World Health Organization

REGIONAL OFFICE FOR Africa

AFR/RC62/9
22 November 2012

REGIONAL COMMITTEE FOR AFRICA **ORIGINAL: ENGLISH**

Sixty-second session
Luanda, Republic of Angola, 19–23 November 2012

Agenda item 13

HEALTH PROMOTION: STRATEGY FOR THE AFRICAN REGION

Report of the Secretariat

EXECUTIVE SUMMARY

1. Health promotion is defined in the Ottawa Charter for Health Promotion (1986) as the process of enabling people to increase control over, and to improve, their health. It is considered as a cost-effective approach and a socially justifiable investment.

2. The rise in premature deaths from the double burden of communicable and noncommunicable diseases in countries of the African Region remains a major concern given that many of the causes are preventable. In 2001, the Fifty-first session of the Regional Committee endorsed the health promotion strategy for the African Region and the progress report on its implementation was presented at the Sixty-first session of the Regional Committee in 2011. The progress report identified issues and challenges in the implementation of health promotion activities across programmes and sectors. Consequently, the Regional Committee recommended the development of an updated strategy that would incorporate current approaches to health promotion.

3. This strategy focuses on multisectoral actions to promote health across public health problems, programmes and sectors. The priority interventions seek to strengthen leadership of the ministry of health; build capacity for health promotion practice; ensure good governance for health including developing healthy public policies, legislation and regulations; gather evidence; strengthen partnerships, alliances and networks and; advocate for sustainable health promotion financing options.

4. The strategy also defines the roles and responsibilities of Member States, WHO and partners in promoting health. The resource implications as well as monitoring and evaluation are highlighted.

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INTRODUCTION

1. Health promotion is defined in the Ottawa Charter for Health Promotion (1986) as the process of enabling people to increase control over, and to improve, their health.[1] The fact that the ultimate outcome of effective health promotion interventions is a healthy and productive generation makes it a socially justifiable investment that leads to improved social and economic development. The Ottawa Charter identifies the prerequisites for individuals and communities to attain optimal health outcomes such as peace, shelter, education, food, income, stable ecosystem, sustainable resources, social justice and equity.

2. Health promotion enables individuals, families, households and communities to realize the highest level of health and development irrespective of age, race, income, geographical location or education level. It advocates for individuals, families, households and communities to be core producers of health outcomes. Health promotion also calls for integration of activities across sectors and encourages multisectoral collaboration.

3. The burden of disease, disability and premature deaths in the WHO African Region continues to be disproportionately high and yet most of the causes are preventable. According to the WHO Global Burden of Diseases Report (2008),[2] this burden accounted for a total of 58.8 million deaths worldwide in 2004 and 18.6% of the deaths were in the WHO African Region. Approximately 64.7% of the deaths in the Region were due to communicable, maternal, perinatal and nutritional diseases; 27.6% were from noncommunicable diseases and; 7.8% from injuries. In addition, internationally-agreed targets such as the Millennium Development Goals (MDGs)[3] are not likely to be achieved by the majority of countries in the Region.

4. Health promotion interventions are essential in order to effectively address specific public health problems including maternal and child diseases, HIV/AIDS, tuberculosis, malaria, neglected tropical diseases, noncommunicable diseases including malnutrition. The interventions seek to promote healthy behaviours and empower individuals, families, households and communities to take necessary action and to reinforce the desired structural changes through policies, legislation and regulations.

5. Health promotion involves information dissemination using multiple channels of communication to increase health knowledge and social mobilization, and requires policies, legislation and regulations to create an enabling environment for health promotion. Effective implementation of health promotion interventions also requires sound planning, good management, systematic monitoring and evaluation, and partnership building among multiple development sectors including health, civil society, the private sector, households and communities.

6. In recognition of the increasing burden of disease, disability and premature deaths from preventable causes in the Region and the benefits of scaling up health promotion interventions to address them, the Fifty-first session of the Regional Committee, in 2001, approved the *Health promotion strategy for the African Region* and adopted a related Resolution AFR/RC51/R4[4] to foster actions that enhance physical, social and emotional well-being.

