new.paho.org/hq/dmdocuments/UNASUR_-_14_DE_ABRIL_DE_20111.pdf

¹¹ http://portal.salud.gob.mx/sites/salud/descargas/pdf/convenios/2011/Ministerial_Declaration.pdf



BOX 16. Examples of Regional Chronic Non-communicable Disease Initiatives

“Regional Strategy and Plan of Action on an Integrated Approach to the Prevention and Control of Chronic Diseases, Including Diet, Physical Activity, and Health” (PAHO, 2007b). Launched by PAHO, this is an integrated and intersectoral strategy that promotes a combination of interventions for the population and for individuals for the prevention and control of the principal chronic diseases and common risk factors (especially diet, physical activity, and tobacco and alcohol use). The Regional Strategy has four lines of action:

- Prioritize chronic diseases on the political and public health agendas;
- Identify surveillance as a key component;
- Recognize that health systems must be reoriented to respond to the needs of people with chronic conditions; and
- Note the essential role of health promotion and disease prevention.

The CARMEN Initiative and Network. The CARMEN initiative (Collaborative Action for Risk Factor Prevention and Effective Management of NCDs) is the main vehicle for implementation of the Regional Strategy. It brings together the Member States, the Secretariat of the PAHO/WHO Chronic Diseases Program, and other partners. The CARMEN Network includes seven areas of action: advocacy, diabetes, cancer, cardiovascular diseases, healthy eating and active living, hypertension, and surveillance. (<http://www.paho.org/english/ad/dpc/nc/carmen-info.htm>, accessed 11 June, 2010.)

CARMEN Schools. Carmen Schools, a special project of the CARMEN network, is a generic name for series of training and public health activities that build a partnership between Schools or Departments of Public Health (SPH), Public Health Agencies and Ministries of Health (MOH) at the country level. It aims to support the development of necessary competencies to enable public health workers and communities to confront the challenges of NCD prevention and health promotion initiatives, and to strengthen the collaboration between schools of public health, public health agencies and Ministries of Health in supporting NCD prevention and control. As of now, five courses have been offered and four were evaluated throughout LAC. Three of them are part of collaboration with the network of Prevention Research Centers (PRC) of the US, situated in 30 Universities throughout the country. A fourth course, in Policy Analyses and Decision Making (PADM), was developed in collaboration with the World Bank. The fifth course is on Chronic Disease Management (CDM) developed with the University of Miami.

CARMEN Policy Observatory. The CARMEN Policy Observatory was established in 2004 as a joint initiative of PAHO/WHO and the PAHO/WHO Collaborating Center for Non-communicable Disease (NCD) Policy at the Public Health Agency of Canada (PHAC). PAHO serves as Secretariat for the CARMEN network of 23 countries in Latin America and the Caribbean (LAC) and the Policy Observatory Initiative supports the development and resolution of common NCD policy challenges, and provides a knowledge base and analytical support to policy decision makers by developing tools and making practical recommendations. The Policy Observatory has four functions: comparative NCD policy monitoring and analysis; policy research; policy development training and capacity building; and policy dialogues as platforms for strengthening national responses to NCDs.

For more information about the CARMEN Network and its related initiatives:

<http://www.paho.org/English/HCP/HCN/IPM/cmn-about.htm>
<http://www.paho.org/english/ad/dpc/nc/cmn-school.pdf>



BOX 17. WARMI II. Building Bridges between the Community and the Health Services with a Gender and Intercultural Approach - Integrated Health Coordination Program (PROCOSI)

The “Warmi” (Quechua and Aymara word meaning woman) educational strategy for women’s reproductive health was developed by Save the Children as a member of the Integrated Health Coordination Program (PROCOSI) Network in Bolivia. Its purpose is to improve women’s reproductive health in rural areas by resolving problems at the community level through the participation of women’s groups. The goal of the project, now in its second phase, is to reduce maternal mortality.

This program was one of two best practices awarded by PAHO/WHO as a result of its “Best Practices in Incorporating a Gender Equality Perspective in Health” contest that was organized in conjunction with the 2008 International Women’s Day. It was financed by the Corporación Andina de Fomento (CAF) and implemented by women’s organizations in Calamarca and Morochata, two rural and predominantly indigenous municipalities in Bolivia.

Bolivia has a population of approximately 9 million, with over 37% living in rural areas. The indigenous majority population is also the group with the highest rates of maternal mortality. Maternal mortality is linked to delays suffered by women when seeking and receiving treatment which are in turn related to: lack of recognition of danger signs that could be fatal; delays in reaching a health service establishment; and lack of infrastructure and/or adequate service provisions at health service establishments. These delays are more prominent in rural and indigenous areas where women often have little or no schooling, are not allowed to make decisions about their own health and where the health services are often physically far and not culturally sensitive.

The WARMI project engages women’s community organizations in areas of high poverty, illiteracy, and maternal and infant mortality rates. Through situational analysis, focus groups, interviews and group analysis in conjunction with the women in the community, the most pressing sexual reproductive health problems are identified along with their key causes. Community women receive training aimed at supporting the exercise of their sexual and reproductive rights, and increasing knowledge and skills that will allow them to improve and maintain their own health and to create more equal relations with their partners and with other women. Men in the community are also given training in issues related to health and gender equality.

A “core team” formed in the framework of the program held meetings with the authorities to maintain a permanent flow of information, receive support, and coordinate activities throughout the project. Local women’s organizations worked directly with local health establishments to allocate resources and determine how to better and more adequately serve the women in the community.

At the end of the project, both groups of men and women demonstrated significantly improved levels of knowledge, practice and attitudes with regards to their health, bodies and reproductive cycles. Positive changes occurred in family relations, especially between couples. These included changes regarding violence against women as well as joint decision-making regarding important issues. Another important project outcome was increased population use of the health services and increased involvement of the community in establishing the conditions for the operation of the health services (opening hours, staff treatment of patients, quality of care). The results and impact on health were a marked drop in maternal and infant deaths in the project communities of approximately 75% and 50%, respectively.

This intervention demonstrated that: educating and empowering women reduces maternal deaths and improves women’s sexual and reproductive health; and that the delays that cause maternal mortality in rural, indigenous areas can be reduced by working on low-cost actions that focus on gender and culture where women’s community organizations and local promoters help women overcome the obstacles that prevent them from receiving life-saving health care services.

By emphasizing women’s empowerment, community participation and a gender and culturally-based approach, this good practice has contributed to reducing maternal and infant mortality in the project areas. The community promoters worked by actively engaging women to learn more about reproductive health and their rights and to demand and obtain access to quality health care. The women also managed to have men, municipal authorities and health providers work together to strengthen their rights and demands. For more information, consult the full document:

<http://new.paho.org/hq/dmdocuments/2008/warmi%20ingles.pdf>

BOX 18. The new PAHO Strategy and Plan of Action for Comprehensive Child Health, Growth and Development (CCH)

Many countries in the Region achieved great progress in reducing deaths in children under 5 years of age because of the widespread use of effective interventions such as vaccination, use of supplements, health promotion, access to high quality services, and the prevention, treatment and integrated case management for dealing with childhood diseases.

Since 2000, Member States have implemented the WHO/UNICEF Key Family Practices using a health promotion strategy for the prevention of common childhood illnesses as the primary intervention to change behaviors and improve growth and development at the family and community levels. This work supported integrated social mobilization efforts implemented by the Ministries of Health in tandem with community leaders and networks, community health workers, non-governmental organizations, families and other social actors and institutions. Building on existing community-based programs at the district level, the Key Family Practices helped to promote equitable access to services, improve access to quality health care at the health facility level, and strengthened local capacity and ownership. It focused on making the best and most cost-effective use possible of scarce resources (PAHO and UNF, 2007).

