

# Effectiveness of alliances and partnerships for health promotion

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## SUMMARY

*This paper assesses the impact of alliances or partnerships for health promotion in northern and southern nations, as described in published papers and through contemporary accounts of best practice. The balance of evidence from published literature and case study accounts is clear. Alliance or partnership initiatives to promote health across sectors, across professional and lay boundaries and between public, private and non-government agencies, do work. They work in tackling the broader determinants of health and well-being in populations in a sustainable manner, as well as in promoting individual health-related behaviour change. The greater the level of local community involvement in setting agendas for action and in the practice of health promotion, the larger the impact. Volunteer activities, peer programmes and civic activities ensure the maximum benefit from community approaches. In addition, durable structures which facilitate planning and decision-making, such as local committees and councils, are key factors in successful alliances or partnerships for health promotion. Such mechanisms also support the sharing of power, responsibility and authority for change, the main-*

*tenance of order and of programmatic relevance, and allow local people one means of reflection and for dissent. At a national, regional, district, village and local community or neighbourhood level, this review found that the existence and implementation of policies for health promotion activities were also crucial to sustainability. The evidence from the review suggests the need for new 'social' indicators to measure the effects of health promotion. Indicators for success which focus only upon benefits for individuals cannot capture adequately the extent of the impact of the many and varied collective, collaborative health promotion initiatives, alliances or partnerships currently underway around the world. These have been shown to affect families, communities, institutions and aspects of the organisation of social and civic life. This paper posits the notion of social capital as one important new framework for organising our thinking about the broader determinants of health and how to influence them through community-based approaches to reduce inequalities in health and well-being.*

*Key words:* alliances; health promotion; partnerships

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## INTRODUCTION

### Recognising the broader determinants of health

Since the Ottawa charter was launched in 1986 there has been growing interest in developing approaches to health promotion which tackle the broader social, economic and environmental determinants of health.

These developments have, in part, been in response to a recognition that individually focused behavioural interventions for health promotion

and disease prevention have had a relatively small but none the less significant impact. Such approaches, grounded in psychological behaviour-change theories, have an impact, at best, on an average of one in four of those who participate (Gillies, 1996). These individuals tend to be the better off, better motivated and better educated. New and compelling evidence has, however,

drawn our attention to the need to understand and address those factors which affect health, but which are beyond the control of individual influence on behaviours or experience.

The social and environmental determinants of health, their causes and consequences for populations, have been subjected to scrutiny in both developed and developing country contexts. From Brazil to Britain, the evidence is clear: wealth, occupation, social support; housing and education are significantly related to wide differences in life expectancy, infant mortality and psychosocial well-being (Marmot *et al.*, 1991; Brunner *et al.*, 1993; Evans *et al.*, 1994; Blane *et al.*, 1996). They are also strongly associated with the quality and level of infrastructure in the neighbourhoods in which people live and with preventive health behaviours (Macintyre and Ellaway, 1996).

Additional analyses by Wilkinson (1996) demonstrate the adverse effects upon health and well-being of relative inequalities in income within societies and point to the benefits of equitable societies with strong social support and cohesion.

### **Social capital as a resource for the promotion of health**

Social support and civic engagement in activities as diverse as taking part in community group meetings, exchanging childcare with neighbours, being involved in neighbourhood watch schemes and voting, build trust in neighbourhoods and in society at large, producing a resource called 'social capital' (Putnam, 1993). The production of this resource is related to the health, wealth and well-being of populations (Putnam, 1993).

Generally, social capital is produced by features of the organisation of our societies and communities which facilitate coordination, cooperation and reciprocity. Therefore high levels of trust, positive social norms and many overlapping and diverse horizontal networks for communication and exchange of information, ideas and practical help, will exist where stocks of social capital are high. The relationships and friendships among adults which form the bedrock of social networks provide an informal structure upon which formal citizenship and civic engagement is built (Coleman, 1988; Cox, 1995). Importantly, then, social capital does not just describe a resource. It can be defined as a specific process embracing clear but culturally nuanced mechanisms for enabling people and organisations to

work together in trust for mutual social benefit. Individuals gain through building social capital, and so too do societies. The relevance of social capital in this review of alliances or partnerships for health promotion lies in the fact that one important aspect of the foundation for building social capital is the existence of networks for communication—such networks are fundamental to alliance and partnership building.

Social capital has been related to good governance, economic prosperity and some measures of the health status of populations such as infant mortality and life expectancy in regions in Italy (Putnam, 1993). There is now good evidence of a relationship between the existence of aspects of this kind of social trust and deaths from stroke, accidents and suicides, and to survival from heart disease in the US (Kawachi *et al.*, 1996). Social capital has also been found to exist in the most disadvantaged settings and to be related to preventive health-related activities among disenfranchised groups (Higgins *et al.*, 1996). Thus, connections, networks and associations within societies are important mechanisms for the promotion of social cohesion and health and for the prevention of disease (Wallace, 1993; Higgins *et al.*, 1996; Wilkinson, 1996).

### **The global context of local health promotion**

In turning our attention to the structural provenance of health-related problems, health promotion in the last decade has, however, had to consider the impact of global economic forces engendered by: the deregulation of markets; initiatives in relation to human rights; democracy; environmental degradation; military expansion; and information technologies (Held, 1996). And yet it has also had to maintain the benefits accrued from best efforts to promote the health of individuals and groups at local and national levels.

This is set against a background of growing gaps in health status and health care around the world: by socio-economic status; between geographical groups; by gender, race and ethnicity and age groups [World Health Organization (WHO), 1996].

This paper reviews the extent to which health promotion has faced these major challenges and how far it has succeeded in promoting the health of populations and individuals through approaches based upon alliances or partnerships. An alliance for health promotion can be defined as a collaboration between two or more parties

that pursue a set of agreed goals for health promotion. Partnerships for health promotion focus on health outcomes rather than specific health promotion goals. Thus a partnership for health promotion is defined as a voluntary agreement between two or more partners to work cooperatively toward a set of shared health outcomes.

This paper will explore current understanding of what counts as 'best practice' in health promotion and how to measure effectiveness. It will conclude by arguing that the cultural construct of social capital provides a coherent way for organising our thinking about the social context of health and for research, practice and policy in health promotion.

### **Reviewing the evidence**

This study adopted two approaches to compiling the evidence of the effectiveness of partnerships for health promotion past and present.

The first of these consisted in a review of the published literature since 1986, using the search strategy of the Cochrane Collaboration. This was commissioned by the Health Education Authority (HEA) for England and provided the original source of data which was abstracted for the analysis presented here (see Roe *et al.*, 1997).

The second approach involved a global network of health promotion experts identifying current best practice around the world. The process was outlined and initiated by WHO, Geneva, and required the support and assistance of the six Regional Offices of the WHO, which identified regional focal points for the development and collection of case studies. Each region was invited to contribute up to five current examples of best practice in alliances or partnerships for health promotion. The Health Education Authority's task was to coordinate and support this initiative and analyse case studies collected. The full results of the analysis of the 46 case studies tabulated are presented elsewhere (Gillies, 1997).

