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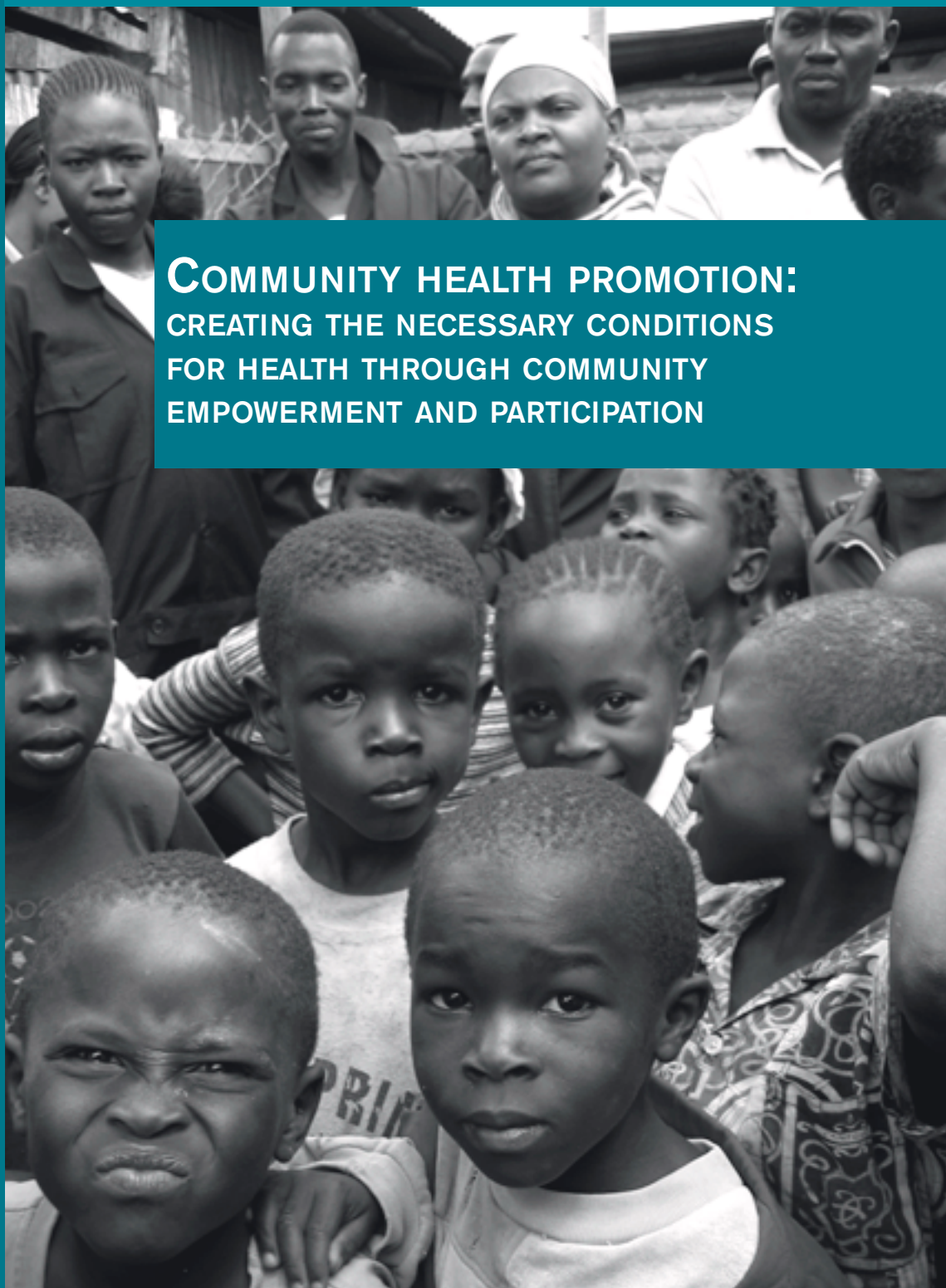
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DE PROMOTION DE LA SANTÉ
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TRIMESTRAL

REVISTA INTERNACIONAL
DE PROMOCIÓN DE LA SALUD
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Health Santé Salud



**COMMUNITY HEALTH PROMOTION:
CREATING THE NECESSARY CONDITIONS
FOR HEALTH THROUGH COMMUNITY
EMPOWERMENT AND PARTICIPATION**



Promotion & Education

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Photo: C. M. Jones

The 'Tuff Gong' group of young community volunteers at the daycare centre in Mitumba informal settlement, Nairobi, Kenya.

Community health promotion– a step further

Sania Nishtar^{1,2}

This themed issue of *Promotion & Education* has received financial support from the United States' Centers for Disease Control and Prevention (CDC), an Agency of the Department of Health and Human Services, under the Cooperative Agreement Number U50/CCU021856 on Global Health Promotion and Health Education Initiatives. The ideas expressed in the articles are those of the authors and do not necessarily represent those of the CDC and the IUHPE.

Community health promotion is of strategic significance in contemporary health systems. The overarching context of this stems from the inability of most countries with mixed health systems to deliver health as a public good; this coupled with the emerging role of the market in health and resource constraints at the social sector level, particularly in the developing countries, necessitate a visible role of the communities in health promotion in order to achieve the equity objective in health. However, in contrast to its significance, community health promotion remains a poorly understood concept, which makes it difficult to advocate it to policy makers. These considerations therefore led the Global Consortium on Community Health Promotion, after its creation in 2003 as a collaborative initiative of the US Centers for Disease Control and Prevention (CDC) and the International Union for Health Promotion and Education (IUHPE) to focus on bringing clarity to concepts and norms as a starting point for the scope of its work; and it is within this context, and as a step in this direction, that this special issue has built further on the Statement of the Consortium (Nishtar et al., 2006).

The issue covers many aspects of community health promotion from the elaboration of its interface with the principles of equity and considerations of population health to spot-lighting a series of case studies to enable a better understanding of what community health promotion involves and how participatory empowering methodologies can be used to harness community assets and why. In addition, the issue also features articles of practical relevance with respect to assisting countries and practitioners to examine whether their general

activities in specific projects meet current standards of good community health promotion practice, and providing guidance on participatory evaluation.

The Consortium's Statement on which this issue further builds, defines community health promotion as a *participatory empowering equity focused process – one that regards community participation as being essential to every stage of health promoting actions as well as one that leverages community assets and knowledge to create the necessary conditions for health*. However, as outlined by Rice in this issue (2007; p. 68), not all health promoting policies and actions conform to this definition. The author uses lessons learnt from the application of participatory evaluation methodologies to Healthy Municipalities, Cities and Communities (HMC) Initiatives in selected countries of the Americas to highlight the point showing that most HMC initiatives had not appropriately taken into account key health promotion principles, such as intersectoral collaboration and community participation. The article by Baum delves deeper into the issue enabling an understanding of the implications of not doing so by referring to the Ottawa Charter galvanised health promoting policies and actions in Australia (2007; p. 90); these have led to a significant impact at the population level across a range of health outcomes, but have remained unsuccessful in addressing inequities and reducing the existing gradients. Such experiences underscore the need to design health promotion policies and actions with a strong equity lens, and it is here that the need to combine top-down political commitment and policy action with bottom-up action from communities and civil society groups referred to by Baum in her article as the 'Nutcracker effect for health equity', assumes importance.

Understanding the role of the communities is therefore critical to health promotion. Within this context, a number of case studies have been featured in this special issue from diverse developing country backgrounds to showcase relevant approaches. Each study used a structured format to highlight both the intervention as well as the lessons that can be extrapolated from the experience for wider application. Weaknesses in their design and evaluation methodologies

notwithstanding, the case studies yield important process-related lessons.

Firstly, the collective message emphasises the importance of understanding the entire process of community project management and its instruments. Foremost is the need to engage all development actors in a locally-suited participatory model for planning and governance; these include local government bodies, NGOs, international development partners, formally established community organizations, local leadership and inter-community federations. Participatory governance with a role, both for the public sector as well as the communities is relevant not only to the sustainability of grass roots initiatives, but also enables transferring successful social technologies to other settings and the adoption and integration of programmes as public policies.

Secondly, the case studies bring to the forefront many considerations that should be taken into account while structuring community initiatives; these include garnering participation and ownership at all steps; ensuring that voices are heard; fostering a sense of cohesion; ensuring that lessons learnt are factored into decision making; allowing for flexibility with program design so that it can be shaped by locally relevant evidence as it emerges during the course of interventions; encouraging self-management and social control; using culturally appropriate and locally validated tools of intervention and paying due attention to the empowerment of women in decision-making. These are regarded as being important to the sustainability of grass roots interventions in general. More specifically, however, these also enable overcoming religious, cultural and ancestral barriers to accessing healthcare as is shown by the case study from the Solomon Islands (MacLaren & Kekeubata, 2007; p. 78); in addition, they can also assist in fostering the empowerment of the most isolated and difficult to access groups, as is shown by the example of the forest peoples, or the 'caboclos', in Brazil, who live in rural, often isolated and difficult to access areas of the Amazon (Scannavino & Anastácio, 2007; p. 85).

Thirdly, most examples highlight the need for intersectoral action within the larger framework of social sector develop-

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ment rather than within the domain of healthcare. Examples of health interventions cited herein have garnered support from across various sectors such as housing, education, youth services, and food security agencies rather than conventional health systems to improve health outcomes. A local perspective within an intersectoral scope can also flag locally specific opportunities for health promotion; for example, the case history from Orissa shows that disaster proneness is one of the strongest determinants of death and disability in the cited region of India; the predictability of disaster in this area therefore warrants institutional capacity strengthening for relief and rehabilitation operations rather than the traditional public health interventions (Mukhopadhyay, 2007; p. 74).

And *finally* the case studies allude to the potential value of networking both globally in terms of promoting values of equity and social justice in health by facilitating sharing of experiences across countries, as in the case of EQUINET (Loewenson, 2007; p. 105), as well as, enhancing peoples' power over their health and well-being in local community settings as was shown for the 'Graniators' in Australia (Sullivan et al. p. 80).

The articles featured herein yield useful lessons for fostering community health promotion. Evidence of the effectiveness of such initiatives underscores the need to move beyond pilot and demonstration projects to mainstream the participation and role of communities for improving health across a range of outcomes (IUHPE, 2000). This necessitates a range of complex interdependent actions and requires going beyond increasing the voice of communities and frontline health workers to strengthening the social policy fabric, shaping social welfare and health financing arrangements and moulding the regulatory environment within country settings. Within the health sector, this also necessitates a number of other overarching measures, such as, redistributing health budgets from tertiary care to prevention and health promotion, and addressing budgetary and health personnel deployment imbalances in favour of rural, informal urban and primary care infrastructure and services. Existing and evolving public health programmes present an opportunity, where prevention, control and health promotion can be integrated as was shown for the non-communicable diseases initiative in Pakistan (Ronis & Nishtar, 2007; p. 98).

However, sustainable engagement of communities in mainstream healthcare is most feasible in countries with systems of governance which involve decentralization of administrative and political power to the

lowest administrative units, such as municipalities. These structures have institutional mandate and responsibility for engaging communities and channeling inputs by development actors to local development plans. The local government perspective can also enable the tying in of health interventions to over-arching development goals, cross-linking these with initiatives for livelihood support, education, savings and credit, given that these are critical to the process of development in general at the grass roots level.

Spurring action at a social sector level within countries along these lines is a prerogative of state institutions; however, multilateral development initiatives such as the WHO's Commission on the Social Determinants of Health can provide an impetus particularly through WHO's leverage in more than 190 countries to encourage governments to make public policy choices organized around the active participation and involvement of communities as outlined in these approaches. A strong state and public sector in health is important to improve population health equitably – both by delivering public good as well as regulating the private market and the role of communities can be critical to the success of both.

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Reducing social inequalities in health: public health, community health or health promotion?

Valéry Ridde¹

Abstract: While the Consortium on 'Community Health Promotion' is suggesting a definition of this new concept to qualify health practices, this article questions the relevance of introducing such a concept since no one has yet succeeded in really differentiating the three existing processes: public health, community health, and health promotion. Based on a literature review and an analysis of the range of practices, these three concepts can be distinguished in terms of their processes and their goals. Public health and community health share a common objective, to improve the health of the population. In order to achieve this objective, public health uses a technocratic process whereas community health uses a participatory one. Health promotion, on the other hand, aims to reduce social inequalities in health through an empowerment process. However, this is only a theoretical definition since, in practice, health promotion professionals tend to easily forget this objective. Three arguments should incite health promoters to become the leading voices in the fight against social inequalities in health. The first two arguments are based on the ineffectiveness of the approaches that characterize public health and community health, which focus on the health system and health education, to reduce social inequalities in health. The third argument in favour of health promotion is more political in nature because there is not sufficient evidence of its effectiveness since the work in this area is relatively recent. Those responsible for health promotion must engage in planning to reduce social inequalities in health and must ensure they have the means to assess the effectiveness of any actions taken. (*Promotion & Education*, 2007, (2): pp 63-67)

Key words: social inequalities in health, public health, community health, health promotion, definition

Article en français à la page 111. Resumen en español en la página 126.

KEY POINTS

- Health promotion's objective to reduce health inequalities and the process of empowerment distinguish it from public health and community health.
- Health promotion professionals must engage in planning to reduce social inequalities in health and ensure they have the means to assess their effectiveness.

There has been much debate around the definition of health practices. Some authors have referred to vague and fluctuating definitions (Gagnon & Bergeron, 1999, p. 257), whereas others have managed to turn this controversy into a research area in and of itself (Fassin, 2000a). According to Bourdieu (2001), it is perfectly normal for scientists working in the same field of knowledge to be in perpetual disagreement. Traditionally, a dichotomy persists in expert opinion discourse between public health and community health, with the former being considered older than the latter. Health promotion emerged more recently, carrying a formal status since 1986. Additionally, three expressions are commonly employed to describe health interventions: public health, community health, and health promotion.

Upon being invited to contribute to this themed issue on community health promotion, the author's immediate reactions were two-fold. First of all, there was a desire to discover how the Consortium managed to define this new concept. The answer can be found at the beginning of this issue, although the communiqué issued by the Consortium at the beginning of 2006 (Nishtar et al., 2006) still leaves one perplexed¹, and makes the present article all the more pertinent. Secondly, the author questioned the relevance of introducing a new definition for health interventions, since no one has yet really succeeded in defining the three processes that already exist. Introducing a new concept without

having ever really succeeded in clarifying older ones puts us at risk of being subjected to critics' accusations, branded as 'wind-bags' (Fassin, 2000a, p.71). It can also lead to more confusion than clarification, as was the case in Canada when the term 'population health' first appeared. The objective of this article is, therefore, to attempt to differentiate the three types of health practices generally encountered in the literature and in the field, in order to situate the term 'community health promotion' and demonstrate that health promotion must take the lead in the fight against social inequalities in health.

An attempt to differentiate practices

Following the example of Rootman et al. (2001), it was considered useful when attempting to establish definitions to distinguish between the process and the goal of a practice. Examples drawn from the author's personal experiences and knowledge of Canadian, French, and African practices are used to support the arguments presented here.

End Goal

Public health and community health generally share a common goal: improving the health status of people, taken as a group and not individually. Many examples could be given of public policies from around the world that share this objective. Curiously, and since it is rare enough to merit specific attention, the first health policy of Quebec

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Table 1. **Attempt to differentiate public health, community health, and health promotion**

	Process	End Goal
Public health	Technocratic	Improve population health
Community health	Participatory	
Health promotion	Empowerment	Reduce social inequalities in health

Source: Author

had a similar goal; however, it was framed negatively: the policy proposed 19 objectives to “*reduce health problems*” (Ministère de la santé et des services sociaux, 1992). This was later revised based on national public health priorities to “*make substantial gains in health matters*” (Ministère de la Santé et des Services sociaux, 1997), which serves as a reminder of the debate on the ‘positive’ versus the ‘negative’ definitions of the concept of health.

The definition traditionally found in public health training manuals follows Winslow’s proposal from 1920 and defines public health as the art and science of promoting health, preventing disease and prolonging life (Fournier, 2003). This article, however, advocates a definition that goes beyond the famous three ‘Ps’ and focuses more on process than on the goals of promotion, prevention and protection, which were the foundation of public health priorities in Quebec from 1997 to 2002. Thus, more in-depth reflection on the teleological level is needed in order to understand the ultimate purpose of health promotion activities. A real paradigm shift is boldly proposed by affirming that health promotion seeks not only to improve the health of the population, but above all to reduce the gaps in the health status among population subgroups. Indeed, the Ottawa Charter states that, “*Health promotion focuses on achieving equity in health. Health promotion action aims at reducing differences in current health status*” (OMS, 1986). This paradigm shift also makes it possible to differentiate health promotion from previous endeavours to establish definitions, since Conill and O’Neill (1984) proposed the objective of community health to be the *improvement in the health status of the population*, making no mention of social inequalities in health. This distinction seems essential, since most interventions that do not specifically aim at reducing disparities almost always end up aggravating them, even when the goal of improving the health of the population is achieved (Fassin, 2000b, p. 33). This was the case for the residents of Montreal (Lessard, 2003). Adopting this definition means questioning beliefs, which are a central notion in the Khunian concept of a paradigm. Health promotion is thus conceived as an under-

taking whose ultimate purpose is social change. If a new ‘*new public health*’ (Horton, 1998) needs to be created in order to achieve this, then so be it. Perhaps this may not be necessary, as will be explained below, since the Ottawa Charter of the *new public health* already contains the objective of reducing inequalities.

Process

In contrast to the view of Conill and O’Neill (1984) who believe that community health can have two poles, one technocratic and the other participative, the author maintains that these two poles actually constitute the distinction between the implementation process in public health and the one in community health. The process of implementing public health interventions seems to correspond to a technocratic top-down approach. If public health stakeholders agree with their counterparts in community health on, for example, encouraging individuals to change their lifestyles or behaviour, the former will use more coercion than the latter in attempting to achieve this change. Terms such as ‘risk factor’ and its corollary ‘victim blaming’ (Lupton, 1995) are characteristic of public health, where the health system, health education and prevention are the biggest budget recipients. In France, the history of public health (Abenheim, 2003), as well as the quarrels about the creation of the National Institute for Prevention and Health Education (INPES), and the recent legislation in 2004 on public health, are all very indicative of this approach, which is centred on prevention and the health care system, and is run by a centralized or decentralized administration. Epidemiology and an evidence-based approach are the cardinal tools of public health, with physicians occupying a central place in the system. There are some authors who directly refer to the work of Weber and even maintain that the only authority really known to public health is rational-legal, based on law (Jaffré & Olivier de Sardan, 1999, p. 364). Regardless of whether this is representative of the history of public health, Fassin’s analysis (2006) of the “double model of constraint and normalization, authoritarian control and moralizing intervention” in

South Africa is the technocratic process paragon since “on many occasions public health has served the racist political project of South African authorities” (p.211). In Africa, health promotion is a relatively unknown concept (Nyamwaya, 2005); public health has the monopoly on words and practices for numerous reasons which would take too long to explain here (Ridde & Seck, 2006).

Community health practitioners, on the other hand, place population participation at the centre of their interventions and the emic point of view is supported. Certain health centres in the United States were pioneers in community medicine practices in North America in the 1960s (Lefkowitz, 2007), as were those of social medicine in certain health centres in South Africa in the 1940s (Fassin, 2006). There is recognition of the relationships between certain individual practices and the triggering of particular pathologies. At the same time, emphasis is placed on understanding the social and structural conditions that can give rise to such practices. Members of the community participate in defining the problem, finding solutions and implementing them. Epidemiology and statistical tools are not ignored, but they are not the only methods used, and the epistemological approach is more constructivist. Planning models using this triangulation of methods (Green & Kreuter, 1999), such as the model applied in Quebec from 1980-90 (Bergeron & Gagnon, 1994), and the one in Belgium (Bantuelle et al., 1998), are good examples of the community health process.

Health promotion interventions are based directly on the approach outlined in the Ottawa Charter. Actors thus attempt to implement a process that provides populations with the means to ensure greater control over and improve their own health (OMS, 1986). This is the concept of ‘empowerment’, which is a guiding value in health promotion but will not be discussed here for reasons of spaceⁱⁱ. Empowerment actions and interventions appear to produce highly effective results in health improvement (Wallerstein, 2006). Evidently, this approach has its critics; in Lupton’s view (Lupton, 1995, p.60), the rhetoric of empowerment serves to obscure public health professionals’ investment and interventions by persuading certain groups to develop their competencies and exercise control over their lives.

The attempt to differentiate these three types of practice is summarized in Table 1-again, this is only an attempt. The distinctions must not be perceived as being set in stone and these characteristics are only highlighted *a priori* in order to force the traits necessary for creating a Weberian ideal type.

Table 2. Inequalities in the use of the health system and mortality in Manitoba, Canada

Indicators	Poor/rich ratio	
	1986	1996
Number of days in hospital	1.40	1.38
Admission rate to hospital	1.31	1.32
Mortality rate from all causes	1.21	1.42
Pre-mature mortality rate	1.39	1.85

Source: Adapted from Ross et al. (2005)

Health promotion must address social inequalities in healthⁱⁱⁱ

In 1988, the Director General of the WHO was already concerned that, “*public health has lost its original link to social justice, social change and social reform*” (Hancock, Labonte et al., 1999). Twenty years later, this fact remains the same. Furthermore, health promotion must recover its original role and challenge social inequalities in health. Stakeholders need to understand that health planning is not simply a technical exercise, but can also be a tool for bringing about social change. This responsibility for action and advocacy must be entrusted to those in the field of health promotion. Besides the fact that public health practice, which is several centuries old, has not been able to eliminate the inequalities in health^{iv} that persist to this day (Mackenbach, 2005) – and which have been measured statistically ever since the 17th Century – three arguments, among others, may be used to support this case. The first two arguments are based on the ineffectiveness of the approaches that characterize public health and community health, i.e. actions generally centred on the health system and health education, for which effects are now well-known. The last argument in favour of health promotion is more political in nature since there is not yet sufficient evidence of its effectiveness, due to the fact that work in this area is very recent (Hills, Carroll et al., 2004).

The Health System

For a very long time, and even today, people have believed that the health system is able to improve the health of the population and reduce disparities in mortality rates among sub-groups. The former French Minister of Health thought that the duty of public health basically involved nothing more than modernizing the organization of health services (Mattei, 2002). Section 2 of the Public Health Act, promulgated in France in 2004, states that the reduction of inequalities in health may be achieved through health promotion and by developing access to care and to diagnostics throughout the country, which no doubt explains why 97% of the health budget is allocated to the care system (Abenheim,

2003). Budget allocation is not any better in Quebec. The expression ‘health promotion’ only appears in French legislation twice: in the above-mentioned section and as a reminder of the mission of the INPES; the latter mention, however, has not resulted in the word ‘prevention’ being replaced by ‘promotion’ in the name of this public entity. According to French researchers, health policy essentially views the reduction of social inequalities in health in France from the angle of primary access to care (Pascal, Abbey-Huguenin et al., 2006, p.118).

Nevertheless, numerous studies have shown that if the health system and medicine can have an effect on the health of *individuals needing care*, they have no or very little effect on *population health*. Due to lack of space, this subject cannot be developed here, but readers are referred to the classic references on the topic (McKinlay & McKinlay, 1977; Ashton & Seymour, 1988). Furthermore, the health system and medicine can also have harmful effects on the health of individuals. In France alone, it is estimated that 18,000 people die each year from the side effects of medication (Abenheim, 2003). In the United States, medical errors cause 98,000 deaths annually (Institute of Medicine, 2000).

Given the limited evidence of the health system’s effects on the population, what evidence is there that the system reduces social inequalities in health? Although work on this topic is rare, recent research carried out in the province of Manitoba in Canada sheds some light on the subject. As is the case elsewhere in Canada, the health system in Manitoba is largely funded and administered by the public sector. A study on the data of the hospital use from 1986 to 1996 seems to show an equitable health system usage since the poorest, who *a priori* have the greatest needs, spent 40% more days in hospital and represented 30% more of hospital admissions than the richest. This difference in use, which favoured the poorest, remained constant over a period of ten years. However, examining the disparities in mortality rates for this same period shows that, not only does the situation remain unfavourable for the poorest,

but the gap has widened to their detriment (Table 2). In other words, although health system usage has been equitable (in terms of need, rare evidence contradicts the “inverse care law”), social inequalities in health have not been reduced. There was also evidence that a 40% reduction in hospital beds has had no effect on population mortality indicators.

Health Education

The second argument concerns the impossibility for health education alone to successfully reduce social inequalities in health. Raising this issue is especially crucial for France and the United States, where health education continues to play a dominant role in overall health strategies (O’Neill & Stirling, 2007). Developing interventions that reduce inequalities in health would be no mean feat, and it could even be claimed that this would constitute a logical contradiction. Rose (1985) explains the importance for prevention activities to target the population as a whole rather than just high-risk groups. He maintains that when a risk factor is normally distributed in a population, reducing its influence will bring about greater change in the general health status of the population than if interventions are solely directed at high-risk groups. Conversely, to complicate matters even further, it is a known fact that when interventions targeting harmful health behaviours are directed at the population as a whole, these interventions appear to have a much greater impact on the most favoured social groups (Whitehead, 1995), thus contributing to increasing inequalities. Some specialists transpose Rose’s propositions to social inequalities in health (Douglas & Scott-Samuel, 2001; Marmot, 2001). For these experts, the determinants of individual differences are dissimilar from the determinants of disparities among population sub-groups. Targeting interventions to increase average life expectancy or to reduce disparities therefore remains tricky. Based largely on English research findings, Paquet and Tellier (2003) affirm that, even if the whole population adopted healthy lifestyle habits, overall life expectancy would increase, but the health gradient among social classes would still persist. In summary, on the one hand, in order for health education to be effective, it is better to act on the population as a whole in order to improve overall population health; this, however, carries the risk of increasing inequalities. On the other hand, interventions targeted directly at individuals or certain sub-groups, rather than at the overall population, can provoke increased feelings of exclusion and there are high risks of stigmatization.

Health Promotion

The third argument for reducing social inequalities in health through health promotion is more political in nature than the two preceding arguments. The argument is inextricably linked to the commitment of professionals working in the field of health promotion. The ineffectiveness of public health and community health in reducing disparities in health can be partly explained by the fact that neither one has been willing to take up this challenge, whereas the new public health has boasted of its novel approach in taking all health determinants into consideration. Fassin argues about the existing difficulty getting beyond the rhetoric and refers somewhat harshly to windbags who do nothing (2000). According to Gepkens and Gunning-Schepers (1996), interventions which were meant to reduce inequalities in health tended to be based more on the traditional and reductionist approaches of health education than on newer proposals of holistic action based on the five pillars of health promotion. Now, almost twenty years later, health promotion must reclaim its original role and become a catalyst for raising questions about the permanence and invisibility of social inequalities in health, at least in France, claims Drulhe (2000). It appears that this moral and ethical necessity is not yet really taken seriously (De Koninck & Fassin, 2004; Ridde, 2004a, 2004b; Bernier, 2006). This would explain why public health and community health still take precedence over health promotion, as is evidenced by the call for experts of the French Public Health High Commission, which excludes specialists in health promotion.

Why should health promotion bear the burden of redressing inequalities in health instead of public health or community health? Simply because the field of health promotion has judiciously ensured that it has a Charter which includes this objective, whereas the other two fields do not. In the 1978 Declaration of Alma-Ata, inequalities in health were formally acknowledged, but their reduction was not an essential objective: "Attainment of the highest possible level of health" (Section 1) was affirmed, but not the reduction of inequalities in health (WHO, 1978). In contrast, the Ottawa Charter affirms that, "Health promotion action aims at reducing differences in current health status" (OMS, 1986). This requires implementation of a process of equity and social justice, one of the six principles underlying health promotion initiatives (Rootman, Goodstadt et al., 2001). One of the documents produced by WHO Europe, as part of the preliminary reflections on the Ottawa Charter, clearly stipulates that reducing inequalities is an integral objective of health

promotion. A European task force recently studied the question of health promotion interventions that are effective in reducing health inequalities, taking for granted that this is the role of health promotion (VIG & ENHPA, 2001).

Attributing this role to health promotion appears to correspond to its mandate of social change and strengthening citizen power to take action on the determinants of health, especially when it is conceded that health inequalities are the result of social and political structures. However, this does not mean that health promotion activities must all be held responsible for reducing disparities in health; that is not an easy task. Through advocacy and the capacity to influence healthy public policy, health promotion must take leadership to advance equity in health.

Conclusion

This attempt at differentiating the three types of practice serves to underline the vital role of health promotion in reducing social inequalities in health through the cardinal value of social justice and the use of empowerment as a fundamental process. From a practical point of view, this means that questions need to be raised in two areas. Firstly, health promotion planners must now examine the objectives they set to ensure these objectives are not aimed only at improving the overall health of the population. At best, this only replicates inequalities and, at worst, it exacerbates them. Secondly, once the objective has been reviewed and the actions initiated, there is a need to gather and evaluate the evidence of their effectiveness in reducing social inequalities in health; this will in result open new theoretical, conceptual, and practical fields of work (Ridde, Delormier et al., 2007).

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Notes

- i. Due to limited space, a detailed analysis of the communiqué will not be given, but certain key elements should be noted in the context of this article. Firstly, in French, the expression 'promotion de la santé communautaire' is liable to create more confusion than its English equivalent, 'Community Health Promotion'. In French, the placement of the caesura in the expression could lead to a reading that is diametrically opposed to the Consortium's mandate. Thus it could refer to either promoting community health, or to promoting health with emphasis placed on the role of the community. Secondly, the communiqué itself leads one to believe that it is this latter sense that is meant by the members of the Consortium. However, the arguments are not really convincing and do not sufficiently permit community health promotion (CHP) to be distinguished from health promotion (HP), as outlined in Ottawa in 1986. The values and the strategic and operational parameters that are described are those of HP, unless it is thought that HP does not concern communities. The term CHP is sometimes not used in full so it is unclear whether CHP or HP is meant; for example: "*This initiative recognizes that health promotion...*" (p.53); "*It is essential to include health promotion in policies...*" (p.53). Lastly, the Consortium has decided to "*promote the application of participative methods*" (p.54). If the distinction proposed in this article between the process used by community health (participatory) versus that used by HP (empowerment) is accepted, confusion will reign because participative methods are the hallmark of community health. Consequently, the Consortium will be promoting community health practices and not health promotion practices centred on the community. There is much confusion that needs to be cleared up. That is the purpose of this special issue and the author is happy to contribute to a better understanding of community health promotion (Nishtar et al, 2006, p.54).
- ii. See the edited author's special issue in the *Canadian Journal of Program Evaluation*, 2006, vol. 21 (3).
- iii. This section develops ideas broached in another article (Ridde, 2005).
- iv. Research to gather the evidence of the existence of health inequalities is much more common than research on how to reduce inequalities. France is among the countries that is most behind in this area in Europe; Quebec does not fare much better. At the same time, France, paradoxically or consequently, is the country where disparities in health between manual and non-manual workers are the greatest in Europe.

Lessons learned from the application of a participatory evaluation methodology to Healthy Municipalities, Cities and Communities initiatives in selected countries of the Americas

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Abstract: Health promotion has made significant strides in the past few decades in the Americas. Creating a healthy and supportive setting, also known as the settings approach, continues to be one of the most widely used health promotion strategies. Interest in evaluating the effectiveness of these strategies has been increasing greatly in the past few years. Participatory evaluation holds great promise for helping to generate this evidence and promote understanding of the factors that affect, positively or negatively, the advances of health promotion in the Region. During 2004-2006, a Participatory Evaluation methodology was introduced into several countries in the Americas through formal trainings conducted by the Pan American Health Organization (PAHO) in collaboration with country partners. This article summarizes the main lessons learned from the application of the participatory evaluation methodology in various countries in Latin America and the Caribbean. Factors affecting the evaluation of the initiatives were identified at multiple levels (individual, community, organizational, political, economic, etc.). Specific issues that were addressed included the political context, turnover of personnel in key institutions, concerns related to the effectiveness of participatory processes, and the existence of strong and sustained leadership at the country level. These factors are intertwined and affect each other in very complex ways, a fact that was reflected in the municipalities' experiences with participatory evaluation. Challenges included the ability to secure resources for the evaluation, the time needed to conclude the process, and working in an intersectoral manner. However, participating municipalities reported that the process of implementing a participatory evaluation and working with various stakeholders had an empowering effect: communities and stakeholders were more willing and interested in participating in health promotion initiatives in a sustained manner; alliances and intersectoral collaboration were strengthened; communication channels were opened; and municipalities were stimulated to review their planning and implementation processes in order to more appropriately incorporate health promotion principles. The article concludes with recommendations to improve the planning and implementation process of participatory evaluation efforts. (*Promotion & Education*, 2007, (2): pp 68-73)

Key words: health promotion, healthy municipalities, communities, participatory evaluation

Résumé en français à la page 115. Resumen en español en la página 126.

The First International Conference on Health Promotion in Ottawa, Canada, in 1986 produced what has since become known as the Ottawa Charter for Health Promotion (PAHO/WHO, 1986). Since then the health promotion strategy has been accepted and utilized as a central element in community development processes. As a result, in the last 3 decades, governments and international organizations have significantly increased their investments in health promotion programs.

The concept of health promotion has shifted from a focus on disease prevention in the 1970s, to the recognition of the need for complementary interventions (such as healthy public policies), to incorporate other sectors, and to create healthy environments in the 1980s and 90s. In the past few years, the concept of health promotion has broadened to include the determinants of health, global movements of social change and the need to invest and strengthen leadership in health promotion.

Health promotion today focuses on addressing the multiple determinants of health. These determinants are both within individuals' control (such as personal practices and behaviors and accessing serv-

ices), as well as outside it (such as physical and social environments, education, income and social status, housing, access to food, social support networks, and working conditions, etc.). These determinants do not act in isolation of each other, but rather interact in very complex ways.

Creating a healthy and supportive setting, also known as the settings approach, continues to be one of the most widely used health promotion strategies. The healthy settings approach is based on the premises that determinants of poverty and equity, and their influence on health, can be addressed through creating sustainable public policies and laws, developing supportive environments, building public-private partnerships, strengthening networks, mobilizing means of communication, and promoting an active role of municipal and local governments in health promotion and development.

The Healthy Municipalities, Cities and Communities (HMC) strategy

The HMC movement is an example of the application of health promotion principles at the local level. The Pan American Health Organization (PAHO) developed

and introduced the HMC Strategy in the 1990s to improve and promote local health and development in the countries of the Americas. This Strategy is being actively implemented in 17 of the 38 countries of the Americas.

An HMC is one that ensures continuous improvements in the conditions that affect the health and wellbeing of its members. This is achieved by facilitating joint action among local authorities, community members and key stakeholders towards improving their living conditions and quality of life. More than just addressing the consequences of disease, the HMC Strategy focuses on the determinants of health, and supports the processes that enable community members to take control over their own health and quality of life, and to participate in the development of an HMC (PAHO, 2002).

HMC is based on the premises that one, various systems and structures governing social, economic, civil and political conditions, as well as physical environments, can impact individuals' and communities' health; and that two, health is inherently linked to individuals' capacity to act in the community and society to which they

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belong. An HMC strives to create a synergy between two premises: promoting individual actions and societies that respond supportively. The ultimate goal is to support processes that enable people to take control over their own health while improving equity, social participation, accountability and responsive local governance.

Evaluating the HMC strategy

The evaluation of health promotion strategies such as HMC has been recognized by the international community as necessary in order to strengthen the capacity of institutions and communities to promote measures that are coherent with the needs and priorities of the population. Thanks to the HMC strategy, countries of the Americas have gained considerable experience with innovative ways of translating health promotion into local action. However, there is little documentation about these experiences and even less about the results achieved.

Health promotion strategies, such as HMC, generate real benefits for people and their environment. It is of particular importance to be able to show these benefits to decision-makers so that they will be willing and motivated to set aside resources to support health promotion programs and activities. The evaluation offers many opportunities to create and disseminate evidence that demonstrates strengths, weaknesses, consequences, and impacts resulting from the development and implementation of these strategies.

The evaluation of these initiatives will also provide stakeholders with the opportunity to better know their community and its resources, and to reflect on the progress of their efforts. This will, in turn, support better design and management of health promotion initiatives in the context of community health resources, as well as create accountability related to what has been proposed and redirect efforts when needed. Given the intersectoral and interdisciplinary nature of health promotion, it is also expected that the evaluation process will create opportunities for collaboration among sectors, improve multidisciplinary dialogue and strengthen participatory efforts within HMCs.

The participatory evaluation of HMC initiatives

In very simple terms, evaluation means collection, analysis, interpretation and reporting of information, and using the results for decision-making. Like health promotion, in the past few decades, the concept of evaluation has also greatly evolved. The goal of evaluating health promotion strategies shifted from the evaluation and

monitoring of projects and interventions, to more complex, thematic and interdisciplinary evaluations.

The implementation of health promotion programs highlighted the need for more flexible and participatory evaluations; ones that reflected health promotion principles as well as the complexity of local development and participatory experiences. This new approach required multiple measures and methods in order to evaluate changes in areas such as governance, social participation, social impact, equity, sustainability, etc.

Instead of judging the success or failure of an intervention or a project, this new approach focused on understanding local realities and on continuous learning. Evaluation, hence, shifted from something done by “outsiders” to a collaborative and participatory endeavor.

It is in this context that the concept of participatory evaluation develops. In a participatory evaluation, the key stakeholders are involved in all phases of the process, including the design, implementation, management, interpretation, and decision-making about the evaluation and its results. A participatory evaluation implies more than the application of participatory techniques to conventional approaches and methodologies for monitoring and evaluation. It requires:

- Participation of key stakeholders in all phases of the process.
- Negotiation and consensus about what to evaluate and how results will be interpreted and utilized.
- Continuous learning that results in capacity building and incorporation of lessons learned in the decision-making process.
- Flexibility to adapt to a continuously changing environment.

Participatory evaluation is considered to be the most appropriate methodology in the context of HMC initiatives because it reflects the principles of the HMC strategy, recognizes the complexities of HMC as a local development initiative, and facilitates the development of capacities, learning and empowerment. As such, participatory evaluation stimulates autonomy and community self-determination as it allows communities to improve their ability to resolve their own problems (PAHO, 2006).

It is expected that the implementation of a participatory evaluation will create opportunities and give voice to a broader range of stakeholders, encouraging them to take ownership of the evaluation process. When conducted in a truly participatory manner, this type of evaluation promotes accountability and motivates continuous and active participation from all stakeholders.

Processes that are based on the commitment and dedication of all stakeholders are likely to create a sense of common interest among those involved and to produce positive changes in their community.

However, the participatory evaluation methodology presents some challenges. As with most collaborative and participatory endeavors, participatory evaluation can be time-consuming, since the process requires bringing together and building consensus among people from various backgrounds, sectors, institutions and groups, that often bring to the table different, if not conflicting, needs, agendas and interests. This emphasizes a need to clarify roles, responsibilities and the evaluation objectives and processes. The participatory evaluation also requires leadership from people with strong facilitation skills as well as people with openness to collaborate, to listen and to take into consideration their colleagues' perspectives, needs and interests. Because it is an open and flexible process, participatory evaluation has no predetermined plan. As a result, this approach may be perceived as less effective and objective and can be unsettling to those who are used to working with traditional evaluation approaches.

PAHO's participatory evaluation initiative

In 1999, PAHO established a Healthy Municipalities Evaluation Working Group, comprised of evaluation experts from various international institutions. The Working Group agreed that specific evaluation tools, frameworks and evidence of effectiveness were needed to support health promotion and similar initiatives. Building upon these recommendations, the Evaluation Working Group has developed a series of evaluation tools, among them, a *Participatory Evaluation Guide for Healthy Municipalities, Cities and Communities*.

The Guide provides recommendations on evaluation processes and tools, as well as a mechanism to showcase and document the rich, extensive, and varied experiences and results related to the HMC strategy. It offers an evaluation framework that incorporates essential HMC and health promotion elements such as intersectoral collaboration, social participation, capacity building and community capacity, among others. The methodology allows for the documentation and analysis of changes and accomplishments in terms of processes, outcomes and results, and guides users on how to act on the results to improve their HMC initiative.