Based on these experiences, PAHO is currently developing a new Strategy and Plan of Action for Comprehensive Child Health, Growth and Development that was presented for review to the PAHO Executive Committee Meeting in June 2011. This is an ongoing effort to support and expand the concept of integration of actions at the levels of health systems, health services, and families and communities in Member States with a strong emphasis on health promotion as a cross-cutting theme.

and co-responsibility; incorporates a social determinants of health and human development approach that recognizes that health should be at the center of the development agenda; and shifts the focus to the operational and structural needs of local health systems.

Various countries of the Americas have adopted and adapted the principles of primary health care to their reality and needs. Many of these countries currently emphasize the social and environmental aspects of primary health care by focusing on community development to achieve healthy lifestyles based on three central elements: to fulfill basic human needs, to strengthen

individual skills, and to optimize the use and management of community assets. Most importantly, there is an increased recognition of the need to emphasize health promotion as a central approach to improve primary health care systems and achieve better population health due to health promotion's emphasis on equity and social justice and integrated and technical strategies to address complex social and political issues.

To improve primary health care, local and national governments might draw on the PAHO/WHO Integrated Delivery Network (IDN) Initiative¹², which provides a roadmap for renewing the focus on primary health care. The essential elements of this

approach include 1) a care model that recognizes the needs and preferences of diverse populations and provides an extensive system to address those needs, 2) centralized and inclusive governance and strategies, 3) organization and management of services and resources, and finally 4) assignments and incentives aligned with the goals of the network (PAHO, 2010f). When health systems are integrated, well-funded, and responsive to the local needs, they can contribute not only to better health, but to the broader Alma-Ata goals of social justice, participation, and solidarity.

¹² In Spanish: Redes Integradas de Servicios de Salud (RISS).

MAINSTREAMING HEALTH PROMOTION

Since 2007, PAHO has engaged in a process of profound institutional change that included the definition of six Cross-cutting Priorities (CCPs), one of which is health promotion¹³. This came from the recognition that health promotion is a core strategy for public health and encompasses a group of tools and methods that should be incorporated into all programs and initiatives.

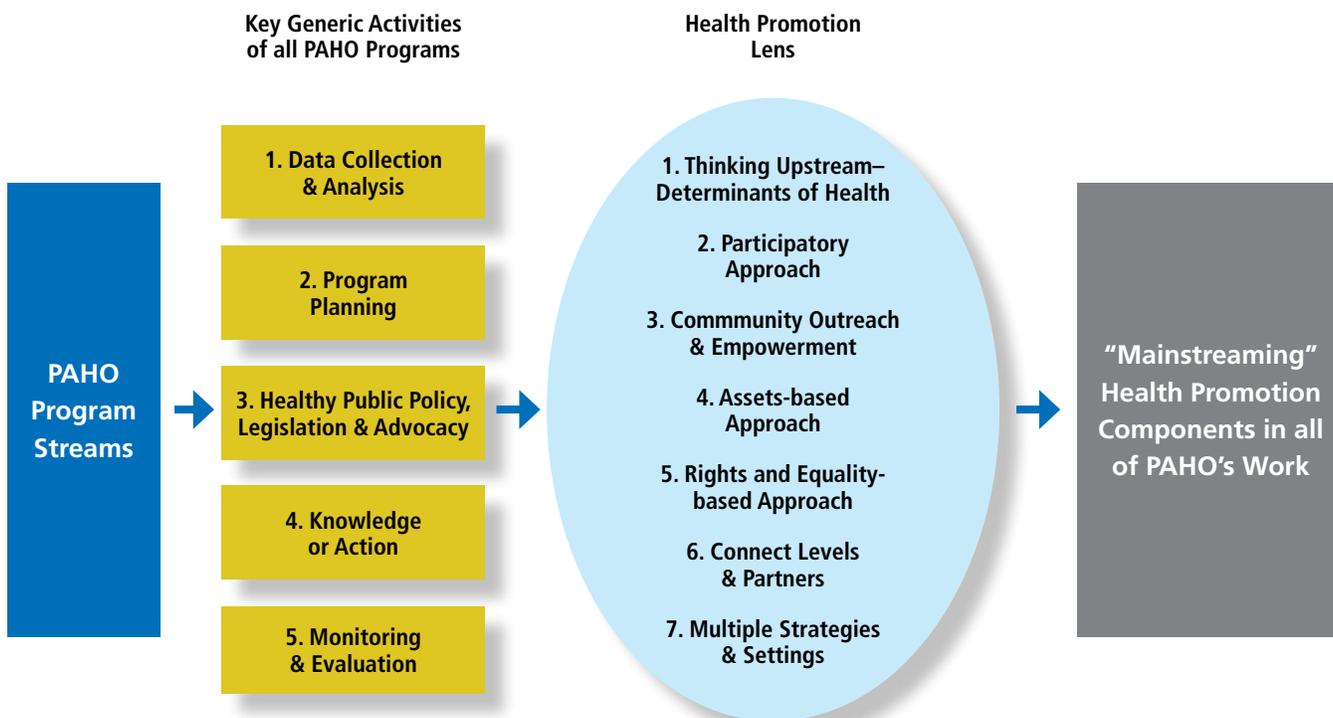
A PAHO Internal Working Group on Mainstreaming Health Promotion was created to help guide this process and develop the neces-

sary guidelines and tools to support PAHO staff and programs in adjusting to the new institutional orientations. As part of this process, PAHO/SDE in collaboration with its Collaborating Center at University of Toronto, developed a framework to guide the development of guidelines and tools to support the mainstreaming of health promotion in the Organization (Figure 1). In this framework the integration of health promotion is summarized as a cross-cutting component throughout the technical cooperation cycle and across PAHO's different programs. All PAHO programs are involved in a number of general activities: data collection and analysis; develop-

ment of guidelines and instruments for implementing public health programs; advisory services and advocacy with decision-makers in the different countries; knowledge management; and monitoring and evaluation. As such, all tasks developed by PAHO can incorporate health promotion elements, from the formulation of policies, to programmatic development, technical cooperation plans, budgets and development of human resources.

The model for mainstreaming health promotion within PAHO supports the existing focus of the Organization on collecting and interpreting data and planning programs that

FIGURE 1. Proposal for PAHO Health Promotion Mainstreaming Model



¹³ The remaining CCPs are gender, ethnicity, human rights, social protection and primary health care.

promote the health of all people in the Americas. In this image, the “lens” of health promotion proposes new perspectives on these activities in all programs, with the expectation of enriching the processes and contributing to the achievement of their objectives.

To orient PAHO staff and programs on how to incorporate this new model into their programs and activities, a checklist was prepared which describes 7 health promotion components to be included in their biennial work plans: thinking upstream (incorporating the determinants of health), using participatory approaches, promoting community outreach and empowerment, capitalizing on an assets-based approach, using a rights and equity-based approach, connecting levels and partners, and using multiple strategies and settings.

As with any institution-wide effort of this magnitude, this process has many achievements and difficulties, as well as challenges that remain to be addressed. As previously discussed, the mainstreaming of health promotion has helped to highlight the approach within the institution and better define its role among PAHO's programs and areas. However, it has also created difficulties, particularly at the country level, as to how to develop and deliver health promotion in the technical cooperation provided to Member States. Some of the factors related to this difficulty include a perception of a weakening of health promotion within the institution by country stakeholders; confusion among PAHO staff related to the new planning process due to weak guidelines and orientation provided to PAHO country staff (in the PWR

offices); and the lack of integration among programs and areas, particularly in those areas that are more specific to health promotion (i.e. nutrition, physical activity, Chronic Non-Communicable Diseases, and primary health care). These emphasize the need to reinforce the PWR staff so they will be able to provide guidance and orientation to country counterparts, foster stronger linkages and search for common lines of work among PAHO's programs and areas, and to reassure country partners of PAHO's continued commitment to health promotion while providing better orientation as to how the mainstreaming process is expected to improve technical cooperation in health promotion.



