Healthy Islands – Health Promotion

Facilitators’ Guide to the Train-the-Trainers Workshop
for Pacific faith-based organizations and local governments

RESOURCES FOR CONDUCTING TRAINING TO REDUCE MODIFIABLE BEHAVIOURAL RISK FACTORS FOR NONCOMMUNICABLE DISEASES (TOBACCO USE, UNHEALTHY EATING, PHYSICAL INACTIVITY AND HARMFUL USE OF ALCOHOL)
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INTRODUCTION

The concept of Healthy Islands was envisioned at the first Pacific Health Ministers Meeting in Yanuca Island, Fiji, in 1995 when the Healthy Islands vision was adopted as a “unifying theme for health promotion and protection in the island nations of the Pacific for the twenty-first century”. The Healthy Islands vision depicts the Pacific islands as a place where: children are nurtured in body and mind; environments invite learning and leisure; people work and age with dignity; ecological balance is a source of pride; and the ocean – which sustains us – is protected.

The Healthy Islands initiative aims to realize this vision through the implementation of innovative settings-based approaches to promoting the health of island people and communities. Various health initiatives have been carried out in the different Pacific island countries and areas by governments, civil society and community groups.

Faith-based organizations are extensive in Pacific island countries and areas, with most of the population affiliated with a faith-based organization. Many activities in communities are led by these organizations. Harnessing their networks, reach and influence is of critical importance in improving people's health. In order to strengthen the capacity of faith-based organizations in the Pacific, the World Health Organization (WHO) developed this Facilitators’ Guide to the Train-the-Trainers Workshop.
USING THE FACILITATORS’ GUIDE

WHAT IS THE GUIDE DESIGNED FOR?

The Facilitators’ Guide is intended to build the capacity of leaders of faith-based organizations so that they may go on to train other members in their organization and community.

The Guide includes sessions which describe and present case studies that highlight components of the health promotion and planning and evaluation cycle, including situation analysis, planning, implementation and evaluation.

WHO SHOULD USE THE GUIDE?

The Guide is meant for leaders of faith-based organizations who are interested in training others to ensure their faith-based settings are health promoting.

It may be easier for those with some background in community mobilization, programme planning, public health, or similar experience to utilize the Guide and facilitate the training.

The case studies highlighted in the Guide are based on the *Healthy Islands: best practices in health promotion in the Pacific* publication.

HOW SHOULD THE GUIDE BE USED?

Presentation and learning materials

The Guide consists of a set of PowerPoint presentations corresponding to each of the following:

- Healthy Islands vision and health promotion principles
- Social determinants of health
- Health promotion planning cycle
- Monitoring and evaluation.
Numbered PowerPoint slides are provided for each topic (see Table 1).

Facilitators are encouraged to add to and adapt the presentations to suit the context and specific needs of participants by including their own resources.

<table>
<thead>
<tr>
<th>TITLE</th>
<th>POWERPOINT SLIDE NUMBERS</th>
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<tbody>
<tr>
<td>Faith-based organizations – where it all started</td>
<td>Session 1</td>
</tr>
<tr>
<td>Building from common foundations</td>
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<tr>
<td>Universal attributes of faith-based organizations</td>
<td>Session 1</td>
</tr>
<tr>
<td>Healthy Islands vision and health promotion</td>
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<tr>
<td>Introduction to the Healthy Islands vision and health promotion principles</td>
<td>Session 2</td>
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<tr>
<td>Faith-based organizations – local contexts</td>
<td>Session 2</td>
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<tr>
<td>Potential actions towards reduction of noncommunicable disease</td>
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<td>modifiable behavioural risk factors</td>
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<tr>
<td>Social determinants of health</td>
<td>Session 3</td>
</tr>
<tr>
<td>Health promotion planning and evaluation cycle</td>
<td>Session 4</td>
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<tr>
<td>Situation analysis: Building an evidence base</td>
<td>Session 5</td>
</tr>
<tr>
<td>Situation analysis: Adapting global/regional guidelines</td>
<td>Session 5</td>
</tr>
<tr>
<td>Situation analysis: Strategic resourcing</td>
<td>Session 5</td>
</tr>
<tr>
<td>Planning: Goal and objective setting</td>
<td>Session 6</td>
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<tr>
<td>Planning: Defining target population(s) and identifying entry point(s)</td>
<td>Session 6</td>
</tr>
<tr>
<td>Implementation: Building capacity</td>
<td>Session 7</td>
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<tr>
<td>Implementation: Strategic resourcing</td>
<td>Session 7</td>
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<tr>
<td>Monitoring and evaluation</td>
<td>Session 8</td>
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<tr>
<td>Planning a way forward</td>
<td>Session 9</td>
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</tbody>
</table>
PRINCIPLES OF ADULT LEARNING

In line with adult learning principles and philosophy, this training is intended to be presented in an interactive style. It is recommended that presentations include the use of demonstrations, role playing, case studies and hands-on practice to involve participants directly and actively in the learning process.

SUGGESTED GROUP SIZE

The ideal size for the workshops described is 10 to 15 participants, who preferably share similar levels of awareness about health promotion and public health.

LEARNING OBJECTIVES

At the end of the training, participants will be able to:

1. determine effective strategies to reduce tobacco use, promote healthy eating, increase physical activity and decrease harmful use of alcohol;
2. discuss the examples highlighted in the Healthy Islands: best practices in health promotion in the Pacific document;
3. identify the social determinants of health and describe their impact on health promotion strategies; and
4. discuss the challenges and opportunities to developing health promotion programmes in community settings.
ORGANIZING A HEALTHY WORKSHOP

It is important to try to run your workshop in a healthy manner. All venues should be free of tobacco, betel nut, kava and alcohol.

EAT HEALTHY

Ensure that:

- Drinking water is available at all times (preferably in jugs instead of plastic bottles);
- Foods low in fat, salt and sugar are available for teas and meals (for example, the use of minimal amounts of margarine in place of butter; baked or fresh foods instead of fried);
- Whole grain options are available in place of white rice/flour;
- Healthy, plant-based options are available for people who do not consume meat or animal products;
- Sauces and dressings are served on the side;
- All meals include fresh fruit and/or vegetables (such as sticks of carrots, cucumber, under-ripe papaya, tomatoes);
- Religious dietary restrictions are considered;
- Reputable and trustworthy caterers are used; and
- Food is covered while waiting for the meeting break.
ENCOURAGE PHYSICAL ACTIVITY

Ensure that:

- Physical activity is incorporated into the meeting through mobility breaks;
- Time for exercise is encouraged; and
- Exercise facilities are accessible in/near the meeting venue.

PROMOTE ENVIRONMENTALLY FRIENDLY OPTIONS

Ensure that:

- Reusable materials are used for serving;
- Room temperature is not too cold;
- Water jugs and reusable glasses are used in place of single-use plastic bottles; and
- Printed materials are limited; promote electronic sharing options instead.
TRAIN-THE-TRAINERS WORKSHOP

DESCRIPTION OF THE TRAINING

| AUDIENCE | Members of faith-based organizations or local governments |
| PURPOSE | To strengthen capacity to develop and implement “Healthy Islands” faith-based health promotion interventions |
| KEY CONTENT | • Healthy Islands vision and health promotion principles  
• Social determinants of health  
• Health promotion planning and evaluation cycle  
• Monitoring and evaluation |
| MATERIALS | Multimedia projector with laptop (and connections)  
Whiteboard (with markers)  
Flip-chart paper  
Flip-chart stand  
Participant name tags or stickers  
Power board(s)  
Extension cords  
Pens/pencils |
**PROGRAMME**

The learning objectives of the workshop are to:

1. determine effective strategies to reduce tobacco use, promote healthy eating, increase physical activity and decrease harmful use of alcohol;
2. discuss the examples highlighted in the *Healthy Islands: best practices in health promotion in the Pacific* document;
3. identify the social determinants of health and describe their impact on health promotion strategies; and
4. discuss the challenges and opportunities to developing health promotion programmes in community settings.

