CME

Health Promotion: An Effective Tool for Global Health

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ABSTRACT

Health promotion is very relevant today. There is a global acceptance that health and social wellbeing are determined by many factors outside the health system which include socioeconomic conditions, patterns of consumption associated with food and communication, demographic patterns, learning environments, family patterns, the cultural and social fabric of societies; sociopolitical and economic changes, including commercialization and trade and global environmental change. In such a situation, health issues can be effectively addressed by adopting a holistic approach by empowering individuals and communities to take action for their health, fostering leadership for public health, promoting intersectoral action to build healthy public policies in all sectors and creating sustainable health systems. Although, not a new concept, health promotion received an impetus following Alma Ata declaration. Recently it has evolved through a series of international conferences, with the first conference in Canada producing the famous Ottawa charter. Efforts at promoting health encompassing actions at individual and community levels, health system strengthening and multi sectoral partnership can be directed at specific health conditions. It should also include settings-based approach to promote health in specific settings such as schools, hospitals, workplaces, residential areas etc. Health promotion needs to be built into all the policies and if utilized efficiently will lead to positive health outcomes.

Keywords: Health promotion, mainstreaming health promotion, healthy public policy, issue based approach, healthy settings

Introduction

Health promotion is more relevant today than ever in addressing public health problems. The health scenario is positioned at unique crossroads as the world is facing a 'triple burden of diseases' constituted by the unfinished agenda of communicable diseases, newly emerging and re-emerging diseases as well as the unprecedented rise of noncommunicable chronic diseases. The factors which aid progress and development in today's world such as globalization of trade, urbanization, ease of global travel, advanced technologies, etc., act as a double-edged sword as they lead to positive health outcomes on one hand and increase the vulnerability to poor health on the other hand as these contribute to sedentary lifestyles and unhealthy dietary patterns. There is a high prevalence of tobacco use along with increase in unhealthy dietary practices and decrease in physical activity contributing to increase in biological risk factors which in turn leads to increase in noncommunicable diseases (NCD).[1-3] Figure 1 below illustrates how lifestyle-related issues are contributing to increase in NCDs.[4] The adverse effects of global climate change, sedentary lifestyle, increasing frequency of occurrence of natural disasters, financial crisis, security threats, etc., add to the challenges that public health faces today.

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Health, as the World Health Organization (WHO) defines, is the state of complete physical, social and mental well being and not just the absence of disease or infirmity. The enjoyment of highest attainable standard of health is considered as one of the fundamental rights of every human being.[5] Over the past few decades, there is an increasing recognition that biomedical interventions

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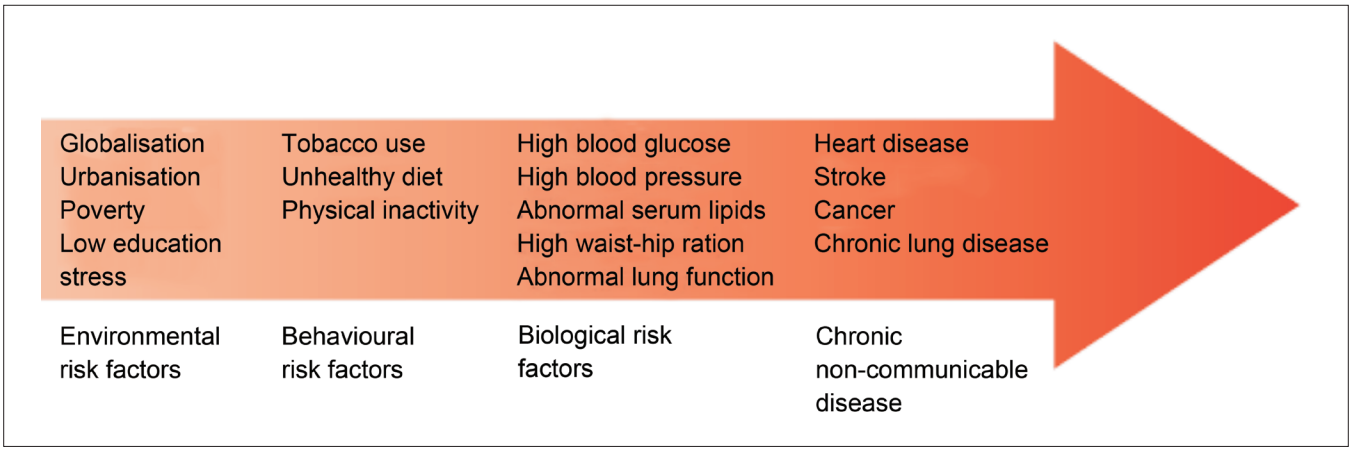

