行政院所屬各機關出國報告

（出國類別：國際會議）

參加第20屆IUHPE世界健康促進大會

服務機關：行政院衛生署 國民健康局

姓名職稱：邱淑媞局長

蔡維誼科長

派赴國家： 瑞士（日內瓦）

出國期間： 99 年 7 月 11 日 至 7 月 16 日

報告日期： 99 年 9 月 30 日

系統識別號： C09902030

摘 要

國際健康促進與教育聯盟（International Union for Health Promotion and Education，簡稱 IUHPE）每三年舉辦一次世界健康促進研討會（IUHPE World Conference on Health Promotion），第 20 屆研討會於2010 年 7 月 11 日至 7 月 15 日由瑞士健康促進聯盟於日內瓦主辦，為全球健康促進議題交流之盛會，計有來自全球 123 個國家，包括健康促進官員、學者專家及民間團體等各國代表，約 2,250 人與會。

本局於 2010 年 7 月 12 日至 15 日由邱局長淑媞及蔡維誼科長赴瑞士日內瓦參加該研討會，此次大會以「健康促進與永續發展：Health and sustainable development」為主題，希望結合健康促進、健康不平等與永續發展為主軸，探討健康人、健康社會與健康地球的三贏策略，大會之各項設施與活動設計，亦遵循環境永續與健康之基本原則，提供與會者服務。

此會議為推動健康促進事務國際交流之寶貴機會；本局除發表菸害防制與慢性腎病等主題之海報論文三篇外，並與大會主席 David McQueen（渠亦任美國 CDC 國際衛生中心副主任）就有關非傳染性疾病防治之交流交換意見；與大會 Scientific Committee 主席 Vivian Lin 討論澳洲健康促進醫院與綠色健康照護參與健康促進醫院國際網絡，並與臺灣交流之事宜；參與研訂「健康促進人員核心職能專業發展標準」(CompHP) 之專家會議；並於研討會過程與來自英、美、加、歐盟、澳、紐、瑞士、香港等地之專家與官員之進行交流。此國際研討會活動模式已就健康促進合作與新興議題，拓展實質國際交流管道及提升我國際能見度。

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壹、目的

國際健康促進與教育聯盟（International Union for Health Promotion and Education，以下稱 IUHPE）為全球最大之健康促進與健康教育之國際組織，該聯盟每三年由各國輪流主辦舉辦一次世界性的學術研討會。本（2010）年為第 20 屆世界健康促進研討會（The 20th IUHPE World Conference on Health Promotion） 於本年 7 月於瑞士日內瓦舉辦，為全球健康促進與健康教育議題交流之年度盛會。本次由行政院衛生署國民健康局（以下簡稱本局）派員參加研討會，預期目的說明如下：

一、蒐集各國與歐洲地區推動健康促進及相關衛生策略或推動計畫，作為未來規劃相關健康促進策略或施政措施之參考。

二、瞭解最新健康促進與健康教育趨勢與現況，持續與各國或地區之健康促進專業人員進行經驗交流，並建立交流管道。

三、發表我國菸害防制與慢性病預防成果之海報論文，分享我國健康促進經驗於國際社會。

四、積極參與國際健康促進活動，拓展我國參與國際活動舞台，提昇國際能見度。

貳、過程

一、出國行程：99 年 7 月 11 日 至 7 月 16 日(含路程)，本局由邱局長及蔡維誼科長參與研討會，行程如下表：

日　期	行 程 內 容 摘 要
7 月 11 日（星期日）	啟程：桃園國際機場→法國戴高樂機場→瑞士日內瓦
7 月 12 日（星期一）	1.中午抵達瑞士日內瓦 2.拜會國際癌症防制組織（UICC） 3.參加研討會
7 月 13 日（星期二）	參加研討會
7 月 14 日（星期三）	參加研討會
7 月 15 日（星期四）	1. 參加研討會 2. 返程：瑞士日內瓦→荷蘭阿姆斯特丹→桃園

	國際機場
7 月 16 日（星期五）	返程：飛抵桃園國際機場

二、主要議程及交流活動之安排：

日期	7 月 12 日	7 月 13 日	7 月 14 日	7 月 15 日
	星期一	星期二	星期三	星期四
Plenary 議題	**1st: Territorial Change and Urbanization**	**2nd: Social and Cultural Change**	**3rd:Environmental change +Food system, healthy 3**	**5 parallel sub-plenaries**
上午	（尚未抵達）	1.本局 2 篇菸害報告之 Poster Guide 2. Social and cultural change Changement social et culturel Cambio social y cultural	1. Food system 白皮書討論 2. SYM: Implementation of Health Promotion Switzerland's best practice concept – showcasing from projects / programmes in private sector, public sector, and in research / evaluation 3.WorkShop: Data required for the Healthy Handprint	1.本局慢性病預防之腎病分析 Poster Guide 2.Capacity Building – sustainable financing and infrastructures for health promotion 3.Mainstreaming health promotion 4. SYM: Effectiveness of governance tools for health in all policies in action
中午	飛抵瑞士日內瓦	參加歐洲地區發展核心職能（CompHP）計畫之專家會議討論		
下午	1. UICC 總部拜會 2. 大會註冊及參加研討會	1.Governance and financing for Health Promotion: Innovations in the Asia-Pacific regin 2.. Healthy and Sustainable settings: Reflections and Future Directions	1.The use of evidence for policy: evidence-informed decision making 2.與大會主席Dr. David McQueen 洽談	1. IUHPE會員大會討論： 'Can IUHPE become a sustainable organization? Responsibilities, opportunities and challenges 2.Closing Plenary Session大會閉幕 3.新任主席演說 4.下屆研討會研規劃

參、會議重點

一、研討會主題：健康促進與永續發展

近年氣候變遷嚴重影響生活環境,對於人的安全與健康亦產生重大影響，2008 年更發生全球經濟危機，目前人類生活處在一個艱困之時期，全球共同探討環境變遷及分享因應經驗，就更顯得重要，此次大會特別以「健康促進與永續發展：Health and sustainable development」為主題，希望結合健康促進、健康不平等與永續發展模式，探討健康人、健康社會與健康地球的三贏策略，大會主題如以下示意圖。在為期五天的 IUHPE 學術會議當中，舉行超過八百場次之研討報告及超過一千篇的海報論文發表，成果豐碩。

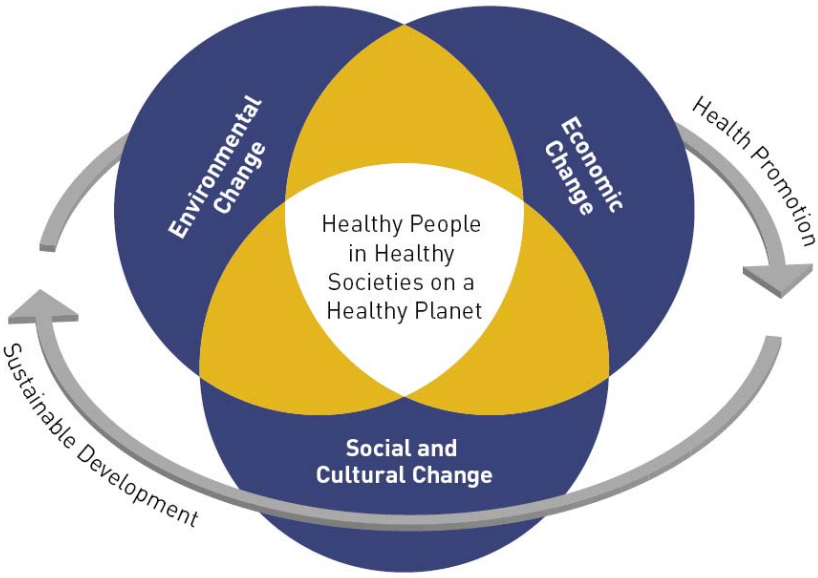
大會議程安排依主題「健康促進與永續發展」來設定相關議題，希望使與會者能藉由各國案例、經驗分享與新興議題討論，建立健康促進與永續發展之橋樑，達成以下目標：

一、報告及蒐集健康促進與永續發展之最新知識及重要議題。

二、提供最佳範例（best practice）之個案分享與研討。

三、分享公私部門所建議或提出之解決健康及福利威脅之前瞻性分析與建議。

四、嘗試推動改善全人類健康與福祉之永續政策或案例之合作伙伴。



今年主辦國瑞士特別依大會主題提出食物系統（The food system）白皮書之研討活，希望提升全球對健康有利的選擇也是對地球最利之概念，並建立永續環境及健康食物供應體系。

二、領土改變及都市化（Territorial Change and Urbanization）：，

（一）都市化與環境變遷

在 7 月 12 日之分組會議討論健康與環境永續發展議題，背景資料指出全球各國之健康狀況與平均餘命呈現出相當不平均之現象，尤其是一些開發中國家面臨更嚴重之健康風險因子，使健康受到威脅之不平等狀況。

自從工業革命開始，人們因為工作需求及就業方便考量，使人口大量由農村或鄉村地區，逐漸往城市或城鎮聚集之都市化現象（Urbanization），以尋找較佳之經濟機會。根據聯合國統計 1900 年城市人口的佔全球總人口數 13% (2 億 2 千百萬人)， 1950 年增加至 29% (7 億 3 千 2 百萬人)， 2005 年到 49% (32 億人)，推估在 2030 年將增加至 60% (49 億人)。這趨勢使城市數量增加、規模擴大，移居者適應城市化之文化、經濟及社會發展之過程。