**OUTCOME**

The expected outcome of the workshop is strengthened capacity to develop and implement “Healthy Islands” faith-based health promotion interventions.
# HEALTHY WORKSHOP

## SUGGESTED TWO-DAY PROGRAMME AND TIMETABLE

### Day 1

<table>
<thead>
<tr>
<th>SESSION</th>
<th>TIME</th>
<th>TOPICS</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>08:30</td>
<td><strong>Registration</strong></td>
</tr>
<tr>
<td>Session 1</td>
<td>09:00</td>
<td>Welcome/opening</td>
</tr>
<tr>
<td></td>
<td>09:10</td>
<td>Overview of resource materials</td>
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<tr>
<td></td>
<td>09:20</td>
<td>Faith-based organizations – where it all started</td>
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<td>Building from common foundations</td>
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<td>Universal attributes of faith-based organizations</td>
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<td>09:50</td>
<td><strong>Healthy Islands vision and health promotion</strong></td>
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<td>Introduction to the Healthy Islands vision and health promotion principles</td>
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<td></td>
<td>10:20</td>
<td>Break</td>
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<td>10:35</td>
<td>Faith-based organizations – local contexts</td>
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<td></td>
<td></td>
<td>Potential actions towards reduction of noncommunicable disease modifiable behavioural risk factors</td>
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<tr>
<td>Session 3</td>
<td>11:00</td>
<td><strong>Social determinants of health</strong></td>
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<td>Group activity</td>
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<td>Discussion and summary</td>
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<tr>
<td>SESSION</td>
<td>TIME</td>
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<tr>
<td><strong>Session 4</strong></td>
<td>11:45</td>
<td><strong>Health promotion planning and evaluation cycle</strong></td>
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<td>- Situation analysis</td>
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<td>- Building an evidence base</td>
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<td>- Building on local knowledge and practices</td>
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<td>- Goal and objective setting</td>
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<td>- Strategic resourcing</td>
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<td>- Monitoring and evaluation</td>
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<td>12:30</td>
<td><strong>Lunch break</strong></td>
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<tr>
<td><strong>Session 5</strong></td>
<td>13:30</td>
<td><strong>Situation analysis: Building an evidence base</strong></td>
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<td></td>
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<td>Case study 1: Reducing imports of fizzy drinks in Tokelau</td>
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<td>Group activity</td>
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<td>Discussion and summary</td>
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<td>14:00</td>
<td><strong>Situation analysis: Analysing data</strong></td>
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<td>Case study 2: Analysing childhood obesity in the Commonwealth of the Northern Mariana Islands</td>
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<td>Group activity</td>
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<td>Discussion and summary</td>
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<td></td>
<td>14:30</td>
<td><strong>Situation analysis: Building on local knowledge and practices</strong></td>
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<td>Case study 3: Strengthening food security in Pohnpei, Federated States of Micronesia</td>
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<td>Group activity</td>
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<td>Discussion and summary</td>
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<td>15:30</td>
<td><strong>Situation analysis: Adapting global/regional guidelines</strong></td>
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<td>Case study 4: Strengthening NCD prevention and management in Samoa</td>
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<td>Group activity</td>
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<td>Discussion and summary</td>
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<td>15:30</td>
<td><strong>Break</strong></td>
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<td></td>
<td>15:45</td>
<td><strong>Situation analysis: strategic resourcing</strong></td>
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<td>Case study 5: Strategic resourcing to support improvements in sanitation in Vanuatu</td>
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<td>Group activity</td>
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<td></td>
<td>Discussion and summary</td>
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<tr>
<td></td>
<td>16:45</td>
<td><strong>Wrap-up</strong></td>
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### Day 2

<table>
<thead>
<tr>
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<tr>
<td>08:30</td>
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<tr>
<td>09:00</td>
<td><strong>Recap of Day 1</strong></td>
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<tr>
<td>09:30</td>
<td><strong>Planning: Goal and objective setting</strong></td>
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<td></td>
<td>Case study 6: Sound planning – Healthy Sianios and Samo Villages, Lihir Island, Papua New Guinea</td>
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<td></td>
<td>Group activity: Community action and participation</td>
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<td>Discussion and summary</td>
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<td>10:15</td>
<td><strong>Break</strong></td>
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<td>10:30</td>
<td><strong>Planning: Defining target population(s) and identifying entry point(s)</strong></td>
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<td>Group activity</td>
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<td>Discussion and summary</td>
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<td>11:15</td>
<td><strong>Implementation</strong></td>
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<td>Case study 7: Flexible implementation for Kau Mai Tonga in Tonga</td>
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<td></td>
<td>Group activity: Increase physical activity in your community</td>
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<td>Discussion and summary</td>
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<td>12:30</td>
<td><strong>Lunch break</strong></td>
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<tr>
<td>13:30</td>
<td><strong>Implementation: Strategic resourcing</strong></td>
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<tr>
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<td>Case study 8: Establishing smoke-free settings in Honiara, Solomon Islands</td>
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<td>Discussion and summary</td>
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<tr>
<td>14:30</td>
<td><strong>Monitoring and evaluation</strong></td>
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<td>What should I evaluate?</td>
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<td>Evaluation research methods/data collection tool</td>
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<td>Group activity</td>
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<td>Discussion and summary</td>
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<td><strong>Break</strong></td>
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<td>15:45</td>
<td><strong>Planning a way forward</strong></td>
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<td>Group activity</td>
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<td>Group presentations</td>
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<td>16:45</td>
<td><strong>Wrap-up</strong></td>
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</tbody>
</table>
ANNEX 1.

HEALTH PROMOTION

Health promotion is defined by WHO as “the process of enabling people to increase control over, and to improve, their health. It moves beyond a focus on individual behaviour towards a wide range of social and environmental interventions.”

There are four key principles of health promotion:

- It addresses the underlying determinants of health and not just proximal causes.
- Is largely determined outside of the health sector.
- It emphasizes prevention.
- It embraces positive health and not just the absence of disease.

Health promotion is distinct from (and not to be confused with) health protection

Health protection has a narrower definition and is focused on preventing and controlling communicable disease and environmental health threats (which are negative health outcomes). It is typically the responsibility of health departments and health services and is more of a historical response to the causes of disease. Health promotion is broader and focused on both encouraging positive health outcomes and preventing negative health outcomes, including from communicable diseases, noncommunicable diseases, as well as injury and violence. It is everyone’s responsibility and a newer approach that takes a more holistic view of health. The Ottawa Charter for Health Promotion (1986) is central to health promotion and remains highly relevant as a guide to health promotion today.

The Ottawa Charter for Health Promotion was an agreement at the First International Conference on Health Promotion as a way forward to bring about positive change for health promotion. It adopts each of these principles just discussed, which are incorporated into the framework for action (Fig. 1).
At the core of the Ottawa Charter are three components which are central to achieving health promotion.

**Advocate:** Political, economic, social, cultural, environmental, behavioural and biological factors can all favour health or be harmful to it. Health promotion action aims at making these conditions favourable through advocacy for health.

**Enable:** Health promotion focuses on achieving equity in health. Health promotion action aims at reducing differences in current health status and ensuring equal opportunities and resources to enable all people to achieve their fullest health potential.

**MEDIATE:** The prerequisites and prospects for health cannot be ensured by the health sector alone. More importantly, health promotion demands coordinated action by all concerned – by governments, health and other social and economic sectors, nongovernmental and voluntary organizations, local authorities, industry and the media. People in all walks of life are involved as individuals, families and communities. Professional and social groups and health personnel have a major responsibility to mediate between differing interests in society for the pursuit of health.

Ottawa Charter: Action Areas

Build healthy public policy
- This involves putting health on the agenda of policy-makers in all sectors and at all levels, directing them to be aware of the health consequences of their decisions and to accept their responsibilities for health. This action area includes diverse approaches such as legislation, fiscal measures, taxation and organizational change.

Create supportive environments
- People are inextricably linked to their environment and we need to take care of each other, our communities and our natural environment. Patterns of life, work and leisure have a significant impact on health, and health promotion generates living and working conditions that are safe, stimulating, satisfying and enjoyable. Assessing the health impact of a rapidly changing environment and action to ensure positive benefits to health is essential; our natural and built environments must be protected.

Strengthen community action
- Health promotion works through concrete and effective community action in setting priorities, making decisions, planning strategies and implementing them to achieve better health. At the heart of this process is the empowerment of communities, their ownership and control of their own endeavours and destinies. Community development draws on existing human and material resources to enhance self-help and social support to develop flexible systems and strengthen public participation in and direction of health matters.

