EDITORIAL

Advancing Culturally Relevant Health Promotion and Disease Prevention: Lessons from the Global Village

Avanzando en la promoción de la salud y la prevención de enfermedades en forma culturalmente relevante: lecciones de la aldea global

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One of the most widely accepted definitions of health is the one provided by the World Health Organization (WHO) which in 1948 defined health as "a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity" (1). Since then, several researchers have expanded the definition of health and currently the field of health education and promotion defines health as "… a dynamic state or condition that is multidimensional, a resource for living, and results from a person's interaction with and adaptation to the environment and therefore exists in varying degrees unique to the individual" (2).

Embodied in the concept of health is the central tenet that a person's perception of, attitudes regarding, and health-related behaviors need to be explored within the cultural context of that individual (3, 4). Elements such as religion, socio-cultural traditions, values, morals, decision-making, perception, risk-taking, and knowledge about healthy living are all intertwined with ethnicity and national origin and are reflected in people's attitudes and health-related behaviors.

The analysis of the perceptual definition of health is of special relevance in understanding and developing health promotion and disease prevention programs among diverse populations (3), In this context, health promotion and disease prevention needs to be understood not only as a diffusion of knowledge, but also as a reinforcement of the individual's perceptual processes especially as it pertains to the etiology of disease. These efforts focus primarily on the development of culturally safe environments in which individuals and populations can engage in activities designed to assist attain their optimal health status which takes into account their realities and understanding of

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the health-disease spectrum. In fact, it has been argued that closing the health gap between socially and educationally disadvantage people and more advantaged people requires the incorporation of activities and policies designed to improve access to health-enhancing goods and services, and create supportive environments.

The development of culturally appropriate programs is important in all societies in order to reach each segment of their populations. In addition to being good policy, this simple reality is embodied in the many health promotions and disease prevention global efforts designed to improve health status for people around the world (see table). Reaching diverse audiences with culturally and linguistically programs, however, is a work in progress and despite efforts to achieve cultural competence, the road ahead is long and arduous nonetheless organizations such as the Association of Schools of Public Health (5) have released guidelines focused on strengthening the workforce. Fortunately, we have many lessons to draw from as we make efforts to bring health promotion and disease prevention services to each corner of the world.

The World Health Organization and the Centers for Disease Control and Prevention, among others, have placed an emphasis on decreasing health inequalities and improving social determinants as a cornerstone in improving the health status of diverse communities. Cultural factors such as an emphasis on individual health vs collective health status need to be taken into account as we develop health promotion programs designed to improve the health status of communities around the world. A basic tenant of health promotion is their emphasis on issues such as public policy focused on maintaining health, improving living conditions, enhancing lifestyles, providing safe work environments, and the empowerment of individuals to engage in decision making and develop personal skills that promote wellness.

In the US, the Affordable Care Act of 2010 has played a key role in increasing access to preventive program covered by health insurance. Currently, these efforts are coordinated through the U.S. Preventive Services Task Force which "…works to improve the health of all Americans by making evidence-based recommendations about clinical preventive services such as screenings, counseling services, or preventive medications" (6).

Despite progress in those areas we still have some catching up to do other counties. Colombia is a South American country of almost 47 million inhabitants (7) and a signatory to the 1978 Alma-Ata Treaty which lays the foundation to access to health care as a basic human right, as such it is not surprising that the Colombian Constitution defines health as a public service and as a right and duty of citizens. A significant change in the perception of health and the increase in emphasis on health promotion occurred in 1990 with the passage of Law 100 which transformed health care financing from a need only to coverage based on customer demand. In Colombia before Law 100 of 1990 less than 50 % of the population had access to basic health care services and to health promotion and prevention programs (8).

In Colombia, Law 1751 of 2015, guarantees the fundamental right to access health care services and provides a funding mechanism which establishes a national health promotion and disease prevention framework.

The resources needed to implement health promotion and disease prevention programs come from the Solidarity and Guarantee Fund which is financed by a tax on all working people and specifies that 0.5 percent of the tax be allocated to prevention and health promotion.