BOX 19: Mainstreaming Health Promotion into PAHO's Programs

The Regional Community Integrated Management of Childhood Illnesses (IMCI) Partnership: Empowering Local Communities to Improve Children's Health in Ten Latin American Countries (PAHO and UNF, 2007).

Starting in 2003, the American Red Cross, the United Nations Foundation/United Nations Fund for International Projects (UNF/UNFIP), and PAHO signed an agreement to scale-up community IMCI activities through a project entitled *Empowering Local Communities to Improve Children's Health in Ten Latin American Countries*. The countries involved included Bolivia, Colombia, Dominican Republic, El Salvador, Guyana, Honduras, Nicaragua, Paraguay, Peru, and Venezuela.

The initiative, which lasted until 2007, supported community IMCI activities implemented by the National Red Cross Operating Societies (ONS) and Ministries of Health with support from community leaders and networks, community health workers, nongovernmental organizations, families and other social actors and institutions. It promoted the use of the WHO/UNICEF Key Family Practices for the Prevention of Common Childhood Illnesses as the primary intervention to change behaviors at the family and community level. It also strengthened the integrated case management of illnesses, especially diarrhea and pneumonia, with the goal of bringing children closer to the health system and generating community resources to improve the quality of care. This work contributed to reducing morbidity and mortality rates in children less than five-years of age.

The Partnership successfully built on existing community-based programs at the district level, promoted equitable access to services, improved access to quality health care at the health facility level, strengthened local capacity and ownership, and made the best and most cost-effective use of scarce resources. Of the many accomplishments achieved, three stand out: 1) the design and implementation of an innovative social-actor community model, 2) the transformation of community IMCI from a training course to part of a national strategic plan of action, and 3) the improvement of case management knowledge and changing behaviors among caretakers. The design and implementation of community projects by social actors was empowering because groups not traditionally working in health became involved in the promotion of the key family practices at the family and community level.

Project activities created links between the health services, social actors, and the family and community to ensure an integrated approach. Over 350 community-based organizations and institutions, international agencies, and NGOs, collaborated in the implementation of community projects and expansion plans. Over 14,000 people were trained in different planning, case management and community teaching courses, and 35 new technical guidelines, tools and materials were developed and used at the national and community levels.

The Partnership provided a unique opportunity for the countries to undertake new challenges and lead a comprehensive, integrated approach to meet the *Millennium Development Goals*. Country partners assumed a leadership role; established IMCI coalitions at the community, district and national levels; and worked collectively to expand and institutionalize key family practices and effective case management into daily life at the local level and into institutional policies at the national level.

However, while there is extensive research on the effectiveness of health-care interventions, there is less evidence on the process of their implementation, cultural appropriateness, cost-effectiveness and effects on health inequalities, all of which are important considerations for policy-making. There is still a need to evaluate how interventions are implemented and which factors help or hinder their success in scaling-up interventions. New approaches are also required to link community actions with health services and health systems to scale-up efforts based on a primary health care model.

V. Country Developments and Achievements in the Americas

The advent of the H1N1 outbreak in the Region changed PAHO's usual way of responding to rapidly mobilizing social communication networks to quickly transmit information about the situation and how to prevent the spread of the virus

COUNTRY CASE: ECUADOR

Ecuador has made great strides in health promotion in the past few years. In 2002, a Health Promotion Commission was included in the National Health Council (CONASA), with the support of PAHO/WHO. In the same year, the Health-Promoting School Initiative was launched in the country with the establishment of the Ecuadorian Network of Health-Promoting Schools, also in collaboration with PAHO/WHO. By the end of 2010, the network counted with close to 3,000 member schools nationwide and the Ministry of Education launched a USD 34 million national program called "Schools of Well Being" that was developed based on the principles and results obtained by the Ecuadorian Network of Health-Promoting Schools.

In 2003, a Health Promotion Unit was created within the Ministry of Health, and, in 2006, a key National Health Law was developed that facilitated the implementation of health promotion programs at various levels. This law defined health as "a state of complete physical, mental and social wellbeing, and not merely the absence of diseases" and as an "inalienable human

right". It also shared the responsibility for the creation of healthy settings and the adoption of healthy behaviors among the State, society, families and individuals.

Under this new law, the Ministry of Health was given the responsibility to formulate and implement health promotion policies and programs, as well as to incorporate them into the National Health System. By 2007, a National Health Promotion Policy was developed and the Healthy Municipalities, Cities and Communities Initiative was launched nationwide. By the end of 2010, the Ministry of Health had developed an important document to guide how to incorporate and monitor the principles of the Faces, Voices and Places Initiative into local development plans.

The new Constitution, created in 2008, highlights health promotion as one of its fundamental principles and as a key duty of the State. The former Health Promotion Unit of the Ministry of Health has now been promoted to being a national program that is expected to implement health promotion as a priority in all health programs nationwide as of 2011.

Despite all the progress made in the last few years, some important challenges remain. The Ministry of

Health still lacks essential human resources to implement its programs. While many initiatives are launched at the local level, their sustainability and evaluation are not guaranteed. Efforts are currently in place at the local and provincial levels to increase capacity to support these initiatives; however, they lack effective political support.

Overall, the future of health promotion in Ecuador is promising. There is strong support for the new Primary Health Care Policy proposed by the government that incorporates a Social Determinants of Health Approach, as well as the constitutional mandate that places social participation as a national priority.

PAHO/WHO has been a strong partner and played a key role in all these processes by providing technical cooperation and orientation, as well as financial support. It can continue to support these efforts by providing methodological tools to facilitate the development, implementation, monitoring and evaluation of health promotion initiatives. These should be integrated into local development plans, promote the participation of local authorities, and focus on the most vulnerable populations.

COUNTRY CASE: MEXICO

Mexico has a long standing tradition of health promotion initiatives and has provided strong models for the Region throughout the years. A turning point for health promotion was in 2004, as the country engaged in a profound health reform and pressure mounted from a variety of key stakeholders to assure the sustainability of the health system through the improvement of health promotion practices and programs. Most of the discussions at that time revolved around how to finance and incorporate health promotion into the health system. One of the main challenges related to the need to develop an effective and sustainable operational model for health promotion.

PAHO's Regional Health Promotion Forum in Rio de Janeiro, in 2005, provided valuable input for this health reform process as it focused on the exchange of experiences, the rise of the social determinants of health and how to incorporate them into health services. The 2005 Bangkok Charter also helped to define policies around health services. PAHO's 2005-6 Capacity Mapping Exercise provided the additional stimulus in the process; taking the example from the national level, the assessment was implemented in all states and highlighted the gaps. This helped to inform and construct the arguments for decision-making related to health promotion programs and initiatives around the country. By the beginning of 2006 an Operational Model for Health

Promotion (MOPS) was officially launched, linking it to the health services. This model supported a cash transfer program for extreme poverty alleviation named "OPORTUNIDADES" ("Opportunities") and promoted the use of the National Health Booklet for reorienting health services which addressed conceptual, organizational and human resources issues related to health promotion. At the time, a nationwide, state by state training process was also initiated.