## **PUBLISHED EVALUATIONS OF THE EFFECTIVENESS OF ALLIANCES OR PARTNERSHIPS FOR HEALTH PROMOTION**

### **Defining and selecting content**

The review by Roe *et al.* (1997) of 19 international databases revealed a total of 185 published

references to the evaluation of alliances or partnerships for health promotion since 1986. Of these studies, only 43 are included in the analysis presented here.

Those selected comprised studies which reported process or outcome data from evaluations and were not merely descriptions of projects. They also reflect the following broad definitions of alliances or partnerships adopted for this study.

- (i) At the micro level: alliances or partnerships which involve one or more collaborators among individuals or groups or organisations in the public, private or non-governmental sectors in the promotion of health, but which do not seek to affect the underlying systems or structures or architecture for health promotion.
- (ii) At the macro level: alliances or partnerships which involve one or more collaborators among institutions, organisations or groups in the public, private or non-governmental sector which seek to affect the structural determinants of health.

This therefore represents a highly selective and interpretative review, with all the limitations that therefore pertain with regard to generalisation of the findings.

The discussion in this section will focus on two principal questions. Firstly, which kinds of alliances or partnerships for health promotion appear to work effectively and why? Secondly, what is the nature and extent of their impact?

### **Which kind of alliances or partnerships work best and why?**

#### *More is better*

Taken together, the findings comprising randomised controlled trials ( $n = 16$ ), studies with control or comparison groups ( $n = 15$ ), and studies with pre- and post-testing of impact ( $n = 12$ ), clearly demonstrated that however one defines the outcome and whoever the partners in the process are, the stronger the representation of the community and the greater the community involvement in the practical activities of health promotion, the greater the impact and the more sustainable the gains (Gillies, 1997).

#### *Local voices in action*

It appears to be important that lay representation in the setting of local and national agendas is

taken seriously and is not mere tokenism. It must connote a sharing of power and control between the public and key protagonists whether they be professionals, business employers, health service providers, organisations or policy-makers. This observation has been borne out in a detailed qualitative investigation of community representation in community action for AIDS prevention in the USA described elsewhere (Schietinger *et al.*, 1995). Thus, durable structures which facilitate a sharing of decision-making—such as: committees of employees and employers (Windsor *et al.*, 1988; Fisher *et al.*, 1994; Glasgow *et al.*, 1994); health cooperatives or groups (Burns, 1990; Shoenbach *et al.*, 1992); school and community coordinating councils (Wotowicz *et al.*, 1992; Heath *et al.*, 1995; Kumpusalo *et al.*, 1996); or volunteer networks (Johnson *et al.*, 1993; Sellers *et al.*, 1994)—are key factors in successful alliances or partnerships for the promotion of health and are, in this review, demonstrably effective at local level.

Mechanisms for involving local people in planning, maintaining order and relevance, and in providing an opportunity for dissent are important. So too is the involvement of local individuals in the practical activities of health promotion. Reviews of the effectiveness of peer involvement, social support and community mobilisation in the prevention of HIV provide the most compelling evidence for this (see, for example, Choi and Coates, 1994; Gillies, 1996). The review reported here confirms this view, not only in respect of HIV prevention and sexual health promotion (Rietmeijer *et al.*, 1996), but also in relation to smoking (Johnson *et al.*, 1990; Shoenbach *et al.*, 1992; Kuiz *et al.*, 1993), environmental health promotion (Klevens *et al.*, 1992), alcohol and drug use (Johnson *et al.*, 1990), and parenting (Johnson *et al.*, 1993).

### *Policy and praxis*

An inability to engage local citizens in productive decision-making about health and social welfare and in policy development has been identified as one of the shortcomings of the Healthy Cities initiatives in Australia and Canada (Baume and Cooke, 1992; Ouellet *et al.*, 1994). Indeed, several of the successful community-based initiatives identified in this review had a policy development element as one of the main activities and identified outcomes of success. Local policy development around single issues may, however, be easier to deliver with citizen involvement than

city-wide healthy public policies in general, because of the immediate relevance and emotional connection of the focus. Workplace policies as part of an integrated package of health promotion approaches may be a good example of this. Kronenfeld *et al.* (1987) found such policies to be associated with a significant reduction in heavy smoking and drinking in one in five employees.

But there is little doubt that the bold attempts of the Healthy Cities projects are in the right direction since healthy public policies are most certainly likely to sustain local community health promotion activities (Kickbusch, 1993). For example, Klevens *et al.* (1992) in a project to create healthy environments described how a local community became mobilised around a long-standing grievance about the dirt and untidiness in their neighbourhood as a result of a health needs assessment. 'Street' leaders emerged in a street cleaning initiative with 20% of the population engaged in the activity at any one time. Pride and competition for cleanliness centred upon streets where trust was high. However, without the development of reinforcement mechanisms such as the implementation of local authority policies to support the residents' effort, interest in the initiative could not be sustained in the longer term. Reciprocity must work and be seen to work across levels in society and across informal and formal networks.

### **The nature and extent of the impact of alliance or partnership health promotion projects**

In the tabulated review of published literature (Gillies, 1997) the outcome focus was predominantly on the impact of intervention upon the health related behaviours of individuals. This was the case in 15 of the 16 randomised controlled trials; 13 of the 15 comparison studies and six of the 12 pre-post test evaluations. Behaviour-change effects reported ranged from 3 to 20% of the populations involved in interventions. This level of impact is the expected range from the application of interventions designed according to popular psychological theories of health-related behaviour change.

Behaviour and behaviour change do not occur in a vacuum, nor are they necessarily rational processes, and just as health and well-being are influenced by social and environmental factors, so too are behaviours. Alliances or partnerships for health promotion have an opportunity to attempt to influence the wider context of beha-

vioural change and of health, but rarely was this recognised in the published studies of alliances or partnerships identified and presented here.

It could be argued that this may have arisen, in part, from the individualistic focus of the interventions which predetermined the goals set for the intervention and the outcomes measured. This, in turn, could be the consequence of the lack of sociologically and politically sophisticated theories of behaviour which can cope with the complexity and diversity of the cross-cultural contexts of change.

However, even in those studies specifically designed with a community-based component, the 'gaze' of the evaluator was firmly fixed on behavioural outcomes alone.

Interestingly, there was some evidence of lateral thinking. An understanding of the pressures of the supply and demand characteristics of localities in relation to alcohol and a report of employees 'organising for change' as an outcome were noted in two randomised controlled trials (Perky *et al.*, 1993; Glasgow *et al.*, 1994). One comparative study reported on the positive educational benefits for young women of an innovative school-based crèche and parenting service (Warwick *et al.*, 1993).