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[1] Ottawa Charter for health promotion. First International Conference on Health Promotion, Ottawa, Canada. 21 Nov 1986.

[2] WHO: The global burden of disease: Update projections. http://www.who.int/evidence/bod. Last accessed on 6 June 2012.

[3] WHO, Towards reaching the health-related Millennium Development Goals: Progress report and the way forward, Brazzaville, World Health Organization, Regional Office for Africa, 2009 (AFR/RC59/3).

[4] Resolution AFR/RC51/R4: Health promotion: Strategy for the African Region. In: *Fifty-first session of the WHO Regional Committee for Africa, Brazzaville, Republic of Congo, 27 August–1 September 2001, Final Report*, Brazzaville, Congo, World Health Organization, Regional Office for Africa, 2001 (AFR/RC51/18), pp. 10–12.

7. During the period 2004–2010, WHO provided technical support to 16 countries[5] to develop their national health promotion policies and to 12 countries[6] to develop their strategic plans. Several guidelines[7] for implementing health promotion interventions were developed. Training workshops on the use of health promotion tools for noncommunicable diseases prevention and control were held in Benin,[8] Uganda[9] and Zimbabwe[10] between 2007 and 2010. The workshops provided information and skills on the application of health promotion strategies and tools to addressing the risk factors and determinants of noncommunicable diseases (NCDs).

8. A series of global health promotion conferences convened by WHO have made declarations calling for collective efforts to improve the health of populations.[11] As a follow-up to these conferences, the World Health Assembly adopted resolution WHA51.12 on *health promotion;*[12] resolution WHA57.16 on *health promotion and lifestyles;*[13] resolution WHA60.24 on *health promotion in a globalized world;*[14] *and* the *Nairobi Call to Action for closing the implementation gap in health promotion (2009).*[15] In addition, Member States also deliberated on, and endorsed, political declarations with health promotion implications namely, the *Rio Political Declaration on Social Determinants*[16] and the *UN Political Declaration on Noncommunicable Diseases.*[17] There has been a major effort by Member States to implement recommendations and proposed actions from these resolutions and declarations.

9. Despite the above milestones, significant gaps and challenges still exist in health promotion with specific regard to stewardship, delivery of interventions, community participation and empowerment, evidence generation and sustainable financing. It is also acknowledged that poverty, gender inequities, natural disasters, conflicts, climate change and weak health systems limit the impact of health promotion initiatives in the Region. This underscores the need for a multisectoral approach to health promotion as proposed in this Regional Strategy.

SITUATION ANALYSIS AND JUSTIFICATION

Situation analysis

10. The WHO African Region continues to experience a disproportionately high burden of communicable and noncommunicable diseases, maternal and child mortality, new and re-emerging threats to health, all of which require health promotion interventions.[18,19] Communicable diseases account for almost two-thirds of the total deaths in the Region, and 88% of these deaths are caused by

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[5] Angola, Benin, Comoros, Congo, Côte d'Ivoire, Democratic Republic of Congo, Gabon, Malawi, Namibia, Niger, Sao Tome and Principe, Sierra Leone, Swaziland, Tanzania, Zambia and Zimbabwe.

[6] Benin, Ethiopia, Kenya, Lesotho, Liberia, Madagascar, Namibia, Nigeria, Senegal, Sierra Leone, South Africa and Zimbabwe.

[7] Guidelines for development of health promotion in countries of the WHO African Region; Guidelines for the implementation of the health-promoting schools initiative (HPSI); Facilitators Guide for regional orientation meetings for health promotion national focal persons and AFRO Health Information and Promotion Officers (HIPs) in the WHO African Region.

[8] Participants were from: Algeria, Benin, Burkina Faso, Côte d'Ivoire, Guinea, Guinea-Bissau, Mali, Mauritania, Niger, Senegal, Togo.

[9] Participants were from: Eritrea, Ethiopia, Ghana, Kenya, Liberia, Sierra Leone, Tanzania and Uganda.

[10] Participants were from: Eritrea, Ethiopia, Gambia, Kenya, Lesotho, Malawi, Namibia, Nigeria, Rwanda, Swaziland, Zambia and Zimbabwe.

[11] WHO 2009: Milestones in Health Promotion: Statements from Global Conferences.