In February 2007, with the new administration, a National Health Promotion and Prevention Strategy was launched. This was a major multi-sectoral initiative that created key mechanisms for the implementation of health promotion initiatives. PAHO's First Urban Health Forum, that took place in Mexico City in 2007, also helped to strengthen the links between health promotion, urban health and the social determinants of health.

Health promotion has also been incorporated into the strategies and plans developed to respond to emergencies. For example, nowadays such plans include actions aimed at improving health communication, building community assets, and improving mental health. A first application of these strategies took place during the Tabasco-Chiapas floods (October-November 2007), in which the Healthy Municipalities Network and community actors took the leadership for responding to the emergency. The Federal General Directorate of Health

Promotion at the Vice-Ministry of Prevention and Health Promotion of the Ministry of Health participated in the preparation for the Influenza Pandemic, focusing specifically non-pharmaceutical interventions. Their staff at the federal and state levels was prepared in 2009 to respond to the major national health crisis that ensued with the emergence of the H1N1 epidemic. The government's fast and effective response was crucial to successfully getting the situation under control. The Health Promotion Units throughout the country were in charge of the non-pharmaceutical interventions at the personal, community and intersectorial levels. PAHO played a key role by providing essential technical cooperation and support to the national teams dealing with the emergency, particularly in relation to school interventions and health communication. The situation also presented an important opportunity for health promotion, since it was incorporated into the technical and political response at the highest level, but also at the one that was based at the local level through primary health care. Health promotion strategies and the operational model were key to address the crisis and, as a result, were validated as an effective strategy with added value. The experience was reproduced in an immediate publication developed with PAHO and made available worldwide ([http://promocion.salud.gob.mx/dgps/descargas1/influenza/mat/INFLUENZA_A\(H1N1\)_03_agosto.pdf](http://promocion.salud.gob.mx/dgps/descargas1/influenza/mat/INFLUENZA_A(H1N1)_03_agosto.pdf)).

Throughout the years, the Mexican Movement of Municipalities for Health has also been a key national platform for the implementation of health promotion interventions at the local level. There has been a large investment in the strategy at a national level. The program is spearheaded by the Ministry of Health's Healthy Communities Initiative in collaboration with PAHO/WHO. State-level networks and the Mexican National Movement of Municipalities for Health, established in 1993, create opportunities for mutual support and the exchange of experiences and best practices in health promotion. The networks also strengthen management capacity for analysis and understanding of health and social problems, and for sharing resources among municipalities. Nevertheless, this Initiative still faces some important challenges, such as the high turnover of mayors and the lack of capacity to document and evaluate the experiences.

The professionalization of the discipline and capacity building within the health promotion operational model, particularly in the areas of financing, restructuring, and institutionalization, also remain critical challenges for health promotion in the country. During 2007-10, three nationwide training programs were established: a short course for technical field personnel (with more than 1200 people trained), a diploma in health promotion (with more than 160 graduates) and a Masters in Public Health with an area of concentration on Health Promo-

tion (currently with 30 graduates). The incorporation of Health Impact Assessments into health programs and capacity building on its use has been emphasized as key to advance health promotion in Mexico. In order to address that, the Mexican National Health Promotion Directorate has developed a technical publication on the application to local experiences of Health Impact Assessments (<http://ebookbrowse.com/analisis-de-impacto-en-salud-marco-conceptual-version-1-0-pdf-d69984368>).

Several intersectoral initiatives were spearheaded by health promotion concerns with the organizational support of the General Directorate at the Ministry of Health within the Vice-Ministry of Prevention and Health Promotion. A key one was the Occupational Health Promotion Program, launched in 2009, in collaboration with the Ministry of Labor, the Ministry of Education, the Ministry of Economy and the Social Security System, and representatives from the private sector and labor unions. Another important multisectoral strategy to incorporate health promotion into national programs is the recently launched "National Agreement on Food Health" (January, 2010). It was developed under the purview of the federal General Directorate of Health Promotion within the Vice Ministry of Prevention and Health Promotion, in collaboration with 15 other sectors and academic institutions, and the private sector. The successful development of this strategy greatly improved health promotion's standing within the country and among key stakeholders.

COUNTRY CASE: H1N1 IN HAITI

For a long time there has been a great demand for PAHO to help countries prepare for and then respond to emergencies and natural disasters. The advent of the H1N1 outbreak in the Region changed PAHO's usual way of responding to rapidly mobilizing social communication networks to quickly transmit information about the situation and how to prevent the spread of the virus. For the first time, there was a strong community component and recognition of how to mobilize community structures and assets to intervene in situations such as these. So, when the earthquake hit Haiti, followed by the cholera outbreak, an opportunity presented itself to showcase how communities could contribute in emergency response by developing long term systems that were built upon community structures that were already in place, structures such as schools, local authorities, religious networks, Ecoclubs, and other civil society organizations.

The way that H1N1 prepared governments to address the emergency in a transparent manner by reporting actual numbers and tracing the spread of the virus, enabled countries to know exactly what was happening within and outside their borders. In a situation like Haiti, where the health services were not in a position to adequately respond, community-based organizations, community health workers, and other volunteers such as religious networks, showed what the community was capable of

achieving. In neighboring Dominican Republic, the local authorities had their own structures and systems of communication and they were able to develop their own response strategies. The health promoting schools already had their partners established to address issues such as clean water, sanitation, and using schools as training sites. It was a natural extension of this initiative to move into responding to the H1N1 outbreak. This created a space for health promotion that did not exist even five years ago, and it was tremendously effective in not only responding to this emergency but in creating long term and sustainable community-based structures for future disasters and emergencies.

WORKING WITH ECOCLUBES INTERNACIONAL

Ecoclubes Internacional is an international movement of young people committed to environmentally sustainable development and the improvement of health and quality of life. There are Ecoclubs all over the world including twenty countries of Latin America, the Caribbean, and Mexico with over 15,000 members in total. The movement is coordinated through representative bodies at local, regional, national and international levels. Each Ecoclub is a democratic civil society organization that collaborates with national and international networks and organizations to address locally-relevant issues and to preserve natural resources. Ecoclub members en-



gage in participatory and innovative strategies that build leadership that will help these groups to be leaders in the “Web 2.0” revolution. This will move them into more effectively utilizing virtual information and communication technology through an open two-way communication on virtual platforms. These clubs have effectively mobilized youth and their communities to address issues such as climate change, water and sanitation, solid waste disposal, sexual and reproductive health, violence and injury prevention, along with dengue and malaria prevention. PAHO’s role has been to facilitate training, provide seed monies and arrange open access to sites that serve as hosts for events and activities in the virtual world. A Memorandum of Understanding is being developed between PAHO and Ecoclubes Internacional that will facilitate training of each Ecoclub in using virtual technologies (cell phones, web cams, blogs, Web sites, etc.) to document their local realities and become active advocates for the most pressing public health issues in their communities. This is the first time that young people are being empowered in this way and it will change the way public health issues are identified and addressed forever. For more information go to:

<http://new.paho.org/ecojovent> and
<http://www.ecoclubes.org>

SOCIAL MEDIA AND PUBLIC HEALTH

May 17, 2011 saw the launch of the Annual International Internet Day. This event had more than 400 connections via Elluminate, Livestream, Tweeter, and Facebook, and it is worth mentioning that often times more than one person was behind one connection. Aside from the virtual audience, the physical venue of the event had over 40 people. This event helped to establish PAHO as a leading public health organization on the forefront of public health information and communication. It helped to increase followers of or visitors to PAHO’s social media outlets (Facebook, Twitter, YouTube, and blog). This is a natural follow-up to the work begun with the Ecoclubs and will serve to continue this virtual work throughout the year and in subsequent years, with each year addressing different public health topics of priority in the Region. For more information, visit <http://new.paho.org/blogs/kmc/?p=1162> and http://new.paho.org/hq/index.php?option=com_content&task=view&id=5301&Itemid=3831&lang=en

VI. Current Challenges and Recommendations for Health Promotion in the Region

In order to address inequality, significant methodological changes and the development of appropriate tools and capabilities are needed

After acknowledging the key trends in health promotion in the Region of the Americas and identifying the heterogeneous nature of the professional and organizational development of health promotion, some key current challenges for the further development of health promotion in the Region are hereby discussed. Recommendations are made to help orient the work of the health promotion community, PAHO Headquarters and Country offices, PAHO/WHO Collaborating Centers, and Member States.

