UNICEF Regional Office for the CEECIS

Capacity Building Workshop on Health Communication, Health Promotion and Risk Communication, Almaty, Kazakhstan 4-8 July 2011

A Summary Report of Key Discussions, Theoretical Inputs and Outcomes

Participants and resource persons at the Almaty workshop, 4-8 July 2011 *Pic:UNICEF/ Ksenia Shklyar*

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Acknowledgements to

UK Department of International Development (Dfid)
UNICEF Headquarters, Health Section
Participating UNICEF Country Offices

World Health Organization
(International Health Regulations (IHR) Geneva/Lyon; Department of Maternal and Child Health; WHO EURO Regional Office; WHO European Office for Investment for Health and Development, Venice; Kazakhstan Country Office)
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July 2011

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EXECUTIVE SUMMARY

Background

Countries in the CEECIS region have frequently faced public health emergencies particularly in relation to immunization, either during vaccination campaigns or outbreaks of vaccine preventable diseases. Governments have been repeatedly challenged in maintaining credibility, authority and trust with the public, and often faced mass resistance to vaccinations, and active anti-vaccine sentiments. Weak capacity to respond to public needs also manifested itself during outbreaks such as A(H1N1) in 2009 and polio in Central Asia in 2010, when countries struggled to coordinate and communicate effectively to gain public cooperation. As with many public health emergencies, these capacity issues were compounded by the added pressure of having to respond within extremely tight timelines and often under international scrutiny because of trans-border threats.

Similar challenges have been noted in achieving public support in on-going health issues such as perinatal care, or lifestyle related chronic diseases and its risk factors. Countries have been faced with a ‘low demand, low trust’ scenario, and with a tertiary care, treatment focussed health system, there have been little systems in place for communicating with, understanding, engaging or empowering the public to take healthy decisions. Structures for promoting health within health systems are often inadequately designed, resourced or institutionalized leading to a vicious cycle of poor services and poor uptake. These limitations also did not help the system to respond appropriately to growing inequities.

Strengthening health system capacities to achieve public engagement on a range of health objectives was thus a strong need in the region. UNICEF Regional Office for the CEECIS identified health promotion as an empowering, cross-sectoral, multi-level, comprehensive and relevant framework to support the development of this capacity.

A series of health promotion capacity assessments were conducted in select countries in 2010. It was evident that indeed, adequate capacity, whether infrastructural, technical or political, needed strengthening, even while awareness on its critical importance existed in some measure.

A sub-regional workshop on capacity building in health communication, health promotion and risk communication was organized in July 2011 at Almaty, Kazakhstan to comprehensively and substantively address this long standing need. Twelve countries in the region actively participated in this five day workshop, and engaged in an intensive process of sharing, listening, reflection and learning. They shared experiences, compared notes, heard lectures, worked in groups, and eventually drafted a vision and plan of strengthening health promotion and risk communication systems within their own countries. They reflected back to the group concepts such as ‘empowerment’, ‘building relationships’, ‘context’, ‘equity’, ‘inter-sectoral collaboration’ distilled and incorporated in innovative, structured and relevant

ways. Follow-up plans with concrete milestones for the following 6-12 months were outlined, while also indicating scope for further technical support.

Goal and objectives

While the goal was to initiate the process of capacity building in health promotion, health communication and risk communication in select CEECIS countries, the specific objectives were to help participating countries collectively review and analyse current experiences, identify existing health system gaps, learn about contemporary theoretical approaches and key concepts, and draft national plans for strengthening health promotion and risk communication within their health systems.

Participants

Participants were senior policy makers from Health Lifestyle Centres, Health Communication / Health Promotion / Social medicine / Preventive Health departments, Public Health Institutes, as well as Press Secretaries or Heads of Press Services departments, Mother and Child Health departments and other public health specialists. UNICEF country office health and communication staff also participated and played a key role as facilitators of their country delegations, actively backstopping the governmental counterparts as required.

Human and Technical Resources

Subject experts from health promotion, risk communication and health communication were invited from a range of countries and organizations. Notable was the collaboration with the World Health Organization – the International Health Regulations Department, HQ/ Geneva and Lyon and its Risk Communication team, the European Regional Office and its Venice Office for Investment for Health and Development, and its country office in Kazakhstan. Other organizations were the Canadian Public Health Association (CPHA), NHS Health Scotland, Centre for Health and Development, Program Mura, Murska Sobota, Slovenia, Public Health Promotion, Switzerland, and the Healthy Lifestyle Centre, Almaty, Kazakhstan.

Experts from these organizations brought a rich and diverse range of source material in the form of case studies, examples, videos, assessment and planning tools, and vast experience and knowledge. They employed a variety of interactive and participatory methodologies to engage the participants and to enhance the learning experience.

Methodology

The methodology was a hands-on learning approach, based on extensive sharing of examples and experiences from within and outside the region, lectures, discussions, mixed group exercises, field visit and country based group work.

Outcomes

The five day intense workshop resulted in a number of key outcomes in terms of both the process and products:

- 12 countries sensitized to the importance of and strategies for initiating the process of capacity strengthening in health promotion and risk communication.
- 12 draft plans that envision the roadmap for advocating for and implementing strengthening of systems drafted jointly by national delegations
- 12 follow up plans for finalising and implementing these in the short and immediate term made
- Senior and key personnel from health ministries and related institutes sensitized and committed
- Enhanced and more comprehensive understanding of health communication through the broader, more integrated approach of health promotion and with convergence with risk communication
- Collective understanding of both theoretical and systemic issues underlying health promotion and risk communication
- Identification of technical support and partnerships for future development at country and regional level.
- Introduction to a range of tools and instruments to support analysis and implementation of the concepts discussed
- Identification of additional capacity building needs based on specific country priorities and scenarios
- Listening, learning and leveraging cross-country experiences and technical resources through exchange within and across regions

UNICEF country and regional offices, in close collaboration with partners, remain committed to continue to work closely with government counterparts to help advocate for and operationalize the plans, backstopping and providing guidance as required. It will work towards forging a sustainable and effective network with regional partners to comprehensively support countries in their endeavour to strengthen health promotion and risk communication capacities.

Think Big; Start Small; Act Now!

– Bertino Somaini, Switzerland

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KEY DISCUSSIONS AND THEORETICAL INPUTS

Day 1 - Opening and Introductory Remarks

The workshop opened with welcome remarks from the UNICEF Kazakhstan office Deputy Representative, Radoslaw Rzehak, and an address by Dr BT Takejanov, Ministry of Health, Government of Kazakhastan.

Dr BT Takejanov, Ministry of Health, Kazakhstan

Dr Takejanov noted with pleasure the significance of holding the workshop in Almaty. Not only was the city of Almaty the venue for the 1978 declaration on Primary Health Care, but Kazakhstan had been a pioneer among the Central Asian countries in the development health promotion and healthy lifestyle policies. In its Salamatty Kazakhstan (Healthy Kazakhstan) Programme for 2011-2015, inter-agency and inter-sectoral collaboration had been enshrined in a public health policy framework that brings together eight ministries in a single coordinated mechanism. The ministries have signed on a common set of indicators to reduce the burden of diseases, and funds have been allocated, indicating the level of support from the highest authorities.

Dr Erio Ziglio, WHO European Office for Investment for Health and Development, Venice / WHO/ EURO Representative

Dr Erio Ziglio thanked the organizers and participants on behalf of the WHO European Regional Office. He commented that the workshop's objective of building capacities in countries on health promotion and address health inequities was important to not just the 12 participating countries but to all 53 Member States of the European Office of the WHO. He explained that health is a unique resource and an asset that must unite Europe, not divide it. With growing inequities in health, Europe is currently running the risk of having an increased health divide between and within countries. It is important, he emphasized, to dwell on how European policies address this and to bring policy coherence within and between health and non-health policies ie how to create a 'whole of government' responsibility.

Dr Ziglio said he was looking to explore three questions during the week – (i) Can we perform better in promoting health? (ii) Can we reduce health inequities by levelling up the health status of the weakest segment of the population across the social gradient? (iii) Can we provide added value to the social, economic and human development of our region, countries and cities?

The new European health policy *'Health 2020'*, which is based on evidence and wide inter-sectoral consultation, seeks to draw the 53 European Member States into a common policy framework that reinterprets and adapts the principles, charters and declarations of the past to

today's needs. He felt that Europe can perform better in health, but we need to upgrade our skills, modernize and strengthen our health systems, use latest findings, utilize new possibilities such as new technologies, strengthen capacities to reposition health promotion vis-à-vis other ministries, and build country capacity. Dr Ziglio reasserted cooperation and commitment on behalf of WHO.

Octavian Bivol, Regional Health Adviser, UNICEF Regional Office for the CEECIS

Dr Octavian Bivol referred to the landmark declaration in Almaty in 1978 on Primary Health Care (PHC), and the 30th anniversary conference in 2008 in the same city which recognized the slow pace of adoption of PHC principles by countries. The CEECIS region had undergone several transitions in a short period, including health reforms which brought in new financing mechanisms, new service delivery models and innovative technologies. Equity, social determinants of health and effective public health interventions however often remained in the shade of most immediate needs. He felt plenty still remained to be done, particularly involving and empowering families and communities. He highlighted that strengthening the overall system of health promotion is essential for ensuring further improvements in maternal and child health and wellbeing. A functional health promotion system is an essential precondition of effective health communication, including risk communication and capacity to respond to public health emergencies. He welcomed everyone to a week of sharing and learning and looked forward to strong cooperation under the upcoming European policy, but also with concrete practical steps.

Sharad Agarwal, Communication for Development Specialist (Health), UNICEF Regional Office for the CEECIS

Sharad also warmly welcomed participants on behalf of the UNICEF Regional Office and introduced them to the background and rationale of the workshop. She referred to the many tumultuous transitions – political, economic, social – in the recent history of the region, and outlined the impact of resultant weakened social systems and family support on youth in particular. Increasing HIV/AIDS, NCDs, suicide rates among young people, unwanted pregnancies, institutionalization of babies, were symptoms of a vicious cycle emanating from the weakened social fabric and poor health outcomes.

At the same time, the fast changing media landscape in the region has meant that traditional media and broadcast agencies that were at the centre of information systems, were no longer so with the advent of social media and web 2.0. Usage of social media had gone up by an astonishing 6000% in the region, and although currently accessed by 22% of the population alone, offers an opportunity to citizens to 'broadcast themselves' – and therefore for multiple perspectives, expression and voice. While this holds tremendous potential as a tool for public engagement, it has been used equally effectively, for instance, by anti-vaccine forces.

Sharad explained that Health Promotion, as an evidence-based cost effective approach that contributes exponentially to social and economic development, builds on the 1986 Ottawa

Charter and the Alma Ata *'Health for All'* approach. An 8 country assessment of health promotion capacities in the Region in 2008 revealed the urgent need for capacity building of health systems in health communication. Without these capacities, countries have been stretched to respond adequately to public health crises in the past years, or to address the growing health concerns in the region. The workshop therefore, aims to initiate the process of building health promotion capacities and through a learning and exchange process, develop plans for strengthening capacities.

