

***Health Promotion White Paper***  
***Section of Chronic Disease Prevention and Health Promotion***  
***Division of Public Health, Department of Health and Social Services***  
***August 2007***

What is health promotion? Are there clear lines to delineate between disease prevention and health promotion or are they inclusive? Is primary prevention the same as health promotion? These are some of the questions that were raised in a recent survey of Section of Chronic Disease Prevention and Health Promotion. This paper will provide an operational definition of health promotion, identify current challenges and strengths that impact the Section's ability to implement effective health promotion programming, and provide preliminary recommendations for future planning and integration of health promotion functions throughout public health.

### **History and Overview of Health Promotion Profession**

While promotion of health practices have been around for the length of recorded mankind, contemporary health promotion can be traced to 1974 when Marc LaLonde, the Canadian Minister of Health and Welfare, released a monograph, titled "A New Perspective on the Health of Canadians"<sup>1</sup>. This was the first time health promotion policy was identified by a national government aimed at the health of a population. It stimulated international interest in health promotion initiatives, and led to the World Health Assembly's passage of the Ottawa Charter of 1986<sup>2</sup>. The Charter highlighted the importance of promoting health for the World Health Organization by adopting these five key themes of health promotion:

1. The importance of **building healthy public policy** through complementary approaches, including legislation, fiscal measures, taxation and organization change.
2. Creation of **supportive environments** to ensure that work, leisure and living environments are a source of health for people.
3. **Strategic community action** to enhance self-help and social support, and to develop flexible systems for strengthening public participation in, and direction of, health matters.
4. **Developing personal skills** through information and education skills, facilitated in school, home, work and community settings.
5. A **re-orientation of health care services** toward prevention of illness and promotion of health.

This position was strengthened by the WHO Bangkok Charter for Health in 2005, which includes the following five key action areas for health promotion<sup>3</sup>:

1. **Partner and build alliances** with private, non-private, non-governmental or international organizations to create sustainable actions.
2. **Invest in sustainable policies**, actions and infrastructure to address the determinants of health.
3. **Build capacity for policy development**, health promotion practice and health literacy.

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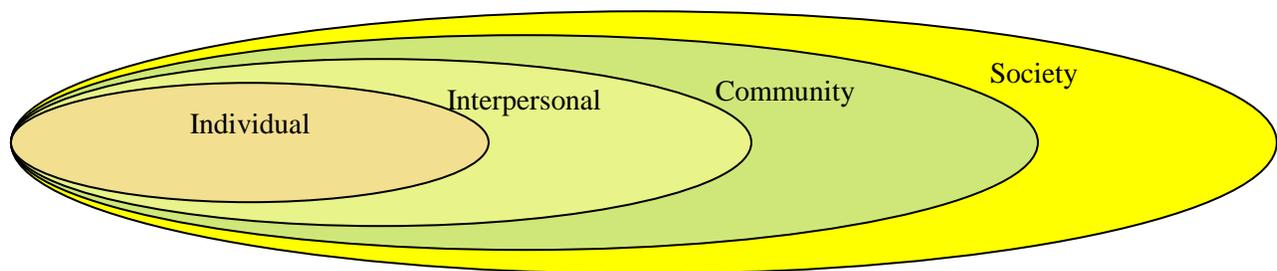
<sup>1</sup> Lalonde, Mark. A New Perspective on the Health of Canadians; a Working Document. Minister of Supplies and Services Canada, 1981.

<sup>2</sup> 1<sup>st</sup> Global Conference on Health Promotion. The Ottawa Charter for Health Promotion. World Health Organization, 1986.

<sup>3</sup> 6<sup>th</sup> Global Conference on Health Promotion. The Bangkok Charter for Health Promotion in a Globalized World. World Health Organization, 2005.

4. **Regulate and legislate** to ensure a high level of protection from harm and enable equal opportunity for health and well being.
5. **Advocate health** based on human rights and solidarity.

It is recognized that in order to be effective health promotion changes must occur at multiple levels. The social ecological framework helps to highlight how this can occur. This framework was first developed by Urie Bronfenbrenner, and was initially applied to child development issues. It has been adopted throughout the Centers for Disease Control and Prevention as a model to use in developing prevention and health promotion programming<sup>4</sup>. It specifies various overlaying systems within which the individual resides.



