Health promoting settings: from Ottawa to Jakarta

The settings approach to improving the health of populations has been in good currency during the 1990s. But does it provide a framework which will enable practitioners in health promotion to undertake their work more effectively? Will we see more rapid gains in the conditions which facilitate health improvements, and in the health outcomes themselves? Although the settings approach is a coherent and realistic framework, is its potential to improve the health of populations overrated? This editorial identifies some of the challenges in implementing a settings approach and explores some pathways to meet these.

The origins of the settings approach appear to have emerged from a variety of sources. Developments in the sociological and organisational psychological fields in the 1960s and 1970s set the foundations for an understanding of the interconnections of the different elements of a community, worksite, school, etc. A recent discussion between Bo Hagland, Michel O'Neill, Eberhardt Wenzel, and Ilona Kickbusch through the Health Promotion Research Internet Network (see Review Section) also identified environmental psychological and social support research, as influencing the development of settings.

The 1986 Ottawa Charter for Health Promotion delineated a coherent direction for health promotion which legitimised using settings and associated strategies in health promotion initiatives. Some 10 years later there are programmes in many countries which adopt the settings approach to health improvements. There have also been international initiatives, mainly under the auspices of WHO, which have sought to involve member states in addressing health issues through a settings approach. Internationally there are now many programmes, all with the prefix of ‘healthy’ or ‘health promoting’, directed at worksites, cities, schools, local communities, hospitals, and correctional centres.

The components of the settings approach has also been fostered by the Ottawa Charter. A simple illustration of this can be demonstrated by using schools as an example of a setting and improved nutrition as a health issue. A health promoting school focusing on nutrition might address:

- **Healthy public policy**—for example, the school authorities decide that food supplies available in the school will reflect dietary guidelines resulting in adequate and cheap supplies of fresh fruit and limited or no access to high-sugar, low-fibre processed foods.
- **Supportive environment**—for example, the school has proper locations, both internally and externally, which enable students to eat quietly and to dispose of food and packaging waste in an environmentally sensitive manner.
- **Community action**—for example, where the local food producers and retailers participate with the school in assisting students to develop skills in food cultivation, purchase and preparation.
- **Personal skills**—for example, where the students are taught and coached in food purchasing and preparation and buying a balanced food supply on a finite budget.
- **Health services**—for example, where the local health practitioner (dietician, general practitioner, nurse, etc.) works with the teachers, parents and students to support the planning and implementation of a schools programme.

This settings approach is quite different from the old and still common approach to school-based nutrition, where the formal curriculum is the only area where the promotion of sound nutrition is addressed. Evidence suggests that the health and educational gains from a more holistic approach, are more effective than those from a classroom based instructional perspective (e.g. Rothman et al., 1994; Cohen, 1995).

**PRESENT CHALLENGES**

The settings approach to health improvement is promising and evidence is emerging to support
the varying models that have been introduced. However, it is not just a matter of adopting a settings framework with a range of building blocks, and assuming gains will automatically occur. There are a number of barriers which limit the effectiveness and potential of the settings approach. These need to be overcome before the rhetoric matches the reality. Some of the key challenges are as follows.

**Developing strategic directions which are shared by the key stakeholders**

We often hope that the majority of citizens, patients, health care practitioners, employees, teachers, students, etc. will support and contribute to achieving health improvements in their setting. This is commonly not the case however. The problem with the settings approach is that it assumes strong allegiance and adherence to the mission of a few. The benefits of using settings for health advancement need to be more clearly articulated to the groups and individuals within the settings as well as policy-makers.

**Increasing the commitment and participation of more individuals and groups**

The settings approach appears to work best when there are widespread contributions from most of the stakeholders. It assumes that all these stakeholders have access to resources and have the rights and capacities to participate. Sadly, there is a degree of inequity in many settings. For example in schools, policies about safety, alcohol and tobacco availability are made by various authorities which impact on schools. Students get no say. In many cases, that is probably appropriate, for example where sufficient data exist to show that the wearing of bike helmets reduces head injuries; or that falls from play equipment on to hard surfaces causes severe injury. However, other cases—such as the wearing of protective clothing to reduce sunburn, or whether both girls and boys should play in the same sporting team—may be best resolved by the students themselves in collaboration with their parents and teachers. Similarly, in many workplaces, policies and practices are changed without reference to the workers, although there is a greater awareness now of the importance of involving staff in shaping companies’ health-related initiatives.