Evaluations which sought to answer questions about the impact of interventions on relationships and skills-building (Burns, 1990), the development of community trust (Kelvins *et al.*, 1992), and the fact of collaborative activities (Bennett *et al.*, 1994), could not capture such outcomes readily in studies other than in simple before-and-after designs. But the findings on behavioural change in the pre-post designs were of the order of those observed in the randomised studies. In this review it could, therefore, reasonably be argued that there is some cause to believe that the interventions described, and not some other effect, did have an impact on the everyday background in which life was lived and experienced—even those evaluated with pre-post designs. There is clearly scope, however, for re-thinking the kinds of community outcome indicators from process or outcome evaluations that would more reasonably and helpfully measure the impact of alliances or partnerships for health promotion.

Only two studies dealt with 'macro' level effects and determinedly set out to affect the underlying structural influences upon health. Both were evaluations of Healthy Cities initiatives and both had appropriately broadly focused indicators of success. Policy development and

cross-agency working are examples of the outcomes reported (Baum and Cooke, 1992; Ouellet, *et al.*, 1994). The thoughtful qualitative analyses of the impact of these studies made visible the difficulties they had in shifting the balance of power and control in cities, in promoting equity and in gaining adequate citizen representation. Perhaps again it was the lack of an appropriate conceptual framework to guide the process of change which led to the partial success of the initiatives. Indeed, it could be argued that to succeed in promoting increased community participation for control over the wider organisational and systemic influences on health as well as individual factors, there must already be measurable cooperative civic engagement, or social capital, in communities. Or, at least there must perhaps be a minimum level of infrastructure (Mulgan, 1997) and economic conditions without too much hardship (Moser, 1996) to allow the possibility for the development of social trust, exchange and cooperation for mutual benefit to happen.

In summary, this review of the already published literature on alliances or partnerships privileged initiatives in industrialised nations. This inevitably means that the review of published reports is significantly biased in favour of nations with certain linguistic capacities and also in respect of Western cultural and philosophical traditions. The majority of studies reported an impact upon behaviour and several observed effects upon the organisation of activities and upon the wider social and physical environments in which people live. There were only rare examples of private sector involvement in alliances and these were principally in workplace settings. There were few examples of attempts at 'macro' level alliances or partnerships to influence the structural determinants of health. Community-based involvement and representation in the practice of health promotion was, however, related to wider-reaching benefits to the volunteers themselves, to service provision, working environments, and to the social and economic life and well-being of local populations. Although necessarily selective, the additional review of best practice from case studies collected by the Regional Offices of WHO and reported here, seeks to redress the balance in accounts of effectiveness, hitherto available only in published sources.

## BEST PRACTICE IN ALLIANCES OR PARTNERSHIPS FOR HEALTH PROMOTION AROUND THE WORLD

This section will consider the types of alliances or partnerships offered up by health promoters from around the world as examples of best practice and then look at the impact of such initiatives. This will be followed by a brief section on measuring the outcomes from partnership approaches to health promotion.

All of the 44 case studies forwarded by the regional focal points were included in the analysis. In addition, two further case studies highlighting corporate involvement in alliances were included after being forwarded to the HEA through WHO, Geneva. A summary of the key findings of case studies which were presented in English is given in Table 1. These accounts were not identified in this form in the systematic review of published literature.

### Which kind of alliances or partnerships constitute best practice?

The data presented in Table 1 demonstrate an overwhelming commitment to alliances or partnerships which traverse the sectors of health, education, social welfare, environment, transport, tourism and employment, and which span public, private and non-government agencies. They show a clear commitment to lay representation in agenda-setting, policy-making and implementation at national, regional, district, village and local community or neighbourhood levels. Emphasis is upon the sharing of power, responsibility and authority for change. There is also an understanding that it is important to maximise the level of community involvement in the practice of health promotion through volunteer networks, peer programmes and civic activities to ensure maximum benefits from the investment.

Thus the findings from case study reports show that around the world there is a great deal of health promotion activity concerned with generating sophisticated and wide-ranging alliances or partnerships for health. Collective and diverse approaches to health promotion, the privileging of equity and lay or local representation at all levels were recurrent themes. The majority of these initiatives were organised at national, district or local level, with an eye to the need for sustainability in the longer term. At least one-third of the case studies reported recognised the need for tangible and practicable means of maintaining initia-

tives and building in flexibility to allow for changes in direction made necessary by structural changes in the wider national or even global environment.

Six studies in addition to the two separate examples provided, spontaneously highlighted the need to work with the corporate sector. This is clearly important, not only for the implementation of workplace health promotion initiatives or efforts which recognise the need to tackle systems of labour and production which provide barriers to preventive health behaviours (Gillies *et al.*, 1996). Corporate support will be crucial in implementing lifestyle health promotion programmes, in setting an appropriate ethos for health promotion, in shaping the wider discourse for debate and discussion, and in helping to raise the new resources that will be needed in the future if we are to fulfil a commitment to promoting the health of individuals, families, communities, organisations and societies.

From this review, the foundation elements of good partnership or alliance development today would appear to be: relevant needs assessment combined with the setting up of committees crossing professional and lay boundaries to steer, guide and account for the activities and programmes implemented.

Although most of the studies described community or country-wide activities, there were examples of network initiatives which recognised the need for international solidarity in the sharing of key values and understandings of economic, social and cultural transformation and change . . . for health.

To summarise, the message from the published literature of the industrialised nations—of more, more intensive and more equitable partnerships for community-based health promotion—has been assimilated and acted upon long ago by health promoters in the field in non-industrialised countries. It is evident from the case studies described here that the developed nations have much to learn from the practice and experience of their ‘developing’ neighbours. It could readily be argued that expertise in this field needs to be captured, documented and exported from the ‘non’ to the industrialised world to provide useful guidelines for future action.

### The nature and extent of the impact of alliances or partnerships for health promotion

#### *Behaviours, health status and service use*

Contrary to the review of published papers, only five case studies reported upon health behaviour

