PUBLIC HEALTH IN LATVIA

WITH PARTICULAR REFERENCE TO

HEALTH PROMOTION
TARGET 13

HEALTHY PUBLIC POLICY

By the year 2000, all Member States should have developed, and be implementing, intersectoral policies for the promotion of healthy lifestyles, with systems ensuring public participation in policy-making and implementation.

ABSTRACT

Public health and health promotion are currently in a positive phase of development in Latvia, but face a number of problems, upon which the State Minister of Health, Mr Viktors Jaksons, invited expert technical advice from the European Regional Office of the World Health Organization (WHO/EURO).

The tasks of the WHO/EURO team were:

1. To review the health promotion function in Latvia, giving particular attention to:
2. To make recommendations for achievable improvements.
3. To take fully into account the proposed health promotion component of the World Bank health sector loan to Latvia, which is under negotiation. The present document describes the analysis, conclusions and main recommendations of the WHO/EURO team aimed at ensuring that health promotion is developed in a systematic and sustainable way in Latvia.

Working method

The team:

⇒ considered the documents which are listed in Annex B;
⇒ discussed the issues with senior people from the Latvian health sector and other sectors, as set out in the programme of work which forms part of Annex A;
⇒ analysed the information it had collected and formulated preliminary conclusions and recommendations;
⇒ discussed its analysis and preliminary conclusions and recommendations with a small “sounding board” (listed in the programme of work);
⇒ prepared a draft report for discussion with Mr Jaksons and subsequent finalization.
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1. INTRODUCTION

1.1 Background and terms of reference

Public health and health promotion are currently in a positive phase of development in Latvia, but face a number of problems, upon which the State Minister of Health, Mr Viktors Jaksons, invited expert technical advice from the European Regional Office of the World Health Organization (WHO/EURO).

A WHO/EURO team visited Latvia from 31 May to 5 June 1998, under the leadership of the Regional Adviser for Health Promotion and Investment for Health, Dr Erio Ziglio, and comprising two other members, both with substantial prior experience in Latvia. The full team membership is set out in Annex A.

The Terms of Reference of the team were:
1. To review the health promotion function in Latvia, giving particular attention to:
   - the measurement and interpretation of health determinants which are especially amenable to health promotion;
   - policy-making for health promotion; and
   - the infrastructure, organization and funding of health promotion practice within the overall public health system.
2. To make recommendations for achievable improvements.
3. To take fully into account the proposed health promotion component of the World Bank health sector loan to Latvia.

1.2 Working method

The team:

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⇒ discussed its analysis and preliminary conclusions and recommendations with a small “sounding board” (listed in the programme of work);
⇒ prepared a draft report for discussion with Mr Jaksons and subsequent finalization.

1.3 Acknowledgements

The WHO team gratefully acknowledges the great cooperation and assistance it received from many people in undertaking this work.

Without the initiative of Mr Jaksons the work would not have happened at all. Moreover, WHO is especially grateful that he gave his time so generously to the work of the team, enabling its understanding to be broadened by his experience and learning.

To all the other people who were prepared to break away from demanding responsibilities to give their time and the benefits of their knowledge and experience to the work of the team, WHO offers its thanks. Without their input the work could not have been undertaken at all, and the quality of their documents, knowledge, ideas and reflections contributed inestimably to the analysis, conclusions and recommendations.
made by the team. Inevitably, in an exercise conducted with so many busy people in a very limited time, the pace of work did not allow everybody to make their full contribution. WHO apologizes for this and accepts full responsibility for any omissions or contentious emphases that may have resulted. Every attempt has been made to keep these to a minimum, so that this report will be a useful and practical document, and so that in due course the Latvian authorities may wish to follow up some of its proposals for further advice and assistance from WHO.

Finally, WHO wishes to offer its thanks to two groups of people who ensured the smooth operation of the work of the team. The staff of the Public Health Department of the Ministry of Welfare warmly welcomed and accommodated the team in well serviced accommodation throughout its work. The commitment, organizational skills and selflessness of the staff of the WHO Latvian liaison office opened many doors to the team and ensured the optimum use of the limited time available. These contributions enabled optimal professional use to be made of limited time in a welcoming, tolerant and supportive fashion. They are deeply appreciated.

2. REVIEW OF THE HEALTH PROMOTION FUNCTION

2.1 Overall review of the health promotion function

2.1.1 The people of Latvia are emerging from a difficult period of transition, during which old social and economic norms disappeared almost overnight. They are being steadily replaced by many new constructs, above all the reintroduction of democratic accountability, the development of the practices and institutions of civil society, and the evolution of openness and transparency in public administration. The dislocations resulting from the transition continue to have a profound impact, not least on the health of the people; this is only now recovering to and beyond pre-1991 levels. Until recently, organized efforts to promote better health have played a small part in Latvian society. Now, as social recovery and economic development have become more established, recognition of the potential contribution of public health and health promotion has grown in parallel. This has resulted in some important initiatives, and the emergence of considerable talent, but is beset by three major difficulties.

First, policy-making for public health and health promotion is not systematically established, and lacks vital skills and input, for example in population health survey techniques and the interpretation and presentation of findings. There is also a lack of clarity about existing agreed policies, leading to a fragile situation for the acceptability and implementation of policy decisions. Policy issues are further considered in section 2.3.

Second, there is fragmentation of effort, with weak management and accountability structures, much episodic activity and some important initiatives, but an overall lack of coherence and coordination. This issue is raised at many points in this report and is dealt with in detail in section 2.4.

Third, there appears to be a widespread misunderstanding, with some notable individual and organizational exceptions, of the concept and principles of modern health promotion and their implications for the organization and conduct of practice in policy and programme terms.

2.1.2 The most common conceptual misunderstanding equates health promotion merely with the provision of a limited part of the health promotion agenda – namely, with individual or population-level health education or, even more narrowly, with health information. This misunderstanding appears to be part of the basis for a further widespread view, that primary health care, and in particular family doctors, should carry most of the responsibility for “health promotion”, and be rewarded accordingly. Such views could lead to expectations which could not be fulfilled, and to poor returns from scarce investment resources. This is explained further below, and in subsection 2.1.3.

Without a well planned, appropriately resourced and competently implemented health promotion strategy, European countries will experience difficulties in achieving lasting improvement in the health of the
population. Furthermore, they are likely to encounter problems in sustaining economic development and regeneration. This issue – of enabling all citizens to achieve the highest possible levels of health and wellbeing – is of particular relevance to countries of the size and population of Latvia. As a point of reference, Annex C provides a selection of terms and definitions from the WHO Health Promotion Glossary, 1997.

The key elements of modern health promotion are:

- **analysis of policies in all sectors of society** for their impact on the health of the population, and the development and implementation of a range of many different policies, in many spheres of life, which are designed to improve the health of the population;

- **action at all levels and in many different spheres of society**, to identify existing “social capital” – in public, private and voluntary organizations and groups, and in informal networks – which are already contributing to the health and wellbeing of the population; and

- the design and implementation of measures to enhance this capacity so as to **enable individuals and communities to increase control over the determinants of their health and thereby improve it**.

These challenging tasks require a range of skills, from people with many different backgrounds and occupations. The core functions of effective health promotion are based on the skills of:

- **advocacy** to different agencies at different levels of society, of the foundations of public health and of the policies and practices required to improve it;

- **enablement** of people and organizations to bring about positive change; and

- **mediation** among different, and often conflicting interests, in the common interest of better health.

Health promotion thus actively engages many sectors of society, stretching well beyond health care services to all the areas which impact on health, or which may create opportunities for health promotion. Therefore, there is scope at all levels of government – nationally and locally – to identify priority areas for investment for health. There are many opportunities in different sectors. Action can be taken by social organizations such as schools, workplaces and voluntary agencies, and by individuals. The greatest impact is achieved by the synergy of carefully planning, coordinating and implementing policy development, legislation, and appropriate, effective actions in different organizations in different sectors and at different levels. From its vantage point, WHO/EURO is well placed and always willing to offer countries advice and assistance, based on learning from the widespread variety of experience across Europe.

Later in this report, recommendation 3.1.1 is intended to help to develop a better understanding of the health promotion concept and principles. Recommendations in sections 3.3 and 3.4 propose steps towards the further operationalization in Latvia of this concept and principles.

2.1.3 Turning now to the role which it appears that primary health care, and in particular the family doctors, may in future be asked to play in promoting better health in Latvia.

First, there is absolutely no doubt of the importance of high quality primary health care. It is vital in many important respects, for example:

- simply through its existence as a key element of a social security system, it provides assurance and thus contributes to underlying wellbeing and hence to health;

- through its ability to advise and enable individuals and families to have greater self confidence in health and medical matters and become more competent in their own and their family’s self-care;
as the key point of self-referral, providing primary clinical services, and acting as an effective and efficient gatekeeper to the rest of medical care services;

• as the best-placed provider of a small number of very important specific preventive procedures, which are the clinical component of public health programmes organized and managed at population level, such as immunization and vaccination, and cervical screening; and

• as the provider of a number of other interventions in health promotion and disease prevention for individuals at increased risk; these include both clinical and non-clinical measures and are axiomatic to ethical modern primary care practice:
  e.g. smoking and alcohol advice and counselling;
  e.g. nutrition advice and counselling;
  e.g. physical activity advice;
  e.g. blood pressure measurement and, where necessary, control.

For these to be effectively introduced and sustained in primary health care, requires thoughtful consideration and planning by the primary health care team of how they are going to reach and engage the relevant members of the population they serve, most of whom are “well” and ordinarily make only rare contact with primary health care; this in turn requires the learning of appropriate skills, and needs backing up by proper performance management; the proposed Cardiovascular Health Programme offers the opportunity to undertake and evaluate such planning, management and practice.

Likewise, the Cardiovascular Health Programme offers the chance to develop and test in the field situation in Latvia the potential roles of the primary health care team in population-based health promotion and disease prevention.

It was already clear from subsection 2.1.2, and is confirmed by the foregoing that, while primary health care has an important contribution to make to health promotion and disease prevention, it is simply not positioned to carry the main weight of health promotion. International experience confirms these conclusions. They are especially important in Latvia, where primary health care is embarking on a fundamental transformation and does not need the additional burden of unachievable expectations. Recommendation 3.1.1 is framed accordingly.

Recommendations are provided in subsection 3.1.3 concerning the Cardiovascular Health Programme.

2.2 Measurement and interpretation of health determinants which are especially amenable to health promotion

2.2.1 Fundamental to the public health function has always been the systematic collection, collation, analysis, interpretation and presentation of information about the health of the population, and about the effectiveness of the measures being taken to improve it, thus contributing centrally to the effective performance of many public health tasks, from policy-making, through strategic planning to outbreak control.

The rise of the epidemics of noncommunicable diseases, and the application of the concept and principles of health promotion to combating them, has placed new demands on the scope and capacities of the information functions. These range, for example, from the need for regular monitoring and reporting of behavioural and other risk factors in populations, through assessment of social capital, to information from social, industrial, agricultural, retail and other sectors which is essential to the tasks of policy impact assessment and to the formulation of policies to improve health.

2.2.2 There seems little doubt that high quality public health information systems are being established in Latvia, and that these are resulting in a valuable flow of information, which is increasingly accessible to potential users. Among the impressive published outputs are an attractive annual public health report on Latvia, a regular epidemiological bulletin from the Environmental Health Service, and joint comparative
publications with the other two Baltic States. However, current arrangements appear to fall far short of meeting Latvia’s needs, for the following reasons:

- there is no overall coordinating institute with the key roles (under clear policy direction) of drawing up and managing a coordinated programme of routine information collection for public health, including:
  - supervising methodological practice;
  - commissioning data from many different sources;
- complete data collection, professional collation, analysis and interpretation, and the publication and dissemination of necessary reports, have not yet been developed in some of the most important areas of public health information practice. These include important aspects of epidemiology, health economics and population questionnaire and examination survey design;
- too many episodic surveys take place without reference to their place in the overall public health system, often without best use being made of their findings, and usually without arrangements for the necessary follow-up of changes and trends; this is a waste of scarce resources, even when funding is externally gifted, as it does not contribute to planned capacity building;
- dedicated finances are apparently inadequate to ensure essential basic tasks.

2.2.3 Recommendations to address these issues are provided in section 3.2.

2.3 Policy-making for health promotion

2.3.1 Within the overall public health function, sound policy-making is fundamental to the formulation of robust strategies and effective practices in health promotion. There appears to be a significant deficit in establishing systematic health promotion policy-making in Latvia. There is also a lack of clarity about existing, agreed policies. This all leads to a fragile situation for the acceptability and implementation of policy decisions.

Responsibility at national level is vested in the Public Health Department of the Ministry of Welfare. It appears to be facing the following constraints on performing its tasks effectively:

- public health and health promotion policy-making does not seem to have achieved sufficiently high political priority, such that all existing Government policies are clearly recognized and acted upon by all those affected by them;
- there seem to be some deficits of accountability and transparency, and the formulation of specific criteria and guidance documentation is often very imprecise;
- resources for policy-making are extremely limited, and the process suffers, for example, by comparison with the EU legislative and regulatory harmonization process undertaken by the Public Health Department;
- although Parliament considers forthcoming annual budget proposals in Committee, the transparency of the decision process is widely questioned.