PROMOTE GOOD GOVERNANCE MODELS

Healthy governance is a key aspect for action for developing and maintaining healthy cities and communities. It is important for governance models to include the active participation of all sectors of society (public, private, academia and civil society) in decision-making processes as well as in mechanisms for planning, management, monitoring, and evaluation of policies and programs that are applied to urban contexts. It is particularly important to foster the participation of excluded groups such as the poor, women,

indigenous, afro-descendants, and disabled.

In order to address inequality, significant methodological changes and the development of appropriate tools and capabilities are needed. Cities must develop healthy public policies focused on the social determinants of health, sustainable local development, and health equity, and adopt planning and management mechanisms that include intersectoral collaboration and participatory decision-making processes.

PAHO can play an important role by providing countries and cities with appropriate tools and methods for assessing local situations and promoting participatory planning and implementation as well as facilitating national and local documentation of successful models and approaches.

STRENGTHEN REGIONAL AND NATIONAL NETWORKS

Regional and national networks, such as for Healthy Municipalities, Cities and Communities; Health-Promoting Schools; Health-Promoting Universities; and Healthy Housing;

are in a position to lead the development and strengthening of strategies in each specific topic and to position health promotion on the political agenda of its Member States and cities to, in turn, contribute to local sustainable development and improvements in the social determinants of health, including urbanization. Given their potentially far-reaching connections throughout a country or a region, and their connection with key stakeholders, such networks can strongly support the implementation and continuity of health promotion efforts.

Additionally, these Regional networks comprise a major forum and offer a Regional model of advocacy for healthy public policies, strengthening alliances on a continental level, articulating initiatives of national and local networks, as well as with related networks, and promoting an interchange of experiences among and solidarity with its members.

It will be important for PAHO to continue to maintain these networks as they serve as a rich source of interchange of experiences, sharing of resources and mechanisms for mutual learning. Improving links with health promotion professional

associations, academia and NGOs would further strengthen these networks. PAHO/WHO Collaborating Centers also play a significant role in providing technical expertise and serving as principle reference points in key topics that are needed to advance the field of health promotion. PAHO/WHO can also promote a better integration of its Collaborating Centers in the programs and activities taking place at the country and Regional levels.

EXPAND HEALTH PROMOTION BEYOND THE HEALTH SECTOR

Influencing sectors other than health is a key stewardship role of health promotion and the health sector. It is impossible to manage the rapidly changing environment by the health sector alone; but the strength of working with other sectors should be used to utilize upstream approaches to improving quality of life.

Promoting the adoption of health promotion by other sectors and institutions that are not linked to the health sector is one of the greatest challenges for the discipline nowadays. In order to incorporate health promotion into the political and technical agenda of other sectors and institutions, it is crucial to build an evidence base that demonstrates the benefits of investing in health promotion principles, values and strategies. Decision makers need to understand these benefits, as well as to act on the structural causes of health problems and on the social

construction of health by linking these issues with local and regional development plans.

One important related challenge continues to be the focus on - and profitability of - medicalized health care and the traditional doctor-centered models for providing health care. Rising health costs, promotion of primary health care and an aging population with a growing burden of Chronic Non-Communicable Diseases have increased interest in health promotion, healthy lifestyles and prevention. However, committing to adopting a health promotion approach to address these issues continues to be controversial.

PAHO should play a leadership role in providing advocacy tools and offering opportunities to promote collaboration with multiple sectors. PAHO can also support the strengthening of capacities among Ministries of Health in the Region to act in an intersectoral manner and to foster the development of alliances and joint activities. This will support the integration of health promotion and the social determinants of health approach into the development agenda of the countries.

EXPAND THE EVIDENCE BASE THROUGH DOCUMENTATION OF HEALTH PROMOTION EXPERIENCES

One of the important responsibilities of PAHO and its partners (i.e. Collaborating Centers) is to expand

the evidence base for health promotion. During the past decade, the field has placed greater emphasis on documentation of health promotion experiences in different contexts. This is important since we need to better understand what works and under what conditions, as well as to make the case with decision makers and funders that health promotion is a cost-effective and economically smart approach to take.

Working with Collaborating Centers in the Region, PAHO led the development, field testing, and production of a documentation template and guidelines for its use. This has now been placed on PAHO's Web site and been used to document multiple instances of how people worked together to create improved conditions for population-level health and human development. A remaining challenge is how to use communications technology to make it easier and more rewarding for partners to document and share with others throughout in the Americas and globally, their health promotion experiences. Wider use of PAHO's Guide for Documenting Health Promotion Initiatives, both within the Region and across the world, will help to create a richer database that will provide the basis for expanding health promotion initiatives worldwide, as well as the basis for the evidence of health promotion effectiveness. It will also be important for PAHO, together with its Collaborating Centers, to maintain and update this database.

MAKE HEALTH PROMOTION SERVICES ACCESSIBLE TO AND EFFECTIVE FOR INDIVIDUALS, FAMILIES AND COMMUNITIES

There are great opportunities to make health promotion services available now, as Primary Health Care Programs are being rejuvenated throughout the Region, and as exploration is taking place as to how to incorporate health into the health reform process taking place throughout the Region. This requires a more precise definition of what health promotion services encompass and what are the most appropriate and effective ways to deliver them.

“Community action” has to be defined based upon people’s activities (work, education, transport, and entertainment), networks, and interests. Many of these categories can be further stratified based upon population-specific criteria, such as for age ranges, wherein adolescents would require a very different focus than the elderly.

PAHO should play a supportive role by creating and helping countries adapt to their own situations and contexts guidelines and tools for identifying the structure of communities, how to most appropriately offer health promotion services and how to mobilize the community’s own health assets. This identification further requires an adjustment in how to make contact with the different communities: it will require

the development of new competencies and innovations in outreach strategies (for example, teenage vaccination or reproductive health campaigns where health promotion and health problem prevention has been delivered through places of entertainment, or for extremely mobile populations). It is also important that services are culturally sensitive, given the enormous cultural and ethnic variations found in the Region.

PAHO should also promote the incorporation of health promotion as an essential component of health systems (such as establishing health promotion centers or introducing health promotion as a service), as well as in the leading critical agendas in the Region (CNCDS, Violence and Injury Prevention, SDH, etc.).

MAINSTREAM HEALTH PROMOTION INTO URBAN HEALTH PROGRAMS

Now is the critical time to respond to the emerging challenges of urbanization. An objective examination of available policy options and the design of more pragmatic and creative responses will be necessary. Decisions made in cities today will shape not only their own destinies, but those of the future social, environmental, and health conditions of the entire Region.