The workshop has been structured around the health promotion framework. Sharad explained that as a multi-strategy, comprehensive and integrated approach, health promotion works both on the demand as well as supply side. It looks to empower not only individuals but also communities. Health Promotion focuses on strengthening health systems ie the nuts and bolts of the systemic structures, policies and management, and also strongly privileges inter-sectoral collaboration in its role in prevention, coherence and equity. Capacity building for health promotion was another cross-cutting dimension.

The **objective** of the workshop was therefore to review and analyze current country experiences, distil key health systems gaps that prevent sustained and effective health promotion, identify opportunities and initiate action for strengthening health promotion systems.

The **expected outcomes** were draft national plans to strengthen health promotion in order to effectively undertake sustained health communication towards public health goals, and during emergencies.

The participants were invited to embrace this process of new learning, reflection and introspection, resolute action and commitment to strengthening systems and building capacities to improve the health of their citizens.

Health Promotion Capacities and Challenges – Country Experiences

Four countries that had conducted formal assessments of their health promotion systems capacities presented a situation analysis of their respective countries. These presentations formed the basis of analysis of system gaps, challenges and opportunities across all the participating countries.

Zamilya Battacova, General Director, Healthy Lifestyle Centre, Kazakhstan

Ms Battacova described the policies and programs of the Kazakhstan within the Healthy Life Style Forming (HLSF) System which was established in 1997. It included 14 regional centres, 2 municipal centres and 136 district centres for promoting health lifestyles. The Healthy Life Style Centre was set up to develop and monitor the HLSF, funding for which grew significantly over the years and programs expanded. The centre is engaged in a wide range of activities to support this mission - from research on social determinants of health for

urbanized populations to monitoring national screening programs to publishing scientific literature. It also organizes events and other outreach programs that reach from 100,000 to 1.5 million people each year. The one hour physical activity campaign supported by the government attracted a record 4.5 million participants and was entered in the Guinness Book of Records.

The HLSF has had several notable achievements to date – an increase in life expectancy rate, inclusion of tobacco smoking in the Health Code, introduction of an inter-sectoral approach for health promotion and a MoU between eight ministries on a common framework for public health, and steps towards establishing a common framework for monitoring and evaluation. She also outlined the challenges facing the Centre - weak coordination within the health system, insufficient financing, a 45% gap in human resources, low implementation of tobacco and alcohol control laws, and low capacity of NGOs to implement social projects. A Press Centre has been established to ensure a harmonised source of information, a National Coordination Centre to assess the quality of education materials produced at regional and central levels, a 3% increase in funding. She also shared the outcome indicators of health promotion under the *Salamatty Kazakhstan* programme.

Robinzon Tziklauri, Chief Specialist, Division of Substance Abuse, Alcohols Abuse and Smoking, National Centre for Disease Control and Public Health, Georgia

Based on the STEPS survey and the UNICEF - NCDC&PH evaluations, Dr Tziklauri presented statistics on the country's lifestyle risk behaviours ie smoking, diet, physical activity, alcohol consumption, cholesterol levels and juxtaposed them with the system's health promotion capacities on the other. While the process of developing a national strategy for Health Promotion (2010-2015) had been initiated and a Department of Health Promotion had also been recently established, the government was severely constrained by structural, financial and technical issues - poor enforcement of legal provisions on health promotion, weak inter-sectoral cooperation including with donors, low involvement of professionals in planning preventive interventions, and lack of reliable methodologies for conducting research. Funding was dependent on external financing, and private insurance companies were not involved. Human resource was inadequate due to low financial incentives and poor opportunities for professional growth. Service delivery was constrained by the above limitations, and quality institutions, infrastructure or material, were not available. There has been low demand and low supply for health promotion services. Media seem disinterested except during outbreaks. While the creation of the department offers opportunities, it is not legally linked to the PHC workers or insurance companies, hence preventive efforts cannot be prioritised. Development of relevant regulations, access to preventive services, inter-sectoral cooperation, public participation, and information systems were needed to implement the strategy and make the newly created department functional.

Ion Salaru, Deputy Director, National Centre of Public Health, and Head of Department of Health Promotion and Non Communicable Disease Prevention, Moldova

Dr Salaru outlined the health promotion vision, structure, functioning, strengths and weaknesses in Moldova. That Moldova recognized and prioritized health promotion was evident from the recent creation of the Centre for Health Promotion and Public Education. Several regulations governed health promotion such as the National Health Policy of the Republic of Moldova (2007 – 2021), National Program for Promotion of Healthy Lifestyle (2007-2015), Optimization of Health Education and Health Promotion Activities (2008-2015) and the Law on Public Health Surveillance (2009).

An active National Programme for Healthy Lifestyle Promotion includes several information campaigns, celebration of 'World Days' and a network of offices offering a variety of counseling and family friendly services. It has experience in running a variety of campaigns on a range of behavioral health issues.

In an interesting SWOT analysis, Dr Salaru laid out the strengths and opportunities for health promotion in Moldova while recognizing the weaknesses and possible threats. A legislative framework which allows for the development of a health promotion strategy and action plan, collaboration with National Health Insurance companies to achieve mandatory financing of health promotion, a network of health promotion and counseling offices, health promotion curricula in public health and post university courses, increase in health promotion professionals, and greater involvement of NGOs were strong assets. However, health promotion needed to ensure that it does not remain declarative and is adequately institutionalized, addresses social determinants, and strengthens links with mass media. It needs to consolidate its financing and human resource base. Dr Salaru envisioned setting up a council or task force with participation of mass media, civil society, academia and health authorities to improve coordination, build capacity at national and peripheral levels, and develop a sound strategy, as well as leverage the potential of the One UN structure.

Aida Pilav, Assistant Minister, Federal Ministry of Health, Bosnia and Herzegovina

Ms Pilav outlined the many laws and stipulations that establish the importance of public health approaches including health promotion and disease prevention in both entities in Bosnia and Herzegovina (BiH). She described how the H1N1 pandemic provided an opportunity for BiH to demonstrate its capacity for synchronized action equally within both its entities – the Federation of Bosnia and Herzegovina and the Republic of Srpska. Another best practice was an information campaign designed to apprise the public about reforms in the primary health care system while also educating them about opportunities to prevent disease and improve healthy lifestyles, called *'We are changing the system – you are changing your habits'*. She also outlined the current limitations – lack of a common strategy at the national level, lack of sustained funding, no harmonized information system, poorly synchronized activities, and media ignorance.

Overall observations:
Participants were urged to distinguish between health promotion and disease prevention. While they were clearly overlapping, the capacity required and how the system is organized

to deliver on these, would significantly differ. While disease prevention is likely be located within a medical or clinical environment and focus on individual with diseases or risk conditions, health promotion focuses more on improving both individual and contextual resources. It was also strongly observed that countries are trying to achieve a lot with little resources, including human resources. This has an implication for both training and retention of health workers. A need for strengthening quality assurance - not just of specific products and campaigns, but through systematizing impact evaluations was also noted.

It was also observed that the linkage between health promotion structures and communicable diseases needed to be reinforced. The importance of strengthening political support– from national councils that drive reforms to inter-sectoral steering committees was also underscored. All countries would also benefit from a task force that would bring together various governmental institutions and stakeholders and drive the agenda.

Group Exercise

Dr Bertino Somaini facilitated a participatory discussion on challenges, system gaps and opportunities in strengthening health promotion. This enabled all countries to share experiences and arrive at a collated set of challenges, gaps and opportunities. Interesting overlaps were observed – challenges were often also listed as opportunities; and system gaps overlapped with challenges. These listings were used as base documents for developing draft country plans for strengthening health promotion later in the workshop.

Bertino noted the apparent low demand for health promotion. This, he felt, could be attributed to a low perceived immediate or short term benefit. Long term benefits of public health interventions were not very motivating for most individuals (except when they related to their children). He urged everyone to think out of the box to find ways of defining health promotion in terms of short and middle term benefits in addition to the long term ones, and thereby attract prioritization and funding.

He also remarked that the term 'health' may be a barrier when attracting partners especially from non-health sectors. 'Quality of life' may be more inclusive and effective concept around which to engage varied stakeholders.

Day 2 - Health Promotion Capacities and Challenges - Country Experiences

- Canada
- Scotland
- Slovenia

The Canadian delegation described the structural features and principles behind the public health and health promotion system at the national, provincial, and community levels in Canada. Moving away from the silo approach of the past, the system is characterized by a coherent, integrated set of agreed and widely institutionalised priorities, around which

structures are aligned. There is creative synergy between policy and technical streams of work. Collaborations within and across sectors and expertise characterize the system, reducing duplication, facilitating linkages and valuing existing expertise and resources.
A number of national networks and non-governmental organizations support the public health functioning of the Canadian government, namely the Canadian Public Health Association, the Canadian Population Health Initiative, the Urban Public Health Network and the Canadian Reference Group on the Social Determinants of Health. These networks and agencies link public health workers outside normal jurisdictional boundaries through common training background or area of responsibility or around a specific set of public health issues of interest. They facilitate the development of communities of practice to share common challenges and solutions at the practice level.

The Regional Health Authorities (RHA) in the decentralized Canadian system ensures local planning and delivery of all health services. In Saskatoon Health Region, Public Health is organized by program area, not by discipline - Healthy Growth and Development; Health Promotion, Safe Communities, Disease Control and Public Health Observatory. Health Promotion functions both as a department delivering services and as a tool/approach for all departments in the Authority. Health promotion in the RHA includes an inherent focus on equity and prioritizes addressing disparities. The goal of the Health Promotion department is to have the social environment and conditions for all people to thrive. It aims to reduce the social gradient against which populations attempt to lead healthy lifestyles, as well as to support the population to make healthy lifestyle choices.

Ann Kerr, **Health, Scotland**, described the systems and structures of Scotland's health system that have produced significant gains in several public health areas. Health in Scotland is characterized by strong disparities especially between parts of West Central Scotland and the rest. Life expectancy at birth varies from 54 years in Glasgow (Calton) to 82 in Glasgow (Lenzie) 8 kms away. The social circumstances that drive health inequalities are a focus for the NHS in Scotland which operates independently of the NHS in other parts of the UK.

Using Scotland's experience with immunization and tobacco cessation as illustrations Ann outlined key drivers of success from within the system. After considerable adverse publicity around MMR vaccination (a few years after which cases of mumps started to increase) and a rapidly implemented Meningitis C program, the NHS did some public research and identified the vital role of the informed health professionals. Health professionals were seen as credible if they spoke about the arguments for and against immunisation and presented them in a balanced way. Following the review of the Meningitis C programme the NHS in Scotland established a protocol for the introduction of new vaccines which recognized the need for communication along with pharmacy, information and surveillance measures. The protocol ensured high quality and comprehensive briefings for its health professionals, created coordinated public communications through pre-tested adverts. Health professionals provided balanced information with the objective of facilitating 'informed consent' and building trust and uptake improved significantly.