2.3.2 As a result:

- the cycle of policy-making – of problem identification, policy analysis, policy formulation, decision-making, implementation, evaluation and review – including all necessary public, professional and political consultation at each appropriate stage, appears weak in comparison with advanced European societies;
- there is evident policy fragmentation, and the constant risk of being driven by crises and external agendas.
Since social and economic development require the concept, principles and strategies of health promotion to be at the heart of government business, these issues are of serious concern. This is particularly the case in the light of Latvia’s needs in the EU accession process, where a great many items for negotiation are directly linked to public health. Addressing these issues would hasten actual realization of the social and economic benefits which could be derived from Latvia’s existing commitment to health promotion, contained in policy documents from the highest level.

Recommendations are provided in section 3.3 which address two needs, namely:

- very urgent short term needs, in view of the World Bank health sector loan negotiations starting to enter their final phase (recommendation 3.3.1);
- the longer-term need for sustainable capacity-building for public health and health promotion policy-making (recommendation 3.3.2).

### 2.4 The infrastructure, organization and funding of health promotion practice within the overall public health system

#### 2.4.1

This review has already suggested that a number of deficits in infrastructure and organization are critically inhibiting the further development of public health and health promotion in Latvia. This section considers these, together with the other generally recognized infrastructure and organization needs of health promotion, including the question of funding.

Table 1 provides a checklist of all these basic functions and agencies needed for effective health promotion; the apparent situation in Latvia is compared with the checklist. Further consideration is provided in subsection 2.4.2.

#### 2.4.2

Further consideration of functions follows.

**Key function 1**

This was considered in detail in section 2.2.

**Key function 2**

Starting with the existing Annual Public Health Report, Parliamentary debate and well prepared media coverage could provide a focus for increased interest in public health and lead to an increase in both its status and understanding. This in turn could stimulate increased accountability for health by Parliament and the Government, helping to create forward movement on some of the more difficult infrastructure, organization and funding issues.

**Key function 3**

Analysis of the way interministerial committees work elsewhere in Europe, and their achievements and problems, suggests the following critical success factors:

- a small highly professional secretariat is essential, to prepare the issues for the committee’s consideration and ensure that decisions are followed up and acted upon;
- using such a committee for routine business rapidly downgrades the seniority of attendance;
- likewise, it is important to avoid any tendency to use the committee only to react to issues;
- the committee needs to deal with matters which regularly lead to follow up discussions at Parliamentary and Government level;
- the committee’s very senior membership and organizational position can enhance the status and understanding of public health; it should be a major contributor to the debates on the Annual Public Health Report.
<table>
<thead>
<tr>
<th>Key Functions</th>
<th>Type of agency required – current Latvian situation</th>
</tr>
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<tbody>
<tr>
<td>1 Regular, systematic monitoring of the state of public health, its environmental, social, economic and other determinants, and monitoring the effectiveness of current measures to improve it</td>
<td>A formally designated organization at national level, directed and funded to coordinate the commissioning, collection, collation, analysis, interpretation, and publication of such information – absent, but a good functional basis exists</td>
</tr>
<tr>
<td>2 Regular presentation of reports on the state of public health to Parliament, Government and the people</td>
<td>A director-general for health, or equivalent, with specific remits for oversight of the health of the public and to engage all the key decision-makers across Latvian society – the basis for this role in Latvia is vested in the Deputy State Secretary of the Health Department</td>
</tr>
<tr>
<td>3 High level multisectoral formulation of health promotion policy, and evaluation of its implementation</td>
<td>A high level interministerial committee – absent, but apparently among the first draft proposals for a new Public Health Act</td>
</tr>
<tr>
<td>4 Effective parliamentary scrutiny of health promotion policy and its implementation, assisting its effective development</td>
<td>A parliamentary committee which deals with health and is prepared to consider these issues – a good basis exists within the health responsibilities of the Parliamentary Social and Labour Affairs Committee</td>
</tr>
<tr>
<td>5 Wide social legitimation of health promotion, and constructive engagement in its advancement</td>
<td>Various possibilities, for example: an annual, multi-sector, multi-agency, multidisciplinary national advisory conference, drawing in statutory bodies, NGOs, professional organizations, the mass media, etc. – currently absent, but previous initiative in Latvia in 1993–1994 might be a good model to update, adapt and reintroduce</td>
</tr>
<tr>
<td>6 National and local multisectoral implementation, through multi-agency, multidisciplinary partnerships, working to well defined programme tasks</td>
<td>Specifically remitted statutory agencies, including the Health Promotion Centre, the Environmental Health Centres, local government, plus NGOs, professional associations etc. working at national, regional and local levels – partly exists, but underdeveloped</td>
</tr>
<tr>
<td>7 Multidisciplinary survey and research capacity for health promotion, including evaluation of effective implementation</td>
<td>Academic and other institutes and universities, research-based public agencies and private consultancies – a good basis exists, but policy and funding are critical</td>
</tr>
<tr>
<td>8 Assessment of professional staff needs – assessing establishment needs and planning deployment, plus: basic and post-graduate education and training; and continuing professional development</td>
<td>A national task force for professional education, training and development for health promotion, comprising managers, professionals and academics – absent</td>
</tr>
<tr>
<td>9 A full range of education and training facilities for basic, postgraduate and continuing professional education and training</td>
<td>Academic departments for health promotion teaching and research; academic departments, private and other organizations providing management training; a well organized system of in-service training and peer review – very incomplete</td>
</tr>
<tr>
<td>10 Robust long-term funding arrangements, preferably from a variety of sources</td>
<td>A national health promotion fund and budget – agreed in the Health Care Strategy 1996 but yet to be implemented</td>
</tr>
<tr>
<td>11 Functionally-based, coherent systems design and management</td>
<td>Organization and management development – mainly absent</td>
</tr>
</tbody>
</table>
Key function 4
The Parliamentary committee also needs professional and technical assistance if it is to play a constructive part.

Key function 5
Appropriate points in the policy cycle, such as the publication of the Annual Public Health Report, provide the most constructive basis for wider social engagement in improving public health.

Key function 6
Recent innovations – the National Centre for Environmental Health and the Health Promotion Centre – appear to be making impressive progress in public health and health promotion, despite serious resource limitations. The resource problem is particularly severe for the Health Promotion Centre. This has led the Health Promotion Centre to accept funds from commercial interests, and to appear to endorse specific products, for example manufactured foods. This runs the risk of breaching the centre’s code of practice and undermining the credibility of health promotion. Activities are often fragmented and isolated from those of other agencies, but work is about to begin on an overall strategy for public health, on the initiative of the head of the Public Health Department of the Ministry of Welfare. This is a priority for formulating appropriate implementation arrangements and clarifying all the key agency responsibilities at both national and local level.

Nevertheless, the need to get on with the development of health promotion at local level in Latvia appears to present a serious problem. The concept and principles of modern health promotion, and the conditions needed for its effective functioning, point strongly towards a base in democratically controlled institutions at local level, and thus away from the hierarchically organized regional environmental health centres. However, there are apparently wide differences in the ability of individual municipalities to cope with such responsibilities at present.

Key function 7
In April 1998, the WHO/EURO working group on health promotion evaluation issued a short set of recommendations to policymakers. They include recommendations that adequate resources need to be devoted to the evaluation of health promotion, and that multiple methods are needed to evaluate health promotion. It is worth introducing this set of recommendations into World Bank loan and other technical assistance negotiations.

Key function 8
Getting human resource planning right can make an impact quickly in a country of Latvia’s size. International technical assistance, perhaps through the World Bank loan, could be useful.

Key function 9
Linked to human resource planning, this again could make good use of the World Bank loan. At this stage in Latvia’s health promotion development careful attention needs to be given to the choice of learning, trying to avoid long absences of critical people, but creating opportunities for people who work with each other across organizational boundaries to learn together away from their regular workplaces.

Key function 10
Providing secure long-term funding for health promotion seems to have been an important issue in Latvia for some time, judging by the innovatory ideas which have been adopted as policy, some of them legislatively. The problems of turning “commitment” into action are unlikely to be resolved, unless the following issues in particular are squarely addressed:

- the ability to obtain adequate funds without causing dislocations in other services;
- the strategy and criteria against which expenditure decisions would be made;
- the capacity of the health promotion infrastructure to utilize funds effectively;
• openness, transparency, effectiveness and fairness in the allocation of funds;
• performance management, monitoring and evaluation.

Recommendations about infrastructure, organization and funding are set out in section 3.4.

**Key function 11**
Like the individual components of which they are composed, systems need active management. This enables them to cope with the ever evolving demands placed upon them, the ever changing external environment in which they operate, and their internal tensions.

### 3. RECOMMENDATIONS

#### 3.1 The health promotion function

3.1.1 Primary health care is not in a position to act as the principal focus for health promotion.

3.1.2 The need to develop an understanding of the health promotion concept and principles among key decision makers could be met through a course which WHO/EURO has developed for very senior public officials, tailored to their country’s needs. Drawn from different sectors, about 50 top civil servants, opinion leaders and politicians have been inducted into how health promotion can be instrumental in the overall social and economic development of the country. The outcome is a shared understanding, the reduction of bureaucratic and professional boundaries, and increased skills and commitment. It has been used in Poland, Italy and (on behalf of the Pan-American Health Organization) by Brazil.

3.1.3 Developing the role of the primary health care team is a centrally important feature of the Cardiovascular Health Programme. The programme provides the opportunity for developing local learning as a basis for subsequent countrywide implementation. For it to succeed, the following criteria need to be met before implementation in Kuldiga:

- the experimental design needs to take into account and properly evaluate operational transferability;
- per capita expenditure at local level should be in keeping with resources available elsewhere in Latvia.

#### 3.2 Health determinants

The public health function is in urgent need of a greatly enhanced information service able to act as described in subsection 2.2.2. The Medical Statistics Bureau would appear to be a good starting point for a Public Health Information Institute to fulfil this need. It would have to develop a number of new functions to meet modern requirements. Its early development would not however be best served by adding yet further responsibilities at its onset. The functional scope and the performance of the institute to date ought to be fully reviewed after three years, with the full participation of the institute itself.

Development of the new functions would be enhanced by well-chosen international partnerships, for which the World Bank loan might be considered a logical source of funding. Such partnerships, to improve local capacity to measure and interpret health determinants, are already well established in Latvia, through programmes such as the Health Behaviour of School Children survey and the Food and Nutrition Survey, both linked to WHO/EURO. These activities need to be further supported and sustained in the years to come.

Appropriate channels for discussion and interpretation of the policy implications of research findings would also need to be designed and implemented.
3.3 Policy-making

3.3.1 Urgent high level decisions appear to be needed about the status of a number of policy documents, so that Latvia’s position on several important issues in the forthcoming World Bank negotiations can be confirmed and clear.

3.3.2 As soon as possible, the Public Health Department will need to develop sustainable policy-making capacity, so as to fulfil its responsibilities to lead the development and implementation of a modern public health and health promotion agenda. Funding the necessary technical assistance and staff development should be considered by the World Bank, given the critical role to be played by the Department in initiating and sustaining modern public health practice.

3.4 Infrastructure, organization and funding

The recommendations in this section have two main intentions, namely:

- to replace episodic practices, incompleteness and fragmentation in public health, with particular reference to health promotion, by a coherent, comprehensive and coordinated system, under the provisions of the proposed new public health law;
- to improve the quality of health promotion practice within the new system.

Subsections 3.4.1 – 3.4.11 are recommendations relating to the key functions set out in Table 1 and subsection 2.4.2, and are numbered correspondingly.

3.4.1 For a public health information institute to be able to fulfil its key roles in the coordinated public health system, at least six conditions would need to be met, namely:

- the institute would need clear and achievable Terms of Reference;
- its programme of work would need to be drawn up under clear policy direction, with the input of good professional advice;
- the institute would need to be subject to strong performance management;
- there would need to be significant development in skills;
- its suppliers would also need to develop their skills to meet the new demands;
- adequate funding would be needed.

Governance of such an institute might be best achieved by a combination of three main measures, namely:

(i) the director should be accountable for the performance of the work of the institute to the Head of the Public Health Department of the Ministry of Welfare (PHD/MoW) or her nominated deputy;
(ii) the director should be advised on professional and management issues by a small advisory board with appropriate qualifications, appointed by the Head of the PHD/MoW;
(iii) the director should be a member of a Public Health Coordination Board (PHCB), which should be established to assist the management of the public health service as a whole.

Under the present division of responsibilities, the Deputy State Secretary of the Health Department would appoint and chair such a Board, and would be accountable to the Minister of Health for its performance. Its membership would need to include the Head of the PHD/MoW and her deputy/deputies, together with the directors of the dependent institutes of the PHD/MoW. It would have to include senior representatives of other very important public health functions and interests, such as local government and academia. For its effective functioning, as a core group of senior people who need to work together in a trusting relationship, it should not be further enlarged. A task which required additional skills could be performed
by a small task-limited working group, established for that specific purpose and dissolved at its completion.

The principal function of the PHCB would be to coordinate strategy in the field of public health. It would thus play the central role in filling the present strategic hiatus, ending fragmentation, and identifying solutions to problems such as gaps in provision and boundary disputes over responsibilities. Its Terms of Reference should be kept simple, short and transparent, and the temptation to add further tasks and responsibilities should be resisted during its establishment and first period of activity. This should last two years and lead to a thorough review of achievements, undertaken interactively with the assistance of appropriately skilled and experienced outside consultants.

The management innovations recommended here would have the additional benefit of releasing sufficient of the day-to-day tasks of the Minister of Health to enable him to give greater attention to overall policy, strategic direction, and the really serious issues which could not be resolved at a lower level. As the Deputy State Secretary is also Project Manager of the proposed World Bank-funded Project, it would also place the public health function in an appropriately close and constructive organizational relationship with that Project.