Under this framework the individual factors, such as personality characteristics, genetic make-up and personal preferences affect health factors. The individual is further influenced by the interpersonal relationships, including family, friends, neighbors, co-workers and peers. The community factors include characteristics in which social relationships exist, and include the workplace, neighborhoods, health care systems, and faith communities. The societal factors reflect the larger system that impacts the individual, including cultural, political, economy, social beliefs and norms. Each system contains roles, norms, and rules that can powerfully shape health conditions, choices and standards. For example, a Native family in a western Alaska village faces many challenges different from a Caucasian family living in Juneau. The western Native family will most likely have more ready access to extended family support systems, but less goods and services, while the Caucasian family experiences the reversal; less access to extended family support systems, but more access to goods and services. Both of these communities require different approaches that build on the community resources, norms and standards in order to reach the same health outcomes.

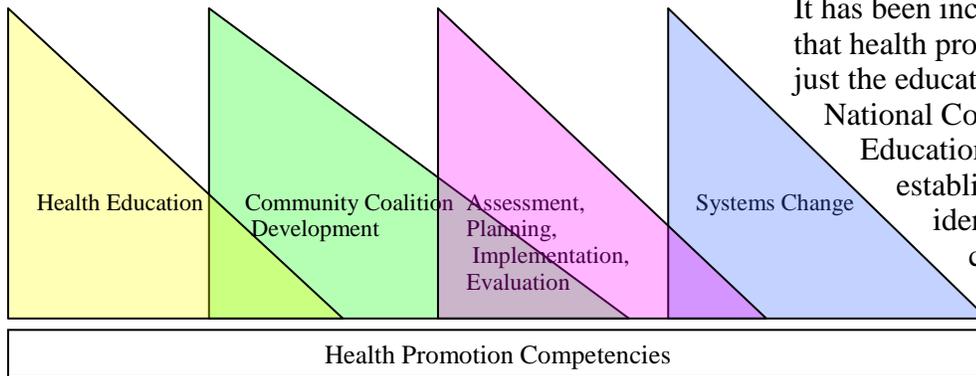
## Definition

Health promotion is a public health function that transcends programs, disease and risk factors. The definition of health promotion has been evolving over the past three decades. It once consisted primarily of health education, and is still commonly referred to by that term. Health education is an educational process concerned with providing a combination of approaches to lifestyle change that

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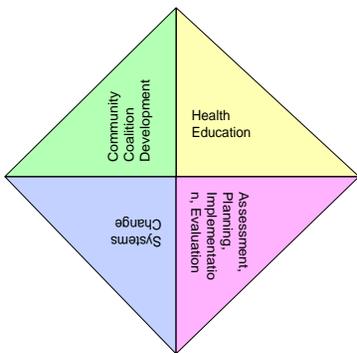
<sup>4</sup> Tomison, Adam M., and Sarah Wise. "Community-based approaches in preventing child maltreatment." Child Abuse Prevention. 11.Autumn 1999.

can assist individuals, families and communities in making informed decisions on matters that affect restoration, achievement and maintenance of health.



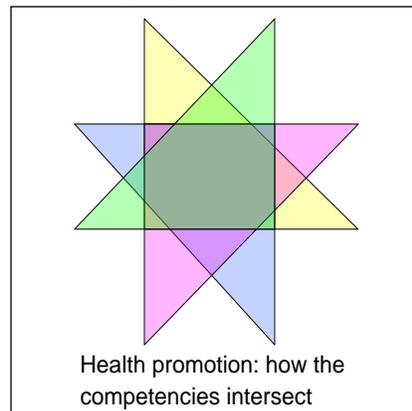
It has been increasingly recognized that health promotion is broader than just the educational component. The National Commission for Health Education Credentialing was established in 1988, and identified seven specific competency areas, including community development, assessment, planning, implementation and evaluation competencies that support the reduction of disease and injury impacts and risk factors, while promoting wellness. More recently, the health promotion profession has been active in systems change through formal and informal policy development, and environmental supports that can affect an entire population, by targeting underlying risk factors for disease and injury. In a study commissioned by CDC and the Directors of Health Promotion and Education, “Policy and Environmental Change, New Directions for Public Health”<sup>5</sup>, it is noted that policy and environmental change has moved health promotion beyond the more traditional focus of changing the behaviors of single individuals and small groups to larger groups and systems simultaneously. This expansion in the professional capacity of health promotion has created the need to systematically address the capacity of public health professionals and organizations to engage in interventions that affect many people at one time.