Figure 1: Illustration of how lifestyle-related issues contribute to increase in noncommunicable diseases[4]

alone cannot guarantee better health. Health is heavily influenced by factors outside the domain of the health sector, especially social, economic and political forces. These forces largely shape the circumstances in which people grow, live, work and age as well as the systems put in place to deal with health needs ultimately leading to inequities in health between and within countries.[6] Thus, the attainment of the highest possible standard of health depends on a comprehensive, holistic approach which goes beyond the traditional curative care, involving communities, health providers and other stakeholders. This holistic approach should empower individuals and communities to take actions for their own health, foster leadership for public health, promote intersectoral action to build healthy public policies and create sustainable health systems in the society. These elements capture the essence of "health promotion", which is about enabling people to take control over their health and its determinants, and thereby improve their health. It includes interventions at the personal, organizational, social and political levels to facilitate adaptations (lifestyle, environmental, etc.) conducive to improving or protecting health.[1,2]

Health Promotion: Historical Evolution

Health promotion is not a new concept. The fact that health is determined by factors not only within the health sector but also by factors outside was recognized long back. During the 19th century, when the germ theory of disease had not yet been established, the specific cause of most diseases was considered to be 'miasma' but there was an acceptance that as poverty, destitution, poor living conditions, lack of education, etc., contributed to disease and death. William Alison's reports (1827-28) on epidemic typhus and relapsing fever, Louis Rene Villerme's report (1840) on Survey of the physical and moral conditions of the workers employed in the cotton, wool and silk factories John Snow's classic studies of cholera (1854), etc., stand testimony to this increasing realization on the web of disease causation.

The term 'Health Promotion' was coined in 1945 by Henry E. Sigerist, the great medical historian, who defined the four major tasks of medicine as promotion of health, prevention of illness, restoration of the sick and rehabilitation. His statement that health was promoted by providing a decent standard of living, good labor conditions, education, physical culture, means of rest and recreation and required the co-ordinated efforts of statesmen, labor, industry, educators and physicians. It found reflections 40 years later in the Ottawa Charter for health promotion. Sigerist's observation that "the promotion of health obviously tends to prevent illness, yet effective prevention calls for special protective measures" highlighted the consideration given to the general causes in disease causation along with specific causes as also the role of health promotion in addressing these general causes. Around the same time, the twin causality of diseases was also acknowledged by J.A.Ryle, the first Professor of Social Medicine in Great Britain, who also drew attention to its applicability to non communicable diseases.[7]

Health education and health promotion are two terms which are sometimes used interchangeably. Health education is about providing health information and knowledge to individuals and communities and providing skills to enable individuals to adopt healthy behaviors voluntarily. It is a combination of learning experiences designed to help individuals and communities improve their health, by increasing their knowledge or influencing their attitudes, whereas health promotion takes a more comprehensive approach to promoting health by involving various players and focusing on multisectoral approaches. Health promotion has a much broader perspective and it is tuned to respond to developments which have a direct or indirect bearing on health such as inequities, changes in the patterns of consumption, environments, cultural beliefs, etc.[3]

The 'New Perspective on the Health of Canadians'