[12] Resolution. WHA51.12: Health promotion.

[13] Resolution. WHA57.16: Health promotion and healthy lifestyles.

[14] Resolution. WHA60.24: Health promotion in a globalized world.

[15] WHO 2009: The Nairobi Call to Action for closing the implementation gap in health promotion. The 7th Global Conference on Health Promotion, Nairobi, Kenya.

[16] WHO: Rio Political Declaration on Social Determinants of Health. World Conference on Social Determinants of Health, Rio de Janeiro, Brazil: 19–21 October, 2011.

[17] UN: Political Declaration of the High Level Meeting of the General Assembly on the prevention and control of noncommunicable diseases, New York, 16 September, 2011.

[18] UNICEF, WHO, World Bank, UNDESA: Levels and trends in child mortality: Report 2011 – Estimates developed by the UN Interagency Group for Child Mortality Estimation, New York, UNICEF, 2011.

[19] HIV/AIDS Sub-Saharan Summary Report: Epidemic update and Health Sector progress towards universal access, Progress report 2011. WHO, UNAIDS, UNICEF.

HIV/AIDS, diarrheal diseases, malaria, tuberculosis and childhood diseases. HIV/AIDS alone accounts for 38.5% of deaths from communicable diseases. Furthermore, communicable diseases such as cholera and typhoid remain recurrent and require multisectoral approaches.

11. The main NCDs in the African Region are cardiovascular diseases, cancers, diabetes, and chronic respiratory diseases. Other noncommunicable diseases exist in the Region and need to be addressed including oral diseases, sickle-cell disease, blindness, deafness, neurological conditions and mental disorders in addition to violence, injuries and disabilities. NCDs including mental disorders represent about 60% of the current global burden of disease. In the Region, it is estimated that NCDs cause 3 million deaths annually, 7.8% of which are due to injuries. The growing burden of NCDs disproportionately affects the poor and disadvantaged populations in both rural and urban settings. According to projections, NCDs will be among the major causes of mortality in the next decade.

12. Most of the chronic health conditions are associated with risk factors and their determinants. The major risk factors include tobacco use, unhealthy diet, physical inactivity and harmful use of alcohol. The key determinants of health include globalization, trade, education, environmental factors, urbanization, water and sanitation, poverty, population ageing, gender, and behavioural and cultural values and beliefs. Increasing inequalities and inequities within and between countries aggravate exposure to these risk factors and their determinants. Most of these factors exist outside the health sector. Lack of information and access to public health services for primary, secondary and tertiary prevention particularly among the marginalized population further worsen the situation.

13. Maternal and perinatal conditions including malnutrition account for 12.2% of deaths in the Region. The risk of maternal deaths remains highest in the African Region where an estimated 500 deaths are recorded per 100 000 live births compared with 16 per 100 000 live births in the European Region.[20] The African Region is not on track to achieve MDG5.[21] Under-five mortality in the African Region remains the highest in the world, estimated at 119 per 1000 live births in 2010.[22] In 2010, eight countries[23] out of the 46 countries in the WHO African Region were on track to achieve MDG4 i.e. reduce child deaths by two-thirds between 1990 and 2015. Although child mortality continues to decline in the Region due to concerted effort in scaling up immunization programmes and the Integrated Management of Childhood Illness (IMCI) strategy, multisectoral health promotion approaches such as social mobilization, communication for social and behavioural change, and community participation are needed to further accelerate progress.

14. One quarter of the world population are between the ages of 10 and 24 years. In the African Region, a huge proportion of young people are exposed to HIV infection; alcohol, tobacco and drug use; teenage pregnancy; violence and injuries. These harmful situations impact negatively on their education, health, employment opportunities and social well-being.

15. The 2.6 million deaths among young people worldwide are generally preventable. This age group is ready to learn and retain new information and skills to prevent disease and promote health. However, if no interventions are implemented, the young people are at risk of adopting negative individual and societal practices that can compromise their health and that of society as a whole. Health promotion in settings such as schools, workplaces and communities presents an opportunity to disseminate health information and impart life skills to people in order to promote healthy behaviors which could be applied throughout the life span.