全球氣候變遷來自人類之開發行為，但卻又影響人類的生活模式與健康，這種變遷起源於已開發國家，但開發中國家又使之持續惡化，各國都將受到威脅。依據 WHO 歐洲區域辦公室（Regional Director Europe of the World Health Organization）主席 Zsuzanna Jakab 表示：這些變遷對人類生活之衝擊甚大，包括指社會階層之梯度（social gradient）、人口結構改變、都市化、慢性疾病及社會不正義等問題，需要加以關注。以工業化之經濟發展主軸，有大量溫室氣體被排放到大氣中而導致氣候變遷，溫度上升使冰河逐漸消失，異常乾旱、暴風雨（雪）、洪水、颱風及龍捲風等異常氣候條件，威脅人們健康及生存環境，另環境污染使地球生態體系持續

破壞，這種問題在開發中國家更為嚴重，依據統計全球因天然災害死亡者，有 90％發生在開發中國家或地區。

在經濟變遷與全球化之挑戰下，我們健康與福利受到國家政策、全球化、經濟與環境之影響，國際社會應該去分析這些複雜的連結與相互關係並以永續發展方式來解決問題。

（二）都市化及改善居住建築為無害環境並促進健康

建築方式對人體健康與福祉影響很大，在考量都市化與健康時，居住者之住屋品質應納入考量，這也就是最近發展的健康促進建築（Health-Promoting Architecture）理論。居住方式影響身體健康程度，往往超乎我們的主觀預期，依日內瓦大學 Roderick Lawrence 教授表示，居家環境影響健康之因子佔了決定人體健康全部因子達四分之一以上，而基礎醫療照顧因素大概只佔十分之一。另以歐洲 19 世紀之發展經驗，貧困地區之住家條件是許多流行疾病傳播的溫床。建築設計不僅是健康促進必須考量的一個風險因素，更是達成健康的一種寶貴資源，良好居住條件可促進居住者的健康及個人發展。

澳洲國立大學 Sharon Friel 教授更以全球化觀點來看居住環境問題，更隱含有嚴重社會不平等之意涵，以非洲撒哈拉沙漠以南地區（sub-Saharan Africa）平均每人佔用 8 平方公尺，且居住環境未能符合住房基礎健康要求，甚至是直接危害健康之主要因子。

相對的在歐洲地區，周遭環境也是傷害健康之因素，更影響生活品質良窳之重要決定因子。窮人生活在破舊的公寓大樓中，而高收入者住在寬敞且有廣大花園之居住環境中。以英國之格拉斯哥（Glasgow）為例，社經地位低者之平均餘命是 54 歲，高收入之社區卻可達 82 歲，台灣地區之山地原住民平均餘命也較平地住民少，亦有類似之社會現象。從社會公平的角度來看，推動促進健康的居住環境，對於解決健康不平等來說，社區除社經地位不同外，更因周遭生活環境

之危害因素、獲取健康食物及取得基層醫療照護的資源差異，而有社會階級影響健康之不平等條件，需要各界更予以關心。

三、環境改變及食物系統（Environmental change and the Food system）：食物系統白皮書討論

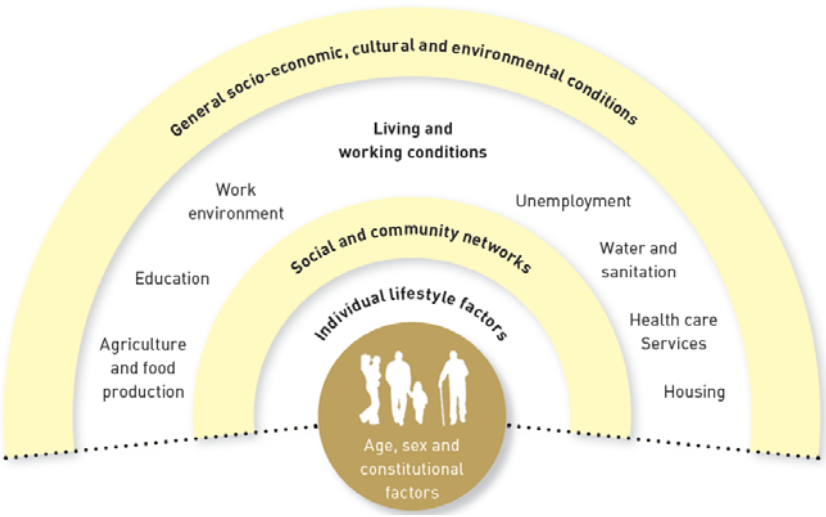
（一）前言

本次研討主辦國瑞士特別大會主題：健康促進與永續發展，提出食物系統白皮書草案（The Food System: a prism of present and future challenges for health promotion and sustainable development）討論，期望能建立健康促進與永續發展之連結性，健康促進主要在解決個人、人群、行為及資源與健康之問題，與永續發展共同目標在思考以人為核心的問題，如永續發展起源自1992 年聯合國永續高峰會之「里約宣言 Rio Declaration」揭示以人為本之永續考量。永續發展更是社會組織運作應考量因子，過去雖然在不同領域進行討論，本會議希望增加這兩個領域交集及連結性更好之交流平台。

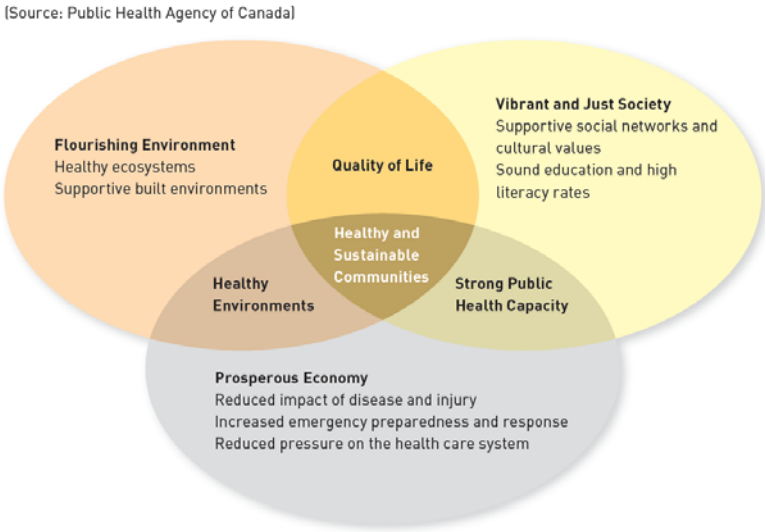
人類食物來源之主題與農業發展、環境及健康密不可分，但必須考慮不同系統間之相互影響及因果關係。依白皮書內容，影響健康有關因素，簡要說明如下圖，討論主軸以如何創造一個可永續的食物體系，且能健康與環境互利雙贏。

永續的食物系統(sustainable food system): 能夠以正向的

[Source: Dahlgren & Whitehead, 1991]



社會利益以及低環境衝擊的方式，供應安全且健康的食物系統。大會更以因為一般而言，對於健康有利的最佳選擇，也會是對地球有利的選擇；而對環境有利的選擇，通常也是有利於健康的初步結論。從公共衛生與健康促進的觀點出發，以影響健康之整體環境、社會及經濟等三大面向之相互關係與思考，因為食物系統確實與永續發展不可分割，其他健康促進議題亦有類似思考模式，三大面向相互關係如下圖：



(二)食物與健康促進和永續發展的連結 (How food links health promotion and sustainable development)

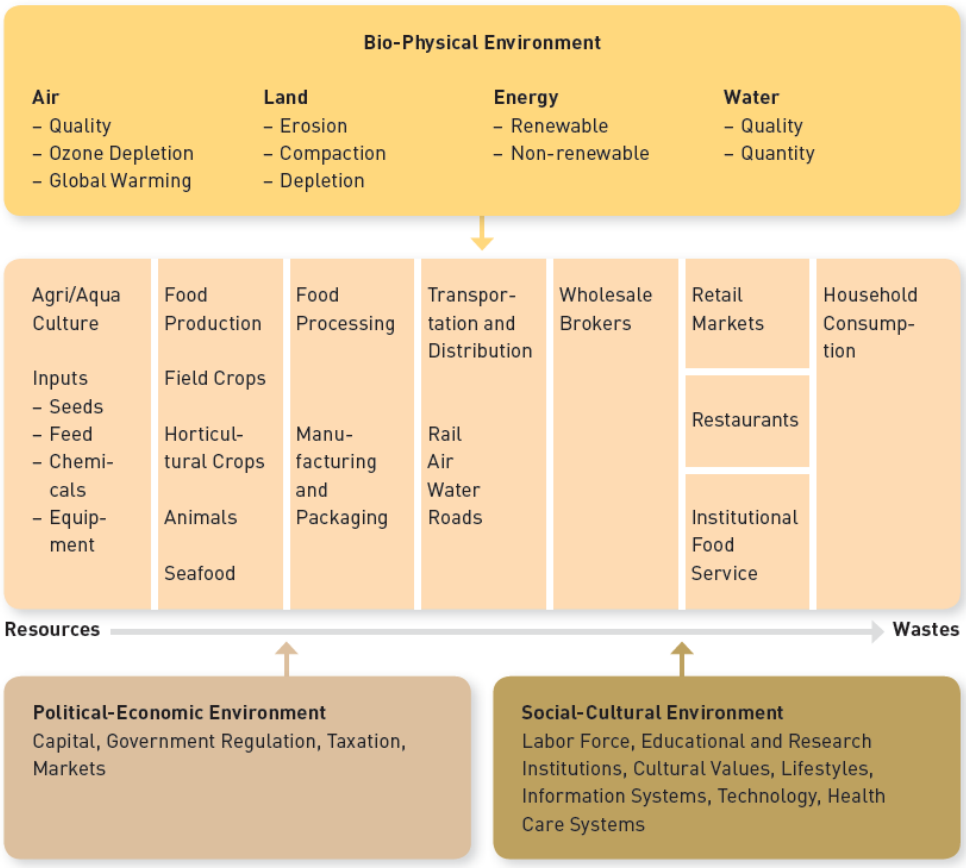
食物供應過程包括土地利用、農業生產、加工處理、分配運輸、準備與消費相關的消費活動，而且這些活動的結果，影響了食物的安全性(security)、有供應與可獲得(availability)、可近性(accessibility)與利用(utilization)。據統計農業生產及土地利用過程所產生溫室氣體約佔全球溫室氣體的三分之一。現代化之食物生產過程，因提高生產效率及降地成本等考量，往往也重度依賴目前仍屬便宜之石化燃料為能源，全球農業及食品工業產值平均為各國 GDP 之十分之一，尤其是以開發國家之肉品生產過程，更是高度依賴石化能源之生產系統，很容易受到能源危機的影響。在開發國家