Since health promotion programs are seen as a component of the established public health structure Law 412 of 2011. The decennial public health plan works eight dimensions with emphasis in Promotion and Prevention. It is noteworthy that the plan places an emphasis on the delivery of culturally appropriate health promotion and disease prevention programs (9). This commitment to culturally relevant programs is seen in directives designed to take into account cultural perceptions of health to address the health needs of diverse cultural groups within Colombian society. In fact, the current model of health delivery known as the MIAS (Integrated Model of Health Care) seeks to deliver all health care-including prevention and promotion programs-in an individualized risk assessment that takes into account the cultural and socio-economic status of people. The Ministry of Social Protection, in fact, requires that all health providers include specific promotion and prevention programs focusing on childhood development, risk reduction programs for adolescents, strict compliance with vaccination guidelines, and sexually transmitted diseases prevention among others.

The development of health promotion and disease prevention (HPDP) in Thailand is older than the Health For All and Primary Health Care era. Thais have long sought to bring services to destitute communities and have developed a well-regarded village health volunteers (VHV) program, which coordinates with public health practitioners to improve the health of their community counterparts (10,11).

In Thailand, programs focusing on HIV/AIDS education and prevention, tobacco control, and promotion of condom use, just to name a few, take into account stakeholders feedback in order to shift the focus from "repairing' to 'building' health. The nationwide, open discussions continue today as the National Health Assembly mandated by Thailand National Health Act 2007 (12).

Another agency that creates phenomena in Thailand regarding HPDP is the Thai Health Promotion Foundation (ThaiHealth) established by law in 2001. ThaiHealth is an autonomous public agency funded by 2 % excise surcharge on alcohol and tobacco. In 2013, the budget was 150 million US dollars. Its missions are to induce changes in health risk behaviors through inspiring, motivating, coordinating, and empowering all sectors to enhance health promotion capability, including healthy society and environments (13). ThaiHealth employs an "innovative financing" to support HPDP activities in Thailand. The financing process is considered innovative due to two reasons. First, the budget allocated to ThaiHealth from excise surcharge on alcohol and tobacco provides the guarantee of support in health promotion and disease prevention. Second, ThaiHealth's granting mechanism is done through a competitive and consultative process (14). ThaiHealth has just turned 12 years old this year and has made a huge impact on HPDP in Thailand. Health issues such as tobacco and alcohol consumption, physical activity promotion and obesity prevention, and accident prevention and road safety have significantly improved.

Lessons from the Global Village

Culturally relevant health promotion and disease activities need to be specific to their countries of origin. There are some lessons, however, that can be applied universally as we seek to improve the health status of populations worldwide.

1. Health promotion and disease prevention programs need to have strong government backing. The Affordable Care Act of 2010 in the US., the Universal Coverage Scheme (UCS) started in 2001 in Thailand, and 1990 in Colombia show how strong government efforts can improve the health status of their populations. Each of these seminal pieces of legislation seeks to provide standard health care for most people in their respective country providing access to health care services and implementing health promotion and disease prevention efforts such as vaccinations and screening.

2. Health promotion efforts cannot be the sole responsibility of governments. While the international health conferences listed in table denote the frameworks developed by government representatives, lessons from the three countries identified in this piece show that communities need to be actively and extensively involved with governments and NGO's in health promotion and disease prevention activities.

3. Sustainable health promotion and disease prevention efforts are effective when we have national agendas that communicate a vision for improving health and achieving health equity. There is three factors key to these efforts and they include knowledge management from relevant and extensive research studies, social movements that occur through social learning and acceptance, and finally acceptances and involvements from the political arenas. These 3 factors can be called "Triangle that Moves the Mountain." The "mountain" is metaphorically referred to as health promotion innovations that will improve the society but difficult to initiate while the "triangle" is the coordinated efforts from the 3 factors (15). Thailand's tobacco control is a perfect example to illustrate the "Triangle that Moves the Mountain" principle.