Smoking rates in Scotland are slowly decreasing and lung cancer rates in men are falling while the rate for women has levelled off and is predicted to fall. There has been a long term and continuing process of introducing drivers of change to the existing national policy eg making Nicotine Replacement Therapy available on prescription, national targets for smoking cessation focussing on deprived areas, and networks of cessation coordinators. National partnerships were critical and influential in the run up to the Smokefree legislation for example in providing public support through coordinated campaigns, helplines, informational websites, and ensuring well briefed and supported health professionals.

Incentives played a major role. Targets and sub-targets around inequalities ensured reach and penetration, while direct payment to General Practitioners incentivised them. A statutory requirement to consult widely before adopting any policies has greatly benefited policy development by engaging major stakeholders such as retailers and user groups in the early stages alongside the support of national partnerships with government, NGOs and statutory bodies. A strong communication strategy is seen as important and is developed together with key stakeholders. The communication messages are research based and pre-tested with the end users.

Mojca Makovec Haložan, Centre for Health and Development, Slovenia presented the experience of Program Mura which started 10 years ago as a pilot to address the poor health and development indicators of the Pomurje region of the country. With technical support from the WHO Euro Venice Office for Health and Development, strong national political support and dynamic programmatic leadership, an innovative program focussing on building healthy communities was initiated in the region. In a few years it achieved a distinct change in lifestyle in relation to diet and physical activity, and is now a regular program. Building partnerships with a range of relevant local stakeholders in the food, eco-tourism and health sectors, and was based on strong advocacy, open dialogue and understanding needs and objectives of stakeholders. Placing health in the regional development agenda, developing a clear vision and structure, forging intersectoral alliances, and achieving support from national and international levels helped the pilot to evolve into a sustained program. Apart from developing health policies and priorities, and developing systems for delivery, the program also invested in capacity building through training and exchange. Apart from the political agenda setting work, securing political support, attracting champions for the agenda, and gaining international support, all helped the process. These helped overcome obstacles and achieve the sustained and recognised program that is delivering results on improved health and development in the region.

Bertino Somaini, as facilitator of the session, extracted some salient points from across the three presentations:

- Create, support and work with networks. It may be most important to create networks – especially in an environment where networks are not predominant.
- Focus on the environment or context, and not just individual behavior. Look for the determining factors.

- Address equity, not just between individuals, but between regions.
- Structure should follow function. In countries undergoing restructuring, this may be a golden opportunity to realign structures according to newly defined functions.
- Uncover the core causes eg the underlying issue in the low coverage of immunization was the health professional. Investing in the health professional to build informed consent and trust yielded results rather than simplistically persuading people. Similarly years of awareness building on tobacco cessation had produced little results, whereas realization about the effect of passive smoking brought in legislation which made a difference.
- Start where the people are.
- Be more active in agenda setting. Be more aware of political developments and opportunities.

These strategies do not cost too much money. They require a shift in thinking, and some courage, but produce results. Bertino also reiterated other key messages:

- Health promotion is about promoting resources. It therefore encourages focusing on strengths and assets rather than on problems.
- It is important to adopt a combination of strategies – between individual and population based; and behavior and structure oriented.

He also elaborated that health promotion entailed three important activities: Enable, Advocate and Mediate.

Illustrating with striking examples, he explained how these captured the different dimensions of health promoting strategies. *Enabling* entailed empowering individuals and groups to promote and protect their health. In an example from his work in Hungary with commercial sex workers and their inability to influence their clients to use condoms, he had suggested to the sex workers that they could offer to their clients a choice between different colours of condoms, and thereby shift the terrain to choosing between colours rather than between whether or not.

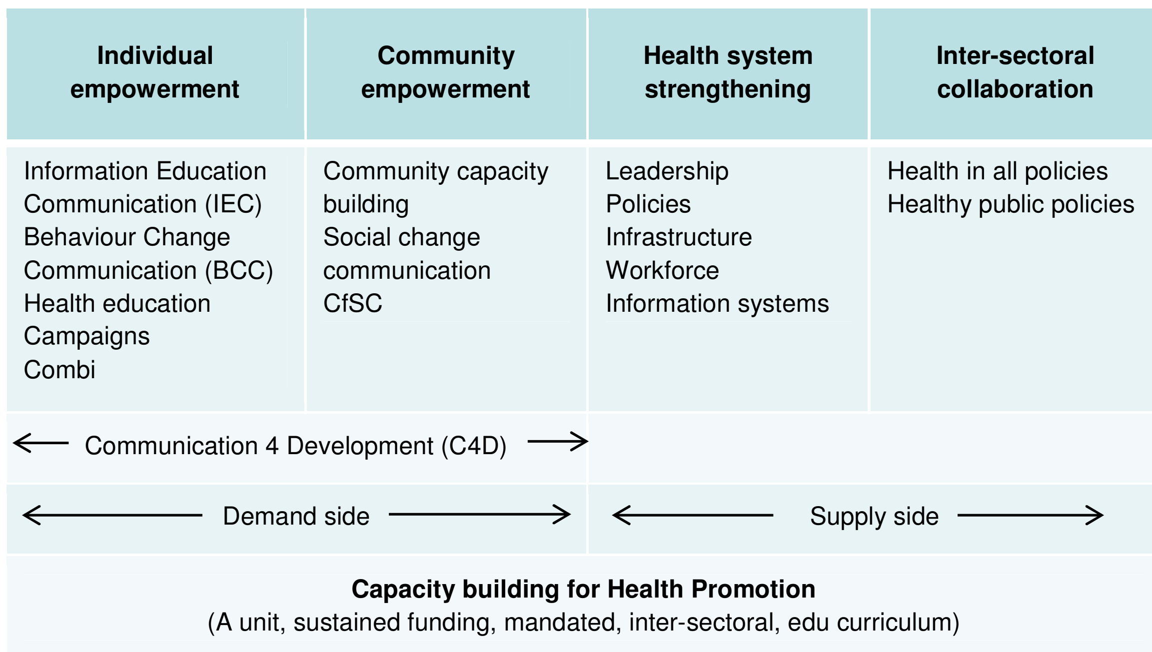
The activities of Antanas Mockus, the mayor of Bogota, helped illustrate the second principle of *advocacy*. Relying on innovation to address the multiple problems of the city of Bogota, he used mime artists to raise awareness among city goers about traffic issues. This was more effective and cheaper than hiring an army of policemen. In order to reduce crime rates in the city, he proposed Wednesday evenings be a women's night out, and thereby encouraged men to stay at home for that evening, which directly led to a drop in crime rates.

The Prolead experience in building capacity in health promotion in the western pacific region illustrated *mediation* when Ministries of health and finance from 10 countries negotiated earmarking tobacco taxes for health promotion. Malaysia convinced Viet Nam, and these in turn influenced several others.

He also outlined how effectiveness requires evidence, infrastructure and implementation. Health Promotion needed to invest in evaluation and monitoring programs – to inform intervention design, measure changes and outcomes, and financial performance. It is wise to invest in long term funding based on long term commitment. He explained that there could be several alternative entry points to health promotion eg through health issues, risk factors, age groups, settings, or social determinants.

Theoretical Concepts of Effective Health Promotion

Sharad Agarwal introduced the next section of the workshop which constituted the 'theoretical' sessions on health promotion and risk communication. She explained the next sessions over the following two days would elaborate on each of the component parts of the health promotion framework:



Individual empowerment	Community empowerment	Health system strengthening	Inter-sectoral collaboration
Information Education Communication (IEC) Behaviour Change Communication (BCC) Health education Campaigns Combi	Community capacity building Social change communication CfSC	Leadership Policies Infrastructure Workforce Information systems	Health in all policies Healthy public policies
← Communication 4 Development (C4D) →			
← Demand side →		← Supply side →	
Capacity building for Health Promotion (A unit, sustained funding, mandated, inter-sectoral, edu curriculum)			

(Adapted from the background documents of the 7th Global Health Promotion Conference 2009)

She elaborated that the workshop had brought together health promotion, health communication and risk communication streams which could often be perceived to be independent fields. The many convergences, in concepts and values, as also the need to have common structures for a range of communication requirements, necessitated this convergence.

Individual and Community Empowerment (Demand Side)

Sharad Agarwal, Communication for Development Specialist, UNICEF Regional Office for CEECIS

Introducing the first of these sessions on empowerment, Sharad Agarwal noted the 'low demand and low trust' scenario in most countries despite several materials and messages being generated. This, she said, reflected a deep seated lack of faith and trust in public institutions. At the same time, people followed their own rationale in their decision making – their perceptions, priorities and perspectives. Hence, in order to win trust, generate demand and influence behaviours, it was important to 'get into the shoes of' and *understand* people. This meant gaining an insight into people's context, concerns, constraints, expectations, assets and strengths.

While the above would lead to well-informed interventions, it may be possible to go further and *engage* people. It means facilitating articulation, 'voice', dialogue and most importantly, 'listening'. Critical understanding, negotiation, solution finding, taking responsibility are all progressive stages of engagement. Strategies can aim for any of these progressive levels as may be most feasible and appropriate.

The next step would be to *enable and empower*. This means encouraging efficacy – the sense of control; ownership, responsibility and the pride; and sustainability.

Illustrating a range of strategies for achieving empowerment and changes in health outcomes, Sharad described some outstanding examples from communication and media initiatives. Mass media initiatives which seem unlikely to have the ability to foster participation, the South African *Soul City* program and BBC World Service Trust's *Jasoos Vijay* from India were cited as examples of programing based on intensive audience research and feedback. The *Healthy Partners Initiative* of the BBC WST project illustrated the effectiveness of community media approaches in 'media dark' areas. This project went beyond creating awareness and engaged communities through an interactive board game designed to make people introspect their own decision-making processes. She cited *Making Waves*, a collection of 50 global examples of community engagement.

She also gave examples of community radio where community members not only watch, but also air, by setting up and managing their own radio station. One such station in Liberia was started in the context of avian flu was fuelled through petrol. When the petrol ran out and the station stopped, voluntary contributions of petrol flowed in from the community providing the true test of the initiative! Farmer women in India acted as a bridge between their community and policy makers through their videos, which served as a potent tool for dialogue. UNICEF's OneMinuteJrs are another example of stakeholders - children - to design their own solutions in their own voice though 1 minute self-produced videos. Mainstream broadcasting media too have realised the potential of participation and few years ago started broadcasting amateur videos collected from ordinary citizens – the 'ireporters', based on the

principle that the power of storytelling was enhanced when narrated with an insider view. Interactive features of web 2.0 have been fully utilised to allow participation and examples abounded of its potency to advocate, as in Ushahidi's sites, harvest small contributions from large numbers of contributors such as in FlickR, YouTube, Slideshare and Wikipedia, or create communities to expand boundaries or facilitate participation eg Connect2Change, the health promotion website for the 7th Global Conference on Health Promotion.

In conclusion, communication for empowerment is not about persuading but engaging, not changing behaviour, but creating understanding, not passive audiences but active stakeholders. This was a paradigm shift in understanding objectives and approach. With such engagement and enabling, trust, proactivity, responsibility, healthy behaviour, positive change was inevitable. Empowerment, therefore is made up of respect and understanding, an attitude of equality, a renegotiation of power, enabling people to take control, and working in partnership.