Report known as the Lalonde report, published by the Government of Canada in 1974, challenged the conventional 'biomedical concept' of health, paving way for an international debate on the role of nonmedical determinants of health, including individual risk behavior. The report argued that cancers, cardiovascular diseases, respiratory illnesses and road traffic accidents were not preventable by the medical model and sought to replace the biomedical concept with 'Health Field concept' which consisted of four "health fields"–lifestyle, environment, health care organization, human biology as the determinants of health and disease. The Health Field concept spelt out five strategies for health promotion, regulatory mechanisms, research, efficient health care and goal setting and 23 possible courses of action. Lalonde report was criticized by skeptics as a ploy to stem in the governments rising health care costs by adopting health promotion policies and shifting responsibility of health to local governments and individuals. However, the report was lapped up internationally by countries such as USA, UK, Sweden, etc., who published similar reports. The landmark concept also set the tone for public health discourse and practice in the decades to come.[7-10] Health promotion received a major impetus in 1978, when the Alma Ata declaration acknowledged that the promotion and protection of the health of the people was essential to sustained economic and social development and contributed to a better quality of life and to world peace.[5]

Conferences on Health Promotion

Growing expectations in public health around the world prompted WHO to partner with Canada to host an international conference on Health Promotion in 1986. It was held in Ottawa, and produced not only the "Ottawa Charter for Health Promotion" but also served as a prelude to subsequent international conferences on health promotion. The Ottawa Charter defined Health Promotion as the process of enabling people to increase control over and to improve their health. To reach a state of complete physical, mental and social well being, an individual or group must be able to identify and to realize aspirations, to satisfy needs, and to change or cope with the environment. Health is, therefore, seen as a resource for everyday life, not the objective of living. The fundamental conditions and resources for health are: peace, shelter, education, food, income, a stable ecosystem, sustainable resources, social justice and equity. Health promotion thus is not just the responsibility of the health sector, but goes beyond healthy lifestyles to well being. The Charter called for advocacy for health actions for bringing about favorable political, economic, social, cultural, environmental, behavioral and biological factors for health, enabling people to take control of the factors influencing their health and mediation for multi sectoral action. The Charter defined Health Promotion action as one a) which builds up healthy public policy that combines diverse but complementary approaches including legislation, fiscal measures, taxation and organizational change to build policies which foster equity, b) create supportive environments, c) support community action through empowerment of communities - their ownership and control of their own endeavors and destinies, d) develop personal skills by providing information, education for health, and enhancing life skills and e) reorienting health services towards health promotion from just providing clinical and curative services.[11]

This benchmark conference led to a series of conferences on health promotion - Adelaide (1988), Sundsvall (1991), Jakarta (1997), Mexico-City (2000), Bangkok (2005) and Nairobi (2009). In Adelaide, the member states acknowledged that government sectors such as agriculture, trade, education, industry and communication had to consider health as an essential factor when formulating healthy public policy. The Sundsvall statement highlighted that poverty and deprivation affecting millions of people who were living in extremely degraded environment affected health. In Jakarta too poverty, low status of women, civil and domestic violence were listed as the major threats to health. The Mexico statement called upon the international community to address the social determinants of health to facilitate achievement of health-related millennium development goals. The Bangkok charter identified four commitments to make health promotion (a) central to the global development agenda; (b) a core responsibility for all governments (c) a key focus of communities and civil society; and (d) a requirement for good corporate practice.[12,13] The last conference in October 2009 in Nairobi called for urgent need to strengthen leadership and workforce, mainstream health promotion, empower communities and individuals, enhance participatory processes and build and apply knowledge for health promotion.

The health promotion emblem [Figure 2] adopted at the first international conference on health promotion in Ottawa and evolved at subsequent conferences symbolizes the approach to health promotion. The logo has a circle with three wings. It incorporates five key action areas in health promotion (build healthy public policy, create supportive environments for health, strengthen community action for health, develop personal skills and reorient health services) and three basic HP strategies (to enable, mediate and advocate).

a. The outer circle represents the goal of "Building Healthy Public Policies" and the need for policies to "hold things together". This circle has three wings inside it which symbolise the need to address all five

key action areas of health promotion identified in the Ottawa Charter in an integrated and complementary manner.

b. The small circle stands for the three basic strategies for health promotion, "enabling, mediating, and advocacy".

c. The three wings represent and contain the words of the five key action areas for health promotion – reorient health services, create supportive environment, develop personal skills and strengthen community action.[14]