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A more accurate definition of current health promotion practice is the combination of education, community development, and environmental supports for actions and conditions of living conducive to health. The actions and behavior in questions may be those of individuals, groups, or communities, of policy makers, employers, teachers or others whose actions control or influence the determinants of health. The purpose of health promotion is to enable

people to gain greater control over the determinants of their own health, while striving to address the inequities of health. The most effective health promotion incorporates the four key components of health promotion, health education, systems change, community development, and assessment, planning, implementation and evaluation into an overlapping discipline, forming the “patchwork” of health promotion.



Where does health promotion fall within the continuum of prevention? It is generally recognized that primary prevention focuses on the development of risk factors associated with diseases and

<sup>5</sup> Association of Directors of Health Promotion and Public Health Education, and U.S. Centers for Disease Control and Prevention. Policy and Environmental Change: New Directions for Public Health. Ed. Tom Kean. Santa Cruz, CA: Toucan Ed, 1999.

injuries. Secondary prevention is aimed at early disease and injury detection, thereby increasing opportunities for interventions to prevent progression of the disease and emergence of symptoms. Tertiary prevention reduces the negative impact of an already established disease and injury by restoring function and reducing related complications. If the purpose of health promotion is to give people greater control over their lives, it stands to reason that health promotion has a role within all three levels of prevention, while recognizing it is most effective when associated with the early interventions of disease and injury prevention, promoting the highest levels of population based health and quality of life.

Health promotion is defined by the World Health Organization as the process of enabling people to increase control over, and to improve, their health, regardless of health condition, risk factor or inequity. It encompasses all prevention efforts, disease and injury related, building on the four competency areas; health education, community and coalition development, assessment, planning, implementation, evaluation, and systems change. In addition to addressing categorical risk factors and conditions pertinent to particular health concerns, health promotion goes further upstream from categorical health issues to focus on healthy lifestyles, attitudes, choices, communities, cultural and social norms, and environments, regardless of specific disease and injury risk factors.

### **Chronology of Health Promotion Development in Alaska**

While health promotion is a function, it can be used to identify units of public health programs, generally associated with community-based, predominantly primary and secondary prevention. The national Directors of Health Promotion and Education advocates for a centralized health promotion function within state agencies. Examples they cite of specific program service areas that could be administered by a central health promotion unit are:

- ◆ Tobacco Prevention and Control
- ◆ Injury Prevention
- ◆ Cardiovascular Risk Reduction
- ◆ Worksite Health Promotion
- ◆ Physical Activity
- ◆ Breast and Cervical Cancer Interventions
- ◆ Diabetes Education
- ◆ HIV Education
- ◆ School Health Education
- ◆ Public Information/Health Education
- ◆ Behavioral Risk Factor Surveillance System
- ◆ Health Communications

The Indian Health Service, Alaska Area Native Health Service (AANHS) maintained a Health Education office from the 1970's into the 1990's. The purpose of this office was to provide support for a regional health education system. This was done through the provision of grants to regional tribal health organizations, provision of technical assistance, and the facilitation of networking between regions. Through these efforts, the Alaska Health Education Consortium (AHEC) was developed, providing the venue to promote networking of health promotion and education across the state that continues today.

Centralized health promotion and education within the State Division of Public Health originated in 1982 with the receipt of the federal Preventive Health and Health Services (PHHS) Block Grant. This office administrated the health education and risk reduction grants to community organizations and agencies in Alaska. The State of Alaska Health Promotion Program has been instrumental in starting a wide range of public health initiatives, including the Alaska Health Summit, the Behavior Risk Factor Surveillance Survey, Heart Disease and Stroke, Obesity Prevention and Control, and Tobacco Prevention and Control. It sponsored community based health promotion throughout the

1990's under the Planned Approach to Community Health (PATCH), including grants, training and technical assistance.