Develop personal skills
- Health promotion supports personal and social development through providing information, education for health and enhancing life skills. By so doing, it increases the options available to people to exercise more control over their health and their environments, and to make choices conducive to health. Lifelong learning is essential and has to be facilitated in school, home, work and community settings.

Reorient health services
- Individuals, community groups, health professionals, health service institutions and governments must work together towards a health-care system which contributes to the pursuit of health. The health sector must move increasingly in a health promotion direction – beyond its responsibility for providing clinical and curative services – and refocus on the total needs of the individual as a whole person. Included here is sensitivity to and respect for cultural needs, supporting the needs of individuals and communities for a healthier life, and open channels between the health sector and broader social, political, economic and physical environmental components.

Adapted from: Health Promoting Schools: Experiences from the Western Pacific Region (WHO Regional Office for the Western Pacific, 2017); 1st International Conference on Health Promotion, Ottawa, 1986 (http://www.who.int/healthpromotion/conferences/previous/ottawa/en/).
What are the social determinants of health?

Social determinants of health (SDH) are the non-medical factors that influence health outcomes. They are the conditions in which people are born, grow, work, live and age, and the wider set of forces and systems shaping the conditions of daily life. These forces and systems include economic policies and systems, development agendas, social norms, social policies and political systems.

SDH have an important influence on health inequities – the unfair and avoidable differences in health status seen within and between countries. In countries at all levels of income, health and illness follow a social gradient: the lower the socioeconomic position, the worse the health.

The following list provides examples of SDH, which can influence health equity in positive and negative ways:

- income and social protection
- education
- unemployment and job security
- working life conditions
- food insecurity
- housing, basic amenities and the environment
- early childhood development
- social support and inclusion
- structural conflict
- access to affordable health services of decent quality.

Research shows that social determinants can be more important than health care or lifestyle choices in influencing health. For example, numerous studies suggest that SDH account for between 30% and 55% of health outcomes. In addition, estimates show that the contribution of sectors outside health to population health outcomes exceeds the contribution from the health sector.

Addressing SDH appropriately is fundamental for improving health and reducing long-standing inequities in health, which requires action by all sectors and civil society.
A social gradient refers to the fact that socially disadvantaged people typically have worse health outcomes than those who are more advantaged. However, it is not enough to simply understand health inequities. Adopting a SDH lens to view a health issue also requires looking at three different levels of causes:

<table>
<thead>
<tr>
<th>LEVEL OF THE CAUSE</th>
<th>DESCRIPTION</th>
<th>EXAMPLES</th>
</tr>
</thead>
<tbody>
<tr>
<td>Distal (farthest away from an individual's health status) or societal</td>
<td>Cultural, political, and infrastructural causes</td>
<td>Education, income, housing conditions, air quality, access to food and water, road safety</td>
</tr>
<tr>
<td>Intermediate</td>
<td>Relationships, social contexts</td>
<td>Community factors, including those related to work, school, family and peer environments</td>
</tr>
<tr>
<td>Proximal (closest to an individual's health status) or individual</td>
<td>Behaviours, capabilities, attitudes and direct biological threats to health</td>
<td>Hygiene habits; exposure to disease vectors that cause diarrhoea, dengue, malaria</td>
</tr>
</tbody>
</table>

At the distal level are the wider circumstances in which people live, including broader cultural values, national or international political forces, laws or policies, or cross-cutting exposures such as those related to climate, conflict or the media. These factors are called distal because they are not directly related to the individual but rather establish the wider context in which a person lives. At the intermediate level are factors related to communities, workplaces, schools, or families that define an individual’s more immediate social environments. Finally, at the proximal level are factors directly related to individuals themselves that impact health, including personal biology, behaviours, capabilities, or attitudes.

Considering the different levels at which determinants operate can help keep track of a complex array of contributing factors, while also highlighting potential pathways between social exposures and physical health.

**SDH within the broader context of global health**

When we think about complex public health challenges, it is easy to get lost in the vast web of causes and consequences impacting populations and individuals around the globe. With that in mind, facilitators often use conceptual frameworks (or thinking tools) to break down complicated problems into their component parts when teaching about public health issues. Conceptual frameworks can help students organize the many relevant factors at play (including SDH), to understand how they contribute to the health issue at hand, and to brainstorm potential responses or critique existing ones. This section of the teaching guide outlines one framework that facilitators might use to help students think systematically about these factors.

In order to understand any global health challenge, we must first ask ourselves two big kinds of questions:

1. What is the problem? How do we understand and contextualize major health issues in the population/community?
2. What are the solutions? What are the ways we can draw upon all of the tools and mechanisms at our disposal to tackle these challenges?
In order to unpack these core questions, we must consider two dimensions within each. To think of this as a conceptual framework, facilitators should write the following two questions on the board:

WHAT IS THE PROBLEM?  WHAT IS THE SOLUTION?

Allow plenty of space on the board to write participants’ answers to these questions. While the framework below uses boxes as an example, instructors may choose to illustrate these framework ideas using whatever graphics are most understandable.

What is the problem?

- **Health conditions**

Understanding the problem

- **Dimension 1: Health conditions**
  
  When thinking about the nature of any public health challenge, we must first understand the health conditions we are referring to. In other words, what are the key issues or features that explain why they are not healthy? To what extent do these contribute to death or impairment in the population/community? How are individuals and communities impacted? These are all salient features that give audiences a sense of the magnitude and impact of the health issue.

- **Dimension 2: Conditions for health (determinants)**

  To understand the context of our given health issue, it is critical to identify all other factors that contribute to it. What are the individual (such as behavioural and attitudinal), social, political and economic factors that may put people at risk or protect them from illness? SDH refer to the conditions for health relating to the various environments individuals occupy, such as home, school, workplace, neighbourhood and society/culture, among others.

What is the solution?

- **Health sector responses**

- **Non-health sector responses**
Identifying solutions

- **Health sector responses**: After developing a firm understanding of the nature of a given health problem and the contextual factors influencing it, participants can begin to consider potential responses to the issue at the community level. Responses from the health sector refer to initiatives that are carried out by people or institutions whose primary job is to improve people's health, including physicians, nurses, hospitals/clinics and community health workers. Since the health sector is positioned to respond to acute and pervasive health challenges through direct outreach to individuals, these types of responses will likely not intervene directly upon the SDH, but must rather be taken into account in order to be maximally effective.

- **Non-health sector responses**: While the health sector is often the first line of defence in the face of major challenges to public health, various other domains of society can also act to improve health outcomes in the population. Non-health sector responses refer to the various ways diverse actors across other areas in society, such as policy-makers, economists, engineers, and the education sector, among others, can work to advance health. To directly tackle SDH in the population generally requires coordinated effort from these non-health sector actors.

Social processes are, by their very nature, messy, complex and difficult to understand. For example, while we may know that malaria is causally contracted through mosquito bites, or tuberculosis through contact with bacteria, there is no easy way to causally show how social exposures like poverty or low education may put someone at a greater risk for disease, since they exert their effects through multiple complicated relationships and processes. To help make sense of these pathways and diverse factors at play, we can draw on other conceptual frameworks to organize our thinking about the social determinants of a given health issue. Such conceptual frameworks are useful pedagogic tools (often presented graphically) that students can use to better understand how social processes influence health. Below are two frameworks with a brief explanation of each.

**FIG. 2. DETERMINANTS OF HEALTH MODEL**

Source: Adapted from Dahlgren & Whitehead (1991).
The Socio-ecological model, like Dahlgren & Whitehead’s Determinants of Health model, also portrays the factors that influence a person’s health, which are shaped by several layers of determinants at individual (or intrapersonal), interpersonal, institutional, community and public policy (or societal) levels. This model was developed by McLeroy et al. (1988), but various adaptations exist, like the one above from the American College Health Association (you can also visit the website for further detail on each of the levels).