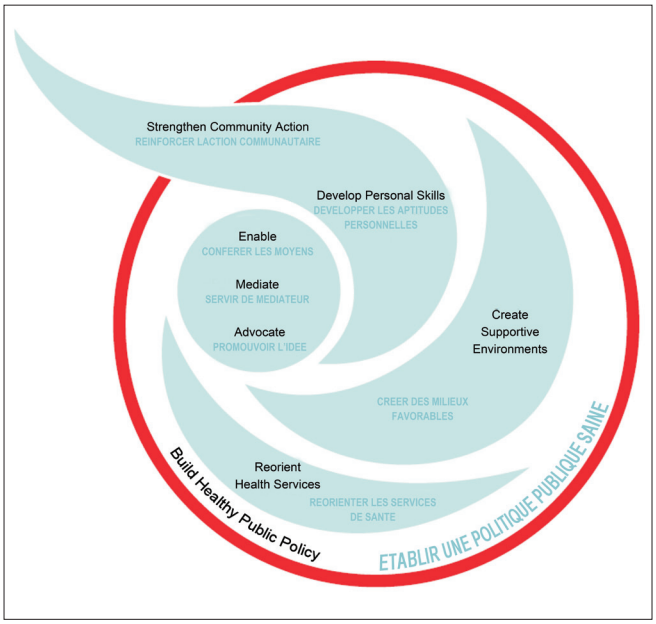

Figure 2: Health promotion emblem

True to its recognition of health being more influenced by factors outside the health sector, health promotion calls for concerted action by multiple sectors in advocacy, financial investment, capacity building, legislations, research and building partnerships. The multisectoral stakeholder approach includes participation from different ministries, public and private sector institutions, civil society, and communities all under the aegis of the Ministry of Health.[3]

Approaches to Health Promotion

Health promotion efforts can be directed toward priority health conditions involving a large population and promoting multiple interventions. This issue-based approach will work best if complemented by settings-based designs. The settings-based designs can be implemented in schools, workplaces, markets, residential areas, etc to address priority health problems by taking into account the complex health determinants such as behaviors, cultural beliefs, practices, etc that operate in the places people live and work. Settings-based design also facilitates integration of health promotion actions into the social activities with consideration for existing local situations.[3]

The conceptual framework in Figure 3 below summarizes the approaches to health promotion. It looks at the need of the whole population. The population for any disease