3.4.2 Members of the PHCB should provide assistance from their departments and institutes to the Deputy State Secretary and the director of the public health information institute for the preparation of the Annual Public Health Report. This should have four main aims – to provide more data, more analysis and more interpretation, and lead to a set of recommendations for action by different social agencies and members of the public. Bilateral or World Bank-loan funded technical assistance with the 1999 and 2000 reports could significantly accelerate and improve this process.

3.4.3 In keeping with the analysis in subsection 2.4.2, it is recommended:

- that a widely representative, high level, interministerial committee for public health is established under the provisions of the proposed new public health law;
- that the principal responsibility of the committee is to draw up a multisectoral investment for health strategy for Latvia, and monitor its implementation;
- that, in addition, the committee deals only with matters which regularly lead to follow up discussions at parliamentary and government level;
- that provision is made in the new public health law for the appointment of a small highly professional secretariat to prepare the issues for the committee’s consideration and to ensure that decisions are followed up and acted upon.

3.4.4 An enhanced role for the Parliamentary Social and Labour Affairs Committee is likely to evolve in response to other developments in public health in Latvia, for example:

- consultation about the work of the interministerial committee;
- the increased legislative, fiscal and regulatory activity which will be required to support modern public health.

As its role evolves, the committee is likely to need the support of a small technical secretariat.

3.4.5 The Public Health Coordination Board should be asked to advise and help to plan measures designed to achieve wide social legitimation and constructive support for health promotion. Bilateral or other technical assistance would be of assistance, including the advice of WHO/EURO. A priority should be the formulation of a good communications strategy, which:

(a) utilizes many different communications channels in a well planned annual programme;
(b) sticks to a small number of issues, whose importance is clear, and which would evidently benefit from wide input and engagement, such as consultation on a draft national strategy for health promotion, or on the Annual Public Health Report.

It would therefore benefit the PHCB if its membership included a strategic communications manager who was accountable to the Deputy Secretary for formulating the communications strategy and its implementation. Ideally, the person would be a member of the MoW public relations team.

3.4.6 Since the principal function of the PHCB would be to coordinate strategy in the field of public health, its work in relation to an overall strategy for health promotion would be critical, in particular for formulating appropriate implementation arrangements and clarifying all the key agency responsibilities at both national and local level. Tough decisions are needed to these sort out.

It is strongly recommended that responsibilities under the new public health law are allocated on the basis of careful functional analyses, taking health promotion principles carefully into account. It is essential that the law contains a description of the fundamental role of local government in the arrangements, and of the responsibilities of the national centres to help to develop locally-based skills and support local work. Carefully selected technical assistance could be of help.

3.4.7 The development of multidisciplinary research capacity is covered by recommendation 3.4.1.

3.4.8 Assessment of professional staff needs – assessing establishment needs and planning deployment, plus basic and postgraduate education and training, and continuing professional development, would be an important early task of the PHCB. It is recommended that it sets up a task force to undertake this work and make recommendations. A member of the PHCB should chair the task force.

3.4.9 It would appear logical to ask the task force described at 3.4.8 to examine in addition the range of education and training facilities for basic, postgraduate and continuing professional education and training, and to make recommendations.

3.4.10 It is strongly recommended that reliable funding for health promotion is provided as a matter of priority. There is no need – indeed it would be infeasible, and probably inappropriate, to try to provide at once all of the funding promised by legislation and government decisions. There needs to be an incremental annual build up, perhaps starting with 0.1% of the State Compulsory Health Insurance Fund in 1999, plus other funds. This percentage should be increased yearly to reach 1% of the State Compulsory Health Insurance Fund, as decided in the Strategy for Health Care Development in Latvia, 1996. Additional methods of funding could also be considered and these are summarized in Annex D.

In order to achieve even a comparatively modest start, the issues set out in subsection 2.4.2 need to be addressed by the PHCB, as another of its early priorities. This would probably be best undertaken by a short term working group, including outside members, for example from the State Compulsory Health Insurance Fund and the Ministry of Finance. Its task would be to propose solutions to the problem of providing robust funding, addressing:

- sources of funding;
- the ability to obtain adequate funds without causing dislocations in other services;
- the strategy and criteria against which expenditure decisions would be made;
- the capacity of the health promotion infrastructure to utilize funds effectively;
- openness, transparency, effectiveness and fairness in the allocation of funds;
- performance management, monitoring and evaluation.

Annex D – the main text of WHO/EURO’s publication on resourcing health promotion – evaluates the pros and cons of many different practical approaches. WHO would be willing to offer further advice, drawing on the wide experience of other countries in Europe and further afield. Specific technical assistance, perhaps under the World Bank health sector loan, to help to establish robust funding for health promotion, would be helpful.
3.4.11 The coordination of organization and management development would fall within the remit of the PHCB. Technical assistance would be essential to help the Board to delineate the scope of this task, and to help to develop the capacity to undertake it as an inherent part of management throughout the public health function. The scope and duration of such assistance would point to a long term donor or the World Bank health sector loan as a possible source of funding.

4. IMPLEMENTATION OF RECOMMENDATIONS

4.1 Overview

The terms of reference for this work (section 1.1) and the briefings and interviews which informed the overall review of the health promotion function (section 2.1) drew attention to three major difficulties in fulfilling the health promotion function in Latvia: fragmentation, lack of policy-making capacity and conceptual misunderstandings. The recommendations are essentially a set of proposals for addressing these difficulties. Their implementation would clearly depend on many factors, especially their acceptability to the Minister of Health, their compatibility with other plans for developments in public health, their priority in competition for limited resources, of management time as well as funds, and the availability of professional and managerial skills to supervise implementation.

If the proposals are accepted, it will therefore be important to schedule their implementation carefully, making best use of local management resources and taking greatest advantage of technical cooperation, assistance and funding. Sections 4.2 and 4.3 deal with each of these issues in turn.

4.2 Implementation scheduling

Without being in a position to take into account the many factors listed in section 4.1, and many other variables, not all of which are currently known (for example, the final shape of World Bank-funded project), sophisticated scheduling is not possible, even if it were desirable. Therefore a possible schedule is proposed as if all other factors were equal, but taking into account constraints known to the WHO team. Additional information, the passage of time, and the process of implementation itself, would all affect the timing and contents of the process. All other things being equal, the Team would propose a schedule along the lines set out in Table 2.

4.3 Technical cooperation, assistance and funding

The rapid growth in ability and confidence in modern public health in Latvia should be a cause of pride and hope by the people and government of Latvia. However, a demanding agenda lies ahead, and this will more than ever require skilled and courageous leadership and full inclusion in meeting the challenge. All those who have appropriate skills, experience and willingness to contribute need to be included in the tasks to be done.

It will also need well-designed foreign technical and professional expertise, and the very carefully tailored exposure of Latvians in key professional and managerial positions to learning from other countries’ experiences, both in Latvia and abroad. This can be achieved through well organized partnership, taking the form of bilateral or multilateral cooperation (e.g. the recently-endorsed Special Memorandum of Agreement between Latvia and the United Kingdom through the Health Education Authority for England and WHO/EURO).

In Latvia’s tightly managed financial situation, much of what needs to be done to bring public health, and in particular health promotion, rapidly up to modern standards will require outside funding. It is of great importance to the social and economic development of Latvia to develop modern public health infrastructures, and sustainable capacity, for policy-making and practice. Therefore, it is highly desirable, and strongly recommended, that future assistance, including a significant part of the World Bank loan, is applied to these purposes.

The WHO Regional Office for Europe has been honoured by the Minister’s invitation to provide advice, and is always ready to be of future service when required.
Table 2. Possible schedule for implementation of recommendations

<table>
<thead>
<tr>
<th>Timing</th>
<th>Recommendation</th>
<th>Action</th>
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<tr>
<td>Most</td>
<td>Negotiate for support in implementing these recommendations with World Bank and others</td>
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<tr>
<td>3.3.1</td>
<td>Clarify status of key public health policy documents</td>
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<td>3.3.2</td>
<td>Strengthen staffing and capacity of MoW public health department</td>
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<td>3.4</td>
<td>Decide public health management and advisory functions and structures and draft into proposals for new public health law</td>
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<td>SUMMER 1998</td>
<td>3.4.1 Deputy State Secretary to establish “shadow” PHCB</td>
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<td></td>
<td>3.4.11 Draw up first plans for organization and management development</td>
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<td></td>
<td>3.4.1 Draft, discuss and implement TOR for “shadow” advisory boards for each dependent institute and agency of PHD/MoW, and establish them</td>
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<tr>
<td></td>
<td>3.4.1 Negotiate and establish clear accountability and performance management arrangements between PHD/MoW and directors of dependent institutes</td>
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<td></td>
<td>3.4.6 Begin to draft health promotion strategy</td>
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<td></td>
<td>3.1.3 Ensure Cardiovascular Programme design meets necessary criteria</td>
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<td></td>
<td>3.4.10 Draw up and start to implement a robust health promotion funding plan</td>
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<tr>
<td>AUTUMN 1998</td>
<td>3.2/3.4.1 Prepare TOR for creating public health information institute from Medical Statistics Bureau (MSB)</td>
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<td></td>
<td>3.4.7 Commission MSB to produce a plan for creating modern survey and research capacity, including evaluation of effective health promotion</td>
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<td></td>
<td>3.4.2 Commission 1999 and 2000 Annual Public Health Reports from MSB, and assistance from other institutes and agencies</td>
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<td></td>
<td>3.4.5 Draft PHCB communications strategy</td>
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<td></td>
<td>3.4.6 Complete and consult widely on health promotion strategy</td>
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<td></td>
<td>3.4.3 Draft proposals for a “shadow” interministerial committee, pending enactment of new public health law</td>
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<td>WINTER 1998/1999</td>
<td>3.1.1 Conduct WHO course on hp concept and principles for senior officials</td>
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<td></td>
<td>3.4.4 PHCB to contact parliamentary social and labour affairs committee to prepare for discussions of 1999 Public Health Report</td>
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<td></td>
<td>3.4.6 Finalize and begin to implement hp strategy, nationally and locally</td>
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<td></td>
<td>3.4.8/3.4.9 Establish professional staff needs and training task force</td>
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<tr>
<td>LATER IN 1999</td>
<td>3.4.2 Launch 1999 Public Health Report for wide consultation and debate</td>
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<td></td>
<td>3.4 Implement new Public Health Law, when enacted</td>
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<td></td>
<td>3.4.8/3.4.9 Decide on report of professional staff needs and training task force and start to implement recommendations</td>
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1 This reference list is built predominantly on WHO sources. For further information on relevant publications refer to: Health promotion bibliography. Geneva, World Health Organization, 1997 (WHO/HPR/HEP/4ICHP/RS/97.2). Health promotion glossary (available on Internet via http://www.who.ch/hep).


Annex A

PROGRAMME OF WORK

WHO/EURO
PUBLIC HEALTH MISSION, LATVIA
1–5 JUNE 1998

Team membership

**Erio Ziglio (Team leader)**  
WHO Regional Office for Europe  
Regional Adviser for Health Promotion and Investment for Health

**David Rivett**  
WHO Regional Office for Europe  
European Network of Health Promoting Schools, with specific responsibility for WHO central European Member States

**Spencer Hagard (Rapporteur)**  
London Health Economics Consortium  
London School of Hygiene and Tropical Medicine  
Professor, Public Health and Policy Consultant  
President, International Union for Health Promotion and Education
Sunday 31 May 1998
Evening briefing with team members
Ms Ineta Pirktnia, Director Health Promotion Centre and Dr Aiga Rurane, NPO, WHO in Latvia

Monday 1 June 1998
08.30 – 09.30  Mr Viktors Jaksons, Minister of Health
Erio Ziglio, Spencer Hagard, David Rivett, Aiga Rurane

09.30 – 11.00  Ms Gita Rutina, Director, Department of Public Health, MOW

11.00 – 12.00  Ms Agrita Groza, Director, Department of Budget and Finance, MOW

12.00 – 13.00  Mr Jan Sand Sørensen, UN Resident Coordinator and
Ms Lotta Relander, Programme Officer, UNDP
Meeting to take place at UNDP Office, Skolas iela 24, 5th floor
Erio Ziglio, Spencer Hagard, David Rivett, Aiga Rurane

12.00 – 14.00  Lunch

14.00 – 15.00  Mr Lennart Bogg, Social Sector specialist, World Bank Regional Office for the Baltic
States and Ms Daiga Ernsone, WB

15.00 – 16.00  Ms Inara Bluke, Director, State Compulsory Health Insurance Fund (SCHIF)
and Mr Zigurds Lasovskis, Deputy Director, SCHIF (translation required)

16.00  Mr Guntis Vasilevskis, Director, Examination and Curricula Centre, Ministry of
Education (translation required)

Tuesday 2 June 1998
08.30 – 09.30  Dr Maris Budovskis, Director, National Environmental Health Centre
(translation required)

09.30 – 10.30  Dr Imants Rezebergs, Deputy State Secretary, MOW
and Ms G. Rutina (translation required)

10.30 – 11.30  Dr Renate Pupele, Deputy Director, Riga Region SCHIF (Riga Health Department)

11.30 – 12.30  Dr Ainars Civcs, Deputy Director and Head of Policy Unit, Department of Medical
Treatment (translation required)

12.30 – 13.00  Lunch

13.00 – 15.00  Dr Anita Villerusa, Dean, Faculty of Public Health, Riga Stradina University (former
Medical Academy) and Associate Professor Girts Brigis, Department of Public Health
and Epidemiology