During 2004-2006, the Participatory Evaluation Guide was introduced into several countries in the Americas through formal trainings conducted by PAHO in collabora-

tion with country partners. Participants in these trainings included staff from the Ministry of Health (MOH) and other key ministries (such as education) at the national as well as state levels; representatives from NGOs, universities, and funding agencies; health workers; municipal staff and authorities; community organizations and members. Following the trainings, several communities in various countries of the Americas applied the participatory evaluation methodology to their HMC initiatives. Follow-up questionnaires were sent to workshop participants every 4 months during 2005-2006 to collect information about the activities taking place as a result of the training received. During this period, countries also submitted reports to PAHO and/or published their experiences with the application of the participatory evaluation methodology.

Lessons learned from the application of the Participatory Evaluation Methodology

This section presents the main lessons learned from the application of the participatory evaluation methodology in Brazil, Dominican Republic, Honduras, Mexico, Peru and Trinidad and Tobago. This information was compiled from reports submitted by the countries to PAHO and from the follow-up questionnaires completed by workshop participants.

1. Take into account the political context and timing

Given the strong emphasis of initiatives such as HMC on the active involvement of local authorities and the public sector, the political context and timing was by far the most important factor affecting the implementation of participatory evaluation in the participating countries. Election periods and political transitions often caused major delays (if not termination) of initiatives, shortage/change of personnel and funds, and great uncertainty about the future of the initiatives, and their evaluation.

In Honduras, for example, plans to conduct participatory evaluations that were incorporated into the municipalities' strategic plans for 2006, were suspended after the local elections and the political changes that took place in that year. Many of the people spearheading the process were removed from their posts. Workshops in the participatory evaluation methodology in municipalities were also suspended due to administrative problems in State Health Secretariats caused by this political transition and the turnover of key personnel.

The political timing of the application of the Participatory Evaluation Guide in the Campinas Region of the State of São Paulo,

Brazil, was also reported as «sensitive», since it occurred right before elections. This generated uncertainty about who would still be present to follow-up on the initiatives, or even if initiatives would be continued (Sperandio et al. 2006).

The experience in the Dominican Republic underscores this difficulty. Even though plans were in place to conduct the participatory evaluation in 10 municipalities during 2006, local elections took place resulting in significant changes of municipal authorities and staff. As a result, efforts had to be redirected to introduce and seek support for the HMC initiative and the participatory evaluation from the newly elected and re-elected officials.

These moments of political/administrative transitions can have considerable impact on the work being conducted at the community level. It causes delays and losses (including financial) since the time necessary to explain and get agreement on the continuation of programs can be lengthy. This has consequences for the evaluation of programs under implementation, but especially for programs conducted by a previous administration that do not continue under the new one.

These experiences demonstrate that the transitory nature of local and national political contexts can weaken programs and public policies, particularly when there is a change in political parties. This emphasizes the need to form a strong coalition among all sectors of society to strengthen and sustain the HMC initiatives and their evaluation (Sperandio et al, 2006). Having a strong and broad base of support can provide continuity and sustainability to HMC initiatives and their evaluation during these transitional periods.

2. Aim for a truly intersectorial process

Incorporating a variety of local partners (MOH, NGOs, universities, community members and community-based organizations, etc.) was important for the sustainability of the HMC initiative and its participatory evaluation in the countries. It is crucial, however, to get buy-in from the main stakeholders in order to begin and sustain the implementation of the participatory evaluation methodology. Lack of support from critical stakeholders, such as municipal program managers or key personnel at public institutions can seriously deter or isolate the advancement of the initiative.

In the experience of Vila Paciencia, in the State of Rio de Janeiro, Brazil, it was difficult to coordinate the activities with the public sector, due to the communities' «historical social isolation and lack of citizenship rights», which was marked by «struc-

tural oppression and violence.» (Becker et al., 2006). As a result, it was not possible to include a representative from the public sector in the evaluation process, given its demonstrated lack of interest in the community. In addition, a weak community organization could not ensure that the community had a voice and, as a result, formal participation from the community association was weak. Even though this did not impede the conduct of the participatory evaluation by other stakeholders involved in the community (NGOs, universities, etc.), it kept the process isolated from the broader community context since it was unclear whether the evaluation results and conclusions would be taken into consideration by all relevant stakeholders.

However, as the Vila Paciencia experience reported, the implementation of a participatory evaluation methodology forced the group to confront these difficulties and to reflect on possible courses of action: «the participatory evaluation's emphasis on intersectorial collaboration contributed greatly to understanding local politics and the role of different actors (public, private, community, etc.), thereby providing a reference for discussions and decision-making» (Becker et al, 2006).

Upon realizing the above, the group decided to create a new intersectorial group focused on the construction of a new community kitchen. The new group includes representatives from the local public sector (municipal education and social development, state's social assistance), as well as community members. The weak community participation also required concerted efforts focused on the process of getting the community organized. The new actors have demonstrated interest in participating in the evaluation process. It is expected that working on the evaluation will help to strengthen the work of the new intersectorial group and favor the sustainability of the Vila Paciencia initiative (Becker et al., 2006).

3. Conducting a participatory evaluation takes time, but it is worthwhile

All countries reported that the participatory evaluation process was lengthy and time consuming due to various factors. It is necessary to bring together and guarantee the buy-in from people from various backgrounds, sectors and interests. These people bring to the table different perspectives and paradigms. They often come from institutions and organizations with rigid and bureaucratic structures and work cultures.

As it happens in processes that emphasize community and multi-sector participation, the various levels of knowledge and literacy among those involved have to be taken into account. Experiences in Brazil,

Peru, Dominican Republic and Trinidad and Tobago all noticed that different levels of education among the community leaders was a challenge to implementing the evaluation.

It is important to recognize the time needed for institutions, organizations and individuals to adapt and accept a new methodology and paradigm that can greatly change how they function and work, such as a participatory evaluation. In many cases, given the appropriate time and stimulation, people become motivated and apply dedicated efforts to implementing these new programs and methodologies.

For example, the participatory methodology was new to most of the health secretariats of the participating municipalities. This often generated an internal movement across public institutions to discuss the new concepts and assess degree of agreement among staff in order to incorporate the new methodology into existing programs, with particular emphasis on intersectoral collaboration and guaranteeing social participation in actions and decision-making processes. This is a slow process as it needs to take place through meetings, forums and discussion groups, and requires linking various levels of administration, breaking existing paradigms, and dealing with individual and collective resistance (Sperandio, 2006).

Respecting the time needed to achieve this acceptance in public institutions and among their staff was critical in order to put in place programs that were consistent with the communities' expectations, making optimal use of resources, adopting approaches that were more consistent with health promotion practices, and improving personal motivation among public staff and other stakeholders.

This initial process also served as an opportunity to strengthen alliances and trust among participants and their institutions (for example, municipal managers, representatives from the community and NGOs). As reported by the experience of communities in the Northeast of Brazil, these new alliances "encouraged an innovative way to promote local empowerment and equity" (De Sá et al., 2006).

Since preparing for and using participatory processes takes time in order to work effectively and even longer to demonstrate results, often, due to political pressures and impending changes in government, countries will bring in evaluators external to the community to conduct an outside and non-participatory evaluation. Although this produces useful information and results, it does not have the same empowering and long-lasting impact of the more participatory processes. It also does not guarantee

that the information collected and analyzed and the lessons learned will be shared with the community.

4. Set aside resources for evaluation

Lack of sufficient resources have in many cases limited or interrupted the participatory evaluation process. The allocation of scarce community resources to conduct a participatory evaluation was a common problem. This was often the result of a general lack of understanding about the effectiveness and the usefulness of the results generated on the part of program managers and others responsible for funding and budget.

This underscores the importance of continuously educating about and raising awareness of the importance of health promotion in promoting equity and better health for all, and the need to establish adequate funding and structures for its evaluation. This includes the need to educate stakeholders on the benefits and the appropriateness of participatory evaluation in producing key information for decision-making at all levels.

Analysis of previous international experiences supports the allocation of a minimum of 10% of total program resources to ensure the development and implementation of evaluation in health promotion (PAHO, 2005). It is important to advocate for the establishment of a fund for health promotion evaluation from the initial planning stages of any initiative (PAHO, 2005).

5. Reach consensus on the definition of key concepts

It was common for the participating countries and the stakeholders to report a general lack of understanding about the concept of health promotion (often considered an approach to disease prevention) and the participatory evaluation methodology. This can have a direct impact on the planning of the evaluation since how people understand key concepts will shape the design, data collection, analysis and presentation of results of the evaluation.

There were also doubts about the benefits of conducting a participatory evaluation, mostly related to the time it takes to conduct the process and the usefulness of the data it will produce. As a result, it was not uncommon to face resistance by those in key institutions in applying a participatory evaluation methodology that, as they understood it, did not emphasize results and project evaluation.

It is important to address these concerns and take into account the challenges faced by stakeholders coming from institutions with rigid and bureaucratic structures, that very often do not have a policy to coordi-

nate with other institutions or to work in an intersectoral manner, and who are often unwilling to share information.

6. Address concerns related to participatory processes

Concerns about working with the community also came up in some instances, often in the form of fears of receiving negative comments and prejudice against actions taken with "too much" input from community members. Representatives from public sectors in some cases were apprehensive that the process would generate "unrealistic demands" on the part of community members or negative criticism. This was particularly true of communities that were not well represented, in which, traditionally, programs and approaches were implemented from the top-down and truly representative and participatory mechanisms for community participation were scarce or non-existent. Often efforts had to be re-directed at organizing the community, and raising awareness about the real meaning of "participation" among the stakeholders.

7. Institutional context and individual factors

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

Personal and professional interests, low technical capacity of personnel, and concerns that participatory evaluation would only lead to a heavier workload that would not necessarily translate into «benefits» for their immediate work also affected people's interest in investing in the process.

Of all challenges, the high turnover of personnel at all levels and institutions was by far the most disruptive and difficult to deal with since it could seriously impair the continuity, feedback and appropriate application of the participatory methodology. Brazil, Peru, Mexico and Trinidad and Tobago all indicated the difficulties faced when changes took place of key personnel (particularly within the Ministry of Health) involved with the health promotion initiatives and their evaluation. Public sector personnel are frequently transferred to another State or unit/program within their institutions and it is often the case that in their new posts they are no longer in a position to follow through with the initiatives for which they were previously responsible.

In Trinidad and Tobago, for example, a series of training workshops in participatory evaluation were planned for MOH/Regional Health Authorities staff and community members but had to be postponed due to limitations caused by institutional changes. This activity is suspended until further notice, until other national counterparts are assigned by the MOH. Changes in key personnel were also responsible for the cancellation of participatory evaluation workshops in Honduras.

On the positive side of working with institutions, the experience in Peru reported that the process of participatory evaluation has opened channels of communication with other levels and sectors providing valuable inputs into the annual evaluation of the Ministry of Health. This has resulted in an improved organizational climate and opened a space for exploring new modes of intersectoral collaboration (Red de Municipios Saludables del Peru, 2004).

Working with institutions also offers the opportunity to regularize processes and methodologies within their work plans, programs, etc. Given institutions' far-reaching structure and linkages with other groups and institutions, this has the potential to promote and support the implementation of health promotion activities, their evaluation and the allocation of resources for these priorities. Another example is that of the San Marco University, a public institution in Lima, Peru. The participatory evaluation methodology was incorporated into the curriculum of their health promotion certificate program, which provides the opportunity to build capacities and increase technical knowledge among professionals working in the field.

8. Strong leadership is central to the sustainability of the evaluation initiative

A common determinant of successful experiences with the participatory evaluation in the countries was the existence of strong, sustained and dynamic leadership to take the process forward. Active commitment and engagement from institutions both at the local and national levels is key to the success of the initiative, as is collaborative work among these institutions.

The role of national and regional HMC networks can be central in these efforts, giving their potential far-reaching connections to municipalities throughout a country or region, as well as their connection with key stakeholders that can support the evaluation process. Gaining the support and working through national and regional HMC networks greatly supported the advancement and sustainability of the evaluation initiative in countries such as Brazil and Peru.

In Peru, the AMARES Project, a program supported by the European Union, the Peruvian Network of Healthy Municipalities and 7 regional Peruvian networks are collaboratively developing a database of baseline data which, in turn, is generating a great deal of baseline data that will be critical to support evaluation efforts in the future.

9. Conducting participatory evaluation can be alone an empowering process

There was an empowering effect of applying a participatory methodology – communities and stakeholders were more willing and interested in participating and maintaining this participation. The process of planning and implementing a participatory evaluation provided a very rich opportunity to discuss, exchange and reflect on countries' experiences with the HMC Strategy.

Most countries reported that these planning discussions brought to light the various interpretations that participants gave to health promotion concepts and principles. Participants quickly realized the implications of these differences for the planning and implementation of the evaluation methodology and the importance of reaching consensus among the group members. This resulted in a productive and positive dialogue among participants to reach consensus on the various concepts and principles utilized in their evaluation processes.

This process also stimulated participants to take into account different aspects of health promotion that had been overlooked in previous evaluation efforts. This brought up a "difficulty" since many realized that their HMC programs were not taking into account some of the health promotion principles (for example, programs were not intersectoral). This is stimulating many municipalities to review their planning and implementation processes in order to more appropriately incorporate health promotion principles.

Conclusions

Health promotion has made significant strides in the past few decades in the Americas. Interest in evaluating its effectiveness has been increasing greatly in the past few years. Participatory evaluation holds great promise for helping to generate this evidence and promote understanding of the factors that affect, positively or negatively, the advances of health promotion in the Region.

The experiences described in this article highlight some of the various challenges posed by the complex and multidimensional local and national contexts in which the participatory evaluation is introduced. Factors affecting the success of evaluation

initiatives were identified at all levels of reality (individual, community, organizational, political, economic, etc.). It is also important to take into account that these factors are intertwined and affect each other in very complex ways. This was reflected in the municipalities' experiences in applying the participatory evaluation.

Even though the development of the Participatory Evaluation Guide happened as a direct response to requests from countries implementing the HMC Strategy, once the methodology was made available and was applied in such initiatives, the majority of countries realized they "were not ready" to implement such an innovative approach to evaluation. This was mainly due to their realization that their HMC and health promotion programs and initiatives had not appropriately taken into account key health promotion principles (such as intersectoral collaboration or community participation).

This was an important contribution that the application of the participatory evaluation made to these initiatives: it shed light on the gaps in their efforts and forced those involved to confront the problems and reflect on how to address them. As a result, the majority of community groups and institutions involved in this initiative perceived the need to re-examine and thereby reorient their planning and implementation processes in order to effectively apply the participatory evaluation methodology in the future. Thus, engaging in the participatory evaluation process has served as a catalyst to generate intersectoral and participatory processes essential to the development of HMC initiatives.

All countries involved in this evaluation initiative reported that the process of engaging in participatory evaluation was highly motivating and revitalizing, concretely allowing those involved to evaluate their actions more consistently, stimulating interest in the issue of evaluation and in-depth reflection on activities. The experience strengthened capacities among those involved, generated commitment to promote health promotion principles, strengthened alliances among key stakeholders, and emphasized the potential of the participatory evaluation as a decision-making tool. These experiences demonstrate that supporting the implementation of participatory evaluation initiatives has the potential to contribute to the advancement of health promotion in the countries of the Americas.

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Aparajita Orissa

Alok Mukhopadhyay¹

Abstract: Following the 1999 cyclone, which devastated important areas in the state of Orissa, India, the Voluntary Health Association of India (VHAI) established *Aparajita* as the long-term aid and reconstruction programme. *Aparajita* aims at empowering the local community and building their capacity to recover from devastation and prepare for future natural disasters. The programme operates in three main areas of the state: Jagatsinghpur, Kendrapara and Puri. After an assessment study of the damage and the communities' socio-economic and health status, *Aparajita* focused its interventions on livelihood support, infrastructure development, capacity building, savings and credit, and health interventions. This programme has served to establish the basis of a disaster management process, which includes two main components, preparedness and relief. Given the number of natural adversities in India, there is a need to both empower the communities in the management process, as well as influence government to support and institutionalise initiatives like *Aparajita*. (*Promotion & Education*, 2007, (2): pp 74-75)

Key words: capacity building, disaster management, India

Résumé en français à la page 115. Resumen en español en la página 126.

Who we are?

Aparajita can be described as a civil society response to the devastating cyclone in Orissa, India, which occurred on October 29, 1999, and completely shattered the rhythm of people's lives. More than 15 million people in 10 districts of Orissa were said to be affected with around a million houses damaged. The aftermath not only revealed the extent of damages in terms of material and human loss but also the inadequacies of individuals, communities and administration vis-a-vis disaster preparedness. A number of individuals and institutions came together under aegis of the Voluntary Health Association of India (VHAI) to provide relief to the cyclone affected people of Orissa. VHAI did not have disaster relief or mitigation in its original mandate, but to turn its back on people's misery and distress was not an acceptable option. Hence VHAI's response to the tragedy was instantaneous and spontaneous.

After three initial weeks of emergency relief and medical assistance by VHAI, *Aparajita* came into being as VHAI's response to the perceived need of long term rehabilitation.

The word "Aparajita" means the woman with the indomitable spirit. It aptly describes the unconquerable spirit of the people who have survived the calamity.

What do we want to achieve?

The main thrust of the rehabilitation has been to strengthen the capacity of the affected community and to minimize their vulnerability to future emergencies.

VHAI recognizes the intrinsic connection between disasters and development. The disaster traumatically brought to focus all the basic problems of the region. The cyclone reduced all issues to their fundamental level and highlighted the inherent weaknesses of the coastal areas of Orissa,

i.e. poverty, underdevelopment and poor disaster preparedness.

What are we doing?

After providing the basic relief, the teams stayed on in the affected areas to make an assessment of the needs of the people and identify key partners for long term relief and rehabilitation work. It was decided to focus operations in 3 blocks, in Jagatsinghpur, Kendrapara and Puri districts.

How are we doing it?

Micro-planning exercises, complete damage assessment and vulnerability mapping were done in the target areas to appraise and determine the needs of the community.

Aparajita initially started with three blocks with 15 Gram Panchayats¹ (G.P.) which later on expanded to 79 G.P.s in June 2001. The main areas of intervention were:

- **Livelihood support** – Cash for work programmes, kitchen garden and agricultural support; fisher folk and post harvest support and artisan rehabilitation, such as, providing raw materials, tools, training and economic support to vulnerable women artisans for micro-enterprise, such as, pottery and bamboo basket making, mat and palm leaf weaving, and handlooms.
- **Infrastructure Development** – restoration and renovation of individual housing, repair of village infrastructure, including schools, roads, community buildings etc.
- **Capacity Building** – training of trainers, training of health workers, training of traditional birth attendants and training relevant to treatment in camps.
- **Savings and credit** – support to self help groups in dry fish, lime production, mat weaving, bamboo crafts, basket making and vegetable growing.

- **Health Interventions** – first aid and curative health services for common ailments, safe drinking water and sanitation, awareness generation on preventive health aspects, care of pregnant and nursing mothers and referral linkages.

Right from the outset, the main thrust of the programme was to include the community perspective in the development and implementation of the program; this enabled community ownership of the program and contributed to its sustainability. With the help of micro-planning and baseline survey, the target areas were assessed, beneficiaries were identified, groups and marketing linkages were formed and with community participation, activities and interventions were planned and carried out systematically.

Project implementation was assisted by a number of committees:

- *Project Coordination Committee*
- *Village Committees*
- *Advisory Committee*
- *Technical Support Committee*

Due to timely and effective implementation of the programme, various health and development interventions, starting from 1999 to date, have been carried out successfully; these are outlined in Table 1.

Aparajita activities were monitored centrally as well as at the field level. Once a month direct monitoring by VHAI's Chief Executive and his team was done through visits to the operational blocks followed by regular staff meetings where team findings, achievements and constraints were discussed and inputs were provided. The core team members undertook field monitoring through field visits at least once a week to each of the field offices and respective villages. Field officers also send their reports on a regular basis. A field office was set up

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Local population working together on reconstruction efforts following the cyclone in Orissa

in Bhubaneswar, which is the State Capital. Setting up the field office there facilitated interaction at various levels.

What are we learning?

The super cyclone sparked many questions for introspection in terms of disaster management. Disaster preparedness and relief are two separate components of the disaster management process, i.e. mitigation, preparedness, response and recovery. While disaster preparedness highlights a continuous planning process and focuses on general principals; disaster response operates with certain end objectives in mind that emerge from the situation resulting from actual realization of the disaster.

Good disaster management must recognize correctly the difference between agent and response-generated needs and demands. There are problems created by the disaster itself, and others generated by the effort of organizing a response. In

Orissa's case many agencies ended up with unorganized relief activities. Doling out free materials even when the immediate need was gone and providing much more than the minimum wages prescribed by the government crippled people's initiative to stand on their own. VHAI from the very beginning considered immediate and humanitarian relief as an interim phase. VHAI did not use very special or extremely qualified professionals. It did not provide huge amount of resources. Consequently, the training is now sustainable with some inputs from the government and some from community and some from us.

How will we know we are making a difference?

India faces a number of disasters every year; a concerted effort to gather evidence from these unfortunate events and the subsequent processes, could enable the country to develop an insight into disaster man-

agement, which could then be used to build institutional capacity. For example, in the cases of cyclone-prone areas, the simplest measure for disaster preparedness can include the construction of cyclone shelters for storing safe drinking water and other essential lifesavers and measures can be taken to make housing cyclone-resistant. Such measures can assist with reducing suffering, morbidity and mortality. However, as opposed to this, disasters fade rapidly from public memory and the Diaspora of expertise is uncoordinated with no institutional linkage. There is an urgent need to take existing evidence into account and institutionalize experiences; the Orissa project can be useful in gaining policy insights into community health promotion in a particular disaster setting, from which lessons should be extrapolated.

i. Gram Panchayats are local government bodies at the village level in India. A Gram Panchayat can be set in villages with a population of more than five hundred.

Table 1. Health and development interventions 1999 to date

Name of block	Astarang	Mahakalpara	Erasama	Total
Activities	No.of beneficiaries	No.of beneficiaries	No.of beneficiaries	No.of beneficiaries
Livelihood Support				
Kitchen Garden	2230	2400	3760	8390
Individual Support	106	205	100	511
Boats and Nets	425	1255	580	2260
Infrastructural Development				
School Renovation	5	5	6	16
House Renovation	109	305	188	602
Pond Desilting, Desalination	11	2	12	25
No. of book banks	48	12	24	84
Capacity Building				
TBA Training	20	24	15	59
Training of health workers	64	25	23	112
Training of Woman Group, Literacy etc	160	28	42	230
Total No. of People Supported	17,752	10,614	18,455	46,821

Shehjar Khoj

Alok Mukhopadhyay¹

Abstract: Turmoil and conflict whether social or political in nature, affects every constituent of the society. No social fabric is strong enough to resist the undercurrents and dissatisfaction manifested violently or otherwise. The conflict in Kashmir is one such phenomenon. Realizing the need for effective health interventions in Kashmir, the Voluntary Health Association of India (VHAI) started Shehjar Khoj project in 1999. The project, among other, aims at promoting social justice and equity in the provision of health services and improvement of the health status for all, with emphasis on the less privileged. The project currently operates in four districts and has implemented numerous interventions, which involved training, motivating and encouraging active participation of the community, including village opinion makers and health workers. Understanding people's cultural and ideological beliefs has been a critical factor in enabling the development of locally-suited programmes, and therefore the project's success. (*Promotion & Education*, 2007, (2): pp 76-77)

Key words: conflict, capacity building, India

Résumé en français à la page 115. Resumen en español en la página 127.

Who we are?

Shehjar Khoj is a project established by the Voluntary Health Association of India in Kashmir since 1999 with the aim of improving health interventions. When turmoil and conflict began in Kashmir, there was a collective numbness to respond, generated by fear and unpredictability. Turmoil and conflict of any type and of any kind - social or political - affects every constituent of the society. No social fabric is strong enough to resist the undercurrents of conflict; the resultant issues manifest themselves in many ways ranging from dissatisfaction to violence.

It was envisaged that the situation in Kashmir would gradually lead to poorer health outcomes particularly with the state's reluctance to enhance the public medical facilities in the far off and remote areas and streamlining the functioning of this sector.¹ It was within this context that *Shehjar Khoj* developed a response to this growing crisis. The word *Khoj* stands for "Quest" or "Search"; Prefixed to *Khoj*, the word *Shehjar* means "Shade." It aims to define the "Shade of Health Awareness and Health Facilities" that *Khoj* project strives to provide to the people of Kashmir against the scorching heat of poverty, negligence and disease.

What do we want to achieve?

Shehjar Khoj has the following aims and objectives:

- Promoting social justice, equality and human rights in the provision and distribution of health services for all, with an emphasis on the less privileged.
- Strengthening people's health movement in the state.
- Advocating congenial policies and programmes, aimed at improving the health status and quality of life of the people.

What are we doing?

In order to develop and achieve the ambitious aims and objectives of the programme, the following strategies are implemented:

- Initiating innovative grass root level sustainable health and development.
- Taking action in some of the least developed pockets of the state.
- Capacity building of voluntary agencies through non-formal orientation training and awareness building programmes.
- Influencing policies and programmes for a cost-effective, preventive, promotional and economically sustainable health care system in the state.

How are we doing it?

District Budgam was chosen as the first area of operation. In consultation with the district administration, five villages of Tehsil Chadoora with a population of over 9,000 were identified. Work commenced in these districts in 1999 by training local dais (traditional birth attendants) and educating girls in community health, hygiene and sanitation. Inspired by the success of *Shehjar* project, another project *Shadab* was started in Wakhawan, a cluster of villages in Pulwama district over 2000-01. By September 2004, project activities were extended to another five villages of Khan Sahib Block of Budgam district under the banner of *Khoj* Project.

The following activities were conducted in preparation for the interventions:

- Meeting district administration, health and education personnel to discuss plans and activities, areas of operation, and modes of implementation.
- Establishment of Village Development Committees (VDC) constituted by reputable local villagers in order to enhance the role of stakeholders in community

programmes, thus enhancing the acceptability of programs.

- Identification of Village Health Workers (VHW) and leveraging their potential to disseminate health information and deliver certain health care services.
- Conducting baseline surveysⁱⁱ to ascertain existing socio-economic conditions and health status in selected villages. The survey revealed that there was a serious lack of health facilities with no antenatal and post-natal arrangements, poor sanitation, low literacy rates and a special need for mental health programmes (See Table 2.) Subsequently, the following interventions were implemented:

- Building capacity of traditional birth attendants (TBAs) in modern methods and techniques of delivery and reproductive health; distribution of *Dai's kit*ⁱⁱⁱ to conduct safe deliveries and the establishment of a monthly training and review programme at *Shehjar* OPD clinic.
- Providing health services via house-to-house visits, setting up of outpatient facilities and sub-centers. *Shehjar* introduced the yellow prescription card for its outdoor patients; the card is widely recognized by all the hospitals in the valley and allows patients access for referral.
- Organising mass health camps for providing free treatment and medicines to patients with trained VHWs, TBAs and supervisors assigned to monitor each patient for follow up.
- Organising Self Help Groups (SHGs) for families involved in arts and crafts through income generation and assisting with the establishment of Thrift and Credit societies^{iv}, which facilitate the dissemination of health care information.
- Expert counseling, monitoring and treatment facilities for people with mental and psychological problems.

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Notwithstanding the turmoil and the subsequent devastation caused by the October 8, 2005, earthquake, several steps have been taken to ensure sustainability of the project.

VHAI in collaboration with State Voluntary Health Associations (SVHA) through a Project Advisory committee has been involved in this project at several levels - conceptualizing, monitoring and training. The Programme Coordinator is mandated with overall planning, monitoring and implementation at the village level; the Medical officer is in charge of health services and capacity building of field staff; and the Supervisor guides grass root level workers like VHWs, TBAs and volunteers in the implementation and monitoring processes. An award in honor of *Sonjoy Gose* - well-known social activist who died in Assam - was conferred by the Government of India to *Shehjar Khoj* project in recognition of its efforts.



Training village women in Kashmir through the *Shehjar Khoj* project.

What are we learning?

During the turmoil, men became the victims of their male identity, as a result of the direct association with their counterparts in the struggle. The woman suffered foremost, on the pretext of their female identity as mothers, sisters or wives; suffering the emotional and financial repercussions of the phenomenon. In such situation of fear and turbulence the first casualty is always loss of trust and community spirit. In order to achieve its aims and objectives, every programme has built rapport and

deep understanding of community's psyche to heal its wounds and provide culturally appropriate responses.

How will we know we are making a difference?

Shehjar Khoj firmly stands on the concept of community motivation through the creation of a "chain" of ever increasing volunteers from the grass-root level. In Kashmir, *Shehjar Khoj* has overcome the orthodox and conservative attitudes of people, while it managed the sociopolitical conflict,

which had created "ideologically opposite groups" amongst the population. The team spirit, community motivation and participation garnered by the project are the key to its success to improve access to health and the health status of the population, which needs to be maintained by the project in the future. However, over the long term, it is also imperative to sustain, improvise and expand the project targets and areas of operation.

Table 1. *Shehjar Khoj* Project District Budgam

Project activities	Beneficiaries covered 2000-05	Beneficiaries covered 2005-06	Total 2000-06
No. of patients examined and treated	10,927	1729	12656
No. of ANCs examined and treated	923	129	1052
No of ANCs (high risk) cases referred	112	15	127
Immunization of Children	2642	723	3365
Village meetings for health awareness	232	60	292
Health Education Training for VHVs\TBAs	521	57	578
No. of SHGs formed	14	14	28
Children treated in School Health Programme	1317	648	1965
Total	16,688	3375	20,063

Table 2. **Baseline Data (1999-2000) Findings**

Name of the village	Literacy Rate			Sex Ratio (per 1000 male persons)
	Male	Female	Total	
Zoohama	62.23	35.20	49.01	958
Dadompura	46.40	24.54	36.04	901
Hanjoora	65.32	37.73	51.90	947
Surayar	42.18	23.11	32.92	844
Nowhar	43.23	19.35	32.11	880

- i. Editorial in The Greater Kashmir, June 13, 2001.
- ii. Baseline Survey was conducted in 5 villages of *Shehjar* Project by the project team comprising of Traditional Birth Attendants and Village Health Workers (VHVs) to ascertain the existing health scenario for the reference year 1999-2000. Besides providing information about basic population and other vital statistics of the villages, the survey facilitated the project team in getting familiar with the villagers.
- iii. Dai's kit is used by Trained Birth Attendants in home delivery. The kit contains a soap piece, gauze piece, disposable gloves, sterilized razor blade (cord cutting instrument) and clean cord ties.
- iv. A cooperative society that makes loans to its members at low interest rates.

Reorienting health services through community health promotion in Kwaio, Solomon Islands.

David MacLaren¹ and Esau Kekeubata²

Abstract: When ethnic minorities adhere to cultural practices which mark them as unique, structural impediments within health services can deny access and significantly add to the burden of disease. This is particularly pertinent if the development of health services is not done in partnership with all population groups in the area. This is the case at Atoifi Hospital, which structure prevents certain Kwaio people (Solomon Islands) from receiving benefits of hospital services and maintaining cultural beliefs at the same time. A Participatory Action Research process was used to collaboratively work with health service providers and community groups to review the situation, design and build a health facility with both medically and culturally appropriate policies and procedures. The Participatory Action Research process of collectively looking, thinking, planning and acting towards reorienting health services to become more culturally appropriate at Atoifi was the first time leaders, from both the community and hospital, had collectively sat together in a mutually respectful way to discuss community health promotion initiatives. The project was complete in 2006 with collaboration and dialogue between both groups proving vital to its success. Numerous indicators are present that the culturally appropriate health facility is making a difference, not only in terms of the hospital usage by all, but also for the feeling of "community ownership." (*Promotion & Education*, 2007, (2): pp 78-79)

Key words: dialogue, minority groups, participatory action research

Résumé en français à la page 116. Resumen en español en la página 127.

Who are we?

The Kwaio people are one of the 12 language groups on the island of Malaita, Solomon Islands. This group is unique given that almost half of the ten thousand Kwaio people uphold traditional ways of life in the tropical rainforest clad mountains and retain customary religious beliefs and ancestral culture. This is in contrast to 95% of their fellow Solomon Islanders who have accepted Christianity. Health services in Kwaio were established in the 1950s and 1960s by the colonial government and Christian churches; these failed to incorporate local understanding or concepts of health in planning, policy or the delivery of curative or preventive services. Little changed for almost four decades. As a result, Kwaio people faced a stark choice when in need of health services – relinquish fundamental precepts of Kwaio culture and religion by accessing health services or remain true to Kwaio beliefs and stay away. Many continue to choose the latter.

This is of particular concern at Atoifi Hospital, established by a Christian Church in 1965 with no Kwaio participation in planning or policy development. Hospital services are delivered in a single building which includes a two-story section. Maternity services are delivered within the building. This causes problems for many Kwaio who consider the entire building a woman's area and taboo for men to enter. In addition, the two story section allows women to be physically above men – an anathema in Kwaio culture. Thus to enter the building contravenes fundamental precepts of Kwaio culture, causing the spirits of the ancestors to allow misfortune or illness to befall the individual or their family. The implication is not only for clinical curative

services, but preventative services including antenatal services, immunization and other community health initiatives. Atoifi is one of the best equipped and most respected providers of health services in the Solomon Islands with people traveling from across the country to utilize the services it provides. The Kwaio do not experience the benefits of having arguably the most respected health service on their land. Because Atoifi is the primary provider of curative and preventative health services for Kwaio, the exclusion they face causes inequalities in health and creates antagonism between the community and Atoifi's service providers.

Since the establishment of Atoifi Hospital, Kwaio community leaders have wanted access to services at the hospital through means that do not cause cultural offence or require the relinquishment of ancestral values. However, because of the colonial and Christian paradigm, which has informed the attitude and practice of many of the hospital administrators and deemed Kwaio who retained ancestral culture and religion as 'backward', 'primitive' and 'heathen', requests were not taken seriously. In 2000 we (the two authors, a community health worker, born and raised in the Kwaio mountains, and the current chairman of the Kwaio *Fadanga*, i.e. the Kwaio Council of Chiefs, and an Australian public health researcher having worked with Atoifi and the Kwaio since 1992) worked with community groups to document a list of barriers faced by Kwaio wishing to access health services at Atoifi (MacLaren, 2000). This was written in English, the language used by hospital administrators as most do not speak Kwaio language. The list was pre-

sented to administrators with a recommendation from the community that a facility be established at Atoifi Hospital specifically for Kwaio people unable to access mainstream services. Administrators agreed to pursue a facility on the hospital campus specifically for Kwaio unable to access mainstream services. In 2002, a Participatory Action Research process began, facilitated by the authors, with the community and hospital staff to collaboratively review the situation, design and build the facility and create relevant policy and procedures.

How are we doing it?

A group named the Atoifi Support Committee comprising community and hospital leaders was formed to discuss community health issues and plan for the future. The group acted as a conduit for information from the community to hospital leaders and from the hospital to community leaders. The culturally appropriate facility was conceptualized, designed and driven forward by members of the Atoifi Support Committee through 2002 with technical assistance provided by external agencies. The process of collectively conceptualizing, planning and implementing plans to develop a culturally appropriate health service at Atoifi was the first time leaders from both the community and hospital had collectively sat together in a mutually respectful way to discuss community health promotion initiatives for the future. A series of parallel meetings were facilitated by the authors with community groups and hospital staff to inform the planning process and provide feedback. This participatory process was respectful of all social, cultural and reli-

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gious knowledge and responsive to new knowledge created through the process. This process was occurring through a particularly tumultuous time in Solomon Islands history. The years 1998-2003 saw civil unrest between the peoples of Malaita and Guadalcanal Islands known as the 'Ethnic Tension.' This included the overthrow of the democratically elected government in June 2000 by rebel elements of the Royal Solomon Islands Police and a militant group called the Malaita Eagle Force. This resulted in the crumbling of law and order and almost total collapse of government services, including health services. Being a non-government health service, Atoifi was one of the only hospitals in the country offering full services. In Early 2003, just months before the Pacific Islands Forum initiated the Regional Assistance Mission to Solomon Islands (RAMSI), a multinational force made up of Australian, New Zealand and Pacific Island military and police got involved to re-establish law and order and the machinery of government violence, which also affected Atoifi. In May 2003, the Australian business manager of the hospital was murdered. This caused most of the staff to flee the hospital campus, where most resided. This resulted in a near collapse of the organization and new projects, including the culturally appropriate health facility, were postponed until the situation stabilized.

Given the community engagement strategies used in the PAR process, the authors were requested and participated in the process to facilitate dialogue between church and hospital administrators and community groups to address the uncertain and volatile situation. In late 2004, after staff returned, a RAMSI police post was established at Atoifi and some stability returned and the process to establish the culturally appropriate facility was re-started. Plans were made and construction began in 2005. All building materials were either donated directly by community members or purchased from community contributions. Two buildings were constructed of local materials, one for the general community and one for women's services (including antenatal services). They were officially opened in June 2006. Both are now used by Kwaio without causing cultural offence or relinquishing religious beliefs.

What are we learning?

Numerous lessons have been learned through the Participatory Action Research Process, which resulted in culturally appropriate health services for the Kwaio at Atoifi Hospital. One of the key lessons was the importance of *participation*. It was only through participation and dialogue that hospital administration and community leaders had mutual understandings of important

issues to each group. Prior to this project there was no process through which community leaders and hospital administration could engage in meaningful dialogue. The result of which was historical mistrust, suspicion, stereotyping and misinformed assumptions. Through the process of engaging in meaningful dialogue as equals working towards a common goal, both groups became aware of the social, cultural, spiritual and economic complexities the other faced in planning health services. Underpinning this participation was the importance of *flexibility*. To be flexible, both in terms of the approach adopted and the response to unexpected events allowed the project to continue through a dynamic and volatile period of history. Having the capacity to *deal with complexity* allowed all involved to acknowledge, respond, value and incorporate complex changes in the project rather than trying to 'control' them. This enabled the project to ultimately come to fruition. We learned that if the project was truly community owned and driven it would be able to adapt to complex and dynamic social, cultural, political, religious and economic situations. This required periodic halts in progress, but was critical to the project's long term successes. The role of the *researcher/facilitator being a catalyst* was also an invaluable lesson learned. Although this community health promotion project was run as a Participatory Action Research project in collaboration with an Australian public health researcher, the researcher always saw himself as a facilitator of the change process, rather than an external 'expert' directing the project. Researchers involved always strove for the process to be *with* and *by* persons, not *on* or *to* them. Being true to this process allowed the responsibility for the project's successes and sustainability to lie with the hospital and community, not the researcher/facilitator. A final major lesson learned throughout the project was the *importance of local leadership*. The reality of a culturally appropriate health facility would never have been realized without visionary leadership in the Kwaio Council of Chiefs. As community leaders they exemplified how oppressed peoples can articulate the situations of oppression in which they live and take actions to transform such oppressive situations.

How will we know we are making a difference?

Change at several levels show that the culturally appropriate health facility is indeed making a difference. Firstly, the Kwaio people are using the facility. Prior to the official opening in June 2006, a senior chief who was ill sought treatment at the facility. He was admitted there for several weeks. This was a powerful signal of support



Atoifi Hospital, Kwaio.

by senior community leadership and opened the way for others to use the facility after its official opening. Subsequently, there has been ongoing 'community ownership' and a feeling of having a facility that is '*in and of Kwaio*' on the hospital campus for the first time. An outcome of this strong feeling of ownership by the community is that relatives of people admitted there are staying for several days, often sleeping in the facility, as is normal in a village setting - of course, this brings a new set of challenges for hospital administrators. The construction of the facility has created a feeling of partnership and goodwill between the community and hospital leadership and has stimulated ongoing debate for the need to provide more culturally appropriate health services for all sectors of the community that address the social and cultural determinants of health for all. This includes the limitations of such initiatives and change in policy and practice that is needed to reorient health services. Given the strong medical, religious and cultural paradigms present, this will be an ongoing challenge. A doctoral thesis has been produced that outlines the intricate historical, political, cultural and religious contexts in which health services operate in Kwaio and a detailed description and analysis of the Participatory Action Research process and outcomes (MacLaren, 2006). This document is being used as a basis for further collaboration and evaluation of the facility by Atoifi Hospital, Kwaio Council of Chiefs and university collaborators. A final indicator of the difference being made by this community health promotion project is the numerous requests the authors have received to present the process, experiences and reflections at local, national and international forums.