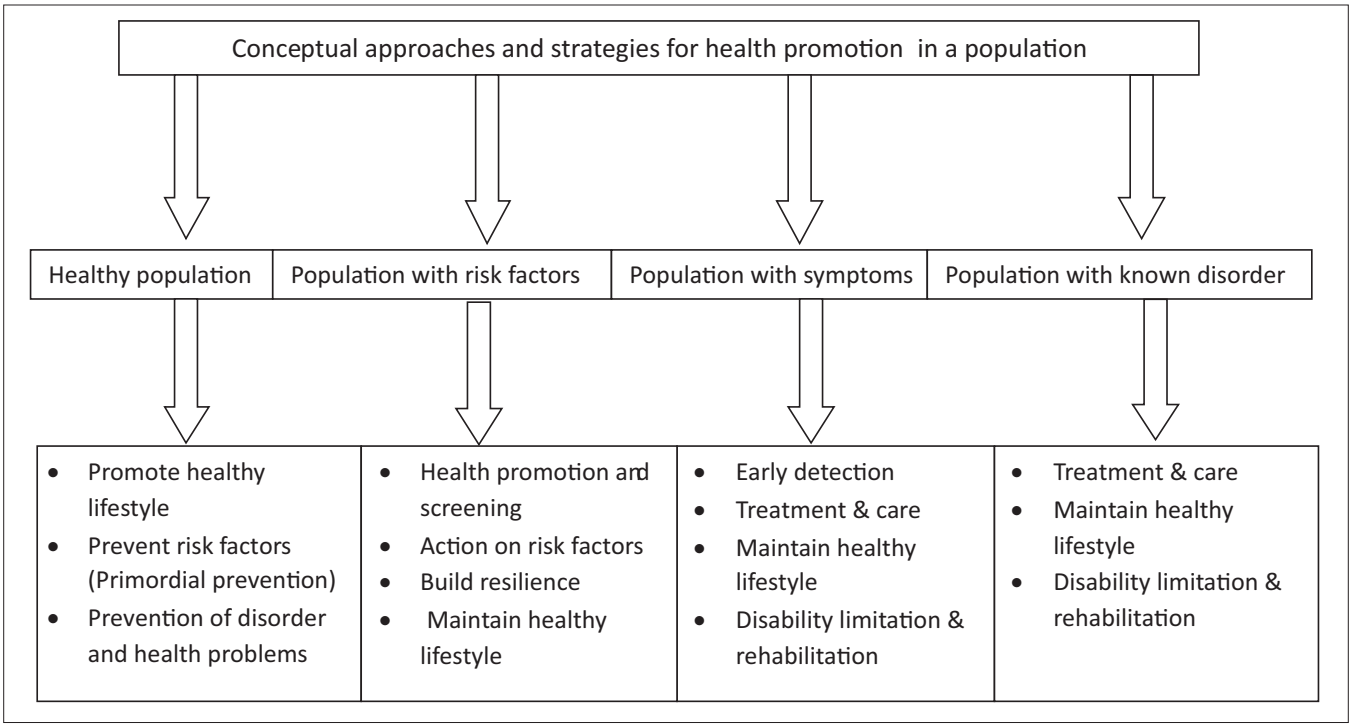

Figure 3: Conceptual framework for health promotion

can be divided into four groups a) healthy population, b) population with risk factors, c) population with symptoms and d) population with disease or disorder. Each of these four population groups needs to be targeted with specific interventions to comprehensively address the need of the whole population. In brief, it encompassed primordial prevention for healthy population to curative and rehabilitative care of the population with disease. Primordial prevention aspires to establish and maintain conditions to minimize hazards to health. It consists of actions and measures that inhibit the emergence and establishment of environmental, economic, social and behavioral conditions, cultural patterns of living known to increase the risk of disease.[15]

Examples of Health Promotion in Communicable and Non-communicable Diseases

Health promotion measures are often targeted at a number of priority disease – both communicable and noncommunicable. The Millennium Development Goals (MDGs) had identified certain key health issues, the improvement of which was recognized as critical to development. These issues include maternal and child health, malaria, tuberculosis and HIV and other determinants of health. Although not acknowledged at the Millennium summit and not reflected in the MDGs, the last two decades saw the emergence of NCD as the major contributor to global disease burden and mortality. NCDs are largely preventable by effective and feasible public health interventions that tackle major modifiable risk factors - tobacco use, improper diet, physical inactivity, and harmful use of alcohol. Eighty percent of heart diseases and stroke, 80% of diabetes and 40% of cancers can be prevented by eliminating common risk factors, namely poor diet, physical inactivity and smoking.[16] Against this background health promotion as the "the science and art of helping people change their lifestyle to move toward a state of optimal health" is a key intervention in the control of NCDs. The following paragraphs showcase the application of an issue based approach of health promotion, using communicable and NCDs as examples capturing the components of individual and community empowerment, health system strengthening and partnership development.

Communicable Diseases

These diseases can be adequately addressed through health promotion approach. Here is one example:

Improving use of ITNs to prevent malaria: Insecticide-treated bed-nets (ITNs) are recommended in malaria endemic areas as a key intervention at the individual level in preventing malaria by preventing contact between mosquitoes and humans. (a) The individual level health promotion action would include providing access to ITNs and encouraging their regular and proper use every night from dusk to dawn. Available evidence points to the fact that this can be best achieved by social marketing campaigns to promote demand of ITNs. The messages should be tailored to cultural beliefs, for example the belief in some communities that mosquitoes have no role in the etiology of malaria. Distribution of ITNs to the community should ideally be followed by 'hang up' campaigns by trained health care workers educating the community on how to use the nets and helping them hang the nets, especially for the most vulnerable groups. (b) The community empowerment efforts, a collaborative initiative with the community to understand the cultural beliefs and behaviours and educating them about the disease would produce desirable results. There are documented examples of how women in a community empowerment program in Thailand developed family malaria protection plans, provided malaria education to community members, mosquito-control measures in a campaign, scaled-up use of insecticide-impregnated bed nets, instituted malaria control among migrant labourers, as well as activities to raise income for their families. Another program in Papua New Guinea empowered community members to take responsibility for the procurement, distribution and effective use of bed nets in the village, which led to a significant decrease in the incidence of malaria-related mortality and morbidity. (c) Strengthen health systems, integration of malaria vector control and personal protection into the health system through innovative linkages to ongoing health programs and campaigns is likely to lead to strong synergies, economies, and more rapid health system strengthening compared to new vertical programmes.. Successful examples of this include piggybacking the distribution of ITNs through antenatal care or immunization campaigns for measles and polio. (d) Partnerships are key in malaria control because of the involvement of multiple sectors. Action outside the health sector to remove barriers to the uptake of malaria prevention strategies has included lobbying for reduction or waiver of taxes and tariffs on mosquito nets, netting materials and insecticides and stimulating local ITN industries. Intersectoral collaboration has played an integral role in vector control measures for malaria prevention, including environmental modification, larval control, etc.[17]