During the mid 1990's two things emerged to change the direction of community-based health promotion capacity. First, Indian Health Services participated in compacting, decentralizing its functions and funding to the tribes. As part of this, it closed the AANHS Health Education Office. Decisions to maintain local health promotion functions was left to each tribe, with some tribes choosing to continue a prevention focus, while many did not. At the same time, PHS Block Grant funds were directed away from PATCH. Funding for community-based grants was gradually reduced and ultimately eliminated.

Over the last five years the state's comprehensive health promotion functions have been segmented due to a series of reorganizations. Established as a unit within CHEMS in 2000, Health Promotion included the community preventive services, tobacco prevention and control, cardiovascular disease, physical activity, and the health survey lab. The unit was linked with Chronic Disease with the development of the Section of Chronic Disease Prevention and Health Promotion in July 2005. The unit was dissolved in July 2006, with the intent that health promotion functions would be accessible across the Section.

### **Current Strengths and Challenges in the Health Promotion System throughout Alaska**

A formal inventory of health promotion programming has yet to be conducted for the Section of Chronic Disease Prevention and Health Promotion, but the following strengths and challenges applicable to health promotion programs generally have been identified through a series of papers. The Visioning of Health Promotion for Alaska<sup>6</sup> is the summary of a two day meeting that took place in Anchorage in September 2004. *A Report of the Ad Hoc Committee: The Recommendation to Establish a Health Promotion Focal Point within the Centers for Disease Control and Prevention (CDC)*<sup>7</sup> covers a March 30, 2004 meeting sponsored by the Directors of Health Promotion as part of a study to ascertain health promotion capacities within state health agencies, as well as to propose possible actions that CDC could take to strengthen health promotion activities and programs. A third paper, still in draft form, is a report prepared by Saint Louis University's School of Public Health on *Health Promotion and Education in State Health Departments: What Makes it Work?*<sup>8</sup> The final paper was released in June 2007 by the International Union of Health Promotion and Education entitled, *Shaping the Future of Health Promotion: Priorities for Action.*<sup>9</sup>

#### **Challenges**

One challenge facing the health promotion field is the lack of continuity in the definition and practice of health promotion across public health, including CDC and Alaska's Division of Public Health. Funding priorities are established by the categorical programs, which decreases the ability for national and state level integration of comprehensive health promotion programming. This is hindered by the absence of clear and reasonably consistent terminology and program standards, as

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<sup>6</sup> Alaska Division of Public Health, Section of Epidemiology. Vision of Health Promotion in Alaska. State of Alaska, 2004.

<sup>7</sup> Directors of Health Promotion and Education. *A Report of the Ad Hoc Committee: The Recommendation to Establish a Health Promotion Focal Point within the Centers for Disease Control and Prevention (CDC)* Directors of Health Promotion and Education, 2004.

<sup>8</sup> St. Louis University. Health Promotion and Education in State Health Departments: What Makes it Work? Directors of Health Promotion and Education, pending.

<sup>9</sup> International Union of Health Promotion and Education, Canadian Consortium for Health Promotion Research. Shaping the future of health promotion: Priorities for Action. IUHPW, CCHPR, June 2007.

identified by the March 2004 ad hoc committee. The Ad Hoc committee unanimously recognized that the lack of a national focal point within CDC creates specific concerns for state and local health professionals who do not work in a specific health or disease categorical program, by limiting the ability of categorical programs to collaborate on cross-cutting initiatives. The committee consisted of health promotion stakeholders representing state and federal health agencies, as well as health philanthropies and academic research and training centers. Their primary charge was to identify critical issues that needed to be addressed to establish a CDC health promotion focal point. Five priority recommendations functions were identified to improve health promotion including:

1. Developing consensus on standards for terminology, program and policy implementation, and program evaluation protocols for effective health promotion science.
2. Conducting regular quality assurance review of all CDC program grants that include health promotion components to ensure that those components apply appropriate health promotion standards, terminology and protocols.
3. Establishing a protocol and review mechanisms that CDC-sponsored health promotion training and technical assistance use the established standards, protocols and terminology.
4. Using stakeholders to develop a health promotion research agency that highlights the priority questions needing to be studied.
5. Developing and implementing communication systems relative to the issues in the first 4 priority functions.