This requires a thorough review of public health programs provided to the population in cities in order to ensure that they include the provi-

sion of health promotion functions with quality and effectiveness. A special consideration is needed for the prevention of Chronic Non-Communicable Diseases (CNCDS) through health promotion actions such as providing options for healthy eating and physical activity, and the prevention and reversal of the obesity epidemic. This will require the development and implementation of healthy public policies that address the availability, labeling and marketing of healthy and local foods over unhealthy and imported ones, and that address built spaces that allow for physical activities, green spaces, and that favor public over private transportation. All five strategies of the Ottawa Charter and their complementary functions have to be applied, and as integrated as possible, for urban public health programs to be effective.

PAHO can support these processes by providing guidelines and criteria (such as PAHO’s public health guidelines for urban health planning) to ensure that the institutional and legal foundations are developed to incorporate health promotion and civil society engagement into urban planning and sustainable development initiatives, as well as to transform information systems to better address issues of equity and to bring updated knowledge into the design of urban health policies and initiatives. PAHO’s Directing Council will approve in September 2011 the Regional Strategy and Plan of Action for Urban Health. The concrete recommendations for Member States

and the PAHO Secretariat, along with reporting on progress achieved every two years with an evaluation after the next five and ten years, will go a long way to supporting and shining a light on effective interventions to initiate in the healthy urbanization context. Baseline data will be included in that document and will serve as a benchmark for countries to measure their progress.

INTEGRATE HEALTH PROMOTION AND HEALTH IN ALL POLICIES

Consistently applying the most appropriate tools, especially those that measure the differential social distribution of health, including gender, migration conditions and ethnic populations, (tools such as Health Impact Assessment (HIA), Health Equity Impact Assessment (HEIA), and Urban HEART) to projects, programs and policies can create the necessary information and evidence to alert decision makers to the need to address equity across the entire population and to integrate health promotion as an effective public health and public policy strategy for participatory and inclusive planning and for prevention and early intervention in potential and emerging health issues. Empirical practical experience needs to be clearly established, and eventually mandated in the normative framework for health planning. The advocacy function for Health in All Policies then will be supported by the evidence from HIA, HEIA and the added value ap-

plied to policies that promote health benefits.

PAHO should provide the methodological and legal framework for inserting “Health in All Policies” into the design of all types of national policies and plans. Additionally, PAHO should provide support for helping countries review and backstop the inclusion of health promotion into all possible national policies and programs. PAHO should take a leadership role in building country capacities to conduct these critical assessments in the early steps of policy and program development, so that the results can be taken into consideration before implementation takes place. Training activities to arm national, local and Collaborating Center personnel with appropriate tools as well as to facilitate the monitoring and evaluation functions should be an essential part of PAHO’s technical collaboration with countries and incorporated into Country Cooperation Strategy (CCS) exercises. Finally, PAHO should collect and disseminate lessons learned from the application of these tools in selected sites and settings.

MODIFY HEALTH DETERMINANTS AND IMPROVE WELL-BEING

Health promotion has to have a clear mandate that enables people living in cities and institutions serving them to modify the health determinants in order to improve the quality of life and wellbeing of the people. This implies interaction

with actors and sectors that manage such determinants (housing, urban planning and development, commerce, education, etc.). Acknowledging that there is a social gradient in the distribution of such determinants, highlights the need to develop evidence, methods and tools to help build personal skills, community action, healthy environments, and healthy services and policies that modify the determinants so that such gradient is taken into consideration.

PAHO should take the leadership, especially at country level, to promote the use of three policy modalities for analysis and selection of intervention strategies that will respond to the health determinants: (1) improving the health of the most disadvantaged population groups through programs targeted through population-based assessments, (2) closing the gaps between those in the poorest social circumstances and better-off groups, and (3) addressing the entire health gradient, that is, the association between socioeconomic position and health across the whole population (Solar and Irwin, 2007). Such policies could be implemented at a municipal level, as well as on a national level.

DEVELOP EFFECTIVE MEASUREMENT TOOLS AND INFORMATION SYSTEMS

Application of appropriate tools and approaches (such as Urban HEART, health included in all policies, evalu-

ation of program effectiveness) and as a consequence adjusting programs to the findings, highlights the significant effort needed to build an information system based upon health determinants, their social distribution and the evidence base in order to appropriately inform policies and programs. This should all be part of a critical first step in helping countries identify their starting points and eventually measure their progress.

PAHO should support countries and cities in building health surveillance systems within cities that go beyond the monitoring of morbidity and mortality and include the continuous collection, analysis and communication of health determinants data. It should also help to develop and disseminate methods for analysis and modification of personal, family and community assets, as well as of social and community networks. PAHO should support activities that will create a mindset change in health promotion practitioners related to their interaction with epidemiologic surveillance systems and the building of systems to collect the appropriate information. PAHO should provide technical cooperation to lead to insights into how surveillance and other information systems can be appropriately modified to incorporate these additional elements, and how they should be used to adjust policies and programs. Additionally, PAHO should support the establishment of a Regional Observatory that will be able to collect baseline and progress

information achieved across the Region, highlighting lessons learned, best practices and successful strategies, approaches, and programs.

INCORPORATE HEALTH PROMOTION INTO THE GLOBAL CORPORATIVE HEALTH AGENDA: WORKING WITH THE PRIVATE SECTOR

Promoting partnerships between the public and private sectors may encourage their participation in the decision-making process as well as policy and program development. This can be a very controversial area, depending upon who the private sector partner is. Therefore it will be important to emphasize the need to define common goals, functions, and principles in these types of public-private partnerships (Buse and Walt, 2000). While these common denominators may be present, research indicates that public-private partnerships also depend to a large extent on the local strategic plans and guidelines of involved and potential key actors (Field and Peck, 2003). Not all private sector actors make suitable partners – Hancock (1998) recommends partnering with organizations that either stand to profit economically from better health, or that are the ‘producers of health’ (e.g. agri-food industry, renewable energy industry). It is important to uncover corporative interests and define benefits for their collaboration, the development of social responsibility programs

and the impact of their activities on health. Finally, with regard to civil society, the active participation of all partners who are involved at the local level, such as through international and regional institutions, national and local NGOs, religious groups, social movements, the media, research, and the education sector, should be emphasized (Dodgson et al., 2002).

PAHO, in collaboration with other international and UN agencies, can serve as a neutral broker for convening private and public sector representatives to discuss and discover ways that both sectors can work together to create environments, conditions and products that promote and maintain health and wellbeing. They can also advocate for the incorporation of health promotion into the regional frameworks related to the regulation of international commerce, particularly in those aspects related to food security and climate change. PAHO should look for Collaborating Centers and Centers of Excellence that can collectively represent the interests of the public and private sectors.

DEVELOP HUMAN CAPACITY, LEADERSHIP AND BUILDING A NETWORK OF LEADERS

To adequately respond to the demand for implementing health promotion strategies, rigorous and high quality health promotion personnel and a job market that can retain and promote them will be es-

sential. There is a large capacity gap, and currently available platforms and institutions need to be utilized to the fullest extent possible, while exploring new and alternative ways to train, refresh and maintain well qualified personnel. The definition and consensus-building of appropriate curriculum and competencies that are tailored to the needs and Regional context is central for mobilizing action and transforming knowledge into health promotion practice.

PAHO should develop and support the offering of virtual courses to make basic and more advanced health promotion capacity-building opportunities more widely available through the PAHO Virtual Public Health Campus. Its virtual short courses for PAHO staff should be adapted for and opened to the general public so that everyone can have a basic understanding of what health promotion is and how their work can incorporate a health promotion lens. A longer health promotion program, with a series of courses, should be offered, capitalizing on the multiple institutions in the hemisphere that can collaborate in offering such a program through PAHO's Virtual Public Health Campus. The National School of Public Health of Cuba would like to offer a diploma in health promotion through the PAHO Virtual Public Health Campus, and this should be explored with the other academic institutions in the Region that are interested in joining forces. PAHO should also encourage the expansion

of health promotion training at the masters and doctoral levels offered by universities in the Region and the incorporation of health promotion training into the preparation of professionals in other allied fields. PAHO could also develop a Health Promotion Leadership Initiative to foster the development of skilled young professionals in the field while building a network of leaders to mobilize and move the field forward. Continuing work with Eco Clubs can provide a nice adjunct to this.