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The Graniators support group program

Emily Sullivan¹, Ilse Blignault¹, Aunt Shirley Duncan² and Lisa Jackson Pulver¹

Abstract: Aboriginal grandmothers (grannies) in many communities throughout Australia are considered the backbone of the social structure. This is the case for the Murri Grannies in a town in regional eastern Australia. Many of these women are also their grandchildren's primary caregivers and disciplinarians, and sometimes this role is detrimental to their own care and well-being. As a response to this stress, the local Aboriginal Medical Service (AMS), which includes a comprehensive primary health care facility, began promoting the program 'Relax to the Max' to the Grannies as part of the holistic care they offer. Since these humble beginnings some three years ago, the group has grown to become the Graniators support group. In addition to their initial work of supporting each other, the group extended their field of action to the entire community to address social issues, particularly those around youth and children. To complement and strengthen their initiative, the Graniators partnered with other organizations in the community including the police, the municipal council, the state government's department of housing, the local primary school and a special youth service group. The program's evaluation has proved to be extremely positive in providing others in the community a clear and positive formula for driving change at a grass roots level. (*Promotion & Education*, 2007, (2): pp 80-81)

Key words: Aboriginal grandmothers, youth, partnership

Résumé en français à la page 116. Resumen en español en la página 127.

Who are we?

Murri Grannies¹ (Aboriginal grandmothers) in a regional town in northern New South Wales are considered the backbone of the community. Many find themselves in the role of primary caregiver and disciplinarian to their grandchildren and great grandchildren, meeting their physical, financial and social needs. This is on top of their need to care for themselves. Nevertheless, they take on the role willingly because they want their grandchildren to thrive and to reach their full potential. Not surprisingly, the Grannies' own needs are often neglected and they become stressed and anxious.

In early 2004, the Counselor at the local Aboriginal Medical Service (AMS) noticed that many of the Murri Grannies who came to see her suffered from stress and anxiety associated with their care-giving role. Others were distressed by the lack of respect that Murri kids in the community showed them as elders. The Counselor talked about this with Auntⁱⁱ Shirley, the Aboriginal Mental Health Worker at the AMS and a Grannie herself. Together, they initiated an eight-week program for the Grannies called *Relax to the Max*. It involved relaxation sessions and discussion on how to care for themselves mentally, emotionally and spiritually, as well as including a bit of pampering, such as a visit to the hair salon. The program had an overwhelmingly positive response and together, the Grannies with the Counselor and Aunt Shirley decided to start a support group for themselves.

The name given to the Support Group, 'the Granitators', was chosen as it identified the strength and determination of the Grannies. Led by Aunt Shirley, the group

decided to meet once a fortnight for about four hours, on an ongoing basis, providing a support network and social outlet for about 25 Murri Grannies in the local area.

What do we want to achieve?

The initial aim of the Group was for the Grannies to support each other in addressing the daily issues they faced. As time went on, the Grannies realised they had a common desire in wanting to reach out and to do something about the problems affecting their grandchildren, families and community. In early 2005 the Grannies visited the 'Linking In' project in another regional town that ran activities to support young people in the community. This was a significant event as it provided them with the motivation and inspiration to expand their own focus. From this point, the Graniators' aim grew to include assisting the community to address social issues, particularly around youth.

What are we doing?

Every second Tuesday, the Grannies meet at a place organised by the AMS. Aunt Shirley sometimes organises guest speakers and at other times invites the Grannies to follow the *Relax to the Max* tape. This meeting provides the Grannies with time-out to relax away from the grandkids, and a chance to reminisce about the old days on the Christian mission station together. Building friendships and trust amongst the group has been an important aspect of the meeting as it has enabled the Grannies to share their stories and problems with each other and they now feel comfortable turning to one another to both offer and receive advice and support.



Group of Murri Grannies and children, New South Wales, Australia.

As well as partnering with the AMS, the Graniators have established partnerships with several organizations in the community including the police, the municipal council, and the state government department of housing, the local primary school, and a special youth service group. With the support of these organisations, they hold the *Brekkie Club* every weekday for up to 30 school children where the Grannies take it in turn to prepare breakfast. Once a month the Grannies assist the local police with a movie night for the families of the community. In addition, the Grannies are often invited to contribute to community activities such as the *Croc Eisteddfod* and *Carols by Candlelight*.

What are we learning?

At the end of 2005 the Graniators' program was formally evaluated as part of a larger project to provide on-site training and capacity-building for AMS staff in service planning and evaluation. Aunt Shirley and the Grannies were involved in the evalua-

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tion of their own project and in compiling the community report (Muru Marri Indigenous Health Unit, 2006).

The evaluation documented positive changes in both the Grannies themselves and in the community. The Grannies have gained strength and confidence and act as new role models for the community. Several informants commented on the way the Graniators are raising the spirit of the community.

Many people have benefited from the Graniators' work. For example, the Grannies have built friendships and mutual support within the group, and formed new and positive relationships with the police. Kids from the *Brekkie Club* not only have a nutritious meal in the morning and get to school, but also now know they have more than one Granny to love them.

Most importantly, the Grannies have new learnings, such as:

- The importance of the friendship and bond between them in achieving success out in the community and to their continuing as a support group for each other.
- The value of taking small steps and working within their own limits.
- The usefulness of having frequent and regular meetings where they focus on their initial aim of supporting each other to avoid 'burn out.'
- The worth of building partnerships within and outside the Murri community in the town and working together to achieve shared goals.
- The fact that challenges can be overcome. In facing the challenges, they have learnt new skills such as networking, and have grown stronger.

How will we know we are making a difference?

Thinking and talking about the issues and reflecting on what others said about the Graniators allowed the Grannies to see more clearly where they have come from, how things are going, and how they might work more effectively in the future. The Grannies are proud of themselves, and are keen to share their success with others.

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Notes

- i. A term derived from Aboriginal languages used by the Aboriginal people in north-west New South Wales and Queensland in eastern Australia when referring to themselves.
- ii. In Australian Aboriginal culture the term 'Aunt' is often used as a sign of respect for female elders in the community.

Motuca healthy municipality project: building together a better future

Rosilda Mendes¹ and Fabio Falvo²

Abstract: The Brazilian Ministry of Health in collaboration with the Municipality of Motuca and the School of Public Health at the University of São Paulo set up in 2002 the Motuca Healthy Municipality project with the aim of improving the population's health and quality of life. The project used a participatory and holistic approach, which addressed the social determinants and structural inequities, and called for strategies of community empowerment, social participation, intersectoral networking and good governance. All local and public actors from rural and urban areas were consulted and participated in the project to collect information on the living conditions and challenges to better well-being. This participatory methodology allowed in turn developing cultural and socially appropriate initiatives to improve local governance and standards of living on a long-term basis. Although there is still the challenge to maintain the momentum and reenergize the efforts, the project serves as a model for further efforts to evaluate the effectiveness of participatory intervention and research methodologies to promote health and well-being in communities. (*Promotion & Education*, 2007, (2): pp 81-82)

Key words: participatory methodology, empowerment, health promotion

Résumé en français à la page 116. Resumen en español en la página 127.

Who we are?

Motuca Healthy Municipality project was set up in 2002 for a total duration of three years by the Ministry of Health in collaboration with the Municipality of Motuca and the School of Public Health, University of São Paulo. The main objective was to create a new managing system with a participatory approach to improve the quality of life of the population.

The municipality of Motuca is located in the Northwest part of São Paulo State, Brazil covering an area of 230 square kilometers with a total population of 3,872 inhabitants. According to the Brazilian Institute of Geography and Statistics (IBGE), the population increased by 12.47% during the period 1993-2000. The majority of the population (63%) lives in the urban areas, where social and commercial services are available and small industries exist. Four groups of settled-out landless people represent 37% of the population. This high population in the rural area is different from the rest of Brazil where, in general, usually only 18% of the population lives rurally. In the 1980's the regional government allotted ownership of government-owned land to these people, which is where they now grow sugar cane and other agricultural products.

The economy of the municipality is based on a large local sugar cane processing plant. In the period between March and November each year the processing plant also employs 1440 local workers. Cultivation

of oranges and the production of carnauba wax contribute to the local economy as well. Additionally, there is a factory which produces hand-woven carpets and rugs.

In terms of health, the main strategy for strengthening primary health care is the Health Family Program, which is run by the State of São Paulo in collaboration with the Federal Ministry of Health. The municipality provides other primary health care services in addition to this and takes responsibility for transporting patients in need for advanced care to a neighboring city - Araraquara, which is 40 kilometers away.

What did we want to achieve?

In its broadest definition, this project encompassed a holistic approach which addressed the social determinants and structural inequities, and called for strategies of community empowerment, social participation, intersectoral networking, and good governance. Through interactions between government and civic representatives, policies and social conditions, which promote good governance at a local level, were constructed. Technical and educational cooperation created an enabling environment in which all the participants focused on the needs of the future.

How did we do it?

Participatory governance strategies were created in order to involve different social actors. Initially, four training work-

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shops called *Oficinas de Sensibilização* - two in the urban area and two in the rural area - were conducted; based on these workshops, a collective vision for the city was developed: “our city nowadays” and “our city in the future”. Collecting and analyzing the information from these groups allowed a better understanding of the potential for and barriers to local governance to improve the standard of living on a long-term basis. Secondly, a *Healthy Municipality Committee* was established with representation from the professional community, decisions makers and community members. A participatory approach was used to integrate the local committee in order to create a common vision for the city and to involve the settled-out landless people, previously excluded from local policies.

Other methods included recognizing the historical context of the city. More than 500 historical photos were exhibited in a local community center; in addition, community thematic maps were created for the rural and urban areas, representing environmental, housing, economic, recreational, and public services aspects. Through these the broad dimensions of the city were elaborated. For instance, it enabled an understanding of distribution of illiteracy, which contrary to popular belief, was in the urban areas. Currently, the *Committee* is prioritizing problems and defining participatory evaluation.

What did we learn?

To-date, three Municipality Conferences have been held with the overall objective of presenting the process-related findings and other related information to the population, specifically, and to other cities in the region, in general.

This process has examined different interests and abilities that shape political agendas, and the possibility of creating alliances and networks to strengthen local governance to improve living conditions. The challenge now is to reenergize these efforts, to think through the problems together focusing on improving policies and institutions that better serve the needs and interests of the population. Empowerment of the groups can be considered the greatest lesson learned.

How do we know we can make difference?

This Project serves as a model for further efforts to evaluate methodologies in participatory intervention and research. Process and outcome data are necessary in order to establish the effectiveness of health promotion initiatives. The question of who conducts the evaluation is impor-

tant. It must include all the social actors. Linking intervention in the planning, implementation and evaluation can be useful to contribute to the capacity to promote health and ensure continuation of the intervention. It means we have established a way to better understand the facilitators and barriers in the initiative, and to better plan for sustainability of efforts within changing political contexts.

Empowered women from rural areas of Bolivia promote community development

Roxana Ríos¹, Catón Olmedo² and Luis Fernández³

Abstract: The United States Agency for Development in Bolivia (USAID/Bolivia) created in 2002 PROSALUD- Partners for Development Project (PfD) with the aim of improving the population's well-being. The project used three components: small grant scheme, technical assistance and database system management. Through the small grants scheme, the PfD supported a Community Participation Strategy (CPS) project over a three year period. The project involved the rural areas of six Bolivian departments and suburban areas of three Bolivian cities. The main objective was to increase health service utilization with a particular emphasis on empowerment of women, strengthening of local organizations and increasing the demand for health services. Women from both the urban and rural areas, and from different indigenous groups, were trained in project management, health promotion, reproductive health and family planning, advocacy and community participation. Participatory methodologies have allowed empowering women in decision making and capacity building throughout the entire project process. The experience shows that it is important to work with formally established grass-root community organizations and strengthen leadership within them. Additionally, the sub-projects demonstrated that interventions are more successful when promoters speak and write native languages, women are more motivated and empowered, projects are designed to be responsive to daily necessities identified by the communities and health services are culturally suitable. A preliminary evaluation, in both quantitative and qualitative terms, shows an overall improvement in health knowledge and practice, and utilization of health services. (*Promotion & Education*, 2007, (2): pp 83-84)

Key words: empowerment, participatory methodology, women

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What is this initiative about?

The United States Agency for International Development in Bolivia (USAID/Bolivia) created a Health Project in September 2002, with the overall aim of improving the health of the Bolivian population to be implemented by PROSALUD, a Bolivian NGO who has been working in the health sector since 1986. The project is entitled Partners for Development (PfD), which comprises three components: small grants, technical assistance, and management of data base systems. The small grants component was designed to benefit the public sector, NGOs and grass-root community organizations through a competitive process.

In the beginning (2003), USAID/Bolivia through the Integral Health Project PROSIN, and since 2005 through the PfD via its small grants component, supported a Community Participation Strategy (CPS) project over a three year period (April 2003 – June 2006) in 35 municipalities as follows:

Department	Number of interventions	
	Rural Municipalities	Sub-urban
Beni	3	1
Chiquisaca	5	
La Paz	11	
Pando	1	1
Potosí	9	
Tarija	3	1

The project was led by a psychologist with expertise in working with communities and was implemented by 15 nurses. The project aims to increase health serv-

ice utilization with a particular emphasis on empowerment of women, strengthening of local organizations and increasing the healthy practices and demand for health services. The total contribution to this project by USAID/PfD was US \$ 280,000.

What is the approach used for?

The Community Participation Strategy has been implemented in the first stage through 73 community based educational sub-projects including basic project managerial training to selected women, some office furniture and materials, basic kitchen tools for community based organizations and equipment for strengthening health services.

Each sub-project comprises two five-day workshops to train women health promoters as cascade trainers. Then, the health promoters replicate the knowledge in 19 sessions three hours each to the women in community workshops. The training is related to reproductive health and family planning in the following themes: contraception, pregnancy and delivery, sexual organs infections, women reproductive and sexual rights, self-esteem among others. Women from indigenous cultures, like Aymaraⁱ, Quechuaⁱⁱ and others were involved in this process.

As an output, 219 women from community based organizations have been trained in basic project management; another 1080 women have been trained as health promoters, which in cascade replicated what

have learned to about 30,000 women of the communities who have received training in reproductive health and family planning (RH/FP).

In relation of the educative materials, the ones developed by the NGO "Manuela Ramos" (Lima, Perú) served as the tools of intervention for this project; these were adapted to the local setting and validated.

In the second stage, as three new sub-projects, the Community Participation Strategy trained the women health promoters, in different but related themes as a continuation of first stage, including leadership, negotiation, small projects management, advocacy and community participation.

As another result, six active networks of women health promoters have been established as well as committees of sexual and reproductive rights defenders; these networks and committees gained insight into community needs, negotiated community requests with respective municipalities' governments and developed conjoint action plans for quality of health services improvement.

Success story: *The women health promoters' network of sub-urban area in Bermejo, Tarija (38,000 people municipality) negotiated with the local Municipal Government in November 2005, the young people orientation center implementation, which is giving today orientation in RH/FP in coordination with local health services. In average, every month around 80 young people seek the services of the orientation cen-*

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ter. In addition, women health promoters offer orientation in contraception and sexual/reproductive rights to the post delivery women at local hospital services.

After the project ended, the promoters of the CPS are also raising funds from different donors for the implementation of new local development project, which result in local capacity building.

How are we doing this?

This project employs participatory methodologies for the empowerment of women in decision making and builds their capacity in the entire project process: from problem analysis and identification to the design and implementation of local solutions. Specific areas of focus include: situational analysis, communities' selection for intervention, self diagnosis, project proposal elaboration, management and evaluation. This enables an understanding of the whole process of community project management and its instruments.

What are we learning?

Implementation of the project has enabled an understanding of community health promotion in a specific setting. The experience shows that it is important to work with formally established community based organizations and strengthen leadership within them. The results of such an intervention are directly proportional to the capacity of the promoters; however, better results can be gained if promoters speak and write native languages, when motivation amongst women is higher, when sub-projects are designed to be responsive to day to day necessities identified by communities, when health services are culturally suitable and with the participation of grass-root community organizations, particularly women have better skills negotiating with local authorities.

How do we know we are making the difference?

A quantitative, qualitative and cost related study to evaluate the effectiveness and empowerment of CPS was conducted in 2005. Results of the qualitative component of the study showed an increase in ante natal care, PAP screening and family planning methods provision, and decrease in the gap between the health services and communities, having in mind sexual and reproductive rights for women. Results also showed that the local authorities were more likely to provide financial support to implement the process. In addition, a visible change was observed in knowledge, attitude and practice of couples with respect to negotiating for and exercising

human/reproductive rights.

The quantitative component of the evaluation yielded the following results:

- Effectiveness average of 37%ⁱⁱⁱ, with the following variables: 73.5% of the woman showed willingness to use RH services, 11% women accepted and used family planning methods (FP), 11.8% assisted ante natal care and delivery services, 27.6% reported gender equity relationships with their couples, and 55.8% reported gender and family relations without violence.
- Empowerment average of 31.4% with the following variables: 50.9% realized healthy practices, 39% had knowledge about prevention of intra-family violence, 27.6% referred to improving communication with their couples; in addition, the demand for RH services have increased by 9.7% in relation to the previous year (2004).
- The average training cost in this project per woman was US \$ 24.

Implications for broader application

The two phases of the CPS strategy include training (including the selection of project intervention areas), advocacy and local activities and consolidation; the latter also includes strategies to establish financial sustainability. Consolidation of the RH/FP component of the program also provides an opportunity to integrate other elements such as environmental interventions. The methodology has shown modest success in Bolivia and can be adapted to other settings, with careful attention to specific characteristics of each country, such as, cultural and working practices, health services accessibility, and the regulatory environment.

Notes

- The **Aymara** are a native ethnic group in the Andes and Altiplano regions of South America; about 2.3 million live in Bolivia, Peru, Northern Chile, and Northeastern Argentina (in particular in Salta Province). They lived in the region for many centuries before becoming a subject people of the Inca, and later of the Spanish in the 16th century. (Wikipedia, free internet encyclopedia).
- Quechua** (Runa Simi; Kichwa in Ecuador) is a Native American language of South America. It was the language of the Inca Empire, and is today spoken in various dialects by some 10 million people (Quechuas) throughout South America, including Peru, South-western Bolivia, southern Colombia and Ecuador, north-western Argentina and northern Chile. It is the most widely spoken of all the languages of the Indigenous peoples of the Americas. (Wikipedia, free internet encyclopedia).
- By means of Net Aggregation Method:

$$\% \text{ Effectiveness} = ((\% \text{ measured in ex post evaluation} - \% \text{ base line}) / (100 - \% \text{ base line})) * 100.$$

Promoting health and happiness in the Brazilian Amazon

Caetano Scannavino¹ and Rui Anastácio¹

Abstract: With the motto "Health, happiness of the body. Happiness, health of the soul", the Health & Happiness Project (PSA) works to promote integrated and sustainable community development in parts of the Brazilian Amazon. PSA grew out of local workers' personal experience in collaborating with communities and the need for sustainable actions for their future development. PSA was established as a not-for-profit organization in 1987. It started off by implementing strategies that would increase the health status of the population, which was identified as the biggest challenge, to then extend to other areas of development. Education, training and community participation were key elements of the project's actions, which included basic sanitation, reproductive health and child health, technical assistance in agricultural practices and youth empowerment through communications, among others. Once the health structure was established, the work moved on to new priorities related to education, economic production, protection of the environment and community management in the medium and long terms. The project's success has helped to institutionalize the practices and today it reaches a total of approximately 5,000 families distributed across 150 rural communities in the mid- and low-Amazon region. (*Promotion & Education*, 2007, (2): pp 85-87)

Key words: health promotion, community health, development

Résumé en français à la page 117. Resumen en español en la página 128.

Who we are?

We hear much about the Amazon and its natural resources, but little is said of its inhabitants, especially the forest peoples, the majority of which are 'caboclos'—descendants of Indians who live in rural, often isolated and difficult to access areas.

These people partly subsist on hunting, fishing, the collection of forest products, growing manioc and other regional crops, but no longer manage to guarantee their own subsistence due to the impacts of deforestation in the Amazon.

Although public services offered by respective municipalities are improving, there still appears to be a major shortfall. This is evidenced by some of the key social sector indicators of the region; 60% of the population is under 18 years of age, of which only 7.5% manage to complete secondary education. Health is one of the key challenges in the social sector domain at the community level. Preventable diseases lead to significant mortality and morbidity due to gaps in the delivery of primary health care services (Gusmão, 2002). Infant mortality is high and Infant deaths account for 15.7% of all deaths in the community; this is reflective of regional health disparities in Brazil given that this is almost double the national average of 8% (Gusmão, 2002). The majority of these deaths are the result of diarrhoeas or preventable infectious diseases.

The population lives in a region extremely rich in natural resources; however, at the same time, they suffer from increasing impoverishment. This is mostly due to the lack of investment in the population's own potential. However, these groups still maintain a strong sense of com-

munity, solidarity and self initiative and are able to effectively mobilize and work together to resolve their own problems, if and when given the opportunity.

The Health and Happiness Project (PSA) was created in 1987, taking the local reality of these populations as a starting point, the project is grounded in the belief that a critical component of safeguarding the Amazon, relates to guaranteeing living conditions for the forest peoples. PSA is a not-for-profit organisation, which works to promote integrated and sustainable community development in riverside locations on the banks of the rivers Tapajós, Amazonas and Arapiuns in the West of Pará, Brazil.

PSA further built on the work of a medical doctor and an art-educator who had experience working with riverside communities in the municipality of Santarém between 1984 and 1985. They created a non-governmental organisation, PSA, to guarantee the continuity of the actions in a broader and more independent manner and without party-political connections.

In 1987 cooperation agreements secured by BNDES- Banco Nacional de Desenvolvimento Econômico e Social and the Federal Government, permitted the work to commence with 16 pilot communities. The Participatory Planning highlighted health as one of the biggest challenges and from here, the other programmes of the Health & Happiness Project were developed.

How are we achieving our aim?

Education and community participation are key elements of the project's actions, which brought immediate results for the whole population, taking advantage of



Mobile Health Unit (Abaré): monthly visits to the communities to promote primary health care for 2.500 families in the municipalities of Santarém, Belterra and Aveiro, a consortium between PSA and the Municipal Councils.

resources from the region itself. Community leaders, health workers, traditional midwives, rural producers, women, teachers, children and young people built their capacity through training to become trainers. The project invested in basic sanitation (chlorine, filters, toilets, wells and adapted water systems). Community events promoting the health of the children, with three-monthly vaccination campaigns were initiated. Rural farmers received technical assistance to increase the availability of food stuffs produced using agro-ecological practices. Groups of women were involved in activities to promote reproductive health and combat malnutrition with the consumption of local plants of high nutritional value. In the schools, teachers and children participated in health and ecology work-

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shops. A communication network was developed with the youth, where they were trained as reporters allowing them to produce, exchange and disseminate educational materials via community newspapers, radios and videos.

The project tries to take a positive in-take on promoting health, instead of disease-oriented, which is where the term “happiness” comes into play in the organization’s name. As a main strategy when visiting communities, team members and community members use the Great Mococongo Circus. The representations of the circus include music, poetry, educational and cultural sketches to promote healthy behaviors, such as, breast feeding, the use of oral re-hydration therapy and hygiene, among other.

What are we learning?

These simple and culturally appropriate education methods had a very positive impact on the communities, who not only began to change their health practices, but also became more stimulated to actively participate and influence other areas of their development. Once the health structure was established, the work could move on to new priorities related to education, economic production, protection of the environment and community management in the medium and long terms. PSA with the community’s involvement in the planning and implementation created integrated development programs, as shown in Figure 1.

How do we know we are making a difference?

The lessons learned made it possible to develop exemplar and culturally-adapted social development technologies, which are low in cost, high in impact and replicable in other regions and contexts. Consequently, in 1999, PSA started to gradually increase the communities it worked in.



Great Mococongo Circus: a small mambembe traveling theatre presented by rural residents with music, poetry, educational and cultural skits, communicating the content in the communities’ own language

Faced with a larger-scale program, certain principles for successful project development were established, i.e.:

- working in partnership with government bodies and other existing development actors to transfer social technologies;
- programmes are readapted in order to be integrated as public policies;
- training trainers is prioritized;
- the concept of territorial communities is reinforced to encourage self-management and social control, focusing on strengthening inter-community federations.

As reflected in Figure 2, over the years it has been possible to significantly improve the quality of life indicators in partner communities, according to comparative data between areas served and those not served by PSA (Souza Lemos, 2000.)

At present, PSA works directly in three

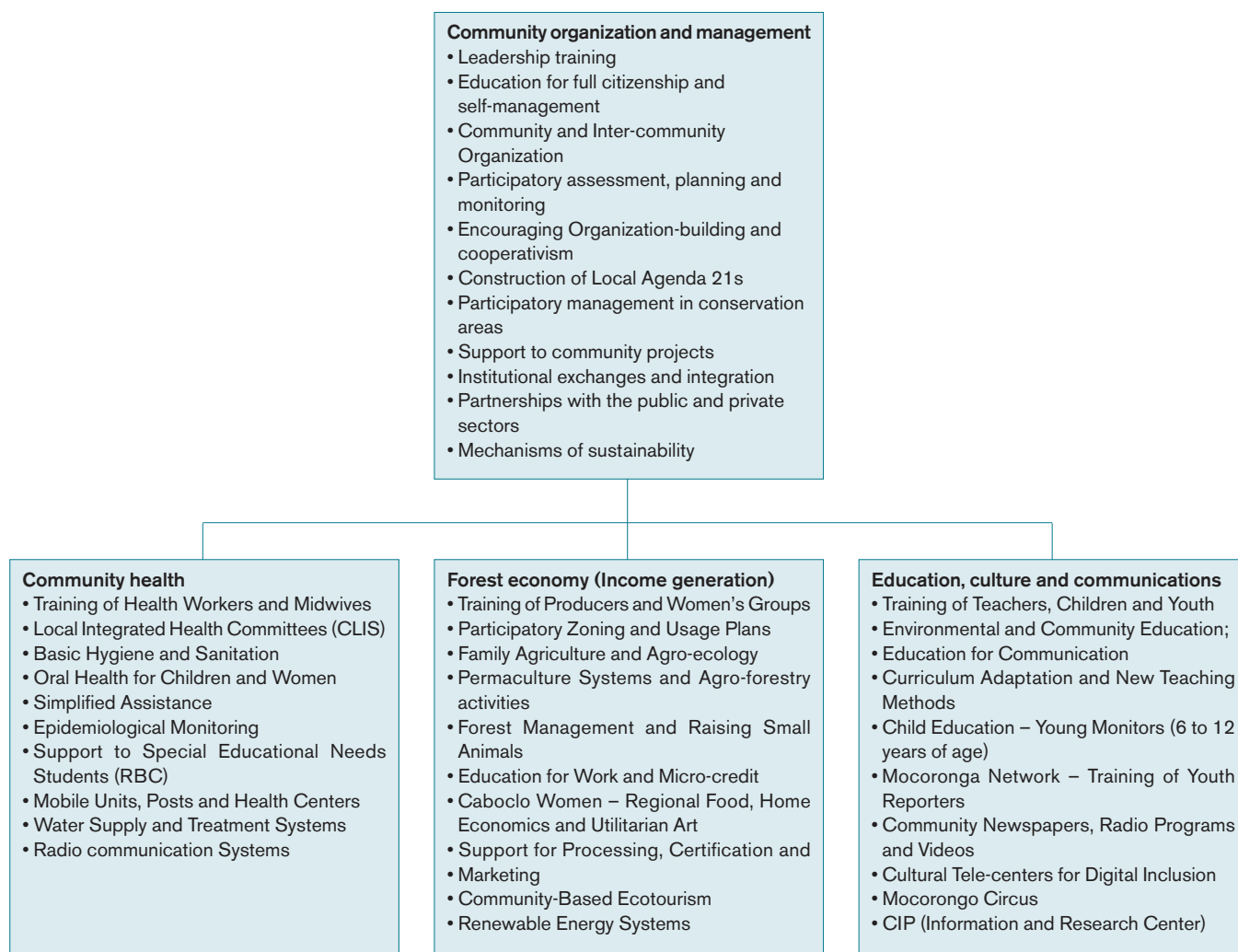
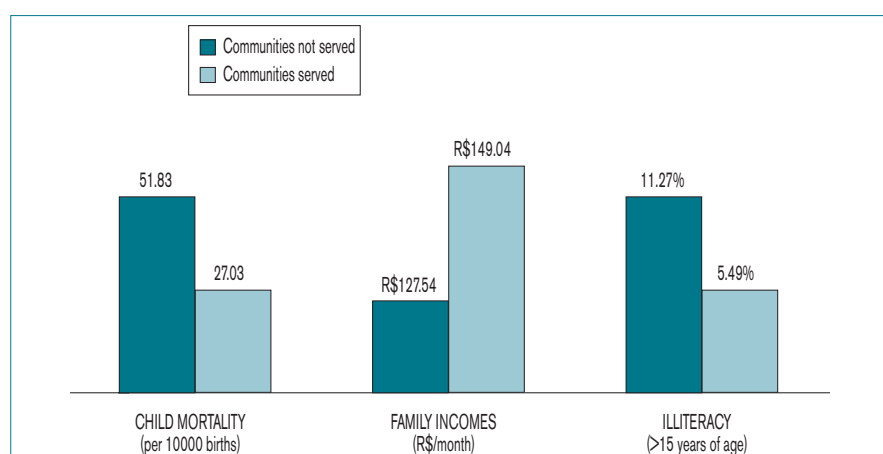
municipalities – Santarém, Belterra and Aveiro – reaching a total of approximately 5,000 families distributed across 150 rural communities in the mid- and low-Amazon region. PSA is also increasingly consulted by governmental and non-governmental bodies, from the Amazon and beyond, to provide advice on the replication of its experiences.

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Mococongo network: youth’s communication initiative for education– radio communications and programmes, and internet access points



Figure 1. **Integrated Development Model**Figure 2. **Quality of life indicators**

Source: Socio-economic Diagnosis /Dr. José de Jesus Sousa Lemos, UFCE

Advocacy for appropriate health policy and effective governance of the health system

Alok Mukhopadhyay¹

Abstract: Health policies supported by sustained advocacy efforts need to continually grow and develop to respond to the increasing pressures of macro-economic policies of globalization, liberalization and privatization. VHAI, the largest network of voluntary agencies in health sector is playing a critical role at both macro and micro levels. Its health advocacy efforts emerge from the grassroots with an understanding of their health and development problems as well as the strategies adopted to address them. The process, of strengthening an upward mobilization of information, towards formulation of an effective health policy, is backed by serious macro research on various policy dimensions of health, done by the Independent Commission on Health and Development in India (ICDHI), set up in 1995 by VHAI. These key policy documents are both reflective and prescriptive and are presented to the highest state authorities along with a discussion at various levels with various groups. One of the recent successes was at getting the giant tobacco companies withdraw from Cricket sponsorship with an association in the formulation of a comprehensive Bill by the Union Government to prevent this in future. Various well-researched policy documents have been put together by the organisation based on its micro and macro level work and persistent advocacy. Appropriate public health and development policies with their effective implementation are the cornerstones to realize the fundamental values of Alma-Ata. The health care system needs to be removed from the current bio-medical model and closer to a socio-political and spiritual model where health care again becomes an organic part of community care as it once was in the traditional society. (*Promotion & Education*, 2007, (2): pp 88-89)

Key words: advocacy, state health policies, grassroots.

Résumé en français à la page 119. Resumen en español en la página 131.

Over decades, the State has played a significant role in the health sector. With the growing process of globalization and the influence of New Economic Policy, there is tremendous pressure to replace this arrangement and put the social sector in the market place. There can be little doubt that the greatest economic force now sweeping through the health care system worldwide is that of the market. Health is a vital human good and Medicare plays a key role in promoting it. Totally commercializing it, even for the sake of choice and efficiency, runs a potent risk of submitting it to the market-forces. The integrity of medicine itself is at stake. Thankfully for the poor in most developing countries the State still remains the principal health care provider. We need to appreciate the importance of advocacy for people-centered health from this backdrop.

Health policies need to grow, develop and be continually creative to meet the changing needs of the situation. This underlines the importance of sustained advocacy on health policy, to ensure that it is people-oriented and relevant. Viable options for health systems must be technically feasible, consistent with public sector capacity, and capable of commanding sufficient social and political support to be sustainable. This is particularly true for the developing world, where a large section of the population does not have well-defined and strong enough platform to air their frustration against inadequate social policies.

VHAI, the largest network of voluntary agencies in the health sector in a massive,

complex and heterogeneous country like India, plays significant role in this area. A large section of the population of India is totally dependant on the Government health sector since they do not have the financial means to buy services from the market. Several studies conducted show that when the public health infrastructures do not work, the health expenditure becomes one of the major contributors for indebtedness of the poor.

In India, the state health policy is outdated. The critical services and facilities are getting frayed due to growing population, non-optimal use of existing facilities and increasing pressure of global financial institutions for dilution of the role of Public Care and to abandon holistic, people-centered community health care and to replace it with a selective "magic bullet" oriented health care. The situation is further complicated by the fact that the large private sector usually does not provide quality services at a reasonable cost. Outreach of the voluntary sector is limited due to the absence of more enabling atmosphere. We, therefore, felt that it is important to work towards a new Health Policy to respond to the current situation adequately.

Plans and policy options should be guided by an ambitious vision of what should be accomplished, but they must also be informed by the realities of the present. Despite the rhetorical vision of a health system with a universal, vertically integrated, publicly provided system, India has not provided funds to make that vision a reality. Raising additional government

finance has its own complexities. Any policy that proposes a significant expansion in the low level of publicly mobilized resources devoted to health needs to provide an explicit proposal for how the additional costs will be financed.

These realities are not immutable. They can be changed through institutional reforms and strong political commitment, but one cannot simply assume that they will disappear. Ultimately changing the shape of the health system depends on political decisions made at national, state and local levels. An explicit approach to policy formulation and implementation must ensure that the health system is improving the health of all in an equitable, accountable and affordable manner. For developing an appropriate and sustainable health care system, the health policy must promote Government, Public and Private Partnerships; an inter-sectoral coordination along with the Decentralisation of the health system, tempered with effective supervision.

Our advocacy effort begins at the grassroots by not only trying to understand people's health and development problems, but to work with them to learn how to develop the alternative approach. This experience-based learning gives us very essential credibility to talk about important health issues with conviction. The knowledge about exciting innovations to address critical issues of health care being taken up in large metropolitan towns or institutions of developed countries reaches all corners of the world within days, but similar effort at the remote rural areas of the developing

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countries hardly attracts anybody's attention. We feel that the process of strengthening upward mobilization of information is an important factor towards appropriate direction of an effective health policy. Experience of our grassroots effort is backed by serious macro research on various policy dimensions of health, involving respected professionals, academics, policy makers and activists. While preparing documents to influence the health policy, we not only rely on primary and secondary data, but they are usually backed-up by focused group discussions with stakeholders and public hearings of beneficiaries and roundtable with concerned professional groups.

We keep the major political parties, key officials and the media fully informed about the endeavour and often they are invited to participate in some of these events. The documents finalized through this participatory process are not just critique of health policies, but are prescriptive. We clearly outline viable solutions to the major public health problems and document examples of successful micro experiences. This elaborate and rigorous process provides the alternative policy documents legitimacy and the desired credibility. Preparation of key policy document is cornerstone of a successful advocacy effort. We ensure that the policy document is formally presented to the highest possible authority of the land. Our policy document for an alternative health policy was presented to the Prime Minister and the President in an elaborate function widely covered by the media. This was followed by discussion with elected representatives of various political parties and Parliamentary Standing Committee on Health. These high profile events create an overall empathetic atmosphere for policy change.

Often the groups working on policy matters lose their steam by sheer demand of preparing the policy document. It is important to ensure that sufficient finance and human resources are available for advocacy related work. Persistent and dogged follow-up is key "mantra" in advocacy.

During our recent successful work for a comprehensive bill to debar tobacco companies from sponsoring sports, we received tremendous support from Cricketers and Cricket Control Boards of other countries and the sporting public. This was backed by our Public Interest Litigation against the Indian Cricket Control Board in the High Court. Eventually the giant tobacco company withdrew from the sports sponsorship due to our dogged advocacy and the successful Public Interest Litigation. The Government is now drafting a comprehensive Bill to prevent this in the future. We are playing an active role in the finalization of the content of this Bill.

Similarly, the revised Health Policy is in the final stage of redrafting with substantial input from the report produced by us. We are also Members of the Steering Committee for drafting the New Health Policy.

We should remember that adoption of an appropriate public policy by the Government is not an end by itself because the major task of effective implementation of the policy is an equally important issue. Advocacy groups have to play dynamic role of monitoring the implementation of the public policy closely, particularly in the initial years. Our grassroots level projects play a very important role of providing us feedback on the effectiveness of the implementation process at the grassroots. The feedback is regularly conveyed to the authorities to enable them to fine-tune the mechanism of implementation.

The importance of urgent and sustained global advocacy for restoration of fundamental values of Alma-Ata, people-centered, holistic and sustainable health care cannot be overstressed. The challenge to health in the new millennium will be to recognize that in no country in the world the private sector has been the answer to the health problems of the population. Even in the United States, forty seven percent of the population is without health insurance coverage. Secondly, there is an imperative need to acknowledge that health improvement is less an outcome of medical technology than of living standards. Health improvements based on narrow technical interventions are bound to be chimerical. Thirdly, the macro-economic policies of globalization, liberalization and privatization, which are increasing the exploitation of low-income countries and communities around the globe, have had profoundly deleterious effects. Finally, it is simply not true that we do not have resources to pay for health for all. It is estimated that the cost of providing basic health care to the world's population will amount to 25 billion dollars. This is about what Western Europe spends on cosmetics, and a fraction of the 400 billion dollars that the world spends on armaments annually.

We obviously need a new paradigm of health care far removed from the current bio-medical model and closer to a socio-political and spiritual model. Currently, health care has become a commodity that can be bought and sold in the market; it is no longer an organic part of community care as it once was in traditional society. The 'germ theory' needs to be replaced by a model where the human being is regarded as central and helped to regenerate a sense of well-being and fitness in his or her life situation. Interestingly, most of the traditional systems approach to health are from this holistic perspective.

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Cracking the nut of health equity: top down and bottom up pressure for action on the social determinants of health

Fran Baum¹

Abstract: The Commission on the Social Determinants of Health (CSDH) was established to advise on ways in which understanding of the social determinants of health can affect practical action to improve population health equitably. This paper considers the factors that are necessary to encourage governments to adopt policies that aim at doing this. It argues that knowledge, while essential, is insufficient. Governments need a commitment to the values of fairness and justice and an ability to cope with the complexity of responding to social determinants beyond exhorting individuals to change their behaviour. The role of civil society is crucial in advocating for governments to do this. The presence of linking social capital is also crucial to creating a social and political environment in which fairness is promoted. A case study of the poor health status of the Aboriginal peoples in Australia is used to illustrate the importance of social capital. (*Promotion & Education*, 2007, (2): pp 90-95)

Key words: social determinants of health, linking social capital, aboriginal health.

Résumé en français à la page 119. Resumen en español en la página 132.

When the late Dr. Lee, Director General of the World Health Organization, announced the formation of the Commission on the Social Determinants of Health (CSDH) at the World Health Assembly in May 2004 he commented:

“The goal is not an academic exercise, but to marshal scientific evidence as a lever for policy change – aiming toward practical uptake among policymakers and stakeholders in countries”

This paper focuses on factors that are likely to encourage and initiate practical action on the social determinants of health inequities. It will include discussion of the need for both evidence and knowledge together with understanding and a commitment to equity. Consideration will be given to the importance of the “nutcracker” effect which describes the power of the combination of top down and bottom up action on health equity. The arguments articulated herein demonstrate that societies, which focus on *linking social capital* (as defined by Szreter & Woolcock(2004) and discussed in detail below) are more likely to be committed to and effective in taking action on the social determinants of health than those with low levels of linking social capital.