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[20] Trends in maternal mortality: 1990–2010. WHO, UNICEF, UNFPA and the World Bank, 2012.

[21] WHO, *Towards reaching the health-related Millennium Development Goals: Progress report and the way forward*, Brazzaville, Congo, World Health Organization, Regional Office for Africa, 2009 (AFR/RC59/3).

[22] UNICEF, WHO, World Bank, UNDESA. Levels and Trends in Child Mortality: Report 2011 - Estimates Developed by the United Nations Interagency Group for Child Mortality Estimation, New York, UNICEF 2011.

[23] Algeria, Cape Verde, Eritrea, Liberia, Madagascar, Malawi, Mauritius and Seychelles.

16. The African Region continues to experience new and re-emerging threats to public health. These threats, related to social, economic, environmental, demographic and political factors, include influenza pandemics; natural and man-made disasters such as floods, earthquakes, droughts, and conflicts; viral haemorrhagic fevers; drug-resistant pathogens; and the effects of climate change on health.

17. A review of the implementation of the *Health Promotion Strategy for the African Region* during the period 2001–2010 was presented to the Sixty-first session of the Regional Committee.[24] The review identified the following issues and challenges that require action: (a) inadequate leadership of ministries of health in coordinating activities across sectors; (b) limited involvement of various players such as community-based groups, civil society, academia and development partners in advocacy actions and regulation and legislation for good health governance; (c) paucity of human resources to carry out health promotion activities at community level; (d) limited application of both qualitative and quantitative health promotion research to monitor implementation progress and to evaluate the effectiveness of programme interventions and; (e) lack of sustainable financing mechanisms for health promotion. There had been concerted effort to build the capacity of both health and non-health professionals through training and policy development in order to address these gaps and challenges. Promoting community mobilization, public awareness and response was prioritized.

18. In health promotion, it is considered that the societal conditions in which people are born, grow, live, work and age and the systems put in place to deal with illness determine health outcomes. Multisectoral approaches are required to address these conditions. In 2009, the *Nairobi Call to Action for closing the implementation gap in health promotion*[25] identified the need to strengthen leadership in health promotion, empower communities and individuals, and enhance the participatory processes of various sectors. The WHO African Region has identified six strategic directions for addressing priority public health conditions including through health promotion.[26] Several WHO programmes have integrated health promotion interventions into their strategies.[27]

Justification

19. Despite the efforts of governments and partners to build healthy and safe community environments, expand quality preventive services in both clinical and community settings and empower people to make healthy choices and eliminate health disparities, huge gaps and challenges remain. However, the risk factors and their determinants can be addressed through intersectoral, innovative and sustained health promotion interventions.

20. The health system should be re-oriented to be more responsive to the needs of all people especially the poor and vulnerable groups, using a primary health care approach.[28] Health promotion should, therefore, be mainstreamed in all national policies and programmes and should be supported by a critical mass of trained people, and sustainable structures and resources.

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[24] WHO, *Progress report on the implementation of the Regional Health Promotion Strategy,* Brazzaville, Congo, World Health Organization, Regional Office for Africa, 2001 (AFR/RC61/PR/4).

[25] WHO: *The Nairobi Call to Action for closing the implementation gap in health promotion*. The 7th Global Conference on Health Promotion, Nairobi, Kenya, October 2009.

[26] WHO/AFRO: Achieving sustainable health development in the African Region: Strategic directions for WHO 2010–2015.

[27] WHO, *HIV prevention in the African Region: a strategy for renewal and acceleration*, Brazzaville, Congo, World Health Organization, Regional Office for Africa, 2006 (AFR/RC56/8); WHO, *Measles elimination by 2020: a strategy for the African Region*, Brazzaville, Congo, World Health Organization, Regional Office for Africa, 2011 (AFR/RC61/8); WHO, *Diabetes prevention and control: a strategy for the WHO African Region,* Brazzaville, Congo, World Health Organization, Regional Office for Africa, 2007 (AFR/RC57/7); WHO, *Cancer prevention and control: a strategy for the WHO African Region*, Brazzaville, Congo, World Health Organization, Regional Office for Africa, 2008 (AFR/RC58/4); WHO, *A strategy for addressing the key determinants of health in the African Region,* Brazzaville, Congo, World Health Organization, Regional Office for Africa, 2010 (AFR/RC60/3); WHO, *Food safety and health: a strategy for the WHO African Region,* Brazzaville, Congo, World Health Organization, Regional Office for Africa, 2007 (AFR/RC57/4); WHO, *Reduction of the harmful use of alcohol: a strategy for the WHO African Region,* Brazzaville, Congo, World Health Organization, Regional Office for Africa, 2010 (AFR/RC60/4); WHO, *Environmental health: a strategy for the African Region,* Brazzaville, Congo, World Health Organization, Regional Office for Africa, 2002 (AFR/RC52/10).