Responsibility goes beyond the health sector

When looking at these models, you may have noticed that many of the determinants of health are outside the health sector. For example, local authorities are responsible for recreational parks and physical spaces for people to enjoy and exercise in. Taxes encouraging health products, or discouraging unhealthy products, are determined by the finance arm of governments, and many laws designed to promote health have come to be developed by lawmakers and politicians. Police and justice departments are also responsible for enforcing these laws, as well as ensuring public safety. Employers provide people with wages that may alleviate stress and increase quality of life. The education sector is responsible for creating awareness of many healthy (and unhealthy) behaviours in children. Therefore, while increasing access to and the quality of health care are important, it is only one factor and achieving this alone may only make a small contribution to improving the health of the population.

We must work with and engage other sectors to improve the many other determinants of health. This includes a wide range of stakeholders and communities, including nongovernmental organizations, village chiefs and traditional land owners, religious authorities, businesses, farmers and agricultural organizations,
transport authorities, educational institutions, all government departments and many more. Health is everybody’s business and we all have a role to play!

**Key take-home messages**

The brief introductory overview offered in this teaching guide is designed to provide educators with a few select tools they may use to guide students through the four lessons in this teaching pack. Below are some of the key takeaway points to keep in mind in any discussion about SDH:

- Understanding and addressing the root causes of health inequities that exist between advantaged and disadvantaged groups in society is a critical goal of working in global health.
- These inequities are explained by SDH; “social determinants of health” is an umbrella term for a broad range of social factors that serve as the root causes of health and disease.
- SDH include the aspects of social environments that shape the contexts in which people live and grow, and have cascading impacts on population health both directly, such as by impacting individuals’ biological processes, and indirectly by influencing individuals’ health-related attitudes and behaviours.
- There are numerous ways to think about SDH, and conceptual frameworks can serve as useful organizational tools to make sense of the complicated web of factors at play.
- Ensuring and improving global health is a team effort requiring action from the health sector, which includes health-care workers, ministries of health, drug companies, and international nongovernmental health organizations, among others, as well as from diverse actors in the non-health sector, for example, urban planners, farmers, policy-makers, lobbyists, multilateral institutions, and many more.
Health promotion is the process of enabling people to increase their control over their health so that they might improve it. This process moves beyond a focus on individual behaviour towards a wide range of social and environmental interventions.

The planning for health promotion actions is arranged in the following cycle:

**Situation analysis**
- Build an evidence base
- Build on local knowledge and practice
- Adapt global guidelines
- Use resources strategically
- Leadership – use effective local leaders and collective decision-making

**Planning**
- Identify, prioritize solutions and achieve consensus
- Write down the plan and update it frequently
- Use SMART objectives
- Plan well for implementation and include evaluation

**Implementation**
- Be flexible
- Build capacity by reorientation, increasing stakeholders and accountability
- Use collective action

**Evaluation**
- Consider process, impact and outcome evaluation
- Use a logic model
- Collect data using appropriate methods
- Give regular feedback within and between stakeholders
Situation analysis

Situation analysis is an assessment of the current health situation and its determinants. It involves trying to make sense of the factors surrounding any potential health promotion project and in particular the problem/health issues it may solve and the determinants of this problem. It is similar to “scoping” or a needs assessment. Reviewing evidence on the problem and potential solutions is advised as we do not want to waste effort and resources “reinventing the wheel” (Eagar, Garrett & Lin, 2001).

Knowledge of the evidence around the problem (scientific literature and data)

Knowledge of traditional or local ways of preventing or managing the problem

Knowledge of global guidelines and how they can be adapted

Strategic resourcing ↔ Leadership
Strategic resourcing and leadership are also important for situation analysis.

**Strategic resourcing**

- The primary audience for evidence gathered is the community or population you hope will benefit from the health promotion activities. Here, information should be delivered in ways and in venues that are familiar to community members.

- A secondary audience is stakeholders who can provide additional leadership, counselling support and financial resources. Common sources of funding include in-kind and cash contributions from ministries of health, other government departments, nongovernmental organizations, international development agencies such as WHO, international development assistance from countries in the region, research institutions, local businesses, as well as funding obtained through fundraising activities.

- Sourcing funds from a variety of sources was a consistent piece of advice from those involved in successful Healthy Islands projects.

- Familiarity and transparency between funders and implementers are important so that funds are used appropriately.

- Leaders of Healthy Islands projects were strategic and creative in how they sourced additional resources.

**Leadership**

- Collective decision-making – community involvement/engagement – is a hallmark of Pacific island health promotion projects.

- For successful health promotion, awareness raising and/or training for local leaders is required to bring them up to speed on the health problem and how to address it.

- The best and more sustainable health promotion programmes were those that:
  - built on a community’s existing assets and strengths;
  - had local leaders; and
  - engaged a wide range of people – including teachers, parents, village leaders, store managers, hotel staff – while project leaders/health promoters motivated them to take action and organized their contribution.

**Knowledge of the evidence around the problem (scientific)**

**Building an evidence base:**

Desk-based research is a good place to start – with a good library, Google, or other search engine, desk-based research is a quick way to bring together key reports, data and policy documents to:

- define and describe the problem;

- assess what is already being done; and

- identify what solutions others have found for similar problems.
Also note that:

- If available, information on the financial cost of the problem is valuable for attracting funds.
- Existing health information from trustworthy sources, such as departments of health and WHO, are a good place to start.
- Richer, more localized and up-to-date information can be obtained by interviewing key stakeholders, experts in the field and/or local champions.

**Knowledge of traditional or local ways of preventing or managing the problem**

**Building on local knowledge and practice:**

- Evidence from public health sources is helpful and local evidence about what has worked or not can strengthen these approaches. Locals often have the best idea of what community needs are as well as creative and potentially lasting solutions. Also, in the process of sharing information, community leaders are often motivated to act on the problem.
- Engaging the community through situation analysis leads to shared ownership and action or a participatory approach. This can be done through simple conversations, or more formally through meetings and interviews, or even via a community readiness assessment.
- Remember to take notes during discussions so you can remember what was covered and can share this information with other key stakeholders.

**Adapting global guidelines**

Global guidelines provide quick access to research evidence about risk factors and international good practices. Often, aspirational targets are associated with such guidelines, making them useful for motivating the behavioural and systems changes required, as well as for benchmarking progress (monitoring and evaluation processes).

- Examples include the global target of no increase in obesity or diabetes prevalence by 2025 and the goal of a Tobacco Free Pacific by 2025 (http://www.wpro.who.int/southpacific/programmes/healthy_communities/tobacco/page/en/).
- Another example is “PEN Fa’a Samoa” – Samoa’s adaptation of the WHO Package of Essential Noncommunicable Disease Interventions (see Annex 5).
Planning

Planning puts details around the initial goal and objectives and builds momentum for action on the issue identified during the situation analysis. It involves bringing people and leaders together, discussing issues, making decisions about preferences, allocating resources and taking collective action (Fry & Zask, 2017).

During the planning process, partners are brought together to share information and identify solutions. After considering a range of possible solutions, they should then be prioritized and strategically aligned with resources to maximize the chance of addressing the health issue sustainably.

Once consensus has been reached, a detailed (action) plan can be developed, specifying the overall goal and how the proposed solution will be achieved. Time spent refining the goal and defining the population is well spent in the planning stage and it is helpful to develop objectives that are SMART.

A written plan is a good idea that can be shared with all stakeholders to achieve a common understanding of the goal and strategies for getting there. It should also be detailed enough that someone picking up the plan can work out what is going on and steps that have to be taken. The plan should be updated frequently so that it is responsive to new information, events, or changes to the health issue that occur over time.
Clear goal and SMART objectives

The goal of your health promotion programme should always be clear. Make sure your objectives are Specific, Measurable, Achievable, Relevant and Time specific:

- **Specific**: Clear and precise
- **Measurable**: Possible to measure and therefore evaluate
- **Achievable**: Realistically achieved on time and with available resources
- **Relevant**: Relevant to the health issue, population group and your organization
- **Time specific**: Report a time frame for achieving your objective

An example of a poorly constructed objective is “to ensure children have a healthy diet” as this is not very specific (which children? what is healthy?), is hard to measure (how would you prove the objective was achieved?) and is not time specific (we do not know when the objective will be achieved). Without further information we also do not know if this objective will help achieve the overall goal or if it is relevant to the population of interest. A good example of a SMART objective is “to increase fruit and vegetable consumption in primary school children by 20% by the end of 2020”.