要快速及有效率的獲得餐桌上 1 卡熱量的食物，生產過程平均投入 7.3 卡的石化燃料為成本；而餐桌上 1 卡熱量之肉類食物之能源成本更達 35 卡。

研討會提倡更永續(more sustainable)、更健康(healthier)與更公平的(more equitable)食物系統，是公共衛生的主要目標，永續議程和健康促進領域的介面是未來必須重視之公共衛生挑戰。

從農業生產到餐桌（from farm to fork）之食物供給鏈，可以以線性模式表示出來，從生產環境、生產資源投入至廢棄之過程，同時考量外部「政治-經濟」環境與「社會-文化」環境之影響性，依白皮書內容，相互關係表示如下圖：

(Source: Northeast Network for Food, Farm and Health Policy Education)



在白皮書討論過程所引發議題為肉類食物及主要糧食製品之生產問題，因其對於全球暖化問題衝擊性最大。在非洲地區肉類飲食與傳統文化有關，但食物供給量不足及分配不

均，不同生活社區需要一個可行的替代方案。攝取低肉類之健康飲食型態，不僅每年可以搶救數百萬人的生命，更是保護環境的行為，例如香港大量雞肉生產與販售場所不當而有禽流感流行之問題。開發中國家有 1 億 4 千萬個兒童人因營養不良而體重過輕，2009 年全球有 10 億 2 千萬人處於飢餓狀態。相對的，現代化之社會飲食型態卻因高油脂、糖、精緻化食物等「西化飲食」型態，導致肥胖、高血壓及糖尿病等慢性健康危害。在人類飲食從吃不飽轉換到吃飽的過程，健康飲食及充足運動概念需要同時建立，不然生活環境將成為一個使人肥胖之社會(obesogenic societies)。

根據美國農業部於1985年至2000年各類食物之價格區比較，健康的蔬果與穀類食物價格是上漲的，新鮮蔬菜（Fresh fruits & vegetables）上漲 38.5%，整體蔬果價格（Total fruits & vegetables）上漲 20.38%，穀類及烘焙食品（Cereal & bakery products）上漲 11.46%，但是比較不健康之食品售價，如奶製品（下跌 0.46%）、肉類（紅肉類下跌 3.18%，白肉類下跌 4.46%）、甜點（下跌 7.01%）、油脂（下跌 14.01%）及碳酸飲料（下跌 23.57%）之價格卻大幅下降，這種價格影響購買負擔（affordable）及食物選擇性。另不同食物種類運送及流佈於不同社經階層之社區，也呈現分佈不平均、價格因素及健康食物可近性等社會不平等現象，例如美國 1960-1980 年期間，20-74 歲成人肥胖率成長至 15%，在 2003 年至 2004 年調查，肥胖盛行率從一路攀升到 32.9%。另依據 WHO 研究指出，兒童肥胖是 21 世紀公共衛生最大之挑戰，2007 年共有 2 千 2 百萬五歲以下兒童體重過中，四分之三生活在中、低社會階層之家庭，成因係由社會階層不平等、肥胖食物產業（obesity industry）及致胖之環境(obesogenic environments)共同造成公衛之挑戰。

一個良好的全球食物供應系統，應該兼顧公平、不匱乏之安全及促進健康三個面向，並且要減少環境的負面衝擊，創造雙贏。各考量因素說明如下：

1.公平（Justice）與安全（Security）：食物是健康、安適以及生產力的決定因素，原因如下:

(1) 全球缺乏食物可近性（access to food ）的人口數增加；(2) 在發展中世界，食物及飲水是不安全的；(3) 氣候變遷是主要的威脅，對貧窮國家的影響更鉅；(4) 農業科學之生物科技的革新引起爭議；(5) 全球五歲以下幼童之死因有三分之一可歸因於營養不良；(6) 在發展中國家兒童貧窮的比率上升；(7) 由於營養不佳造成的個人發展遲緩所導致的經濟衝擊極大。根據國際農糧組織統計，在 2009 年全球飢餓人口已超過一億人，且在持續增加中。

2.健康：營養問題的轉型及惡化，營養不良與不健康飲食導致肥胖問題及慢性疾病的增加，原因如下:

(1) 食物之生產與消費的改變，以及低度的身體活動，導致了全球慢性疾病的盛行；(2) 營養不良與肥胖並存；(3) 促使食物攝取增加以及缺乏健康食物的食物系統，與身體缺乏活動共同造成了「致胖的社會」(obesogenic societies)；(4) 肥胖的盛行影響下一代的健康；(5) 較健康的飲食每年能拯救數百萬的生命並且降低對環境的衝擊。

3.永續：對健康與環境的負面衝擊，原因如下:

(1) 現有的食物系統，以環境以及人類健康的高成本，提供低成本的食物；(2) 現在的食物系統，由於農業工業化之故，高度受到全球石油危機的影響;(3) 不同飲食型態的環境效應很顯著；(4) 肉類的消費對於環境的負面衝擊很大，特別是與能源和水資源之使用有關。

（三）食物的各層級政府之治理體系(governance)與健康

全球層次(或稱聯合國體系) 在不同的機構、國家以及其他角色扮演者的全球集體行動的需求日漸增加，並且需要以全球性的規範環境(如永續的食物與健康政策)因應，包括以下三個食物政策概念及理想目標：

1.公正性(food justice)：健康權與食物權是永續的食物體系的規範基礎(normative base)。

2.安全性(food security)：確保食物的可近性

3.主權(food sovereignty)：強調無權力(powerlessness)和缺少民主(democratic deficit)之問題，關切全球食物系統中，各國權力不對等的窘迫狀況，以及需要設立永續的發展目標，以增加民眾的權力。

國家層級而言，各級政府對於民眾吃什麼？如何取得？對健康都有顯著的影響力。基於健康、永續與公平的基礎，在各級政府治理層次，發展跨部門（multi-sect oral）及思考「上游」永續食物政策(sustainable “upstream” food policy) 。而在地方或社區層次，於地方層級發起的食物政策特別重要。常用策略包括成立食物政策委員會(food policy councils)、社區食物安全聯盟(community food security coalitions)、社區食物體系行動(community food system initiatives)、有目標的食物計畫(targeted food programmes)、以及食物健康識讀(food literacy)能力等。而推測目前食物系統之政府治理的挑戰，說明如下：

1. 理想化之全球分配： 若要公平地餵飽全球的人口，必須在各個層次的政府治理上有重要的改變，並且需要許多國際組織與計畫的重新調整，例如食物在非洲盧安達佔家戶支出 72%，巴基斯坦佔 48%，英國佔 22%，美國佔 14%；自然資源，例如水、土地、能源以及人類和動物的健康，因為現有的食物系統運作之故，而受到極大的限制。
2. 全球的食物系統：創造了可觀的環境限制並且顯著地造成全球暖化現象；全球食物系統也造成全球慢性疾病的增加，因而危及整體的生產力和健康體系的永續性，對於國家長期醫療支出與經濟損失甚巨。
3. 食物系統經濟學：是地緣政治學(geo-politics)和權力的全球重新結構的一部分；食物與營養產業是全球最大的產業之一；食物危機變成國家安全的課題；食物市場的自由化與全球化增強了工業化的食物生產，大規模的食物生產者、貿易者與零售者，成為全球市場的重要成員；高漲的消費者意識，在已開發國家創造了新的消費型態；食物政策可

能成為未來全球政治與國際貿易角力的新領域。

（四）未來永續發展與健康食物之建議 (Recommendations)

健康促進要將食物供應當成重要因子來考量，一般建議策略是倡議、使能及調解，分別說明如下：

1.倡議(Advocate)：迫切需要去倡議能夠促使永續發展、改善健康以及確保公平的食物系統。

2.使能(Enable)：需要去增強社區，以俾參與較健康的食物生產與消費。

3.調解(Mediate)：需要政策制定者、媒體、食品及相關產業、公共衛生、營養、環境與發展等專業的共同參與，共同研商改善食物系統的解決之道。

全球、國家及地方或社區層次的永續與健康食物政策，說明如下：

1.全球的永續與健康食物政策(Global sustainable and healthy food policy)是採取行動、倡議並支持全球性規範(global regulatory environment)的改善，例如食物行銷之國際規範與非酒精飲料及電視廣告限制（International Code on Marketing of Foods and Non-Alcoholic Beverages to Children and such as children's television standard），藉由支持全球性的合作以及部門間之夥伴關係，引導各國朝向全球的永續與健康食物政策之方向努力。