The State of Alaska and CDC's structure is not organized to establish and maintain interagency input and collaboration across and beyond chronic disease programming. There is a lack of consistent leadership or support in health promotion policy development due to on-going changes in administration and organization. With decreasing visibility of a health promotion entity at the state level, it is difficult to maintain a consistent prioritization of health promotion efforts. Limited funds and differing agendas of administration and categorical funding sources impact our ability to carry out effective health promotion at both the state and local levels.

To date, health promotion programs have lacked strong outcome measures, making it difficult to document program effectiveness. Community-based health promotion has focused on process measures that track the number of services provided to the number of beneficiaries, but hasn't tried to answer the question, "so what?" This has been due, in large part, to the delayed benefits of successful health promotion. Even with good outcomes, there are delayed benefits making it difficult to see the long-term value. For example, finding the correct blood pressure medication will result in lower blood pressure readings. Also, an effective immunization campaign will decrease the disease rates very quickly. Launching a 10,000 steps community project to reduce levels of overweight and obesity, however, will not show significant changes in obesity rates during the first one to two years. It can take longer than that to see consistent population based change in obesity rates, thereby requiring a consistently longer term commitment to these initiatives before recognizing impacts on the health status of the target audience.

Another challenge is increasing health professionals' understanding of the need to develop comprehensive population-based health promotion initiatives. Developing and printing brochures and conducting one-time events have not proven to have an impact in the overall health status of people or communities. Because funding is often limited, especially for local and state health promotion, public health needs to become more cognizant of the need to develop initiatives that address all levels of the socio-ecological model, and are based on the specific needs of the target audience in order to effect the needed behavioral changes to improve the quality of life.

## **Strengths**

There are several health promotion strengths within the Section of Chronic Disease Prevention and Health Promotion. The Planned Approach to Community Health and community-based health promotion grants have provided a wealth of information on community contacts and partnering with community efforts. The Alaska Health Education Library Project and the Current Health Topic are viewed as viable resources for health promotion professionals. The Tobacco Prevention and Control program has been highly effective in developing and supporting comprehensive health promotion programming at the state and local levels. Using comprehensive health promotion standards, it has been able to impact social norms through its priority levels. The national tobacco effort was instrumental in identifying and institutionalizing health promotion best practices.

Following a decrease of community level health promotion programs since the mid 1990's, Alaska is experiencing a revitalization of health promotion at the local level. This is related primarily to a reprioritization within the tribal health organizations, as well as the strong inroads in primary prevention and health promotion that have been experienced as a result of the tobacco prevention and control efforts. Several innovative approaches are being implemented, including the development and utilization of community wellness advocates in smaller communities.

The matrix exercise conducted by the Section in 2005 reflects the extensive number of community partnerships that exist across the programs. There is a significant amount of overlap across the programs with community and statewide partners. The Section of Chronic Disease Prevention and Health Promotion works with core groups of dedicated health promotion people. Much of our work could not be accomplished without these partners.

There have been some excellent collaborative efforts that are proving fruitful for the Section, as well as communities. The Worksite Health Promotion Collaborative has combined the resources and knowledge of several chronic disease prevention and health promotion programs to partner with Premera Blue Cross Blue Shield and four small employers to identify ways for more Alaskans to receive health promotion at the worksite. The Team Nutrition project has partnered the Department of Education and Early Development with several health promotion programs to support local school districts in the development and implementation of wellness policies and initiatives for students and employees. The Coordinated Media project has identified five common messages to promote across the section; Eat Smart, Be Physically Active, Get Check, Think Positively, Live Tobacco Free. Promoting these common messages through further through website development will hold promise, although progress has been delayed due to limited resources and Departmental priorities. These efforts are providing a model for integration of planning across the various categorical programs and funding streams.