Implementation

Simply put, implementation is “putting the plan into action”. However, it is not always that simple – in fact, there is a whole body of knowledge (called implementation science) dedicated to it!

Many factors can affect implementation, whether it be due to the changing nature of the problem your programme addresses, changes to the people/organizations/leadership behind it, funding challenges, improvements in technology, changes in supporting evidence, or even events such as a cyclone or political upheaval.

Before we move into what makes for good implementation, one of the most valuable factors enabling smooth implementation is to plan well:

- Allow sufficient time and budget. Be realistic in these estimations and provide updated adjustments where necessary.
- Be flexible. Flexibility (such as modifying your approach or timing) helps you work around (manage) unforeseen events and allows you to change your approach should new evidence come to light.
- Build capacity: Provide training and learning occasions.
- Reorienting stakeholders, for example, by changing the way stakeholders think and act in relation to a health issue, such as fruit and vegetable availability, will help embed the changes in settings (such as for food retailers) and systems (such as the food system) so that these become the norm. Reorientation requires continuous communication with stakeholders.
- Involve and train more stakeholders to deliver the project as a priority during implementation. Through working in collaborative partnerships, the workload, ownership and reach can be shared across different groups and organizations.
Setting up the appropriate accountability structures is essential. Accountability could come in the form of management, reporting, and ensuring a proper governance structure is set up so people have clear roles and responsibilities. These structures may already exist and working within them can help with sustainability.

The Collective Action Framework supports these principles and is a useful framework for helping you work together with others to implement your plan.
ANNEX 4.
MONITORING AND EVALUATION OF HEALTH PROMOTION PROGRAMME

What is monitoring?

Monitoring is a process of tracking or measuring what is happening – collecting data and measuring progress towards programme objectives. In simple terms it is checking how you are doing.

- Monitoring involves counting what we are doing (the process).
- Monitoring involves regularly looking at the quality of our services (the quality).

Monitoring counts how often, how much and how frequently activities are carried out, as well as how many participants were involved.

Monitoring answers the following questions:

- Is the activity reaching the people it was designed for?
- What do the audience/participants think of the activity? (feedback)
- Is the activity being implemented as planned?
- Are all aspects of the strategy of good quality?
- What kind of participation is happening?
- To what extent is the direction of the strategy changing in response to the needs of the audience/participants?

A good plan contains a clear process for tracking the implementation of campaign activities. It includes information on who will do the monitoring and how. For example, how will you know if clinic materials – such as handouts – are in all of the appropriate places and are being distributed to the intended audience? How will you work out whether community events have occurred according to the strategy? Who will track the advertising to make sure that it is aired or published on schedule? Who will be responsible for making sure there is a continuous supply of campaign materials? Who will collect client service statistics?

During the implementation of your project, monitor what you do, adjust (make changes to) what is not working well, and reinforce messages and activities that are working to achieve the objectives you have set and the results you want.
Evaluation of health promotion programme

Health promotion evaluation is “an assessment of the extent to which health promotion actions achieve a ‘valued’ outcome” (WHO, 1998). Evaluation tells the story of your work.

A comprehensive evaluation measures how you are doing at all stages of a project and how much it costs. Types of evaluation include the following.

- Formative evaluation ensures that a project or activities within it are feasible, appropriate and acceptable before the project is implemented (Salabarria-Peña, Apt & Walsh, 2007).
- Process evaluation determines whether the project has been implemented as intended.
- Impact and outcome evaluation measures whether or not a project is achieving its short- or medium-term objectives (impact) or longer-term overall goals (outcome).
- An economic evaluation occurs throughout a project and captures the resources being used to deliver the project compared to the benefits or outcomes achieved.
- It is often difficult to directly link particular health promotion activities to health outcomes due to the complexity of isolating cause and effect in complex, real-world situations (WHO, 1998). For this reason, most health promotion projects and programmes look towards changing outcomes but are often only able to measure process and impact.
**Evaluation design**

Evaluation typically involves designing a study and collecting data. Please note that as a faith-based organization, you may wish to engage partner(s) with expertise in study design and evaluation to support this aspect of the health promotion planning cycle to ensure the information you want to collect is being measured accurately. Later, we will describe additional ways to simplify evaluation.

**Design**

Choose a design that gives you the best evidence possible. Where you cannot use an ideal design, look for other designs or sources of information. Due to limited resources, this may mean designing an evaluation that utilizes data already being collected and/or proxy measures.

For example, to assess the outcome of an intervention to reduce children’s consumption of sugar-sweetened beverages (SSB), a design that measures children’s intake before and after the intervention compared to intakes in children not receiving the intervention (a control group) may be an option. However, if this is not possible, perhaps you could collect the information from an existing regular survey. An example of a proxy measure is assessing the change (if any) in SSB sales in shops near schools.

**Collecting process evaluation data**

Process evaluation data are data on the implementation of the project in terms of its reach (does it involve everyone who should be involved?) and level of implementation (is the project gathering sufficient information?).

Process evaluation data are often (but not exclusively) qualitative, that is, data that are rich, in-depth and exploratory. They are often described through written narratives and largely analysed in non-statistical ways – for example, a review and report on project documents.

**Collecting impact and outcome evaluation data**

These data are usually collected from the people your project is targeting and capture short-term changes (such as increased awareness of the power of marketing of SSB) and longer-term impacts (such as reducing SSB consumption) and outcomes (such as preventing unhealthy weight gain).

Impact and outcome data are often quantitative, that is, data that can be analysed numerically using statistical approaches. Table 2 describes some evaluation techniques that can be used in a nutrition or obesity programme.
<table>
<thead>
<tr>
<th>Process evaluation</th>
<th>Research question</th>
<th>Indicators</th>
<th>Data collection method(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Are healthy eating goals being adopted by all stakeholders?</td>
<td>Proportion of eligible stakeholders who have incorporated goal</td>
<td>Reviewing documents from different stakeholders to determine whether or not healthy eating has been incorporated (secondary data). Facilitating a focus group with stakeholders, and asking questions such as: “How have you incorporated the healthy eating workshop into your organization’s goals?”</td>
</tr>
<tr>
<td></td>
<td>What factors affected the programme’s implementation?</td>
<td>Identification and exploration of key themes that affected the programme</td>
<td>Interviews with individual stakeholders involved in implementation of the healthy eating programme, with questions such as: “Was the workshop implemented differently to how it was planned? If so, what factors affected this?”</td>
</tr>
<tr>
<td>Impact evaluation</td>
<td>Is the programme reaching the intended people/organizations?</td>
<td>Proportion of eligible participants/stakeholders involved</td>
<td>Counting the number of people who participated in each workshop, or taking photos while the workshop is being run (observation).</td>
</tr>
<tr>
<td></td>
<td>Are recipients of the programme finding it beneficial?</td>
<td>Proportion of positive attitudes toward the educational activity</td>
<td>Facilitating a survey using close-ended questions such as: “Participating in this healthy food workshop improved my knowledge of healthy foods”, with the options of Strongly agree / Agree / Neutral / Disagree / Strongly disagree. Open-ended questions could also be included, such as: “What was the most helpful aspect of this workshop?”, with space for participants to write in their own suggestions.</td>
</tr>
<tr>
<td></td>
<td>Has the programme influenced participants’ eating habits?</td>
<td>Proportion of participants meeting recommended nutritional intake of fruit and vegetables</td>
<td>Facilitating a close-ended survey using the WHO STEPS survey instrument, which contains questions such as: “In a typical week, on how many days do you eat fruit?”, where participants insert the number of days. This could be asked before and after the workshop to account for any changes in eating habits.</td>
</tr>
<tr>
<td>Outcome evaluation</td>
<td>Are participants losing weight as a result of the programme?</td>
<td>Changes in body mass index score over a period of time</td>
<td>Conducting measurements in the form of weight and height of workshop participants before and after the programme. Reviewing secondary data on weight already collected by schools before and after the programme.</td>
</tr>
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</table>
Data collection, analysis and interpretation

A variety of research methods can be used to collect data. The main methods used in health promotion research are described in Table 3.

Data analysis involves identifying and summarizing the key findings, themes and information contained in the raw data (Round et al., 2005). Specify here what data analysis techniques and computer software you intend to use (Victorian Government Department of Health, 2010).