Wednesday 3 June 1998
09.00 – 10.00  Dr Diana Puntule, Director, School of Public Health, Riga Stradina University School
of Public Health and Dr Ilga Albina, Lecturer

10.00 – 11.00  Dr Romens Psavke, Health Information Specialist, Latvian Centre for Health
Statistics, Informatics and Medical Technology
11.00 – 11.45 Mr V. Jaksons, Minister of Health and Ms G. Rutina

12.00 – 13.00 Lunch

13.00 – 14.00 Associate Professor Viesturs Silins, Post-graduate Medical Education Centre

15.00 – 18.00 Health Behaviour in School-aged Children (HBSC) seminar

Thursday 4 June 1998

09.00 Briefing, WHO Liaison Office

17.00 “Sounding board”
   Ilga Albina, D. Biezaite, G. Brigis, I. Pirkina, A. Rurane, G. Rutina

Friday 5 June 1998

11.00 Mr V. Jaksons, Minister of Health and Ms G. Rutina

12.00 Press conference, Mr V. Jaksons (Chairperson)
Annex B

DOCUMENTS CONSIDERED

1995/1996
- Environmental Health Action Plan for Latvia, Ministry of Welfare and Ministry of Environmental Protection and Regional Development, Republic of Latvia

1996
- Strategy for Health Care Development in Latvia, Cabinet of Ministers
- Aims and Tasks of the National Health Promotion Centre, Registered Statute No. 000332259
- Law on the production, distribution and sale and advertising of tobacco products, and the control of smoking, Government of Latvia
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- Health in Latvia – Year Book of Latvian Health Statistics 1996, Medical Statistics Bureau, Latvian Centre of Health Statistics, Informatics and Medical Technology, Ministry of Welfare
- Public Health Report – Latvia 1996, Medical Statistics Bureau
- Public Health in Latvia 1997 pages 34, 35 and Annex III, (BRIMHEALTH Foundations of Public Health Pt 2., course work)
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- Structure of the Ministry of Welfare (1/01/98), Ministry of Welfare
- Towards Better Health in Latvia. Priority setting and policy direction for future cost-effective investment in health, World Bank Regional Office for the Baltic Countries
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- Purview of PHC nurses in Riga during transition period, Riga City Council
- Project Information Document, World Bank Regional Office for the Baltic Countries
- Structure of Public Health Service, Public Health Department, Ministry of Welfare
- List of Involved Institutions in the Field of Public Health in Latvia, Public Health Department, Ministry of Welfare
- Public Health Promotion Financing 1998 and 1999 (proposed), Public Health Department, Ministry of Welfare
- List of Main Laws and Regulations in the Field of Public Health, Public Health Department, Ministry of Welfare
- Alternative cost estimates for immunization programmes against tick-borne encephalitis, Public Health Department, Ministry of Welfare
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• Brochure, map, national and regional structure charts of National Environmental Health Centre
• Epidemiological Bulletin, 21 May 1998, National Environmental Health Centre
• Brochure and structure chart of the National Health Promotion Centre
• Nutrition leaflet and poster, National Health Promotion Centre
• Proposed health promotion strategy 1998–2003, National Health Promotion Centre
• Promoting Better Health in Latvia, Technical Partnership Agreement, Ministry of Health, World Health Organization Regional Office for Europe, Health Education Authority, England, National Health Promotion Centre
• Cardiovascular Health Programme in Latvia, Draft Programme Document, HEDEC, Finland
• Brochure, Latvian School of Public Health
• The National Budget 1998, Bulletin No. 1
• Surveys of the State Budget, February–April 1998, Ministry of Finance
Annex C

Health Promotion Glossary

Section I: List of basic terms

Source: Health Promotion Glossary
WHO/HPR/HEP/98.1

Health

Health is defined in the WHO constitution of 1948 as:

A state of complete physical, social and mental well-being, and not merely the absence of disease or infirmity.

Within the context of health promotion, health has been considered less as an abstract state and more as a means to an end which can be expressed in functional terms as a resource which permits people to lead an individually, socially and economically productive life.

Health is a resource for everyday life, not the object of living. It is a positive concept emphasizing social and personal resources as well as physical capabilities.


In keeping with the concept of health as a fundamental human right, the Ottawa Charter emphasizes certain prerequisites for health which include peace, adequate economic resources, food and shelter, and a stable eco-system and sustainable resource use. Recognition of these prerequisites highlights the inextricable links between social and economic conditions, the physical environment, individual lifestyles and health. These links provide the key to an holistic understanding of health which is central to the definition of health promotion. Today the spiritual dimension of health is increasingly recognized. Health is regarded by WHO as a fundamental human right, and correspondingly, all people should have access to basic resources for health.

A comprehensive understanding of health implies that all systems and structures which govern social and economic conditions and the physical environment should take account of the implications of their activities in relation to their impact on individual and collective health and wellbeing.

See also social responsibility for health.

Health promotion

Health promotion is the process of enabling people to increase control over, and to improve their health.


Health promotion represents a comprehensive social and political process, it not only embraces actions directed at strengthening the skills and capabilities of individuals, but also action directed towards changing social, environmental and economic conditions so as to alleviate their impact on public and individual health. Health promotion is the process of enabling people to increase control over the
**determinants of health** and thereby improve their **health**. Participation is essential to sustain health promotion action.

The **Ottawa Charter** identifies three basic strategies for health promotion. These are **advocacy** for health to create the essential conditions for health indicated above; **enabling** all people to achieve their full health potential; and **mediating** between the different interests in society in the pursuit of health. These strategies are supported by five priority action areas as outlined in the **Ottawa Charter** for health promotion:

- Build healthy public policy
- Create supportive environments for health
- Strengthen community action for health
- Develop personal skills, and
- Reorient health services.

Each of these strategies and action areas is further defined in the glossary.

The **Jakarta Declaration** on Leading Health Promotion into the 21st Century from July 1997 confirmed that these strategies and action areas are relevant for all countries. Furthermore, there is clear evidence that:

- Comprehensive approaches to health development are the most effective. Those that use combinations of the five strategies are more effective than single-track approaches;
- **Settings for health** offer practical opportunities for the implementation of comprehensive strategies;
- Participation is essential to sustain efforts. People have to be at the centre of health promotion action and decision-making processes for them to be effective;
- **Health literacy**/health learning fosters participation. Access to education and information is essential to achieving effective participation and the **empowerment** of people and communities.

For health promotion in the 21st century the **Jakarta Declaration** identifies five priorities:

- Promote social responsibility for health
- Increase investments for health development
- Expand partnerships for health promotion
- Increase community capacity and empower the individual
- Secure an infrastructure for health promotion.

Each of these priorities is further defined in the glossary. Increasing community capacity is addressed in the definition of **community action for health. Empowerment for health** is included as a definition.

**Health for All**

The attainment by all the people of the world of a level of health that will permit them to lead a socially and economically productive life.


Health for All has served as an important focal point for health strategy for WHO and its Member States for almost twenty years. Although it has been interpreted differently by each country in the light of its social and economic characteristics, the health status and morbidity patterns of its population, and the state of development of its health system, it has provided an aspirational goal, based on the concept of **equity in health**. The Health for All strategy is currently being redeveloped to ensure its continued
relevance into the next century. A new policy is being developed, to be adopted by the World Health Assembly in 1998.

Public health

The science and art of promoting health, preventing disease, and prolonging life through the organized efforts of society.


Public health is a social and political concept aimed at the improving health, prolonging life and improving the quality of life among whole populations through health promotion, disease prevention and other forms of health intervention. A distinction has been made in the health promotion literature between public health and a new public health for the purposes of emphasizing significantly different approaches to the description and analysis of the determinants of health, and the methods of solving public health problems. This new public health is distinguished by its basis in a comprehensive understanding of the ways in which lifestyles and living conditions determine health status, and a recognition of the need to mobilize resources and make sound investments in policies, programmes and services which create, maintain and protect health by supporting healthy lifestyles and creating supportive environments for health. Such a distinction between the “old” and the “new” may not be necessary in the future as the mainstream concept of public health develops and expands.

The concept of ecological public health has also emerged in the literature. It has evolved in response to the changing nature of health issues and their interface with emerging global environmental problems. These new problems include global ecological risks such as the destruction of the ozone layer, uncontrolled and unmanageable air and water pollution, and global warming. These developments have a substantial impact on health which often elude simple models of causality and intervention.

Ecological public health emphasizes the common ground between achieving health and sustainable development. It focuses on the economic and environmental determinants of health, and on the means by which economic investment should be guided towards producing the best population health outcomes, greater equity in health, and sustainable use of resources.

Primary health care

Primary health care is essential health care made accessible at a cost a country and community can afford, with methods that are practical, scientifically sound and socially acceptable.


The Alma-Ata Declaration, also emphasizes that everyone should have access to primary health care, and everyone should be involved in it. The primary health care approach encompasses the following key components: equity, community involvement/participation, intersectorality, appropriateness of technology and affordable costs.

As a set of activities, primary health care should include at the very least health education for individuals and the whole community on the size and nature of health problems, and on methods of preventing and controlling these problems. Other essential activities include the promotion of adequate supplies of food and proper nutrition; sufficient safe water and basic sanitation; maternal and child health care, including family planning; immunization; appropriate treatment of common diseases and injuries; and the provision of essential drugs.
Primary health care as defined above will do much to address many of the prerequisites for health indicated earlier. In addition, at a very practical level, there is great scope for both planned and opportunistic health promotion through the day to day contact between primary health care personnel and individuals in their community. Through health education with clients, and advocacy on behalf of their community, PHC personnel are well placed both to support individual needs and to influence the policies and programmes that affect the health of the community.

The primary health care concept and themes are currently being reviewed by WHO.

**Disease prevention**

Disease prevention covers measures not only to prevent the occurrence of disease, such as risk factor reduction, but also to arrest its progress and reduce its consequences once established.


Primary prevention is directed towards preventing the initial occurrence of a disorder. Secondary and tertiary prevention seeks to arrest or retard existing disease and its effects through early detection and appropriate treatment; or to reduce the occurrence of relapses and the establishment of chronic conditions through, for example, effective rehabilitation.

Disease prevention is sometimes used as a complementary term alongside health promotion. Although there is frequent overlap between the content and strategies, disease prevention is defined separately. Disease prevention in this context is considered to be action which usually emanates from the health sector, dealing with individuals and populations identified as exhibiting identifiable risk factors, often associated with different risk behaviours.

**Health education**

Health education comprises consciously constructed opportunities for learning involving some form of communication designed to improve health literacy, including improving knowledge, and developing life skills which are conducive to individual and community health.

Reference: modified definition.

Health education is not only concerned with the communication of information, but also with fostering the motivation, skills and confidence (self-efficacy) necessary to take action to improve health. Health education includes the communication of information concerning the underlying social, economic and environmental conditions impacting on health, as well as individual risk factors and risk behaviours, and use of the health care system. Thus, health education may involve the communication of information, and development of skills which demonstrates the political feasibility and organizational possibilities of various forms of action to address social, economic and environmental determinants of health.

In the past, health education was used as a term to encompass a wider range of actions including social mobilization and advocacy. These methods are now encompassed in the term health promotion, and a more narrow definition of health education is proposed here to emphasize the distinction.
Health Promotion Glossary

Section II: Extended list of terms

**Advocacy for health**

A combination of individual and social actions designed to gain political commitment, policy support, social acceptance and systems support for a particular health goal or programme.


Such action may be taken by and/or on behalf of individuals and groups to create living conditions which are conducive to health and the achievement of healthy lifestyles. Advocacy is one of the three major strategies for health promotion and can take many forms including the use of the mass media and multi-media, direct political lobbying, and community mobilization through, for example, coalitions of interest around defined issues. Health professionals have a major responsibility to act as advocates for health at all levels in society.

**Alliance**

An alliance for health promotion is a partnership between two or more parties that pursue a set of agreed upon goals in health promotion.

Reference: new definition.

Alliance building will often involve some form of mediation between the different partners in the definition of goals and ethical ground rules, joint action areas, and agreement on the form of cooperation which is reflected in the alliance.

**Community**

A specific group of people, often living in a defined geographical area, who share a common culture, values and norms, are arranged in a social structure according to relationships which the community has developed over a period of time. Members of a community gain their personal and social identity by sharing common beliefs, values and norms which have been developed by the community in the past and may be modified in the future. They exhibit some awareness of their identity as a group, and share common needs and a commitment to meeting them.

Reference: modified definition.

In many societies, particularly those in developed countries, individuals do not belong to a single, distinct community, but rather maintain membership of a range of communities based on variables such as geography, occupation, social and leisure interests.

**Community action for health**

*Community action for health* refers to collective efforts by communities which are directed towards increasing community control over the determinants of health, and thereby improving health.

Reference: new definition.
The Ottawa Charter emphasizes the importance of concrete and effective community action in setting priorities for health, making decisions, planning strategies and implementing them to achieve better health. The concept of community empowerment is closely related to the Ottawa Charter definition of community action for health. In this concept an empowered community is one in which individuals and organizations apply their skills and resources in collective efforts to address health priorities and meet their respective health needs. Through such participation, individuals and organizations within an empowered community provide social support for health, address conflicts within the community, and gain increased influence and control over the determinants of health in their community.

**Determinants of health**

The range of personal, social, economic and environmental factors which determine the health status of individuals or populations.

Reference: new definition.

The factors which influence health are multiple and interactive. Health promotion is fundamentally concerned with action and advocacy to address the full range of potentially modifiable determinants of health – not only those which are related to the actions of individuals, such as health behaviours and lifestyles, but also factors such as income and social status, education, employment and working conditions, access to appropriate health services, and the physical environments. These, in combination, create different living conditions which impact on health. Achieving change in these lifestyles and living conditions, which determine health status, are considered to be intermediate health outcomes.