Noncommunicable Diseases

In NCDs, two path-breaking studies need special mention. These studies are the Framingham Heart Study (started in 1951) and study on smoking among British doctor (started in 1948) have helped us in understanding how lifestyle affects various NCDs. The study in British

doctors showed that prolonged cigarette smoking from early adult life tripled age-specific mortality. The excess mortality associated with smoking mainly involved vascular, neoplastic and respiratory diseases caused by smoking. The Framingham Heart Study has led to the identification of major CVD risk factors such and blood pressure, blood triglycerides and cholesterol level, age, gender and psychosocial issues (Framingham Heart Study).[18]

Cardiovascular Diseases

In the early 1970s the mortality rate from coronary heart disease was the highest in the world among men of Finland. The dietary practices of the Finnish population centered around dairy products and their food was rich in saturated fats, salt and low in unsaturated fats, fruits and vegetables. The North Karelia project, a major community-based intervention was launched in North Karelia, a fairly rural and economically poor province. This project developed comprehensive community based strategies to change the dietary habits of the population, with the main goal to reduce the high cholesterol levels in the population. The strategy focused on reduction intake of high saturated fat as well as the salt intake and to increase the consumption of fruits and vegetables. At the individual and community level, health information and nutritional counseling were made available, skills were developed, social and environmental support was provided all the while ensuring community participation. The health system was closely involved with the project. The project also developed strong partnerships with schools, health related and other nongovernmental organizations, supermarkets and food industry, community-based organizations and media. Collaborations were done with the food industry to reduce the fat and salt content of common food items such as dairy food, processed meat and bakery items. Dairy farmers were encouraged to switch to berry farming through the launching of a Berry project. The North Karelia project was extended to the entire country with the health care services also responsible along with schools and nongovernmental agencies in implementing nutrition and health education. Nation-wide nutrition education and collaboration with food industry were backed by legislative actions and were rewarded with remarkable results. Surveys showed a transformation in dietary habits with a marked reduction intake in saturated fats and salt and declared ischemic heart disease mortality declining by 73% in North Karelia and by 65% in Finland from 1971 to 1995.[19]

Diabetes Mellitus

Diabetes mellitus is one of the NCDs which has led to high rates of morbidity and mortality worldwide. Health promotion is being increasingly recognized as a viable, cost-effective strategy to prevent diabetes. The interventions at the individual and community level includes lifestyle modification programs for weight control and increasing physical activity with community participation using culturally appropriate strategies. The Kahnawake School's Diabetes Prevention Project (KSDPP) in Canada provides an example of a project that involved the local Mohawk community, researchers and local health service providers, in response to requests from the community to develop a diabetes prevention program for young children. The long-term goal of KSDPP was to decrease the incidence of type 2 diabetes, through the short-term objectives of increasing physical activity and healthy eating. Such preventive interventions have to be backed by strengthening of the health system which combines identification of high risk groups with risk factor surveillance and availability of trained primary health care providers for risk assessment and diabetes management. Online training courses offer an innovative approach to enhance health system capacity for diabetes health promotion, such as a course targeted at workers in remote indigenous communities in the Arctic to foster learning related to the Nunavut Food Guide, traditional food and nutrition, and diabetes prevention. Partnership and network development is key to the achievement of these measures. As part of the city-wide 'Let's Beat Diabetes initiative' in South Auckland, New Zealand the district health board with support from local government provided safe environments for physical activity by upgrading parks and worked with the food industry to provide healthier food options at retail outlets in order to reduce consumption of sweetened soft drinks and energy dense foods. Sugar-free soft drinks were made available as default options to customers, unless specifically requested otherwise. Intersectoral action on risk factors for diabetes also acts on the determinants of the other major risk factors for the NCD burden, such as heart disease, cancer and respiratory disease, hence health promotion activities aimed at reducing risk of diabetes mellitus have added advantages.[17]