PAHO should also invest in the strengthening of capacities within Ministries of Health in the Region so they can take the leadership to advocate for, disseminate and create linkages that foster health promotion among relevant stakeholders, and to incorporate it into the policy development discussion and the development agendas of their countries.

BUILD COMMUNICATION THAT GROWS

It is critical to improve communication with the different communities and stakeholders. This calls for the use of effective and innovative approaches that include new social communication and health education methods that recently have come on the scene.

The new Web site being set up by PAHO/SDE will be an important avenue for promoting ongoing interchange of ideas, materials,

information and lessons learned.

It will be important to nurture and improve this vehicle over time so it is current to the extent possible, while maintaining an historic perspective through the SDE Virtual Public Health Library, incorporating where possible the grey literature. PAHO/SDE should also maintain and strengthen the Healthy Municipalities, Cities and Communities Network and its quarterly newsletter, currently managed by PAHO/SDE, as well as make more use of social networking tools such as Facebook, Twitter and Flickr, to disseminate relevant information and bring together practitioners in the Region. Future Annual International Internet Days can be devoted to the challenges of preventing health issues and promoting healthier lifestyles and conditions that create and support a healthier quality of life. The recent experience in setting up a Community of Practice for the work we are doing with 21 countries on applying the instruments of Urban HEART and Health Impact and Health Equity Impact Assessments is a great way for us to share our resource, common thinking and debates about new issues and ways to resolve them.

PROMOTE EFFECTIVE MULTISECTORAL COLLABORATION

Increased attention has been paid lately to how to improve and promote multisectoral collaboration and to incorporate "Health in All Policies". This is a complex issue

for countries to address given long standing bureaucratic and rigid institutions and structures that do not foster such types of collaboration.

PAHO should develop tools and support countries in their efforts to bridge the various sectors and stakeholders that can support more effective health promotion. Identification and sharing of strategies, lessons learned and information from monitoring and evaluation will help to contribute to this goal.

CONSOLIDATE AND STRENGTHEN THE CONCEPT OF HEALTH PROMOTION IN THE REGION

Even though health promotion has gained a lot of strength in the Region over the past decades, it is still not a clearly understood concept in many countries. Many still don't see health promotion as a cross-cutting issue, but as a strategy to be incorporated into or to bridge different programs.

PAHO should continue to promote the concept and provide guidance on how to apply it. PAHO should develop guides to help countries identify, analyze and develop strategies to mobilize personal, family and community assets; monitor and act on health determinants at the local level; and analyze and mobilize social and community networks.

There is an urgent need to systematize and improve health promo-

tion methods and strategies. PAHO should work to ensure that health promotion and the use of a health promotion lens is incorporated into critical leading agendas such as Chronic Non-Communicable Diseases (CNCDS), Violence and Injury Prevention, Social Determinants of Health, and Health and Human Security, among others. Countries should understand how to embrace health promotion with integrated and holistic actions, that are appropriately funded, and not with fragmented programs. It is important that PAHO promote the broader vision of health promotion, as well as its different components (policies, surveillance, capacity building).

To help strengthen health promotion in the Region, PAHO should help to integrate the PAHO/WHO Collaborating Centers into daily and ongoing activities at country and Regional levels. Links with health promotion professional associations, academia and health promotion non-governmental organizations (NGOs such as the International Union for Health Promotion and Education) will serve to strengthen country and Regional initiatives as well as any health promotion network.

MOBILIZE AND SUSTAIN RESOURCES FOR HEALTH PROMOTION

There are still not enough resources available for health promotion in the Region. PAHO should help to raise awareness and galvanize potential

donors in health promotion-related issues. To make steady advances, health promotion needs to reach a sufficient critical mass of people in countries in a way that can guarantee the sustainability of health promotion advances. PAHO can do this by creatively linking entities with potential resources (technical, material and financial) with people working to promote health and wellbeing in general as well as those working to prevent or intervene early with specific health issues and problems.

PAHO should also help countries create steady financing systems through the creation of mechanisms such as health promotion foundations and the use of "sin" taxes (taxes on tobacco, alcohol, junk food) for health-promoting initiatives. PAHO can also play a role by strengthening health promotion structures, organizations and capacities at the Ministries of Health to guarantee the adequate funding and allocation of resources to support and maintain health promotion efforts over time.

INCORPORATE HEALTH PROMOTION AS A CORNERSTONE FOR UPCOMING GLOBAL INTERNATIONAL CONFERENCES, MEETINGS AND INITIATIVES

Incorporating health promotion as an essential component is a key

step for the future of public health action. There are several initiatives and at least four Global high level meetings taking place during 2011 and 2012. These represent a golden opportunity to incorporate a health promotion lens into the public health agenda by having it as a core component in the preparations for, discussions during, and follow-up recommendations of each of these events and initiatives.

The *UN High Level Meeting on Non-Communicable Diseases* (New York City, September 19th and 20th 2011) offers an opportunity to focus attention on the factors that contribute to these conditions and the ways that they can be prevented by establishing public policies and developing favorable settings to make healthy behaviors easier, more accessible and more socially desirable.

During the Global Conference on the *Social Determinants of Health* (Rio de Janeiro, October 19th to 21st 2011), country delegations will have an opportunity to see the synergies between addressing and creating conditions for people to be healthy, tackling the social gradient and inequities that contribute to un-

healthy lifestyles and inhibit wellbeing in the population, and promoting policies and programs that will maximize the mobilization of community assets and encourage more equitable distribution of resources, opportunities and decision-making power. There are three pillars to support sustainable development: social, environmental and economic pillars. Health is included in the social pillar and although the other two areas have advanced considerably, the social pillar has fallen behind. In today's world, health promotion is in a key position to make a contribution to sustainable development by integrating health with the action of other sectors within the social pillar, while linking directly with the environmental and the economic pillars.

In preparation for the *Rio+20* United Nations Conference on Sustainable Development (Rio de Janeiro, June 4th to 6th 2012), countries can use a health promotion approach to propose more participatory and empowered social mobilization, in a manner that is locally based and ecologically sound, along with improved governance mechanisms and appropriate technologies and approaches to provide the neces-

sary services to their populations in a way that is healthier and more sustainable for their populations and the environment. A common theme for all the afore-mentioned conferences is the need for intersectorial action; this implies that a new role for Ministries of Health needs to be developed.

In 2013, the 8th WHO Global Conference on Health Promotion will take place in Finland with special emphasis on the need to move forward in translating health promotion strategies into concrete action through multi-sectoral action. This is an opportune time for the health promotion field to analyze its capacity to respond to the demands posed by previous trends and to highlight the evolution of the field and new developments. The concepts of Health, Human Security and Wellbeing are providing the Region with a further challenge to use a public health approach that is person-centered while at the same time increasing community resilience; an approach based on intersectoral policies that can generate favorable settings for the strengthening of personal, family and community assets as a cornerstone of health promotion.