2.國家的永續與健康食物政策上，發展跨部門的食物政策。理想上，此政策應涵括整個食物鏈，根據現有的環境證據調整營養建議，並且整合營養、食物永續和食物安全的資訊。發展策略時必須考慮到社會不平等、心理與生理的安適、文化與社會階層的差異性，建構各類型食品之完善供應體系，抑制低價不健康食品與較不環保之肉類製品，滿足人類於「健康的地球」的需求。另外規劃全國之永續發展與健康與食物識讀能力(food literacy)之國家發展政策。

3.鼓勵地方行動以支持永續與健康食物政策：建立地方的食物政策委員會或社區食物安全聯盟，以發展促進健康及永續食物之可取得性的政策。鼓勵地方政府和地方行動團體共同發起「社區食物系統行動」(Community Food System Initiatives)。進一步發展符合地區特色之食物識讀(food literacy)的概念，就不同價格之食物，區別食物具有營養及健康影響，並與其他健康促進概念(如健康識讀)，和連結地區性健康促進活動。

（五）未來展望 (Outlook and way forward)

1986 年渥太華健康促進憲章（Ottawa Charter for Health Promotion）提出維持人類健康之基本條件與資源：和平、居住所、教育、食物、所得、穩定生態系統、永續資源、社會公平與正義。在非洲地區之許多國家，因為天然災害、政治動盪、戰亂、基礎建設殘破及傳染疾病之流行等因素，窮苦之民眾經常不能獲取應有之食物供應而遭受傷害，民眾已喪失主張獲得穩定食物供應之權利。已開發國家因不健康飲食、缺乏運動，亦有導致國民肥胖等之國家，需要分別予以關注。

從健康促進與永續發展的觀點，食物系統必須採取「上游」(upstream)的介入，將行動的標的放在農業、食物的生產和加工(processing)等生產規劃前期。健康促進與永續發展需要共同合作，使食物成為各級政府治理(governance at all levels – local, country and international level)的重要焦點，因為食物治理與健康議題息息相關。

本次研討會藉由白皮書草案提供更多實際解決方案，也提醒不健康食物引起肥胖、慢性疾病及社會不平等之問題日趨嚴重。另開發中國家推動國家發展之建設時，更呼籲考量農業生產環境維持與工業開發業之關係，主管政府部門應共同合作食物治理問題，以達成產業開發能兼顧環境生態永續發展，也是促進健康之共同目標。

四、永續研討會（A Sustainable Conference）之規劃與特色

本年度研討會主題是健康與永續發展（Health and sustainable development）主辦單位瑞士健康促進學會一藉由各種會議活動與服務社之設計，提昇與會者在工作及居家生活中能採取環境友善行為的認知，並珍惜自然環境資源及保護地球之生態環境。研討會前成立專案工作小組設計研討會活動，盡可能以永續研討會（A Sustainable Conference）之概念來規劃與設計，減少 CO_2 排放及廢棄物產生、綠能辦公與服務、提供與會者計算 Footprint 評估工具之電腦服務站，提醒節能減碳愛地球之重要性。

許多科學實證已經證實，大會設計之提醒或提示服務系統，對於與會者是有引發行動之動機與激勵作用的，在此次日內瓦會議期間，認知並養成健康促進與環境永續之習慣。此會議服務方法，是首見用於處理「環境」和「健康」這兩個結合的時尚議題，並落實於大會活動之規劃及設計。

大會以簡單（It's simple）之環境友善與健康之設計與安排。大會免費提供各種蔬果，如蘋果、桃子、李子、番茄及胡蘿蔔等健康食物，會有別於一般國內外研討會，會場並不提供高糖、油脂或高熱量之餅乾或蛋糕等甜食給與會者食用。在會議活動區及活動進行中，如在餐飲區用餐或洗手間清洗雙手之場合，與會者可以看到大會主辦單位精心設計幾十個紅色的宣導旗幟與桌面提醒用之小招牌，顯示環境友善之宣導信息，如節省 - 再利用 - 回收（Reduce - reuse - recycle!），大會並提供自行車之免費借用服務。因為簡單的生活對於環境資源消耗與污染減少，少吃肉類對於身體健康，環境友善（生產肉品消耗能源及產生溫室氣體）及節省家庭購買肉品支出之三贏狀態（Less meat is a win-win-win situation!）。

依據大會估算，平均每個參與研討會的人，從世界各國搭飛機或其他交通工具到瑞士日內瓦參加會議者，其前端旅行能源消費量佔 98%，大會活動期間力行節能減碳措施，能源消耗僅佔 2%，更希望藉由大會活動期間，與會者能認知環境友善概念，更

希望與會者能在尋找適當機會來運用這個概念，並可能在日後轉為其他會議活動、工作或居家生活之一部分，保護地球。研討會相關照片如附錄三。

五、參與衛生政策之實證基礎(Evidence-base)研討

鑑於未來各國衛生政策與健康促進計畫已被要以經過認可或可接受之標準進行實證之效益評估（evidence-based evaluation)，使政策與計畫能以理性合理方式進行決策，並提高計執行品質與經費之效益。本研討會亦舉行實證基礎(Evidence-base)之衛生政策與計畫之討論，有來自非洲、美洲、歐洲及亞洲地區國家之代表，分別發表各國推動衛生政策與計畫實際經驗之分享，討論過程相當熱烈，各國代表分別表達各國健康促進政策或計畫之實證基礎為何？已開發國家表示，許多研究可以提供政策研擬之科學證據，來評估計畫成效。非洲地區代表表示，因國家資源有限，健康促進計畫經常是政治環境與決策官員共同決定，非洲地區科學研究很缺乏，無法提供本土證據供決策使用，建議先進國家代表可以協助歐洲地區之國家，成立各種健康促進議題之技術委員會，並進行案例實證分析，以彌補非洲地區實證資料不足之問題。大會鼓勵各國代表重視非傳染疾病之全球趨勢及採取有效預防政策與計畫，希望能在共同努力下，亦使非傳染病預防成為健康服務之主流（mainstream)。

在研討會期間，本局邱局長亦針對我國如何發展實證基礎來推動國家衛生政策與重大計畫，並以推動酒品健康危害政策與研擬酒品健康福利捐為例，分享我國政策實務與規劃經驗。另亦與大會主席 David McQueen，渠亦任美國 CDC 國際衛生中心副主任（National Center for Chronic Disease Prevention and Health Promotion, Centers for Disease Control and Prevention, NCCDPHP /CDC)短暫會談，就有關實證式健康促進政策相關議題與未來非傳染性疾病防治交流交換意見。

六、參與歐洲地區發展健康促進核心職能與專業標準(CompHP)

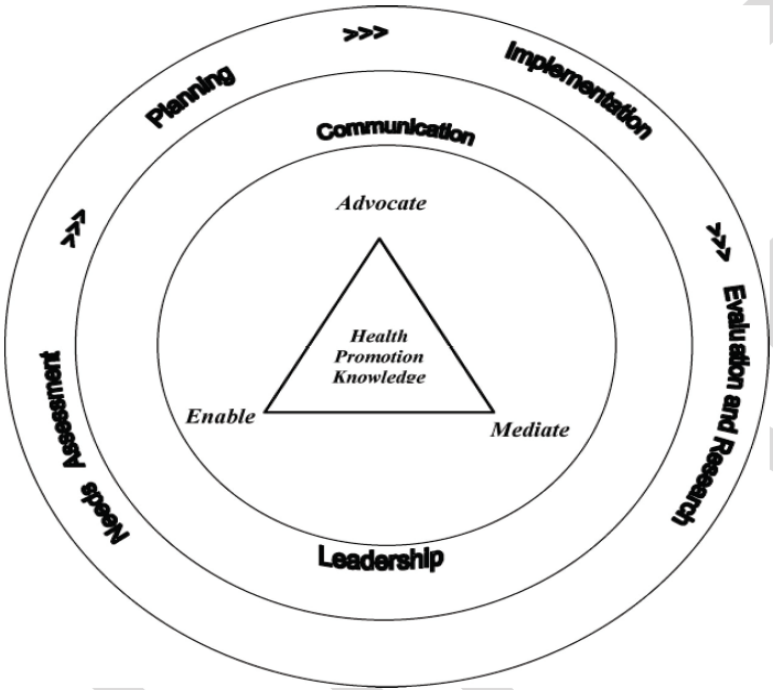
2007 年 IUHPE 會議中，各國與會者體認到健康促進服務範圍大幅擴增及影響健康之環境、政治及經濟等因素之快速變遷，產生解決健康促進議題之迫切需求。會議通過 Galway 共識宣言（The Galway Consensus Statement）並在健康促進領域扮演重要角色，提供全球發展健康促進人力及能量分享健康促進共同願景（a shared vision）共同發展之起點，更代表健康促進核心價值與核心能力之向前演進，並強調應建立健康促進工作人員（workforce）之核心能力設定標準並發展品質保證機制。在 IUHPE 推動這宣言之三項工作：發展健康促進之核心職能領域（Domains of Core Competency）、標準（Standards）及品質保證（Quality Assurance）機制。其倡導與傳播過程，應特別強調健康促進政策在解決特定健康議題之符合度（policy fit）、執行架構及具有可解決問題之有效性證據（evidence of effectiveness）。該宣言更建議未來之三個努力焦點為促進交流對話、發展全球共識並向利害關係人傳播健康促進成果。