**Empowerment for health**

In health promotion, empowerment is a process through which people gain greater control over decisions and actions affecting their health.

Reference: new definition.

Empowerment may be a social, cultural, psychological or political process through which individuals and social groups are able to express their needs, present their concerns, devise strategies for involvement in decision-making, and achieve political, social and cultural action to meet those needs. Through such a process people see a closer correspondence between their goals in life and a sense of how to achieve them, and a relationship between their efforts and life outcomes. Health promotion not only encompasses actions directed at strengthening the basic life skills and capacities of individuals, but also at influencing underlying social and economic conditions and physical environments which impact upon health. In this sense health promotion is directed at creating the conditions which offer a better chance of there being a relationship between the efforts of individuals and groups, and subsequent health outcomes in the way described above.

A distinction is made between individual and community empowerment. Individual empowerment refers primarily to the individuals’ ability to make decisions and have control over their personal life. Community empowerment involves individuals acting collectively to gain greater influence and control over the determinants of health and the quality of life in their community, and is an important goal in community action for health.
**Enabling**

In health promotion, enabling means taking action in *partnership* with individuals or groups to empower them, through the mobilization of human and material resources, to promote and protect their health.

Reference: new definition.

The emphasis in this definition on *empowerment* through *partnership*, and on the mobilization of resources draws attention to the important role of health workers and other health activists acting as a catalyst for health promotion action, for example by providing access to information on health, by facilitating skills development, and supporting access to the political processes which shape public policies affecting health.

**Epidemiology**

Epidemiology is the study of the distribution and determinants of health-states or events in specified populations, and the application of this study to the control of health problems.


Epidemiological information, particularly that defining individual, population and/or physical environmental risks has been at the core of *public health*, and provided the basis for *disease prevention* activities. Epidemiological studies use social classifications (such as socioeconomic status) in the study of disease in populations, but generally make less than optimal use of social sciences, including economic and public policy information, in investigating and understanding disease and health in populations.

**Social epidemiology** has evolved as a discipline during the past two decades. Social epidemiology is the study of health and illness in populations which is informed by a social, psychological, economic and public policy information, and uses that information in the definition of *public health* problems and proposal of solutions. As the discipline of epidemiology further develops and expands such distinctions will be less important in the future.

**Equity in health**

Equity means fairness. Equity in health means that people’s needs guide the distribution of opportunities for wellbeing.


The WHO global strategy of achieving *Health for All* is fundamentally directed towards achieving greater equity in health between and within populations, and between countries. This implies that all people have an equal opportunity to develop and maintain their health, through fair and just access to resources for health. Equity in health is not the same as equality in *health status*. Inequalities in *health status* between individuals and populations are inevitable consequences of genetic differences, of different social and economic conditions, or a result of personal *lifestyle* choices. Inequities occur as a consequence of differences in opportunity which result, for example in unequal access to health services, to nutritious food, adequate housing and so on. In such cases, inequalities in *health status* arise as a consequence of inequities in opportunities in life.
Health behaviour

Any activity undertaken by an individual, regardless of actual or perceived health status, for the purpose of promoting, protecting or maintaining health, whether or not such behaviour is objectively effective towards that end.


It is possible to argue that almost every behaviour or activity by an individual has an impact on health status. In this context it is useful to distinguish between behaviours which are purposefully adopted to promote or protect health (as in the definition above), and those which may be adopted regardless of consequences to health. Health behaviours are distinguished from risk behaviours which are defined separately as behaviours associated with increased susceptibility to a specific cause of ill-health.

Health behaviours and risk behaviours are often related in clusters in a more complex pattern of behaviours referred to as lifestyles.

Health communication

Health communication is a key strategy to inform the public about health concerns and to maintain important health issues on the public agenda. The use of the mass and multi media and other technological innovations to disseminate useful health information to the public, increases awareness of specific aspects of individual and collective health as well as importance of health in development.


Health communication is directed towards improving the health status of individuals and populations. Much of modern culture is transmitted by the mass and multi media which has both positive and negative implications for health. Research shows that theory-driven mediated health promotion programming can put health on the public agenda, reinforce health messages, stimulate people to seek further information, and in some instances, bring about sustained healthy lifestyles.

Health communication encompasses several areas including edutainment or enter-education, health journalism, interpersonal communication, media advocacy, organizational communication, risk communication, social communication and social marketing. It can take many forms from mass and multi media communications to traditional and culture-specific communication such as story telling, puppet shows and songs. It may take the form of discreet health messages or be incorporated into existing media for communication such as soap operas.

Advances in communication media, especially in the multi media and new information technology continue to improve access to health information. In this respect, health communication becomes an increasingly important element to achieving greater empowerment of individuals and communities.

Health development

Health development is the process of continuous, progressive improvement of the health status of individuals and groups in a population.


The Jakarta Declaration describes health promotion as an essential element of health development.
Health expectancy

Health expectancy is a population-based measure of the proportion of expected life span estimated to be healthful and fulfilling, or free of illness, disease and disability according to social norms and perceptions and professional standards.

Reference: new definition.

Health expectancy belongs to a new generation or type of health indicator which are currently being developed. These indicators are intended to create measures which are more sensitive to the dynamics of health and determinants. Health expectancy indicators combine information from life expectancy tables and health surveys of populations. They need to be based on life expectancy at country level or a similar geographic area.

Examples of health expectancy indicators currently in use are disability free life years (DFLY) and quality adjusted life years (QALY). They focus primarily on the extent to which individuals experience a life span free of disability, disorders and/or chronic disease. Health promotion seeks to expand the understanding of health expectancy beyond the absence of disease, disorder and disability towards positive measures of health creation, maintenance and protection, emphasizing a healthy life span.

Health gain

Health gain is a way to express improved health outcomes. It can be used to reflect the relative advantage of one form of health intervention over another in producing the greatest health gain.

Reference: new definition.

The Jakarta Declaration indicates that health promotion “acts on the determinants of health to create the greatest health gain for people”.

See also health outcome and intermediate health outcomes.

Health goal

Health goals summarize the health outcomes which, in the light of existing knowledge and resources, a country or community might hope to achieve in a defined time period.

Reference: new definition.

Health goals are general statements of intent and aspiration, intended to reflect the values of the community in general, and the health sector in particular, regarding a healthy society. Many countries have adopted an approach to setting health goals and health targets as statement of direction and intent with regard to their investments for health. WHO has supported the development, and promoted the use of health goals and targets at global and regional, national and local levels.

Health indicator

A health indicator is a characteristic of an individual, population, or environment which is subject to measurement (directly or indirectly) and can be used to describe one or more aspects of the health of an individual or population (quality, quantity and time).

Reference: modified definition.
Health indicators can be used to define public health problems at a particular point in time, to indicate change over time in the level of the health of a population or individual, to define differences in the health of populations, and to assess the extent to which the objectives of a programme are being reached.

Health indicators may include measurements of illness or disease which are more commonly used to measure health outcomes, or positive aspects of health (such as quality of life, life skills, or health expectancy), and of behaviours and actions by individuals which are related to health. They may also include indicators which measure the social and economic conditions and the physical environment as it relates to health, measures of health literacy and healthy public policy. This latter group of indicators may be used to measure intermediate health outcomes, and health promotion outcomes.

**Health literacy**

Health literacy represents the cognitive and social skills which determine the motivation and ability of individuals to gain access to, understand and use information in ways which promote and maintain good health.

Reference: new definition.

Health literacy implies the achievement of a level of knowledge, personal skills and confidence to take action to improve personal and community health by changing personal lifestyles and living conditions. Thus, health literacy means more than being able to read pamphlets and make appointments. By improving people’s access to health information, and their capacity to use it effectively, health literacy is critical to empowerment. Health literacy is itself dependent upon more general levels of literacy. Poor literacy can affect people’s health directly by limiting their personal, social and cultural development, as well as hindering the development of health literacy.

**Health outcomes**

A change in the health status of an individual, group or population which is attributable to a planned intervention or series of interventions, regardless of whether such an intervention was intended to change health status.

Reference: new definition.

Such a definition emphasizes the outcome of planned interventions (as opposed, for example, to incidental exposure to risk), and that outcomes may be for individuals, groups or whole populations. Interventions may include government policies and consequent programmes, laws and regulations, or health services and programmes, including health promotion programmes. It may also include the intended or unintended health outcomes of government policies in sectors other than health. Health outcomes will normally be assessed using health indicators. See also intermediate health outcomes, and health promotion outcomes.

**Health policy**

A formal statement or procedure within institutions (notably government) which defines priorities and the parameters for action in response to health needs, available resources and other political pressures.

Reference: modified definition.

Health policy is often enacted through legislation or other forms of rule-making which define regulations and incentives which enable the provision of health services and programmes, and access to those
services and programmes. Health policy is currently distinguished from healthy public policy by its primary concern with health services and programmes. Future progress in health policies may be observed through the extent to which they may also be defined as healthy public policies.

As with most policies, health policies arise from a systematic process of building support for public health action that draws upon available evidence, integrated with community preferences, political realities and resource availability.

Health-promoting hospitals

A health-promoting hospital does not only provide high quality comprehensive medical and nursing services, but also develops a corporate identity that embraces the aims of health promotion, develops a health-promoting organizational structure and culture, including active, participatory roles for patients and all members of staff, develops itself into a health-promoting physical environment and actively cooperates with its community.


Health-promoting hospitals take action to promote the health of their patients, their staff, and the population in the community they are located in. Health-promoting hospitals are actively attempting to become “healthy organizations”. Health-promoting hospitals are being implemented since 1988. An international network has developed to promote the wider adoption of this concept in hospitals and other health care settings.

Health-promoting schools

A health-promoting school can be characterized as a school constantly strengthening its capacity as a healthy setting for living, learning and working.


Towards this goal, a health-promoting school engages health and education officials, teachers, students, parents and community leaders in efforts to promote health. It fosters health and learning with all the measures at its disposal, and strives to provide supportive environments for health and a range of key school health education and promotion programs and services. A health-promoting school implements policies, practices and other measures that respect an individual’s self esteem, provide multiple opportunities for success, and acknowledge good efforts and intentions as well as personal achievements. It strives to improve the health of school personnel, families and community members as well as students, and works with community leaders to help them understand how the community contributes to health and education.

WHO’s Global School Health Initiative aims at helping all schools to become “health promoting” by, for example, encouraging and supporting international, national and subnational networks of health-promoting schools, and helping to build national capacities to promote health through schools.
Health promotion evaluation

Health promotion evaluation is an assessment of the extent to which health promotion actions achieve a “valued” outcome.

Reference: new definition.

The extent to which health promotion actions enable individuals or communities to exert control over their health represents a central element of health promotion evaluation.

In many cases it is difficult to trace the pathway which links particular health promotion activities to health outcomes. This may be for a number of reasons, for example, because of the technical difficulties of isolating cause and effect in complex, “real-life” situations. Therefore, most recent outcome models in health promotion distinguish between different types of outcomes and suggest a hierarchy among them. Health promotion outcomes represent the first point of assessment and reflect modifications to those personal, social and environmental factors which are a means to improve people’s control over their health. Changes in the determinants of health are defined as intermediate health outcomes. Changes in health status represent health outcomes.

In most cases, there is also “value” placed on the process by which different outcomes are achieved. In terms of valued processes, evaluations of health promotion activities may be participatory, involving all those with a vested interest in the initiative; interdisciplinary, by involving a variety of disciplinary perspectives; integrated into all stages of the development and implementation of a health promotion initiative; and help build the capacity of individuals, communities, organizations and governments to address important health problems.

Health promotion outcomes

Health promotion outcomes are changes to personal characteristics and skills, and/or social norms and actions, and/or organizational practices and public policies which are attributable to a health promotion activity.

Reference: new definition.

Health promotion outcomes represent the most immediate results of health promotion activities and are generally directed towards changing modifiable determinants of health. Health promotion outcomes include health literacy, healthy public policy, and community action for health. See also health outcomes and intermediate health outcomes.

Health sector

The health sector consists of organized public and private health services (including health promotion, disease prevention, diagnostic, treatment and care services), the policies and activities of health departments and ministries, health related nongovernmental organizations and community groups, and professional associations.

Health status

A description and/or measurement of the health of an individual or population at a particular point in time against identifiable standards, usually by reference to health indicators.


Health target

Health targets state, for a given population, the amount of change (using a health indicator) which could be reasonably expected within a defined time period. Targets are generally based on specific and measurable changes in health outcomes, or intermediate health outcomes.

Reference: new definition.

Health targets define the concrete steps which may be taken towards the achievement of health goals. Setting targets also provides one approach to the assessment of progress in relation to a defined health policy or programme by defining a benchmark against which progress can be measured. Setting targets requires the existence of a relevant health indicator and information on the distribution of that indicator within a population of interest. It also requires an estimate of current and likely future trends in relation to change in the distribution of the indicator, and an understanding of the potential to change the distribution of the indicator in the population of interest.

Healthy cities

A healthy city is one that is continually creating and improving those physical and social environments and expanding those community resources which enable people to mutually support each other in performing all the functions of life and in developing to their maximum potential.


The WHO Healthy Cities project is a long-term development project that seeks to place health on the agenda of cities around the world, and to build a constituency of support for public health at the local level. The healthy cities concept is evolving to encompass other forms of settlement including healthy villages and municipalities.