**Table 1:** Health promotion case studies from around the world<sup>a</sup>

Title	Author/resource person	Region	Intervention	Alliances	Level	Outcomes
Auditing Health Promotion Capacity in Slovenia	Peter Makara	EURO (Hungary)	New auditing service; consensus building tool; strategy for investment in health promotion; policy-making potential	Government with outside agencies (WHO/EURO)	Macro	Practical strategy; model for application in other European countries
Central European Network on Education & Research in Health & Health Care	Peter Makara	EURO (Hungary)	Network to establish training and exchange programmes; comparative research programme; health promotion activities	Northern Centre for Health Care Research (Holland). Zagreb School of Public Health, Slovakian Health Management School	Micro	Teaching programmes for health professionals; research on healthy aging and transitions in health care; health promotion on the agenda for discussion
Investment in Health—WHO Model Regional West Saxony	Peter Makara	EURO (Hungary)	Health relevant policy options developed in discussion with regional representatives in the Healthy Region Project; local participation; range of approaches	Research Centre for Regional Health Promotion; WHO/EURO, Yale USA and OPM (London), businesses and projects	Micro and macro	Employees participation; cross sectoral collaboration; diverse activities initiated; redevelopment of regions under discussion
Hungarian School Health Curriculum—International Collaboration: an example of good practice	Peter Makara	EURO (Hungary)	Curriculum development; school environment improvements; links to health services	University of Southampton and National Institute for Health Promotion of Hungary; Ministry of Welfare and of Culture and Education	Micro	Cross ministry collaboration; collaboration of international experts; broadening of perspective on health promotion
Health Promotion in Hungarian Gypsies	Peter Makara	EURO (Hungary)	Peer outreach on the streets and in the community; outreach work with gypsies in organisations and institutions such as prisons, juvenile homes, schools; information leaflets and materials such as condoms	National Institute for Health Promotion, street gypsies; social work profession	Micro	Reorientation and reform of social work practice
The School—a caring Community for Welfare	L. Tavesa (Vivian Rasmussen)	EURO (Macedonia)	European Health Promoting Schools, network member; monitoring of physical growth; health education classes; health clubs	Teachers, pupils, parents, physicians, university	Micro	Not yet available
Influences from the Danish Network of Health Promoting Schools on the National Curriculum for Health Education	B. B. Jansen (Vivian Rasmussen)	EURO (Denmark)	European Health Promotion Schools, network member; curriculum development; collaboration between school and community; European learning and a European dimension	Politicians, teachers, health personnel, school managers, researchers, community representatives	Micro	Not yet available

**Table 1:** (cont.)

Title	Author/resource person	Region	Intervention	Alliances	Level	Outcomes
Promoting Healthy School Meals for Norwegian Children	Knut-Inge Klepp (Leif Aarø)	EURO (Norway)	National recommendations and materials, economic incentives for schools; national campaigns; legislation	Ministers, schools	Macro	Policy change; significant increase in pupils reporting that they eat lunch every day
From Control Policy to Comprehensive Family Planning: Success Stories from Finland	Matti Rimpela (Leif Aarø)	EURO (Finland)	Family planning policy; integration of contraceptive consultancy and municipal primary health care; legislation, local training and workshops	National agencies, local health care and government	Macro	Policy development; decrease in teenage pregnancies and abortions; incidence of STD/HIV is low; improved infrastructure
Everybody is needed— Sorba Skaraborg, Sweden	Charli C.-G. Eriksson (Leif Aarø)	EURO (Sweden)	Coalition building across sectors and NGOs development for environmentally disadvantaged, peer leader programme	National agencies, local health care and government, volunteer citizens	Micro	Inter-agency coalition is thriving; bottom up approach worked
The prevention of night blindness in Bangladesh	Akhtar Hussain (Leif Aarø)	EURO (Norway)	Mass media, folk singers, women volunteers at local level, village films, neighbourhood groups, school sessions	Worldview international foundations, University of Bergen, Local Authority Governments and NGOs	Micro	Reduce night blindness in children under 9 years; increased knowledge; increase in consumption of dark green leafy vegetables
Health Policy Development in Costa Rica	Charli C.-G. Eriksson (Leif Aarø)	EURO (Sweden)	Health Policy Development and implementation in primary and secondary care; socio-economic development and fertility reduction; needs assessment; community development and educational opportunities	International cross Government; cross sectoral within Government; local authorities and citizens	Macro	Significant decrease in infant mortality; policy development; improvement in equity, integration with economy, democracy and good governance, social relationships and values
Health Education by Community Participation	M. Al Khateeb	EMRO (Sudan)	Needs assessment by officials trained; local villagers; health volunteers	Ministry of Health, WHO University Faculty of Medicine	Micro	Significant increases in knowledge
Health on the School Curriculum in Bahrain	M. Al Khateeb	EMRO (Iran)	Alliance development between government ministries, NGOs and the community; participation of teachers in policy development; reorientation of services	Ministries of Health, Education, Information, NGO, Private Sector, Teachers	Micro	Significant improvement in families and pupils' knowledge and behaviours
Practical Health Promotion—Healthy City project	M. Al Khateeb	EMRO (Iran)	Community participation in planning for the city's health; inter sectoral collaboration; volunteering; improving education of children and women	Inter-government departments, NGO; business; local people	Macro	Increases in number of women health volunteers; skills training in micro industrial developments



Healthy Villages, Sanitation & Employment project	M. Al Khateeb	EMRO (Egypt)	Development of information and communication system; low cost sanitation technologies; mobilisation of local resources for health; volunteers	Organisation for the development of Egyptian villages and Ministry of local administration	Macro	Environmental improvement and mobilisation of local resources for income generation
Health Promotion in a modern village of basic minimum needs programme	M. Al Khateeb	EMRO (Pakistan)	Village development committee; concept and communication skills development; group discussions at local level; income generating schemes; loans for small businesses; local health workers	Local authorities, local volunteers, outside grant aid education	Macro	Improvements in environment; increase in school enrolment and immunisation level
The impact of intensified health education on sexual behaviour & attitudes in primary school pupils in Kabale and Soroti districts	Bernadette Babishangire (David Nyamwaya)	AFRO (Uganda)	Teacher training & counselling programme; local project steering committees to facilitate collaboration between pupils, teachers, supervisors & community and NGOs; school health clubs; community leaders	Ministry of Education; local agencies; new project steering committee	Micro	Knowledge of sexual health issues increased; 20% of pupils report abstaining from sex
Training of village health committees to facilitate community participation & involvement in health promotion in Botswana	David Nyamwaya	AFRO (Botswana)	Village health committees enhanced health promotion training programme; increased community participation; income generation activities in localities for nutritional improvements re. vegetable production	Ministry of Health; local committees & district officials; local community	Macro	Food security at household level; increased consumption of indigenous foods; acquisition of skills in crop rotation; increased food production; better local economic management
The Zimbabwe School Health Programme	David Nyamwaya	AFRO (Zimbabwe)	Teachers involved in school health workshops of local agency representatives	Local agencies; schools & health management team	Micro	Not described
Network of African NGOs for Participatory Communication in women and girls	Marie Bernadette Kabre	AFRO (Abidjan)	Strengthening the capacity of NGOs to engage in community participation & education of women; national workshops; local projects, e.g. training rural women research workers in nutrition	NGOs	Macro	Share information; select priorities for action; coordination
Policy Reforms, Community Participation & Primary Health Care	Joshua Adeniji	AFRO (Ibadan, Nigeria)	Primary health care committees at local level to encourage community participation; village health worker training; birth attendants	Ministry of Health; local governments	Micro	Community participation and ownership in the programme was established