Powerful combination of evidence, knowledge, understanding and values

Knowledge and evidence are clearly important to achieving action on health equity. The CSDH has established a knowledge network on Evidence and Measurement. The first paper from this network (Kelly et al., 2006) argues strongly in favour of methodological pluralism and epistemological variability in approaches to studying the social determinants of health and health

inequity. They note “Humans use different forms of knowing and different forms of knowledge for different purposes. There is no necessary hierarchy of knowledge involved until we need to discriminate on the basis of fitness to purpose” (Kelly et al., 2006). An understanding of the complexity of factors that contribute to the social determinants requires an insight into many different disciplines and the use of a range of methods. However, the most useful qualitative research methodology involves interviews of key informants to ascertain ways in which social, economic and political structures shape individual experiences. For example longitudinal epidemiological studies that enable the determination of causal links between exposure to certain social and economic conditions and diseases or policy studies of the outcome of different systems of social welfare. Such knowledge is often context specific and contingent on political and economic circumstances. The complexities of this process and the broad range of knowledge on social determinants is often envisaged to be an impediment to the uptake of the knowledge in this area. Commenting on the challenge of getting knowledge to inform policy and practice, Speller (2001) used Stacey’s (1996) Agreement & Certainty Matrix demonstrate that health promotion and public health initiatives often fall into a zone of complexity that leads to uncertainty about what works and consequently to a lack of agreement among policy makers and practitioners. Stacey stresses the need for non-linear and creative thinking when organisations are working at the edges of chaos and dealing with complex information to obviate issues emerging from lack of consensus. It is envisaged that such situations often arise when organisations attempt to address the social determinants of health. Thus it will take a particu-

lar combination of commitment to justice, understanding of complexity and the ability to lead organisations through the change necessary to cope effectively with complexity in order to lead to the actions, which the Commission envisages lending impetus to.

Evidence on health inequities has been available in many developed countries for sometime; however, this has not ensured the institutionalization of remedial action. Most notably, the “Black Report” in the United Kingdom (Townsend & Davidson, 1992) was rejected by the incoming Thatcher Government despite the compelling information it presented on the existence of inequities and the possible reasons for their existence. This and many other examples show that while evidence on inequities is necessary it is certainly not sufficient to ensure action. Policy makers also need to know what can be done to reduce inequities and need to work from a values base that emphasises the pursuit of social justice as crucial to society. Knowing what is to be done requires coming to grips with the range of choices that lie inside and outside the health sector.

The international health promotion movement has come a long way in the past twenty years. In the 1970s and 1980s, behaviour change using pamphlets and marketing campaigns was the overriding tool of health promotion. Subsequently, the concept of health promotion was revolutionized by the Ottawa Charter for Health Promotion (WHO, 1986), which established that while changing behaviours was indeed a crucial aim of health promotion, bringing change at that level involved a complex interplay of policy and strategy, creating supportive environments, encouraging community action and reorienting health services. The Ottawa Charter was instrumental in galva-

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nizing action in many countries. In Australia, for example, impact at the population level was clearly evident and manifested itself as reduction in prevalence of smoking and smoking related morbidity, decrease in road accident-related fatalities, reduction in suicide rate and decline in the rate of skin cancer (Baum, 2002). Each of these has been achieved not through single measures but through a battery of self reinforcing measure. While these are significant public health gains, they have done little to address inequities and reduce the existing gradients. Here it is important to recognize that unless designed with a very strong equity lens, health promotion can act to increase the difference between groups rather than reduce them even if they improve population health as a whole. For example, there is evidence that people in higher socio-economic groups are more likely to be successful in quitting smoking (Osler & Prescott, 1998; Barbeau, Krieger, Soobader, 2004). In Australia over the period 1998-2004, while there has been a 9% decline in smoking among the lowest quintile, the rate of change for the highest socio-economic quintile is 35% (see Table 1). A reasonable conclusion is that anti-smoking messages have been more successful with better off people and, at least temporarily, have increased inequality.

Further complicating our message is the fact that health inequities do not reflect a dichotomy between a disadvantaged group at the bottom of the social advantage pile and the rest sharing equal health status. The work of Sir Michael Marmot (Chair of the Commission on the Social Determinants of Health) and colleagues (see summary in Marmot, 2004) has shown that the distribution of health in communities is in the form of a gradient. This gradient is also illustrated in Table 1 where the percentage decline in smoking across socio-economic quintiles is in the form of a gradient from high to low. This has great significance for the strategies we adopt to bring about equity. The gradient in health suggests that we need population wide universalist strategies as well as those targeted at the most disadvantaged. Again this is a more complex argument to advocate to policy makers than the one which

focuses on the need to target those at the bottom of the pile.

Taking action on the social determinants of health to reduce health inequity will also require politicians and policy makers to resist what Kickbusch (2006) has called "the doability of medicine". Modern medicine offers individuals considerable possibilities. But many of its interventions will not have a discernable impact on population health (as opposed to the health of a few individuals, usually towards the end of their life). Perhaps this is the hardest lesson for policy makers and politicians to grasp. Yet it is also the most important lesson to grasp if we are to have the understanding necessary to bring about a real determination to improve health across populations. Rose (1985) has set this lesson out most clearly. He points out that treating high risk or diseased individuals does not have much impact on population health levels overall, but changing a risk factor across a whole population by just a small (and often clinically insignificant) amount can have a great impact on the incidence of a disease or problem in the community. For example reducing salt intake in manufactured food by a small proportion across a population (at a level individuals would not notice) would reduce blood pressure levels and in time reduce death rates from cardiovascular disease. Add to this the need to implement population-wide strategies in a way that is equitable and the extent of complexity of knowledge and concepts is considerable. Rose's message about population health is counter intuitive and the difficulties of grasping it effectively is, in all likelihood, the reason why we face challenges in shifting our health care system to a focus on prevention, health promotion and social determinants of health, despite so many WHO and Government sponsored reports that have called for this reorientation (Benezeval, 2003; Independent Inquiry into Inequalities in Health, 1998; Stahl et al., 2006; Stegeman & Costongs, 2003; WHO, 1978; WHO, 1986; Wilkinson & Marmot, 2003).

Understanding of Rose's dictums on preventive medicine are likely to be heeded more easily in those who have a more collective mind set rather than those more

committed to a strong individualism. This fact was pointed out by Tesh (1988) when she pointed to the strong individualism that underpins public health policy in the United States. A strong ethos of individualism is likely to lead to victim blaming assumptions (Crawford, 1977). Such an attitude is obvious in the following comment by an Australian federal health minister, Tony Abbott (2005) on a television program on childhood obesity:

"No-one is in charge of what goes into my mouth except me. No one is in charge of what goes into kid's mouths except their parents. It is up to parents more than anyone else to take this matter in hand... if their parents are foolish enough to feed their kids on a diet of Coca Cola and lollies well they should lift their game and lift it urgently".

Tesh (1988) points out that the very research questions we ask are shaped by core values. Thus a focus on individualism would lead to questions about why individuals are over weight and explore their motivations while a more collective ideology would explore questions about why it is that obesity levels in all high income countries have increased in the past decade and consider what features of the society have encouraged this. The assumption that changing behaviour is about personal motivation is very common despite the evidence that people need supportive environments in which to make healthy choices and that pressures from social mores, advertising and constraints of health food availability are likely to have strong influences on the choices people are able to make (Baum, 2002). There are many factors that reinforce ideologies of individualism. These include the fact the ideology is less threatening to many vested interests, especially commercial interests, the philosophy of some political parties are grounded in a strong belief in the individual rights even when these are at the expense of the common good and the fact that protecting the rights of individuals has often been a guard against the excesses of totalitarian regimes. Consequently public health is often viewed as being aligned with a 'nanny state' that seeks extreme measures that restrict rights. This view has been voiced during campaigns to introduce tobacco control, enforce seat belt legislation, restrict the ownership of firearms, restrict the advertising of junk food and enforce sun protection in schools.

The fact that many of the determinants of health of health lay outside the formal health sector also complicates the tasks of implementing action on the social determinants of health. In the past twenty years the importance of cross sectoral action has

Table 1. Percentage smoking and percentage change by five socio-economic quintiles in Australia, 1998-2004

	1998	2001	2004	% Change
1st Lowest	30.0	25.8	27.3	-9%
2nd	27.0	25.1	23.6	-13%
3rd	28.4	23.7	21.7	-16%
4th	25.8	23.6	18.2	-29%
5th Highest	23.1	18.4	15.1	-35%

Source: Data derived from Adhiknit and Summerhill, 2000; Australian Institute of Health and Welfare 2002 & 2005.

Figure 1: **The nutcracker effect: top down and bottom up action for health equity**

been repeatedly reinforced and put into practice. Through the Healthy Cities projects, the need to integrate government initiatives in the intersectoral domains was demonstrated, particularly with reference to road injuries, substance abuse, and poverty (Ashton, 1992; Baum 2002; WHO, 2007). European Union's current focus on 'Health in All Policies' is testimony to the acceptance of this message (Stahl et al, 2006). The crucial task now remains to ensure that this intersectoral action happens effectively and as a matter of course and is implemented with a strong focus on reducing equity.

The messages of modern health promotion then are complex. They involve understanding the factors that impact on population and the existence of a health gradient, the limitations of most medical therapy as a means to make significant

improvement to population health, and understanding that while behaviour change is the aim of health promotion, achieving this effectively is not about simply telling people to do so, but in creating supportive environments which will require action from multiple agencies. The task of equity health promoters would be much easier if there were a simple message to pitch to politicians and senior policy makers. But the reality of the situation makes equity a hard nut to crack. The following section considers the social and political environments in which equity is more likely to make it to the policy agenda.

The "nutcracker" effect

The "nutcracker" effect is illustrated in Figure 1. It demonstrates the value of combining top down political commitment and policy action with bottom up action from

communities and civil society groups. Government commitment to taking action on the social determinants of health equity is likely to result from a belief in social justice and an understanding of the complexities of health promotion as detailed in the previous section. If a government reflects a political commitment to individualism and is wary of a overly interventionist 'nanny state' then the pursuit of equity is unlikely to be on its social policy agenda to any extent. In this situation it will be hard to find much pressure exerted on the top of the lever. Such was clearly the case in Thatcher's Britain. Action on health equity only resulted when Blair Labour Government was elected on a platform that included a strong commitment to pursuing equity. By contrast, a government driven by a belief in social justice is likely to implement policies designed to reduce inequities; the Nordic welfare states have provided a strong example of such governments. A powerful influence on government's desire to be socially just is the pressure from the more socio-economically better off in a society to do so. The existence of this pressure has been described as linking social capital and is described in more detail below. The other crucial part of the nutcrackers effect is the bottom up action from civil society.

Civil society action

One way in which governments can be persuaded to take action is through bottom up pressure. This is a consequence of growing inequities as a result of which communities prefer governments who state a commitment to reduce such inequities. Within this context, history provides numerous examples of the role of civil society in bringing about change. Outstanding examples are the suffragettes in ensuring votes for women; the civil rights movement in the USA in stopping sanctioned segregation; and the anti-apartheid movement in bringing democracy to South Africa; and the green movement in putting environmental issues on national and international agendas and the land rights movement in Australia. (See Burgmann, 2003, for a discussion of these various social change movements). In each case, years of grass roots actions led to irresistible pressures for change. In recognition of the important role that the civil society may play in arguing for action on the social and economic determinants of health the Commission on the Social Determinants of Health has established a stream of work on the role of civil society which has involved many civil society players. The report from the June 2006 meeting of the Commission (Commission on the Social Determinants of Health, 2006)

notes that the Commissioners recognised the distinctive contribution of civil society in country level action on the social determinants of health including direct engagement with national governments and national commissions on social determinants such as those in Kenya and Brazil. They also noted the importance of mass mobilization such as the Indian People's Health Assembly and the crucial role of labour organisations and trade unions (Commission on the Social Determinants of Health, 2006, p. 22). Civil society groups may also play a major role as advocates of equity. Globally the People's Health Movement (PHM) has played such a role since its formation at the first People's Health Assembly. The movement has organized two People's Health Assemblies to date (intended as alternative World Health Assemblies) from which two key documents have emerged – the Peoples' Health Charter written in 2000 and the Cuenca Declaration (2005) (see PHM, 2006, for copies) have made powerful statements about the need to reduce global inequities. Many health promotion and public health associations around the world make similar calls. Locally community-based health promoters also play crucial advocacy roles for health equity. It can therefore be argued that collectively, civil society is crucial to bring the bottom up political pressure to bear on politicians and policy makers so that they are willing to take action on health equity. Civil society can be oppositional to governments and in extreme situations can bring about social and political change by contributing pressure for a change of government. In other situations, progressive civil society can work through advocacy and incremental change and will be opportunistic about chances to influence policy agenda.

Linking social capital

So far we have seen that bringing about action on health equity will reflect a complex mix of sufficient evidence, good understanding of what changes population health, a political elite committed to changes and active civil society pressure for that change. But we are still left with the question of how is it that some societies are more inclined towards taking action to reduce health inequities than others. Some clues can be found in the notion of linking social capital. Szreter & Woolcock (2004, p.655) define linking social capital as “norms of respect and networks of trusting relationships between people who are interacting across explicit, formal or institutionalised power or authority gradients in society.” What does this mean in practice? A society high in linking social capital is

likely to be characterised by the following features:

- High trust in formal institutions.
- Fair and transparent public policy processes.
- Commitment to redistribution by the better off people in society.
- Commitment to activities of State (e.g. low taxation evasion).
- Opportunities for people from different groups to interact in a respectful manner.

There are indications that many of these factors are declining rather than increasing. Trust in institutions has declined significantly in the past two decades in most countries where this is measured (Eckersley, 2004). While transparency and fairness are upheld as hallmarks of democracy in practice there have been significant challenges to this. The extent of commitment to redistribution varies around the world from the Nordic countries, where it is high, to others where taxation policy is moving away from redistribution, Australia and the US included (Stretton, 2005). Many corporations and very rich individuals seek to avoid tax and show little commitment to the country in which they operate, preferring to avoid tax whenever possible (Korten, 2006). A society high in linking social capital would have its richest corporate and individual citizens committed to supporting a strong taxation base. This base would make possible redistributive measures. In the Australian context, Stretton (2005) has pointed out that under the conservative Menzies government in the 1950s the top margin tax rate was far higher than it is in Australia today. Finally, what opportunities are there for people to interact respectively across class and ethnic difference? The degree to which this can happen varies from society to society but in societies marked by considerable inequity it happens less. The consequence is that there are less common bonds and less understanding. Linking social capital implies that there is a sense of obligation from powerful institutions in society towards the less powerful. Bourdieu's (1986) conception of social capital makes it clear that the networks and reciprocities involved in exchanges most commonly work to the benefit of the already well-off and more powerful groups. They do this by giving people pathways by which they gain access to educational, cultural and employment opportunities. Policies aimed at reducing inequities should, as an aim, work towards ensuring that benefits that accrue to certain classes in society are made available to other less powerful and privileged groups as well, on the premise that a society that supports and encourages such policies is

likely to be characterised by high linking social capital. The importance of this notion of linking social capital is best illustrated by a case example articulated herein, which focuses on a case study of the absence of linking social capital between Australian Aboriginal and non-Aboriginal peoples. The case shows how the absence of linking social capital can have profound impact on health and illustrates how the presence of strong linking social capital has the potential to encourage government commitment to equity.

Australian case study of the lack of linking social capital

The case of the relationship between non-Indigenous Australians and Indigenous Australians illustrates the importance of the concept of linking social capital to the likelihood of effective intervention to reduce health inequity. Indigenous people in Australia have been described as second class citizens in Australia (Chesterman & Gilligan, 1997). In the early days of settlement there is solid evidence (Hunter 1993; Reynolds 1998) that they were subjected to considerable violence. In the 20th century much Indigenous experience was shaped by the welfare policies purported to be in the best interests of Indigenous people. In fact, it controlled their lives to the extent that children were removed from their families and the law dictated who Indigenous people could and could not marry. The experience of the “stolen generation” has been well-documented in the Bringing Them Back Home Report (Human Rights and Equal Opportunity Commission 1997). It demonstrates the significant impact that these experiences have had on the health and well-being of the Indigenous people caught up in this shameful period of Australian history. Clearly one of the sequelae of these experiences is a legacy of deep mistrust that the Indigenous people have towards mainstream institutions of the non-Indigenous society, such as, the police, health and welfare systems, and schools. Clearly, very little linking social capital was evident in this area.

Non-Indigenous Australians often project negative views of Indigenous Australians that reflect purely on their current behaviour and situation without taking into account the impact of the historical experience of Indigenous peoples. Indigenous peoples are far more excluded from the social and economic mainstream of Australian life than are other Australians (Trudgen, 2000). They are also subjected to significant racism (Hunter, 1993) and live in a world which is dominated by invisible and largely unacknowledged assumptions of whiteness (for further details of concept of

'whiteness' see Riggs 2004; Fein et al., 1997). The history of Australia since the invasion by white people shows that a number of factors have worked to determine the health of the indigenous people; these include: the way society has been organized, the degree and nature of interaction between Indigenous and other Australians, the levels of trust between the two groups and the extent of care extended to Indigenous Australians by the wider society. Limited attempts have been made to bridging the social capital between Indigenous and non Indigenous Australians and therefore the scope for linking social capital to development has sadly been lacking in Australian society. This has led to the exclusion of the Australian Indigenous people from mainstream economic, educational and social life in Australia. Some insights into the likely impact of social exclusion on health can be gained from the recent literature debating the impact of income inequality across populations. Wilkinson (2005) has argued that a key determinant of population health outcomes is the extent to which societies distributed their income equally with more equal societies achieving higher population health outcomes. He theorised that part of the explanation for this pattern was that countries with less equal distribution of income also had lower levels of social capital. He argues that this link exists because unequal societies are characterized by individuals with increased anxiety and low social support institutions and by higher levels of violence and disrespect between citizens. His work has been strongly criticized for underplaying the role of access to material factors (especially employment and housing) that underpin inequalities (see for example, Lynch et al., 2000). However it gains support from the work of Michael Marmot and colleagues (Marmot et al., 1991; Brunner & Marmot, 1999) who explain health status gradients in populations through the stress people experience from not being at the top of hierarchies and the consequent absence or loss of autonomy over one's life, working and neighbourhood environment. Applied to the experiences in the Australian context, it is evident that racism and economic inequity have led to lack of control on part of the indigenous people, over their life in terms of its direction, culture and traditional ways and the ownership of land. This has led to extreme stress for Indigenous peoples; Marmot's work indicates that it is likely to have a very significant impact on health. The situation principally results from the lack of supportive policies from mainstream Australia – the lack of linking social capital. Szreter and Woolcock (2004) argue that consideration of the relationship of the state in terms of the initiation and sus-

taining of networks, trust and social structures is crucial. They show, with illustrations from a case study from nineteenth century England, that states (local and central) can create and encourage the conditions in which linking social capital can operate. They can do this by ensuring that resources flow from more powerful to less powerful groups. Szreter and Woolcock's (2004) argument leads to the conclusion that greater linking social capital in Australia can lead to increased empathy about the dispossession suffered by Aboriginal people, and increase in the level of concern with respect to improving the material conditions and facilities and services available to Aboriginal people; this will contribute to advancing the common commitment to a goal of a society of mutually respecting citizens. While there have always been accounts of some sympathy and empathy and desire to link with Indigenous peoples from those more powerful, this has rarely been from other than a small minority (Reynolds, 1998).

Theories on linking social capital suggest that it is most evident at times when networks and trust develop between groups. Over the last fifty years, the Australian history does suggest that there has been a growing movement in which Indigenous peoples in Australia have been able to assert their rights more than in the past (Burgmann, 1993). Their endeavours have been supported by non-Indigenous people as was seen in the referendum on constitutional rights for Indigenous peoples and during the reconciliation marches of 2000. The early 1990s held promise of being a period in which linking social capital between Indigenous and non-Indigenous Australians might take root, as evidenced by the then Australian Prime Minister Paul Keating's 1993 Redfern speech:

"And, as I say, the starting point might be to recognise that the problem starts with us non-Aboriginal Australians. It begins, I think, with the act of recognition. Recognition that it was we who did the dispossession. We took the traditional lands and smashed the traditional way of life. We brought the disasters. The alcohol. We committed the murders. We took the children from their mothers. We practised discrimination and exclusion. It was our ignorance and our prejudice. And our failure to imagine these things being done to us. With some noble exceptions, we failed to make the most basic human response and enter into their hearts and minds. We failed to ask - how would I feel if this were done to me?"

This political will received strong support from an active reconciliation movement that reached a height with a reconciliation walk involving 250,000 Australians

across Sydney Harbour Bridge in May 2000. But recent events with the promotion of more punitive policies suggest any linking social capital has been on the decline in recent years. Recent policy directions such as the imposition of "Shared Responsibility Agreements" which demand certain behaviours from Indigenous people as a condition for receiving social security benefits have acted to reduce the autonomy of Indigenous peoples and have been interpreted as a return to more paternalistic policy days (Collard et al., 2005; Anderson, 2006). Our knowledge of the importance of *control to health status* (Marmot, 2004) suggests that policies should aim to encourage self-determination supported by resources that can make a difference. Linking social capital suggests a policy approach, which is trustful of communities, encourages them to do the right thing for their children and provides them with the infrastructure to create a health promoting environment.

Conclusion

This article has examined the factors that are important for encouraging practical action on social and economic factors that affect population health and health inequities. It has argued that knowledge is crucial but insufficient and that in order to crack the nut of inequity, practical action is needed both from governments as well as the civil society. Civil society is constituted by a rich array of groups, many of whom remain concerned about promoting justice at a local level and lobby and advocate for equity-oriented policies. Their actions can encourage governments to take action and can develop popular constituencies to support action initiated by the government. Governments need to recognize that taking effective action would be reflective of their commitment to equity and justice and will enable them to deal with the complexity of evidence and devising complex responses. These responses need to be based on strategies that go beyond blaming individuals to those that focus on creating health and equity promoting environments. However, the exact process by which such commitment comes about differs from one context to another. Notwithstanding, it is likely to emanate from a society in which governments and their agencies have both the ability to deal with complex evidence and devise solutions that deal with this complexity leveraging social capital. This form of social capital ensures that the better off in a society are prepared to support and encourage action to improve the health in a way that reduces inequity. Thus when the Commission on the Social Determinants of Health reports in May 2008 a crucial legacy will include improved knowledge on how

action on social and economic determinants can be used by governments to improve population health equitably; examples of governments who are successfully taking such action; a strengthened civil society with a louder voice about the importance of this action and improved understanding of the processes (such as linking social capital) by which societies adopt fairness and justice as the basis of their social and health policies.

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Criteria and checkpoints for better community health promotion

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Members of the Global Consortium on Community Health Promotion have been wrestling with two questions in their work together over the term of this Consortium. These questions are: 'How best can community health promotion practitioners check out whether their general activities and specific projects meet current standards of good community health promotion practice? And, where do practitioners start, whether working alone or in a team, in order to make certain they are working most effectively?'

To address these questions, the Consortium members decided to compile a simple list of criteria and checkpoints to assist practitioners in appraising their project activities step by step. Although this is definitely an early work-in-progress, we have decided to place the initial draft in the public domain so as to encourage practitioners to provide us with feedback since the list will only be able to be verified after field-based testing of these suggested steps.

The values outlined in the Statement of the Global Consortium published in previous edition of this journal (Nishtar et al., 2006), need to be read in conjunction with these criteria and checkpoints as these values form the foundation on which this list has been compiled. The most pertinent of these values and principles in relation to this checklist is the recognition that "community participation... must drive every stage of health promoting actions" (Nishtar et al., 2006). The term 'community health promotion' refers here to health promotion action initiated *with* community members, *by* community members and *for* community members. Working in partnership with communities throughout all activities is the essence of good community health promotion.

Two existing works-in-progress have served to lay the foundations for this checklist and the Consortium gratefully acknowledges these contributions. The Centre for Community Health Promotion Research, University of Victoria in Canada has done some far-reaching work in developing a framework to assess the effectiveness of community health promotion interventions, and this Centre has been very generous in sharing their developing material with us.

The Western Pacific Region of the World Health Organization has in recent years developed regional guidelines for implementing a Healthy Islands approach to promoting health (WHO WPRO, 2001), with a special focus on checking out progress in initiating and implementing community health promotion action. This development in particular has occurred through extensive consultation with communities across the Pacific island countries.

The criteria and checkpoints for community health promotion practice are here set out in two stages: Stage I: 'Getting Started' and Stage II: 'On the Go'. We hope that despite not yet being tested in the field, they can be refined with your feedback, and eventually offer real value to practitioners.

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Stage 1: Getting Started

Criteria for initiating community health promotion action

As you begin

Invite the community to identify and prioritise the issues they want addressed by health promoting action.

- Outline the issue to be addressed.
- State the population concerned.
- Describe how the community context – physical environment, and/or social, cultural, political, economic or gender aspects – has influenced the issue in the first place.
- Indicate source and amount of specific funding, if available.

'Starting': Collaborative Planning and Organisation

How does the community want to take this action forward?

Which other key persons have an interest or stake in addressing the nominated issue?

How can they come to agree on appropriate action?

What is the goal of community health promotion action in this instance?

What strategies can be harnessed to meet this goal?

In partnership with the community, consider: what steps need to be taken to implement this action?

- Identify the issues important to the community in starting this action
- Identify key stakeholders, reflecting the full diversity of views and recognising the power different ones hold.
- Provide opportunities for different views to be aired and discussed.
- Plan discussions to work towards developing a common vision.
- Document the shared vision.
- With community:
 - Determine leader responsibilities.
 - Identify community leader.
 - Implement structures for relevant data collection and management.
 - Implement structures for regular forums for reflection on progress.
 - Determine health promotion goal to address this issue.
 - Determine health promotion strategies to meet this goal.

Checkpoints

Which immediate outcomes have you achieved in Stage 1?

Community mobilised?

☐ Very well ☐ Well ☐ Somewhat ☐ Not well ☐ Not at all well

Relevant data sought?

☐ Very well ☐ Well ☐ Somewhat ☐ Not well ☐ Not at all well

Collaborative partnerships initiated?

☐ Very well ☐ Well ☐ Somewhat ☐ Not well ☐ Not at all well

Leader identified?

☐ Yes ☐ No

Priorities identified?

☐ Very well ☐ Well ☐ Somewhat ☐ Not well ☐ Not at all well

Goal determined?

☐ Very well ☐ Well ☐ Somewhat ☐ Not well ☐ Not at all well

Strategies planned?

☐ Very well ☐ Well ☐ Somewhat ☐ Not well ☐ Not at all well

Communities involved in all stages of planning?

☐ Very well ☐ Well ☐ Somewhat ☐ Not well ☐ Not at all well

Initiating action able to be sustained?

☐ Very well ☐ Well ☐ Somewhat ☐ Not well ☐ Not at all well

Plan able to be disseminated to others?

☐ Very well ☐ Well ☐ Somewhat ☐ Not well ☐ Not at all well

Stage 2: 'On the Go'

Criteria for implementing community health promotion action

'Doing': Community organisation and action

Have mechanisms been put in place to engage the community at every stage?

Have key stakeholders adequate capability to implement strategies identified in Stage 1?

Has appropriate leadership evolved?

Have appropriate resources been mobilised for this implementation?

Is the process being monitored?

- Engage the community.
- Confirm leadership.
- Support key stakeholders with on-going training if required.
- Mobilise resources for action.
- Monitor the process of implementation.

'Making Waves': Bringing about transformational change

Has community action led to wider a social understanding of health promotion?

Have stakeholders connected with champions from other sectors? Has the community decided they want health promotion action to be publicised?

Has this health promotion action managed to positively influence wider public policy?

Has the development of a health promotion initiative in collaboration with the community led to the establishment of an evidence base for community health promotion action?

- Connect stakeholders with champions from other sectors.
- Publicise this health promotion action.
- Influence wider public policy by stakeholders.
- Influence wider social understanding by community action.
- Identify components of an evidence base for community health promotion action.

Checkpoints

Which immediate outcomes have you achieved in Stage 2?

Communities involved in all stages of planning and implementing?

☐ Very well ☐ Well ☐ Somewhat ☐ Not well ☐ Not at all well

Relevant data collected and used?

☐ Very well ☐ Well ☐ Somewhat ☐ Not well ☐ Not at all well

Collaborative partnerships cemented?

☐ Very well ☐ Well ☐ Somewhat ☐ Not well ☐ Not at all well

Leader confirmed and followed?

☐ Very well ☐ Well ☐ Somewhat ☐ Not well ☐ Not at all well

Priorities confirmed?

☐ Very well ☐ Well ☐ Somewhat ☐ Not well ☐ Not at all well

Goal confirmed?

☐ Very well ☐ Well ☐ Somewhat ☐ Not well ☐ Not at all well

Strategies confirmed and implemented?

☐ Very well ☐ Well ☐ Somewhat ☐ Not well ☐ Not at all well

Implementing action continuing to be sustained?

☐ Very well ☐ Well ☐ Somewhat ☐ Not well ☐ Not at all well

Plan able to be disseminated to others?

☐ Very well ☐ Well ☐ Somewhat ☐ Not well ☐ Not at all well

Community health promotion in Pakistan: a policy development perspective

K. A. Ronis¹ and S. Nishtar²

Abstract: Pakistan was one of the initial signatories to the Alma-Ata Declaration in 1978; however, it was not until 2004 that the first policy dedicated solely to public health and health promotion was launched. The National Action Plan for Prevention and Control of Non-communicable Diseases and Health Promotion in Pakistan has gained a prominent place on the nation's health agenda competing for resources with traditional health policies that focus on treatment, cure and evolving technology. From a health promotion perspective the action plan was unique in that it focused on the community setting through two major behavioral communication change initiatives – one through the media and the other by integrating non-communicable disease prevention into the work plan of the Lady Health Workers.

The development phase of this inaugural public health/health promotion policy follows closely the pathway of the Australian Policy Cycle and celebrates a comprehensive consultation process. Its strength comes from the tripartite partnership between the Government, the World Health Organization and a Non-Government Organization, Heartfile who lent impetus to the creation of the initiative. This public-private partnership greatly facilitated the process of policy development and continues to support research, implementation and evaluation. This paper endeavors to analyze the development of the National Action Plan with a focus on community health promotion. (*Promotion & Education*, 2007, (2): pp 98-99)

Key words: community health promotion, policy cycle, public-private partnerships

Résumé en français à la page 120. Resumen en español en la página 132.

Historical background to health promotion policies in Pakistan

In 1978, Pakistan became one of the initial signatories to the World Health Organization's (WHO) Alma-Ata Declaration, which laid the foundation and target for *Health for All by the Year 2000* (WHO, 1978). One of the five principles to emerge from Alma-Ata focuses on disease prevention, health promotion, and curative and rehabilitative services. Policies to address this principle in Pakistan did not appear until 1990 when the Pakistan Government launched its first *National Health Policy* (Ministry of Health, Government of Pakistan, 1990). From a public health and health promotion perspective this policy focused on school health services; family planning; nutrition programs; malaria control programs; control of communicable diseases (e.g. tuberculosis and infective hepatitis); sanitation and safe drinking water.

In 1997, the second *National Health Policy* (Ministry of Health, Government of Pakistan, 1997) was launched and health promotion and health education received a prominent place under priority health programs and non-communicable diseases, such as, cardiovascular disease, cancer and diabetes were highlighted for prevention and control measures. The focus for health promotion was "health education" and the five principles of the *Ottawa Charter for Health Promotion* (WHO, 1986) as a guiding framework per se were not alluded to.

The most recent *National Health Policy* (Ministry of Health, Government of Pak-

istan, 2001) was launched in 2001 and omits the prevention and control aspect of non-communicable diseases; it does not specifically refer to health promotion and, in relation to public health, the main goal is ...to create mass awareness in public health matters with a major focus on the use of multi-media to disseminate information.

In 2003, a Pakistani non-government organization (NGO) by the name of *Heartfile* (<http://heartfile.org>) approached Pakistan's Ministry of Health and lobbied for the development (implementation and evaluation) of a public health/health promotion policy that specifically addressed non-communicable diseases from a prevention and wellbeing perspective. A tripartite partnership was formed between the Ministry of Health, the World Health Organization and *Heartfile*, a unique combination of public-private sectors working together to support national health goals (Nishtar et al., 2005).

In 2004, the *National Action Plan for Prevention and Control of Non-communicable Diseases and Health Promotion in Pakistan* (NAP-NCD) (Ministry of Health, WHO and *Heartfile*, 2004) was launched and the first planning phase for implementation was initiated. This public health/health promotion policy is both a policy and an implementation document and is Pakistan's first national policy devoted specifically to the prevention and control of non-communicable diseases and health promotion and therefore is a milestone in public health/health promotion policy development.

What policy development cycle did the NAP – NCD follow?

In the absence of a *Pakistani Policy Cycle* reference, the *Australian Policy Cycle* (Bridgman & Davis, 2004) has been utilized to analyze the development of the NAP – NCD policy as seen in Figure 1.

Bridgman and Davis (2004) state that *much policy begins with identifying issues* and during the initial planning phase of the NAP - NCD, there was the identification that non-communicable diseases such as cardiovascular disease, lung disease, diabetes and cancer contribute significantly to the illness of the Pakistani population; secondly, these diseases are very costly in their treatment (incurred on the health system) and thirdly, if there are significant numbers of people affected by morbidity then this affects the social and economic productivity of a nation (Heartfile, 2003a).

Figure 1

Identify issues ⇒ policy analysis ⇒ policy instruments ⇒ consultation ⇒ co-ordination ⇒ decision ⇒ implementation ⇒ evaluation ⇒ identify issues etc.

In addition to the identification of the impact that the afore mentioned diseases have on the Pakistani society, they *do not feature prominently in Pakistan's National Health Policy and are not addressed in a prevention and control paradigm* (Heartfile, 2003a). According to Bridgman and Davis

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(2004) *sometimes an existing policy proves no longer effective and requires an overhaul....* and with this new public health/health promotion policy, *Heartfile* identified the fact that the current national health policy did not give due coverage of these non-communicable diseases and community health promotion therefore a new strategic framework was needed.

Heartfile successfully identified the issues and put non-communicable diseases, prevention and community health promotion on the agenda for consideration by the Federal Government.

According to Bridgman and Davis (2004), **policy analysis**, is often - though not always - the work of the public service, drawing on broader debates among specialists in a policy field. In the development of the NAP - NCD, decision makers were provided with a situational analysis by *Heartfile* about the policy problem (i.e. non-communicable diseases and health promotion) so the decision makers could make an informed decision and provide information/data for debate. *Heartfile* provided a situational analysis due to their technical expertise in the area which examined programs and policies within Pakistan to review existing prevention and control related efforts and to identify gaps related to policy, implementation and research. The action plan was led by *Heartfile* until the time of its development and launch.

Policy analysis leads to *identification of appropriate policy instruments* (Bridgman & Davis, 2004) and with this public health/health promotion policy, the instrument selected was a national action plan with an Integrated Framework for Action. The dual approach provided a guide for the policy maker and bureaucrat and was scientifically written to appeal to the public health/health promotion community.

Bridgman and Davis (2004) state that, *through consultation, policy proposals are improved, ideas tested and, appropriate, support gathered.* One of the major strengths in the development phase of the NAP - NCD is related to the wide consultation which started with the tripartite collaboration of the Ministry of Health, Government of Pakistan; WHO and *Heartfile*. In addition to the three main partners, other relevant players or actors were consulted, for example: the scientific community; public health practitioners; related organizations; other stakeholders, key leadership and staff.

In an Australian policy cycle context, the **co-ordination** element of the cycle requires discussions with treasury about available funding and to consider the relation between a new proposal (in this example the NAP - NCD) and overall government direction (in this example Pakistan's

National Health Policy). The development of the NAP - NCD was well situated within the overall direction of the government's health policy and availability of resources was discussed. *Heartfile* successfully lobbied the Ministry of Health to allocate funding to the action plan and transform it into a program.

The **decision phase** in the policy cycle means consideration by cabinet or other recognized authority and in this case a committee of the Ministry of Health and the Planning Commission had the mandate to take such a decision. According to Bridgman and Davis (2004), **implementation must follow, in which policy is given expression through legislation or a program, in pursuit of the goals agreed by ministers.** With the NAP - NCD an Integrated Framework for Action was included to prioritize and direct the implementation of the policy.

Under a formally approved Planning Commission 1 (PC 1) (Ministry of Health, Planning Commission, 2003) allocations have already been made to support two major community health promotion initiatives namely the media focused behavioral change communication strategy and a communication campaign at the grass roots level utilizing the Lady Health Workers of the National Program for Family Planning and Primary Health Care (2nd Goal) (*Heartfile*, Ministry of Health, WHO and 2004).

According to Bridgman and Davis (2004) **evaluation is essential so government can gauge the effects of a policy and adjust or rethink policy design as appropriate.** Similarly, partners that have supported a policy development, such as, WHO and *Heartfile*, also need to know the effectiveness of the policy and to assess the viability of continuing as a partner both in terms of time commitment and other resources (e.g. funding). In addition, evaluation can help in redesigning or fine tuning community health promotion programs in response to process, impact and outcome evaluation findings.

In conclusion, the development of Pakistan's first *National Action Plan for Prevention and Control of Non-communicable Diseases and Health Promotion* adhered to a comprehensive and well planned policy cycle; its implementation in the community setting aimed at promoting health and well-being has been initiated and ongoing monitoring reports indicate a supportive public - private partnership approach.

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From testimony to advocacy: a humanitarian NGO's experience

J. Ancien, p. 118

Doctors of the World France (*Médecins du Monde*, MdM) is an international humanitarian aid NGO working to support access to health care to vulnerable populations of the world excluded from these services. MdM has fixed two strategies to «cure and give witness,» especially in light of the flagrant injustices lived by the populations they work with. Based on the need to improve the situation of these populations, and using the Anglo-Saxon model, the association wanted to take their strategy one step further by progressively developing advocacy actions in partnership with other organizations. This case study shows the different success obtained through advocacy actions in two campaigns: one against the World Bank's promotion of health systems' privatization in 1993 and another one for the increase in training of health care workers in the Southern hemisphere in 2006.

A healthy park: the case of a prevention and community health promotion programme in a marginalised area in the Peruvian forest

E. Peñaherrera Sánchez and W. Palomino, p. 129

The healthy park initiative is an example of a prevention and health promotion programme in a community affected by high levels of drug use. It was developed through a strategic partnership with local actors (such as community leaders and youth groups), public institutions (Health and Education Ministries and the local police) and private sector institutions (NGOs, local commerce). The community involvement was essential throughout the project's entire process of design and implementation. Community members were empowered through direct responsibility for carrying out the project and its follow-up, through advocacy initiatives and financial accounting with the funding agency, the Belge Technical Cooperation group. The key programme outputs include the creation of a framework for community coexistence and a community development plan, which allowed not only to plan and distribute responsibilities among the neighbours for the park's care and maintenance, but also to coordinate an increase in services and development opportunities with the local authorities.

Network of healthy communities of Rio de Janeiro – Brazil

Daniel Becker^{1,2}, Katia B. Edmundo¹, Wanda Guimarães¹, Maria S. Vasconcelos¹, Daniella Bonatto¹, Nilza R. Nunes¹ and Ana Paula Baptista¹

Abstract: Poor communities in Rio de Janeiro, which are known as *favelas*, suffer from various problems related to poor housing, poverty, unemployment, violence and organized crime, and lack of access to basic services, such as health care and education. In order to tackle these determinants, and inspired by WHO's international Healthy Communities/Cities movement, the Network of Healthy Communities of Rio de Janeiro was formed in 2004. The Network is coordinated by the Center for Health Promotion (CEDAPS) and now includes more than 100 community groups and organizations in the state of Rio de Janeiro. Their aim is to promote health, community development and equity through community empowerment, participation, capacity building and advocacy. The paper describes the work that has been done since the Network's inception and the challenges which they face to reach their goals in the context of a country like Brazil. The Network represents an important landmark of how poor populations can organize themselves in a collective, participatory and constructive way to influence public policy and strive for better conditions of life in disadvantaged settings, like the *favelas*. (*Promotion & Education*, 2007, (2): pp 101-102)

Key words: poor communities, empowerment, equity

Résumé en français à la page 123. Resumen en español en la página 133.

