# Thematic tool 15

## Valuing, Sharing, Aligning, Improving: Ensuring people's participation in learning for health (YD articles 7,8,10,15,19,20)

### Phase 3 of the enactment process: Putting the learning for health policy into action


The questions this sheet answers

- How can we promote participation in the lifelong learning for health policy?

### Articles of the Yeonsu declaration

| | | | |
|---|---|---|---|
| 7. Demonstrating the necessary political will | 8. Paying attention to contextual factors | 9. Crisis implementation of plans for essential services | 10. Empowering local people to build capacity to protect their health |
| 11. A new paradigm of Learning for Health in cities | 12. Promoting health literacy in the city | 13. Strengthening and promoting Citizenship for Health | 14. Strengthening community resilience through multisectoral planning |
| 15. Proving learning opportunities for vulnerable populations, including children | 16. Recognising the contribution of the formal education sector | 17. Building the capacity of non-formal learning providers | 18. Making use of informal spaces in cities |
| 19. Broadening the scope of stakeholder involvement at city level | 20. Strengthening our efforts to achieve the 17 SDGs | | |

### Summary

Participation of citizens is a key condition of the success of the lifelong learning for health policy. To ensure participation, there is need for spaces for discussion with citizens in which to reflect on the nature of problems; spaces for decision-making with organized interaction with

citizens, civil society groups, governments and other actors to establish plans of action; organization of such actions involving all stakeholders; and their involvement in evaluation.

## Working path for practical enactment

When cities set up learning for health schemes, there is a considerable risk that these will only be aimed at the more accessible parts of the population. The most vulnerable and least socially integrated people are more difficult to reach. Ethnicity, migration, gender, cultural differences, religion, language, age and disability are sources of exclusion. For example, migrants generally score lower on literacy and health literacy measures, and they have poorer access to - and use less - information and health promotion, disease prevention and care services (Kickbusch et al., 2013). Their social situation, the cultural difference and linguistic barriers make the implementing of learning for health strategies more difficult to achieve.

Participation of citizens is a key condition of the success of the lifelong learning for health policy. If participation processes are inclusive – meaning that all of the population are entitled and have the skills to participate – social participation can be understood as a key driver of health equity. To ensure participation, there is need for spaces for discussion with citizens in which to reflect on the nature of problems; spaces for decision-making with organized interaction with citizens, civil society groups, governments and other actors to establish plans of action; organization of such actions involving all stakeholders; and their involvement in evaluation.

The WHO document "Participation as a key driver of health equity" describes the key component of the governance of a participatory process (WHO, 2019) as follow:

### Spaces for discussion

The configuration of participatory institutional and noninstitutional spaces for discussion offers opportunities for promoting health equity.

#### *Communication-related opportunities for health equity*

The configuration of a participatory space requires that all affected stakeholders, including those in disadvantaged situations due to social conditions (groups with lower socioeconomic capacity, invisible and oppressed groups, and minorities, for instance), are contacted and their participation facilitated. The creation of a participatory space (through specific communication and mobilization strategies for groups that are disadvantaged in terms of health) promotes

raising awareness and recognition of the rights of groups with the highest level of health disadvantage.

### *Reflexive opportunities for health equity*

Opening a space for participation provides a reflexive (or deliberative) opportunity through interaction, communication, information production, training, reflection, deliberation and appropriation, defining problems and the agenda of priorities based on the needs of those who participate in the process, and not only on technocratic or administrative criteria. This requires, therefore, a change in the collective framing of the problem and priority-setting to take account of the most disadvantaged groups, who go from being considered mere beneficiaries of interventions to agents and protagonists of the policies and programmes that affect them.

### *Pedagogical opportunities for health equity*

Opening a space for communication and discussion on health issues generates a space for learning that encourages health literacy, through which individuals gain control over individual behaviours that promote health. Health literacy can be understood as a bidirectional process, as health professionals, scientists, civil servants and others can gain knowledge about the wider determinants of health inequities through participants' narratives.

## Decision-making

Establishing a more or less formalized system for interaction with citizens, civil society groups, governments and other stakeholders allows for an approach to address problems that generate inequality in health.

### *Coherence*

Participatory processes can serve to align the objectives of different actors in the struggle against health inequity to achieve a more consensus-based strategic vision.

### Responsiveness

As a result of negotiation, deliberation and opening spaces for consensus (or conflict), responsiveness is developed on behalf of all intervening stakeholders in general, and governments in particular, enabling institutions to better serve all stakeholders, including those most in need.

### *Transparency*

Interaction requires the development of a transparent system of exchange. It should guarantee that information is available, accessible and comprehensible. Participants' narratives and the

available information create new knowledge about the social determinants of health.

### *Rule of law*

There is a tendency to formalize the decision-making process to favour the rule of law (because of a restriction in the informal exercise of power) to reduce possible mechanisms of abuse of power and discrimination.

## Implementation

The participation of everyone with a stake in decisions in applying strategies, programmes and activities permits the following to occur.

### *Coordinated action*

This involves stakeholders involved in the participatory process working in synergy, improving effectiveness and the efficiency of interventions.

### *Identification of the population with policies*

It is possible to achieve greater acceptance of policies in which the population feels ownership due to participation in their development and implementation. When policy implementation takes place from a technocratic model in which elites make decisions based on technical and professional criteria, there is a tendency to generate greater symbolic violence with groups that do not share the cultural codes of the socially dominant groups because of their positions in the social structure.

## Evaluation

Evaluation favours the following issues.

### *Determining the impact of learning for health policies*

Impact evaluation links decisions made with possible effects on the population, which increases information about how decisions increase or reduce health inequalities. This serves to reorient action towards health equity.