**Table 1:** (cont.)

Title	Author/resource person	Region	Intervention	Alliances	Level	Outcomes
The use of problem based learning approach to improve the health of school children in the Lake Regions of Tanzania	David Nyamwaya	AFRO (Tanzania)	School based parent–teacher associations to coordinate school activities; screening for worm infestation; school education training of teachers and health workers	Teachers; parents and health workers	Micro	Sustained collaboration between parents & teachers; behavioural changes (e.g. hand washing) in parents & children; significant reduction in worm infestation
A Health Promotion activity by the ‘ISO LENTUTHUKO’ a community-based organisation network Kwa Zulu Natal, South Africa	Patti Joshua	AFRO (South Africa)	Network for health promoting activities; capacity building for community projects; mobilisation of community members; local workshops on health topics; peer educators	Government departments; local community workers and volunteers	Micro	Network is operational
Healthy Start Project	Tariq Bhatti	AMRO (Canada)	Increased public participation through collective action; parents and caregivers input; service and policy development; provision for supplementary foods for infants; information	Local citizens; social workers; Ministry for Social Assistance Plan	Micro	Sustainability of parent & caregiver programmes; increased level of awareness & requests for food; local action on issues raised by parents in discussion with social workers; policy implementation; collaboration
National Strategy for the Integration of Persons with Disabilities (NSIPD)	Tariq Bhatti	AMRO (Canada)	Collaboration among organisations; agencies and individuals to positively affect active living of those with disabilities; National Strategy for the Integration of Persons with Disabilities	Government; local agencies; local forms	Micro	National alliances worked effectively; policy development
Family violence prevention initiative (provincial)	Tariq Bhatti	AMRO (Canada)	Improved capacity for government departments to act cooperatively to respond to family violence	Cross governmental departments & inter-agency working	Micro	Protocols & procedures for action; service inventories; communications strategy; funding identified; training programmes
Heart Health Demonstration Project	Tariq Bhatti	AMRO (Canada)	Tobacco Advocacy Committee; policy development, conference, activities	Government & Tobacco Advisory Committee	Micro	Policy development; tobacco reduction strategies implemented; partnership/ collaborative activities

Women Helping Women	Tariq Bhatti	AMIRO (Canada)	Women's network & skills development for social action, self help activities advisory committee; training sessions	Local health departments, Women's Group	Promotional materials, committee, large recruitment of women, action plan for sustainability, trust
Nobody's perfect	Tariq Bhatti	AMIRO (Canada)	Skills development; needs assessment; mutual support	Parents working together with educators	Improved behaviour, high levels of satisfaction, self help group participation, increased knowledge and mutuality
Nguaguandi, the Mother/Child project Woorabinda, Queensland	Shirley Perkins, Rhonda Dorman	WPRO (Australia)	Needs assessment of ante-natal clinic attenders developed with indigenous people & an understanding of local culture; collaborative community-based programme working with local women on ante natal care and parenting; easier access to primary health care. Aboriginal health care workers outreach	Local population, health professionals involved in planning, implementation and evaluation	High level of satisfaction among women & increased communication with health staff; earlier presentation for ante-natal care; improved health & well being of 0-5 year old children; trust between women & service providers
The Papua New Guinea Population & Family Planning Project	Rachel Burdon, Anamaria Decock	WPRO (Papua New Guinea)	Supports the National Population Policy launched in 1991; improvements in family planning services; training & staffing of health professionals & local health staff; needs assessment; awareness sessions	National, regional and district agencies	Rural health staff trained; 25 000 people attended the Family Planning awareness sessions; increased rate of clients for family planning
The Evolution of a Health Promoting Schools Movement in Australia	Louise Rowling	WPRO (Australia)	Health promoting school framework; organisational change in school to develop supportive psychosocial & physical environments; school as a workplace; collaborative links between school & communities	Pupils, parents, teachers, health and youth services	More resources available for health promotion in schools; policy development; cross agency interest in comprehensive approaches; political commitment
The Kadavu Rural Health Project 1994-1997	Graham Roberts	WPRO (Fiji)	Community capacity strengthening; information giving; policy & planning development in village settings; village health worker training course	Local people, researchers, village health authorities	Village health committees in all villages; Provincial Health committee; improvements in sanitation; local policy development; increased learning
Tongan National Weight Loss Project	Lois Engleberger	WPRO (Tonga)	Raising awareness of diet & exercise; national competitions for weight loss; mass media, leaflets and posters	National Food & Nutrition Committee; His Majesty the King; local businesses	Significant weight loss in population; increase in tourism through international coverage

**Table 1:** (cont.)

Title	Author/resource person	Region	Intervention	Alliances	Level	Outcomes
Positive Directions for Maori Health	Tim Rochford	WPRO (New Zealand)	Maori care givers, parenting skills, home based, community owned, improved access to health services	Government, health agencies, Maori people	Macro	National policy development; health policy; reduction in smoking in pregnant women; increased birth weights; immunisation; breast feeding
Healthy Cities—Healthy Islands (Kuching City, Malaysia)	Jamila Hashim	WPRO (Malaysia)	WHO Healthy City Designation; needs/situational assessment; city plan; steering committee; Healthy City week to raise public awareness; neighbourhood watch programmes	Government; city officials; organisations; local business importance of characteristic individuals with energy and vision	Macro	Support of politicians; agency discussions & collaboration on City planning; 20% reduction in crime in participating areas
Health Promoting Settings in the Philippines	Jamila Hashim	WPRO	Philippine Health Promotion Programme (PHPP) encourages community development incentives & advocacy for health; planning workshops	National & local government; local business	Macro	Local government units allocated funds to the programme; policy development
Shanghai worksite health promotion project	Jamila Hashim	WPRO	Surveys for needs assessment; competitions; health education programmes; working environment improvements; worksite health promotion committee; Health Steering Committee	Municipal health bureau; businesses & employers; employees; university and health service researchers & providers	Macro	Improvements in physical working environment policies; behaviour change in employees
Clean & Healthy Behaviour programme	Martha Osei	SEARO (Java)	Emerged from plan of Health Development of Indonesia, needs assessment at regional level, supervisory teams at local level, community staff reliance committee in each village, skills development for community peer leaders	Women's organisations, Government Ministers & local government	Macro	Increasing participation of villages & of local groups in environmental & health programmes. New monitoring systems in place. Communities evaluating own programmes in behavioural change through quarterly meetings
Worms Control Programme	Martha Osei	SEARO (North Sumatra, Indonesia)	Emphasises cooperative efforts of community; government and local immigrants; public health education; repair of water systems & latrines; school health programmes	Department of Health, local health authorities and private industry	Macro	Increased awareness and knowledge of the dangers of worm infestation. Reduced prevalence of disease