Background

The Network of Healthy Communities of Rio de Janeiro is a social initiative for promoting health and equity, especially through community development. The approach was inspired by the international Healthy Cities movement, which was launched in 2005 by 59 communities, with the support of the Dreyfus Health Foundation, the Brazilian Ministry of Health, the Rio de Janeiro Municipal Health Secretariat, the Pan-American Health Organization (PAHO), the Ford Foundation, several universities and NGOs.

Poor communities (*favelas*) in Rio de Janeiro suffer from serious problems, such as poor housing and environmental conditions, unemployment, lack of recreation and cultural life, and restricted access to basic services such as health and education. In addition, they are severely affected by violence from organized crime and the state police.

Public policies directed towards low-income communities in Brazil are scarce and almost always implemented without taking local needs into account; therefore, they fail to harness the potential of local talent. Residents have limited opportunities to participate and contribute to the development of these policies. As a result, the effectiveness, sustainability and ownership of social interventions are reduced.

It is thus crucial to increase opportunities for community participation in the development and implementation of social sector community projects. Networking of community groups can increase their collective political strength and enable them to operate autonomously. Networking can also enable the building of capacity in low-

income communities thus enabling them to participate in decision-making relevant to programs that affect them.

Besides, poor communities have many untapped resources. These include: social networks, solidarity, celebration and culture, businesses, informal activities on education, recreation, religion, politics and much more. There are men and women that even in the midst of extreme poverty, violence and lack of services, break the isolation of their homes and become agents of a social action that benefits their communities. Capacity building and networking can strengthen this potential.

Given better opportunities to develop their skills and potentials, with better chances of interaction with the civil society and the state, community members can increase their contribution to the economic, social, and cultural development of their communities.

It was within the context of these realizations that the initial goals of the Network were formulated; these are to:

- strengthen and empower each community group through capacity building, planning and systematization of actions, meetings and exchange of experiences and opportunities;
- improve the collective power to strengthen the capacity of communities to defend their right to health and to negotiate programs and public policies;
- increase social participation to influence local governance and open avenues for communities to become stakeholders in health (and other) public policies;
- increase visibility of positive actions in *favelas*, fighting prejudice and stigma.

The Network of Healthy Communities

presently comprises 106 members - groups and associations that work for development and health promotion in poor communities in the State of Rio de Janeiro. According to a recent survey, the total population of those territories is over 1.4 million people. 68% of leaders are women, and 75% are African-Brazilian. 92% use their own resources (including personal finances) for their work. They engage in all kinds of forums and committees to obtain resources to their communities and to voice their problems and needs. Their work reaches directly 130,000 people and many more indirectly.

The Rio de Janeiro-based non-governmental organization Center for Health Promotion (Cedaps, 2007) acts as a technical and political reference for support, channeling its resources, projects, and institutional partnerships to the Network. Cedaps builds the capacity of organizations to plan strategically and develop local actions, helps them to produce educational material and activities, articulates integrated actions and events, promotes partnerships and strengthens the capacity to negotiate with the government and the private sector.

To reach these goals, CEDAPS uses an empowerment-oriented methodology, "Shared Construction of Solutions" (Cedaps, 2007), based on the Problem Solving for Better Health (PSBH) program, developed by the Dreyfus Health Foundation, based in New York, in more than 30 countries worldwide (Dreyfus Health Foundation, 2002), and on additional elements from well known methodologies: Healthy Cities; Carlos Matus' Strategic Planning (Azevedo, 1992); Local Development (Becker et al., 2005), Paulo Freire's Popular Education (Freire, 2000) and others.

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This social 'technology' creates an opportunity for the direct participation of community leaders and groups, enabling them to contribute in problem solving, through indigenously derived solutions that harness available resources and partnerships. This enables mobilization of the community and its resources and a network of social projects, with solutions that have the potential to generate direct impacts. The people who suffer with the problems become problem solvers and active stakeholders acting to change the social determinants of health. The collective construction systematizes and organizes local actions, promoting ownership and sustainability to the development process initiated.

Community-based interventions have contributed to tackling issues such as domestic and street violence, lack of cultural and sport activities, prevention of HIV/Aids and other infectious diseases, adolescent pregnancy, income generation, environmental and sanitation problems, smoking, hypertension and diabetes and community organization.

Meeting the challenges

A major challenge of the network is how to evaluate and demonstrate changes and benefits of such a program, which works with so many intangible variables; and therefore, systematizing and collecting these results is very important. Many of the member communities have been working with CEDAPS for more than 10 years to do so. Some of the results achieved at a process and output level are as follows:

- 13 HIV/Aids community managed Prevention Centers;
- Almost 400,000 condoms distributed every year;
- More than 1,200 educational events and activities yearly;
- Several health promotion activities developed by community leaders;
- Creation of innovative educational strategies and material;
- 700 adolescents in 11 communities have participated in education programs that promote autonomy, self-esteem, and social entrepreneurship; 80% of them express better understanding of citizenship, better self care, social responsibility, and better perspectives for the future;

Local development programs that engage residents since the diagnostics phase, creating integrated networks of community projects in health, environment, leisure, education, and income generation.

Another important challenge consists on broadening those results into the collective perspective of a network organization. In addition to strengthening local actions, it is also important to break the iso-

lation and engage people in collective and solidarity actions. Some indicators reflect this empowerment process (Wallerstein, 2006), such as, the leaders, who:

- Learn to develop projects, to speak in public, to organize their actions and physical space;
- Establish partnerships, circulate in academic and political environments;
- Negotiate and co-manage social programs;
- Support the actions of their peers, disseminate information and opportunities, exchange experiences, get organized to fight for collective causes;
- Obtain media coverage and campaigns, gain visibility and break the segregation of favelas;
- Broaden their horizons, participating in forums, meetings, conferences, and councils.

A third challenge is to effectively increase social participation in public policies in a country like Brazil. In this area, changes have started to emerge. The Network is directly involved in partnerships with public policies, in Primary Health Care programs, the Pan-American Games in Rio de Janeiro, groups that fight social violence and others. In this regard, CEDAPS is working to improve the Network capacities in advocacy and social control of public resources.

The forth challenge is sustainability. CEDAPS doesn't have a direct line of funding for the Network's activities, and it is struggling to obtain resources that allow for intensifying the collective and capacity building activities. In the long term, we expect that cooperation with public policy makers will help to sustain the program.

Finally, there is also the challenge of how to disseminate this experience and facilitate an exchange. CEDAPS is constantly seeking for such opportunities. As part of the Dreyfus Health Foundation's global PSBH community (with 30 countries), we plan to integrate other initiatives into an international network of communities. CEDAPS has published several articles about the Network, it is co-creating the Brazilian Network of Healthy Communities and Municipalities, and has joined IUHPE's Global Consortium for Community Health Promotion and the Knowledge Network for Urban Settings of WHO's Commission for Social Determinants of Health. Our next goal is to participate in South-South cooperative programs.

Perspectives

The Network of Healthy Communities represents an important step in the ability of poor populations to obtain better public policies. Our work recognizes that there are

community leaders and groups that strive for better conditions of life in *favelas*, and that their work must be reinforced.

The Network is demonstrating that an organized movement, created in a collective, participatory, and constructive way, can reinforce the effectiveness of each group, and create collective power for broader and more ambitious achievements. We hope that it will represent a landmark for health promotion in communities.

We all seek utopia – an integrated, equitable, and healthy city. As Mário Quintana, Brazilian poet, used to say, "certain things cannot be achieved, but this is not a reason to give up seeking them". The Network of Healthy Communities wants utopia and works to achieve it.

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Development of Healthy Cities networks in Europe

Eberhard Goepel¹

Abstract: The Healthy Cities network in Europe was inspired by the Ottawa Charter for Health Promotion when it was launched in 1987. The networking process was initiated by the WHO Regional Office for Europe, but developed its own dynamics in different European countries during a time marked by fundamental political transformations in many of the countries of Eastern Europe. The networks then connected with the 'Local Agenda 21' and the 'Sustainable Cities and Towns Campaign' to create a new and broader programmatic agenda at the local level. In particular, the «Aalborg plus10 – commitments» of local governments in 2004 have the potential to inspire a new phase of participatory and sustainable policies at the level of local communities in Europe. However, the extent to which these initiatives will influence the macro-politics of the European Union towards a proclaimed "Europe of Citizens" remains to be watched carefully during the coming years. (*Promotion & Education*, 2007, (2): pp 103-104)

Key words: healthy cities, Europe, sustainability

Résumé en français à la page 123. Resumen en español en la página 133.

The founding role of the WHO European Region

The Healthy Cities project was launched in Europe in 1987 by the WHO Regional Office for Europe. It was clearly inspired by the Ottawa Charter and the "Health for All" strategy. The public response revealed that the initiative was timely in a Europe, which was undergoing a political transition, especially in the East. Besides the organization of a formal WHO-led European Healthy Cities Network, which has so far implemented over four, 5-year phases of structured and goal-oriented collaborative activities with a limited number of especially committed cities, an open process of regional and national networking of interested cities and counties has also been stimulated.

The movement quickly spread and, after two years, in 1989, more than 350 cities in Europe had declared themselves members of a national healthy city network and many more expressed their interest in joining to address the public concerns related to urban health and living conditions. Today more than 1300 cities, districts and counties are members in more than 30 national networks; however the motivational impetus to these efforts is clearly on the decline and needs new political commitment to take this process successfully into the future.

During the last 20 years the importance of the urban dimension of living conditions and the key role of local governance for the planning of appropriate health services and of sustainable living conditions has become widely recognized. The European region has experienced enormous political and constitutional changes during the last 20 years. Between 1989 and 1996, 27 states in the eastern part of the Region adopted new constitutions with the overall trend to

decentralize and democratize political processes. Municipal governments have been delegated more responsibility and autonomy to set priorities and decide policies in areas such as education, social services, health services, community care, environment, and health and urban planning.

During this process of change, a parallel process of dramatic decline of public financial resources also took place and imposed severe constraints for political initiatives at the local level. Under these circumstances, the development of activities at the local level and the organization of national networks varied considerably in the different countries and regions. The structure of national health systems, the existence or lack of supportive national and regional policy frameworks for "Health for All" or for sustainable development in the context of the Local Agenda 21, as well as the distribution of responsibilities and resources for service delivery between local governments, regional structures and the national governments, heavily influenced the potential for common actions.

During the first years of the European Healthy Cities network the WHO mainly helped to share information and to facilitate training and resource development for the networks. Later, in addition, it tried to strengthen the organizational and strategic capacity of the national networks and urged national governments to recognize them as important structures and players in urban and public health. Coordinators and political leaders from national healthy cities networks met regularly and cooperated directly with WHO in a special European forum for networks. An important achievement of this cooperation has been the adoption of a common set of minimal standards

for a Healthy City and an action framework, which aspired to raise the professional standards of healthy cities activities in the different networks and their constituent cities.

As a new working method, city health profiles or health development plans were introduced. These techniques were originally developed by piloting within the WHO European Healthy Cities network. The profiles should provide a basis for a city to develop an intersectoral plan for joint actions with its partners derived from a quantitative and qualitative analysis of social, environmental and health data, as well as the actual experience of citizens. In some countries, member cities have undertaken population surveys with the aim of spotlighting community priorities and citizens' views on health and environmental development.

National institutes of public health, universities and other research organizations have become increasingly important partners for many networks, since they can secure a sound methodological approach for core tasks, such as the city health profile. National networks and the improvement of international communication have encouraged many cities to move away from a culture of organizing single events to a culture of producing strategic health plans, in which promoting health through intersectoral cooperation becomes an aim for all city departments. The employment of health promotion specialists at the municipal level has fostered these innovative processes in public bureaucracies.

Different surveys and assessments carried out in the European Region indicate that long-established healthy cities networks showed a clear potential to:

- provide a testing ground for new participatory health policies and citizen

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- involvement;
- generate and disseminate knowledge and new ideas through cooperation, conferences, newsletters, websites and organizational development;
- promote best practices by setting standards, giving guidance and consultation, providing training and supporting the professional development of health promotion specialists;
- strengthen local capacities in adopting good governance approaches based on the principles of "Health for All" and the Local Agenda 21;
- inform national policy developments by condensing and advocating local needs.

Opening towards sustainable development and health in a global context

During the last 10 years a number of attempts have been made in Europe to link the Healthy Cities networks with urban planning and sustainable local development initiatives.

The following principles were seen as key for healthy urban planning (Barton et al., 2003):

- Human health as a key facet of sustainable development.
- Cooperation between planning and health agencies.
- Cooperation between the public and the private sectors.
- Community consultation and empowerment.
- Political commitments at the highest level
- Health integrated plans and policies.
- Health integration at all scales from macro to micro.
- A comprehensive approach to determinants of health.
- Evidence-based planning for health.

WHO Regional Office for Europe has made healthy urban planning a core developmental theme of the fourth phase (2003-2007) of the European Healthy Cities Network.

Common programmes at the level of the European Union have been launched, which led in 1994 to the Sustainable Cities and Towns Campaign to integrate health into the broader sustainability discourse.

The national Healthy Cities networks in Europe rarely reached the level of common goal setting with regard to local policy development. The Sustainable Cities and Towns Campaign, conversely, initially obtained 80 European local authorities to sign up to the Aalborg Charter on 'European cities and towns towards sustainability' and committed themselves to its objectives. This document was then renewed in 2004 with the "Aalborg plus 10 – commit-

ments" including a common vision that "cities and towns are inclusive, prosperous, creative and sustainable, and provide a good quality of life for all citizens and enable their participation in all aspects of urban life." (Aalborg Commitments, 2004) The amended document takes into account the challenges faced with globalization and the revolution in technology, as well as the other social, economic, environmental and political determinants; and underlines that working with all the spheres of government is central to combat the determinants.

The next European conference of the Sustainable Cities and Towns Campaign in Sevilla (Spain) in 2007 will reveal the extent to which the ambitious commitments laid out by the Charter have gained substantial support by the different European governments and the European Commission on the route towards a proclaimed "Europe of Citizens."

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EQUINET: Networking for equity in health in eastern and southern Africa

Rene Loewenson¹

Abstract: This short report outlines the perspectives and motivations for the work of the Regional Network for Equity in Health in eastern and southern Africa (EQUINET). It presents key areas of work on health equity being implemented to strengthen the state and public sector in health; organised around the active participation and involvement of communities. This includes work on strengthening people's power for health, on increased fair financing; and on retaining health workers and challenging trade policies that encroach on health. Such work faces challenges that can be met through increased regional networking to exchange experience, information and expertise, particularly given the demand for learning by doing. (*Promotion & Education*, 2007, (2): pp 105-106)

Key words: health equity, Africa, networks

Résumé en français à la page 123. Resumen en español en la página 133.

EQUINET was formed to promote and realize shared values of equity and social justice in health. It involves people working in government, civil society, research, Parliament and other institutions in east and southern Africa (ESA) (www.equinet africa.org).

We have since 1998 used and supported research and policy analysis, held forums for skills development, analysis, dialogue, learning and engagement, strengthened networks and formed alliances towards achieving health equity. These activities jointly have contributed to an affirmative vision of the health systems that we would want to build to deliver on equity goals.

The lessons learned indicate that achieving equity, while demanding technical and public policy choices, is centred on a strong state and public sector in health, organised around the active participation and involvement of communities. As found in other regions, rising investment in health through the public sector is necessary to support the universal health systems and redistributional policies necessary for improved health outcomes (UNDP HDR 2003; EQUINET SC 2000).

Different areas of work in EQUINET thus feed into an understanding of how to achieve this, with research, capacity building, policy dialogue and information exchange to:

- Support the strengthening of **people's power for health**, including the power and ability that people have to make and implement choices over health inputs. Work in the network is informing parliamentary and civil society processes and building skills for participatory methods in health systems. EQUINET supported research highlights that public participation in health can have a positive impact on health outcomes and the performance of health systems, particularly when linked to mobilisation

around collective action to realise social and economic rights (Loewenson et al., 2005; Ngulube et al., 2005; London, 2004).

- Provide **increased fair, sustainable and equitable financing** for health at national, regional and global level. This includes exploring options for increasing resource mobilization through mechanisms that provide for universality (like taxes and social health insurance), and that protect households against the impoverishing effects of health costs. This complements work done on mechanisms for allocating public resources fairly between geographical areas, in reflection of health need (McIntyre et al., 2005).

- **Ensure that health workers are valued, motivated and retained within our health systems.** Responding to the outflow of skilled health workers from public sector district health systems to high income countries, work is underway with the Regional health secretariat in east, central and southern Africa to review and support implementation of incentives to retain health workers and to identify and propose options to manage the costs and benefits of health worker migration. (EQUINET, TARSC, HST, UNAM 2006)

- **Challenge trade liberalization and encroachment on health**, through identifying ways of protecting health in trade agreements, and exploring how health systems can promote nutrition in ways that support household control of food production, particularly for women farmers (Bond 2006, Chopra 2005).

Challenges to equity actions

As in many networks, EQUINET faces challenges of communicating across different constituencies, and of spreading skills and capacities across the region in a context of under-resourced institutions facing

multiple demands. While universal access to life-saving antiretroviral medicines (ART) is now recognized as a policy goal, treatment access is still affected by constraints within health systems. This calls for 'learning while doing' approaches that share knowledge and experience while implementing change (Makwiza et al 2005). We are challenged to learn not only about what measures and processes will enhance health equity, but also how to advance equity-oriented change in policy and practice in ways that strengthen local capabilities and autonomy.

"I learned that learning participatory approaches starts with three days and takes three decades"

Participant at an EQUINET training workshop, Tanzania, 2006.

We do this in a process of globalization that is unequal in its distribution of costs and benefits, weak in regulating and managing its social costs and promoting market led reforms within the health sector that widen inequalities in health (UN WCDG 2004; EQUINET SC 2004). As the health costs of such polarization visibly increase, so too does the gain from networking across countries to protect equity in health in the region.

Acknowledgements

This article outlines work of institutions in EQUINET more fully described and published at www.equinet africa.org. EQUINET is governed by a steering committee involving institutions leading work in the network in eastern and southern Africa, ie Training and Research Support Centre, Peoples' Health Movement, Tanzania; Community Working Group on Health, University of Zimbabwe, CHESORE, Centre for Health Policy, Wits University, Health Economics Unit, University of Cape Town, Tanesa, Tanzania; Malawi Health Equity Network; Health Systems Trust, University of Namibia, University of Cape

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Global Equity Gauge Alliance

Antoinette Ntuli¹

Abstract: The lack of attention to equity in health, health care and determinants of health is a burden to the attainment of good health in many countries. With this underlying problem as a basis, a series of meetings took place between 1999 and 2000, culminating in the creation the Global Equity Gauge Alliance (GEGA). GEGA is an international network of groups in developing countries, mainly Asia, Africa and Latin America, which develop projects designed to confront and mitigate inequities in health, known as Equity Gauges. Equity Gauges aim to contribute towards the sustained decline in inequities in both the broad sociopolitical determinants of health, as well as inequities in the health system. Their approach is based on three broad spheres of action, known as “pillars”: 1) measurement and monitoring, 2) advocacy, and 3) community empowerment. Through a series of examples from local or national level gauges, this paper showcases their work promoting the interaction between research and evidence-based policy formulation and implementation, and the interaction between the community and policy makers. (*Promotion & Education*, 2007, (2): pp 107-108)

Key words: equity, determinants of health, empowerment

Résumé en français à la page 123. Resumen en español en la página 133.

The Global Equity Gauge Alliance (GEGA) is an international network of groups in developing countries that facilitate processes designed to confront and mitigate inequities in health. In 1999 and 2000, a series of meetings involving researchers and activist NGOs noted that, despite the 1978 Alma-Ata Declaration, which emphasizes the importance of equity for the attainment of good health, inequities still prevailed and continued to grow worldwide. The concern that few countries were giving adequate attention to measuring and monitoring equity in health, healthcare, and the underlying determinants of health, culminated in the establishment of an organized consortium of eleven (now grown to fifteen) health equity projects, called Equity Gauges, based in Asia, Africa and Latin America.

Equity Gauges focus on disparities that are unjust and unfair, and place health equity squarely within the larger framework of social justice. Their focus goes beyond the monitoring of inequities. Equity Gauges aim to contribute towards the sustained decline in inequities in both the broad sociopolitical determinants of health as well as inequities in the health system. On the understanding that socio-political and health inequities are mediated by differentials in power, the Equity Gauge strategy includes an explicit set of activities designed to empower those who are marginalised and disempowered as an essential element of improving health equity. This active approach to equity is supported through three broad spheres of action, called “pillars” of the Equity Gauge. The *Measurement and Monitoring* pillar is focused on monitoring and measuring population health, and identifying socioeco-

nomic and other determinants at work; *advocacy* for pro-equity policy aims to motivate action by policy makers and to increase accountability; and, the *community empowerment* pillar aims to amplify the voices of marginalised communities and plays a critical role in creating a sustainable culture of expectation for equity in society.

Equity Gauge teams are varied in their membership and include representation from Ministries of Health, Education, Water and Sanitation, local governments, legislators, policy makers, community organisations, public and private research and policy institutions, universities, international NGOs and other social groups. These diverse groupings utilize the three pillar approach to formulate individual country or local area activities that promote the interaction between *research and evidence based policy formulation and implementation*, and interaction between the *community and policy makers*.

Research conducted by Equity Gauges has been influential in the inclusion of equity indicators in some national information data sets, has strengthened measurement capacities at country level, and has pointed to the need for regular monitoring of inequities in health. In South Africa, the Cape Town Equity Gauge demonstrated the unfair allocation of financial and human resources between health districts serving those who are rich and those serving poor communities in the metropolitan council and their work led to policy changes in human resource allocations.

Some of the success of the Gauges has been attributed to the inclusion of political representatives and senior health managers in the steering committee of the project. The inclusion of parliamentarians as

core Equity Gauge team members has promoted the use of research to assist them in monitoring the implementation of pro-equity policies. An additional benefit has been the strengthening of participating parliamentarians appreciation of the difference between “pro-poor” and “equity oriented” activities and policies.

Reliable and valid information gathered from the measurement process forms a strong basis for evidence based policy recommendations and raising of public awareness. Equity updates emanating from equity studies are disseminated through publications, newsletters, newspaper articles, conferences and seminars with policy makers and training workshops. The Chilean, Nairobi and Zambian Gauges have held Equity workshops for journalists to ensure that concepts of health equity filter into the public domain. These platforms provide advocacy opportunities in which the potential of evidence gathered locally for pro-equity policy development is demonstrated.

Evidence gathered by Gauges assists in identifying communities affected by unjust resource allocation. Equity Gauges collaborate with affected communities to make information available and accessible and to advocate for pro-equity changes. This collaborative and empowering effort has at times resulted in the development of the community’s own monitoring processes and the recognition of the right of the community to participate in the planning, implementation and management of health and other social services.

The Pakistan Equity Gauge facilitated the process of understanding fairness in health and included participation of men and women from a rural district, health care

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providers from public service, NGOs, and elected representatives. In twenty three villages men and women conducted an equity analysis separately and prioritized disparities that would receive immediate attention. A joint workshop attended by villagers, local government, civil society and community members resulted in the development of an advocacy plan aimed at influencing stakeholders to work on the identified disparities.

In Zambia, a series of in-depth workshops at the local level involving community representatives and health workers led to joint action that improved the quality of care, strengthened skills for local monitoring and assessment, increased the communities' capacities to influence local deci-

sion making, and amplified community voices at national level.

Many of the Equity Gauges originated in research and tertiary institutions with an "expert" role in research. This has proved to be a limiting factor for implementing the community empowerment pillar which requires specific sets of technical abilities and which can be time consuming. This challenge is being overcome through capacity development of the Gauges themselves and through collaboration with local organisations recognised for their expertise in community development.

GEGA has also been active at the global level. Concern with unjust international political and economic frameworks and policies has resulted in GEGA partnering

with health activist organizations, including the People's Health Movement and Medact, to produce the Global Health Watch, evidence based analysis of the political economy of health and health care.

GEGA's shared vision and approach has benefited Alliance partners and has enabled:

- Sharing of lessons learnt and experiences between the different Gauges
- The creation of critical mass of experience to enable evaluation of the Equity Gauge strategy and to develop a proof of concept
- Sharing of skills and expertise between Gauges
- Country Location of Equity Gauges.

Country Location of Equity Gauges



Showcasing networks – Abstract

The Quebec Healthy Cities and Towns Network: a powerful movement faced with new challenges

P. Simard, p. 121

After twenty years serving its members, the Quebec Healthy Cities and Towns Network (QHCTN) faces several challenges. There are currently many changes being made in the local organization and the administration of services. The Network, through its capacity to mobilize the different municipalities, is the best placed to advocate and support a coordinated approach to government initiatives and also to encourage partnerships with other institutions (education, health, socio-economic) and communities. There is, nonetheless, a need to rethink its direct support to members, especially in terms of communication and networking among them.

La Promotion de la santé communautaire – un pas en avant

Sania Nishtar^{1,2}

Ce numéro thématique de *Promotion & Education* a bénéficié du soutien financier des Centres américains de Contrôle et de Prévention des Maladies (CDC), une Agence du Département américain de la Santé et des Services sociaux dans le cadre d'un Accord de Coopération Numéro U50/CCU021856 sur des Initiatives mondiales de Promotion de la Santé et d'Éducation pour la Santé. Les opinions exprimées dans les articles sont celles des auteurs et ne sont pas nécessairement celles des CDC et de l'UIPES.

La promotion de la santé communautaire revêt une importance stratégique dans les systèmes de santé d'aujourd'hui. L'incapacité de la plupart des pays ayant des systèmes de santé mixtes à produire de la santé comme un bien public, associée au rôle émergeant du marché dans la santé et des contraintes en termes de ressources au niveau du secteur social, en particulier dans les pays en voie de développement, nécessite une participation visible des communautés dans la promotion de la santé afin d'atteindre les objectifs d'équité en santé. Cependant, malgré l'importance qu'elle revêt, la promotion de la santé communautaire reste un concept mal compris, ce qui la rend difficile à défendre auprès des responsables politiques. Ces considérations ont amené le Consortium mondial sur la Promotion de la Santé communautaire, une initiative de collaboration mise en place en 2003 par les Centres américains de Contrôle et de Prévention des Maladies (CDC) et l'Union internationale de Promotion de la Santé et d'Éducation pour la Santé (UIPES), à axer avant tout son travail sur la clarification des concepts et des normes ; et c'est dans ce contexte, comme un pas de plus dans cette direction, que le présent numéro spécial a développé plus avant la Déclaration du Consortium (Nishtar et al., 2006).

Ce numéro couvre de nombreux aspects de la promotion de la santé communautaire, en soulignant son interface avec les principes d'équité et les considérations propres à la santé de la population, et en mettant en avant une série d'études de cas permettant de mieux comprendre ce qu'implique la promotion de la santé communautaire ainsi que la manière et les raisons d'utiliser les méthodologies participatives d'*empowerment* pour exploiter les atouts de la communauté. En outre, ce

numéro présente également des articles pertinents et concrets pour aider les pays et les acteurs de santé à examiner si leurs activités générales dans des projets spécifiques correspondent aux critères actuels de pratiques exemplaires de promotion de la santé communautaire, de même que pour fournir des lignes directrices sur l'évaluation participative.

La Déclaration du Consortium, à partir de laquelle s'est développé ce numéro, définit la promotion de la santé communautaire comme un processus participatif d'*empowerment* axé sur l'équité – un processus qui considère la participation communautaire comme essentielle à chaque niveau des actions promotrices de santé, et qui met en valeur les atouts et les connaissances de la communauté de manière à créer les conditions nécessaires à la santé. Cependant, comme cela a été souligné par Rice dans ce même numéro (2007 ; p. 68), toutes les actions et les politiques promotrices de santé ne s'inscrivent pas dans cette définition. L'auteur utilise les enseignements tirés de l'application de méthodologies participatives d'évaluation aux initiatives des Municipalités, Villes et Communautés en Santé (MCS) dans une sélection de pays du continent américain, pour mettre en évidence les éléments indiquant que la plupart de ces initiatives n'ont pas correctement pris en compte les principes clés de la promotion de la santé, comme la collaboration intersectorielle et la participation communautaire. L'article de Baum approfondit encore cette question pour permettre de comprendre les implications du non respect de ces principes en se référant aux politiques et aux actions promotrices de santé australiennes, galvanisées par la Charte d'Ottawa (2007 ; p. 90) ; celles-ci ont eu un impact significatif sur la population en termes de résultats de santé, mais ne sont pas parvenues à réduire les inégalités de santé ni les écarts existants. De telles expériences mettent en évidence la nécessité de concevoir des politiques et des actions de promotion de la santé fortement axées sur l'équité, et c'est là que la nécessité de combiner un engagement et une action politique descendant avec une action ascendante à partir des communautés et des groupes issus de la société civile prend toute son importance, pour avoir un 'effet déclencheur en faveur de l'équité en santé', comme le décrit Baum dans son article.

Comprendre le rôle des communautés est par conséquent essentiel à la promotion de la santé. Dans ce contexte, ce numéro spécial comporte plusieurs études de cas issues des contextes propres à différents pays en voie de développement pour présenter des approches pertinentes. Chaque étude a utilisé un format structuré de façon à mettre en lumière à la fois l'intervention et les enseignements que l'on peut retirer de l'expérience pour une application plus large. Malgré des faiblesses au niveau de leur conception et de leurs méthodologies d'évaluation, ces études de cas apportent d'importantes leçons sur les processus.

Premièrement, un message collectif accentue l'importance de la compréhension de l'ensemble du processus de gestion d'un projet communautaire et de ses instruments. Au premier plan figure la nécessité d'engager tous les acteurs du développement dans un modèle participatif adapté à la situation locale pour la planification et la gouvernance ; cela inclut les organismes gouvernementaux locaux, les ONGs, les partenaires internationaux pour le développement, les organisations communautaires reconnues, les autorités locales et les fédérations intercommunautaires. Une gouvernance participative accordant un rôle à la fois au secteur public et aux communautés est non seulement pertinente pour la durabilité des initiatives locales, mais elle permet également de transférer des technologies sociales fructueuses à d'autres lieux de vie, ainsi que d'adopter et d'intégrer des programmes comme politiques publiques.

Deuxièmement, les études de cas font ressortir de nombreuses considérations qui doivent être prises en compte en structurant les initiatives communautaires ; parmi ces considérations, on peut citer la participation et l'appropriation à chaque étape ; la garantie que la voix des plus démunis va être entendue ; la cohésion du groupe ; la garantie que les enseignements tirés vont être pris en considération dans la prise de décisions ; de la souplesse dans la conception du programme de façon à ce qu'il soit déterminé par des données probantes pertinentes au niveau local, telles qu'elles émergent dans le courant des interventions. Il faut aussi encourager l'auto-gestion et le contrôle social, utiliser des outils d'intervention culturellement adap-

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tés et validés au niveau local et veiller attentivement à l'empowerment des femmes dans la prise de décisions. Ces éléments sont considérés comme importants pour la viabilité des interventions locales en général. De façon plus spécifique, ces éléments permettent aussi de dépasser les barrières religieuses, culturelles et ancestrales pour accéder aux soins de santé, comme le montre l'étude de cas des Iles Salomon (MacLaren & Kekeubata, 2007; p. 78). De plus, ils peuvent aussi contribuer à favoriser l'empowerment des groupes les plus isolés et les plus difficilement accessibles, comme le montre l'exemple des 'caboclos' du Brésil, peuples de la forêt vivant dans certaines zones rurales d'Amazonie, souvent isolées et difficiles d'accès (Scannavino & Anastácio, 2007; p. 85).

Troisièmement, la plupart des exemples soulignent la nécessité d'une action intersectorielle au sein d'un cadre plus large de développement du secteur social plutôt que dans le seul domaine des soins de santé. Les exemples d'interventions de santé cités ici montrent comment elles se sont appuyées sur divers secteurs comme ceux du logement, de l'éducation, des services à la jeunesse, et des organismes de sécurité alimentaire, plutôt que sur des systèmes de santé conventionnels, pour améliorer les résultats en termes de santé. Une perspective locale à l'intérieur d'un cadre intersectoriel peut aussi signaler des opportunités locales spécifiques pour la promotion de la santé ; par exemple, le cas d'Orissa montre que la prédisposition aux catastrophes naturelles est l'un des déterminants les plus forts de mortalité et de handicap dans cette région de l'Inde ; ainsi la prédictibilité des catastrophes dans cette région justifie que les capacités institutionnelles y soient renforcées pour des opérations de secours et de réhabilitation plutôt que pour des interventions traditionnelles de santé publique (Mukhopadhyay, 2007; p. 74).

Enfin, les études de cas font référence à la valeur potentielle du travail en réseau, que ce soit au niveau mondial, en termes de promotion des valeurs d'équité et de justice sociale en santé, en permettant un plus large partage des expériences entre pays, comme c'est le cas d'EQUINET (Loewenson, 2007; p. 105), ou encore en encourageant les personnes à contrôler elles-mêmes leur santé et leur bien-être dans les milieux de vie communautaires, comme nous le montrent les 'Super Mamies' australiennes (Sullivan et al., p. 80).

Les articles présentés ici apportent des enseignements utiles à la promotion de la santé communautaire. Les preuves de l'efficacité de telles initiatives mettent en évidence la nécessité d'aller au-delà de projets pilotes et de démonstration, de façon à inté-

grer la participation et le rôle des communautés pour améliorer la santé avec différents résultats (UIPES, 2000). Cela nécessite une série d'actions interdépendantes complexes et doit aller au-delà du seul fait de donner davantage la parole aux communautés et aux acteurs de santé, afin de renforcer le tissu des politiques sociales, de donner forme au bien-être social et au financement de la santé, et de régler les milieux de vie dans les pays. Au sein du secteur de la santé, cela nécessite également un certain nombre d'autres mesures globales, comme une redistribution des budgets de la santé alloués aux soins tertiaires vers la prévention et la promotion de la santé, et le redressement des déséquilibres budgétaires et en termes de répartition du personnel de santé au profit des infrastructures et des services en milieu rural, urbain non réglementé et des soins primaires. Des programmes de santé publique en cours ou en développement présentent une opportunité dans laquelle la prévention, le contrôle et la promotion de la santé peuvent être intégrés, comme le montre l'initiative de lutte contre les maladies non transmissibles au Pakistan (Ronis & Nishtar 2007; p. 98).

Cependant, un engagement durable des communautés pour des soins de santé intégrés est plus facile à obtenir dans les pays dont les systèmes de gouvernance impliquent la décentralisation des autorités administratives et politiques vers les plus petites unités administratives, comme les municipalités. Ces structures ont la responsabilité et un mandat institutionnel pour engager les communautés et canaliser les contributions émanant des acteurs du développement vers des plans locaux de développement précisément. La perspective des autorités locales peut également permettre de faire concorder des interventions de santé avec des objectifs plus larges de développement, en les liant à des initiatives de soutien : moyens de subsistance, éducation, épargne et crédit, tous essentiels au processus de développement au niveau local en général.

Encourager l'action selon ces principes au niveau du secteur social à l'intérieur même des pays est une prérogative des institutions étatiques ; cependant les initiatives multilatérales de développement, comme la Commission de l'OMS sur les Déterminants sociaux de la Santé, peuvent donner une impulsion, en particulier par l'appui qu'apporte l'OMS à plus de 190 pays, pour encourager les gouvernements à faire des choix de politiques publiques autour de la participation active et de l'engagement des communautés, comme cela a été souligné dans ces approches. Un secteur étatique et public fort en termes de

santé est important pour améliorer la santé de la population de façon équitable – le fait de bien répartir le bien public tout comme de réguler le marché privé et le rôle des communautés peut être essentiel à cette réussite.

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Réduire les inégalités sociales de santé : santé publique, santé communautaire ou promotion de la santé ?

V. Ridde¹

Résumé : Si le Consortium sur la « community health promotion » suggère une définition de ce nouveau concept pour qualifier des pratiques sanitaires, nous nous interrogerons, dans cet article, sur la pertinence de son introduction, alors même que personne n'arrive encore véritablement à délimiter les trois processus habituellement rencontrés : santé publique, santé communautaire, promotion de la santé. À partir d'une recension des écrits et d'une analyse des pratiques, nous suggérons de différencier ces trois formes de pratique selon leur processus et leur finalité. La santé publique et la santé communautaire visent le même objectif, soit l'amélioration de la santé des populations. Pour l'atteinte de cet objectif, la santé publique a recours à un processus technocratique tandis que la santé communautaire use d'un processus participatif. La promotion de la santé cherche, quant à elle, plutôt à réduire les inégalités sociales de santé en employant un processus d'*empowerment*. Cependant, il ne s'agit encore que d'une définition théorique car dans la pratique, les acteurs de promotion de la santé oublient encore trop souvent cet objectif. Trois arguments devraient inciter ces promoteurs de santé à devenir enfin les chantres de la lutte contre les inégalités sociales de santé. Les deux premiers arguments reposent sur l'inefficacité des approches caractérisant la santé publique et la santé communautaire, centrées sur le système de santé et l'éducation à la santé, incapables de réduire les inégalités sociales de santé. Le troisième argument en faveur de la promotion de la santé est de nature politique puisque nous ne disposons pas encore de preuves suffisantes de son efficacité compte tenu du caractère récent des travaux à cet effet. Les responsables des actions de promotion de la santé doivent planifier pour lutter contre les inégalités sociales de santé et se doter des moyens pour en évaluer l'efficacité. (*Promotion & Education*, 2007, (2) : pp. 111-114)

Mots-clés : inégalités sociales de santé, santé publique, santé communautaire, promotion de la santé

English article on page 63. Resumen en español en la página 126.

MOTS RÉSUMÉS

- La promotion de la santé se distingue de la santé publique et de la santé communautaire par son objectif de réduction des inégalités de santé et son processus d'*empowerment*
- Les acteurs de promotion de la santé doivent planifier pour lutter contre les inégalités sociales de santé et se doter des moyens pour en évaluer l'efficacité.

Que de débats n'a-t-on pas lus susceptibles de définir les pratiques sanitaires ! Certains auteurs ont parlé de « *délimitation floue et changeante* » (Gagnon et Bergeron, 1999), d'autres ont trouvé le moyen de faire de cette controverse un objet de recherche à part entière (Fassin, 2000a). Rien de plus normal, selon Bourdieu (2001), que de constater des luttes incessantes entre scientifiques oeuvrant dans un même champ de connaissance. Classiquement, une dichotomie est mise en avant dans les discours des experts entre la santé publique et la santé communautaire, la première étant pensée comme plus ancienne que la seconde. Mais plus récemment, et de manière formelle dès 1987, la promotion de la santé est apparue. Aussi, trois expressions ont communément pignon sur rue pour qualifier les pratiques sanitaires : santé publique, santé communautaire, promotion de la santé.

Aussi, lorsque nous avons été invités à participer à l'entreprise éditoriale de ce numéro spécial sur la « promotion de la santé communautaire » (*community health promotion*), nous avons spontanément eu une double réaction. D'abord, nous avons souhaité savoir comment le Consortium avait réussi à définir ce nouveau concept. La réponse a été donnée au début de ce numéro bien que la lecture du communiqué du Consortium paru début 2006 (Nishtar et al., 2006) nous laisse encore perplexe¹, ce qui rend d'autant plus judicieux le présent article. Ensuite, nous avons voulu nous interroger sur la pertinence d'introduire une nouvelle définition d'une pratique sanitaire, alors même que personne n'arrive encore véritablement à délimiter les trois processus habituellement rencontrés. Introduire un nouveau concept sans avoir véritablement réussi à clarifier les anciens risque de laisser les esprits critiques nous qualifier encore de « *discoureurs* » (Fassin, 2000a). Cela peut également engendrer plus de confusion que de clarification, comme au Canada lorsque le terme « santé des populations » est apparu. Ainsi, l'objectif de cet article est une tentative de distinction des trois formes de pratiques sanitaires généralement rencontrées dans les écrits et sur le terrain afin de situer la « *community health promotion* » et de montrer que la promotion de la santé doit être le chantre de la lutte contre les inégalités sociales de santé.