一個稱職之健康促進人力，應具有必要之知識、技巧及能力，將政策、理論及研究結果轉化成推動健康促進之有效行動方案（effective action），並符合全球健康促進之發展與成長。依 **Arantxa S-M Morales** 研究歐洲地區之認證制度，目前已有英國、愛沙尼亞(Estonia)及荷蘭以建立國家層級之完整認證程序，歐洲外之國家亦有美國、加拿大、澳洲及紐西蘭建立認證體系。英國由政府衛生機構或教育機關辦理認證，2008 年全國有 360 個通過公共衛生認證之人員登記執業。愛沙尼亞建立大學教育及認證兩種體系，專業資格分成五個等級（Level），其中健康促進專業人員必須具有第三級以上之合格專業，並且具有健康促進之碩士學位，或具有至少五年健康促進工作經驗且累積 25 個學分以上且具有高等教育之學歷者，認證由法定專業機構辦理，另荷蘭認證制度亦由法定專業機構辦理認證。依 2010 年 Viv Speller 等人研究比較現有美國與英國認證制度發展之經驗，為了提升國際競爭力，發展全球通用之促進健康認證系統是有必要的，但是要比較與調和不同國家認證系統之差異，可以先釐清這些不同國家

健康促認證使用專有名詞與執行認證之根本差異為起點。因為在全球化之下，國際上應發展通用之職能認證標準並運用於不同國家或地區辦理健康促進之專業服務及專業人力培育體系。

從 2005 年起 IUHPE/EURO 歐洲地區委員會（IUHPE European Regional Committee）在歐盟機構（European agency for health and consumer）補助下，推動健康促進核心職能與專業標準計畫（Developing Competencies and Professional Standards for Health Promotion Capacity Building in Europe，簡稱 CompHP），希望發展、測試及定義歐洲地區執行健康促進人員之核心職能標準，在經過可行性評估並推動以職能為基礎之泛歐洲認證系統（a pan-European accreditation system）。

計畫希望諮詢全歐洲地區之執行人員、決策官員及教育訓練機構來達成認證之共識，目前 CompPH 計畫已研擬出健康促進人員之核心職能架構示意圖及核心職能領域。



在經過國際與歐洲地區學術文獻及出版品回顧、專家會議審查及專家疊慧法調查(Delphi survey)、焦點團體、諮詢及 CompHP 參與專家建議伙伴之回饋意見之研擬過程，非歐洲地區之全球經驗亦納入考量。過去 IUHPE 已建議之健康促進領域（domain）之職能架構（**Competency frameworks**）包括以下各項：

- 評估（assessment）

- 規劃與諮詢（planning and consultation）
- 執行（ implementation）
- 評估與研究（ evaluation and research）
- 知識（knowledge – principles, values and ethics）
- 溝通傳播（communication）
- 政策、倡導及策略發展（policy, advocacy and strategy development）
- 組織運作及管理（organization and management）
- 社區合作及充權（working with communities, community empowerment）
- 建立伙伴及合作（partnership building and collaborative working）
- 策略領導（ strategic leadership）.

本次討論乃在 CompHP 發展過程，使出席第 21 屆 IUHPE 會議之歐洲與各國專家能參與標準研發及討論，廣納各界意見與經驗。目前 CompHP 發展核心職能草案包括以下 10 項，詳細資料如附錄二：

1. 健康促進之知識（Knowledge）
2. 促成轉變（ Enable Change）
3. 健康議題倡導（Advocacy）
4. 伙伴協調（Mediate through Partnership）
5. 健康訊息傳播（Communication）
6. 領導（Leadership）
7. 需求評估（Needs Assessment）
8. 計畫（Planning）
9. 執行（Implementation）
10. 評價及研究（Evaluation and Research）

本局邱局長參與討論過程亦提出許多建議事項，例如可進一步就健康促進者之主要工作分為臨床、管理以及混合型，考量訂定不同核心職能組合。並應對於核心職能認證進行成效評估（例如其服務品質與健康結果是否較佳），用實證來使本認證制度發展更為完善。

肆、心得及建議

一、各國推動健康促進政策或計畫應基於實證（Evidence-based）並應進行負責任的成效評估，本次研討會介紹許多健康指標發展及政策效益評估模式，未來我國應辦理相關研究及決策人員訓練，使國家資源能發揮更大效益。

二、我國亦面臨國人肥胖率增加之公共衛生問題，除了應規劃協助肥胖及過重民眾減重以降低相關的健康威脅外，亦要致力於了解及改善食品供應體系與肥胖之關連，並創造有益健康的飲食與運動環境。

三、健康促進應重視弱勢族群之需要，注意到社會決定因子與健康之關連，致力於消弭健康不平等。

四、在全球抗暖化的風潮下，更加顯示國民健康與環境永續是相得益彰的；例如：在地蔬果低碳、新鮮、且更便宜，可降低弱勢者購買蔬果之經濟障礙，而在鼓勵在地蔬果時，又可改善農民經濟進而改善其生活條件與健康；如此一來，又因增加消費帶動增加耕種，更加減碳，形成健康-公平-永續的良性循環。低碳交通也有類似的效果。低碳交通（走路、騎腳踏車以及大眾運輸）本身既是較廉價的，也是較有益健康的，政府若能鼓勵這些交通方式，在友善環境的同時，也提昇了公平正義與民眾健康。

五、台灣可參考國際上「健康促進人員核心職能專業發展標準」之經驗，作為建立我國健康促進人員專業訓練與發展認證制度之參考。

六、大會實際活動設計與會務安排遵循環境永續與健康之主軸設計，影響使與會者能改變其生活態度，值得我國舉辦國際會議或活動時，納入參考。

七、台灣地區推動健康促進醫院網絡已受世界各國肯定，我國將於 2012 年於台北主辦第 20 屆 WHO 健康促進醫院國際研討會，宜對國際社會持續宣傳，以提升國際能見度。

八、IUHPE 國際研討會是一個能直接與國際健康促進專家以及各國健康促進官員直接互動、既學習也宣傳台灣的絕佳平台，我國應持續參與 IUHPE 國際研討會活動，持續展現各項健康促進之施政或研究成果，讓國際看到台灣長期耕耘的成績。

附錄一、研討會重要議程資料

Opening plenary: Inspiring insights into health and sustainable development
11.07.2010 (Sunday, 16:00-18:00)
Co-chairs:

- **Mr. Joachim Eder**, President of the Foundation Council, Health Promotion Switzerland
  See the Webcast
- **Prof. Vivian Lin**, La Troube University; Chair, Global Scientific Committee Geneva 2010; IUHPE Vice President for Scientific Affairs
  See the Webcast

Coordinator:

- **Dr. Ursel Broesskamp-Stone**, Head, International Affairs/ Senior Advisor Policy, Health Promotion Switzerland; Vice-Chair, Global Scientific Committee; IUHPE Vice-President for Europe

Welcome Addresses:

- **Mr. Pascal Strupler**, Director, Swiss Federal Office of Public Health (MoH), Switzerland
  See the Webcast
- **Prof. David McQueen**, President IUHPE
  See the Webcast

Key welcome speeches addressing the conference theme:

- **Dr. Zsuzsanna Jakab**, Regional Director Europe, World Health Organization (WHO-Euro)
  See the Webcast
- **Mr. Michael Hübel**, Health and Consumer Affairs, European Commission on behalf of Paola Testori-Coggi, Director General
  See the Webcast

Key panel discussion (20-30min) with the speakers above: Dr. Zsuzsanna Jakab, WHO-Euro; Mr. Pascal Strupler, MoH Switzerland; Mr. Michael Hübel, DG Sanco, European Commission.
Moderator: Prof. David McQueen, President IUHPE
See the Webcast
Technical keynote speeches:

- **Dr. Sarah Cook**, Director, United Nations Research Institute for Social Development, UK
  See the Webcast
- **Prof. Paul Hunt**, University Essex, UN Special Rapporteur on the Right to Health (2002-2008), New Zealand
  See the Webcast

1st plenary: Territorial change and urbanisation
12.07.2010 (Monday, 09:30-11:00)
Short presentation by **Michael Sparks**: "World conference and Sustainability"
See the Webcast
Co-Chairs:

- **Dr. Wilfred Kreisel**, Former Director WHO Centre for Health Development, Kobe, Japan
  See the Webcast
- **Mr. Andrew Kiyu**, Consultant epidemiologist, Sarawak Health Department, Sarawak, Malaysia

Keynote speakers:

- Prof. David Satterthwaite, International Institute for Environment and Development, London, UK
  See the Webcast
- Dr. Enrique Llorca Ibáñez, President of the Spanish Healthy Cities Network, Mayor of Sant Andreu de la Barca, Spain
  See the Webcast
- Ma. Maria Lourdes C. Fernando, Mayor Marikina City, Philippines
  See the Webcast

2nd plenary: Social and cultural change
13.07.2010 (Tuesday, 09:00-10:30)
Short presentation by **Andy Biedermann**: "Sustainability Tools at the World Conference"
See the Webcast
Co-Chairs:

- **Prof. Dr. Thomas Abel**, Chair of the Swiss Scientific Committee, University of Bern, Institute of Social and Preventive Medicine, Bern, Switzerland
  See the Webcast

- **Prof. Katherine Frohlich**, Department of Social and Preventive Medicine, University of Montreal, Montréal, Canada
  See the Webcast

Keynote speakers:

- Dr. Mirai Chatterjee, Self Employed Women's Association, India
  See the Webcast
- Prof. Maria De Koninck, Department of Social and Preventive Medicine, University Laval, Québec, Canada
  See the Webcast
- Ms. Molly Melching, Founder and Executive Director of Tostan, Senegal/France/USA
  See the Webcast

3rd plenary: Environmental change (healthy3)
14.07.2010 (Wednesday, 09:00-10:30)

Short presentation by **Ursel Broesskamp**: "Travel and communication"
See the Webcast

Co-Chairs:

- **Dr. Krissada Raungarreerat**, Chief Executive Officer, Thai Health Promotion Foundation, Bangkok, Thailand
- **Dr. Thomas Mattig**, Director Health Promotion Switzerland, Bern, Switzerland
  See the Webcast

9:00-9:20:
Keynote speaker: Prof. Rajendra Pachauri, Chairman, Intergovernmental Panel on Climate Change (IPCC), India
See the Webcast

9:20-9:30:
Introduction of the White Paper "The Food System: a Prism of Present and Future Challenges for Health Promotion and Sustainable Development" (PDF, 1.92 MB)
Key Speaker: Prof. Ilona Kickbusch, Lead Author of the White Paper; Kickbusch Health Consult, Director Global Health Programme, Graduate Institute of International and Development Studies, Geneva, Switzerland
See the Webcast

9:30-10:30: **Panel discussion on White Paper** by the Platform for Opinion Leaders (POL):
See the Webcast

- Prof. Rajendra Pachauri, Chairman, Intergovernmental Panel on Climate Change (IPCC), India
- Dr. Mary Amuyunzu-Nyamongo, Executive Director & co-founder of the African Institute for Health and Development (AIHD), Nairobi, Kenya
- Dr. Hans Rudolf Herren, Founder and Director of Biovision, Winner of the World Food Prize in 1995, President of the Millennium Institute, Switzerland
- Dr. Mihaly Kökeny, Former Minister of Health, Hungary
- Dr. Olivier Raynaud, Senior Director, Global Health and Healthcare Sector, World Economic Forum, Geneva, Switzerland
- Moderator: Dr. Thomas Streiff, CEO, The Sustainability Forum, Zürich, Switzerland

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4th plenary: Economic Change and Global Challenges
15.07.2010 (Thursday, 14:00-15:30)
Short presentation by **Mark Dooris**: "Can IUHPE become a sustainable organisation?"
See the Webcast
Co-Chairs:

- **Dr. Gordon Alexander**, Senior Policy Advisor in UNICEF's Regional Office, Central and Eastern Europe and the Commonwealth of Independent States, Geneva, Switzerland
- **Prof. Lyuba Zarsky**, Associate Professor in the International Environmental Policy Program of the Monterey Institute of International Studies, Senior Research Fellow with the Global Development and Environment Institute (Boston), International Research Fellow at the International Institute for Environment and Development (London)

Keynote speakers:

- **New President**, IUHPE (to be determined upon elections)
- Dr. Ala Alwan, Assistant Director-General - Noncommunicable Diseases and Mental Health, World Health Organization
  See the Webcast
- Prof. Walden Bello, Member of Parliament, Philippines & Senior Analyst of Focus on the Global South
  See the Webcast

- Ms. Sarah Schulman, PhD Student, University of Oxford; InWithFor, Australia
  See the Webcast
-

- 20th IUHPE 實錄之視訊檔案，可由網路錄影資料了解相關內容（http://www.klewel.com/page-iuhpe-conference-2010)

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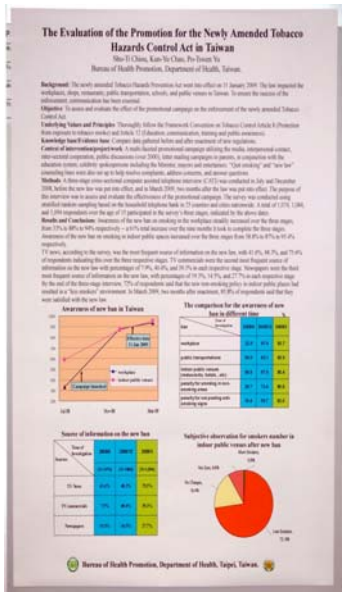
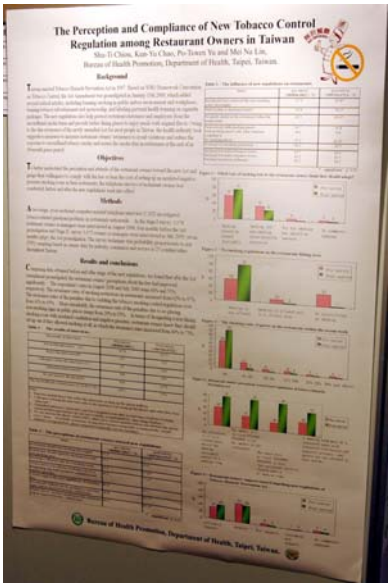
www.iuhpe.org

Gesundheitsförderung Schweiz
Promotion Santé Suisse
Promozione Salute Svizzera
Health Promotion Switzerland