Obtain advice (and include in your programme) from experienced researchers with organizations such as universities, ministries of health or WHO, particularly if you are not familiar with qualitative or quantitative data analysis.

The WHO STEPwise Approach to NCD Risk Factor Surveillance (STEPS) surveys (https://extranet.who.int/ncdsmicrodata/index.php/home) are a good example of a comprehensive report produced from a rigorous research and data collection process. While your organization would not undertake such a survey on its own, the results of such surveys may be helpful to planning and seeing longer-term impacts.

**TABLE 3. DATA COLLECTION METHODS**

<table>
<thead>
<tr>
<th>DATA COLLECTION METHODS</th>
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</thead>
<tbody>
<tr>
<td>Measurement (quantitative): A tool is used to measure something and the value is recorded.</td>
</tr>
<tr>
<td>Observation (qualitative or quantitative): Looking at the physical environment and recording observations through writing notes, using a checklist or taking photos.</td>
</tr>
<tr>
<td>Close-ended surveys/questionnaires (quantitative): Written questions that are numerical or have limited response options, such as multiple choice.</td>
</tr>
<tr>
<td>Open-ended surveys/questionnaires (qualitative): Written questions with a blank space for respondents to write in their own words.</td>
</tr>
<tr>
<td>Interviews (qualitative): One person is interviewed, and the interviewer may use an interview guide to ask them questions.</td>
</tr>
<tr>
<td>Focus groups (qualitative): Similar to an interview but with 2–10 individuals – this can often result in a more collective conversation where participants feed off each other’s comments.</td>
</tr>
<tr>
<td>Secondary data (qualitative or quantitative): Using data already collected by another organization. This is often in the form of access to a database, or analysing documents, but could also include using existing data from any other method.</td>
</tr>
</tbody>
</table>

Simplified evaluation

Where there are limited resources and/or time, simple evaluations are still of value. When it comes to evaluation, something is always better than nothing. Some examples of simple but effective evaluation measures are:

- **Formative evaluation** – using a pilot study (that is, implementing and evaluating a part of the programme in one area before rolling it out to other areas), which is also a useful and cost-effective strategy if you want to test and improve something before significant resources are used for a wider programme.
I **Process evaluation** – meeting with key stakeholders to discuss how the healthy eating workshop went (this is like an informal process evaluation using an interview/focus group); it could also include taking photos of the workshop in action (an informal process evaluation using observation).

I **Impact and outcome** – handing out a quick one-page survey to participants of the workshop asking if it increased their knowledge/skills/attitudes towards eating healthy foods (an informal impact evaluation using a short survey/questionnaire).

**Dissemination**

In all stages of a programme, regular and ongoing feedback is essential – this includes talking and listening to all people and stakeholders involved. Emphasis should also be placed on the community.

Feedback should be multidirectional – for example, not just from programme facilitators to the community, but also from the community to the programme facilitators (they may hold information valuable to the programme). Some organizations use the term “360-degree feedback”, meaning an employee receives feedback from their subordinates, peers and supervisors, and also reflects on their own performance.

Evaluation and dissemination of results is an important mode of feedback – those who were involved in any aspect of the programme (including beneficiaries) are likely to want to know how it went. It is also instrumental to report to funders – if they like the results, this demonstrates that their money is being well spent, which could encourage them to commit even further.
ANNEX 5.
CASE STUDIES – BEST PRACTICES IN HEALTH PROMOTION IN THE PACIFIC

Situation analysis: Building an evidence base

CASE STUDY 1: Reducing imports of fizzy drinks in Tokelau

The prevalence of overweight and obesity is high in Pacific island populations and Tokelau is no exception. Soft drinks (or fizzy drinks) were identified by the Department of Health as a contributor to this chronic disease risk factor. In addition, the discarded drink cans and bottles were polluting the environment and expensive to remove from the island. In 2008, annual soft drink consumption was calculated by the Tokelau Ministry of Health to be 43 litres per person. This information was presented to the leaders, or Taupulega, of each atoll. As a consequence, one atoll, Fakaofo, completely banned carbonated soft drinks in 2011. Local bans were also introduced in Nukunonu and Atafu. In 2013, a national policy was introduced that banned imported fizzy drinks.

This initiative was described by the Minister of Health at the time as a decision from local community leaders. Department of Health interviewees recognized that empowering community leaders was important for ensuring that the ban lasts long term. Likewise, community elders were a key group of stakeholders consulted, and they played a key role in advocating for the policy.

As such, the advocacy for the ban on fizzy drinks policy included raising awareness by sharing evidence such as survey and study results about noncommunicable diseases (NCDs) and their risk factors, encouraging community engagement in addressing the NCD crisis, and advocating to community and island leaders in Tokelau. It is important to ensure that community members feel empowered with knowledge and understanding required to make good decisions. One community member pointed out that “when the decision is their own, they will willingly implement, monitor and sustain their decision”. Collecting and sharing evidence with the right people was central to getting the project off the ground and to its success. Information on the health of the population was gathered and shared with communities and local leaders. Community leaders then identified solutions and shared them across the country. Project leaders made it clear that a “coral-up” or community-driven approach is the way to get things done in Tokelau.

Initially, policy implementation was difficult as it was met by complaints and attempts to smuggle in fizzy drinks. However, all imports to Tokelau come on one boat, and with assistance from the Department of Transport, the ship’s crew, and customs and immigration authorities, the smuggling was halted. Another challenge relates to the fact that once a policy is in place, the work is not finished. “There are continuing threats on this policy and local council can reverse their decision any time they want to and this is a great risk,” said one Department of Health staff member. “Hence our ongoing support to continue to empower
local council and communities to continue to appreciate the need and the benefit of the decision they have made. There have been some comments from local councils on taking the same approach towards tobacco and alcohol, and this indicates that they are proud and appreciate the benefit of their decision on banning fizzy drinks and how they can apply the same approach towards other health risks.

Potential challenges to the policy were met by engaging with the community to reiterate the positive impacts of the policy on health. The sustainability of a policy such as the ban on fizzy drinks in Tokelau will depend on the ability to address the challenges identified. As part of the policy development process, the Department of Health highlighted the problem and the underlying, or causal, factors of NCD risk – including obesity – to the community by gathering and using evidence. The Department of Health staff then helped empower the community by encouraging community members and leaders to identify possible solutions to address the health concerns at hand.

**Situation analysis: Analysing data**

**CASE STUDY 2: Analysing childhood obesity in the Commonwealth of the Northern Mariana Islands**

TASA, which takes its name from the four villages it serves, aims to provide a role model for healthy lifestyles for children and adults and to create healthy environments. The project has a number of behaviour change goals: increasing sleep, physical activity and the consumption of fruits, vegetables and water; decreasing leisure time spent viewing computer, television and gaming screens; and cutting back on sugar-sweetened beverages. It was established in early 2013 by the Northern Marianas College-Cooperative Research, Extension and Education Service (NMC-CREES) and the Children’s Healthy Living Program (Rachel Novotny, principal investigator) with the villages of Tanapag, Achugao, San Roque and As Matuis (TASA) in Northern Saipan. It takes a community-based multi-strategy, multi-setting intervention approach. In particular, project implementers have improved the safety and appeal of local parks in two communities, improved the grounds of schools and childcare centres, and worked closely with one supermarket in the community to both advertise and provide healthier foods. The TASA role models project is supported by Agriculture and Food Research Initiative Grant No. 2011-68001-30335 from the United States Department of Agriculture’s National Institute of Food and Agriculture.

The support from staff at CREES was identified as both a catalyst for the project and also a factor contributing to the project’s success. Their ability to identify community-minded people, not necessarily known leaders, from a range of organizations and settings, and to get them to work together was considered the main driving force behind the project. Also, participants felt that TASA was strongly based on local needs and gave a range of examples to demonstrate this – from the TASA logo, to promoting local foods and the empowerment of local leaders. The stated reason behind this was CREES-run focus groups designed to foster community engagement. A strength of this project was that information on childhood obesity provided motivation for community change. The TASA role models project was aligned with a larger research project that collected information on children’s weight status and associated eating and physical activity behaviours. The alignment with an externally funded research project was strategic because it allowed the project to gather relevant data without incurring large data collection costs. The information gathered was provided to community leaders and members to motivate changes in the community that made healthy choices easier ones for children. The data also became a baseline that could be used to see if the project had the expected impact on children’s weight status.
During the TASA role models project, Typhoon Soudelor significantly disrupted operations, and priorities in the community shifted to basic needs. Overcoming the damage caused by the typhoon was an ongoing challenge for TASA. Obtaining small levels of ongoing funding was a challenge that took the time of project leaders; for the store-based activities, the ongoing challenge was looking for ways to provide affordable and healthy food.