4. Health needs to be understood from the perspective of those we try to reach. Many time health promotion programs are designed by experts who do not understand the cultural realities of the target population. Cultural irrelevance can fast be achieved when we fail to take into account regional variations in language or the literacy level of the target population.

5. Research needs to be culturally relevant (16, 17) conducted by an educated workforce committed to serving the needs of their target populations.

6. Health promotion needs to empower the populations they seek to reach. Perez and Pinzón (20) describe the use of the health Tree as a needs assessment tool for low-literacy populations. This tool is easy to utilize and can provide a useful tool for community involvement empowering the target populations to take ownership of programs thereby assuring their sustainability.

7. Health promotion programs need to be relevant to the people they attempt to reach, we cannot ask people to improve their nutritional status when they lack access to a basic food basket.

8. Theoretical constructs need to account for the culture of the target population. Two of the most often used theoretical frameworks in health promotion are the Health Belief Model and the Stages of Change Model. As noted before, the perception of risk is relative to the cultural standards of a given society, therefore, failing to take into account those differences and the cultural perception of risk will result in failing programs. The PEN-3 Model (21) is a theoretical model which has been used around the world to develop programs which are culturally appropriate for their target populations.

The 2016 World Statistics Report provides a foundation for tracking health-related objectives established in The Sustainable Development Goals (22). A close review of those objectives reveals that health promotion and disease prevention will play a critical role in achieving those goals. Efforts to improve the health status worldwide, however, will not be effective unless we apply the seven lessons listed above which are required for the implementation of culturally appropriate health promotion and disease prevention programs.

In this edition articles by Martinez, Hernandez and collegues , Castillo L, as well as the article by Borda Perez and Acevedo-Silva illustrate the work that is being conducted and that encompass the concepts described in this editorial. The work presented focuses on the application of health promotion strategies to distinct population segments and are made available thanks to the policies promoted through the international agreements explored by the authors. The work of each of these individuals highlights the basic concepts promoted in the Alma Ata Conference of Health for All.

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Table Selected International Conferences Dealing with Health Promotion and Disease Prevention

Alma-Ata
The 1978 International Conference on Primary Health Care focused primarily on the delivery of primary care, its emphasis on improving the health status of individuals worldwide, however, provided a new direction which emphasized people's involvement, cooperation between sectors of society, with primary health care as its foundation (23).
The Ottawa Charter for Health Promotion
The 1986 Charter set the challenge for a move toward the new public health by reaffirming social justice and equity as prerequisites for health, and advocacy and mediation as the processes for their achievement. The Charter identified five health promotion action areas including 1) Building Health Public Policy; 2) Creating supportive environments; 3) Developing personal skills; 4) strengthening community action; and 5) Reorienting health services. These strategies for action were centered on three primary action areas including enablement, mediation, and advocacy (24).
The Jakarta Declaration on Leading Health Promotion into the 21st Century
In 1997, the 1997 Jakarta Conference sought to social responsibility for health called for 1) increasing investments for health development, 2) extending partnerships for health promotion; 3) increasing capacity at the community level and of responsibility at the individual level; and 4) ensuring the infrastructure for health promotion (25).
The Mexico Ministerial Statement for the Promotion of Health
The 2000 Mexico Ministerial Statement called upon the international community to position the promotion of health as a fundamental priority in local, regional, national and international policies and programs and to establish or strengthen national and international networks which promote health among others (26).
Bangkok Charter for Health Promotion
In 2005, the international community acknowledged that health promotion needs to become a central element on the global development agenda; that it is the main responsibility of all governments; that it should be a key element for civil communities and societies; and will be based on demand for corporative good practice (27).
The Helsinki Statement on Health in All Policies
The 2013 conference resulted in the creation of a framework designed to provides countries with a practical means of enhancing a coherent approach to Health in All Policies (HiAP) at a national level. This particular approach is based on health-related rights and obligations and spells out the accountability of policymakers in each country for health systems, determinants of health, and well-being. It is expected that this 2013 accord will also serve as a foundation to sustainable development around the world (28).