[28] WHO, World Health Report 2008: Primary health care: Now more than ever, Geneva, Switzerland, 2008.

21. In 2011, the Sixty-first session of the WHO Regional Committee recommended updating of the document *Health promotion: A strategy for the African Region* in response to the growing burden of preventable public health conditions. This updated strategy therefore contains a range of established and proven priority interventions designed to address these challenges and is consistent with recent global developments.

THE REGIONAL STRATEGY

Aim, objectives and targets

22. This strategy covers a period of 10 years. Its aim is to build on and scale up existing multisectoral health promotion interventions in order to contribute to reducing the leading causes of preventable deaths, disabilities and major illnesses from communicable diseases and noncommunicable diseases, violence and injuries, maternal and child health conditions, and new and re-emerging threats to health in the African Region.

Objectives

23. The objectives of this updated strategy entitled *Health promotion: Strategy for the African Region,* are:

(a) to facilitate multisectoral actions such as community participation, social dialogue, partnerships and innovative financing to promote and protect health across population groups;

(b) to strengthen the capacity of Member States to develop, implement, monitor and evaluate health promotion strategies, policies, and regulatory and legislative frameworks that address the risk factors and the determinants associated with communicable diseases and noncommunicable diseases, violence and injuries, maternal and child health conditions, and new and re-emerging threats to health;

(c) to foster effective partnerships, networks and alliances among health and non-health professionals, government, private sector, civil society, multiple development sectors and communities in order to harness new technical and financial resources.

Targets

24. By the end of 2013 the African Region would have developed a regional framework to assess planning, implementation and evaluation of priority health promotion interventions;

25. By the end of 2015 the African Region would have:

(a) at least 30 countries develop or revise their health promotion policy or strategic plan of action;

(b) at least 15 countries establish a national association or network of health promotion practitioners;

(c) at least 10 countries engage in a multisectoral dialogue to establish innovative financing using dedicated tax;

(d) at least 10 academic training institutions incorporate core modules in health promotion in their curricula;

26. By the end of 2018 the African Region would have:

(a) all countries develop or revise their health promotion policy or strategic plan of action;

(b) at least 15 additional countries establish a national association or network of health promotion practitioners;

(c) at least 10 additional countries engage in a multisectoral dialogue to establish innovative financing using dedicated tax;

(d) at least 10 additional academic training institutions incorporate core modules in health promotion in their curricula;

27. By the end of 2017 and 2022 the African Region would have conducted mid-term and final assessment of implementation of the regional strategy respectively.

Guiding principles

28. The strategy upholds the following principles to promote health:

(a) **Ownership** of programmes by individuals and communities through their participation in all activities;

(b) **Equity in health** to ensure access, availability and affordability of health promotion services for all;

(c) **Human rights and gender equity** to protect vulnerable groups;

(d) **Intrasectoral and intersectoral collaboration and coordination** of various players to promote health;

(e) **Mutual accountability and shared responsibility** among national governments, service providers, funding agencies and intended beneficiaries in order to monitor implementation progress including financial management and agreed commitments, using evidence.

Priority interventions

29. The health promotion interventions proposed for the African Region are based on multisectoral approaches to tackling priority public health conditions. They address the preventable causes of disease, disability and premature deaths in the Region in all population groups throughout the life course. The intended outcomes are increased community health awareness, participation and empowerment; positive changes in health-related behaviours and societal structures; and evidence-based policies and legislations.