Healthy islands

A healthy island is one that is committed to and involved in a process of achieving better health and quality of life for its people, and healthier physical and social environments in the context of sustainable development.


The Yanuca Island Declaration states that Healthy Islands are places where children are nurtured in body and mind; environments invite learning and leisure; people work and age in dignity; and ecological balance is a source of pride. This Declaration was ratified by the Health Ministers of fourteen Pacific Island nations in 1995 and has since become an interregional source of reference for Healthy Islands programmes throughout the world.
Healthy public policy

Healthy public policy is characterized by an explicit concern for health and equity in all areas of policy, and by an accountability for health impact. The main aim of healthy public policy is to create a supportive environment to enable people to lead healthy lives. Such a policy makes healthy choices possible or easier for citizens. It makes social and physical environments health enhancing.


The Ottawa Charter highlighted the fact that health promotion action goes beyond the health care sector, emphasizing that health should be on the policy agenda in all sectors, and at all levels of government. One important element in building healthy public policy is the notion of accountability for health. Governments are ultimately accountable to their people for the health consequences of their policies, or lack of policies. A commitment to healthy public policies means that governments must measure and report on their investments for health, and the subsequent health outcomes, and intermediate health outcomes of their investments and policies in a language that all groups in society readily understand. Closely related to the health promotion concept of healthy public policy is the strategy of investment for health. Investment for health is a strategy for optimizing the health-promoting impact of public policies.

Infrastructure for health promotion

Those human and material resources, organizational and administrative structures, policies, regulations and incentives which facilitate an organized health promotion response to public health issues and challenges.

Reference: new definition.

Such infrastructures may be found through a diverse range of organizational structures, including primary health care, government, private sector and nongovernmental organizations, self-help organizations, as well as dedicated health promotion agencies and foundations. Although many countries have a dedicated health promotion workforce, the greater human resource is to be found among the wider health workforce, workforces in other sectors than health (for example in education, social welfare and so on), and from the actions of lay persons within individual communities. Infrastructure for health promotion can be found not only in tangible resources and structures, but also through the extent of public and political awareness of health issues, and participation in action to address those issues.

Intermediate health outcomes

Intermediate health outcomes are changes in the determinants of health, notably changes in lifestyles, and living conditions which are attributable to a planned intervention or interventions, including health promotion, disease prevention and primary health care.

Reference: new definition.

See also determinants of health, health outcomes and intermediate health outcomes.

Intersectoral collaboration

A recognized relationship between part or parts of different sectors of society which has been formed to take action on an issue to achieve health outcomes or intermediate health outcomes in a
way which is more effective, efficient or sustainable than might be achieved by the health sector acting alone.


Intersectoral action for health is seen as central to the achievement of greater equity in health, especially where progress depends upon decisions and actions in other sectors, such as agriculture, education, and finance. A major goal in intersectoral action is to achieve greater awareness of the health consequences of policy decisions and organizational practice in different sectors, and through this, movement in the direction of healthy public policy and practice. Not all intersectoral action for health need involve the health sector. For example, in some countries the police and transport sectors might combine to take action to reduce road transport injury. Such action, although explicitly intended to reduce injury, will not always involve the health sector. Increasingly intersectoral collaboration is understood as cooperation between different sectors of society such as the public sector, civil society and the private sector.

Investment for health

Investment for health refers to resources which are explicitly dedicated to the production of health and health gain. They may be invested by public and private agencies as well as by people as individuals and groups. Investment for health strategies are based on knowledge about the determinants of health and seek to gain political commitment to healthy public policies.

Reference: new definition.

Investment for health is not restricted to resources which are devoted to the provision and use of health services and may include, for example, investments made by people (individually or collectively) in education, housing, empowerment of women or child development. Greater investment for health also implies reorientation of existing resource distribution within the health sector towards health promotion and disease prevention. A significant proportion of investments for health are undertaken by people in the context of their everyday life as part of personal and family health maintenance strategies.

See also healthy public policy and supportive environments for health.

Jakarta Declaration on Leading Health Promotion into the 21st Century

See health promotion (section I).

Life skills

Life skills are abilities for adaptive and positive behaviour, that enable individuals to deal effectively with the demands and challenges of everyday life.


Life skills consist of personal, inter-personal, cognitive and physical skills which enable people to control and direct their lives, and to develop the capacity to live with and produce change in their environment. Examples of individual life skills include decision making and problem solving, creative thinking and critical thinking, self awareness and empathy, communication skills and interpersonal relationship skills, coping with emotions and managing stress. Life skills as described above are fundamental building blocks for the development of personal skills for health promotion described as one of the key action areas in the Ottawa Charter.
Lifestyle (lifestyles conducive to health)

Lifestyle is a way of living based on identifiable patterns of behaviour which are determined by the interplay between an individual’s personal characteristics, social interactions, and socioeconomic and environmental living conditions.

Reference: modified definition.

These patterns of behaviour are continually interpreted and tested out in different social situations and are therefore not fixed, but subject to change. Individual lifestyles, characterized by identifiable patterns of behaviour, can have a profound effect on an individual’s health and on the health of others. If health is to be improved by enabling individuals to change their lifestyles, action must be directed not only at the individual but also at the social and living conditions which interact to produce and maintain these patterns of behaviour.

It is important to recognize, however, that there is no “optimal” lifestyle to be prescribed for all people. Culture, income, family structure, age, physical ability, home and work environment will make certain ways and conditions of living more attractive, feasible and appropriate.

Living conditions

Living conditions are the everyday environment of people, where they live, play and work. These living conditions are a product of social and economic circumstances and the physical environment – all of which can impact upon health – and are largely outside of the immediate control of the individual.

Reference: modified definition.

The Ottawa Charter action of creating supportive environments for health is largely focused on the need to improve and change living conditions to support health.

Mediation

In health promotion, a process through which the different interests (personal, social, economic) of individuals and communities, and different sectors (public and private) are reconciled in ways that promote and protect health.

Reference: new definition.

Producing change in people’s lifestyles and living conditions inevitably produces conflicts between the different sectors and interests in a population. Such conflicts may arise, for example, from concerns about access to, use and distribution of resources, or constraints on individual or organizational practices. Reconciling such conflicts in ways which promote health may require considerable input from health promotion practitioners, including the application of skills in advocacy for health.

Network

A grouping of individuals, organizations and agencies organized on a non hierarchical basis around common issues or concerns, which are pursued proactively and systematically, based on commitment and trust.

Reference: new definition.
WHO actively initiates and maintains several health promotion networks around key settings and issues. These include, for example, the intersectoral healthy cities network, networks of health-promoting schools, and WHO country networks for health promotion such as the WHO mega country initiative. Networks of networks are also being established. Examples include the WHO(EURO) initiative “Networking the networks” and global networking initiatives for health promotion in order to build a global alliance for health promotion.

**Ottawa Charter for Health Promotion**

See health promotion (section I).

**Partnership for health promotion**

A partnership for health promotion is a voluntary agreement between two or more partners to work cooperatively towards a set of shared health outcomes.

Reference: new definition.

Such partnerships may form a part of intersectoral collaboration for health, or be based on alliances for health promotion. Such partnerships may be limited by the pursuit of a clearly defined goal – such as the successful development and introduction of legislation; or may be on-going, covering a broad range of issues and initiatives. Increasingly health promotion is exploring partnerships between the public sector, civil society and the private sector.

See also social responsibility for health and primary health care (section I).

**Personal skills**

See life skills.

**Quality of life**

Quality of life is defined as individual’s perceptions of their position in life in the context of the culture and value system where they live, and in relation to their goals, expectations, standards and concerns. It is a broad ranging concept, incorporating in a complex way a person’s physical health, psychological state, level of independence, social relationships, personal beliefs and relationship to salient features of the environment.


This definition highlights the views that quality of life refers to a subjective evaluation, which induces both positive and negative dimensions, and which is embedded in a cultural, social and environmental context. WHO identified six broad domains which describe core aspects of quality of life cross-culturally: a physical domain (e.g. energy, fatigue), a psychological domain (e.g. positive feelings), level of independence (e.g. mobility), social relationships (e.g. practical social support), environment (e.g. accessibility of health care) and personal beliefs/spirituality (e.g. meaning in life). The domains of health and quality of life are complementary and overlapping.
Quality of life reflects the perception of individuals that their needs are being satisfied and that they are not being denied opportunities to achieve happiness and fulfillment, regardless of physical health status, or social and economic conditions. The goal of improving the quality of life, alongside preventing avoidable ill-health, has become of increased importance in health promotion. This is particularly important in relation to meeting the needs of older people, the chronically sick, terminally ill, and disabled populations.

**Reorienting health services**

Health services reorientation is characterized by a more explicit concern for the achievement of population health outcomes in the ways in which the health system is organized and funded. This must lead to a change of attitude and organization of health services, which focuses on the needs of the individual as a whole person, balanced against the needs of population groups.


The *Ottawa Charter* also emphasizes the importance of a health sector which contributes to the pursuit of health. Responsibility for achieving this is shared between all the health professions, health service institutions and government, alongside the contribution of individuals and communities served by the health sector. In most cases this will require an expansion in health promotion and disease prevention action to achieve an optimal balance between investments in health promotion, illness prevention, diagnosis, treatment, care and rehabilitation services. Such an expanded role need not always be achieved through an increase in direct health system activity. Action by sectors other than the health sector may be more effective in achieving improved health outcomes. Governments need to acknowledge the key role of the health sector in supporting such intersectoral action for health.

See also health-promoting hospitals.

**Risk behaviour**

Specific forms of behaviour which are proven to be associated with increased susceptibility to a specific disease or ill health.

Reference: modified definition.

Risk behaviours are usually defined as “risky” on the basis of epidemiological or other social data. Changes in risk behaviour are major goals of disease prevention, and traditionally health education has been used to achieve these goals. Within the broader framework of health promotion, risk behaviour may be seen as a response, or mechanism for coping with adverse living conditions. Strategies to respond to this include the development of life skills, and creation of more supportive environments for health.

**Risk factor**

Social, economic or biological status, behaviours or environments which are associated with or cause increased susceptibility to a specific disease, ill health, or injury.

Reference: modified definition.

As is the case with risk behaviours, once risk factors have been identified, they can become the entry point or focus for health promotion strategies and actions.
Self help

In the context of health promotion, actions taken by lay persons (i.e. non health professionals) to mobilize the necessary resources to promote, maintain or restore the health of individuals or communities.

Reference: modified definition.

Although self help is usually understood to mean action taken by individuals or communities which will directly benefit those taking the action, it may also encompass mutual aid between individuals and groups. Self help may also include self care – such as self medication and first aid in the normal social context of people’s everyday lives.

Settings for health

The place or social context in which people engage in daily activities in which environmental, organizational and personal factors interact to affect health and wellbeing.

Reference: new definition.

A setting is also where people actively use and shape the environment and thus create or solve problems relating to health. Settings can normally be identified as having physical boundaries, a range of people with defined roles, and an organizational structure.

Action to promote health through different settings can take many different forms, often through some form of organizational development, including change to the physical environment, to the organizational structure, administration and management. Settings can also be used to promote health by reaching people who work in them, or using them to gain access to services, and through the interaction of different settings with the wider community. Examples of settings include schools, work sites, hospitals, villages and cities.

Social capital

Social capital represents the degree of social cohesion which exists in communities. It refers to the processes between people which establish networks, norms, and social trust, and facilitate coordination and cooperation for mutual benefit.

Reference: new definition.

Social capital is created from the myriad of everyday interactions between people, and is embodied in such structures as civic and religious groups, family membership, informal community networks, and in norms of voluntarism, altruism and trust. The stronger these networks and bonds, the more likely it is that members of a community will cooperate for mutual benefit. In this way social capital creates health, and may enhance the benefits of investments for health.

Social networks

Social relations and links between individuals which may provide access to or mobilization of social support for health.

Reference: modified definition.
A stable society is far more likely to have established social networks which provide access to social support. De-stabilizing influences such as high unemployment, rehousing schemes, and rapid urbanization can lead to considerable dislocation of social networks. In such circumstances action to promote health might focus on support for re-establishing social networks.

**Social responsibility for health**

Social responsibility for health is reflected by the actions of decision makers in both public and private sector to pursue policies and practices which promote and protect health.


The policies and practices pursued by the public and private sectors should avoid harming the health of individuals; protect the environment and ensure sustainable use of resources; restrict the production of and trade in inherently harmful goods and substances, as well as discourage unhealthy marketing practices; safeguard the citizen in the marketplace and the individual in the workplace, and include equity-focused health impact assessments as an integral part of policy development.

See also *healthy public policy*.

**Social support**

That assistance available to individuals and groups from within communities which can provide a buffer against adverse life events and living conditions, and can provide a positive resource for enhancing the quality of life.

Reference: modified definition.

Social support may include emotional support, information sharing and the provision of material resources and services. Social support is now widely recognized as an important determinant of health, and an essential element of social capital.

**Supportive environments for health**

Supportive environments for health offer people protection from threats to health, and enable people to expand their capabilities and develop self reliance in health. They encompass where people live, their local community, their home, where they work and play, including people’s access to resources for health, and opportunities for empowerment.


Action to create supportive environments for health has many dimensions, and may include direct political action to develop and implement policies and regulations which help create supportive environments; economic action, particularly in relation to fostering sustainable economic development; and social action.
Sustainable development

Sustainable development is defined as development that meets the needs of the present without compromising the ability of future generations to meet their own needs (WCED 1987). It incorporates many elements, and all sectors, including the health sector, which must contribute to achieve it.