VII. Conclusions

PAHO should be a leader in promoting primary health care and universal coverage to increase efficiency and equity for providing health care

Health promotion has made great strides in the past few decades and has been able to establish itself as a valuable public health strategy. Yet, there is still much ground to be covered so health promotion does not remain an unfulfilled promise. Now is the time to reflect on how to reorient health promotion practice, its actions and resources, in order to achieve political change and promote more balanced power relationships among all relevant social actors, while taking into account national contexts and building the necessary structure and legislation to sustain the achievements. These are key conditions that will allow health promotion initiatives to materialize and function as entry points to strengthen country capacities to improve health and actions associated with equity, human rights and the social determinants of health.

One key barrier to be tackled is to shift the paradigm within the public health community to transform the still predominant medical and disease prevention approach to one focused on population and community health. Health promotion, as a multi-sectoral and participatory approach, offers a more balanced and integrated epistemological understand-

ing of the health-disease paradigm, and as such needs to have more active advocacy and promotion. To support this process, more needs to be done to build health promotion models and frameworks, based on evidence of its effectiveness; one that takes into consideration the diverse economic, political, ethnic, social and cultural characteristics of the countries in the Region.

Health Promotion is an ethical and political imperative for the countries of the Americas. An analysis of its achievements and challenges poses interesting and complex questions for the discussion about development, health and wellbeing. What does development really mean for the people of the Americas and how can it be achieved? What kind of indicators should be used to measure such advances? What is the best way to strategically respond to the emerging challenges of chronic diseases, widespread obesity disorders, insecurity, inequity, urban health and climate change in an integrated and holistic manner? Health promotion can provide a rich and fresh framework to help reflect upon these questions; it also offers a well-rounded approach to formulate the responses to address these complex issues.

Incorporating health promotion into national and international political agendas and practices, for example, through technical cooperation, will lead to a process of change that will result in more pragmatic and successful action. PAHO's agenda, as an international technical cooperation agency that works closely with governments, should aim to: strategically position health promotion, resource mobilization, promotion of agreements, and analysis and synthesis of results, all of which provide an important basis on which to build effective management and advocacy strategies.

PAHO should be a leader in promoting primary health care and universal coverage to increase efficiency and equity for providing health care. Health promotion is a central component of this. PAHO should showcase best practices and innovative approaches, and share evaluations of transformative health systems based on health promotion and consumer participation. PAHO should lead, support and fuel this transformation to reduce costs, ensure equity and above all, prevent behaviorally induced chronic diseases that are the main causes of suffering and death in the Region.



RESOURCES

PAHO PUBLICATIONS AND TOOLS

Curso Introductorio sobre los Determinantes de la Salud
<http://www.bvsde.paho.org/bvsdemu/fulltext/cursodssv2.pdf> (available only in Spanish)
<http://dds-dispositivoglobal.ops.org.ar/curso/>

Evaluation Recommendation for Policymakers in the Americas
 English: http://www.bvsde.paho.org/bvsdemu/fulltext/MC_Recommendation.pdf

Guide to Document Health Promotion Experiences — Community for Health Promotion Initiatives (CIPS)
<http://devserver.paho.org/hpd/>

Guide to Economic Evaluation of Health Promotion
 English: <http://www.bvsde.paho.org/bvsacd/cd65/finalecoeva.pdf>
 Spanish: <http://www.bvsde.paho.org/bvsacd/cd68/EvalEcoProm.pdf>

Healthy Municipalities, Cities and Communities Network of the Americas
 Listserv
 English: <http://listserv.paho.org/archives/red-mcs.html>
 Spanish: <http://listserv.paho.org/archives/red-mcs.html>
 Newsletter
 English: <http://www.bvsde.paho.org/bvsdemu/bolmunicipi/bolmunicipieng.html>
 Spanish: <http://www.bvsde.paho.org/bvsdemu/bolmunicipi/bolmunicipi.html>

Mayor's Guide for Promoting Quality of Life
 English: http://www.bvsde.paho.org/bvsacd/cd63/MCS_Guiaeng/MCS_Guiaeng.html
 Spanish: http://www.bvsde.paho.org/bvsacd/cd63/MCS_Guiaesp/MCS_Guiaesp.html

Participatory Evaluation Guide for Healthy Municipalities, Cities and Communities
 English: <http://www.bvsde.paho.org/bvsdemu/fulltext/guiaevaleng/guiaevaleng.html>
 Spanish: <http://www.bvsde.paho.org/bvsdemu/fulltext/guiaevalesp/guiavelesp.html>

Roadmap to contribute to the achievement of the Millennium Development Goals of Healthy Municipalities, Cities and Communities
 English: <http://www.bvsde.paho.org/bvsdemu/fulltext/roadgoals/roadgoals.html>

Spanish: <http://www.bvsde.paho.org/bvsdemu/fulltext/hojaobjetivos/hojaobje.html>

CHARTERS AND DECLARATIONS

Alma-Ata Declaration on Primary Health Care
http://www.who.int/hpr/NPH/docs/declaration_almaata.pdf

Bangkok Charter for Health Promotion
http://www.who.int/healthpromotion/conferences/6gchp/bangkok_charter/en/

Ottawa Charter for Health Promotion
http://www.who.int/hpr/NPH/docs/ottawa_charter_hp.pdf

REPORTS AND DOCUMENTS

First Meeting of the PAHO Urban Health Forum
<http://www.bvsde.paho.org/bvsacd/cd68/foroeng.pdf>

Hidden Cities: unmasking and overcoming health inequities in urban settings
<http://www.hiddencities.org>

Our cities, our health, our future. Acting for Social Determinants for Health Equity in Urban Settings. Report to the WHO Commission on Social Determinants of Health from the Knowledge Network on Urban Settings
http://www.who.int/social_determinants/resources/knus_final_report_052008.pdf

Global Status Report on Road Safety 2009
http://www.who.int/violence_injury_prevention/road_safety_status/2009/en/index.html

WHO World Health Report 2008: Primary Health Care (Now More Than Ever)
<http://www.who.int/whr/2008/en/index.html>

WHO World Health Report 2010: Health systems financing: the path to universal coverage
<http://www.who.int/whr/2010/en/index.html>

Global Status on Noncommunicable Diseases 2010
http://www.who.int/nmh/publications/ncd_report2010/en/

First Ministerial Conference on Healthy Lifestyles and Control of Noncommunicable Diseases (2010) (Moscow Declaration)
http://www.who.int/nmh/events/moscow_ncds_2011/conference_documents/en/

WEBSITES

- Brazilian National Commission on the Social Determinants of Health
<http://www.cndss.fiocruz.br/pdf/home/relatorio.pdf>
- Carmen Network
<http://www.paho.org/english/ad/dpc/nc/carmen-info.htm>
- First Hispanic and Iberoamerican Contest on Best Practices on Urbanism and Health
http://new.paho.org/hq/images/stories/AD/SDE/UH/informe_final_de_blanca_patricia1.pdf
- International Union for Health Promotion and Education
<http://www.iuhpe.org>
- Kansas University Community Toolbox
<http://ctb.ku.edu/es/>
- PAHO's Virtual Library for Sustainable Development and Environmental Health
 English: <http://www.bvsde.paho.org/bvsacd/cd68/foroeng.pdf>
 Spanish: <http://www.bvsde.paho.org/sde/ops-sde/bvsde.shtml>
 Portuguese: <http://www.bvsde.paho.org/sde/ops-sde/bvsde.shtml>
- Social Network for Health Promoters
<http://www.connect2change.org>
- WHO 1000 Cities 1000 Lives Campaign
<http://1000cities.who.int>
- WHO Commission on the Social Determinants of Health
http://www.who.int/social_determinants/thecommission/en
- WHO Global Alcohol Database
<http://apps.who.int/globalatlas/default.asp>
- WHO Global Forum on Urbanization and Health
<http://www.gfuh.org>

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