**Gathering sufficient evidence of what works effectively**

The settings approach has been legitimised more through an act of faith than through rigorous research and evaluation studies. If it is to be sustained as a major concept and strategy in achieving better health, then it needs to foster more evaluation studies. The few studies which examine the effectiveness of using a settings approach, show the complexity and the sophisticated skills and competencies which are required by people who are required to plan, implement, evaluate, lead, advocate and facilitate the passage of the various health issues through the setting. However, the data are still thin and much more attention needs to be given to building the evidence and learning from it. Perhaps we should focus less on designing and implementing settings-based initiatives and interventions, and more on analysing their processes and impact, reflecting on and discussing these learnings and disseminating them widely.

**Riding the boundaries with other sectors**

The settings approach should involve intersectoral collaboration. This key component of the Ottawa Charter is probably the biggest barrier to overcome. We all still jealously guard our professional territory through registration requirements, professional associations, policies and practices. Similarly, we have limited experience of what it is like to work in another setting. The local general practitioner often carries stereotypes about how teachers work and the processes of schooling. Similarly, the teacher usually has a media-shaped and idiosyncratic view of how the local health clinic operates. This begins to explain why partnerships between the education and health sectors have been superficial. Stakeholders from one sector do not appreciate the best ways of establishing and sustaining productive intersectoral collaboration with other sectors. As a result, intersectoral action is often attempted, but rarely is as productive as it could be. Our basic training and allegiance to a professional culture with its policies and practices, mitigates against the enthusiastic and sincere efforts of many individuals who wish to work with people from other sectors in productive partnerships. It is a barrier that needs urgent attention.
Looking at the big picture—the organisational structures, policies and practices

Working for better health using a settings approach is tough enough. However, many exacerbate the difficulty by focusing on minutiae. There is a need to always stay with the big picture and to enhance the most pertinent strategies which create the conditions and supportive environments for health gain by improving policies, organisational infrastructure and practices.

Achieving some early tangible gains and affirming them to people

Working in settings is not short term. It takes time to get to the reality of the vision. However, it is essential to have early and obvious successes and to acknowledge people who have contributed to them and to celebrate such achievements.

Building the intersectoral teams and supporting constituencies at the beginning

The early ideas for a settings approach may emerge from an individual or a group, for example, recreation officers, hospital staff, worksite health staff, teachers, etc. This is fine. However, it is essential that a broad and active constituency be built at the outset, and that the key individuals and groups be involved in shaping the programme. In a worksite this would involve employers, management, unions, health staff, perhaps clients; in a school the key participants would be students, teachers, parents, local health workers, etc. This approach facilitates implementation, and sharing of resources, increases commitment and assists in problem resolution, planning and review.

Investing in multidisciplinary education and training

Implementation of health promotion programmes in the different settings is usually multidisciplinary. However, pre-service education and training, and continuing professional development is often very focused and directed at knowledge and skill acquisition related to specific professional roles. There is a paucity of pre-service and post-service educational opportunities which address the knowledge and skills of multidisciplinary planning, intersectoral implementation, agency partnerships, and leadership. Competencies in these areas are germane to the success of the settings approach. Changes in pre-service education and training are probably less likely to occur than changes in post-service professional development. The settings approach movement needs to be more proactive in shaping the training it needs.

Integrating the different elements, stakeholders and approaches

Another high hurdle is the integration of all the different elements in the settings approach. There are different strategies, a multitude of stakeholders, diversity in values, beliefs, policies and practices in the setting, and finite resources, including time. We often aim for an unrealistic ideal in how we integrate these components. There is the expectation that it will be easy and will occur at the beginning of a partnership. It is not possible to achieve such a level of integration. The process of integration needs to be built slowly and pragmatically with close monitoring of its progression. Then we might be a little more realistic and satisfied with our efforts in improving health using the settings approach.

The settings approach to health has shown promise. But rhetoric and a belief in its results has preceded the evidence of its usefulness. Our challenge is to build an evidence-based argument for using settings in health promotion and to be more critical and less euphoric about its outcomes. Let us start this process at the 4th International Conference on Health Promotion in Jakarta, Indonesia. The journal therefore welcomes papers grounded in practice which contribute to a better understanding of settings.

Lawrence St Leger
Associate Editor

REFERENCES