No Smoking Islands	Martha Osei	SEARO (Maldives)	Youth engaged in active anti-smoking campaign with the Island Development committee; community leaders lobbied for tobacco ban; forums for discussion; peer education	Local community, Development committee & government Ministry of Health	Macro	Policy for a no smoking island was implemented; legislation against tobacco advertising and smoking in public buildings. No tobacco use on the island Clubs were popular
Comprehensive School Health Education	Martha Osei	SEARO (Sri Lanka)	School health clubs	International funding agencies; schools, Ministry of Education	Micro	
Mongar Health Services Development	Martha Osei	SEARO (Bhutan)	Reorganisation of infrastructure of primary health care; local needs assessment; community participation; local committees; community leaders; village health workers; environmental programmes; health education programmes	Community members, agencies	Macro	Pit latrines run by local community health workers; increased use & coverage of primary health care; community members sensitised to health issues
Promoting Health Through Partnerships <sup>b</sup>	David Rivett (Jack Mullen)	USA initiative	Network/communication links; manual for mental & emotional health promotion; teacher training; exchange visits of teachers & pupils between USA and Europe; computer hardware in schools	Corporate Sector: Johnson & Johnson European Philanthropic Committee; European Schools; WHO/EURO; Community based foundation (New communities Foundation)	Micro	Exchange visits and exchange of information has occurred
Project Hope: Reforming the Polish Healthcare Programme <sup>b</sup>	William Walsh, Deborah Mehanec		Five-week training of managers for healthcare reform; conference	International health education foundation (Project Hope) supported by the corporate sector; Ministry of Health & Social Welfare; School of Public Health	Micro	Sharing learning, developing skills of management leaders in healthcare and health promotion in Poland

<sup>a</sup>The data in this table are necessarily brief—apologies to case study authors for truncated descriptions.

<sup>b</sup>Two additional case studies were forwarded to WHO, Geneva for consideration demonstrating the contribution of the private sector in the initiation and support of health promotion and are included for completeness.

change, mainly in respect of changes in smoking and diet. This is not unexpected given the broader goals adopted by the case study initiatives.

Six studies reported upon the positive health status benefits of their interventions for populations, which included reductions in teenage pregnancies and abortions in Finland (see Aarø) to reductions in night blindness in Bangladesh (Aarø) and reduced worm infestation in Tanzania (Nyamwaya) (see Table 1).

In addition, six studies recorded how their partnership work had led to better service access in respect of primary care in Bhutan (Osei), among indigenous peoples in Australia (Perkins and Dorman) and New Zealand (Rochford), in rural villages in relation to immunisation in Pakistan (Al Khateeb), across all social groupings but most particularly those in hardship in a range of health services in Costa Rica (Aarø) and in family planning and contraceptive services among the very young in Finland (Aarø) (Table 1).

The overwhelming focus of attention in the evaluation of the case studies was, however, upon the *process* of change, and the assessment of the extent to which many of the social action programmes had impacted upon the broader physical, working, economic and social environment.

#### *Process as outcome*

Unlike the published studies of alliances or partnerships for health promotion, interest in the outcome of the interventions in case study reports focused upon the process of initiating and maintaining the alliances and upon connections in societies and communities. The key outcomes were therefore: getting agencies to work together; engaging local people; training and supporting volunteers and networks; creating committees; capturing politicians' interest and sustaining political visibility; resource allocation; reorienting organisations and services; and promoting flexibility in working practices and undertaking needs assessments as a way of identifying priorities and galvanising interest in the venture. There are many successful accounts of how to create connections for health in communities and in society as a whole and how to access these connections. One challenge for the future may be how to ensure that such networks can be sustained in the much longer term and how organisations and systems can be encouraged to build in a measure of flexibility which will allow

them to respond to change in the immediate local or national environments or, indeed, in response to global shifts.

Important outcomes identified were therefore concerned with the practicalities of changing the context within which preventive and health promoting activities take place and in sustaining changes. Not surprisingly then, one-quarter of studies reported policy development as a major achievement and success indicator of intervention. Policies ranged from those in settings such as cities, schools and healthcare centres, to those for particular populations, such as the disabled or women and children, to tobacco control initiatives.

#### *The wider context of health promotion*

In stark contrast to published accounts, almost one-third of the partnership studies reported here were 'macro' level partnerships involving one or more institution, organisation or group in the public, private or non-governmental sectors, which had attempted to influence the structural determinants of health, or aspects of these. The published literature on alliances or partnerships for health promotion from primarily developed countries does not therefore reflect the extent to which health promotion in practice is tackling the broader determinants of health. Brief examples of case study efforts in this area are presented below.

(i) *Physical environment.* Problems of sanitation and clear water were identified as priorities in the environment. The Healthy Village project in Egypt is a good example of a broad approach to health promotion which set out to tackle the pressing local environmental issue of poor sanitation. It developed and applied new low-cost sanitation technologies, raising local investment for the programme and mobilising resources for other health-related initiatives at the same time (Al Khateeb).

In Pakistan, the Healthy Villages programme implemented by the village development committee resulted in a range of environmental improvement schemes including improvements to local schools. School enrolment subsequently increased (Al Khateeb).

In Fiji, the Kadavu Rural Health Project (Roberts) also tackled sanitation and other environmental issues, and reported significant improvements in sanitation and an increase in awareness of health related problems generally

with a consequent increase in the development of policy related to health promotion.

In Mongar, Bhutan (Osei), the pit latrine programme by local health workers was very successful and community members were more sensitised to health issues as a result.

Finally, in Sumatra, Indonesia, a water system and latrine repair programme in schools combined with health education not only increased awareness of the knowledge of how to prevent worm infestation, but also decreased prevalence (Osei).

(ii) *Working environment.* The Shanghai worksite health promotion project not only developed healthy policies producing behavioural changes among employees, it physically changed the working environment to make it safer and healthier.

(iii) *Economic environment.* Four case studies emphasised the need for health promotion to engage in identifying ways to develop local economies and one study in Tonga (Engleberger) reported on an unintended economic benefit, through tourism, of the international media coverage given to a national weight loss programme which profiled His Majesty King Taufa'ahau Tupou the Fourth.

The study in Costa Rica (Aarø) outlined the way in which government initiatives to develop the economy underpinned and complemented health policy development. In Tehran, micro-enterprise initiatives were part of the Healthy Village concept, and in Pakistan (Al Khateeb), there was a strong focus on local income-generating schemes and loans for small businesses. In Botswana (Nyamwaya), income-generating activities focused upon the successful development of crop rotating skills and the increased growth of local vegetables. This resulted in increased food security within households and increased consumption of nutritious, inexpensive indigenous foods.

(iv) *Social environment.* An understanding of the need to develop social trust and social skills, to extend and support social relationships and networks was emphasised in six case reports. At the family level, Bhatti described two projects in which trust and social support were crucial to women helping women to counter family violence and to develop better parenting skills. In Tehran, the proliferation of women's volunteer networks

delivered practical health promotion projects (Al Khateeb). The mother and child development projects among the indigenous aboriginal people of Australia (Perkins and Dorman) described how the development of trust between local people and service providers was the linchpin of the successful implementation of their project. Makara noted how trust between Hungarian gypsy populations and social workers was facilitated by professional flexibility and the training of gypsy outreach social workers in the community. Finally, at the city-wide and national levels in Costa Rica, Eriksson emphasised the importance of social relationships and values, democracy and good governance as the foundation for and outcome of their health promotion initiative. (see Table 1).