30. **Strengthening the stewardship role of the ministry of health:** The stewardship role broadly includes coordination and advocacy for making health promotion a key focus of all government ministries, private sector, community and civil society. This would ensure that adequate human, financial and infrastructural resources are allocated. Policy, legislative and regulatory frameworks to promote and protect health across priority public health conditions should be developed. Existing treaties such as the WHO Framework Convention on Tobacco Control[29] should be fully implemented. All national policies, across different sectors, should protect and sustain social and cultural values and beliefs deemed beneficial to society especially gender equality, and militate against those values and beliefs considered harmful to health.

31. **Strengthening national technical capacity for health promotion:** Training in health promotion should be provided to people from health and non-health backgrounds through pre-service, in-service,

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[29] WHO. WHO Framework Convention on Tobacco Control, Geneva, Switzerland, 2003.

continuing education and post-graduate training. Health promotion training programmes should provide trainees with a wide range of competencies including content and practical skills to address social, cultural and behavioural aspects of health. Governments and development partners should support academic and training institutions to recruit and retain competent faculty, and to incorporate core modules on health promotion into existing training programmes in order to improve health promotion curricula.

32. **Sustaining institutional capacity for health promotion at national, regional and local levels**: Ministry of Health should establish a sustainable organizational structure at national and subnational levels to coordinate and manage health promotion activities across programmes and sectors. At the national level a health promotion organizational structure with adequate financial and human resources allocation should be established, and at sub-national level, an effective mechanism for coordination and implementation should be put in place. The health promotion infrastructure should: (a) provide guidance on development and implementation of health promotion policy and programmes; (b) coordinate public health education and awareness raising activities; (c) initiate and sustain partnerships, alliances and networks for promoting health and monitoring progress and; (d) ensure sound planning for multisectoral actions based on evidence.

33. **Communication, social mobilization and advocacy:** The use of various communication channels and processes is a prerequisite for increasing awareness, interest and positive behaviour change among individual, families, households and community. Both the traditional communication (television, radio, posters, pamphlets, billboards, video) and new information media (mobile text messaging, internet social media) should be harnessed to empower individuals, households and communities with knowledge and skills essential to effect behavioural and structural change. The participation of other stakeholders including high profile citizens (champions) for purposes of lobbing government officials and private corporations is highly encouraged. Individual, families, households and communities should participate in the production and distribution of information aimed at promoting health. Communication should aim to increase health literacy, promote positive health behaviour and adoption of appropriate coping strategies.

34. **Gathering and disseminating evidence on best practice and effective health promotion approaches**: This includes monitoring the trends in the implementation of health promotion approaches, national and institutional capacity strengthening, resource allocation and documenting structural changes due to policies, legislation and regulations on sectors such as food, tobacco and alcohol industries. Both qualitative and quantitative information should be gathered and analysed in order to document the efficacy and effectiveness of health promotion interventions.

35. **Establishing sustainable mechanisms for innovative financing of health promotion to ensure adequate funding of interventions across programmes:** Sustainable financing mechanisms for health promotion include: (a) equitable allocation of financial resources for health promotion through a government line-item budget; (b) setting aside a percentage of the budget of each programme for health promotion activities and; (c) establishing a Health Promotion Fund, using a special levy (hypothecated or earmarked tax) on alcohol, tobacco or others. The health promotion fund should receive its mandate from an Act of Parliament. In this regard, the experiences of countries such as Australia,[30] Thailand[31] and Zimbabwe[32] could be drawn upon.

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[30] VicHealth Foundation, Victoria, Australia: The first Health Promotion Foundation established in 1987 using 5% levy on tobacco www.vichealth.vic.gov.au/ last accessed on 26 February 2012.

[31] ThaiHealth Promotion Foundation, Thailand: Established in 2001 using a 2% surcharge levied on alcohol and tobacco excise tax. http://en.thaihealth.or.th/ last accessed on 26 February 2012.

[32] Zimbabwe AIDS Levy: Established in 1999 by the Government of Zimbabwe using 3% of all taxable income http://www.who.int/hiv/HIVCP_ZWE.pdf last accessed on 26 February 2012.