附錄二、重要活動照片



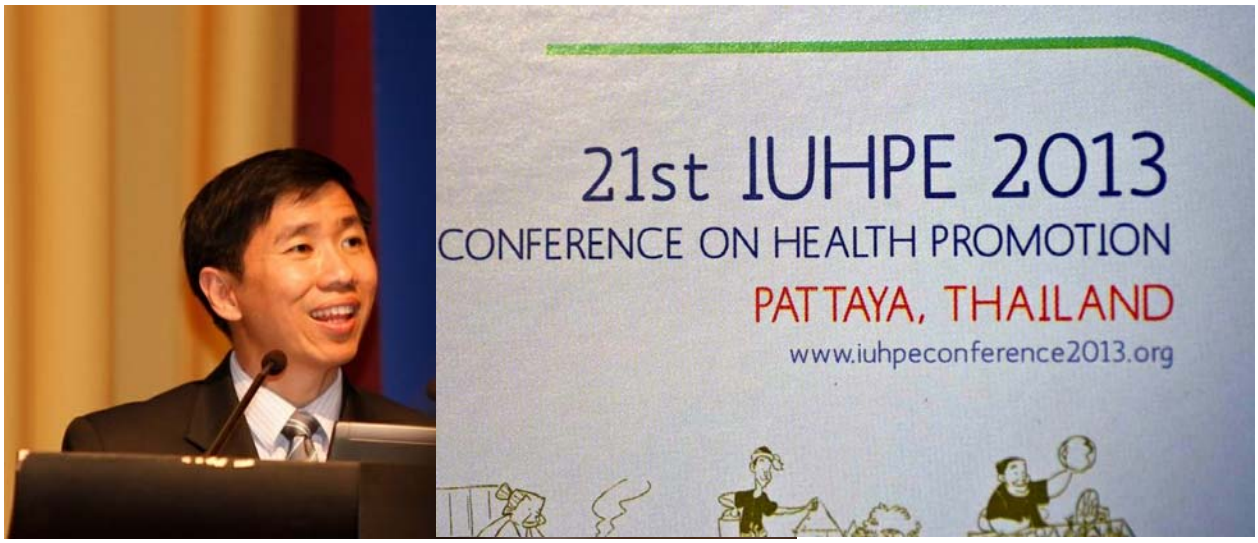


會議情形 1：本局於大會海報論文區所發表之 3 篇海報論文

會議情形 2：進行實證為基礎之健康政策之分組討論

會議情形 3：邱局長宣傳台灣主辦 2012 年健康促進醫院研討會

會議情形 4：IUHPE 新任主席為澳洲籍 Michael Sparks（現任副主席）

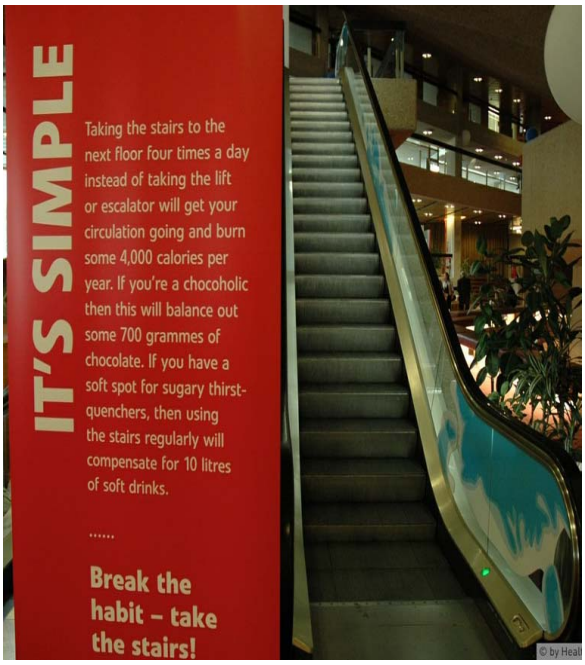


下屆研討會於 2013 年由泰國在 Pattaya 主辦

會議情形 5：永續研討會（A Sustainable Conference）之特色紀錄

研討會位於日內瓦國際會議中心採簡樸設計

每日研討會會場以滾動地球之永續發展活動



飲食健康（蔬果 snack）與環境節能（不使用電扶梯）之活動設計

大會提供健康飲食之新鮮蔬果、少肉飲食及自然環保材料

大會提供與會者免費租用環保交通工具--自行車

主辦國瑞士設立生態足跡（Footprint）值估算之活動攤位

邱局長及與會者於估算每日 Footprint 數值及合影留念

附錄三、參與研訂「健康促進人員核心職能專業發展標準」（CompHP）之專家會議資料

CompHP

DEVELOPING COMPETENCIES AND PROFESSIONAL STANDARDS FOR HEALTH PROMOTION CAPACITY BUILDING IN EUROPE

CompHP Core Competencies for Health Promotion Draft 3

Introduction

This document presents a set of core competencies for health promotion practitioners in Europe. The core competencies are being developed as part of a European wide project on 'Developing Competencies and Professional Standards for Health Promotion Capacity Building in Europe' (CompHP) [1], which is funded by the European Agency for Health and Consumers. The CompHP project builds on a Europe-wide scoping study (1) and a feasibility study (2) on implementing a competency-based accreditation system, undertaken on behalf of the IUHPE European Regional Committee. The project aims to develop, test and refine the implementation of a framework for competency-based standards and accreditation for health promotion in Europe. The project uses a consensus building process based on consultation with practitioners, policymakers and education providers across Europe. This document concerns specifically the development of the competency framework as part of the overall CompHP project.

The competency framework is informed by a review of competency developments in health promotion and related fields in Europe and internationally. The core competencies for health promotion are being developed using the following processes:

- Review of the international and European literature, including existing competency frameworks, both published and unpublished (Dempsey, Barry and Battell-Kirk, 2010)
- Review of the draft framework by CompHP project partners and International Expert Advisory Group[2]
- Delphi survey with health promotion experts from across Europe to consider the draft framework and reach consensus on the competencies. Experts are identified from a formal stakeholder analysis using agreed criteria[3]

[1] See CompHP Website at http://www.iuhpe.org/?page=614&lang=en

[2] List International Expert Advisory Group Available on CompHP website

[3] The criteria for inclusion in the sample are 6 representatives from each country, 2 each from the areas of practice, policy and academia based on, in order of priority: national role in health promotion, experience in health promotion, experience in the competency approach.

- Focus groups with health promotion experts and other key stakeholders from across Europe
- Consultation with practitioners, academics and policy makers in health promotion through an online consultation process
- Feedback on the development process from the CompHP partners and the International Expert Advisory Group

The final framework will, therefore, be the result of an extensive consultation and consensus building process with input from international experts and health promotion specialists from across Europe.

Core Values and Principles Underpinning the CompHP Competency Framework

The competencies are based on the core concepts and principles of health promotion as outlined in the Ottawa Charter (4) and successive WHO charters and declarations on health promotion (5-10). Health promotion is, therefore, understood to be 'the process of enabling people to increase control over, and to improve, their health' (4). The Ottawa Charter embraces a positive definition of health as being, 'a state of complete physical, social and mental well-being, and not merely the absence of disease or infirmity'. Health is conceptualised as a resource for everyday life, emphasising social and personal resources, as well as physical capacities. Health promotion is viewed as not only the responsibility of the health sector, but goes beyond healthy lifestyles to well-being. Health promotion, therefore, is a comprehensive social and political process which not only embraces action directed at strengthening the skills and capabilities of individuals, but also action directed toward changing social, environmental and economic conditions so as to alleviate their impact on public and individual health (11). Within this set of competencies, health promotion actions are understood to be programmes, policies and other organised interventions that are empowering, participatory, holistic, intersectoral, equitable, sustainable and multi-strategy in nature (12).

The competencies are underpinned by an understanding that health promotion has been shown to be an ethical, principled, effective and evidence-based discipline (13, 14) and by the knowledge that there are well-developed theories, strategies, evidence and values that collectively constitute a guide to good practice in health promotion (15).

Health promotion is guided by a set of core values and principles (3) including:

- a social-ecologic model of health that takes into account the cultural, economic, and social determinants of health
- a commitment to equity, civil society and social justice
- a respect for, and sensitivity to, cultural diversity
- a dedication to sustainable development
- a participatory approach to engaging the population in identifying needs, setting priorities, planning, implementing and evaluating the practical and feasible health promotion solutions to address needs

Core Competencies for Health Promotion Practitioners

The CompHP core competencies are mainly for use by health promotion practitioners whose prime role and function is health promotion and who have a graduate or post graduate qualification in health promotion or a related discipline[4]. The framework may also be useful to those working in other professional areas, e.g. community health, whose role may include health promotion. It is envisioned that the core competencies, could in the future, form the basis for developing more advanced competencies for practitioners working in more senior management positions in health promotion and could also be adapted to identify more specialised competencies for health promoters working in more specialised roles. It is recognised that job titles and academic course titles may not always include the term 'health promotion', given the wide range of contexts and systems within which health promotion is practiced across Europe. However, this framework is designed to be relevant to all practitioners whose main role reflects the Ottawa Charter (4) definition of what constitutes health promotion and which endorses the ethical principles of empowerment, equity and accountability.

A health promotion practitioner for the purpose of this document, is defined as a person who works to promote health and reduce health inequities through the actions defined by the Ottawa Charter (4):

- building healthy public policy

[4] For example, public health, social sciences including psychology, epidemiology, sociology, education, communication, environmental health, community, urban or rural development, political science. This is not an exclusive list as other academic qualifications may also be deemed as appropriate in given situations.

- creating supportive environments
- strengthening community action
- developing personal skills
- reorienting health services

Despite this broad definition it is recognised that the particular combination of knowledge and skills required to ensure quality health promotion practice need specific education and /or training in health promotion and ongoing professional development to maintain levels of knowledge.

Defining Core Competencies

There is no agreed definition of competencies despite the fact that the competency approach has been widely used in the health and other fields for over 20 years. The definition of competencies used in this framework is: 'a combination of attributes such as knowledge, abilities, skills and attitudes which enable an individual to perform a set of tasks to an appropriate standard' (16). Core competencies are understood to be the minimum set of competencies that constitute a common baseline for all health promotion roles, that is '*they are what all health promotion practitioners are expected to be capable of doing to work efficiently, effectively and appropriately in the field*' (17).

Uses of Core Competencies for Health Promotion

Health promotion core competencies can be used for a range of purposes including:

- Ensuring that there are clear guidelines for the knowledge, skills, attitudes and values needed to practice effectively and ethically
- Forming the basis for accountable practice and quality assurance
- Assisting employers and managers to gain a better understanding of health promotion roles in individual workplaces and develop appropriate job descriptions
- Assisting in career planning and identifying professional development and training needs
- Facilitating movement across roles, organisations, regions and countries through the use of shared understandings, qualifications and, where appropriate, accreditation systems based on the competencies

- Informing education, training and qualification frameworks to ensure that they are relevant to practice and workplace needs
- Promoting better communication and team work in multidisciplinary and multisectoral settings by providing a common language and shared understanding of the key concepts and practices used in health promotion
- Contributing to greater recognition and validation of health promotion and the work done by health promotion practitioners

The CompHP competencies include all the key elements agreed to be core to health promotion practice in any setting. It is recognised that those using the competencies may wish to identify different levels of expertise for each of the competencies statements or emphasise some competencies to a greater degree than others. However, as these are **core competencies,** all domains should be addressed to some degree if they are to be used as the basis for consistent, quality practice which can be recognised internationally and, if so desired, be accredited though a pan-European accreditation system. The core competencies described here, should be subjected to a regular review process and updated in response to changes in contemporary practice.

CompHP Core Competency Domains and Statements

The selection of the CompHP core competencies is based on a review of the international and European literature, in particular the domains of core competencies outlined in the Galway Consensus Statement (3), together with the modifications to the statement suggested in a global consultation process, and the core competencies for health promotion developed in Australia (17), Canada (18), New Zealand (19) and the UK (20).

For the purposes of this document the term 'health promotion actions' is used throughout to indicate programmes, policies and other organised health promotion interventions.