Human beings are at the centre of sustainable development. Sustainable development refers to the use of resources, direction of investments, the orientation of technological development, and institutional development in ways which ensure that the current development and use of resources do not compromise the health and wellbeing of future generations.

There is no single best way of organizing the complex development-environment-health relationship that reveals all the important interactions and possible entry points for public health interventions. In health promotion, sustainable development is particularly important in terms of building healthy public policy, and supportive environments for health in ways which improve living conditions, support healthy lifestyles, and achieve greater equity in health both now and in the future.
RESOURCING HEALTH PROMOTION

WHERE TO FIND RESOURCES FOR HEALTH PROMOTION

Regular national state budgets

What are they?

The national government allocates designated funds at a national level from its general income on a recurring basis for broadly-based health promotion work. These can be spent directly through a health promotion unit within a government department (usually the ministry of health) or allocated to a quasi-autonomous nongovernmental organization (QUANGO) such as a national health promotion agency. Alternatively funds can be parcelled out as long-term grants and contracts to other national organizations such as charities, professional organizations or subnational bodies such as health authorities.

What are the potential advantages?

• Demonstrates the commitment of the government
• Allows longer-term and comprehensive planning
• Encourages better coordinated work
• Enables stability and continuity
• Can help to reduce inequalities
• Open to transparent and democratic political control

What are the potential disadvantages?

• Can tend to inhibit other bodies with no specific funding for health promotion from active participation
• Can limit activities to the domain of the health sector and reduce intersectoral action
• Hard to change funding level quickly
• Does not necessarily satisfy local community health promotion needs
• Political imperatives can distort priorities and rational planning
• Constrains NGOs and other originally independent bodies

Country examples: One of the longest-standing health promotion initiatives at national level funded by government has been in Ireland. Since the 1970s progressive programmes have been running which have concentrated particularly on smoking control (e.g. the Knot campaign). Starting life as a QUANGO, the Irish Health Education Bureau was assimilated into the Department of Health in the late 1980s where the work still continues.

2 Source: Resourcing health promotion. Copenhagen, WHO Regional Office for Europe and Finland, Ministry of Social Affairs and Health and Cancer Society of Finland, 1995 (European Health Promotion Series, No. 3).
Additional national state budgets

What are they?

The national government allocates designated funds at a national level from its general income on a non-recurring basis for special health promotion projects and initiatives. These can be spent directly through a health promotion unit within a government department (usually the ministry of health) or allocated to a QUANGO such as a national health promotion agency. Alternatively, funds can be parcelled out as short-term grants and contracts to other national organizations such as charities, professional organizations or subnational bodies such as health authorities. Each project has a life of its own, with a beginning and an end. A competitive element can be introduced into the funding process.

What are the potential advantages?

- Responds quickly to an urgent situation
- Easier way to win additional resources from government
- Can result in the regular budget being uplifted at the end of the project
- Better planned and costed projects
- Evaluation is more likely to be emphasized
- Competition can help get better value for money
- Can unlock resources for further use at the end of the project

What are the potential disadvantages?

- Politically reactive and open to substantial biases
- Narrow perspectives uncoordinated with other activities
- Lack of continuity and follow-through
- Loss of skills, expertise and contacts at the end of the project
- Short-termism does not help the broader development of health promotion
- Preoccupation of keeping within budget can reduce overall impact
- Evaluation is often inaccurate or simplistic because of the short time frames
- Projects are often under-budgeted
- Favours those groups that know how to apply and win in competitive situations

Country examples: When the impact of the AIDS epidemic became apparent in the late 1980s the national body for England, the Health Education Authority (HEA), received a substantial additional budget for HIV prevention work. This almost equalled the HEA’s core budget and provided much needed assistance in strengthening health promotion work more generally. Over time these sums were absorbed into the core budget.

Regular local state budgets

What are they?

Local municipal bodies (usually health authorities) allocate designated funds from their general income on a recurring basis for broadly-based health promotion work. These can be spent directly through a health promotion unit within the authority or can be parcelled out as long-term grants and contracts to local organizations such as charities or professional organizations.
What are the potential advantages?

- Demonstrates the commitment of the authority
- Allows longer-term and comprehensive planning
- Encourages better coordinated work
- Enables stability and continuity
- Can help to reduce inequalities
- Open to transparent and democratic accountability

What are the potential disadvantages?

- Can tend to inhibit other bodies with no specific funding for health promotion from active participation
- Can limit activities to the domain of the health sector and reduce intersectoral work
- Hard to change funding level quickly
- May not synchronize with national programmes
- Local political imperatives can distort priorities and rational planning
- Constrains NGOs and other originally independent bodies

**Country examples:** In Switzerland a foundation for health promotion has been set up which combines national and local funding. It receives more than half its resources from the local cantons and the remainder comes from the federal state and health/sickness insurance funds, both private and public. In addition to the foundation there is a specific funding at federal level for prevention of HIV infections and the use of drugs. The foundation supports various projects, both cantonal, intercantonal and national.

In Wales budgets spent by government-funded health authorities have progressively increased over the last 10 years. There is now a requirement for them to spend 0.75% of their income on specialist health promotion services, which represents a ten-fold increase in the same number of years. Together with other national funding for health promotion, including financing Health Promotion Wales, approximately 1.0% of the total health service budget for Wales is spent on specialist health promotion (i.e. excluding the day-to-day health education work of doctors and nurses and preventive procedures such as immunization and contraception).

**Additional local state budgets**

What are they?

Local municipal bodies (usually health authorities) allocate designated funds from their general income on a non-recurring basis for special health promotion projects and initiatives. These can be spent directly through a health promotion unit within the authority, or can be parcelled out as short-term grants and contracts to local organizations such as charities or professional organizations. Each project has a life of its own, with a beginning and an end. A competitive element can be introduced into the funding process.

What are the potential advantages?

- Responds quickly to an urgent situation
- Easier way to win additional resources from the authority
- Can result in the regular budget being uplifted at the end of the project
- Better planned and costed projects
- Evaluation is more likely to be emphasized
- Competition can help get better value for money
- Can unlock resources for further use at the end of the project
What are the potential disadvantages?

- Politically reactive and open to substantial biases
- Narrow perspectives uncoordinated with other activities
- Lack of continuity and follow-through
- Loss of skills, expertise and contacts at the end of the project
- Short-termism does not help the broader development of health promotion
- Preoccupation of keeping within budget can reduce overall impact
- Evaluation is often inaccurate or simplistic
- Projects are often under-budgeted
- Favours those groups that know how to apply and win in competitive situations

**Country examples:** If possible, health promotion should be financed through different sectors to avoid dominance by the health sector. This has been the case in Horsens, Denmark, where the Healthy City Project of Horsens is additionally funded to encourage health promotion activities in all sectors. This kind of targeted funding allows a wider spectrum of health promotion in all settings of the city.

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**Health insurance/Sickness funds**

What are they?

Health insurance/sickness funds reimburse practitioners for specific health promotion procedures for individual patients (e.g. smoking cessation advice). They may also fund community-based health promotion programmes by direct grant aid or by contributing to a national or local health promotion budget administered by a health promotion agency set up by local or national government.

What are the potential advantages?

- Funds can be used with less political interference
- Considerable potential for substantial investments
- Flexibility in the use of resources
- Businesslike approaches may encourage better value for money

What are the potential disadvantages?

- Focus on health problems of working age people
- Targeted towards those in employment
- Emphasis on quick returns
- Problems associated with short-term funding (where appropriate) (see 2.4)
- May take health promotion to an individual-based rather than population-based approach

**Country examples:** In several European countries health insurance/sickness funds, both public and private, have an obligation to promote health and to allocate some of their resources to health promotion. They are often required to report formally on their activities. Some sickness funds (for example in Germany) are relatively free to use their resources and have done so in very innovative ways. Employers’ organizations and employees’ trades unions are generally positive towards this approach.

For example in the Netherlands there is a prevention fund, resourced by the health insurance funds, both private and public. In France there are two key sources of funding health promotion: health insurance funds are mainly used for individual preventive activities and state funding for community health promotion. (The insurance policies themselves can also be used to encourage healthy behaviour by reducing premiums for nonsmokers, those who have regular dental check-ups, etc.)
Special health taxes

What are they?

Part of the government’s tax revenue on certain items (e.g. tobacco, alcohol) is earmarked for health promotion expenditure. A specific proportion or sum is predetermined by law or regulation. This may be directly handed to a special health promotion agency (QUANGO) to administer in prescribed ways but free of direct political control. The funds can generally be used in the same manner as regular or additional state budgets (see 2.1–2.4).

What are the advantages?

- Public acceptance and support is easier to gain
- Percentage share changes logically with the tax revenue
- Substantial incomes possible
- Free from political interference
- Greater potential for innovation
- Longer-term planning and evaluation is possible
- Continuity and sustainability of programmes increased

What are the disadvantages?

- Strongly resisted by the industry concerned and those in their patronage
- Narrow definition of the purpose of funds may restrict their use
- Treasuries tend to dislike the mechanism as outside their control
- May give too much power to the unit channelling the funds
- Principle of funding health promotion by taxation of harmful substances may cause official objections
- Needs a well developed control mechanism
- Requires detailed knowledge of sales

Country examples: Several countries are now funding health promotion activities through a predetermined tax mechanism on tobacco, as shown in the table below. For example, the Victorian Health Promotion Foundation was established in November 1987 as an independent statutory body and is funded by a wholesale tax levied on tobacco products. This levy raises approximately AUS $30 million each year which is then disbursed by the Foundation whose remit is to promote food health and prevent disease, accident or disability. As well as breaking new ground through its programme of tobacco sponsorship replacement in sport and the arts, the Victorian Health Promotion Foundation also funds public health research and community-based health promotion projects. This integrated funding approach ensures that the Foundation supports a range of health promotion methods across a broad span of community and health sectors.

Further information on the schemes in other countries is presented below.

<table>
<thead>
<tr>
<th>Country</th>
<th>Year of legislation</th>
<th>Share of revenue</th>
<th>Revenue source</th>
<th>Defined purpose</th>
</tr>
</thead>
<tbody>
<tr>
<td>Australia (Victoria)</td>
<td>1987</td>
<td>5%</td>
<td>Tobacco cross sale</td>
<td>Health promotion</td>
</tr>
<tr>
<td>Finland</td>
<td>1976</td>
<td>0.45%</td>
<td>Tobacco excise tax</td>
<td>Health education and promotion</td>
</tr>
<tr>
<td>USA (California)</td>
<td>1988</td>
<td>20%</td>
<td>Tobacco surtax (25 c/pack)</td>
<td>Tobacco control</td>
</tr>
<tr>
<td>Portugal</td>
<td>1991</td>
<td>1%</td>
<td>Tobacco tax</td>
<td>Cancer control</td>
</tr>
<tr>
<td>Iceland</td>
<td>1984</td>
<td>0.2%</td>
<td>Tobacco gross sale</td>
<td>Anti-smoking</td>
</tr>
</tbody>
</table>

Lotteries

What are they?

Funds are raised by collecting profits from slot machines and gambling activities such as raffles and football pools. The lottery is usually set up to raise money for specified social purposes and is administered by a special body or company. Resources can be distributed in response to applications or as grants to public and voluntary organizations.

What are the potential advantages?

- Funds are earmarked and cannot be used for other purposes
- Allocation does not have to conform to governmental strategies and constraints
- Local organizations can receive direct support
- Opportunity for innovation and development work

What are the potential disadvantages?

- Reactive with little long-term planning
- Uncoordinated work with reduced continuity
- Tendency for stagnation if strategic reviews are not carried out

Country examples: In Finland there is a monopoly which owns gambling machines. Profits are distributed mostly to NGOs for health promotion or other activities.

Loans

What are they?

A loan is taken out from a bank to finance a specific activity or purchase which is agreed in advance. The security of the loan has to be guaranteed. A programme of repayments of both capital and interest is drawn up for a long or short period.

What are the potential advantages?

- Enables capital purchases to be made if capital budgets are not available
- Allows projects and programmes to be started in the absence of sufficient revenue budgets
- Low interest rates can be found from philanthropic organizations

What are the potential disadvantages?

- Once agreed, loan conditions are hard to change
- Repayments may cause severe financial constraints unless additional funding has been previously found
- Paying interest costs money
- Finding securities are difficult unless the government will guarantee the loan. Require solid country health promotion infrastructure both to negotiate good loans deals and to absorb the loan locally

Country examples: A number of governments of central and eastern European countries (such as Croatia, Hungary, Poland and Romania) have successfully taken out loans for health promotion from the World Bank. The success of these has been mixed; delays have occurred due to inadequate planning, weak health promotion infrastructure, inexperience in loan implementation or difficulties over the loan agreement.
Foreign aid grants

What are they?

Funds, services or equipment are provided by governments or organizations from abroad in response to particular health needs for which there has often been public concern in their own countries. This commonly takes the form of either humanitarian assistance or development aid in which the donor has some interest.

What are the potential advantages?

- Support is mostly provided free of charge
- Assistance is provided quickly

What are the potential disadvantages?

- Support may not actually be needed or be realized in the best form for the receiving country
- Revenue consequences (maintenance of equipment, etc.) may cause problems in the future
- Externally provided services may de-skill local resources
- Operational factors may be disruptive and time-consuming
- Maintains dependence on outside assistance
- Feelings of inadequacy and disempowerment
- Opportunities for uncontrollable vested interests

Country examples: Concerns for the HIV/AIDS epidemic have prompted a number of western countries to provide valuable technical assistance and funding support to eastern Europe. Examples can also be found for the control of illicit drug use. The European Union PHARE programme has been utilized, with varied degrees of impact, in several countries of central and eastern Europe; increasingly it has opened up to health promotion areas of intervention.