There are several "hot topics" at the national and state level that can support health promotion and primary prevention programming. The obesity epidemic is one, as well as rising health care costs. There is a growing recognition that we must begin impacting health before the disease occurs. There is also a growing recognition that we must develop more integrated programming across the categorical, disease and body part method currently employed by the Centers for Disease Control and Prevention's Center for Chronic Disease Prevention and Health Promotion. Primary prevention has an expanding role with the categorical programs that have traditionally focused on secondary and tertiary prevention (Diabetes, Arthritis and Cancer), as well as the Center for Injury Prevention.

Finally, there is a growing body of evidence that health promotion is effective. The Guide to Community Preventive Services has provided the science base for population-based community-level health promotion effectiveness. Population-based programming is being incorporated throughout public health at both the national and state levels. Each one of the programs within the Section utilizes health promotion principles and practices, which can be used to broaden the case for health promotion efficacy.

## **Recommendations**

As a Section, we need to work at both the national and state levels to develop and apply health promotion standards and protocols with input and collaboration from those responsible for managing health promotion components of programs. Active involvement is necessary in national organizations such as Directors of Health Promotion and Education, the Chronic Disease Directors and related councils, the Association of State Health Officers, and the Association of State and Territorial Nutrition Directors, as well as statewide associations such as AHEC and the Alaska Public Health Association. As part of this, we need to develop and promote an agreed upon common definition of health promotion for use within the Section and the Division of Public Health.

With more outcome-based programming, a focus on policy and environmental change, and the effectiveness of comprehensive approaches, it is increasingly apparent that we need to develop health promotion initiatives, rather than activities, that are multi-faceted and comprehensive. Initiatives need to incorporate social marketing principles to ensure that intended audiences are identified, understood, and targeted. It is imperative that outcome-based evaluation be incorporated into all levels of health promotion programming.

The Section needs to build on existing collaborative efforts, as well as continue to work toward integration of health promotion across categorical programs within the Section and beyond. Integration is as much a process with a product, as it is a mind set for looking at how we do what we do. Identification of common preventive threads has already begun with the Coordinated Media Project. Once a preventive theme is identified, the Section needs to build comprehensive health promotion initiatives that span the categorical programs. There are many ways to look at how to organize this development, but some possible ways are by setting, by health promotion function, and/or using the socio-ecological framework. As with worksite health promotion, each program will be able to identify the elements of the initiative that support their categorical goals, building the complete picture. It is not just a matter of coordinating around a topic, but developing programming around the settings, target audiences and competencies necessary to reach health outcomes. It means incorporating social marketing principles into program development, as well as identifying the social norm changes that need to take place. Health promotion needs to be expanded to nurture the continuation of cross-cutting programs implemented by state and local health agencies. Promoting on-going collaboration, capacity building, and communication with partners will enhance the research, training and practice of health promotion.

We need to enhance the science of health promotion through on-going quality improvement and development of terminology, standards and protocols for health promotion. We need to ensure that evaluation takes place for all programs from beginning to end, process and outcome. It is important to build a health promotion system based on our best and promising practices, and what we already know. We need to ensure that we translate the abundance of information into action steps.

The Section will benefit from developing a better understanding of Alaskan communities by sharing information across the community-based health promotion programming. We need to actively strive

to integrate our expectation and resource development for community-based health promotion to ensure that local health promotion efforts incorporate all systems (schools, families, health care, worksites, communities, etc.) to take responsibility for promoting positive health.

The Section needs to develop an integration training and technical assistance agenda for developing health promotion competency internally, as well as with external state and local partners. Closer links and partnerships must be made with complementary disciplines, such as tribal health, public health nursing, injury prevention and EMS, environmental health, and Women, Children, and Family health.

### **Summary**

While significant challenges exist at the national, state, and local levels, the Alaska Section of Chronic Disease Prevention and Health Promotion can take a leadership role in improving and expanding health promotion efforts across the state. Implementation of these recommendations will increase the effectiveness of existing programming through maximization of resources and efforts, as well as plays an instrumental role in developing a statewide health promotion system that is committed to supportive environments, which foster healthy choices.