Tentative de distinction des pratiques

À l'instar de Rootman et ses collègues (2001), nous croyons utile d'inscrire notre définition dans une distinction entre le processus et la finalité des pratiques. Notre connaissance particulière des pratiques au Canada, en France et en Afrique sera mise à contribution pour étayer nos arguments.

De la finalité

Santé publique et santé communautaire disposent généralement d'un but commun : l'amélioration de l'état de santé des individus, pris dans leur ensemble et non individuellement. On pourrait multiplier les exemples de politiques publiques conçues de par le monde avec cet objectif. Curieusement, et c'est assez rare pour le souligner, la première politique québécoise de santé s'est donnée un but semblable mais dans une version « négative » (la politique propose 19 objectifs afin de « *réduire les problèmes de santé...* » (Ministère de la santé et des services sociaux, 1992), révisé plus tard dans les priorités nationales de santé publique « *faire des gains substantiels en matière de santé* » (Ministère de la Santé et des Services sociaux, 1997), nous rappelant ainsi les débats sur la définition « positive » ou « négative » du concept de santé.

La définition que l'on retrouve classiquement dans les manuels de formation de santé publique, reprenant la proposition de 1920 de Winslow, est celle d'une science et

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d'un art de promouvoir la santé, de prévenir la maladie et de prolonger la vie (Fournier, 2003). Cependant, nous souhaitons préconiser une définition qui se situe au delà des fameux 3P relevant plus du processus que des finalités soit la promotion, la prévention et la protection, fondements des priorités de santé publique 1997-2002 au Québec. Il nous faut donc aller plus loin dans la réflexion sur le plan téléologique et comprendre la finalité des actions de promotion de la santé. Nous oserions proposer une réelle rupture paradigmatique en affirmant que la promotion de la santé cherche, non seulement à améliorer la santé de la population, mais surtout à réduire les écarts d'état de santé entre les sous-groupes qui la composent. En effet, « *la promotion de la santé vise l'égalité en matière de santé. Ses interventions ont pour but de réduire les écarts actuels caractérisant l'état de santé* », précise la charte d'Ottawa (OMS, 1986). Cette rupture permet également de se différencier des entreprises définitionnelles préalables, puisque Conill et O'Neill (1984) proposaient que l'objectif de la santé communautaire soit « *l'amélioration de l'état de santé de la population* », sans dire mot des inégalités sociales de santé. Cette distinction paraît essentiel, car nous savons que « *la plupart des interventions qui ne se fixent pas pour but la diminution des disparités [...] produisent presque toujours, même lorsqu'elles réussissent à atteindre leur objectif d'amélioration de la santé de la population dans son ensemble, une aggravation des écarts* » (Fassin, 2000b), ce qui a été le cas pour les habitants de Montréal (Lessard, 2003). Adopter cette définition constitue une remise en cause des croyances, notion centrale du concept khunien de paradigme. Nous concevons ainsi la promotion de la santé comme une entreprise disposant d'une finalité de changement social. S'il faut pour cela créer une nouvelle « *new public health* » (Horton, 1998), pourquoi pas ? Mais peut-être n'est-ce pas nécessaire, tel que nous le démontrerons plus bas, puisque la charte d'Ottawa de la « *nouvelle santé publique* » disposait bien de cet objectif de réduction des inégalités.

Du processus

Contrairement à Conill et O'Neill (1984) qui pensent que la santé communautaire peut être constituée de deux pôles, l'un technocratique et l'autre participatif, nous croyons que ces deux pôles forment justement la distinction du processus de mise en œuvre, entre la santé publique et la santé communautaire. Ainsi, la santé publique nous paraît être en phase avec une approche technocratique et jacobine du processus d'implantation des interventions. Si les acteurs de la santé publique s'entendent

Tableau 1. Tentative de distinction entre la santé publique, la santé communautaire et la promotion de la santé

	Processus	Finalité
Santé publique	Technocratique	Améliorer la santé des populations
Santé communautaire	Participatif	
Promotion de la santé	Empowerment	Réduire les inégalités sociales de santé

Source : Auteur

avec ceux de la santé communautaire pour inciter les individus à changer leurs pratiques ou leurs comportements, par exemple, les premiers useront de plus de coercition que les seconds. Des termes comme « *facteur de risque* » (Berlivet, 2001) et son corollaire « *victim blaming* » (Lupton, 1995) sont caractéristiques de la santé publique où le système de santé, l'éducation à la santé et la prévention sont les plus gros bénéficiaires budgétaires. En France, tant l'histoire de la santé publique (Abenhaim, 2003) que les querelles liées à la création de l'Institut National de Prévention et d'Éducation pour la Santé (INPES) et la récente loi de 2004 sur la santé publique traduisent assurément cette approche centrée sur la prévention et le système de soins, et dirigée par l'administration centrale ou déconcentrée. L'épidémiologie et les données probantes sont les outils cardinaux de la santé publique, les médecins disposant d'une place centrale dans le dispositif. Certains, faisant directement référence aux travaux de Weber, avancent même que « *la santé publique ne connaît vraiment que l'autorité à caractère "rationnel-légal", fondée sur le droit* » (Jaffré et Olivier de Sardan, 1999). Sans pour autant que cela soit représentatif de l'histoire de la santé publique, l'analyse du « *double modèle de la contrainte et de la normalisation, du contrôle autoritaire et de l'intervention moralisatrice* » que fait Fassin (2006) à propos de l'Afrique du Sud est le parangon d'un processus technocratique puisque « *la santé publique a [...] servi à maintes reprises le projet politique raciste des autorités sud-africaines* » (p.211). En Afrique, la promotion de la santé est un concept relativement peu connu (Nyamwaya, 2005), la santé publique ayant le monopole des mots et des pratiques pour de multiples raisons qu'il serait trop long ici d'évoquer (Ridde et Seck, 2006).

Les praticiens de la santé communautaire, quant à eux, mettent au centre de leurs interventions la participation de la population, et le point de vue émique est privilégié. Les pratiques de médecine communautaire de certains centres de santé aux États-Unis d'Amérique font figures de pionnières en Amérique du Nord comme l'on été celles de la médecine sociale au sein de certains centres de santé dans les

années 1940 en Afrique du Sud. Les liens entre certaines pratiques individuelles et le déclenchement de pathologies particulières sont reconnus. En revanche, l'accent est mis sur la compréhension des conditions sociales et structurelles qui peuvent induire de telles pratiques. Les membres de la communauté participent à la définition du problème, à la réflexion sur ses solutions et à l'application de ces dernières. L'épidémiologie et les outils statistiques ne sont pas occultés, mais ils ne constituent pas les seuls moyens utiles, et l'on se situe plutôt dans une épistémologie plutôt constructiviste. Des modèles de planification usant de cette triangulation de méthodes (Green et Kreuter, 1999), celui appliqué dans le système québécois des années 1980-90 (Bergeron et Gagnon, 1994) ou en Belgique (Bantuelle, Morel et al., 1998), sont de bons exemples caractérisant le processus de la santé communautaire.

Les acteurs qui interviennent selon un processus de promotion de santé se réfèrent directement à une manière d'agir qui a été consacrée dans la charte d'Ottawa. Ils tentent de mettre en œuvre un processus qui confère aux populations les moyens d'assurer un plus grand contrôle sur leur propre santé qu'auparavant, et d'améliorer celle-ci (OMS, 1986). Il s'agit là du concept d'*empowerment*, au sujet duquel nous n'avons pas la place ici de discuterⁱⁱ, et qui est une valeur phare de la promotion de la santé. Agir selon un processus d'*empowerment* paraît fournir des résultats fort efficaces pour l'amélioration de la santé (Wallerstein, 2006). Évidemment, ce type d'approche n'a pas manqué de critiques : « *la rhétorique de l'empowerment sert à masquer l'investissement et les interventions des professionnels de santé publique pour persuader certains groupes de développer leur compétences et l'exercice du contrôle sur leur vie* » (Lupton, 1995).

Ainsi, nous résumons la tentative de distinction entre ces trois formes de pratiques dans le tableau 1. Évidemment, il ne s'agit bien que d'une tentative. Ces distinctions ne doivent pas être perçues comme figées et si leurs caractéristiques sont *a priori* accentuées, ce n'est que pour forcer le trait nécessaire à la création wébérienne de l'idéal-type.

Tableau 2. **Inégalités d'utilisation du système de santé et de mortalité au Manitoba, Canada**

Indicateurs	Rapport Pauvres/Riches	
	1986	1996
Nombre de jours d'hospitalisation	1.40	1.38
Taux d'admission hospitalière	1.31	1.32
Taux de mortalité toutes causes confondues	1.21	1.42
Taux de mortalité prématurée	1.39	1.85

Source: Adapté de Ross et al. (2005)

La promotion de santé doit s'attaquer aux inégalités sociales de santé¹

Déjà en 1988, le directeur général de l'OMS s'inquiétait : « *public health has lost its original link to social justice, social change and social reform* » (Hancock, Labonté et al., 1999). Vingt ans après, le constat est le même. Aussi, la promotion de la santé, doit, selon nous, retrouver son rôle originel et être un moteur de la remise en question des inégalités sociales de santé. Il devient nécessaire que les acteurs comprennent que la planification sanitaire ne se résume pas à un exercice technique et qu'elle peut aussi être un outil pour impulser le changement social. Cette responsabilité d'actions et de plaidoyer doit être dévolue au champ de la promotion de la santé. Outre que les pratiques de santé publique, vieilles de plusieurs siècles ont montré leur incapacité à enrayer ces inégalités de santé² qui perdurent (Mackenbach, 2005) — mises au jour par des statistiques dès le 17^e siècle — trois arguments, parmi d'autres, peuvent être soulignés pour étayer notre proposition. Les deux premiers arguments reposent sur l'inefficacité des approches caractérisant la santé publique et la santé communautaire, puisqu'elles ont généralement recours aux actions centrées sur le système de santé et l'éducation à la santé dont nous connaissons bien maintenant les effets. Le dernier argument en faveur de la promotion de la santé est de nature plus politique puisque nous ne disposons pas encore de preuves suffisantes de son efficacité compte tenu du caractère récent des travaux à cet effet (Hills, Carroll et al., 2004).

Le système de santé

Pendant très longtemps, et encore aujourd'hui, certains ont pensé que le système de santé était en mesure d'améliorer la santé de la population et de réduire les écarts de mortalité entre les sous-groupes. L'ancien ministre français de la santé pensait que le « *devoir de santé publique, [...] n'est autre, en définitive, que celui d'organiser de façon moderne le fonctionnement des services de santé* » (Mattei, 2002). L'article 2 de la Loi de santé publique promulguée en 2004 en France affirme que la réduction

des inégalités de santé peut se concrétiser par « *la promotion de la santé, par le développement de l'accès aux soins et aux diagnostics sur l'ensemble du territoire* », ce qui explique certainement que 97 % du budget de la santé, soit consacré au système de soins (Abenhaim, 2003). L'allocation budgétaire n'est pas plus brillante au Québec. L'expression « promotion de la santé » n'apparaît dans la loi française qu'à deux reprises, celle-ci et pour rappeler la mission de l'INPES, sans pour autant changer le mot « prévention » par « promotion » dans l'intitulé de l'organisme public. Selon des chercheurs français « *la réduction des inégalités sociales de santé dans notre pays [est] essentiellement envisagée par le politique sous l'angle de l'accès primaire aux soins* » (Pascal, Abbey-Huguenin et al., 2006).

Et pourtant, d'une part, de nombreuses études ont montré que si le système de santé et la médecine pouvaient avoir un effet sur la santé des *individus nécessitant des soins*, ils n'agissaient en rien, sinon très peu, sur la *santé de la population*. Faute de place, on ne s'étendra pas sur le sujet, renvoyant le lecteur aux références classiques à ce propos (McKinlay et McKinlay, 1977 ; Ashton et Seymour, 1988). D'autre part, le système de santé et la médecine peuvent aussi avoir des effets néfastes sur la santé des personnes. Rien qu'en France, on estime que 18 000 personnes meurent chaque année des effets secondaires des médicaments (Abenhaim, 2003). Aux États-Unis d'Amérique, les erreurs médicales engendreraient annuellement 98 000 morts (Institute of Medicine, 2000).

Les preuves populationnelles de l'effet du système de santé étant plus que réduites, qu'en est-il de celles concernant sa contribution à la réduction des inégalités sociales de santé ? Bien que rares soient les travaux à ce sujet, une récente recherche réalisée dans la province du Manitoba au Canada est éclairante de ce point de vue. Comme ailleurs dans le pays, le système de santé est majoritairement financé et organisé par le secteur public. Lorsque l'on étudie les données d'utilisation des services hospitaliers entre 1986 et 1996, on se rend compte que le système de santé paraît fort équitable puisque ceux qui ont *a priori* le

plus de besoins, les plus pauvres, ont effectué 40 % de plus de jours d'hospitalisation que les plus riches et 30 % de plus d'admissions à l'hôpital. Cette utilisation différente et favorable aux plus pauvres reste stable sur cette période de 10 ans. Maintenant, lorsque l'on étudie pour cette même période les écarts de mortalité, on découvre que non seulement la situation demeure défavorable aux plus pauvres, mais qu'en plus, l'écart s'est accru au détriment de ces derniers (tableau 2). Autrement dit, si l'utilisation du système de santé a été équitable (en fonction des besoins, rare preuve contradictoire de l'« *inverse care law* »), cela n'a pas été en mesure de réduire les inégalités sociales de santé. Les auteurs montrent également que la réduction de 40 % du nombre de lits dans les hôpitaux n'a pas eu d'effets sur les indicateurs de mortalité populationnelle.

L'éducation à la santé

Le second argument concerne l'impossibilité des seules actions d'éducation à la santé à agir en faveur de la réduction des inégalités sociales de santé. Evoquer cette question est d'autant plus important que dans le contexte français ou états-uniens, l'éducation à la santé possède encore une place prépondérante dans l'ensemble des stratégies de santé (O'Neill et Stirling, 2007). Or, le développement des interventions visant à réduire les écarts de santé n'est pas une mince affaire, et nous pourrions même avancer que l'on se trouve face à une aporie. Rose (1985) explique l'importance dans les activités de prévention de cibler la population dans son ensemble plutôt que les groupes à risques élevés. Il nous dit que lorsqu'un facteur de risque est normalement distribué dans la population, réduire l'influence de ce dernier apportera plus de changement dans l'état de santé de la population que si l'on dirige l'intervention uniquement sur les groupes dits à risques élevés. Cependant, pour ajouter de la confusion à cette impasse, nous savons que les interventions visant le changement de comportements néfastes à la santé, lorsqu'elles sont dirigées vers la population dans son ensemble, paraissent avoir eu des impacts bien plus importants auprès des groupes sociaux les plus favorisés (Whitehead, 1995), participant ainsi à l'accroissement des inégalités. Quelques spécialistes transposent les propositions faites par Rose aux inégalités sociales de santé (Douglas et Scott-Samuel, 2001 ; Marmot, 2001). Pour ces experts, les déterminants des différences individuelles sont dissemblables de ceux des écarts entre sous-groupes de la population. Il demeure donc délicat de cibler l'intervention pour accroître l'espérance de vie moyenne ou réduire les écarts. S'appuyant notamment

sur des résultats de recherches anglaises, Paquet et Tellier (2003) affirment que « *même si toute la population adoptait de saines habitudes de vie, l'espérance de vie globale serait augmentée, mais le gradient de l'état de santé entre les classes sociales persisterait* ». En résumé, d'un côté, si l'on veut être efficace en matière d'éducation à la santé, il vaut mieux agir sur l'ensemble de la population pour améliorer la situation globale, mais avec le risque que cela puisse entraîner l'accroissement des inégalités. D'un autre côté, si l'on intervient de manière trop directe auprès d'individus ou de certains sous-groupes particuliers plutôt qu'auprès de la population dans son ensemble, les écueils qui conduisent à un accroissement du sentiment d'exclusion des personnes visées sont importants et les risques de stigmatisation ne sont pas négligeables.

La promotion de la santé

Le troisième argument pour chercher à réduire les inégalités sociales de santé par la promotion de la santé est de nature plus politique que les deux précédents. L'argumentation est indubitablement liée aux engagements pris par les acteurs du champ de la promotion de la santé. Le constat sévère de l'inefficacité de la santé publique et de la santé communautaire à réduire les disparités de santé s'explique en partie par le fait qu'aucune des deux n'a voulu prendre à bras le corps ce défi, alors que la nouvelle santé publique se targuait de nouveauté en voulant considérer l'ensemble des déterminants de la santé. « *On a du mal à dépasser le niveau de la rhétorique* », disait Fassin (2000) en évoquant un peu rudement des « *discoureurs sans pratiques* ». Selon Gepkens et Gunning-Schepers (1996) les interventions qui ont tenté de réduire les inégalités de santé ont été plus fondées sur les approches classiques et réductrices d'éducation à la santé que sur les propositions nouvelles d'actions holistiques qui s'appuient sur les cinq piliers de la promotion de la santé. Près de 20 ans après, la promotion de la santé doit, selon nous, retrouver son rôle originel et être un moteur de la remise en question de la permanence et l'invisibilité, à tout le moins en France, disait Drulhe (2000), des inégalités sociales de santé. Or il semble que cette nécessité morale et éthique ne soit pas encore vraiment prise au sérieux (De Koninck et Fassin, 2004 ; Ridde, 2004a, 2004b ; Bernier, 2006), expliquant donc la préséance de la santé publique et de la santé communautaire sur la promotion de la santé, tel qu'en témoigne l'appel à candidatures du Haut Conseil de la Santé Publique en France qui ignore les experts en promotion de la santé.

Pourquoi faire porter le fardeau de la lutte contre les inégalités de santé plus à la promotion de la santé qu'à la santé publique ou

à la santé communautaire ? Tout simplement parce que la première s'est judicieusement dotée d'une charte comprenant cet objectif alors que les deux autres n'en n'ont pas. Dans la déclaration d'Alma-Ata de 1978, on prenait acte des inégalités de santé mais leur réduction n'était pas un objectif essentiel, on réclamait « *l'atteinte du plus haut niveau possible de santé* » (art 1) et non la réduction des inégalités de santé (WHO, 1978). En revanche, la charte d'Ottawa affirme que les : « *interventions [de promotion de la santé] ont pour but de réduire les écarts actuels caractérisant l'état de santé* » (OMS, 1986). Cela nécessite donc la mise en œuvre d'un processus d'équité, de justice sociale, un des six principes constitutifs des initiatives de promotion de la santé (Rootman, Goodstadt et al., 2001). L'un des documents produits par l'OMS Europe à l'occasion des réflexions préalables à la Charte d'Ottawa stipulait clairement que la réduction des inégalités était un objectif à part entière de la promotion de la santé. Récemment, un groupe de travail européen s'est penché sur la question relative aux interventions de promotion de la santé efficaces pour réduire les inégalités de santé, prenant pour acquis que ce résultat incombait à ce champ de pratiques (VIG et ENHPA, 2001).

L'attribution à la promotion de la santé de ce rôle paraît en phase avec son mandat de changement social et de renforcement du pouvoir des citoyens dans leur capacité à agir sur les déterminants de leur santé, dès lors que nous acceptons la proposition explicitant que des inégalités de santé sont engendrées par les structures sociales et politiques. Cependant, nous ne voulons pas ici avancer que les *activités* de promotion de la santé doivent *toutes* être tenues responsables de la réduction ou non des écarts de santé, cela n'est pas chose facile. La promotion de la santé, par ses interventions de plaidoyer et sa capacité (volonté) à induire des politiques publiques saines, doit être le porte-parole d'une prise en compte de cette dimension équitable.

Conclusion

Ainsi, cette tentative de distinction des trois formes de pratiques permet de mettre en exergue le rôle indispensable de la promotion de la santé, où la justice sociale est une valeur cardinale et l'*empowerment* un processus fondamental en vue de réduire les inégalités sociales de santé. D'un point de vue pratique cette proposition implique deux remises en cause. D'une part, les planificateurs en promotion de la santé doivent maintenant s'interroger sur les objectifs qu'ils se fixent afin de vérifier qu'ils ne cherchent pas uniquement à améliorer la santé de la population dans son ensemble. Car au mieux, cela ne ferait que

reproduire les inégalités et, au pire, les accroître. D'autre part, une fois cette révision d'objectif réalisée et les actions subséquentes mises en branle, il ne reste plus qu'à entreprendre la démonstration de leur efficacité à l'égard de la réduction des inégalités sociales de santé, ce qui ouvre de nouveaux chantiers pratiques, conceptuels et théoriques (Ridde, Delormier et al., 2007).

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Références

Voir page 66.

Notes

- i. Cette partie constitue le développement de réflexions amorcées dans un autre texte (Ridde, 2005).
- ii. Les recherches qui démontrent l'existence des inégalités sont bien plus nombreuses que celles qui traitent des interventions visant la réduction des inégalités. La France est un des pays européens les plus en retard à ce sujet, le Québec n'étant pas au mieux, alors que la France est en même temps, paradoxalement ou conséquemment, celui où les écarts de santé entre les travailleurs manuels et les non manuels sont les plus importants d'Europe.
- iii. Faute de place, on ne s'aventurera pas dans une analyse détaillée du contenu du communiqué, mais notons simplement quelques éléments clefs dans le contexte de cet article. D'abord, l'expression « promotion de la santé communautaire » en français prête assurément plus à confusion que celle de « Community Health Promotion » en anglais. En effet, en français, la place de la césure de l'expression peut provoquer une lecture diamétralement opposée du mandat du Consortium. Soit il s'agit de promouvoir la santé communautaire, soit il s'agit d'évoquer la promotion de la santé en mettant l'accent sur le rôle de la communauté. Ensuite, la lecture du communiqué nous laisse croire que c'est le second sens que veulent évoquer les membres du Consortium. Cependant, les arguments ne sont pas vraiment convaincants et ne permettent pas suffisamment de distinguer la promotion de la santé communautaire (PSC) de la promotion de la santé (PS) telle que dictée à Ottawa en 1987. Les valeurs, les paramètres stratégiques et opérationnels décrits sont ceux de la PS, à moins de penser qu'elle ne s'intéresse pas aux communautés. Le terme PSC n'est parfois pas écrit dans sa totalité faisant en sorte que l'on ne sait plus s'il s'agit de parler de la PSC ou de la PS, par exemple « *cette initiative reconnaît que la promotion de la santé* » (p.53), « *il est primordial d'inscrire la promotion de la santé dans les politiques* » (p.53). Enfin, le Consortium a décidé de « *promouvoir l'application de méthodes participatives* » (p.54). Or, si l'on accepte notre proposition de distinction des processus employés par la santé communautaire (participatif) par rapport à la PS (empowerment), la confusion perdure puisque les méthodes participatives sont l'apanage de la santé communautaire, le Consortium ferait donc la promotion des pratiques de santé communautaire et non celles de la promotion de la santé axées sur la communauté... autant d'enchevêtrements qu'il s'agit de clarifier. Mais c'est l'objet de ce numéro auquel nous sommes heureux de participer pour « *améliorer la compréhension de la promotion de la santé communautaire* » (Nishtar et al, 2006, p54).
- iv. Voir le numéro spécial que nous avons préparé pour le *Canadian Journal of Program Evaluation*, 2006, vol 21 (3).

Les enseignements tirés de l'application d'une méthodologie participative pour évaluer les Initiatives en faveur des Municipalités, Villes et Communautés en Santé dans certains pays des Amériques

M. Rice et M. C. Franceschini, p. 68

La promotion de la santé a réalisé des progrès significatifs dans les Amériques au cours des dernières décennies. La création des milieux favorables à la santé et à l'estime de soi, connu également sous le nom de 'settings approach' (approche de lieux de vie), reste l'une des stratégies de promotion de la santé les plus largement utilisées. Ces dernières années, on s'est de plus en plus intéressé à l'évaluation de l'efficacité de ces stratégies. L'évaluation participative est très prometteuse pour permettre de générer des preuves et de promouvoir la compréhension des facteurs qui influencent, que ce soit de façon positive ou négative, les progrès réalisés par la promotion de la santé dans cette région. Entre 2004 et 2006, une méthodologie participative d'évaluation a été introduite dans plusieurs pays du continent américain par le biais de formations officielles dirigées par l'Organisation panaméricaine de la Santé (PAHO) en collaboration avec les pays partenaires. Cet article résume les principaux enseignements tirés de l'application de cette méthodologie participative dans divers pays d'Amérique latine et des Caraïbes. Les facteurs qui influencent l'évaluation des initiatives ont été identifiés à de multiples niveaux (individuel, communautaire, organisationnel, politique, économique, etc.). Des questions spécifiques ont été abordées, notamment celle du contexte politique, du renouvellement du personnel dans les institutions clés, des préoccupations liées à l'efficacité des processus participatifs, et de l'existence d'un leadership fort et durable au niveau national. Ces facteurs sont liés les uns aux autres et s'influencent les uns les autres de manières très complexes ; ce qui est ressorti des expériences des différentes municipalités en matière d'évaluation participative. Parmi les difficultés constatées figuraient la capacité d'assurer les ressources nécessaires à l'évaluation, le temps nécessaire à la réalisation complète du processus, et le fait de travailler de manière intersectorielle. Cependant, les municipalités impliquées ont rapporté que le processus de mise en œuvre de cette évaluation participative, ainsi que le fait de travailler avec les différentes parties prenantes, avait eu un effet mobilisateur : les communautés et les intervenants se sont intéressés et se sont mobilisés davantage pour prendre part à des initiatives de promotion de la santé de manière durable ; les alliances et la collaboration intersectorielle s'en sont trouvées renforcées ; des voies de communication se sont ouvertes ; et les municipalités ont été stimulées pour revoir leurs processus de planification et de mise en œuvre afin d'intégrer les principes de promotion de la santé de façon plus adaptée. Cet article conclut avec des recommandations destinées à améliorer le processus de planification et de mise en œuvre des efforts déployés au niveau de l'évaluation participative.

Aparajita Orissa

A. Mukhopadhyay, p. 74

Après le cyclone de 1999, qui avait dévasté d'importantes zones de l'état d'Orissa, en Inde, l'Association bénévole indienne pour la Santé (VHAI) a lancé le programme *Aparajita* d'aide et de reconstruction à long terme. Le programme *Aparajita* vise à responsabiliser la communauté locale qu'elle se relève après ce drame, et qu'elle se prépare à faire face aux catastrophes naturelles qui pourraient survenir à l'avenir. Ce programme est actif dans trois zones principales de l'état : Jagatsinghpur, Kendrapara et Puri. Après une étude des dommages causés et de la situation sanitaire et socioéconomique de ces communautés, le programme *Aparajita* a centré ses interventions sur le soutien au niveau des moyens de subsistance, le développement des infrastructures, le renforcement des capacités, l'épargne et le crédit, et les interventions sanitaires. Ce programme a servi à établir les bases du processus de gestion des catastrophes naturelles qui comprend deux éléments principaux : la capacité de réaction et le secours. Étant donné la fréquence des catastrophes naturelles en Inde, il est nécessaire à la fois de renforcer les communautés au niveau du processus de gestion de ces événements, et d'influencer le gouvernement pour qu'il soutienne et institutionnalise les initiatives telles qu'*Aparajita*.

Shehjar Khoj

A. Mukhopadhyay, p. 76

Les troubles et les conflits, qu'ils soient de nature sociale ou politique, affectent toutes les composantes de la société. Aucun tissu social n'est assez solide pour résister aux courants sous-jacents et à l'insatisfaction, qu'ils soient exprimés violemment ou d'une autre manière. Le conflit qui se déroule au Cachemire s'inscrit dans ce cadre. Constatant la nécessité de mener des interventions sanitaires efficaces au Cachemire, l'Association volontaire indienne pour la Santé (VHAI) a lancé le projet *Shehjar Khoj* en 1999. Ce projet, parmi d'autres, vise à promouvoir la justice sociale et l'équité au niveau de la prestation des services de santé et de l'amélioration de l'état de santé de tous, tout en mettant l'accent sur les plus démunis. Ce projet est actuellement actif dans quatre districts et a mis en œuvre de nombreuses interventions qui ont nécessité de former, de motiver et d'encourager la communauté afin qu'elle participe activement, notamment en ce qui concerne les meneurs d'opinion et les acteurs de santé. La compréhension des croyances culturelles et idéologiques des populations a été un facteur essentiel pour permettre le développement de programmes adaptés à l'environnement local, et assurer ainsi le succès de ce projet.

Des services de santé appropriés culturellement à Kwaio, dans les Iles Salomon

D. MacLaren et E. Kekeubata, p. 78

Lorsque des minorités ethniques adhèrent à des pratiques culturelles qui les différencient, les obstacles structurels au sein des services de santé peuvent en réduire l'accès et accroître de façon significative le fardeau des maladies. Cela est tout particulièrement vrai si les services de santé ne sont pas développés en partenariat avec tous les groupes de population de la région. C'est le cas à l'hôpital Atoifi dont la structure empêche certaines populations Kwaio (Iles Salomon) de bénéficier des services hospitaliers tout en respectant leurs croyances culturelles. Un processus de Recherche-Action participative a été utilisé pour travailler en collaboration avec les prestataires de soins de santé et les groupes communautaires de façon à analyser la situation, concevoir et développer une structure sanitaire qui intègre des politiques et des procédures adaptées sur le plan à la fois médical et culturel. Ce processus de Recherche-Action participative d'Atoifi, destiné à examiner, réfléchir, planifier et agir de façon collective pour réorienter les services de santé de façon à ce qu'ils soient mieux adaptés sur le plan culturel, est le premier du genre et a permis à la communauté et à l'hôpital de s'asseoir ensemble pour discuter dans le respect de l'autre d'initiatives de promotion de la santé communautaire. Ce projet a pris fin en 2006, la collaboration et le dialogue entre les deux groupes ayant fait la preuve qu'ils étaient essentiels à son succès. De nombreux indicateurs existent pour prouver qu'une structure sanitaire culturellement adaptée fait toute la différence, non seulement en termes d'utilisation de l'hôpital par tous, mais également en termes « d'appropriation communautaire. »

Le groupe de soutien des 'Super Mamies'

E. Sullivan et al., p. 80

Dans de nombreuses communautés à travers l'Australie, les grand-mères aborigènes sont considérées comme la colonne vertébrale de la structure sociale. C'est le cas des Mamies Murri, un terme par lequel se désigne elle-même la population aborigène du nord-ouest des Nouvelles Gales du Sud et du Queensland, dans l'est de l'Australie. Nombreuses de ces femmes se chargent aussi des soins primaires et de l'éducation donnés à leurs petits enfants, parfois au détriment de leur propre santé et de leur propre bien-être. En réponse à ce stress, le Service médical aborigène (AMS) local, qui comprend une structure globale de soins de santé primaires, a commencé à promouvoir auprès des Mamies le programme '*Relax to the Max*' (Relaxez-vous au maximum), comme partie intégrante des soins holistiques qu'il dispense. Depuis ses timides débuts, il y a environ trois ans, le groupe s'est développé pour devenir aujourd'hui le 'Graniators support group' (le Groupe de Soutien des Super Mamies). Outre leur travail initial de soutien mutuel, le groupe a élargi son champ d'action à la communauté toute entière afin d'aborder les problèmes sociaux, en particulier ceux liés à l'enfance et à l'adolescence. Pour compléter et renforcer leur initiative, les Super Mamies se sont associées à d'autres organisations de la communauté, notamment avec la police, le conseil municipal, le département d'état au logement, l'école primaire locale, ainsi qu'un groupe spécial de services aux jeunes. Le programme une fois évalué s'est avéré extrêmement positif en ce qu'il fournit aux autres membres de la communauté une solution claire et positive pour susciter le changement au niveau local.

Municipalité en santé pour construire ensemble un avenir meilleur – Le projet de Motuca

R. Mendes et F. Falvo, p. 81

En 2002, en collaboration avec la Municipalité de Motuca et l'École de Santé publique de l'Université de Sao Paulo, le Ministère brésilien de la Santé a établi le projet Motuca, Municipalité en Santé dans le but d'améliorer la santé et la qualité de vie de cette population. Ce projet a eu recours à une approche participative et holistique pour s'attaquer aux déterminants sociaux de la santé et aux inégalités structurelles, et a fait appel à des stratégies d'*empowerment* de la communauté, de participation sociale, de travail en réseau intersectoriel et de bonne gouvernance. Tous les acteurs publics locaux des zones urbaines et rurales ont été consultés et ont participé au projet pour recueillir des informations sur les conditions de vie et les obstacles à un meilleur bien-être. Cette méthodologie participative a permis de développer des initiatives culturellement et socialement adaptées de façon à améliorer à long terme la gouvernance locale et le niveau de vie. Bien qu'il faille encore assurer la continuité de ce dynamisme et de ces efforts, ce projet sert de modèle pour les efforts à venir en matière d'évaluation de l'efficacité des méthodologies de recherche et d'intervention participatives dans le but de promouvoir la santé et le bien-être dans les communautés.

Sensibiliser les femmes des zones rurales de Bolivie pour promouvoir le développement communautaire

R. Ríos, C. Olmedo et L. Fernández, p. 83

En 2002, l'Agence des Etats-Unis pour le Développement en Bolivie (USAID/Bolivie) a créé le projet PROSALUD – Partenaires pour le Développement (PfD) dans le but d'améliorer le bien-être de la population. Ce projet a eu recours à trois éléments : un plan d'octroi de petites subventions, une assistance technique et la gestion d'un système de données. À travers le plan d'octroi de subventions, le PfD a soutenu pendant trois ans un projet de Stratégie de Participation communautaire (CPS). Ce projet a impliqué les zones rurales de six départements boliviens ainsi que les banlieues de trois villes boliviennes. Son objectif principal était d'accroître l'utilisation des services de santé en insistant plus particulièrement sur l'*empowerment* des femmes, le renforcement des organisations locales et l'augmentation de la demande pour les services de santé. Les femmes issues de différents groupes autochtones, que ce soit dans les zones urbaines ou rurales, ont été formées à la gestion de projet, à la promotion de la santé, à la santé reproductive et à la planification familiale, au plaidoyer et à la participation communautaire. Les méthodologies participatives ont donné aux femmes les moyens et les capacités de prendre des décisions, et de renforcer leurs capacités à travers l'ensemble du processus de ce projet. Cette expérience montre qu'il est important de travailler avec les organisations communautaires locales reconnues, et de renforcer leur leadership. En outre, les sous-projets ont démontré que lorsque les promoteurs parlent et écrivent les langues locales, les interventions ont plus de succès, les femmes sont plus motivées et mieux sensibilisées et capables de participer, les projets sont conçus pour répondre aux nécessités telles qu'elles sont identifiées par les communautés elles-mêmes, et les services de santé sont culturellement adaptés. Une évaluation préliminaire, à la fois quantitative et qualitative, montre une amélioration globale des connaissances et des pratiques en termes de santé, ainsi qu'au niveau de l'utilisation des services de santé.

Promouvoir la santé et le bonheur en Amazonie brésilienne

C. Scannavino et R. Anastácio, p. 85

Sous le mot d'ordre "Santé, joie du corps. Bonheur, santé de l'esprit," le Projet Santé et Bonheur travaille à promouvoir un développement communautaire intégré et durable dans certaines régions d'Amazonie. Le projet a grandi à partir de l'expérience personnelle des travailleurs locaux qui collaborent avec les communautés, et de la nécessité d'actions durables pour leur développement futur. Il est devenu officiellement une organisation sans but lucratif en 1987. Cette initiative a débuté en mettant en œuvre des stratégies destinées à améliorer l'état de santé de la population, ce qui était alors reconnu comme une difficulté majeure, pour étendre ensuite ses activités à d'autres domaines de développement. L'éducation, la formation et la participation communautaire ont été des éléments clés des actions du projet, qui comprenaient, entre autres, l'hygiène de base, la santé reproductive et la santé des enfants, l'assistance technique dans les pratiques agricoles et l'*empowerment* des jeunes par le biais de la communication. Une fois la structure sanitaire établie, le travail s'est orienté vers de nouvelles priorités liées à l'éducation, à la production économique, à la protection de l'environnement et à la gestion communautaire à moyen et long terme. Le succès de ce projet a contribué à institutionnaliser les pratiques et il touche aujourd'hui 5.000 familles réparties dans 150 communautés rurales de Basse et Moyenne-Amazonie.

Du témoignage au plaidoyer : l'expérience d'une ONG humanitaire

Julie Ancian¹

Résumé : Médecins du Monde (MdM) est une ONG humanitaire internationale qui agit partout dans le monde pour favoriser l'accès aux soins des populations vulnérables qui en sont exclues. MdM s'est fixé comme mandat « soigner et témoigner », afin de dénoncer les atteintes flagrantes dont sont victimes les populations auprès desquelles l'association travaille. À partir de ce besoin d'agir pour améliorer la situation des populations, l'ONG cherche à aller plus loin en développant progressivement des actions de plaidoyer en partenariat avec d'autres organisations. Cette étude de cas montre le différent succès de deux mobilisations, avec l'exemple des campagnes « Banque mondiale : la santé mise à prix ! » lancée fin 2003 et « Personnels de santé au Sud : pénurie mortelle » en 2006.

Mots-clés : plaidoyer, humanitaire, personnel soignant

English abstract on page 100. Resumen en español en la página 132.

Médecins du Monde (MdM) est une ONG humanitaire internationale qui agit partout dans le monde pour favoriser l'accès aux soins des populations vulnérables qui en sont exclues. À sa création en 1980, l'association se fixe comme mandat « soigner et témoigner » : à côté des programmes de soins, la dénonciation des atteintes flagrantes dont sont victimes les populations que nous aidons sur le terrain est une priorité.

À partir de sa pratique médicale, Médecins du Monde *témoigne* donc depuis 25 ans des entraves à l'accès aux soins, des atteintes aux droits de l'homme et à la dignité. Mais depuis quelques années, l'association cherche à aller plus loin en développant progressivement des actions de *plaidoyer*. Cette pratique bien connue des anglo-saxons est encore d'usage récent dans le paysage associatif français, bien que prenant de l'importance. Médecins du Monde a ainsi décidé de créer un service « Plaidoyer », considérant désormais que cette activité fait partie intégrante de son action humanitaire. Il s'agit d'une importante évolution qui exige l'acquisition d'un savoir-faire spécifique. En effet, en comparant deux expériences de mobilisations collectives auxquelles a participé MDM – l'une menée en 2004 sur les politiques de la Banque mondiale en matière de santé, l'autre en 2006 sur la pénurie de personnels soignants au Sud –, on constate que les résultats de nos campagnes internationales peuvent être améliorés.

C'est à l'invitation d'Agir Ici, association de solidarité spécialisée dans les actions de sensibilisation, que Médecins du Monde a rejoint six autres organisations travaillant dans le champ de la santé, du développement ou de la justice sociale, pour la campagne « Banque mondiale : la santé mise à prix ! » lancée fin 2003. Celle-ci visait à pro-

mouvoir un accès universel aux soins de santé et à rappeler le rôle de l'État, garant du droit à la santé pour tous.

À cette fin, nous demandions à la Banque mondiale :

- de cesser de promouvoir la privatisation des services de santé et de réorienter ses financements vers des systèmes de santé publics et solidaires ;
- de ne plus soutenir les politiques de tarification aux usagers (*user fees*), qui limitent l'accès aux services de santé pour les plus pauvres ;
- d'accorder son aide sous forme de dons et non de prêts, afin que le financement de l'accès aux soins ne contribue plus au surendettement des États.

En avril 2006, Médecins du Monde a lancé avec Agir Ici et deux autres organisations humanitaires – le Secours Catholique (Caritas international) et Aide Médicale Internationale – la campagne « Personnels de santé au Sud : pénurie mortelle » ; témoins de ce fléau dans quasiment tous les pays où nous intervenons, nous avons exhorté le gouvernement français :

- à s'engager à tripler dès 2007 son aide publique au développement consacrée au secteur de la santé ;
- dans le cadre de cet effort financier, à augmenter de manière significative la part destinée à appuyer les politiques nationales de renforcement des ressources humaines (soutien à l'augmentation des effectifs et à la prise en charge des coûts salariaux, ainsi qu'à l'amélioration de la formation et des conditions de travail) ;
- à s'opposer systématiquement au sein des institutions de Bretton Woods à toute mesure aboutissant au gel du recrutement ou des salaires du personnel de santé dans les pays confrontés à une

pénurie de ressources humaines et demander l'adoption d'une position officielle consacrant cette politique.