Private sector donations

What are they?

Companies give grants to fund specific activities, materials or items of equipment. These are usually in response to health issues which are of widespread concern so that the company can benefit from positive public relations. Often companies have special funds to provide funding for community work. There are tax advantages for making donations. Often staff associations are instrumental in obtaining the funding. Sometimes companies set a target for spending such as 1% of their profits.

What are the potential advantages?

- Useful funds are available, often quite quickly
- Often focuses on important felt needs in the local community
- Funds can be used outside direct government control
- Funds can often be drawn down when required and rolled forward to the next year
What are the potential disadvantages?

- Hard to compete for support against other more emotive subjects
- Demand-reactive and open to substantial biases
- Narrow perspectives uncoordinated with other activities
- Lack of continuity and follow-through
- Loss of skills, expertise and contacts at the end of the project
- Short-termism does not help the broader development of health promotion
- Public or professional support may be lost

**Country examples:** There are a number of international companies with charitable funds that have a long track record of supporting health promotion and other socially-oriented activities, including the Kellogg’s and Ford Foundations and the Philanthropic Committee of Johnson & Johnson. National companies are also becoming more interested and examples can be found among supermarkets, banks and retailers. Educational grants can often be obtained to support training in health promotion, for example through the Sires Foundation.

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**Private sector sponsorships**

What are they?

Funds are provided for specific health promotion projects by commercial companies under sponsorship agreements which allows them to be publicly associated with the project. The marketing impact of this may be low key with the aim simply to demonstrate the caring and pro-social nature of the company and to win positive public relations support. Alternatively, the marketing may be designed to promote vigorously a particular brand name. The mere association with a community health promotion project is often sufficient for the product to be viewed by the public as endorsed or approved by the health promotion body concerned. This is often perceived by companies as being extremely valuable in itself. A sponsorship relationship ties health promotion work more closely with commercial interests.

What are the potential advantages?

- Substantial funds are available, often quite quickly
- Often focuses on important felt needs in the local community
- Easier to win support for projects concerning exercise, nutrition, safety, dental care
- Funds can be used flexibly outside direct government control
- Funds can be drawn down when required and rolled forward to the next year

What are the potential disadvantages?

- Ethical values may be compromised
- Products involved may not be health-promoting, e.g. some food stuffs, drugs
- Competitor companies may be jealous and not contribute in other ways
- Hard to compete for support against other more emotive subjects
- Public or professional support may be lost
- Hard to demonstrate commercial benefits in controversial or unpopular areas
- Objectives can become distorted and strategic directions lost
- Narrow perspectives uncoordinated with other activities
- Lack of continuity and follow-through
- Loss of skills, expertise and contacts at the end of the project
- Short-termism does not help the broader development of health promotion
Country examples: Numerous cases can be found of successful sponsorships of health promotion projects where the disadvantages above have been minimized. Manufacturers of sporting equipment, producers of low fat products, supermarket chains offering healthy choices, low or no alcohol drinks producers are just a few sources of funding. More difficult has been the area of smoking control but now there are good examples of producers of nicotine substitutes having a genuine interest in promoting health and sponsoring quit smoking campaigns.

Private sector partnerships

What are they?

Resources are provided jointly by commercial companies and health promotion bodies for projects which are mutually beneficial, i.e. they promote health as well as the interests of the company. Marketing budgets of the companies are used extensively and there is very full involvement of the marketing staff. This is the closest type of relationship with commercial organizations. The gains for the company need to be quantified financially.

What are the potential advantages?

- Substantial resources are available, often quite quickly
- Often focuses on important felt needs in the local community
- Easier to win support for projects concerning exercise, nutrition, safety, dental care
- Funds can be used flexibly outside direct government control
- Funds can be drawn down when required and rolled forward to the next year

What are the potential disadvantages?

- Projects are jointly managed or managed almost entirely by the company concerned
- Ethical values may be compromised
- Products involved may not be health-promoting, e.g. some food stuffs, drugs
- Competitor companies may be jealous and not contribute in other ways
- Hard to compete for support against other more emotive subjects
- Public or professional support may be lost
- Hard to demonstrate commercial benefits in controversial or unpopular areas
- Objectives can become distorted and strategic directions lost
- Narrow perspectives uncoordinated with other activities
- Lack of continuity and follow-through
- Loss of skills, expertise and contacts at the end of the project
- Short-termism does not help the broader development of health promotion

Country examples: In the Netherlands the funding of health promotion is based on several different resources. The state funds approximately 60% of the activities of the national health promotion unit. The rest comes from various sources, project by project. The major public health foundations are wealthy and their funding by the state is minimal, so that they are not under political control. It could be estimated that approximately 50% of health promotion is funded privately and the other half by the government.
Trading profits

What are they?

Funds are raised from the profits of trading activities such as sales or rental of health education materials, surplus equipment, or facilities or services such as consultancy, counselling and screening. Usually this form of income generation activity requires venture capital or spare staff/facility capacity. Business skills are essential. There are often tax and investment advantages from setting up a trading company back-to-back to a charitable trust. Trading can take place directly with the general public or with other organizations.

What are the potential advantages?

• Resources raised can be used flexibly, as they need not be constrained by the requirements of funders/donors
• Funds can be kept in a trust fund or a separate bank account and can be drawn on in a subsequent financial year

What are the potential disadvantages?

• Considerable venture capital or spare staff/facility capacity may not be available
• Government funders may subtract from their allocation an equivalent sum to that raised by trading
• Inputs from senior management can be quite time-consuming
• Return on investment may be quite small
• Losses can occur as in any business venture
• Trading activities may compromise the organization’s values, programmes and partners
• Remit of the health promotion organization may prohibit trading activities or restrict them

Country examples: The United Kingdom national health promotion agencies have some experience of income generation activities which support health promotion work. These chiefly concern the sale of literature to organizations (such as employers’ organizations) or the general public through mail order or high street retailers. The return on the investment has not been that great.

Workplace funds

What are they?

Employers and/or trade unions provide funds for health promotion work, which is generally directed at staff in a particular workforce. Trade unions tend to be interested more in the quality of working conditions and employers in the health behaviour of individuals. Both see advantages in improving health status for staff morale, public relations and productivity. The programme can comprise a combination of lifestyle questionnaires, medical screening, counselling for specific behavioural support (e.g. exercise, stopping smoking), training (e.g. resuscitation skills), and environmental improvements (e.g. healthy canteens).

What are the potential advantages?

• Funding is directed at practical programmes which promote health
• Workplace settings provide a good opportunity to reach adults
• Programmes in the home and wider community can be initiated and supported
What are the potential disadvantages?

- Activity is very sensitive to the financial situation of the employer/trade union at the time
- Cash flow can be a problem if additional staff salaries have to be paid for in advance
- Inequalities can increase as programmes are directed to those in work
- Action can tend to focus on behavioural aspects and “victim-blaming”
- Workloads can fluctuate, making business management difficult

Country examples: Some national and district health promotion agencies in the United Kingdom have considerable experience of this type of activity. Generally the result has been positive and rewarding. Often slight surpluses are made which can be reallocated to other health promotion work. It is also interesting to note that the commercial service sector now sees this as a potential growth area and is beginning to provide private schemes.

Charitable donations

What are they?

Funds are raised by voluntary donations from charitable bodies as well as the general public. It can help if the recipient organization is also a registered charity to avoid tax on the interest from investments and to benefit from rate reductions, discounts, etc. Special fund-raising activities are usually necessary such as flag days and street collections, newspaper advertising, establishing local community groups, mail shots to charities, solicitors for wills, etc.

What are the potential advantages?

- Resources can be used flexibly outside the control of government
- Fund-raising itself can develop positive public support and support health education
- Monies can be invested to produce income
- Funds can be drawn down when required and rolled over from one year to the next

What are the potential disadvantages?

- Venture capital is often needed
- It is often necessary to employ a competent fund-raiser
- Return on investment of time and money can be quite limited
- Losses and disruptions can occur

Country examples: A number of the charitable health organizations have an important health promotion remit. These include many national heart and cancer charities e.g. in Finland and the Netherlands. Experience shows that health promotion issues often stimulate public donations and help to balance the research orientation that many of these bodies also have. Considerable amounts of money can be raised with proper management. In the United Kingdom the Heartbeat Wales Charitable Trust brought in some very valuable funding which was used to support local heart health initiatives.
Health promotion trusts

What are they?

Funds are provided by a specific trust which has been set up to finance health promotion. The trust often derives its resources from compulsory or voluntary subscriptions from commercial organizations (sometimes referred to as “conscience money”). Because of the source of the finance, specific restrictions may apply to the use of the funds, for example contributions from the alcohol industry may go into a fund which can only be used to support alcohol education and research activities.

What are the potential advantages?

- Resources from unhealthy commercial interests are “cleaned” and used to fund health promotion over and above state levels
- Resources can be used flexibly outside formal government controls
- Monies can be invested to produce income
- Funds can be drawn down when required and rolled over from one year to the next

What are the potential disadvantages?

- Unhealthy commercial interests may win favour politically and/or publicly so that they can continue their activities without further regulation
- Direction is determined by trustees who may be influenced by the source of funding or may not be aware of health promotion values and methodologies

Country examples: Some countries have monopolies for sales of alcohol. This gives the state the option to use the money for health purposes, among other things. In Finland and some other Nordic countries much discussion has surrounded the role of these monopolies in actually encouraging and advancing the harmful effects of alcohol. This dilemma has often been solved by making them support research, inform the public, and show some interest in the care of the victims. This has created ethical problems for health promoters who have been unsure whether to accept funding from these sources.

Even more difficult is the area of tobacco, because in many countries there is a state monopoly. A well known example of a conflict of interest in receiving funds is in the United Kingdom where the Government set up a Health Promotion Research Trust. Funds were provided by the tobacco industry who also appointed some of the trustees (i.e. directors). Research projects concerning smoking were explicitly excluded from funding support. This caused considerable division and disharmony among health researchers as some accepted funding while others rejected it on a point of principle. Other somewhat problematic areas are monopolies of the oil industry or refineries and pharmaceutical companies.

Services in kind

What are they?

Additional resources for health promotion are obtained through the contribution of people’s time and the use of facilities and equipment. For example:

- volunteers help with community outreach programmes
- staff are seconded from a commercial organization to help manage a programme
- teachers and nurses change their work programmes to support a project
- a voluntary organization “adopts” a health promotion project or “cause”
• rooms and facilities are loaned without payment
• office support (e.g. photocopying, telephone) is given without charge
• local council rates and taxes on a building are waived
• free media time is given (e.g. public service announcements, features articles and programmes).

Such support can be vital for the success of health promotion work and can be very substantial. Yet on paper there is no actual money transaction.

What are the potential advantages?
• Wins commitment from key partners
• Resources can be used flexibly outside formal government controls
• Supports partnership and ownership
• Financial management and accountability avoided
• Future assimilation of programmes more likely

What are the potential disadvantages?
• Can distort priorities and strategic directions
• Inputs can fluctuate considerably
• Continuity and reliability can be a problem
• Harder to manage people as they are not accountable to you
• Can become cumbersome and inefficient
• Projects can “run off the rails”

**Country examples:** Health promotion is not health promotion if there is not free and willing participation of others in programme development and implementation. As a result there are many examples throughout Europe of services in kind, including the active support of volunteers, community leaders, teachers, nurses, doctors, journalists, retailers, even publicans, bank managers and politicians. Many of the large community interventions such as the Stockholm Cancer programme, Heartbeat Wales, CINDI programme areas, Healthy Cities projects, and the Health Promoting Schools projects in Denmark, Hungary, Slovenia and Sweden have benefited considerably from a range of additional resources that are not measured in terms of dollars but in hours, column inches and use of facilities. These services in kind not only provide valuable resources but also emphasize the health promotion ethos.

**Research grants**

What are they?

Funds are provided by research bodies to finance basic and applied research but more usually intervention studies or health needs assessments. The intervention component does not usually receive funding as this is seen as a service responsibility outside the remit of the research funding body.

What are the potential advantages?
• Evaluation is given a high priority
• Planning is thorough and objectives are clear
• Projects are carefully reviewed prior to funding
• Scientific theories and methodologies are incorporated
• Advances the scientific base of health promotion
What are the potential disadvantages?

- Hard for those without strong research backgrounds to apply
- Scientific objectives and timetables come before health promotion ones
- Staffing and resources are biased towards the research needs
- Projects can be often unrealistic or idealistic in their delivery
- Intervention components can often be weak
- Poor continuity, integration, sustainability and assimilation
- May answer research questions but does not promote public health

**Country examples:** Heart health programmes throughout the world have been greatly assisted by the pioneering work undertaken in the United States by the National Heart, Lung and Blood Institute of the National Institutes of Health. During the 1980s three community-based heart disease prevention studies were set up: the Stanford Heart Disease Prevention Program, the Minnesota Heart Health Program, and the Pawtucket Heart Health Program. As well as contributing to advances in knowledge about the epidemiology of heart disease and health promotion methodologies, they also made a substantial contribution to community improvements in health. This was largely accomplished through generous funding support from research bodies. Innovative experience can also be found in Canada where the Directorate for Health Promotion at federal level is playing a crucial facilitating role in supporting health promotion research at provincial level and the establishment of a network of health promotion centres. European experience has not matched this but the German Heart Programme (DHP) and the Kilkenny Heart Programme in Ireland have made important strides in promoting health with largely research funding as the financial base.