### *Return of results*

The return of results is a two-way process. On the one hand, it permits the population to make use of the knowledge and information provided (which, in reality, is their own), and on the other, it is helpful in validating the information obtained in the participatory process (results validation).

*Activity: For different groups how are they involved in participation work?*

*How could we engage them more meaningfully?*

*Examples:*

# Thematic tool 16

## Building coherence and visibility: Monitoring the enactment of the Yeonsu declaration

### Phase 3 of the enactment process: Putting the learning for health policy into action


### The questions this sheet answers

- How to evaluate the enactment of the Yeonsu declaration?

### Articles of the Yeonsu declaration

| | | | |
|---|---|---|---|
| 7. Demonstrating the necessary political will | 8. Paying attention to contextual factors | 9. Crisis implementation of plans for essential services | 10. Empowering local people to build capacity to protect their health |
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### Summary

Evaluation of the enactment of the Yeonsu declaration needs to consider process evaluation in the short-term as well as long-term impact and, eventually, outcome evaluation. Short-term process evaluation is important because it allows the assessment of the project and

early identification of problems and helps keep the morale of participants high by demonstrating and monitoring progress. The participation of the population in the lifelong for health policy is a major issue and should be evaluated on a regular basis.

## Working path for practical enactment

Evaluation needs to consider process evaluation in the short-term as well as long-term impact and, eventually, outcome evaluation. Short-term process evaluation is important because it allows the assessment of the project and early identification of problems and helps keep the morale of participants high by demonstrating and monitoring progress.

The focus of the evaluation depends, at least in part, on the maturity of the project of lifelong learning for health policy and the level of funding. Process indicators are particularly important to collect in the setting-up stage of a project, while outcome indicators are more appropriate for a more mature project. Of course, both are important in a project, but outcome indicators will only be possible over a reasonably long term.

Indicators should be developed with specific relevance to local communities. The development of indicators is not a technical issue, but an issue of values and beliefs about processes necessary for developing health. Consequently, the type and interpretation of indicators will vary from community to community. Relevant, sensitive and easy to collect indicators may be used for the monitoring of, and comparison between, a number of Lifelong Learning for Health policies at the country or inter-country levels. These indicators should demonstrate changes and the participating projects should find them easy to collect.

Stage One: Short-term impacts and implementation. This stage is concerned with describing the implementation of the health learning pathway project and, in particular, with ensuring that the project has been implemented according to established guidelines and criteria. For example, a project that had brought about intersectoral action but had not sought to increase opportunities for community participation would not be judged to have been implemented properly.

Stage Two: Medium-term learning outcomes. This stage concerns the intermediate outcomes that could be shown to be linked to long-term health and environmental outcomes.

Increase in the knowledge of people on health crises, non-communicable diseases, and development of the psychosocial skills of young children are examples of these outcomes.

Stage Three: Education, health and development outcomes. This stage underscores the specific individual, communal or environmental health outcomes. Level of health literacy, a decline in mortality or morbidity from particular diseases linked to an intermediate outcome, an improvement in living environments or a higher than before level of perceived health status in a community are distinct examples of such outcomes.

In the early stages of the project, the evaluation focus should be on Stage 1. As the project develops to Stage 2, the intermediate outcomes could be monitored. The individual, communal or environmental health outcomes of Stage 3 are likely to take years or even decades to achieve.

We propose here two tools for monitoring the initial phases of the enactment of the Yeonsu declaration.

*Monitoring implementation*

Process evaluation of the enactment of the Yeonsu declaration checklist (from WHO, 2000):

1. How were the priorities for action arrived at?
2. What information was collected to inform this process? Was it appropriate?
3. Who was involved? Did all groups feel satisfied with the say they had? If not, why not? What would have enabled them to have more say?
4. What process is there for reviewing and revising priorities?

### Project management

1. What sectors are represented on the management bodies? Which are not represented? Why aren't they represented?
2. What form does the community representation take? Do the community representatives make a genuine contribution? What are the constraints to them doing this?
3. Who holds most power in decision-making? Is this appropriate?
4. What connection does the management group have to the key decision-makers in the city (usually the mayor and town clerk)?
5. What is the strength of political support for the project?
6. How have policies, structures, practices and human resources been influenced?

### Characteristics of the project activities

1. Description of all initiatives which have been part of the lifelong learning for health project.
2. Details of the contribution of each component of the health learning pathway.
3. Documentation of the process of how change was achieved.
4. Detailed accounts of problems encountered in implementing the project.
5. Details of alternative ways to implement the project.
6. Determining whether the initiative was worth the money.
7. Status of innovation after the initial impetus.

### How successful was the cross-sector activity and collaboration in the project?

1. Which sectors appear most supportive of the Healthy Cities initiative and why?

2. Which sectors are not supportive of the initiative and why not?
3. What are the most successful cross-sector initiatives? What factors appear to account for their success?
4. Are there any cross-sector activities that have not been successful? Why does this appear to be the case?

### The future of the project

1. How is innovation being maintained after the initial impetus is over?
2. Is political support for the project continuing? If not, how can it be revived?
3. Are the project successes sustainable?
4. Is the project continuing to generate new ideas?

### *Monitoring participation*

To evaluate participation, at least three key questions should be answered (from WHO, 2019).

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| Who participates (inclusivity)?<br>The degree of openness to participation of people who are not formally organized | |
| How do they participate (intensity)?<br>The extent to which participants interact, exchange information and influence decision-making in participation processes | |
| How are discussions and decisions linked with policy or public action (influence)?<br>The orientation of participation processes in relation to city or institutional actions | |

*Activities-Develop relevant indicators to assess the implementation of the declaration at the city level.*

*Examples:*