Annie Portela, Technical Officer, Maternal and Child Health Department, WHO/HQ

Annie took forward the theme of empowerment, defining some of the concepts and using case studies to help the participants focus on experiences of powerlessness in health scenarios and actions that allow health programmes to support the empowerment of women, families and communities to contribute to improvements in health. In the first case, Maria, a young first time mother, receives advice from her health care provider on exclusively breastfeeding for 6 months and advice from her mother-in-law who insists the baby should be fed the traditional gruel after the first month. The group reflected on the actions that a health programme could take at individual, family, community, service and policy levels: better supporting Maria to discuss the recommendation in the home, linking Maria with support groups such as mothers groups; holding educational activities with families – the mothers-in law, fathers, or other gatekeepers to create wider understanding of exclusive breastfeeding. Health managers would need to consider the competencies that must be ensured in the staff to be able to take on the different activities proposed. One such skill highlighted was the ability to communicate, dialogue and counsel as well as to understand the perspectives of mothers-in-laws and the young mothers. Annie asked the participants to consider if the health providers currently spent enough time with mothers in antenatal clinics to communicate this well. If patterns were to emerge across individuals in a community, then actions would need to be taken at the policy level. Participants again highlighted the importance of working with others in the household including men (husbands, fathers etc) to improve maternal and newborn health outcomes.

In another case study, disempowerment was considered from a health service provider perspective. Pavel, a family health doctor, was asked by his supervisor to undertake a project at short notice. His staff midwife is reluctant to spare additional time for this activity. Pavel who feels frustrated and powerless talks harshly with the midwife who in turn also feels frustrated and powerless. Participants touched upon empowering actions at several levels: the three parties could find a way to discuss so that the rationale behind the proposal is better

understood, which could in turn generate joint ownership and discussion on options for reaching the objectives; the supervisor could use his managerial skills to streamline the workflow such that time is freed up; the supervisor could ensure there is better routine communication within the team, and that there is a positive attitude to work; Pavel could discuss options with the midwife on how other partners could be involved; the midwife could also consider innovative solutions once she was convinced about the importance of the objectives.

Annie further added the importance of language and its ability to disempower or enable. Encouraging positive words, simple technical terms, encouraging participation, feedback, sharing experience and comments, two-way, non-coercive language is likely to be empowering, which is both effective and important in itself.

Annie described the application of these principles to the WHO Making Pregnancy Safer strategy, where empowering individuals, families and communities is one of the strategic components of the global strategy and is considered to be the critical link in ensuring the continuum of care between pregnancy, childbirth and postpartum/postnatal periods. A Framework (Working with individuals, families and communities to improve MNH – IFC) was developed based on a review of the literature and country experiences to identify those strategies and interventions with the objective of contributing to the empowerment of women and communities to increase control over and improve maternal and newborn health; and to increase access and utilization of quality health services. Interventions identified were classified into four areas: developing individual capacities, increasing awareness of MNH needs, strengthening linkages between services and communities and improving quality of care and health services from the community perspective. A participatory planning process at district level has been developed to allow community voices to be heard to identify key MNH problems and solutions. The IFC framework was being implemented in the EURO region and the concept of involving communities and other sectors was slowly evolving. She emphasised the need to reflect on the competencies required by health programme managers to work with other actors including other sectors, local authorities, NGO partners and develop and negotiate a plan based on common objectives.

Gauhar Abouva, Kazakhstan WHO Country Office described the experience of implementing the IFC framework within the Salamatty Kazakhstan 2011-2015 framework in a pilot project in South Kazakhstan oblast in Sozak district, which was one of the poorest districts in the country. The project succeeded in initiating an inter-sectoral process, and achieved a draft plan with the participation of communities and oblast and regional authorities. It established a strong feedback mechanism between communities and the health service staff and helped health providers learn about going beyond leaflets to mechanisms for empowerment. It continued to face, however, challenges in overcoming stereotypes and attitudes while scaling up.

The plenary discussion led to other critical insights:

- Despite resistant mindsets, every attempt at initiating participatory and empowering processes helps to open boundaries. Each attempt helps to get ‘the feet wet’, that is, creates readiness.
- The possibility of participating is in itself health promoting.
- Understanding, building relationships, and enabling dialogue is central to empowerment. Communication is the process that facilitates the above. Innovation is often key.
- A relationship between policy makers and communities was critical to enable understanding, partnership and the ability to influence each other’s agendas.

Strengthening Health Systems for Promoting Health (Supply Side)

Dr Erio Ziglio, WHO European Office for Investment for Health and Development, Venice

In an engaging and interactive session, Dr Ziglio outlined the role of health systems in promoting health, and the critical need to apply innovation, evidence and insights, especially in the face of fast changing context of increasing disparities in Europe.

Erio illustrated the importance of understanding ‘context’ - that it varies, that what works in one context may not in another, and this may indeed also apply to measures related to health promotion and disease prevention. He explained that the health context in Europe was rapidly evolving, particularly since the last 20 years, and Europe is running the risk of being divided over health disparities. National data reveal disturbing trends in growing inequities between countries, but it hides the disparities within countries, between cities and districts. Micro statistics, he felt, was the future of health accountability.

The key question is how health policies are managing this ‘context’. WHO is developing *‘Health 2020’*, a new update of *‘Health for All’* in the current context, and a practical policy framework for all countries in Europe and Central Asia. Health Promotion, which is a key activity of the health system, implies addressing system issues. He gave examples of how the performance of health systems in health promotion is hampered by a number of barriers. These may include: unsustained political commitment, system rigidities, unskilled human resources, isolated programmes and poorly integrated approaches, lack of incentives, fragile financing mechanisms etc. Building capacity of health promotion implies managing change.

Erio illustrated solutions, or possible change, through compelling examples. Koranyi Hospital, Budapest, which offers DOTS therapy for TB was faced with an 83% reinfection rate of its treated TB patients. Closer observation revealed that patients infected with TB were often also affected by drug dependence, smoking addiction, alcohol, HIV infection, homelessness, mental health, joblessness etc. To address these problems affecting re-infected patients, the hospital offered an integrated programme of prevention and health promotion

(see WHO, 2004, Health Systems Confronting Poverty). They created a cooperative and built housing shelter for discharged patients. They offered a contract to patients, where in return for continuing with the DOTS and other health promotion and prevention programmes, including mental health promotion, smoking cessation and other therapies, they would receive access to job search and counselling services. The reinfection rate reduced to about 10%, and so did the crime rate and other social issues related to the impact of the disease.

This illustrated the four objectives of health systems – to improve health; reduce health inequities; improve responsiveness in terms of services and therapies; protect people from financial loss caused by illness. And highlighted the four functions of health systems that are needed to meet these objectives – stewardship, human resource generation, service delivery, and financing.

> **Micro statistic is the future of health accountability**
> - Erio Ziglio, WHO EURO, Venice

He described an example from Blackpool, UK, (also reviewed in the 2004 WHO publication mentioned above) where Primary Health staff were trained to sensitively assess whether 70+ year old women coming to request sleeping pills were in actual fact attempting to save on heating bills, and persuade them to apply for a heating allowance, and facilitate the application process. This simple but insightful human resource policy action helped avert a health risk, and addressed a root cause factor.

In Croatia, in a Roma settlement, the community's access to vaccination that was limited by the procedural requirements of registration, permanent addresses of children's family etc was overcome by the health professionals stepping beyond the boundaries of health and holding discussions with senior community members. Health systems, in such a stewardship function, need to assess and decrease differential exposure, vulnerability, access and consequences of ill-health; and increase health 'assets'. He also stressed the importance and potential of strengthening 'informal' health systems. Erio gave references of relevant literature in this field.

In conclusion, he reiterated 7 overarching points relevant to sustainable and equitable health promotion programmes and policies:

1. The critical importance of increasing health system capacity through sufficient personnel with the right training and sufficient mandate.
2. Managing systems, rather than separate interventions; and focussing on risk conditions, in addition to risk factors, and maximizing salutogenic individual and community assets.
3. Following an integrated model of health promotion action eg focussing on behaviour change programmes within the context of broader policy change, to create equitable and sustainable conditions for people to promote their health, rather than isolated programmes for individual behavioural change.

4. Use relevant and innovative tools to both measure the problem and identify solutions (eg a mapping of fast food outlets in Manhattan helped identify obesity patterns in the area.)
5. Understanding information seeking behaviour of decision makers and communities (eg whether they prefer data, percentages or anecdotes to facilitate policy action).
6. Reposition health within national and local social, economic and human development to make the contribution of and linkages with health clear.
7. Maximize local salutogenic 'assets', illustrating the protective, promotive and preventive resources for health that need to be nurtured in both individuals and communities.

Octavian Bivol wrapped up the day with some overarching points:

- Health systems refer to the ensemble of all public and private organizations – institutions and resources – mandated to restore or improve health.
- They include both personal and population services, as well as activities to influence the policies of other sectors to address the social determinants of health. Health system performance assessments are often not based on such an understanding.
- The new European policy framework presented to Ministers of Health at Andorra, in March 2011, *'Health 2020'* frames an understanding of health and health systems, and strongly influences regional and national health policy processes. It offers an important distinction between disease prevention, health promotion and health protection.
- In order to deliver on personal and population services, health promotion and risk communication, a functional health system is essential. Hence this workshop brings these elements together and focuses on system strengthening or capacity building of systems.
- Our responsibility is to not just to provide information and to let recipients manage their own health, but to 'empower' ie to listen, ensure participation and enable.
- It is vital to understand inequities and access good data that helps build that understanding.

Day 3 - Vaccination Campaigns, Adverse Events Following Immunization (AEFIs) and Crisis Communication

- Polio Outbreak in Tajikistan, 2010
- Restoring Trust in Immunization, Ukraine, 2008 - 2011
- H1N1 Experience in Canada, 2010

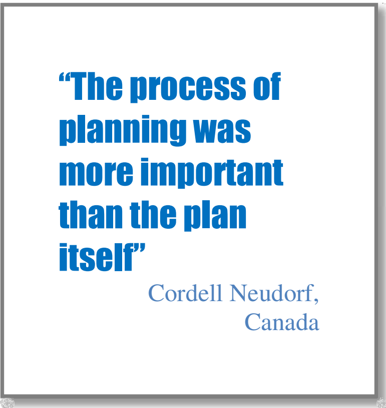
Dr Pirov, Deputy Director of Healthy Lifestyle Centre (HLSC) and Sabir Kurbanov, UNICEF, Tajikistan

Tajikistan, as a part of the European region, had been certified polio free in 2002 and had not seen any cases since 1997. However, in early 2010 an unusual number of acute flaccid

paralysis were reported, which led to an emergency response by the Ministry, UNICEF and WHO. A national polio steering committee was set up to coordinate the response. The media and donor community were also engaged in what became an emergency for the entire sub-region. While the partners launched a successful campaign against polio over the following months, a key learning was the urgent need to strengthen routine immunization in the country. Demand for vaccination through improved health worker trainings, media engagement and involvement of community and religious leaders was seen to be essential.