36. **Strengthening functional partnership, alliances and networks:** There is a need to strengthen partnership between government and individuals, communities, civil society, academic and research institutions and the private sector to promote health. The partnerships, alliances and networks should safeguard against conflict of interest. The formation of national and regional health promotion associations or networks would create forums for various health promotion practitioners to share experiences and provide update on latest developments in professional norms and standards for health promotion practice. A clearly-defined role for national, regional and global health promotion organizations and public health associations should be established to support health promotion.

37. Strengthening **community capacity for health promotion:** This could be achieved by ensuring active community participation through effective engagement in the design, planning and implementation of interventions and evaluation of outcomes. Promoting social dialogue on health, and fostering partnerships and alliances are mechanisms for community ownership of health promotion interventions and these should be created to ensure that the voices and aspirations of the community are taken into account throughout planning and implementation.[33] This will have a positive impact and contribute to the expected changes in health outcomes at community level. Regular community-led assessment will be required.

Roles and responsibilities

Member States

38. Member States should:

(a) establish structures in the Ministry of Health at national and subnational levels with adequate human and financial resources to coordinate and manage implementation of multisectoral and multi-disciplinary health promotion actions across programmes and sectors;

(b) build the capacity of both health and non-health professionals to plan, implement, monitor and evaluate health promotion interventions at national and subnational levels and to advocate for legislative frameworks, policies and strategic plans of action to promote health;

(c) establish/strengthen health promotion partnerships, networks and alliances in order to harness technical and financial resources for health promotion;

(d) strengthen information, education and communication processes and actions for better social mobilization, community empowerment and advocacy to promote health among the population;

(e) allocate adequate financial resources for health promotion activities from the national budget and consider changes in financing options, including legislating the use of earmarked dedicated special levies from tobacco, alcohol or other sources;

(f) monitor progress of the implementation of the health promotion priority interventions, including documentation and dissemination of lessons learnt through case studies, surveys and research.

WHO and other partners

39. WHO and other partners should:

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[33] Fawcett S, et al. 2010: Constructing an action agenda for community empowerment at the 7th Global Conference on Health Promotion in Nairobi. Global Health Promotion, journal 17(4): 52–56.

(a) support Member States to strengthen the capacity of health and non-health professionals to implement health promotion actions across priority public health programmes;
(b) reinforce the stewardship role of government to strengthen community participation, social dialogue among various players and to integrate health in all policies;
(c) facilitate the establishment of health promotion partnerships, networks and alliances in order to harness technical and financial resources for health promotion;
(d) develop indicators and tools to monitor progress in implementation of interventions, trends in health-related behaviours and structural changes and support research through national and regional public health institutions and associations.

Resource implications

40. The actions identified in this strategy would need investments (financial, human, infrastructure and time) by Member States, WHO and partners. It is estimated that the national budget for prevention and public health services including health promotion in most countries of African Region to be 23% of the total health expenditure.[34] Currently the lowest level is estimated at 8% and the uppermost level is 36%. The average level of real per capita total health expenditure on prevention and public health services including health promotion is estimated at US$ 3.2, and ranges from US$ 2.2 to US$ 47.2. It is proposed to increase this proportion and to consider both the government budget allocated to the health sector and the per capita expenditure to meet the needs of essential health services. The WHO Secretariat will require, in each biennium, a total of US$ 3 million to support the implementation of this strategy.

MONITORING AND EVALUATION

41. To monitor the implementation of each proposed intervention, a framework with a set of performance indicators will be developed. Reviews including surveys on the efficacy and effectiveness of health promotion actions in selected public health programmes will be conducted every three years in collaboration with national, regional and international experts and partners. Policies, legislative actions and use of financial resources will be monitored and evaluated as appropriate. A progress report will be presented to the Regional Committee every three years.

CONCLUSION

42. In order to effectively implement the identified multisectoral priority interventions, strong political action, broad participation and sustained advocacy are required. This calls for the involvement of various players including government, the private sector, civil society, the media and communities. The leadership of the ministry of health in coordinating social dialogue, facilitating community participation and fostering partnership is critical.

43. The Regional Committee has considered and adopted this strategy.

[34] http://apps.who.int/nha/database/DataExplorerRegime.aspx last accessed on 3 April 2012.