Settings Based Approach to Health Promotion

The concept of 'healthy settings' which maximizes disease prevention through a whole system approach had emerged from WHO's Health for All strategy and Ottawa Charter. The call for supportive environments was followed up by the Sundwal statement of 1992 and the Jakarta declaration of 1997. The settings approach builds on the principles of community participation, partnership, empowerment and equity and replaces an over reliance on individualistic methods with a more holistic and multidisciplinary approach to integrate

action across risk factors. The 'Healthy Cities' programme launched by WHO in 1986 was soon followed up by similar initiatives in smaller settings such as schools, villages, hospitals, etc.[20]

Health Promoting Schools

Health promoting schools build health into all aspects of life in school and community based on the consideration that health is essential for learning and development. To further this concept, WHO and other UN agencies developed an initiative, 'Focusing Resources on Effective School Health (FRESH), emphasizing on the benefit to both health and education if all schools were to implement school health policies, a healthy school environment, with the provision of safe water and sanitation an essential first step, skills-based health education and school-based health and nutrition services.[21]

Healthy Work Places

Currently, globally an estimated two million people die each year as a result of occupational accidents and work-related illnesses or injuries and 268 million nonfatal workplace accidents result in an average of three lost workdays per casualty, as well as 160 million new cases of work-related illness each year.[22] Healthy work places envision building a healthy workforce as well as providing them with healthy working conditions. Healthy working environments translate to better health outcomes for the employees and better business outcomes for the organizations.[23]

Health Promotion in India

Health promotion is strongly built into the concept of all the national health programs with implementation envisaged through the primary health care system based on the principles on equitable distribution, community participation, intersectoral coordination and appropriate technology. Nevertheless, it has received lower priority compared to clinical care. The government, through the component of IEC has always strived to address the issue of lack of information, which is a major barrier to increasing accessibility of health care services.[24] The National Rural Health Mission (NRHM) called for a synergistic approach by relating health to determinants of good health such as segments of nutrition, sanitation, hygiene and safe drinking water and by revitalizing local traditions and mainstreaming the Ayurvedic, Unani, Siddha and Homeopathic systems of medicine to facilitate health care.[25] NRHM offers an excellent opportunity to target and reach every beneficiary with appropriate interventions through microplanning into district planning process.[26]

Health promotion component needs to be strengthened with simple, cost-effective, innovative, culturally and geographically appropriate models, combining the issue-based and settings-based designs and ensuring community participation. Replicability of successful health promotion initiatives and best practices from across the world and within the country needs to be assessed. Efforts have already been initiated to build up healthy settings such as schools, hospitals, work places, etc.[20,22,27] For effective implementation of health promotion we need to engage sectors beyond health and adopt an approach of health in all policies rather than just the health policy.

Conclusions

Today, there is a global acceptance that health and social well being are determined by a lot of factors which are outside the health system which include inequities due to socioeconomic political factors, new patterns of consumption associated with food and communication, demographic changes that affect working conditions, learning environments, family patterns, the culture and social fabric of societies; sociopolitical and economic changes, including commercialization and trade and global environmental change. To counter the challenges due to the changing scenarios such as demographic and epidemiological transition, urbanization, climate change, food insecurity, financial crisis, etc. health promotion has emerged as an important tool; nevertheless the need for newer, innovative approaches cannot be understated. A multisectoral, adequately funded, evidence-based health promotion program with community participation, targeting the complex socioeconomic and cultural changes at family and community levels is the need of the hour to positively modify the complex socioeconomic determinants of health.

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