Anna Sukhodolska, Communication for Development Officer and Katerina Bulavinova, Medical Expert, UNICEF Ukraine

Ukraine presented its experience with immunization related crises since 2008. The misinformed public outcry over the MR vaccination campaign in 2008 led to a domino effect of a cancelled campaign, wasted doses, loss of trust in public health services and immunization, political fallout and increased numbers of measles and rubella cases in the country. UNICEF mounted a multi-strategy campaign to rebuild trust in immunization by orientating and sensitizing health care workers, media and religious groups, as well as a public education campaign on the lifesaving nature of vaccines through outdoor advertising and the internet. According to surveys, negative attitudes dropped significantly. However, the country is now gripped with a shortage of vaccines. Complex political and cultural issues combined to create a situation of low trust in vaccinations in Ukraine, and while the attitudinal issues have improved due to the efforts of UNICEF, the political matters continue to make it a vexed issue.



Dr Cordell Neudorf, Chief Medical Health Officer, Saskatoon Health Region, Canada

The Canadian experience in planning and responding to the H1N1 pandemic revealed that the key was investing in building public health capacities in advance of the crisis. Ensuring surge capacity, and vaccine safety messages in the periods between crises helped in responding effectively during crises. It also indicated that the process of planning was more important than the plan itself. The process helped identify relationships, roles and responsibilities, and build trust, while a top to mid-level plan sufficed to provide broad guidance. Advance planning clearly blunted the effect of the pandemic on the system. The public health system was able to deliver an unprecedented number of vaccines in a short time helping Canada achieve a higher rate of immunization than many other developed countries. Providing authoritative information from a consistent source and spokesperson(s) helped to manage the media and inform the public that had access to multiple sources of information in a 24 hour internet environment. Being transparent, factual and sticking to key messages helped counter both complacency and anxiety among the public at different stages of the pandemic.

Risk Communication and the International Health Regulations (IHR)

Satyajit Sarkar, International Health Regulations (IHR)/Risk Communication Capacity Building, WHO HQ/Lyon

Through graphic visuals and compelling data, Satyajit Sarkar outlined the scenario in Egypt in 2006 when the avian influenza was first detected among chicken in the country. He described how the poultry production sector in Egypt works largely through backyard farming which is managed mostly by poor households with few alternate sources of income. The chickens are produced in backyards, rooftops, cramped spaces and crowded conditions. Entire families including children are engaged in the production process.

He pointed out several key features of this phenomenon as it unfolded in 2006. The Avian Flu epidemic, which affected both humans and animals, has continued for more than five years, raising the key question as to what constitutes an 'emergency' response. Early messaging in the communication campaigns focused predominantly on behaviours protecting human health and missed those relating to prevention of the spread of the virus among animals. Impact assessment evaluations revealed that while awareness of signs, symptoms and protective measures was high, practices around management of sick or dead birds was poor. There was little awareness of the importance of notifying authorities, and of not slaughtering and eating, selling or transporting infected birds.

Satyajit then screened a video of community voices which starkly illustrated how underprivileged backyard poultry producers were not only poorly informed, but that the questionable messaging had flawed their perception of the risk of the disease. The policies offered no compensation for culled birds, nor any alternative livelihood, and instead contributed to their further impoverishment. With few alternatives, the producers were compelled to simply continue with their business and ignore the law. From a public health perspective, this was an example of policies that hindered rather than helped disease control. From a communication perspective, it revealed the critical need to listen to, involve and work with the community stakeholders to develop policies that are effective. From a human rights perspective, people were not properly informed, and were deprived of the right to earn a legitimate livelihood.

The participants broke into groups to discuss critical issues that needed to be addressed and the best strategy for doing so. The discussion highlighted and led into an elaboration of the principles of effective risk communication.

- Dialogue, participation and empowerment form the backbone of all communication including risk communication
- There is often a disconnect between the physical reality focussed upon by the expert and the psychosocial reality operating upon the community. Risk Communication recognizes and addresses this.

- There are four functions of risk communication – enlightenment; trust building; behavioural change; participative functions. Understood within this perspective, risk communication is far more than dissemination of messages.
- It entails knowing and communicating facts, explaining the rationale behind the facts, and engaging the public in partnering in the process.
- Risk communication helps populations make informed decisions, adopt protective behaviours, complement surveillance systems, coordinate health and non-health actors, and build trust.
- Trust is made up of six components – perceived competence, objectivity, fairness, consistency, sincerity, and faith.
- It is important to improve trust in the message, the personal communicator and the institution. Trust grows with the experience of trustworthiness.
- Emergencies have unique yet common characteristics – high impact, extreme time pressure, involvement of multiple organizations. There is usually a surge in demand, and an internationalization of interest, a strongly political dimension, and economic consequences in the immediate future.

Satyajit introduced the International Health Regulations (IHR) which is a legally binding instrument between WHO and its 194 States Parties to maximize international health security and minimize impact on international trade and transport. The IHR came into force in 2007 and ensures a response to public health emergencies of international concern. It outlines eight core capacities essential for an effective response, and risk communication is one of them.

Four capacity components define risk communication under the IHR – transparency and early announcement of a real or potential risk; public communication coordination; information dissemination including media relations, and listening through dialogue. These are further defined through *'abilities'* associated with each *'capacity component'*. A set of indicators and assessment tools have been developed to help systematically build in-country capacities in risk communication under the IHR.

A key observation was the strong points of convergence between the principles of risk communication and health promotion/communication. Countries can hardly afford to have separate systems for each of these, and capacities must be built to strengthen common systems that respond to multiple situations. It was also once again seen that the process of building a plan has proven to be more important than the plan itself. Relationships are developed which are invaluable in building trust, and creating understanding of roles and relationships.

Day 4 – Inter Sectoral Collaboration

Canadian Public Health Association (CPHA) - Cordell Neudorf, Rick Trimp, Tanya Dunn-Pierce

The representatives of the Canadian Public Health Association (CPHA) working on different aspects of the Canadian public health system, spoke as practitioners of inter-sectoral collaboration and shared their experiences with collaborative approaches.

Tanya Dunn-Pierce outlined the principles and lessons learned internationally on why and when inter-sectoral collaboration (ISC) is effective. She described the ISC as coordinated and integrated environmental and policy responses at a population level with shared accountability across governmental sectors, supported by community and political action. Clearly the health sector cannot deliver on its own, or even necessarily lead the response. A WHO and Public Health Agency of Canada review of 18 case studies published in 2008 revealed the key lessons:

> **Health promotion professionals, who are by definition promoting change, need to acquire the ability to 'work the room'**
> - Rick Trimp, Canada

- A shared recognition of the need for inter-sectoral action and strong buy-in to the rationale was important
- Genuine sharing of power among stakeholders with a significant role for members was critical

To achieve these, certain strategies were seen to be useful eg using political champions to advocate; framing issues to resonate with non-health partners; taking advantage of political transitions; building consensus through shared gatherings of different sectors; connecting internationally and making linkages with international leadership.

A precondition for success was proactively and intentionally building trust and relationships through inviting a broad range of participants, ensuring significant roles for each stakeholder, and defining processes and structures. She explained that where the health sector carries the greatest knowledge, experience and control, it should lead. But when it has the knowledge but does not control the setting or implementation, it should lead in promoting strategies and in generating ownership with other sectors; and where it possesses neither, it should lead in inter-sectoral work and partner in policy development and implementation. These require new competencies around transformational change and leading in multi-sectoral contexts.

Rick Trimp further reflected that health promotion professionals who are by definition promoting change, need to acquire the ability to 'work the room' ie to proactively meet people, understand different perspectives, and get into others' shoes. Working inter-sectorally requires stepping outside own comfort zones, understanding culture and behavior, and building relationships.

He described the example of collaboratively developing the Saskatchewan Tobacco Strategy. In keeping with the collaborative approach of the Saskatchewan Population Health Council (SPHC), and also its principle of maintaining synergy between policy, technical and operational aspects, it invited a range of stakeholders to participate in the development of the provincial tobacco strategy. They had one on one meetings with advocacy groups, industry members, convenience store operators that sell the cigarettes, the media, community members and engaged them in process of each one bringing its own perspective, and resources. When the Minister launched the strategy, he had the activists, store owners, community members, even industry members behind him, and the strategy was widely owned. The groups remain engaged even in the implementation of the strategy. Similar approaches were adopted for the development of the community led provincial HIV strategy.

Cordell Neudorf described the concept and impact of the Regional Inter-sectoral Committees (RICs) in Saskatoon, Canada, in achieving change in health inequities. The RICs were a regional grouping of senior decision makers. Regional health, education, justice, social services, aboriginal authorities come together and discuss common issues, areas of overlap and duplication, and of cross-functioning. In Saskatoon, the RIC discovered common root causes eg poverty, homelessness, social determinants, which were earlier always placed in the 'parking lot' in planning meetings. Responding to long standing civil society action, the health sector brought data that proved that poverty made people sicker. They invested in evidence based global research scans of effective solutions and presented to the RIC. The RIC then commissioned the Community Action Plan on Poverty Reduction, and made the business case for different stakeholders on what they could do and why they should be involved. With such citizen engagement, and inter-sectoral action, integrated planning and service delivery could be directed towards reduction of inequities.

Cordell also provided an example of using a health care equity audit to identify the reason behind pockets of low immunization coverage - and also in acute care in addressing diabetes. Focus group research revealed reasons behind people's reservations, and changes made in the practice eg more clinics, or changes in timings. This resulted in not only an increase in overall coverage but also a narrowing of the gap.

A concluding point by Tanya underscored a key message in ISC – if trust and relationships are key to empowerment, communication, strengthening systems and ISC, then we should be more intentional about building them through deliberate strategies, competencies and evaluation measures.

Building Capacity for Health Promotion

Dr Bertino Somaini, Public Health Promotion, Switzerland

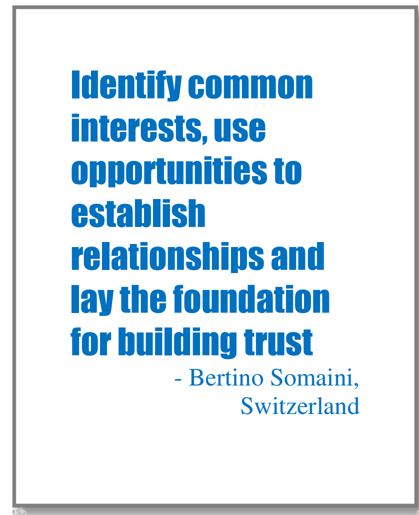
To integrate the learnings of the previous days and prepare the participants for the upcoming development of draft plans, Dr Bertino Somaini asked the participants to consider writing a

one pager on the essence of health promotion, and carefully think about what they would include. In a style true to the content, Bertino illustrated key principles through establishing a personal connection, visuals, simple stories and engaging facilitation.