Pour ces deux campagnes nous avons procédé de la même manière : rencontres avec les décideurs politiques concernés, sensibilisation des médias, des associations et du grand public. Pourtant, et quoi qu'il soit très complexe d'évaluer les résultats obtenus au regard des objectifs fixés, il nous semble que la campagne de 2006 aura eu beaucoup plus d'impact que celle de 2004, si l'on considère les retombées médiatiques de chacune, la sensibilisation du grand public aux deux sujets traités ou les déclarations des décideurs en faveur des revendications formulées à leur adresse.

Quelques différences fondamentales entre les deux campagnes peuvent expliquer leur différent succès : au sein même de MdM, le thème de la pénurie de soignants a suscité une plus grande adhésion que celui des politiques de la Banque mondiale, jugé trop complexe et trop éloigné des urgences du terrain que connaissent les acteurs humanitaires. Un sentiment de solidarité professionnelle entre médecins du Nord et médecins du Sud a conduit les membres de l'association à s'impliquer davantage, facilitant le recueil de données probantes (témoignages et chiffres issus des pays les plus touchés par la pénurie) pour élaborer l'argumentaire. Apparemment moins technique que les arbitrages macro-économiques de la Banque mondiale, le thème de la pénurie de soignants a ainsi été mieux relayé par les médias et mieux appréhendé par le public français. Il faut dire qu'il fait écho à d'autres sujets d'actualité comme les débats sur la politique migratoire de la France et la captation

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des migrants qualifiés (*brain drain*). De plus, les faiblesses du système de santé national font craindre, ici aussi, une pénurie de soignants dans quelques années. Enfin, le dialogue avec les décideurs politiques a été beaucoup plus fructueux, des engagements ont été pris allant dans le sens de nos revendications.

Il nous reste donc de nombreuses leçons à tirer de ces expériences pour améliorer notre récente pratique du plaidoyer à l'échelle internationale. En nous inspirant aussi de notre travail en France, où depuis 1986, Médecins du Monde conduit la moitié de ses activités et se bat pour réintégrer

les exclus des soins dans le droit commun : SDF, migrants, prostitué-e-s, usagers de drogue. MdM est ainsi devenu un interlocuteur incontournable des pouvoirs publics pour toute nouvelle mesure concernant l'accès aux soins et l'état de santé des populations vulnérables (adoption de la CMU – Couverture Maladie Universelle –, hébergement des sans-abri, réforme du droit d'asile etc.).

Le succès de ces actions réside dans la proximité qu'entretient MdM avec ses bénéficiaires : plus de cinquante programmes à travers le territoire national et vingt ans d'accompagnement sans interruption ; ce lien renforce la justesse des préoccupations

exprimées et accroît la légitimité de l'association aux yeux de l'opinion et des décideurs. C'est probablement ce qui nous fait défaut dans nos programmes internationaux où les lieux et durées d'interventions sont beaucoup plus limités. Notre force de frappe vis-à-vis des cibles politiques n'en est donc que plus réduite. Pour renforcer la pertinence de notre plaidoyer international, il faut par conséquent travailler plus étroitement avec les *communautés* locales et les réseaux de la société civile concernés. C'est déjà le cas pour les programmes de soins, mais cela reste à approfondir pour les campagnes de plaidoyer.

Plaidoyer

Plaider pour des politiques de santé adaptées et une gestion efficace du système de santé

A. Mukhopadhyay, p. 88

Des politiques de santé soutenues par un effort de plaidoyer durable doivent se développer et s'étendre de façon continue pour répondre à la pression croissante des politiques macro-économiques de la mondialisation, de la libéralisation et de la privatisation.

La Voluntary Health Association of India (VHAI), le réseau le plus large d'organismes sans but lucratif du secteur de la santé, joue un rôle majeur à la fois au niveau macro et microéconomique. Les efforts qu'elle déploie pour plaider en faveur de la santé émanent de la population locale, avec une compréhension de ses problèmes en termes de santé et de développement ainsi que des stratégies adoptées pour y faire face. Le processus vers la formulation d'une politique de santé efficace, qui consiste à renforcer une mobilisation ascendante des informations, est appuyé par de sérieuses macro recherches sur les différentes dimensions de la santé, menées par la Commission indépendante indienne sur la Santé et le Développement (ICDHI), fondée en 1995 par la VHAI. Ces documents essentiels de politique générale, à la fois réflexifs et prescriptifs, sont présentés aux plus hautes autorités de l'Etat et donnent lieu à une discussion à différents niveaux, avec des groupes variés.

L'un des récents succès a été l'obtention du retrait des industries géantes du tabac du sponsoring du cricket associée à l'élaboration par le Gouvernement de l'Union d'une loi globale destinée à prévenir ce type de publicité à l'avenir. Plusieurs documents de politique générale bien étayés par des recherches ont été rassemblés par l'organisation sur base de son travail au niveau micro et macro-économique, et de son plaidoyer continu.

Des politiques adaptées de santé publique et de développement, ainsi que leur mise en œuvre efficace, sont les pierres angulaires de la réalisation des valeurs fondamentales d'Alma Ata. Le système des soins de santé doit s'éloigner du modèle biomédical actuel pour se rapprocher du modèle sociopolitique et spirituel dans lequel les soins de santé deviennent une partie organique des soins communautaires comme cela était le cas dans la société traditionnelle.

S'atteler au problème de l'équité en santé : des pressions descendantes et ascendantes pour agir sur les déterminants sociaux de la santé.

F. Baum, p. 90

La Commission sur les Déterminants sociaux de la Santé a été établie pour conseiller quant aux manières dont la compréhension des déterminants sociaux de la santé peut affecter l'action pratique afin d'améliorer la santé de la population pour qu'elle soit équitable. Cet article considère les facteurs nécessaires pour encourager les gouvernements à adopter des politiques allant dans ce sens. Elle affirme que la connaissance est essentielle mais insuffisante. Les gouvernements ont besoin d'un engagement envers les valeurs d'équité et de justice, et doivent être capables de gérer la complexité de l'action sur les déterminants sociaux au-delà de l'exhortation des individus à changer leurs comportements. Le rôle de la société civile est essentiel pour plaider auprès des gouvernements dans ce sens. La présence d'un capital social assurant la liaison est également essentielle pour créer un environnement social et politique qui promeuve l'équité. Une étude de cas de l'état de santé médiocre des populations autochtones d'Australie est utilisée pour illustrer l'importance du capital social.

Un parc en santé : le cas d'un programme de prévention et de promotion de la santé communautaire dans une région isolée de la forêt péruvienne

E. Peñaherrera Sánchez et W. Palomino, p. 129

L'initiative Parc en Santé est un exemple de programme de prévention et de promotion de la santé mené dans une communauté présentant des niveaux élevés de toxicomanie. Ce programme a été développé à travers un partenariat stratégique avec les acteurs locaux (comme les dirigeants communautaires et les groupes de jeunesse), les institutions publiques (les Ministères de la Santé et de l'Éducation ainsi que la police) et les institutions du secteur privé (les ONGs, le commerce local). L'engagement communautaire était essentiel tout au long du processus d'élaboration et de mise en œuvre du projet. Les membres de la communauté ont été mobilisés en se voyant confier la responsabilité directe de mener le projet à bien et d'assurer son suivi, ainsi qu'en ayant à assumer eux-mêmes les initiatives de plaidoyer et la comptabilité générale avec l'organisme financier, le groupe Coopération Technique Belge. Les principaux résultats du programme incluent la création d'un cadre de référence pour une coexistence communautaire et un plan de développement communautaire, ce qui a permis, non seulement de planifier et de répartir les responsabilités entre les riverains pour l'entretien du parc, mais également de coordonner une augmentation des services et des opportunités de développement avec les autorités locales.

Promotion de la santé communautaire au Pakistan : une perspective de développement de politiques

K. A. Ronis et S. Nishtar, p. 98

Le Pakistan figurait parmi les signataires initiaux de la Déclaration d'alma Ata en 1978, mais ce n'est qu'en 2004, cependant, que la première politique consacrée exclusivement à la santé publique et à la promotion de la santé y fut lancée. Le *Plan d'Action national pour la Prévention et le Contrôle des Maladies non transmissibles et la Promotion de la Santé au Pakistan* a gagné une place prédominante à l'ordre du jour national de la santé rivalisant pour obtenir des ressources avec les politiques de santé traditionnelles axées sur les traitements, les soins, et les technologies en constante évolution.

Du point de vue de la promotion de la santé, ce plan d'action était unique en ce qu'il était axé sur le lieu de vie de la communauté à travers deux initiatives majeures de communication pour le changement comportemental – l'une par le biais des médias, et l'autre en intégrant la prévention des maladies non transmissibles dans le plan de travail des *Lady Health Workers* (les Travailleuses de la Santé).

La phase de développement de cette politique inaugurale de santé publique/de promotion de la santé suit étroitement le chemin tracé par l'*Australian Policy Cycle* (Cycle australien de Politiques) et célèbre un processus global de consultation. Sa force vient d'un partenariat tripartite entre le Gouvernement, l'Organisation mondiale de la Santé et *Heartfile*, une organisation non-gouvernementale à l'origine de cette initiative. Ce partenariat public-privé a grandement facilité le processus de développement de politiques et continue à soutenir la recherche, la mise en œuvre et l'évaluation.

Cet article nous encourage à analyser le développement du *Plan d'Action national* et plus particulièrement au niveau de la promotion de la santé communautaire.

Le Réseau québécois des Villes et Villages en santé : un mouvement fort confronté à de nouveaux défis

Paule Simard¹

Résumé : Au service de ses membres depuis vingt ans, le Réseau québécois des Villes et Villages en santé fait actuellement face à plusieurs défis. L'organisation des territoires locaux de même que les multiples responsabilités qui leurs sont dévolues sont actuellement en mutation. Le RQVVS, par sa capacité à mobiliser les municipalités, est extrêmement bien placé pour diffuser, encourager et appuyer ses membres à non seulement arrimer les différentes démarches gouvernementales, mais pour les inciter à le faire de concert avec d'autres partenaires institutionnels (éducation, santé, socio-économiques, etc.) ou communautaires. Il doit cependant repenser son soutien direct à ses membres tout en poursuivant ses activités de diffusion d'informations et de réseautage. (*Promotion & Education*, 2007, (2) : pp 121-122)

Mots clés : promotion de la sante, ville, travail en réseau

English abstract on page 108. Resumen en español en la página 134.

Le Réseau québécois des Villes et Villages en santé

Au Québec, le mouvement des Villes et Villages en santé naît en 1987 avec le projet de Rouyn-Noranda, première Ville en santé en Amérique, auquel d'autres villes emboîtent rapidement le pas. Ressentant le besoin d'échanger de l'information et leurs expériences, ces villes et villages en santé mettent sur pied le Réseau québécois des Villes et Villages en santé (RQVVS). D'abord informel, ce dernier se dote d'un Centre d'information qui allait soutenir son développement et faciliter son incorporation en 1990. En septembre 2006, il comptait 157 membres cumulant plus de 1 100 projets dans une variété de domaines allant de l'environnement, à la pauvreté ou à l'accès à des services de santé¹.

Le RQVVS est un organisme à but non lucratif dont le conseil d'administration est composé de douze membres comprenant une majorité d'élus municipaux. Depuis sa mise sur pied, le Centre d'information du RQVVS est soutenu par le ministère de la Santé et des Services sociaux. Il est maintenant rattaché à l'Institut national de santé publique du Québec (INSPQ) où cinq personnes y travaillent. Ce centre d'information offre plusieurs services aux municipalités membres, tels le bulletin de liaison, un centre de documentation, une boîte à outils, des conseils attentifs, un certain soutien aux démarches locales et un colloque annuel, etc.

Un environnement favorable

Au fil des années, plusieurs politiques et rapports québécois, canadiens ou internationaux (*Charte d'Ottawa*, 1986 ; *Politique de santé et de bien-être*, 1992 ; *Priorités nationales de santé publique 1997-2002*, 1997 ; *Rapport Romanow*, 2002 ; *Building Healthy Rural*

Communities, 2002) sont venus faciliter l'émergence et soutenir l'évolution du mouvement VVS au Québec. Toutefois, ce n'est que tout récemment qu'émerge une certaine volonté de convergence dans l'action de différents ministères et approches de développement. En effet, au cours des dernières années, plusieurs orientations gouvernementales (*Programme national de santé publique*, 2003 ; Loi 25 créant les réseaux locaux de services de santé et de services sociaux, 2004 ; *Plan d'action gouvernemental en matière de lutte à la pauvreté et à l'exclusion sociale*, 2004 ; *Politique nationale de la ruralité*, 2001 ; *Plan de développement durable*, 2004 ; *Politique ministérielle en prévention de la criminalité*, 2001 ; *Rapport Perreault*, 2005 ; *Loi sur les compétences municipales*, 2005 ; *École en santé*, 2005) sont venues réaffirmer non seulement le rôle des gouvernements locaux comme acteurs de premier plan dans l'amélioration de la santé et du bien-être des citoyens, mais également la nécessité de traiter les grands dossiers touchant la société québécoise de manière intersectorielle.

Le RQVVS, par sa capacité à mobiliser les municipalités, est extrêmement bien placé pour diffuser, encourager et appuyer ses municipalités membres à arrimer les différentes démarches gouvernementales tout en les incitant à le faire de concert avec d'autres partenaires institutionnels (éducation, santé, socio-économiques) ou communautaires. D'ailleurs, c'est grâce à cette expertise de plus en plus reconnue que VVS réapparaît de plus en plus présent dans le discours de santé publique (*Programme national de santé publique*, 2003).

Au sein même du réseau, plusieurs conditions gagnantes semblent être actuellement réunies (renouvellement au sein du conseil d'administration et à la présidence ;

réorganisation de l'équipe et ajout d'une nouvelle ressource), ce qui devrait permettre au RQVVS de se positionner comme un acteur incontournable pour accompagner le monde municipal dans ses nouvelles responsabilités. D'autant plus d'ailleurs que l'on sent également du côté municipalité une certaine ouverture à s'investir dans de nouveaux champs de compétence.

Les défis

Cependant, bien que plusieurs facteurs concourent à créer un contexte favorable à son épanouissement, le RQVVS est actuellement confronté à un certain nombre de défis.

En dépit du fait que l'on reconnaisse aux municipalités une responsabilité accrue au regard de la santé et du bien-être et que celles-ci ont la volonté de s'y attaquer, la diversité de ces nouveaux mandats de même que les champs d'expertise que cela suppose font en sorte que les municipalités ne sont pas toujours à même de répondre à toutes ces commandes. Les besoins de soutien au sein des municipalités sont donc considérables.

Si le RQVVS veut continuer à être un acteur significatif pour le monde municipal, la question de son rôle dans l'accompagnement de ses membres se pose. Si ce dernier est tributaire des ressources disponibles au Centre d'information, qui n'ont pas augmenté en proportion du nombre de membres, il apparaît nécessaire que le RQVVS s'interroge sur le type de soutien qu'il entend accorder à ses membres.

La question du soutien aux membres du RQVVS interpelle également les niveaux régionaux et locaux du réseau de la santé et des services sociaux qui sont engagés, selon des modèles très différents d'une région à l'autre, dans le développement et

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La Fête des Voisins à Gatineau, Ville en santé.

le soutien du mouvement VVS. Et encore là, les transformations récentes du rôle des agences régionales et des centres de services de santé et des services sociaux (CSSS) ont une incidence importante. Si le mandat des premières consiste principalement à soutenir le niveau local, ce dernier vit une reconfiguration significative de ses façons d'intervenir. Les nouvelles responsabilités locales amènent les CSSS à se préoccuper du bien-être de l'ensemble de leur population et à travailler de concert avec les acteurs locaux que sont les municipalités. Toutefois, les ressources locales qui, dans certaines régions, étaient affectées au soutien de démarches municipales comme VVS se voient souvent confier d'autres dossiers sectoriels.

Dans le contexte actuel d'insuffisance des ressources pour offrir le soutien direct, le RQVVS doit plutôt développer et diffuser des outils d'accompagnement appropriés. Un des documents clés de l'approche VVS *L'obsession du citoyen* est en train d'être réécrit et le Centre d'information prévoit la rédaction d'un guide d'implantation de démarches VVS qui poserait les grandes lignes de ce que comporte un projet VVS et des outils pour l'implantation. L'équipe travaille également au développement d'outils d'évaluation qui permettraient aux projets VVS de mener leurs propres évaluations et d'intégrer la question de l'évaluation à la planification.

Par ailleurs, une entente de collaboration actuellement en discussion avec le Centre Québécois du développement durable amènera le RQVVS à promouvoir le développement des Agendas 21 dans les municipalités, démarches par ailleurs très similaires à celles proposées par VVS. Ce nouveau mandat viendra enrichir les outils qui seront produits au cours des prochaines années.

Un autre enjeu important relatif au mouvement VVS est le soutien des gouvernements à ce genre d'initiatives alors même que l'État réduit ses dépenses tout en augmentant les responsabilités locales. Pour pouvoir collaborer efficacement avec les municipalités et respecter les dynamiques locales, les partenaires institutionnels doivent disposer d'une certaine marge de manœuvre qui permette d'appuyer sans contrôler, tant en ce qui concerne le type de soutien professionnel qu'ils offrent qu'en ce qui touche l'affectation des budgets. Et au-delà de cette flexibilité, il faut sans contredit que des ressources financières supplémentaires soient accordées pour soutenir les initiatives locales.

En définitive, il apparaît que le contexte politique et administratif actuel favorise un rôle accru des territoires locaux, notamment des municipalités, dans la mise en place de conditions favorables à la santé et au bien-être, même s'il faut reconnaître que ces responsabilités ne s'accompagnent pas de ressources financières conséquentes. Les nouvelles responsabilités dévolues aux territoires locaux constituent une excellente opportunité pour le RQVVS de repenser son soutien direct à ses membres tout en poursuivant ses activités de diffusion d'informations et de réseautage.

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Note

1. Voir le site Internet du RQVVS (www.rqvvs.qc.ca).

Le Réseau des Communautés en Santé de Rio de Janeiro au Brésil

D. Becker et al., p. 101

Les communautés pauvres de Rio de Janeiro, connues sous le nom de *favelas*, souffrent de divers problèmes liés aux mauvaises conditions de logement, à la pauvreté, au chômage, à la violence et au crime organisé, ainsi qu'à leur manque d'accès aux services de base, comme les soins de santé et l'éducation. Afin de lutter contre ces déterminants, et sous l'inspiration du mouvement international de l'OMS pour les Communautés/Villes en Santé, le Réseau des Communautés en Santé de Rio de Janeiro a été constitué en 2004. Ce Réseau est coordonné par le Centre de Promotion de la Santé (CEDAPS) et compte aujourd'hui plus de 160 groupes et organisations communautaires de l'état de Rio de Janeiro. Leur but est de promouvoir la santé, le développement communautaire et l'équité par l'*empowerment*, la participation, et le développement des capacités des communautés ainsi que par le plaidoyer. Cet article décrit le travail qui a été réalisé depuis les débuts du Réseau, ainsi que les obstacles qu'il leur faut encore surmonter pour atteindre leurs objectifs dans un pays comme le Brésil. Ce Réseau constitue un important point de repère pour montrer comment les populations démunies peuvent s'organiser de façon collective, participative et constructive afin d'influencer les politiques publiques et de lutter pour de meilleures conditions de vie dans les milieux défavorisés, comme les *favelas*.

Développer des réseaux de Villes en Santé en Europe

E. Goepel, p. 103

À ses débuts en 1987, le Réseau européen des Villes en Santé a été inspiré par la Charte d'Ottawa pour la Promotion de la Santé. Le processus de développement de ce réseau a été lancé par le Bureau régional de l'OMS pour l'Europe, mais a ensuite développé sa propre dynamique dans différents pays européens à une époque marquée par des transformations politiques fondamentales dans de nombreux pays d'Europe de l'Est.

Ces réseaux se sont ensuite joints à l'*Agenda 21* local et à la campagne *Villes et Villages durables* pour créer un nouvel ordre du jour plus large au niveau local. Les Profils de Villes en Santé et les politiques participatives pouvant contribuer à de nouvelles formes d'urbanisation et de gestion locale, en particulier les « engagements – Aalborg plus 10 » des gouvernements locaux en 2004, ont le potentiel d'inspirer une nouvelle phase de politiques participatives et durables au niveau des communautés locales d'Europe.

Quelle que soit l'ampleur de l'influence qu'auront ces initiatives sur les macro-politiques de l'Union européenne dans le sens d'une « Europe des Citoyens » proclamée, il nous faudra surveiller attentivement ces développements au cours des prochaines années.

EQUINET : Travailler en réseau pour l'équité en santé en Afrique de l'est et australe

R. Loewenson, p. 105

Ce court rapport met en évidence les perspectives et les motivations qui sous-tendent le travail du Réseau régional pour l'Équité en Santé en Afrique de l'est et australe (EQUINET). Il présente des thèmes de travail clés sur l'équité en santé qui sont mis en œuvre afin de renforcer le secteur public dans le domaine de la santé, et organisés autour de l'engagement et de la participation active des communautés. Cela inclut le travail déployé pour le renforcement des capacités de la population en faveur de la santé ; pour l'accroissement de financements justes ; pour le maintien des travailleurs de la santé et la lutte contre les politiques commerciales empiétant sur la santé. Un tel travail se heurte à des obstacles qui peuvent être surmontés par le développement du travail en réseau à l'échelle régionale afin de partager les expériences, les informations et l'expertise, en particulier au vu de la demande pour « apprendre en agissant ».

L'Alliance mondiale pour l'Équité sociale (GEGA)

A. Ntuli, p. 107

Le manque d'attention portée à l'équité en santé, aux soins de santé et aux déterminants de la santé est un obstacle qui empêche de nombreux pays d'atteindre une bonne santé. Partant de ce problème sous-jacent, une série de rencontres ont été organisées entre 1999 et 2000, culminant par la création de l'Alliance mondiale pour l'Équité sociale (GEGA). La GEGA est un réseau international de groupes issus de pays en voie de développement, principalement en Asie, en Afrique et en Amérique latine, qui développe, sous le nom de 'Equity Gauges' (Indicateurs d'Équité), des projets destinés à lutter contre les inégalités de santé et à les atténuer. Les 'Equity Gauges' visent à contribuer à une diminution marquée des inégalités au niveau des déterminants sociopolitiques de la santé au sens large, ainsi qu'au niveau des systèmes de santé. Leur approche est basée sur trois grandes sphères d'action, nommées « piliers » : 1) les mesures et le contrôle, 2) le plaidoyer, et 3) l'*empowerment* de la communauté. À travers une série d'exemples tirés d'indicateurs locaux et nationaux, cet article présente le travail réalisé dans le but de promouvoir l'interaction entre la *recherche et l'élaboration de politiques basées sur des données probantes ainsi que leur mise en œuvre, de même que l'interaction entre la communauté et les responsables politiques*.

La promoción de la salud comunitaria: un paso más

Sania Nishtar^{1,2}

Este ejemplar monográfico de *Promotion & Education* ha recibido apoyo financiero de los Centros para el Control y la Prevención de Enfermedades (CDC) de los Estados Unidos, una agencia del Departamento de Salud y Servicios Humanos, en virtud del Acuerdo de Cooperación n° U50/CCU021856 sobre Promoción de la Salud y Educación para la Salud Mundiales. Las opiniones expresadas en los artículos son aquellas de los autores y no representan necesariamente la posición oficial de los CDC y la UIPES.

Dentro de los sistemas de salud actuales, la promoción de la salud tiene una importancia estratégica. El contexto general en el que se inserta esta afirmación es fruto de la incapacidad de casi todos los países, cuyos sistemas de salud son mixtos, de ofrecer la salud como bien de interés público. Si a esto le añadimos el protagonismo creciente del mercado en este campo y la precariedad de los recursos en el sector social, especialmente en los países en vías de desarrollo, se impone la necesidad de que las comunidades asuman un rol visible en la promoción de la salud en aras a lograr el objetivo de la equidad en este campo. No obstante, a pesar de su importancia, la promoción de la salud comunitaria sigue siendo un concepto difícil de entender, lo que hace difícil defenderlo ante los responsables de elaborar las políticas. En vista de la situación, el Consorcio Mundial para la Promoción de la Salud Comunitaria, tras su creación en 2003 como iniciativa de colaboración de los Centros de Control y Prevención de Enfermedades (CDC) y la Unión Internacional de Promoción de la Salud y de Educación para la Salud (UIPES), decidió centrar su empeño en puntualizar los conceptos y normas y que ese fuera el punto de partida de su trabajo; en este contexto, el presente número especial constituye un paso más en esta dirección y se ha elaborado a partir de la Declaración del Consorcio (Nishtar et al., 2006).

Este número abarca muchos aspectos de la promoción de la salud comunitaria desde la elaboración de su conexión con los principios de equidad, pasando por reflexiones sobre la salud de la población hasta la presentación de una serie de casos prácticos que permiten una mejor comprensión de lo que implica la promoción de

la salud comunitaria y de cómo y por qué pueden emplearse las metodologías participativas que potencian a las comunidades para sacar el máximo partido de sus activos. Asimismo, este número de la revista contiene artículos de relevancia práctica en el sentido de ayudar a los países y a los profesionales de salud a comprobar si las actividades generales de sus proyectos concretos cumplen las normas de las buenas prácticas de la promoción de la salud, y ofrece orientación sobre la evaluación participativa.

La Declaración del Consorcio, la cual estructura este número de la revista, define la promoción de la salud comunitaria como *proceso participativo y capacitador de las comunidades centrado en la equidad, que considera esencial la participación de la comunidad en todas las fases que integran las acciones de promoción de la salud y que reconoce y potencia los activos y los conocimientos de las comunidades a fin de generar las condiciones necesarias para la salud*. No obstante, como explica Rice en su artículo (2007; p. 68), no todas las políticas y acciones de promoción de la salud se ajustan a esta definición. La autora hace uso de las lecciones aprendidas en la aplicación de las metodologías de evaluación participativa a la Iniciativa de Municipios, Ciudades y Comunidades Saludables (HMC) en algunos países de América Latina y el Caribe para poner de relieve el hecho de que en la mayoría de los proyectos no se han tenido en cuenta de manera adecuada los principios básicos de la promoción de la salud, como por ejemplo, la colaboración intersectorial y la participación de las comunidades. El artículo de Baum ahonda todavía más en la cuestión y ayuda a entender las consecuencias de no aplicar dichos principios refiriéndose a las políticas y acciones de promoción de la salud llevadas a cabo en Australia que tuvieron su origen en la Carta de Ottawa (2007; p. 90); unas y otras han incidido enormemente en muchos aspectos de salud de la población, pero no han conseguido abordar las desigualdades ni reducir las diferencias existentes. Estas experiencias subrayan la necesidad de diseñar políticas y acciones de promoción de la salud que incidan directamente en la equidad, y es en este punto donde adquiere importancia la necesidad de combinar el compromiso político desde

arriba con la acción desde abajo por parte de las comunidades y de los grupos de la sociedad civil, fenómeno al que Baum denomina en su artículo como “El efecto cascanueces para lograr la equidad en el ámbito de la salud.” En consecuencia, es fundamental comprender el papel que desempeñan las comunidades en la promoción de la salud. En este contexto, el número que tenemos en las manos ofrece una serie de casos prácticos de varios países en vías de desarrollo que muestran enfoques ilustradores de la cuestión. Cada caso ha utilizado un formato cuya estructura subraya tanto la intervención como las lecciones que pueden extrapolarse de la experiencia concreta y aplicarse más ampliamente. A pesar de los puntos débiles existentes en las metodologías empleadas para su diseño y su evaluación, los casos prácticos ofrecen lecciones importantes relativas al proceso.

En primer lugar, el mensaje colectivo subraya la importancia de comprender todo el proceso de gestión del proyecto comunitario y sus instrumentos. Lo más importante es implicar a todos los actores del desarrollo en un modelo participativo adaptado a la cultura local a la hora de planificar y decidir la gobernanza; entre los actores figuran los organismos gubernamentales locales, las ONGs, los socios internacionales de desarrollo, organizaciones comunitarias formalmente establecidas, los líderes locales y las federaciones presentes en la comunidad. Que el poder sea ejercido de forma participativa y otorgue un papel tanto al sector público como a las comunidades repercute no sólo en la sostenibilidad de las iniciativas de base, sino que además permite la transferencia de tecnologías sociales que funcionan a otros entornos y la adopción e integración de los programas en forma de políticas públicas.

En segundo lugar, el estudio de estos casos prácticos coloca en primer plano muchas consideraciones que deberían tenerse en cuenta cuando se estructuran las iniciativas comunitarias; por nombrar unas cuantas, lograr la participación y el sentimiento de pertenencia en todas las fases; asegurarse de que las voces se hacen oír; fomentar la cohesión; asegurarse de que las lecciones aprendidas se incluyan como factores a tener cuenta en la toma de decisiones; dotar de flexibilidad al diseño

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de los programas de manera que se puedan modelar a partir de la evidencia propia del lugar, a medida que ésta se manifiesta en el transcurso de las intervenciones; fomentar la autogestión y el control social; utilizar herramientas de intervención adecuadas a la cultura local y validadas por ella; y prestar la debida atención a la capacitación de las mujeres para la toma de decisiones. Todos ellos se consideran importantes para la sostenibilidad de las intervenciones de base en general. Pero de manera más concreta, también permiten superar barreras religiosas, culturales y ancestrales que impiden el acceso a la atención de salud, como se muestra en el caso práctico de las Islas Salomón (MacLaren & Kekeubata, 2007; p. 78); además pueden asimismo ayudar a promover la autonomía y la capacitación de los grupos más aislados a los que es más difícil acceder, como nos muestra el ejemplo de las poblaciones de la selva de Brasil, o “caboclos”, que viven en áreas rurales y remotas del Amazonas (Scannavino & Anastácio, 2007; p. 85).

En tercer lugar, casi todos los ejemplos subrayan la necesidad de llevar a cabo acciones intersectoriales dentro del marco más amplio de desarrollo del sector social más que dentro del ámbito de la atención de salud. En los ejemplos de las intervenciones de salud que se citan aquí, para mejorar los resultados de salud han logrado el apoyo de diversos sectores como la vivienda, la enseñanza, los servicios a la juventud y de las agencias de seguridad alimentaria más que de los sistemas de salud convencionales. La perspectiva local dentro de un ámbito intersectorial puede también señalar oportunidades locales concretas de promoción de la salud; ejemplo de ello es el caso de Orissa en el que la predisposición de aquella zona a los desastres naturales es uno de los determinantes más fuertes de la muerte y la discapacidad en esta región de la India; por lo tanto, la previsibilidad del desastre justifica el fortalecimiento de la capacidad institucional para llevar a cabo las operaciones de asistencia a las víctimas y de rehabilitación, en lugar de realizar las intervenciones de salud pública tradicionales (Mukhopadhyay, 2007; p. 74).

Por último, los casos prácticos se refieren al valor potencial del trabajo en red a nivel mundial, en el sentido de promover los valores de la equidad y de la justicia social en el campo de la salud, facilitando el intercambio de experiencias entre unos y otros países, como es el caso de EQUINET (Loewenson, 2007, p. 105), pero también en tanto que aumenta el control de las personas sobre su salud y bienestar en entornos comunitarios locales, como nos muestra el ejemplo de las “Graniators” en Australia (Sullivan et al., p. 80).

Los artículos que siguen brindan valiosas lecciones para favorecer la promoción de la salud comunitaria. Las pruebas de la efectividad de dichas iniciativas subrayan la necesidad de ir más allá de los proyectos piloto y de demostración para integrar la participación y el papel que desempeñan las comunidades en la mejora de todo un conjunto de aspectos de la salud (UIPES, 2000). Ello requiere toda una gama de acciones complejas e interdependientes, y exige no limitarse a fortalecer la voz de las comunidades y de los trabajadores de salud de primera línea, sino además reforzar el tejido social de las políticas, configurando el bienestar social y los acuerdos de financiación de la salud y moldeando el contexto normativo dentro de los entornos de cada país. Para ello se necesitará, dentro del sector sanitario, la aplicación de una serie de medidas generales, como la redistribución de los presupuestos sanitarios, pasando de la atención terciaria a la prevención y la promoción de la salud, y hacer frente a los desequilibrios tanto presupuestarios como en el despliegue de personal sanitario para favorecer las infraestructuras y servicios rurales, las urbanas de tipo informal y las de atención primaria. Los programas de salud pública existentes, y los que se están desarrollando, nos brindan la oportunidad de integrar la prevención, el control y la promoción de la salud, como quedó demostrado en Pakistán en relación con la iniciativa de lucha contra las enfermedades no transmisibles (Ronis & Nishtar, 2007; p.)

No obstante, la participación sostenible de las comunidades en la atención sanitaria mayoritaria sí es viable en los países cuyos sistemas de gobernanza contemplan la descentralización de las competencias políticas y administrativas hacia las unidades que se hallan en la parte inferior de la escala, como los municipios. Estas estructuras ostentan el mandato y la responsabilidad institucional de involucrar a las comunidades y canalizar sus aportaciones a través de los actores locales hacia los planes de desarrollo local. La perspectiva del gobierno local puede asimismo posibilitar que las intervenciones de salud concuerden con los objetivos generales de desarrollo, vinculándolas, a su vez, con iniciativas de apoyo a la subsistencia, de enseñanza, de ahorro y crédito, puesto que estas son decisivas para el proceso de desarrollo de las bases en general.

Estimular las acciones en este sentido dentro del sector social es una prerrogativa de las instituciones estatales de cada país; no obstante, las iniciativas de desarrollo multilaterales como la Comisión sobre los Determinantes Sociales de la Salud de la OMS, puede darle un impulso, especialmente por la influencia que ejerce esta

organización en más de 190 países, exhortando a los gobiernos a optar por políticas públicas estructuradas en torno a la participación activa y a la implicación de las comunidades, como ha quedado expuesto en los enfoques citados. Un estado y un sector público fuertes en materia de salud es un elemento importante si se pretende mejorar la salud de la población de manera equitativa, tanto para realizar la prestación de un bien de interés público, como para regular el mercado privado. El papel de las comunidades puede ser decisivo para el éxito de ambos.

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Reducir las desigualdades sociales en el ámbito de la salud: ¿Salud pública, salud comunitaria o promoción de la salud?

V. Ridde, p. 63

Mientras el Consorcio para la "Promoción de la Salud Comunitaria" propone una definición de este nuevo concepto para calificar unas determinadas prácticas de salud, este artículo cuestiona la pertinencia de introducir dicho concepto, puesto que nadie ha logrado diferenciar todavía los tres procesos existentes: salud pública, salud comunitaria y promoción de la salud. Si nos basamos en la literatura existente al respecto y en un análisis del abanico de prácticas, los tres conceptos pueden distinguirse en función de sus procesos y de sus fines. La salud pública y la salud comunitaria coinciden en un objetivo: mejorar la salud de la población. Para lograrlo, la salud pública utiliza un proceso tecnocrático, mientras que la salud comunitaria emplea un proceso participativo. La promoción de la salud, por otro lado, aspira a reducir las desigualdades sociales en el ámbito de la salud a través de un proceso que fomenta la autonomía y la preparación de las personas. No obstante, esta no es más que una definición teórica, puesto que en la práctica, los profesionales de la promoción de la salud tienden a olvidar este objetivo fácilmente. Tres argumentos debían empujar a los promotores de salud a convertirse en la voz cantante de la lucha contra las desigualdades sociales en materia de salud. Los dos primeros se basan en la falta de efectividad de los enfoques que caracterizan a la salud pública y a la comunitaria, centrados en el sistema de salud y en la educación para la salud, a la hora de reducir las desigualdades sociales en el ámbito de la salud. El tercer argumento a favor de la promoción de la salud, es de naturaleza más política pues no hay suficientes pruebas de su efectividad debido a que el trabajo en este campo es relativamente reciente. Los responsables la promoción de la salud tienen que implicarse en la reducción de las desigualdades sociales en el ámbito de la salud y deben asegurarse de que cuentan con los medios para evaluar la efectividad de todas las acciones que emprendan.

Lecciones aprendidas de la aplicación de una metodología de evaluación participativa a las Iniciativas de Municipios, Ciudades y Comunidades Saludables en algunos países de América Latina y el Caribe

M. Rice y M. C. Franceschini, p. 68

En los últimos decenios, la promoción de la salud ha dado pasos importantes en América Latina y el Caribe. Generar entornos saludables y propicios -lo que se conoce como el enfoque de los entornos- sigue siendo una de las estrategias de promoción de la salud más ampliamente empleada. En los últimos años, ha aumentado enormemente el interés por evaluar la efectividad de estas estrategias. La evaluación participativa tiene el gran potencial de ayudar a generar esta evidencia y promover la comprensión de los factores que afectan, positiva o negativamente, a los avances de la promoción de la salud en la Región. En el periodo 2004-2006, se introdujo en varios países de América Latina y el Caribe una metodología de Evaluación Participativa, a través de cursos de formación llevados a cabo por la Organización Panamericana de Salud (OPS) en colaboración con los países. El artículo resume las principales lecciones aprendidas de esta aplicación de la metodología de evaluación participativa en dichos países. Se identificaron los factores que afectan a la evaluación de las iniciativas a múltiples niveles (personas, comunidad, organizativos, políticos, económicos, etc.). Entre las cuestiones concretas que se abordaron figuraban el contexto político, los cambios de personal en las instituciones clave, inquietudes relacionadas con la efectividad de los procesos participativos y la existencia de liderazgos fuertes y estables en el país. Estos factores se entrelazan y se afectan mutuamente de maneras muy complejas, hecho que quedó reflejado en las experiencias de los municipios con la evaluación participativa. Entre los retos a los que hubo que hacer frente figura la capacidad de garantizar recursos para la evaluación, el tiempo que se necesitaba para concluir el proceso y el trabajo intersectorial. No obstante, los municipios que participaron concluyeron que el proceso de implementación de una evaluación participativa y el hecho de trabajar con distintos grupos de interés tuvo un efecto potenciador: las comunidades y los grupos de personas interesadas tenían más ganas y mayor interés en participar en las iniciativas de promoción de la salud de manera estable; se fortalecieron las alianzas y la colaboración intersectorial; se abrieron canales de comunicación; y se motivó a los municipios a revisar sus procesos de planificación y de implementación para incorporar de forma más adecuada los principios de la promoción de la salud. El artículo concluye con recomendaciones para mejorar el proceso de planificación y de implementación de las iniciativas de evaluación participativa.

Aparajita Orissa

A. Mukhopadhyay, p. 74

Como consecuencia del ciclón de 1999, que devastó extensas zonas del estado de Orissa (India), la Asociación Voluntaria de Salud de la India (Voluntary Health Association of India -VHAI), creó *Aparajita*, un programa de ayuda a largo plazo y de reconstrucción. *Aparajita* pretende fomentar la autonomía y la responsabilidad de las comunidades y capacitarlas para recuperarse de la devastación y prepararse para futuros desastres naturales. El programa funciona en tres zonas principales del estado: Jagatsinghpur, Kendrapara y Puri. Tras un estudio que evaluó los daños y el estatus socioeconómico y sanitario de las comunidades, *Aparajita* centró sus intervenciones en ayudas a la subsistencia, desarrollo de infraestructuras, capacitación, ahorro y crédito e intervenciones de salud. El programa ha servido para sentar las bases de un proceso de gestión de las catástrofes integrado por dos elementos principales: estar preparados y prestar auxilio inmediato a las víctimas. Teniendo en cuenta la cantidad de desastres naturales que suceden en la India, es necesario preparar a las comunidades para que sepan gestionar el proceso, así como presionar al gobierno para que apoye e institucionalice iniciativas como *Aparajita*.