The TASA project is an excellent example of a grassroots community intervention that is strongly grounded in health promotion theory. A key to the project’s sustainability was community empowerment. Project leaders placed a strong emphasis on identifying community needs and the importance of community leadership – the fact that those leading the project were known to the community and to other community leaders was mentioned by several interviewees. Equally important, however, was the need for a facilitating agency to catalyse action, facilitate networking, provide specific expertise and raise accountability.

**Situation analysis: Building on local knowledge and practices**

**CASE STUDY 3: Strengthening food security in Pohnpei, Federated States of Micronesia**

The Island Food Community of Pohnpei (IFCP) is a small non-profit organization that was chartered in 2004 with the primary goal of promoting local food for its many benefits. These benefits are summarized in the CHEEF acronym, which stands for culture, health, economy, environment and food security. IFCP was founded by a group of interested community members and prides itself on its community-based participatory approach, which involves community leaders in planning and implementation, and values local knowledge. The IFCP initiative promotes locally available foods, such as banana, breadfruit, taro and pandanus, particularly in schools and local communities, using a wide variety of information, education and communication tools.

Having appeal beyond the health sector and linking health with other ambitions – such as cultural preservation, the environment, economy and food security – assisted in establishing support from the community and a wide pool of partnering personnel and organizations. The IFCP also strongly emphasizes a local response, from the development and promotion of local foods to the local problem of vitamin A deficiency and NCDs. Public concern around these problems was significant, creating a window of opportunity for the IFCP’s founders at the time.

The IFCP works closely in partnership with representatives from nongovernmental organizations, the private sector, industry and government. It also works with and provides support to many community groups and in particular women’s groups, farming families and faith-based groups. The IFCP gets strong support from traditional leaders who have significant influence in their communities and knowledge of traditional foods and agricultural practices. Women are also very influential as they often make decisions at the household level.

The story of the IFCP is very much one of making the most of traditional foods and practices, and highlighting the benefits of these over new and foreign practices. Its innovative marketing campaigns, such as the “Let’s Go Local” campaign and CHEEF benefits, were founded on traditional practices that resonated with the local community.

Despite the IFCP’s successes, its significant challenges included funding, capacity and limited resources, as well as the expense and perishability of local food, and the difficulty of reaching the outer islands of the country.
Given the funding challenges, it was especially important to share ideas, expertise and available resources. The involvement and support of volunteers have been valuable to this project and have encouraged its sustainability. Furthermore, community support has been garnered through awareness-raising activities, developing catchy and well-publicized slogans, and partnering with a range of organizations in various sectors from the local village level to the international level. Education activities in schools help nurture children and teach them that sourcing and promoting a diversity of local foods facilitates ecological balance, which helps sustain the IFPC’s message and to pass on traditional practices to children.

**Situation analysis: Adapting global/regional guidelines**

**CASE STUDY 4: Strengthening NCD prevention and management in Samoa**

PEN Fa’a Samoa means “PEN the Samoan way”, whereby the WHO Package of Essential NCD Interventions (PEN) has been adapted by Samoa to reflect the local culture and customs (WHO, 2015). In doing this, PEN Fa’a Samoa has been introduced to village members, who are supported to provide better NCD management for their communities (Samoa Ministry of Health, 2016).

PEN Fa’a Samoa was launched in 2014 under leadership of the Samoa Ministry of Health and National Health Service with support from WHO. Two villages, Faleasiu and Lalomalava, were identified as pilot demonstration sites. Importantly, the role of traditional leaders is emphasized in PEN Fa’a Samoa. The overall goal of PEN Fa’a Samoa is to strengthen linkages between health services and the community. It uses three pillars which can be broken down into the following objectives.

- **Pillar One: Early detection of NCDs**
  - Provide comprehensive population screening for NCDs.
  - Increase the detection rate of people with risk factors for NCDs.

- **Pillar Two: NCD management**
  - Increase the percentage of people with risk factors for NCDs who obtain appropriate treatment and/or management strategies.
  - Increase compliance with NCD treatment and management protocols.

- **Pillar Three: Community awareness of NCDs**
  - Build capacity among district health professionals and community representatives (village women’s committee representatives) on prevention and treatment of NCDs at the community level.
  - Increase health literacy and raise community awareness of lifestyle risk factors related to NCDs (diet, smoking, unsafe alcohol consumption, physical inactivity).

Besides adopting the principles of successful situation analysis, planning and implementation, such as engaging with local communities, adapting global guidelines and engaging local people in the delivery of the programme, project leaders conducted a comprehensive evaluation, which was largely a formative evaluation of the pilot sites, but also consisted of aspects of process and impact/outcome evaluation. This was done using a range of methods, as follows.

- Recording measurements on instruments such as scales, blood pressure devices and blood glucose screening devices.
Surveying participants’ demographic information, such as age and gender, alcohol and tobacco use, level of physical activity, as well as whether they had experienced any cardiovascular disease symptoms.

Recording the number of participants and comparing this to the total number of people in the community to find a participation rate.

Holding focus groups with people (mostly women) from villages involved in the implementation of the PEN Fa’a Samoa programme to review the programme, identify more intervention opportunities and pre-test communication materials.

By doing this they could not only refer participants at risk of NCDs to health professionals and follow them up over time, but they also obtained data to prove the success of the programme alongside each objective. For example, by collecting data on the number of people screened who had not been screened before, they could directly evaluate their objective to achieve “increase in the percentage of people with risk factors for NCD who obtain appropriate treatment and/or management strategies”.

The evaluation based on the two pilot village sites demonstrated the success and feasibility of this programme. This prompted a national steering committee to be established and government support to roll this programme out at a national level – which is likely to have a huge impact on NCD prevention and management in Samoa!

**Situation analysis: Strategic resourcing**

**CASE STUDY 5: Strategic resourcing to support improvements in sanitation in Vanuatu**

In the 1980s and 1990s, the United Nations Children’s Fund (UNICEF) funded a large sanitation project in response to high numbers of people with diarrhoea in Vanuatu. It was estimated, at the time of the project, that 80% of the Ni-Vanuatu population had access to a well-constructed ventilated improved pit (VIP) toilet. However, there were limitations to VIP latrine construction design that meant they could only be built in areas with solid soil and not areas, such as coastal settlements, where the soil is sandy. Also, the toilets were often located far from dwellings, had a squat design and were prone to collapse due to rainwater coming in the sides during heavy downfalls, and to infestation by rats and cockroaches. It was also observed that when the pits became full, people reverted to traditional pit toilets because they did not have the inclination or expertise to maintain the VIP toilets.

This information was supported by evidence in the national Multiple Indicator Cluster Survey (MICS) – an important demographic and health survey that gathers data on fertility, child mortality, family planning, maternal and child health, nutrition, sexually transmitted infections and other health issues.

In response to these issues, an experienced team of environmental health officers (EHOs) within the Ministry of Health, and in particular the EHO for Sanma, developed two new designs for VIP toilets (NVIP) that overcome these challenges on the island of Espiritu Santo.

Each NVIP requires three bags of concrete, reinforcing wire for the slab, chicken wire for the riser seat, PVC pipe and a toilet seat. The cost is approximately 3000 Vanuatu vatu per toilet (about US$ 30) and communities do not have funds to build as many toilets as required. There are also costs associated with transporting sand/gravel to inland areas to make the concrete.
The Samna Sanitation project purposefully encourages the use of local building materials for constructing the shelters over the VIP toilets they are building in schools. Not only does the use of local building materials reduce the initial cost of the project but it also means that materials are available to repair the shelter if required and that local community members can do the repairs.