At the outset he reminded everyone that we must invest in strengths. Through a clever device of a listing of mathematical sums, some of which were incorrect, he established how we tend to look for errors or weaknesses, and ignore the strengths.

Engaging the audience with photographs, he established the tremendous importance of identifying common interests, using opportunities to establish relationships, and laying the foundation for building trust. He also indicated the possibility of enlarging the set of relationships around an established core. Through building relationships, one has an opportunity to understand perceptions, contexts and mindsets. Often this entails adapting plans and schedules to arrive at consensus. Through an innovative device, Bertino also made a related point that if someone empowered you, or if you received something from someone, you should tell them so. Use opportunities to empower or be empowered.

A reason why some countries perform better than others is that some governments invest in empowering their people, in building relationships between people, and between people and institutions. These help in creating trust. The same principle applies to governmental departments within a country. He urged the participant government counterparts to start right away, and use small opportunities to build leadership abilities, and gain valuable experience. He said it was wise to invest in knowledge – it expands when shared, and provides an opportunity to build relationships, empower and again, create trust.



Explaining possible reasons why health promotion is not prioritized in some countries, Bertino outlined the following – lack of understanding of health promotion; confusion about who is in charge of health promotion; isolation of health promotion from health systems development; narrow focus on behaviour change without consideration of complex contexts; and inability to show effectiveness of health promotion in improving quality of life. He echoed the point made by the Canadian delegation earlier and Erio Ziglio that it was important to position or reframe health promotion as a methodology for improving 'quality of life'.

Through the dramatic example of Hanoi that ushered in helmet use within a period of 6 months in 2007-2008, he explained the usefulness of creating laws. However, this was so only if supported by effective enforcement mechanisms, and by communicating clearly to the public its rationale and benefit to different stakeholders. A few effective laws but well

enforced would contribute to building trust. Motivational laws were also effective particularly where enforcement was not feasible or desirable. This could entail incentivizing smaller organizations to motivate people through financial and other support. He cited the Framework Convention for Tobacco Control as an example of legal frameworks that are useful especially when well communicated. He explained that the public in several regions in Switzerland were asked to approve a proposed law on indoor smoking and it received a 75% vote in favour, leading to a national legislation. He added a tip that it was useful to be aware of ‘agenda setting’ and to introduce relevant wording in policy documents when the opportunity arises (not overlooking regional opportunities as well). It is not always necessary to have a separate law. Integration is a health promotion principle.

In order to strengthen or institutionalize health promotion, it was critical to have a technical unit for health promotion; adequate and qualified personnel; a commission or body on health promotion; clearly defined roles for public, private and volunteer organizations. Inter-sectoral collaboration was the way forward as addressing common root causes through common resources and a shared purpose was feasible. The H1N1 pandemic created good experiences in synchronized planning and action in some countries. Switzerland’s SlowUP initiative was another illustration of effective collaborative effort which brought together environmental, security, touristic, health, commercial and other interests to encourage self-powered mobility for one Sunday in a year when one road was closed to vehicles. Ukraine’s efforts through ‘off records’ meetings with the media was a good example of collaboration with the media. He also illustrated leadership and its impact though the example of Antanus Mockus, the Mayor of Bogota, who though a series of innovative and collaborative initiatives such as 7000 community security groups, dramatically altered several serious issues such as crime rates, water over-usage, traffic fatalities, drinking water and provision of sewerage supplies.

He outlined various possibilities for funding but emphasized the importance of sustained funding mechanisms. Monitoring and evaluation systems were important too, but it was important to first design the goals and some indicators, and start with utilizing existing data and ongoing surveys.

He formulated three overarching recommendations – One common strategy; one central coordination unit; and one national monitoring and evaluation system.

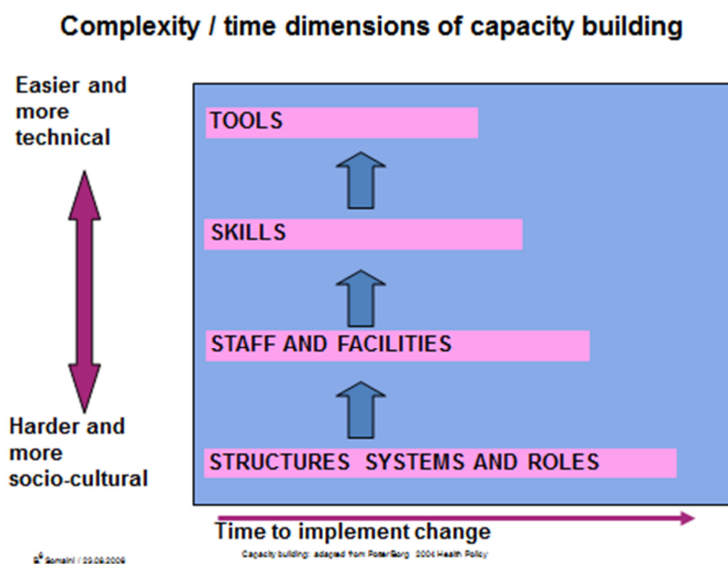
To conclude, Bertino, recommended Stephen Covey’s acclaimed book *‘7 Habits of Highly Effective People’* and its 7 principles of leadership that everyone has the capacity to adopt and implement. He urged all to Think Big; Start Small; Act Now!

Briefing for final exercise on developing draft plans for strengthening health promotion and risk communication systems and programs.

Referring to the health promotion framework, Octavian Bivol reiterated the rationale of using this comprehensive and integrated framework as the basis for the workshop. It offered a systemic approach that strategically combined both the demand and supply side, and if

capacities were developed, improved systems would deliver improved health. He outlined a framework for capacity building which delineated three areas for strengthening – system governance, including vision, legislation, health policies and healthy public policies; system infrastructure ie financing, workforce, information systems, program delivery systems; and system outputs ie the health promotion programs and services.

He also laid out the infrastructural aspects of systems capacity building along a time and complexity continuum, illustrating how developing tools and skills might be easier to achieve and could be attempted earlier than a more complex task such as generating appropriate staff and structures. He suggested that it may be prudent to consider adopting a mix of the above strategies and combining relatively easily achievable 'low hanging fruit' with more complex but long term changes.



(Adapted from Potter/Borg 2004 Health Policy by Bertino Somaini, 2006)

Based on the above, Octavian outlined an exercise for developing draft plans for strengthening health promotion and risk communication in each participant country. The task was broken into four parts and each was supported by a set of guidance and/or informational tools.

The first task was to develop a plan for strengthening the health promotion infrastructural capacities. The teams were asked to review the challenges, gaps and opportunities listed on the first day and identify their own national priorities and objectives. They were to then develop both short term (6 month) and medium term strategies and priority plans for strengthening health promotion capacity. They could consider developing tools, skills, staffing, structures, inter-sectoral collaborations, policies, and/or legislation as most appropriate.

Secondly, they were asked to build a plan for reinforcing health promotion in a specific programmatic area eg immunization, and were advised to use the health promotion framework.

Thirdly, they were tasked with developing a plan for consolidating risk communication in their countries using the assessment tool and checklist for identifying gaps and opportunities.

Fourthly, the teams were to define immediate follow up steps for the next 6-12 months on all three components. This was important to keep the momentum, and help UNICEF identify and provide necessary support in finalising and implementing the plans.

The resource persons were allocated teams to provide support, and all teams were expected to present the draft plans the following afternoon. All teams were asked to submit finalised plans upon their return to their countries and after internal discussions.

Day 5 - Presentation of draft plans for strengthening health promotion

Twelve draft country plans that recognized country challenges, analysed priorities and proposed concrete ways forward, were presented. As assigned, countries were to present their draft plans in 3 parts and a follow-up section – (i) strengthening health promotion systems (ii) enhancing a specific programmatic health promotion intervention (iii) building risk communication plans.

> **Rather than perfecting the plans, it is important to select a few priorities, demonstrate results, share widely and leverage additional resources**
>
> - Octavian Bivol, UNICEF CEECIS

While some countries prioritized the analysis and review of existing legislation and policies, and to develop policies to functionally strengthen health promotion, others looked to improve the financial basis, human resource training and information systems within the existing units. Most countries prioritised the need for mechanisms for inter-sectoral collaboration, and laid plans for developing the capacity to do so - from mapping partners to developing the protocols and capacities to engage other sectors within the government, across levels or with external entities such as NGOs, private sector, media or communities. Developing curricula in contemporary concepts of health promotion and health communication including strategies for community empowerment, and offering a variety of pre-service, in-service, short courses, one- time and/or ongoing courses in universities and institutes were proposed in different combinations. While some plans were more broad-based in addressing fundamental gaps in health promotion structures, others were more focussed on specific aspects depending on the level of experience and support already received by them.

Specific plans for addressing a priority health issue were also presented by all countries. Most countries focussed on immunization, including utilizing the introduction of new vaccines as

an opportunity to build trust. Some countries chose Early Childhood Development, while one focussed on adolescent health. Approaches to developing plans for risk communication in coordination with the country IHR focal points were also developed and presented.

The plans reflected the degree to which the wide and varied inputs in the previous days had been taken on board by the participants, all of whom faced severe challenges in strengthening their systems for effective health promotion, health communication and risk communication.

Bertino Somaini advised participants to focus on a few priorities and create success stories; approach the challenging task of inter-sectoral collaboration with small steps and demonstrate positive results; and create evaluation indicators for all activities no matter how small, so evidence of results could be generated. Satyajit Sarkar emphasized the importance of 'listening' and of creating mechanisms for doing this on a sustained basis. Octavian Bivol rounded off the discussion by reiterating the importance of selecting a few priorities and leveraging additional resources. He strongly advised all to initiate early involvement of partners. He encouraged participants to start implementation soon and commit to achieving some tasks before the year end and by mid next year, and to start implementing and learn by doing rather than perfecting the plans. Finally he emphasized the importance of sharing results widely – with the regional office, WHO, partners and others. He expressed commitment to supporting countries in their efforts, and in coordinating with WHO in developing mechanisms to do so jointly.

OUTCOMES AND NEXT STEPS

The key outcomes of the workshop in terms of both the products and the process were:

- 12 countries sensitized to the importance of and strategies for initiating the process of capacity strengthening in health promotion and risk communication.
- 12 draft plans that envision the roadmap for advocating for and implementing strengthening of systems drafted jointly by national delegations
- 12 follow up plans for finalising and implementing these in the short and immediate term made
- Senior and key personnel from health ministries and related institutes sensitized and committed
- Enhanced and more comprehensive understanding of health communication through the broader, integrated approach of health promotion and with convergence with risk communication
- Collective understanding of both theoretical and systemic issues underlying health promotion and risk communication
- Identification of technical support and partnerships for future development at country and regional level.
- Introduction to a range of tools and instruments to support analysis and implementation of the concepts discussed

- Identification of additional capacity building needs based on specific country priorities and scenarios
- Listening, learning and leveraging cross-country experiences and technical resources through exchange within and across regions

The workshop was considered to be a sound success judging by the ratings ascribed in the feedback forms, and also the feedback provided by the resource persons. See Annex C.