Shehjar Khoj

A. Mukhopadhyay, p. 76

Los disturbios y conflictos, ya sean de naturaleza social o política, afectan a todos y cada uno de los integrantes de la sociedad. No existe tejido social capaz de aguantar las tendencias ocultas y la insatisfacción manifestadas violentamente o de cualquier otra forma. El conflicto en la región de Cachemira es un fenómeno de este tipo. Consciente de la necesidad de llevar a cabo intervenciones efectivas en el campo de la salud en Cachemira, la Asociación de Voluntarios para la Salud de la India (VHAI) inició el proyecto *Shehjar Khoj* en 1999. Entre otros objetivos, el proyecto pretende promover la justicia social y la equidad en la prestación de los servicios sociales y la mejora del estado de salud de la población, sobre todo de los menos favorecidos. En la actualidad, el proyecto funciona en cuatro distritos y ha realizado numerosas intervenciones, que conllevan actividades de formación, motivación y fomento de la participación activa de la comunidad, incluidos los trabajadores de salud y las personas con influencia en las comunidades. Un factor decisivo para el desarrollo de programas adaptados al lugar, y por lo tanto para el éxito del proyecto, ha sido comprender las creencias culturales e ideológicas de la población.

Reorientar los servicios de salud mediante la promoción de la salud comunitaria en Kwaio, Islas Salomón

D. MacLaren y E. Kekeubata, p. 78

Cuando las minorías étnicas poseen prácticas culturales que las hacen únicas, los obstáculos estructurales en el seno de los servicios de salud pueden impedirles el acceso a los mismos y por eso mismo aumentar la enfermedad. Esto es particularmente cierto cuando el desarrollo de los servicios de salud no se ha llevado a cabo junto con los grupos de población de la zona a la que sirven. El Hospital Atoifi es un ejemplo, en el que la estructura impide que determinadas personas Kwaio (Islas Salomón) sean beneficiarias de los servicios del hospital y mantengan al mismo tiempo las creencias propias de su cultura. Se utilizó un proceso de Investigación Participativa gracias al cual los proveedores de los servicios de salud trabajaron con las comunidades a fin de estudiar esta situación, para luego diseñar y construir conjuntamente un centro de salud cuyas políticas y procedimientos fueran adecuados desde el punto de vista médico y cultural. El denominado proceso de Investigación Participativa, que consiste en observar, pensar, planificar y actuar conjuntamente para reorientar los servicios de salud de modo que se adaptaran culturalmente en Atoifi, fue la primera ocasión en que los líderes, tanto de la comunidad como del hospital, se sentaron juntos a hablar sobre las iniciativas de promoción de la salud en un ambiente de mutuo respeto. El proyecto se finalizó en 2006, y la colaboración y el diálogo entre ambos grupos se demostraron imprescindibles para el éxito logrado. Existen numerosos indicadores que apuntan a que este centro de salud que respeta la cultura local está cambiando las cosas, no sólo en relación a la utilización de los servicios del hospital por parte de todos, sino también por el "sentimiento de pertenencia" que comporta.

El grupo de apoyo Graniators

E. Sullivan et al., p. 80

Las mujeres de muchas comunidades aborígenes de toda Australia se consideran la columna vertebral de la estructura social. Un ejemplo de ello son las Murri'Granies de una localidad de la región oriental de Australia. Muchas de estas mujeres son las principales responsables del cuidado y la disciplina de sus nietos, en ocasiones en perjuicio de su propia salud y bienestar. Para dar respuesta a este problema, el Servicio Médico para los Aborígenes local (AMS, en sus siglas en inglés), que cuenta con unas instalaciones completas de asistencia primaria de salud, empezó a promover el programa *Relájate al máximo* para las mujeres, integrándolo en el servicio que ofrecen. Desde aquellos modestos orígenes hace ahora tres años, la idea ha crecido hasta convertirse en el grupo de apoyo *Graniators*. Además de la labor inicial de apoyo mutuo, el grupo extendió su campo de acción a toda la comunidad y empezó a abordar cuestiones sociales, especialmente las relacionadas con jóvenes y niños. Para complementar y fortalecer su iniciativa, las *Graniators* colaboraron con otras organizaciones de la comunidad, entre ellas, la policía, el ayuntamiento, el departamento estatal de la vivienda, la escuela primaria local y un grupo especial de servicio a los jóvenes. La evaluación del programa ha resultado sumamente positiva en tanto que ofrece a la comunidad una fórmula constructiva de impulsar cambios en la base.

1. Expresión propia de las lenguas empleadas por la población aborigen del noroeste de Nueva Gales del Sur y de Queensland, en el Este de Australia, para referirse a sí mismos.

El proyecto de Municipio Sano de Motuca: construir juntos un futuro mejor

R. Mendes y F. Falvo, p. 81

El Ministerio de Salud de Brasil, en colaboración con el Ayuntamiento de Motuca y con la Escuela de Salud Pública de la Universidad de São Paulo, puso en marcha en 2002 el Proyecto de Municipio Sano en dicha localidad a fin de mejorar la salud y la calidad de vida de la población. En el proyecto se empleó un enfoque holístico y participativo, que abordó los determinantes sociales y las injusticias estructurales, y recurrió a estrategias de potenciación y capacitación de la comunidad, participación social, trabajo en redes intersectoriales y buena gobernanza. Se consultó a todos los actores locales y públicos de las zonas rurales y urbanas, quienes participaron en el proyecto recopilando información sobre las condiciones de vida y los obstáculos para lograr un mayor bienestar. A su vez, esta metodología participativa permitió desarrollar iniciativas apropiadas desde el punto de vista social y cultural para mejorar la gobernanza local y los niveles de vida a largo plazo. Aunque sigue pendiente el reto de mantener el impulso y renovar las energías, el proyecto sirve de modelo para otras iniciativas de evaluar la efectividad de las intervenciones participativas y de las metodologías de investigación que aspiran a promover la salud y el bienestar en el seno de las comunidades.

Las mujeres de las áreas rurales de Bolivia promueven el desarrollo de sus comunidades

R. Ríos, C. Olmedo y L. Fernández, p. 83

La delegación en Bolivia de la Agencia de los Estados Unidos para el Desarrollo (USAID/Bolivia) estableció en 2002 el proyecto PROSALUD- Socios para el Desarrollo (SpD) cuyo objetivo era mejorar el bienestar de la población. El proyecto contenía tres elementos: un plan de pequeñas subvenciones, asistencia técnica y gestión del sistema de la base de datos. Por medio del plan de subvenciones, SpD apoyó un proyecto de Estrategia de Participación Comunitaria a lo largo de un periodo de tres años. El proyecto abarcaba las zonas rurales de seis departamentos bolivianos y las áreas suburbanas de tres ciudades. El objetivo principal era incrementar la utilización de los servicios de salud, centrándose especialmente en potenciar la autonomía y las capacidades de las mujeres, en el fortalecimiento de las organizaciones locales y en el aumento de la demanda de los servicios de salud. Las mujeres, tanto de las zonas rurales como urbanas, así como las pertenecientes a grupos indígenas recibieron formación en gestión de proyectos, promoción de la salud, salud reproductiva y planificación familiar, defensa pública de sus intereses y participación comunitaria. Las metodologías participativas permitieron capacitar a las mujeres para tomar decisiones y aumentar su capacidad a lo largo de todo el proceso del proyecto. La experiencia muestra que es importante trabajar con organizaciones comunitarias de base formalmente establecidas y fortalecer los liderazgos en el seno de las mismas. Asimismo, los subproyectos demostraron que las intervenciones logran mejor sus objetivos cuando los promotores hablan y escriben en la lengua nativa, las mujeres están más motivadas y potenciadas, los proyectos se diseñan para responder a las necesidades diarias detectadas por las comunidades y los servicios de salud son adecuados desde el punto de vista de la cultura en que se enmarcan. La evaluación preliminar realizada, tanto cuantitativa como cualitativa, muestra una mejora general en los conocimientos y en las prácticas de salud, y la utilización de los servicios sanitarios.

Promover la salud y la alegría en el Amazonas brasileño

C. Scannavino y R. Anastácio, p. 85

Con el lema "Salud, alegría del cuerpo. Alegría, salud del alma", el proyecto Salud y Alegría (PSA) promueve el desarrollo integrado y sostenido de las comunidades de algunas áreas del Amazonas brasileño. El PSA surgió de la experiencia personal de los trabajadores locales que colaboraban con las comunidades y de la necesidad de llevar a cabo acciones sostenibles para su desarrollo futuro. En 1987, el proyecto se convirtió en una organización sin ánimo de lucro. El PSA empezó aplicando estrategias para mejorar el estado de salud de la población, que era el problema más importante, y posteriormente se amplió a otros aspectos del desarrollo. La enseñanza, la formación y la participación comunitaria fueron los elementos clave de las acciones del proyecto, que se centraron en el saneamiento básico, salud reproductiva y salud infantil, asistencia técnica en las prácticas agrícolas y potenciación de los jóvenes a través de comunicaciones, entre otras. Una vez establecida la estructura sanitaria, el proyecto pasó a ocuparse de otras prioridades relacionadas con la enseñanza, la producción económica, la protección del medio ambiente y la gestión de la comunidad a medio y largo plazo. El éxito del proyecto ha ayudado a institucionalizar las prácticas y alcanza hoy a unas 5.000 familias distribuidas en 150 comunidades rurales de la región ocupada por el curso medio y bajo del Amazonas.

El Parque Saludable: una experiencia de prevención y promoción de la salud a nivel comunitario en un barrio marginal de la selva del Perú

Edwin Peñaherrera Sánchez¹ y Wilson Palomino

Resumen: El parque saludable es una experiencia comunitaria desarrollada desde los enfoques de la prevención comunitaria y la promoción de la salud. Se basó en el establecimiento de alianzas estratégicas con actores sociales locales incluidos líderes comunitarios, agrupaciones de jóvenes y adolescentes, funcionarios de instituciones públicas (ministerio de salud, educación, policía nacional) e instituciones privadas (empresas de la zona, comerciantes, ONG). La estrategia implementada involucró activamente a la comunidad en todo el ciclo del proyecto desde la elaboración del diagnóstico participativo, hasta el diseño mismo de la intervención. Los actores comunitarios fueron responsables directos de la ejecución, seguimiento, acciones de abogacía para conseguir apoyos específicos a favor del proyecto, así como la rendición financiera a la Cooperación Técnica Belga, entidad responsable de la asignación de los fondos. La ejecución del proyecto permitió recuperar el parque que estaba en manos de consumidores de drogas y pandilleros. Se logró elaborar de manera concertada un reglamento de normas de convivencia y un plan de desarrollo para la comunidad, lo que permitió no solo planificar y distribuir responsabilidades de cuidado y mantenimiento del parque entre los vecinos, sino que les permitió coordinar con autoridades locales en busca de mayores servicios y oportunidades al desarrollo. (*Promotion & Education*, 2007, (2): pp 129-131)

Palabras clave: promoción de la salud, prevención, empoderamiento.

English abstract on page 100. Résumé en français à la page 120.

Esta propuesta de prevención del consumo de drogas a nivel comunitario fue impulsada desde la entidad gubernamental Desarrollo y Vida sin Drogas, DEVIDA, a través de un Programa de Cooperación Técnica I entre Perú y el Reino de Bélgica (CTB) durante el periodo enero 2003 a diciembre 2006. A partir de este Programa se desarrolló un modelo conceptual de intervención, basado en el reconocimiento que la problemática del consumo de drogas requiere un enfoque de carácter intersectorial que promueva la participación activa de la comunidad en las acciones de prevención del consumo y, especialmente, en la identificación de recursos y potencial individual y comunitario que creen mayores oportunidades de desarrollo y desalienten el consumo y las prácticas asociadas a éste.

Esta propuesta articula estrategias de promoción de la salud y las de la prevención a nivel comunitario, lográndose con ello mayores niveles de empoderamiento de los actores sociales de una comunidad, especialmente de adolescentes y jóvenes que constituyen el público objetivo del Programa.

El modelo de intervención comunitaria ha generado una dinámica local que ha logrado impactar el diseño de políticas locales concertadas de prevención del consumo de drogas y de promoción de estilos de vida y ambientes saludables. La participación intersectorial, interinstitucional y comunitaria han reforzado una visión conjunta sobre el desarrollo local y la creación de condiciones adecuadas para que las acciones impulsadas sean sostenibles.

Objetivos del Programa DEVIDA – CTB

El objetivo general del programa fue el fortalecimiento del rol de los Comités Multisectoriales (instancias de coordinación y concertación impulsadas por DEVIDA desde 1998) en la articulación de iniciativas de prevención del consumo de drogas y promoción de estilos de vida y entornos saludables.

El programa quería lograr compromisos políticos y comunitarios en favor de acciones concertadas de prevención del consumo de drogas y la promoción de estilos de vida y entornos saludables. Asimismo, se propuso desarrollar procesos de empoderamiento individual y comunitario que contribuyeran a un comportamiento activo y responsable frente a la prevención del consumo de drogas y la promoción de estilos de vida y ambientes saludables.

El modelo conceptual

El modelo conceptual desarrollado se basó en la articulación de los enfoques de promoción de la salud con los de la prevención a nivel comunitario:

1. Un enfoque de salud pública/promoción de la salud

Con el objetivo de influir sobre los determinantes individuales, sociales y ambientales que llevan al consumo de drogas, este modelo ofrece un marco de trabajo favorable a la implementación de iniciativas y estrategias que involucren a los actores políticos y comunitarios. El éxito del programa se ha basado en el empoderamiento

de los individuos y la comunidad, tanto en el control y determinación de su propio bienestar, como en el desarrollo de su capacidad para abogar por el establecimiento de políticas públicas saludables, en especial relativas al consumo de drogas entre los jóvenes. El programa se basó en la implementación de las cuatro estrategias de la Carta de Ottawa de 1986 (OMS, 1986):

- **Diseño de políticas públicas saludables:** se buscó introducir la prevención y la promoción de la salud en la agenda de los responsables de elaborar políticas de todos los sectores y niveles de decisión locales principalmente.
- **Creación de ambientes favorables,** involucrando a colegios y organizaciones de la comunidad en acciones que promuevan el desarrollo de estilos de vida y ambientes saludables.
- **Fortalecimiento de la acción comunitaria,** buscando su participación activa en todos los niveles del ciclo de proyectos y apoyando la formación de redes comunitarias y juveniles como estrategia clave.
- **Desarrollo de habilidades sociales,** a través de talleres *ad hoc* utilizando metodologías participativas e involucrando a los adolescentes en acciones comunitarias para que utilicen las habilidades aprendidas.

2. Una aproximación de prevención comunitaria del consumo de drogas

Estrategias de prevención a nivel comunitario, pueden ser implementadas a través de diferentes actores y con diferentes impli-

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caciones políticas para la comunidad. Para este proyecto se han considerado dos componentes en base al fortalecimiento de redes sociales y partenariados:

La creación de redes locales entre actores clave y con grupos con gran nivel de empoderamiento y pertenencia, basados en iniciativas propias.

La creación de redes locales entre agencias e instituciones, bajo la idea de constituir un *grupo de trabajo* en base al establecimiento de alianzas estratégicas que en la práctica lleven a cabo intervenciones locales concertadas.

El Proyecto adolescentes y desarrollo comunitario

Descripción de la comunidad beneficiaria

La población objeto del proyecto fue el Asentamiento Humano conocido como «AA.HH. 13 de Mayo», que se encuentra ubicado en el área urbana marginada del cono sur-oeste del Distrito de Callería, a 15 minutos de la ciudad de Pucallpa en la Región Selva de Perú. Tiene una población de 860 habitantes de los cuales, aproximadamente, 150 son adolescentes.

El «AAHH 13 de Mayo» ha existido desde hace 25 años. Durante este tiempo no se ha actuado sobre las condiciones de postergación y abandono, lo cual ha favorecido el incremento de la pobreza, la desocupación y la desintegración familiar. Como consecuencia de estos determinantes negativos, los espacios de riesgo e inseguridad se han desarrollado así como el alto consumo de alcohol y drogas, la presencia de pandillas callejeras y delincuencia juvenil en los alrededores del único parque de la zona.

La Municipalidad Provincial de Coronel Portillo, la Dirección Regional de Salud, la Red Nacional de Promoción de la Mujer y la Junta Directiva del «AA. HH. 13 de Mayo» decidieron formar una alianza con el objetivo de mejorar la calidad de vida de los adolescentes del «AA. HH. 13 de Mayo» y fortalecer su entorno familiar y comunitario. El programa se dirigió a unos 100 adolescentes y 180 familias (constituyendo 860 personas.)

Acciones y estrategias empleadas

1. **Abogacía:** acercamiento a líderes, grupos de adolescentes, jóvenes y empresarios locales a través de seminarios y talleres de sensibilización y capacitación empleando metodologías participativas.
2. **Empoderamiento:** implicación y compromiso de jóvenes en todo el ciclo del proyecto a fin de fortalecer sus capacidades y competencias y traducirlas en acciones concretas, como es participación en espacios de concertación (Consejos de Concertación Local, Mesas de

Concertación de Lucha Contra la Pobreza) y acciones comunitarias.

3. **Fortalecimiento de redes juveniles y sociales:** generando una dinámica que refuerce su capacidad de propuesta e interlocución con líderes comunitarios, decisores políticos y representantes de instituciones públicas (ministerios de salud y educación, policía nacional) y privadas (ONG y otras organizaciones vecinales).. Se involucró también a los jóvenes de manera sostenida en el cuidado y mantenimiento de las áreas verdes, en la gestión de recursos para mejorar la iluminación, en la refacción de bancas y el establecimiento de contenedores de basura con la participación y apoyo de las empresas privadas de la localidad.

4. **Alianzas y acción comunitaria concertada:** recuperando el parque de la zona como un espacio para el buen uso del tiempo libre (oferta de juegos recreativos diversos, teatro en vivo, danzas regionales).

5. **Elaboración del reglamento local de convivencia comunitaria:** fortaleciendo la idea de contar con un Barrio Saludable. Se negoció con los dueños de bodegas y cantinas para regular y prohibir la venta de bebidas alcohólicas y cigarrillos a menores de edad y beber en lugares públicos.

6. **Elaboración de un plan estratégico concertado de desarrollo:** permitiendo dar direcciones estratégicas a sus acciones dirigidas al desarrollo local, y fortaleciendo su capacidad de gestión y articulación con otros espacios de concertación, como puede ser el desarrollo y administración de presupuestos participativos (fondos provistos por el gobierno local para apoyar iniciativas vecinales a través de proyectos).

7. **Comunicación y educación para la salud:** promoviendo la emisión de mensajes de prevención y promoción de la salud, esfuerzos que son administrados y autogestionados por los y las adolescentes y los líderes vecinales de la comunidad.

8. **Capacitación:** reforzando la capacidad de directivos locales y líderes juveniles en el diseño y la autogestión de proyectos e implementación de estrategias de incidencia política

Resultados

- Red de adolescentes y jóvenes que participa activa y ordenadamente (organizadamente no es lo mismo que ordenadamente; organizadamente da cuenta de un actuar en Red, como organización juvenil) en el cuidado y mantenimiento del Parque y dirigiendo estrategias de

abogacía e incidencia política para involucrar actores sociales y captar recursos para dar sostenibilidad a (la sostener) la iniciativa.

- Acuerdos, alianzas y planes concertados a favor del mantenimiento y cuidado del Parque con colaboración de vecinos, adolescentes, jóvenes y empresas privadas.
- Plan estratégico de desarrollo del «AAHH 13 de mayo», con enfoque de prevención, promoción de la salud y desarrollo local.

Conclusión

Esta metodología basada en la articulación de los enfoques de prevención con promoción de la salud ha permitido una mayor participación de los actores locales, quienes han centrado su atención en la creación de oportunidades y no sólo en la identificación de factores de riesgo. Se ha logrado que se reconozca que el trabajo en partenariat y de colaboración interinstitucional y comunitaria es una estrategia clave para aquellas intervenciones que buscan generar condiciones y oportunidades para el desarrollo individual y colectivo, lo cual finalmente cumple el objetivo de desalentar el consumo de drogas.

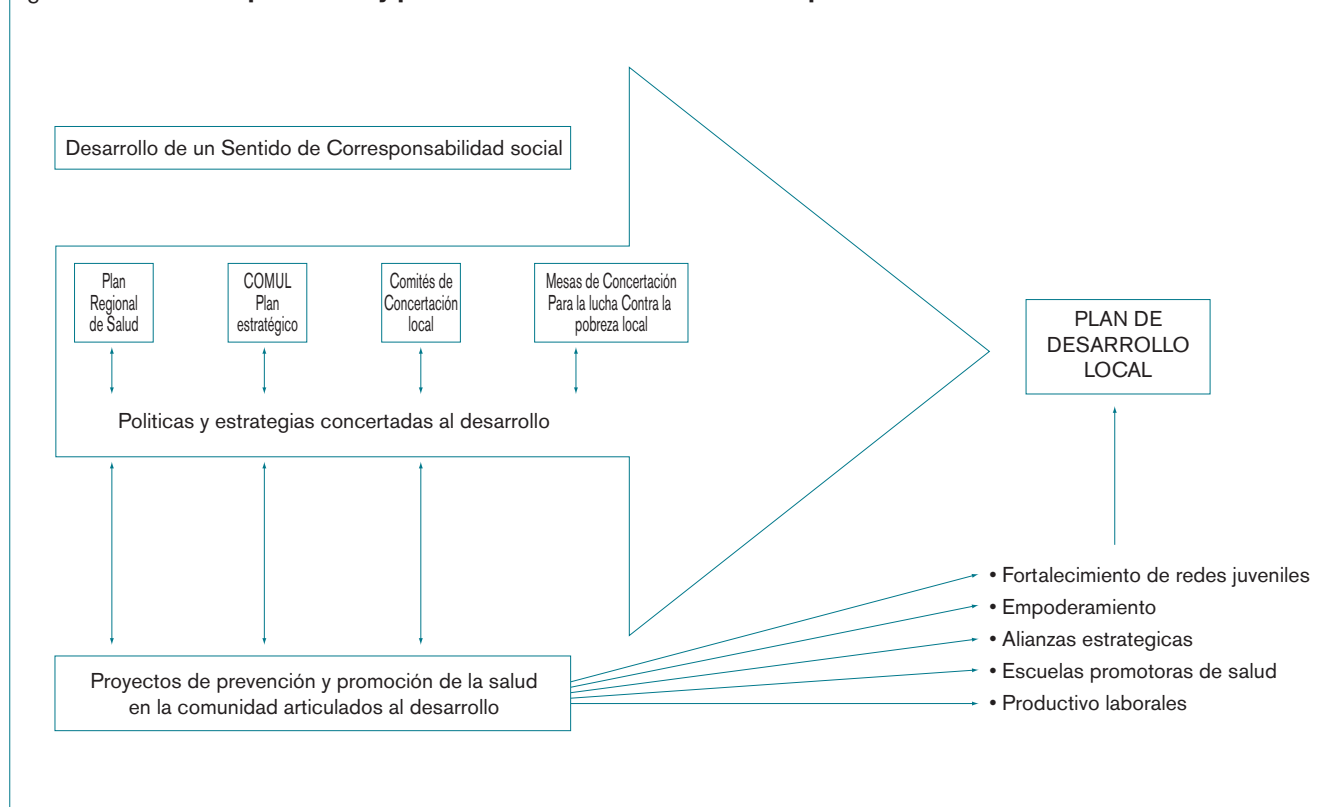
De esta intervención se han sacado varias lecciones. La dedicación de un período de tiempo del proyecto para la capacitación de los actores locales es clave para asegurar el desarrollo de competencias y capacidades que les permita cumplir con eficiencia las nuevas responsabilidades y roles que tendrán que asumir.

La implementación de proyectos comunitarios que articulan enfoques de prevención y promoción, promueven la sostenibilidad social a través del empoderamiento de los actores locales, especialmente de las organizaciones juveniles y comunitarias, constituyéndose en mecanismos clave para el desarrollo de factores protectores en la prevención del consumo de drogas y en la promoción del desarrollo local.

La participación activa de las organizaciones comunitarias y juveniles en el diseño e implementación de proyectos comunitarios genera procesos de empoderamiento individual y comunitario, que asegura sostenibilidad e impacto de las intervenciones, a partir del desarrollo de capacidades para la organización, gestión y negociación.

Referencia

OMS (1986) *Carta de Ottawa para la Promoción de la Salud*. Organización Mundial de la Salud. Ginebra, Suiza.

Figura 1. **Acciones de prevención y promoción de la salud articuladas a procesos de desarrollo dentro de la comunidad**

Abogacía: Resúmenes

Defender públicamente políticas de salud adecuadas y una gobernanza efectiva del sistema de salud

A. Mukhopadhyay, p. 88

Las políticas de salud apoyadas por iniciativas que las defienden públicamente y de manera continuada tienen que crecer y desarrollarse permanentemente para responder a la creciente presión que ejercen las políticas macroeconómicas de la globalización, la liberalización y la privatización.

VHAI, la red más extensa de agencias voluntarias del sector sanitario, desempeña actualmente un papel decisivo tanto a pequeña como a gran escala. Su labor de presión política nace de la base, de una profunda comprensión de los problemas de salud y de desarrollo de su entorno, así como de las estrategias emprendidas para hacerles frente. El proceso de fortalecer la movilización hacia arriba de la información para lograr la formulación de políticas de salud efectivas, viene apuntalado por investigaciones serias y a gran escala sobre las diversas dimensiones políticas de la salud, realizadas por la Comisión Independiente sobre Salud y Desarrollo de la India (ICDHI, en sus siglas en inglés) creada por VHAI en 1995. Estos documentos fundamentales para la elaboración de las políticas, a la vez reflexivos y normativos, se presentan a las más altas instancias estatales, y paralelamente se realizan debates a distintos niveles y con diversos grupos.

Uno de los éxitos recientes fue lograr que las grandes compañías tabacaleras abandonaran el patrocinio del cricket, junto con la formulación de una Ley General del Gobierno de la Unión para evitar este tipo de patrocinios en el futuro. La organización ha recopilado varios documentos de política, basados en estudios solventes, en su trabajo a pequeña y gran escala, y en su incansable labor de presión política.

Para materializar los valores fundamentales de Alma-Ata, la piedra angular se desdobra en una salud pública adecuada y en el desarrollo de políticas que se apliquen de manera efectiva. El sistema de atención de salud necesita salir del actual modelo biomédico y acercarse a un modelo sociopolítico y espiritual en el que la atención de salud forme parte orgánica de la atención a la comunidad como lo fue en su día en la sociedad tradicional.

Abordar la equidad en el ámbito de la salud: presionar desde arriba y desde abajo para incidir en los determinantes sociales de la salud

F. Baum, p. 90

La Comisión sobre los Determinantes Sociales de la Salud se creó para asesorar sobre maneras en que la conciencia de dichos determinantes puede afectar a las acciones concretas que pretenden mejorar la salud de la población equitativamente. El artículo estudia los factores que son necesarios para presionar a los gobiernos a adoptar políticas que aspiren a ello. Defiende que el conocimiento, si bien es esencial, también resulta insuficiente. Los gobiernos tienen que comprometerse con valores como la justicia y la equidad, y deben tener la capacidad de manejar la complejidad que conlleva el dar respuesta a los determinantes sociales sin limitarse a exhortar a las personas a que modifiquen sus conductas. Es de vital importancia que la sociedad civil reclame este aspecto a los gobiernos. La existencia de redes sociales interconectadas es también fundamental para generar un entorno social y político en el que se promueva la justicia. Para ilustrar la importancia de las redes sociales, se presenta un caso práctico sobre el precario estado de salud de los pueblos aborígenes en Australia.

La promoción de la salud comunitaria en Pakistán: una perspectiva para la elaboración de políticas

K. A. Ronis. y S. Nishtar, p. 98

Pakistán fue uno de los países signatarios de la Declaración de Alma-Ata en 1978, aunque hasta 2004 no desarrolló la primera política dedicada íntegramente a la salud pública y a la promoción de la salud. *El Plan de Acción Nacional para la prevención y el control de las enfermedades no transmisibles y para la promoción de la salud en Pakistán* ha conquistado un lugar destacado en la agenda de salud del país y se disputa los recursos con las políticas sanitarias tradicionales que se centran en el tratamiento, la curación y la tecnología punta.

Desde el punto de vista de la promoción de la salud, el plan de acción fue único en el sentido de que se centraba en el entorno comunitario mediante dos grandes iniciativas que pretendían cambios de comportamiento a través de la comunicación: una mediante los medios de comunicación y otra integrando la prevención de las enfermedades no transmisibles en el plan de trabajo de las Lady Health Workers (Trabajadoras sanitarias).

La fase de desarrollo de esta primera política de promoción de la salud y de salud pública sigue de cerca los pasos del *Australian Policy Cycle* (Ciclo de políticas australiano) y celebra un ciclo de consultas exhaustivo. Su fuerza reside en la colaboración trilateral entre el Gobierno, la Organización Mundial de la Salud y una organización no gubernamental, *Heartfile*, que impulsó la iniciativa. Esta colaboración de lo público y lo privado facilitó el desarrollo de la política y sigue apoyando la investigación, la implementación y la evaluación de la misma. El artículo intenta analizar el desarrollo del *Plan de Acción Nacional* centrándose en la promoción de la salud comunitaria.

De testigos a defensores: la experiencia de una ONG humanitaria

J. Ancian, p. 118

Médicos del Mundo (MdM) es una ONG humanitaria internacional que actúa en todo el mundo para facilitar el acceso a la atención sanitaria a las poblaciones vulnerables que se ven privadas de ella. Médicos del Mundo se propuso como mandato “prestar atención sanitaria y ser testigos”, sobre todo en vista de los atentados flagrantes de que son víctimas las poblaciones con las que trabajan. A partir de esta necesidad de actuar para mejorar la situación de las poblaciones, y en base a las prácticas anglosajonas, la asociación pretende ir más lejos y llevar a cabo progresivamente acciones de defensa pública y denuncia (*advocacy*) en colaboración con otras organizaciones. Este caso práctico muestra el diverso grado de éxito de este tipo de acciones, concretamente en las campañas “Banco Mundial: ¡se ha puesto precio a la salud!” lanzada a finales de 2003 y “Personal de salud en el Sur: penuria mortal”, en 2006.

Red de Comunidades Saludables de Río de Janeiro, Brasil

D. Becker et al., p. 101

Los barrios pobres de Río de Janeiro, denominados favelas, padecen muchos problemas relacionados con la precariedad de las viviendas, la pobreza, el desempleo, la violencia y el crimen organizado y la falta de acceso a los servicios básicos, como la atención de salud y la enseñanza. Para abordar estos determinantes, e inspirada por el movimiento internacional de la OMS de las Comunidades/Ciudades Sanas, se creó la Red de Comunidades Sanas de Río de Janeiro. La Red está coordinada por el Centro de Promoción de la Salud (CEDAPS) e integra en la actualidad a más de 100 grupos y organizaciones comunitarias de Río de Janeiro. Su objetivo es promover la salud, el desarrollo comunitario y la equidad potenciando la autonomía y la responsabilidad de las comunidades, la participación, la capacitación y la defensa de sus intereses. El artículo describe el trabajo realizado desde el nacimiento de la Red y los retos a los que se enfrenta para alcanzar sus fines en el contexto de un país como Brasil. La Red constituye un ejemplo importante de cómo las poblaciones pobres pueden organizarse de manera colectiva, participativa y constructiva e incidir en las políticas públicas al tiempo que luchan por conseguir mejores condiciones de vida en entornos desfavorecidos como son las favelas.

Desarrollo de la Red de Ciudades Saludables en Europa

E. Goepel, p. 103

La Red de Ciudades Saludables de Europa nació en 1987, inspirada por la Carta de Ottawa para la Promoción de la Salud. Fue la Oficina regional de la OMS para Europa la que inició el proceso de establecimiento de redes, pero luego cada país europeo desarrolló su propia dinámica, en una época marcada por transformaciones políticas de base en muchos países de la Europa Oriental.

Posteriormente, las redes se conectaron con la "Agenda Local 21" y la "Campaña de las Ciudades y Pueblos Sostenibles" para elaborar una nueva agenda programática más amplia a escala local. Concretamente los "Compromisos de Aalborg+10" de los gobiernos locales (2004) tienen el potencial de inspirar una nueva fase de políticas participativas y sostenibles en el seno de las comunidades locales europeas.

Sin embargo, habrá que estar atentos durante los próximos años para comprobar en qué medida estas iniciativas incidirán en la macro-política de la Unión Europea en aras a lograr la proclamada "Europa de los Ciudadanos".

EQUINET: Trabajar en red a favor de la equidad en el ámbito de la salud en África oriental y meridional

R. Loewenson, p. 105

Este breve informe expone las perspectivas y motivaciones de la labor que lleva a cabo la Red regional para la equidad en el ámbito de la salud en África oriental y meridional (EQUINET). Presenta las áreas clave del trabajo a favor de la equidad para fortalecer el sector sanitario público y estatal, que se organizan en torno a la participación activa y la implicación de las comunidades. Ello significa fortalecer la capacidad de las personas de asumir su salud, aumentar la financiación hasta que sea suficiente, contratar a los trabajadores de salud y poner en tela de juicio a las políticas comerciales que inciden negativamente en la salud. Esta labor se enfrenta a problemas que pueden resolverse si se intensifica el trabajo en red en toda la región para intercambiar experiencias, información y habilidades especializadas, en especial la demanda de "aprender haciendo".

Alianza Mundial para la Equidad en Salud

A. Ntuli, p. 107

La falta de atención a la cuestión de la equidad en los temas de salud, atención de salud y sus determinantes constituye un obstáculo en muchos países para alcanzar un buen estado de salud. Partiendo de este problema de base, entre 1999 y 2000 se celebraron una serie de reuniones que culminaron con la creación de la Alianza Mundial para la Equidad en Salud (GEGA, en sus siglas en inglés). GEGA es una red internacional de grupos –denominados Grupos de trabajo en equidad– asentados en los países en vías de desarrollo, principalmente de Asia, África y América Latina, que desarrolla proyectos dirigidos a luchar contra las desigualdades en el ámbito de la salud. Los Grupos de trabajo en equidad pretenden contribuir a reducir de manera sostenida las desigualdades existentes tanto en los determinantes sociopolíticos generales de la salud, como en el sistema sanitario. Su planteamiento se basa en tres esferas de acción amplias, a las que denominan "pilares": 1) medición y seguimiento, 2) defensa pública de sus postulados y presión política y 3) potenciación de la autonomía y de la capacidad de las comunidades. A través de una serie de ejemplos de grupos de escala local o nacional, el artículo da a conocer su trabajo que fomenta la interacción entre *la investigación y la formulación y aplicación de políticas basadas en la evidencia, y entre la comunidad y los responsables de elaborar las políticas*.

La Red de Ciudades y Pueblos Saludables de Québec: un movimiento potente ante nuevos retos

P. Simard, p. 121

La Red de Ciudades y Pueblos Saludables de Québec (RQVVS), que lleva veinte años al servicio de sus miembros, se enfrenta hoy en día a diversos retos. Actualmente, la organización de los territorios locales, así como las múltiples responsabilidades que les corresponden, están en proceso de cambio. Gracias a su capacidad de movilizar a los municipios, la RQVVS se halla en situación óptima para divulgar, animar y ayudar a sus miembros no sólo a armonizar las diversas medidas gubernamentales, sino también para animarlos a hacerlo en coordinación con otros socios institucionales (educación, salud, socio-económicos, etc.) o comunitarios. No obstante, tiene que reformular su apoyo directo a los miembros, sin dejar de llevar a cabo sus actividades de divulgación de la información y de trabajo en red.



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These structures are currently being developed

The IUHPE is a Global Professional Association devoted to contributing to greater equity in health through health promotion and health education. Founded in 1951, the IUHPE works in close cooperation with major inter-governmental and non-governmental organisations to influence and facilitate the development of health promotion strategies and projects.

The journal is one of the IUHPE's main communication tools and it aims to:

1. provide an international and interdisciplinary forum for the dissemination and exchange of health promotion, health education and public health theory, research findings, practice and reviews in a range of settings and specific populations;
2. publish articles which ensure wide geographical coverage and are of general interest to an international readership;
3. encourage and support authors from low- and middle-income countries, as well as, non-English speakers to publish through the Health Promotion Journals Equity Project (HPJEP);
4. remain committed to equitable access in publication, in terms of language and type of contribution. The journal's content spans wider than a traditional academic journal to reflect the daily practical success stories and challenges of practitioners in the field in terms of their lessons learned from interventions, and their experiences in terms of areas like advocacy, networking and partnership.
5. provide a fair, supportive and high quality peer review process;
6. ensure a multi-lingual print dissemination tool for information on IUHPE projects, events and other relevant communications for members of the network.

L'IUPES est une Association professionnelle mondiale dont la mission est de contribuer à la réduction des inégalités de santé à travers la promotion de la santé et l'éducation pour la santé. Fondée en 1951, l'IUPES travaille en étroite collaboration avec de nombreux Organismes intergouvernementaux et non gouvernementaux pour influencer et développer des stratégies et projets de promotion de la santé partout dans le monde.

La revue a pour but de :

1. Fournir un forum international et interdisciplinaire pour diffuser et échanger des théories de promotion de la santé, d'éducation pour la santé et de santé publique, des résultats de recherches, des pratiques et des évaluations, dans différents environnements, et auprès de populations spécifiques ;
2. Publier des articles qui garantissent une large couverture géographique et présentent un intérêt d'ordre général pour un lectorat international ;
3. Encourager et soutenir les auteurs de pays à faible et moyen revenu, de même que les non anglophones, afin qu'ils puissent publier en bénéficiant du Projet Équité des Publications de Promotion de la Santé (HPJEP) ;
4. S'engager pour un accès équitable à la publication, que ce soit en termes linguistiques ou au niveau des types de contribution. Le contenu de la revue est plus étendu que celui d'une revue académique traditionnelle, et cela afin de refléter les réussites et les difficultés que connaissent quotidiennement les acteurs de ce domaine sur le terrain en termes de leçons tirées des interventions, ainsi que leurs expériences dans des domaines tels que le plaidoyer, le travail en réseau et le partenariat.
5. Garantir un processus de révision des articles qui soit juste et de grande qualité, et qui soutienne les auteurs ;
6. Garantir un outil de diffusion multilingue sur papier des projets et des événements de l'IUPES, ou d'autres communications pertinentes pour les membres de son réseau.

La IUPES es una Asociación profesional mundial dedicada a la consecución de la equidad en materia de salud a través de la promoción de la salud y la educación para la salud. Fundada en 1951, la IUPES trabaja en estrecha cooperación con importantes organizaciones intergubernamentales y no gubernamentales para influenciar y facilitar el desarrollo de estrategias y proyectos de promoción de la salud.

La revista aspira a:

1. Ofrecer un foro internacional e interdisciplinario para la divulgación e intercambio de la teoría, los descubrimientos de la investigación, la práctica y la crítica de la promoción de la salud, de la educación para la salud y de la salud pública, en diversidad de entornos y de poblaciones concretas;
2. Publicar artículos que garanticen la diversidad geográfica y que sean de interés general para una red de lectores de ámbito internacional;
3. Promocionar y prestar apoyo a los autores procedentes de países de rentas medias y bajas, así como a los de habla no inglesa, para que puedan publicar, gracias al Proyecto de Equidad en las Revistas de Promoción de la Salud (HPJEP, en sus siglas en inglés);
4. Mantener su compromiso de trabajar por una mayor igualdad de oportunidades a la hora de publicar respecto de los diferentes idiomas y tipos de textos. El contenido de Promotion & Education es mucho más amplio que el de una revista académica tradicional en aras a reflejar los éxitos cosechados y los problemas surgidos en la práctica cotidiana de los profesionales de nuestro campo, es decir, las lecciones aprendidas a partir de las intervenciones realizadas y sus experiencias en el campo de la abogacía, el trabajo en red y los partenariados.
5. Ofrecer un proceso de revisión por iguales que sea equitativo, constructivo y de elevada calidad;
6. Garantizar una herramienta multilingüe de difusión impresa que ofrezca información sobre los proyectos y las actividades de la IUPES, así como otro tipo de información relevante para los miembros de la red.

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