These contemporary examples of health promotion in action demonstrate the major impact globally that the WHO Healthy City initiative, and offshoots therefrom, has had upon the conceptualisation and practice of health promotion. However, the community capacity strengthening, participation, agenda-setting, empowerment, political management and network approaches that define the Healthy Cities movement (Hancock, 1993) have yet to be underpinned by a coherent explanatory model and, therefore, not surprisingly, a consistent means of measuring success.

Leonardi (1997) has argued that the Healthy Cities movement presupposes the existence of cooperative civic engagement and high social capital within communities. Good social relationships nurturing mutual trust, shared norms and civic activity seem to be fundamental to achieving the outcomes desired.

The weight of evidence therefore points to the importance of developing social capital as part of the theoretical and practical project of health promotion.

## **MEASURING OUTCOMES IN HEALTH PROMOTION**

### **Study designs**

Study design and method of measurement clearly depend upon the questions posed by an evaluation. If we are interested in testing the efficacy of a rather simplistic intervention to provide information or to change individuals knowledge levels, attitudes or behaviours, then as this

review of published papers has shown, a randomised controlled trial (RCT) design can be applied with quantitative methods of data collection. We now have very good evidence indeed of the significant but limited efficacy and cost-effectiveness of such approaches. Qualitative and quantitative methods of data collection can be used in RCT and comparison study designs—they are not mutually exclusive. But the object and focus of study was typically narrow.

However, as the published and case study reviews both demonstrated, community or societal level initiatives seeking to influence the context in which individual behaviour occurs or in which health is created and experienced, do not lend themselves to such constraining designs. The RCT and comparison designs combined with quantitative and rather limited qualitative methods of data collection, simply cannot capture the richness of the process nor give a detailed enough understanding of the meanings of activities and actions, nor of the process of change. They simply are not sufficiently sophisticated to deal with the complexity and diversity of the process and outcome of health promotion at community level. It is evident from the case study evaluations and from a smaller number of evaluations of projects with pre- and post-testing in the published accounts, that naturalistic designs and qualitative techniques are more appropriate for exploring community-based approaches.

### **Indicators of outcome in health promotion**

Interestingly, in most of the published accounts, but in a minority of the case studies, the outcome measures for assessing the effectiveness of community-based alliances or partnerships for health promotion were often measures of individual-level changes.

From the perspective of the economic analysis of health promotion, Shiell and Hawe (1996) have argued cogently that programmes which have the community or community processes for health promotion as their focus need some indicators which are completely different to those that can be measured by summing individual outcomes. Indeed, they go further to stress that if programmes are seeking to strengthen community competence for health through peer network action, local representation and the like, then these activities should be considered as 'functionings' and outputs. They invoke health economists to develop new constructs to deal

with these new approaches in health promotion, lest the application of existing techniques to community or partnership approaches mislead health decision-makers about their value and potential by underestimating their effectiveness.

It is now largely accepted by those engaged in health promotion that we need a new package of indicators to measure the effects of community-based health promotion. In the USA, the Centers for Disease Control and Prevention (CDC) are developing a package of community indicators for health promotion for HIV prevention (CDC, 1997). In addition, the CDC in collaboration with the WHO Working Group on Evaluating Health Promotion Approaches of the Regional Office for Europe are looking at how indicators of social capital may be used to measure community-level interventions in health promotion at a national level (Kreuter *et al.*, 1996). The challenge for both of these new initiatives is to devise indicators from the perspectives of local government, organisations and systems, as well as from the individual's view. Thus measurements of the extent to which individuals, for example, trust or share information about childcare and engage in reciprocal schemes could be enriched by measures of the supporting infrastructure: availability, accessibility, mechanisms for exchanging information, flexibility of childcare organisation, policies, physical safety of neighbourhoods and so on. The findings from the case study review presented here suggest that measures of this type may be helpful in evaluating the health promotion process of building alliances or partnerships.

Useful though indicators of aspects of social capital such as trust, reciprocity, shared norms and civic engagement may be in measuring the effects of community health promotion based upon current models of community participation, it could be argued that Kreuter *et al.* (1996) have perhaps left unexplored the dynamic potential for social capital to be a construct *for* the promotion of health. Even though the notion of social capital is as yet undeveloped theoretically, as a construct it can provide an explanation of the process for promoting health in communities and societies, and provide a new way of organising and planning our thinking and actions to create opportunities for health, particularly in respect of the promotion of alliances or partnerships for health.

Could Social capital be the construct that the economists need to help them measure the cost—



benefit and effectiveness of community health promotion? Health promotion desperately needs models that are more sociologically and politically sophisticated and have greater explanatory power. Could the construct of social capital lead to the development of new theories and to new indicators for measuring the diverse benefits from alliance or partnership approaches to health promotion identified in this review? Could the development of our understanding of how to build social capital through nurturing social relationships, networks and patterns of reciprocal activities reinforce the alliance or partnership building process for health promotion and even offer new insights or approaches? And will these new processes or mechanisms bring new insecurities and challenges in an increasingly fluid and insecure world, thereby requiring the health promoters of the future, be they lay or professional, to be working within and outside communities with new skills: leading, communicating, organisation, managing, marketing and connecting?

#### **PROMOTING HEALTH AND REINFORCING ALLIANCE AND PARTNERSHIP APPROACHES TO HEALTH PROMOTION BY BUILDING SOCIAL CAPITAL**

This paper argues that the notion of social capital provides a coherent and compelling way of conceptualising the 'best practice' in health promotion alliance or partnership approaches that exists in abundance in industrialised and non-industrialised nations alike. It advances our thinking about capacity building for health and for the promotion of alliances or partnerships for health in four ways.

Firstly, it demands that the unit of analysis is the community rather than the individual. This is because social capital is produced through interactions between individuals and social agencies and systems. It does not reside within individuals or within organisations, but provides benefits for both and is a resource which grows the more it is used. This allows us to look in a fresh way at indicators for assessing the effectiveness of health promotion and particularly those approaches which seek to build alliances or partnerships for health promotion.

Secondly, it brings the social, economic, political and environmental determinants of health firmly into view and reinforces the need for

health promotion approaches, such as alliance or partnership building, across all sectors of societies and across lay and professional boundaries, which can work to influence these broader determinants of health and well-being.

Thirdly, it focuses our attention on the *mechanisms* for 'networking' or connecting people, particularly with public institutions and with power at a local level, rather than merely describing the relationships. Development of an understanding of how these mechanisms work will be crucial if we are to consider building social capital as a resource for the poorest in societies in an effort to reduce inequalities in health. Therefore, unlike the assumptions underpinning much of the empowerment and community participation literature, that power for change is infinite and all we have to do is build it up in those who do not have it, the construct of social capital will allow us to attend to asymmetries in power and could provide one means for its redistribution.