The Ministry of Health in Vanuatu made a strategic decision to pay the initial costs of building the NVIP toilets in return for free labour from community members. Most funding for the sanitation project came from WHO and approximately 15 toilets were funded by an Australian university that had students run a fundraiser for the project. The team is continuing to look at small sources of funding and donations in kind. The building of NVIP toilets was supported by the overarching water, sanitation and hygiene (WASH) model which has been adapted to local communities in Vanuatu.

**Planning: Goal and objective setting**

**CASE STUDY 6: Sound planning – Healthy Sianios and Samo Villages, Lihir Island, Papua New Guinea**

Lihir Island, in the New Ireland Province of Papua New Guinea (PNG), contains numerous villages in remote areas with dense vegetation and high rainfall. Malaria and lymphatic filariasis, transmitted by mosquitoes, have been major health issues on the island, with Sianios and Samo villages, located in Ward 8, being among the most severely affected.

The Healthy Sianios and Samo Villages project is an initiative of these villages which aims to support a holistic approach to building healthy communities and populations through community action, environmental management, and policy and infrastructure management (Whelan, 2013).

The Healthy Sianios and Samo Villages project used a Community Action and Participation (CAP) workshop to effectively plan (and upskill) for a community intervention in Sianios village. Six processes were involved in the CAP workshop which have significant overlap with the health promotion/action research process (Fig. 4).

Keen to act in the interests of their own health, 27 participants identified 23 key issues in the community and prioritized five main action areas: draining and backfilling of swamps (to control mosquitoes), water supply, VIP toilets, training and a community post.

The workshop was facilitated by the Sub District Health Office and the Lihir Island Community Development Program.
In the months and years that followed the CAP workshop, the community worked together to drain water and redirect it to the sea (Sianios village was previously swampy and mosquito infested), remove waste, build VIP toilets, and beautify the village by clearing waste and overgrown vegetation. Also in their sights was a more holistic approach to development on the island, as ingrained in the Healthy Islands vision.

**Implementation**

**CASE STUDY 7: Flexible implementation for Kau Mai Tonga in Tonga**

The Kau Mai Tonga Ke Tau Netipolo (C’mon Tonga – Let’s Play Netball) project began in 2010 and was one of several Australian Sports Commission (ASC) projects initiated across the Pacific. This joint initiative of the Tongan and Australian governments, with funding of approximately AU$ 1.45 million through the Australian Sports Outreach Project, aimed to reduce NCDs – a major government priority in Tonga – by increasing women’s participation in physical activity.

Netball was identified as the best sport and because of its popularity in Tonga since the 1970s and 1980s, it is the favourite sport of most women in Tonga and has a social element. Other types of physical activity were also encouraged and a number of walking groups were established. Since this project, netball’s popularity has expanded rapidly in Tonga. A lot of clubs have seen past players come back to run the clubs and Tonga is now seeing talented players being given netball scholarships to schools in New Zealand.

The ASC together with the Tongan Government saw an opportunity to direct funding towards a project that promoted sport but also prevented NCDs through the promotion of physical activity. This required two government ministries – the Ministry of Internal Affairs (through the Sports Division) and the Ministry of Health – to work closely together. This partnership, which quickly expanded to include the Tonga Health Promotion Foundation and the Tonga Netball Association, was key to getting the project off the ground.

It was not only the leading organizations that adapted to the course of the project after it was first established, but also the intended audience of the programme. The core target group had initially been women aged 15 to 45 years, but the programme became so popular, partly due to the success of the social marketing campaign, that teams were created for older age groups, and men participated as well. The project was particularly accommodating of larger women and a senior B grade division was set up for women aged 35+ years or with a body mass index of 35 and over.

The Kau Mai Tonga project team was aware that local sport depends on volunteers and therefore that communities needed to be involved. They achieved this by being inclusive and adaptable, as well as by providing attractive and dependable community-based activities.

Also important for Kau Mai Tonga was its accountability structures. While they varied in nature, all projects had management, reporting and governance structures set up to support implementation. A valuable insight from the projects was that, in most cases, these structures were not developed from scratch but borrowed from organizations or other projects. In the case of Kau Mai Tonga, for example, the Australian Department of Foreign Affairs and Trade provided support setting up a governance structure for netball.
Implementation: Strategic resourcing

CASE STUDY 8: Establishing smoke-free settings in Honiara, Solomon Islands

The Honiara Central Market is the only place in Honiara where people from different provinces in Solomon Islands gather to sell fresh fruit, vegetables, seafood and other agricultural and farming products. It is a place where children, women, young people, and people of different social statuses with various cultural backgrounds meet (Leamana, 2013). The Honiara Central Market is under the control and management of the Honiara City Council (HCC).

The health issues being addressed by creating a healthy Honiara Central Market include:

- providing improved toilet facilities and water supply;
- enforcing a smoke-free policy;
- prohibiting vendors from selling tobacco, betel nut, alcohol, salty fish and second-hand clothing;
- ensuring proper storage facilities, breastfeeding areas, spaces for selling cooked food and the control of prices for goods; and
- creating specific areas to sell different products.

The Solomon Islands Tobacco Control Act was enacted in 2010. Part 5 of the Act prohibits smoking in all schools, including outdoor areas and grounds of schools. This created an imperative to ensure all schools are smoke free, and the Global Youth Lexus Network (GYLN) was given the leadership role to coordinate, oversee, design and develop a smoke-free school policy in collaboration and partnership with the Ministry of Health and Medical Services (MHMS), the Ministry of Education and Human Resources Development (MEHRD), representatives from the Solomon Islands National University (SINU), the Honiara City Education Authority, and a host of selected school principals of some of Honiara’s most prominent schools.

The Smoke Free Schools project aims to:

- increase the awareness level and reduce risk behaviour of tobacco use among students by engaging in a multifaceted and multisectoral approach, and working with constituencies to develop policy on a tobacco-free educational environment;
- work closely with the Curriculum Department of the Ministry of Education to ensure tobacco issues are broadly integrated into the school curriculum; and
- integrate the aspect of the smoke-free school key messages and practices in all school outdoor activities.

In both projects, collaborative partnerships with stakeholders were seen as essential, particularly given scarce resources. In order to drive the healthy marketplace concept, the MHMS worked in partnership with the HCC, which was responsible for the management and control of this setting. The support (and ownership) of HCC was crucial. In the Smoke Free Schools project, GYLN was given the leadership role of coordinating, overseeing, and designing and developing a smoke-free school policy. To plan their activities, GYLN collaborated closely with the MHMS, MEHRD, SINU, Honiara City Education Authority, and principals of some of Honiara’s most prominent schools. Partnership allowed this project to build upon existing capacity and also utilize the existing systems of both health and education departments.
Making healthy eating and reducing tobacco “everybody’s business” was an important ingredient for good collaboration. For example, it was considered particularly important that schools take ownership of the GYLN project. “I think what needs to be done is that the principals or teachers within the schools need to take ownership of the document and really move it forward,” said one interviewee. “If they depend on [the health department] to come in to do that every time, then it won’t be as sustainable as [they would] like it to be. But if the principal takes [it on], they become passionate.” Challenges included the need to work more closely with those that are able to enforce policy, such as school inspectors and environmental health officers, and to give them enforcement power, such as levying penalties, so that healthy markets are genuinely healthy and smoke-free schools are genuinely smoke free.

Another challenge was maintaining community ownership throughout the project so that health improvements did not end with the project. For example, training teachers and keeping them on board was identified as a challenge for Smoke Free Schools. “Unless people own the project from the initial conception [to] implementation, the project will go as far as the term of the project – that’s it.” The Smoke Free Schools project was designed to be a pilot effort with the intention of taking it to a national scale. If that is achieved, it should help make it sustainable. One participant also identified the need for awareness-raising activities and the development of accompanying legislation as ways of achieving sustainability. For example, future expansions in the Tobacco Control Act and tobacco control movement could work towards creating a smoke-free generation. This was considered particularly important as the project noted increased interference from the tobacco industry – for example, through supporting school-based activities – as the project progressed. Awareness raising and advocacy were also identified as important for the sustainability of the Honiara Central Market project.


Whelan C (2013). Proposal to progress the Healthy Islands initiative in Sianios and Samo 1 and 2 Villages [unpublished document].