Follow up plans to the workshop include:

Country Follow up

- Follow up with countries to facilitate the implementation of the plans, ensure engagement of partners, inter-sectoral stakeholder meetings, internal advocacy and sharing of results as most appropriate
- Identification of technical needs and areas of support and facilitate technical support through country visits and / or consultants or other.
- Based on progress, plan and organize sub-regional workshops on priority specific aspects such as leadership trainings, executive courses, technical inputs, tools and methods.

Regional Platforms

- Consolidate partnership with WHO by setting up a regional collaborative network/platform that synergizes the complementary assets of both organizations and brings expertise, tools, guidance, regional and country influence to bear on countries in an appropriate way considering readiness of countries at different stages. This includes collaboration with both health promotion and risk communication teams at WHO.
- Continue collaboratively contributing to and drawing upon on-going related activities in both organizations regionally.
- Engage roster of experts and resources to provide technical guidance as and when needed.

ANNEXES

A. Agenda
B. Participants List
C. Participant Feedback
D. List of Select Resources

Annex A – Agenda

Day	Session Description	Resource Persons
Day1	**Objective: Establishing expected outcomes** **Identifying key challenges/system gaps in effective health promotion and opportunities for strengthening**	
8.30	Registration	
9.00	Ceremonial opening UNICEF Country Office, Kazakhstan Ministry of Health, Kazakhastan	*Chair R Rzehak, UNICEF Country Office, Kazakhstan* Erik Baizhunissov, Vice Minister of Health, Kazakhstan
9.30	Welcome World Health Organization Regional Office for Europe and UNICEF Regional Office	Erio Ziglio, WHO EURO Octavian Bivol, UNICEF Regional Office CEECIS
10.00	Introductory Remarks, Rationale and Objectives	John Budd/Sharad Agarwal, UNICEF Regional Office CEECIS
10.30	Tea/Coffee	
11.00	Health Promotion Capacities and Challenges – Country Experiences Country presentations of health promotion capacity assessments - Kazakhstan - Georgia - Moldova - Bosnia and Herzegovina	*Chair O Bivol, UNICEF Regional Office CEECIS* Country Teams
13.00	Lunch	
14.00	Discussion: Understanding challenges in institutionalizing health promotion Identifying challenges, key system gaps and opportunities for strengthening health promotion - group discussions	Bertino Somaini, Public Health Promotion, Switzerland
15.00	Tea/Coffee	
15.15	Report back to plenary and discussion	
16.30	Wrap up	Octavian Bivol, UNICEF Regional Office CEECIS John Budd, UNICEF Regional Office CEECIS
17.15	Departure for the National Healthy Lifestyle Centre, Kazakhstan	
Day 2	**Objective: Identifying key building blocks of an effective health promotion system**	
9.00	Health Promotion Capacities and Challenges – Country Experiences (contd) - Canada - Scotland - Slovenia	*Chair B Somaini, Public Health Promotion, Switzerland* Cordell Neudorf, Rick Trimp, Tanya Dunn-Pierce, Canadian Public Health Association (CPHA) Ann Kerr, NHS Scotland Mojca M. Halozan, Project Mura, Slovenia

10.30	Discussion: Identifying strategies for strengthening Health Promotion	Bertino Somaini, Public Health Promotion, Switzerland
11.15	Tea/Coffee	
11.30	Theoretical concepts of effective health promotion Overview of 5 domains of Health Promotion - Individual empowerment - Community empowerment - Health system strengthening - Inter-sectoral action - Building capacity for health promotion	*Chair S Agarwal, UNICEF Regional Office CEECIS*
11.45	Individual and Community empowerment (Demand side) - Community engagement, context, perceptions, voice	Annie Portela, WHO HQ Gaukhar Abuova, WHO Kazakhstan
13.00	Lunch	
14.00	Individual and Community empowerment (Demand side) contd	
15.30	Tea/Coffee	
15.45	Health system strengthening (Supply side) - Policies, finances, workforce, information systems, services - Innovative approaches	Erio Ziglio, WHO EURO
17.45	Wrap up	Octavian Bivol, UNICEF Regional Office CEECIS John Budd, UNICEF Regional Office CEECIS
19.00	Reception	
Day 3	**Objective: Key building blocks for managing crises - reviewing national risk communication plans against the International Health Regulations (IHR) Risk Communication framework and tools**	
9.00	Vaccination Campaigns , Adverse Events Following Immunization (AEFIS) and crisis communication - Ukraine MMR 2008 - Tajikistan Polio 2010 - Canada H1N1 2010 Discussion: Impact on region; new media and its implication	*Chair O Afsar* UNICEF Regional Office CEECIS Country teams
10.45	Tea/Coffee	
11.00	Risk Communication and its component competencies - Case study - Egypt Avian Flu Outbreak	Satyajit Sarkar, WHO HQ/Lyon
13.00	Lunch	
14.00	Risk Communication - IHR and the Risk Communication Assessment Tool - Assessing systemic and operational capacities	

16.15	Tea/Coffee	
16.30	Report back to plenary - Gaps identified - Strategy for addressing gaps and follow up	
17.45	Wrap up	Octavian Bivol, UNICEF Regional Office CEECIS John Budd, UNICEF Regional Office CEECIS
Day 4	**Objective: Identifying and examining key building blocks of an effective health promotion system**	
9.00	Theoretical concepts of effective health promotion (contd) Inter-sectoral collaboration - Equity and determinants - Health in all policies - Whole of government approach	*Chair A Kerr, UNICEF Regional Office CEECIS* Cordell Neudorf, Rick Trimp, Tanya Dunn-Pierce, Canadian Public Health Association (CPHA)
10.30	Tea/Coffee	
10.45	Building capacity for health promotion - Infrastructure, technical capacity	Bertino Somaini, Public Health Promotion, Switzerland
13.00	Lunch	
14.00	Developing draft national plans of action for strengthening health promotion and effective health communication – group work in country teams	Octavian Bivol, UNICEF Regional Office CEECIS Resource persons support group work
Day 5	**Objective: Developing draft national plans of action for strengthening health promotion and effective health communication**	
9.00	Group work (contd)	Resource persons support group work
10.30	Tea/Coffe	
10.45	Group work (contd)	
13.00	Lunch	
14.00	Presentations to plenary	*Chair O Bivol,* UNICEF Regional Office CEECIS All delegations
15.45	Tea/Coffee	
16.00	Discussion: Milestones, Follow-up, Support	
17.30	Wrap up and evaluation	Octavian Bivol, UNICEF Regional Office CEECIS John Budd, UNICEF Regional Office CEECIS

Annex B – List of Participants

List of Participants				
#			Delegations	Emails
1	**Armenia**	1	Irina Nersisyan, Leading Specialist, Department of Mother and Child Health, Ministry of Health	irina_nersisyan@mail.ru
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		3	Shushan Hunanyan, Press-secretary, Ministry of Health	hpr@moh.am
		4	Emil Sahakyan, UNICEF Communications Officer	esahakyan@unicef.org
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		6	Rauf Mammadov, Deputy Director, Public Health and Reforms Center , Ministry of Health	rauf.mammadov@isim.az
		7	Anar Qadirli, Head of PR Department, Ministry of Health	kadirly@yandex.ru
		8	Elnur Aliyev, C4D (Communication for Development) Officer, UNICEF	ealiyev@unicef.org
		9	Tahmina Taghi-Zade, Health Officer, UNICEF	ttaghizada@unicef.org
3	**Kosovo**	10	Faik Hoti, Director, Department for Information, Ministry of Health	faik.hoti@ks-gov.net, fhoti2004@hotmail.com
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4	**Moldova**	13	Tatiana Zatic, Head, Department Policy in Medical Care, Ministry of Health	tatiana.zatic@ms.gov.md
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		17	Sergiu Tomsa, Adolescents Service/Participation Officer, UNICEF	stomsa@unicef.org
		18	Angela Capcelea, Child and Adolescent Health Officer, UNICEF	acapcelea@unicef.org
5	**Georgia**	19	Ketevan Goginashvili, Chief Specialist, Health Policy Division, Health Care Department, Ministry of Labor, Health and Social Affairs	kgoginashvili@moh.gov.ge; goginashvili@yahoo.com
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		23	Tamar Ugulava, Health Specialist, UNICEF	tugulava@unicef.org
		24	Nana Pruidze, Health Education Officer, UNICEF	npruidze@unicef.org

6	**Serbia**	25	Jelena Gudelj Rakic, Head, Health Promotion Department, Institute of Public Health of Serbia “Dr Milan Jovanovic Batut”	jelgud@gmail.com jelena_gudelj@batut.org.rs
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		34	Alma Herenda, ECD/Health Officer, UNICEF	aherenda@unicef.org
8	**Ukraine**	35	Alona Tereshchenko, Deputy Head, MCH Department, Ministry of Health	tav@moz.gov.ua
		36	Iuriy Iashchenko, Deputy Head, Institute of Strategic Research, Ministry of Health	
		37	Zoya Tsikhon, Deputy Head,Department of Mother and Child Health, Ivano- Frankivsk Oblast State Administration	
		38	Maryna Kashtalyan, Deputy Minister,Health of AR Crimea	
		39	Anna Sukhodolska, C4D (Communication for Development) Officer, UNICEF	asukhodolska@unicef.org
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		41	Katerina Bulavinova, Medical Expert, MD Pediatrician, Child Infectionist, UNICEF	kbulavinova@unicef.org
9	**Kazakhstan**	42	Erik Baizhunissov, Vice-Minister of Health (for opening)	
		43	Radoslaw Rzehak, UNICEF Deputy Representative (for opening)	rrzehak@unicef.org
		44	Bolat Tokezhanov, Director, Department of Strategic Development	
		45	Zhamilya Battakova, General Director, Healthy Lifestyle Center (HLSC)	
		46	Sholpan Karzhaubayeva, Deputy General Director,HLSC	
		47	Shalgynbay Zhandossov, Director, Republican SES	
		48	Zhumagaisha Medetova, Head, Information Department,SES, South Kazakhstan oblast	
		49	Mrs. Zhylkaidarova, Director, Health Promotion Department of HLSC	
		50	Ainagul Kuatbayeva, Head, Epidemiological Department of Republican SES (for CCHF)	
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10	**Turkmenistan**	55	Shirin Rejepova, Leading Specialist, State Sanitary and Epidemiological Service, Ministry of Health and Medical Industry of Turkmenistan	
		56	Altyn Rahmanova, Chief , Prevention Department of the Health Information Centre "Saglyk", Ministry of Health and Medical Industry of Turkmenistan	