In the context of this review, however, such mechanisms may also help us to consider how to enhance health through alliance or partnership building health promotion approaches.

Finally, as a construct which emerged from the political science literature yet which has been applied to the conceptualisation of health-related issues and behaviours (Putnam, 1993; Moser, 1996; Higgins *et al.*, 1996), social capital crosses disciplinary boundaries and may underpin the development of new theoretical frameworks for understanding health and health behaviour in individuals and societies and the broader social determinants of health, particularly in respect of alliance or partnership building.

#### **Infrastructure for change: tackling the broader determinants of health and social development**

Building social capital could be seen as a relatively inexpensive means of tackling the structural determinants of health and disease and offsetting the most abrasive effects of health inequalities in societies. However, we must not forget that the provenance of many of the inequalities in health in terms of experience, the prevention of ill health and the promotion of positive health and well-being, lie in structural issues such as poverty, relative poverty, homelessness, unemployment and the like. Healthy public policy to address such issues must clearly continue to be pursued vigorously.

It is the case that the social trust at the core of

social capital cannot be simply produced by the injection of investment into poor areas through enterprise initiatives alone. Indeed, Lehmann (1994) points out that enterprise masquerading as community development in the USA and employed as a solution to some of the worst health and social problems in disadvantaged areas has failed, principally because of the poor welfare safety net available. In the UK, the work of Bartley *et al.* (1997) suggests that there is some flux among those living in poverty, with the provision of employment at reasonable levels of pay and good welfare support being the key to helping people move out and stay out of the so-called poverty trap. Hutton (1997) notes that the promotion of social citizenship as one of the principle responses to inequalities and difficulties in society (and thereby reliance upon the building of social capital) is unsustainable without adequate social welfare safety nets. This point may be particularly important in non-industrialised-country contexts. The work of Moser (1996) for the World Bank has shown that whilst aspects of social capital can be found in impoverished communities where it is generated through volunteer networks of women in the main, a point of economic crisis or hardship is reached beyond which reciprocity between households ceases. Thus the extent of hardship in societies may be the stumbling block to the promotion of health through social capital initiatives which are founded upon alliance or partnership networks. In this context the role of voluntary agencies in providing social welfare bridges between individuals, families, communities and the state, is of considerable import (Sassoon, 1996). The project of building social capital as a resource for health promotion is quite clearly an ambitious one.

### **Mechanisms for building social capital and promoting alliances and partnerships for health promotion**

#### *Information technology: a mechanism for connecting for health*

The process of building social capital in industrialised countries is likely to be assisted by the global phenomenon of the development of information technologies (IT). Mulgan (1997) has argued that new technologies could open the door to multiple ways for individuals to make flexible social connections. He maintains that these connections should be underpinned by moral values and principles. He also points out

that they will be responsive to change and therefore sustainable. Mitchell (1997) has described the way in which the connections made on the Internet can cut through stifling boundaries and categories defining status. In this way then, interactions through new technologies contribute to the horizontal connections or networks that Putnam (1993) identified as a conduit through which social capital flows and which could provide the 'glue' for alliances and partnerships for health promotion. And, in an exciting new development, such connections can now be made to work with and for communities as well as for individuals (SHM Productions Ltd, 1997). The potential for such city-wide Internet systems to deliver health and social benefits by providing access to information and services in civic spaces and also to build social capital is considerable, particularly in the light of the forthcoming home-based digital television services. These technical developments could also be used to underpin alliances and partnerships for health promotion. Such important benefits should not, however, accrue solely to those in the northern nations, difficulties in distributing and maintaining IT infrastructure notwithstanding.

Infrastructure development in IT will certainly be important in building social capital, but so too might the provision of safe spaces in which connections and transactions can be made. Putnam (1993) has conceived of these civic spaces as physical ones—in parks, libraries, post offices and so on, but virtual spaces in the imagination of communities may be something to ponder, as may be the extent to which education may or may not evolve to support such possibilities.

As this review shows, there are no simple solutions or single approaches to the promotion of health through alliance and partnership initiatives, nor to the evaluation of impact in our diverse and complex world, and there are several issues around social capital for health promotion that must be given careful consideration.

#### *Crucibles of capital*

Many writers in this area, including Fukuyama (1996) and Etzioni (1995), have proposed the 'family' in society as the key cornerstone, network 'node' and even progenitor for the production of social capital and for community and social regeneration. There are perhaps two notes of caution to strike in this regard.

In thinking about social capital for the promotion of health and as part of the process of

building and reinforcing alliances and partnerships for health promotion in a global sense, we must ensure that the notion of family is not too narrowly conceived and should perhaps be substituted with notions of family with kinship relationships of all sorts. Mobilisation of the diversity of family formulations across societies is unlikely therefore to be a straightforward task.

Secondly, the evidence from the case study reports in this paper underpins the work of others which has demonstrated that women are particularly adept at fostering alliances and partnerships for health promotion, and at local activism for health, creating durable health supporting networks and groups (Moser, 1996). However, Campbell (1995) has recognised the danger in tasking only women with the communitarian project to promote better parenting and social and civic life, without addressing imbalances of power and control between men and women. It may disadvantage women even further, making it more, not less, difficult to work, to achieve ambitions, to achieve equitable relationships. Such approaches may also obscure the impact that unemployment in men and low wages for both men and women has upon the family, family health and family cohesion.

#### *Theoretical development*

The issues mentioned above underline the extent to which social capital and its relationship to health is, as yet, poorly characterised, particularly in respect of gender, ethnicity and socio-economic disadvantage. To develop our understanding in this field, the HEA for England has commissioned an ambitious programme of work in the UK looking at the relationship between social capital and health in adults in disadvantaged communities; in families and children; and from the perspective of local government. New interest in studying the health promotion potential of social capital is emerging in several sites around the world from Kwazulu Natal in South Africa (Preston-Whyte *et al.*, 1997) to North America (Higgins *et al.*, 1996; Kreuter *et al.*, 1996). This mixed and varied programme of work spanning cultures and continents is critical, for social capital has thus far been conceptualised from a Western philosophical perspective. A cross-cultural programme of research may challenge this ethnocentric view and help us understand how versatile or elastic social capital might

be as a resource and construct. It will certainly keep the notion under constant interrogation as we move towards developing new theories for health promotion in a changing world.

It could be argued that despite the publication of the Ottawa Charter in 1986 and the development of the successful WHO Healthy Cities Programme in the middle of the 1980s, individualism continues to dominate many of the practical health education and disease prevention agendas, at least in industrialised countries. The construct of social capital may help in the shift towards developing theoretical frameworks which provide better explanations of collective, collaborative alliance or partnership approaches for health promotion. Will it allow us to deliver more effective health promotion?—only time will tell, but the evidence presented here from health promotion alliances or partnerships in action around the world gives cause for optimism.

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