		57	Oguljeren Annamuradova, Chief, Faculty on Medical Ecology and Hygiene, Turkmen State Medical University	
		58	Ayna Seyitlieva, C4D (Communication for Development) Officer, UNICEF	aseyitlieva@unicef.org
11	**Belarus**	59	Alena Bohdan, Chief, Department of Medical Aid to Mothers and Children, Ministry of Health	
		60	Sofiya Dunko, Leading Expert, Department of Hygiene, Epidemiology and Preventive Maintenance, Ministry of Health	
		61	Tatsiana Pronina, Head, Department of Hygiene of Children and Teenagers of «National Scientific and Practical Center for Hygiene»	
		62	Alena Volakh, Hygienist, Department of Public Health, National Center for Hygiene, Epidemiology and Public Health	
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12	**Tajikistan**	64	Davron Pirov, Deputy Director, Healthy Lifestyle Center	davron-pirov@yandex.ru
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		67	Sabir Kurbanov, Health Specialist, UNICEF	skurbanov@unicef.org
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			Resource Persons	
	Switzerland	70	Bertino Somaini, Former Director, Swiss Health Promotion Fund	bsomaini@publichealthpromotion.com
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	Canada	72	Tanya Dunn Pierce, Canadian Public Health Association Expert; Manager of Health Promotion Department, Public Health Service, Saskatoon Health Region	tanya.dunnpierce@saskatoonhealthregion.ca
	Canada	73	Cordell Neudorf, Canadian Public Health Association Expert	Cory.Neudorf@saskatoonhealthregion.ca
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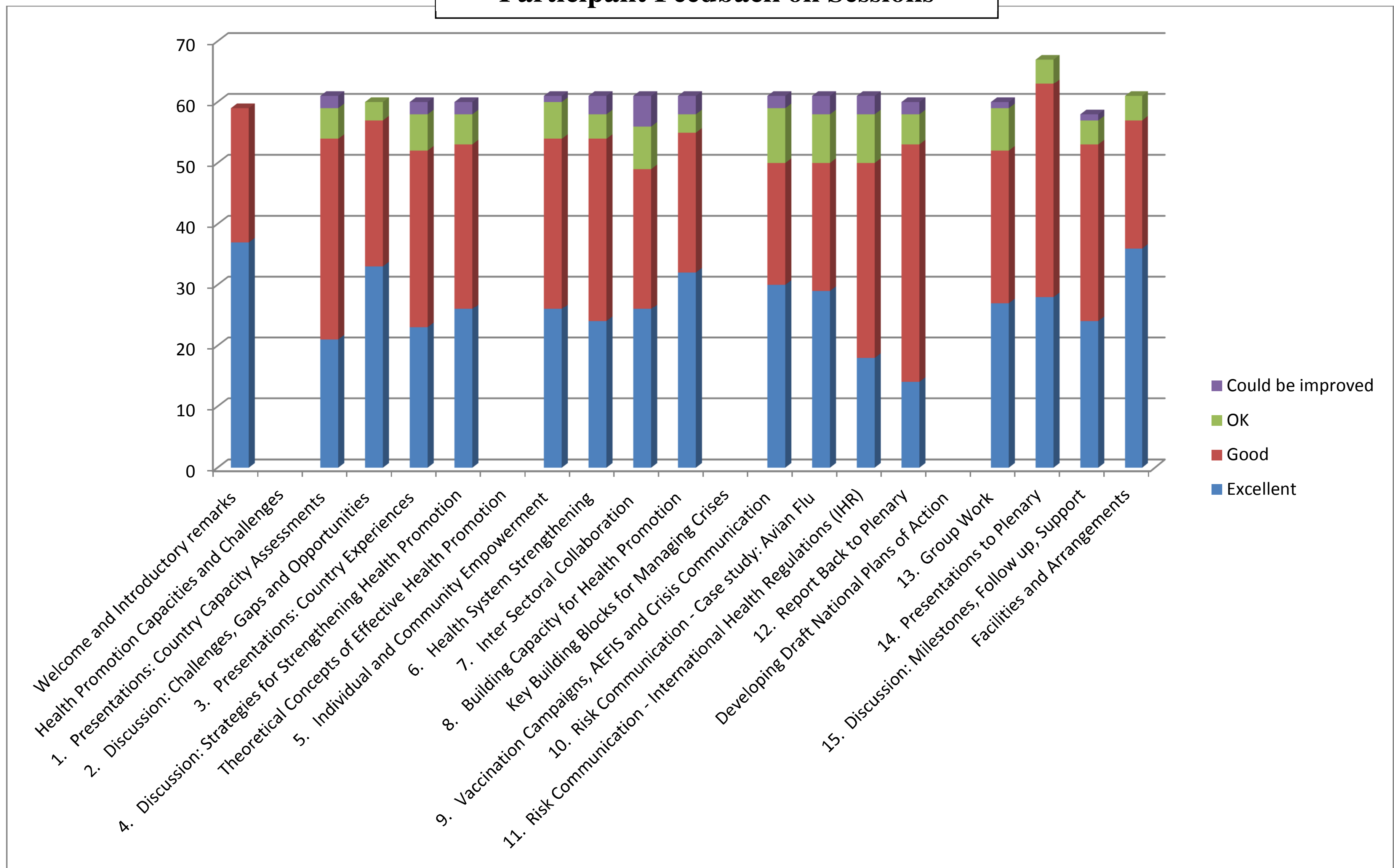
		85	Jesus Lopez-Macedo, C4D Specialist	jlopezmacedo@unicef.org

Annex C – Participant Feedback

- *You have excellent presenters. This is one of the best prepared workshops that I have attended*
- *The training was well prepared. I commend the organizers and thank for this possibility.*
- *A very useful and comprehensive workshop which allowed changing one's attitude to this issue to see the situation in one's country in a different light and assess our health care system from a critical point… We started thinking globally and, what is also important, we have defined for ourselves the local activities for now and future.(Translated from Russian)*
- *Workshop content was very useful and timely developed. HP/HC will be integrated as an inalienable part of the future health promotion strategies and plans.*
- *Very good. Despite bilinguality and size, every one participated. Could be followed up with more in-depth knowledge, skills and strategy discussions and trainings.*
- *Trainings workshops for decision makers on key issues of health promotion organization and policy making; trainings on strategy development based on best practices; trainings for managers*
- *Meetings aimed to define and discuss main problematic issues + to get training on strategy development based on best practices.*
- *Such workshops/orientations seminars would be very helpful at country level.*


Participant Feedback on Sessions
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Welcome and Introductory remarks
Health Promotion Capacities and Challenges
1. Presentations: Country Capacity Assessments
2. Discussion: Challenges, Gaps and Opportunities
3. Presentations: Country Experiences
4. Discussion: Strategies for Strengthening Health Promotion
Theoretical Concepts of Effective Health Promotion
5. Individual and Community Empowerment
6. Health System Strengthening
7. Inter Sectoral Collaboration
8. Building Capacity for Health Promotion
Key Building Blocks for Managing Crises
9. Vaccination Campaigns, AEFIS and Crisis Communication
10. Risk Communication - Case study: Avian Flu
11. Risk Communication - International Health Regulations (IHR)
12. Report Back to Plenary
Developing Draft National Plans of Action
13. Group Work
14. Presentations to Plenary
15. Discussion: Milestones, Follow up, Support
Facilities and Arrangements
Could be improved
OK
Good
Excellent

Annex D – List of Select Resources

Charters and important documents

1. Ottawa Charter (English) http://www.who.int/hpr/NPH/docs/ottawa_charter_hp.pdf
2. Tallinn Charter (English and Russian) http://www.euro.who.int/en/who-we-are/policy-documents/tallinn-charter-health-systems-for-health-and-wealth
3. Nairobi Global Conference on Health Promotion Conference Documents (English) http://www.who.int/healthpromotion/conferences/7gchp/documents/en/index.html

Resources on Empowerment and Communication for Development

1. UNICEF Communication for development resources http://www.unicef.org/cbsc/index_43099.html
2. UNICEF Links to Communication for Development resources in other UN and International agencies http://www.unicef.org/cbsc/index_42731.htm
3. The Complexity of Social Mobilization in Health Communication: Top-Down and Bottom-Up Experiences in Polio Eradication, Rafael Obregón & Silvio Waisbord http://www.tandfonline.com/doi/abs/10.1080/10810731003695367
4. Participatory Communication, Thomas Tufte and Paolo Mefalopulos http://books.google.com/books?id=Aoo109Ure0AC&printsec=frontcover&dq=related:ISBN0821375229&lr=#v=onepage&q&f=false
5. Panos London *At the heart of Change* http://panos.org.uk/resources/at-the-heart-of-change/
6. Communication for Empowerment, UNDP Oslo Governance Centre and Communication for Social Change Consortium (CfSC) http://www.communicationforsocialchange.org/pdfs/c4e-globalreport-june2010.pdf
7. Communication for Social Change Anthology: Historical and Contemporary Readings http://books.google.ch/books?id=85WbPmx9QlcC&pg=PA332&lpg=PA332&dq=alfonso+gumucio+anthology&source=bl&ots=6CCSMayW8P&sig=442BwdeWcCvrEqucIvv0D3Fe9dM&hl=en&ei=n40MToCSCIfZsgbQ4emUDw&sa=X&oi=book_result&ct=result&resnum=3&ved=0CCkQ6AEwAg#v=onepage&q&f=false
8. Glenn Laverack http://www.bookfinder.com/author/glenn-laverack/

Resources on Health System Strengthening

Concepts and principles for tackling social inequalities in health: Leveling up Part 1
ENGLISH: http://www.euro.who.int/__data/assets/pdf_file/0010/74737/E89383.pdf
RUSSIAN: http://www.euro.who.int/__data/assets/pdf_file/0011/74738/E89383R.pdf

European strategies for tackling social inequities in health: Leveling up Part 2
ENGLISH: http://www.euro.who.int/__data/assets/pdf_file/0018/103824/E89384.pdf
RUSSIAN: http://www.euro.who.int/__data/assets/pdf_file/0019/103825/E89384R.pdf

Adelaide Statement on Health in All Policies
ENGLISH: http://www.who.int/social_determinants/hiap_statement_who_sa_final.pdf
RUSSIAN: http://www.who.int/social_determinants/russian_adelaide_statement_for_web.pdf

Investment for Health and Development in Slovenia: Program MURA
ENGLISH: http://www.eu2008.si/en/News_and_Documents/Fact/March/0310_publikacija.pdf

Health Promoting Health Systems *From the 7th Global Conference on Health Promotion organized by WHO and Kenya Ministry of Public Health held in Nairobi, 26-30 October 2009*
ENGLISH: http://www.who.int/healthpromotion/conferences/7gchp/Track3_Inner.pdf

Poverty and Social Exclusion in the WHO European Region: Health Systems Respond
ENGLISH: http://www.euro.who.int/__data/assets/pdf_file/0006/115485/E94018.pdf

Resources on Inter-sectoral Action

1. Health Equity through Inter-sectoral Analysis: An Analysis of 18 Country Case Studies, WHO-PHAC http://www.who.int/social_determinants/resources/health_equity_isa_2008_en.pdf

Resources on Capacity Building

1. http://www.quint-essenz.ch/en/dimensions
2. http://www.quint-essenz.ch/en/tools/1052
3. http://www.quint-essenz.ch/en/topics/1089

Resources on Risk Communication

1. http://www.influenzaresources.org/
2. http://flu.gov/

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