The ten domains of core competencies for health promotion practitioners, as illustrated in Figure 1, are:

1. Knowledge

2. Enable Change

3. Advocacy

4. Mediate through Partnership

5. Communication

6. Leadership

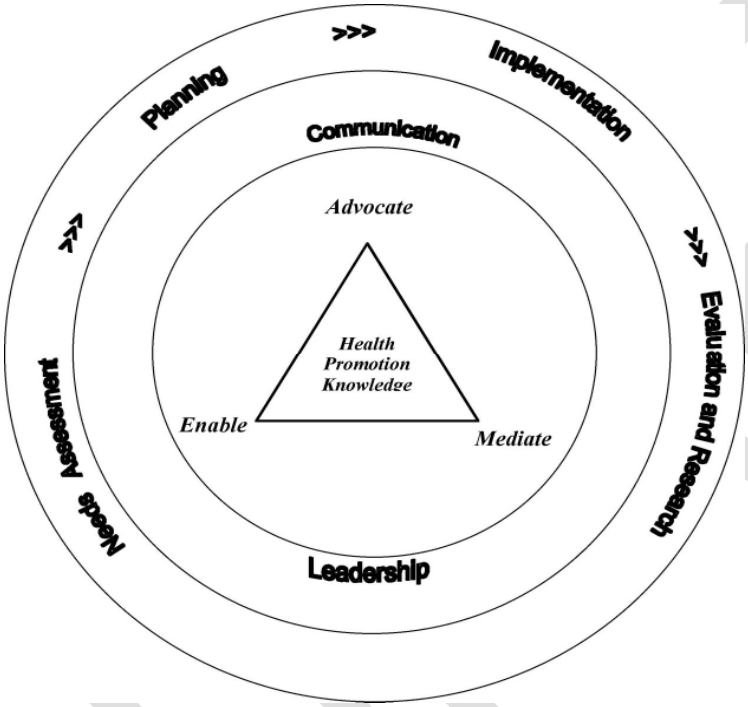
7. Needs Assessment

8. Planning

9. Implementation

10. Evaluation and Research

Figure 1: Illustration of CompHP Competency Domains



1. Knowledge

Demonstrate understanding of, and the ability to apply in practice, the theory, research, values and multidisciplinary knowledge base of health promotion which underpins the competencies including:

1.1 The history and development of health promotion internationally, including the Ottawa Charter (WHO, 1986) and successive charters and declarations

1.2 The core concepts and principles of health promotion and their application in practice

1.3 The concepts of equity and social justice, their impact on health status and relevance for health promotion

1.4 The theories and research underpinning health promotion and their application in practice

1.5 The socio-ecological model of health (social, environmental, behavioural and biological determinants) as the basis for health promotion and its implications for practice

1.6 The impact of local, national, regional and international health systems, policies and priorities and their relevance for health promotion actions

1.7 The implications of social and cultural diversity in all aspects of health promotion

2. Enable Change

Enable individuals, communities and organisations to improve health and reduce health inequities through undertaking a variety of health promotion actions:

2.1 Work across sectors to ensure that all health, economic and social policies lead to improved health and reduced health inequities

2.2 Use a range of approaches such as the settings-based approach to create environments which support health

2.3 Facilitate community participation and ownership in health promotion actions through community development processes and building capacity within communities

2.4 Facilitate the development of personal skills to maintain and improve health using empowerment strategies

2.5 Work in collaboration with key stakeholders to reorient health services towards health promotion

3. Advocacy

Advocate with, and on behalf, of individuals, communities and organisations to improve health and well-being and build capacity for undertaking health promotion actions:

3.1 Use a range of advocacy strategies and techniques which reflect health promotion principles

3.2 Identify and create opportunities for advocacy on health promotion actions

3.3 Facilitate communities and groups to articulate their experiences of health needs and to identify capacities for health promotion action

3.4 Raise awareness and influence public opinion on health issues by identifying and accessing relevant media and disseminating a range of resources and information

3.5 Engage with key decision-makers (including local authority, government agencies and officials, community leaders and non-governmental organisations) to advocate for health promotion action

3.6 Participate in lobbying processes for health promotion including making oral and written submissions, preparing and circulating petitions and position papers

3.7 Advocate for the development of policies, guidelines and procedures which impact positively on health and reduce health inequities

4. **Mediate through Partnership**

Mediate and work collaboratively across disciplines, sectors, and partners to enhance the impact and sustainability of health promotion actions:

4.1 Identify and engage partners from different sectors who have the potential to actively contribute to the development and implementation of health promotion actions

4.2 Facilitate intersectoral collaboration by mediating between different sectoral interests

4.3 Establish and manage effective partnership working with key stakeholders, including statutory bodies, community groups and voluntary/non-governmental organisations

4.4 Sustain local, regional and national coalitions and networks for health promotion action

4.5 Monitor and review partnership working in terms of impact, outcome and adherence to health promotion principles

5. **Communication**

Communicate health promotion actions effectively using appropriate methods for diverse audiences:

5.1 Use a range of skills including written, verbal, non-verbal and listening skills communicate effectively with individuals, groups, communities and organisations on health promotion actions

5.2 Develop written, oral and electronic communication (including reports, presentations and focused messages) that are adapted to specific contexts

5.3 Use the media and current information technologies to receive and disseminate information

5.4 Use effective and culturally appropriate communication methods and techniques for specific groups and contexts

5.5 Use interpersonal communication and groupwork skills to facilitate individuals, groups, communities and organisations to develop personal skills and community action to improve health and reduce health inequities

6. Leadership

Contribute to the development of a shared vision and strategic direction for health promotion actions:

6.1 Use democratic and empowerment leadership skills including active listening, negotiation, team work, motivation, conflict resolution, decision-making, facilitation and problem-solving skills

6.2 Network with and motivate key stakeholders in relevant organisations, including one's own, in leading change to promote health.

6.3 Reflect on learning and achievement needs at individual and organisational levels to build health promotion capacity

6.4 Incorporate new knowledge and ideas to improve practice and respond to emerging challenges in health promotion

6.5 Mobilise and manage resources for health promotion actions

7. Assessment

Conduct assessment of needs and assets in settings and systems that lead to the identification and analysis of the political, economic, social, cultural, environmental, behavioural and biological determinants that promote or compromise health:

7.1 Identify priorities for health promotion actions in consultation and partnership with key stakeholders, using available evidence and health promotion principles

7.2 Collect, review and critically appraise relevant data, information and literature

7.3 Use a variety of assessment techniques including quantitative and qualitative research methods

7.4 Engage stakeholders in the assessment process

7.5 Use culturally appropriate assessment approaches

7.6 Identify existing assets and resources in individuals, organisations and communities

7.7 Identify political, economic, social, cultural, environmental, behavioural and biological determinants which impact on health

7.8 Identify the key drivers for and barriers to health promotion action

8. Planning

Develop measurable health promotion goals and objectives in response to assessment of needs and assets and identify strategies that are based on knowledge derived from theory, evidence, practice and consultation with stakeholders:

8.1 Use a systematic approach to health promotion action planning

8.2 Develop and communicate appropriate, realistic and measurable goals and objectives

8.3 Identify an appropriate mix of strategies to achieve objectives

8.4 Identify and secure resources (skills, personnel, partner contributions, finance, materials, training and support) for sustainable health promotion action

8.5 Develop a feasible action plan within resource constraints and with reference to existing needs and assets

8.6 Mobilise, support and engage the participation of key stakeholders

9. Implementation

Implement effective and efficient, culturally sensitive, and ethical health promotion strategies to ensure the greatest possible improvements in health, including management of human and material resources:

9.1 Use culturally relevant and appropriate health promotion implementation approaches

9.2 Use ethical, empowering and participatory processes appropriate to specific contexts

9.3 Develop, pilot and use appropriate programme resources and materials

9.4 Monitor the quality of implementation of programmes in relation to agreed goals and objectives

9.5 Use process evaluation feedback to maintain and improve effective implementation

9.6 Manage the resources needed for effective implementation

9.7 Facilitate programme sustainability and stakeholder ownership through ongoing consultation and collaboration

10. Evaluation and Research

Determine the reach, effectiveness and impact of health promotion actions. This includes utilising appropriate evaluation and research methods to support programme improvements, sustainability and dissemination:

10.1 Integrate evaluation into the planning and implementation of all health promotion actions

10.2 Use appropriate health promotion evaluation and monitoring methods and tools in partnership with stakeholders to record process, impact and outcome evaluation

10.3 Use evaluation findings to refine and improve health promotion actions

10.4 Use research and evidence-based strategies to inform practice

10.5 Contribute to the planning, conducting and writing of evaluation initiatives

Glossary

In addition to the terms defined in this glossary, the project uses the definitions from the World Health Organisation's (WHO) Glossary of Health Promotion (http://www.who.int/hpr/NPH/docs/hp_glossary_en.pdf) and in the update (http://heapro.oxfordjournals.org/cgi/reprint/dal033v1.pdf) The wording in some of the definitions has been slightly changed from the original reference to make them more directly relevant to the CompHP Project

Capacity Building: an approach to the development of sustainable skills, organisational structures, resources and commitment to health improvement in health and other sectors. (21)

Competencies: a combination of attributes such as knowledge, abilities, skills and attitudes which enable an individual to perform a set of tasks to an appropriate standard. (16)

Competencies as described in health promotion literature:

- Refer not only to the knowledge, but also to the skills and attitudes needed to produce a performance
- Focus on *doing* and *acting* so that a competent person not only knows something, but also knows how to do something with what they know
- Have to do with the capacity to face new contexts and respond to new challenges. (22)

Consensus: means overwhelming agreement. It is important that consensus be the product of a good-faith effort to meet the interests of all stakeholders. The key indicator of whether or not a consensus has been reached is that everyone agrees they can live with the final proposal after every effort has been made to meet any outstanding interests. Most consensus processes seek unanimity, but settle for overwhelming agreement that goes as far as possible toward meeting the interests of all stakeholders. It is absolutely crucial that this definition of success be clear at the outset of the process. (23)

Consultation: a tool for managing two-way communications between project developers and stakeholders. The goal is to improve decision-making, reduce risk, and build understanding by actively involving individuals, groups and organisations with a stake in the project. Their involvement increases the project's long-term viability and enhances its benefits to stakeholders. To be meaningful, consultation should be carried out in a culturally appropriate manner, with locally appropriate timeframes. (24)

Continuing professional development (CPD): refers to study designed to upgrade knowledge and skills of practitioners in the professions. (25)

Core competencies: are the minimum sets of competencies that constitute a common baseline for all health promotion roles. They are what all health promotion practitioners are

expected to be capable of doing to work efficiently, effectively and appropriately in the field. (17)

Delphi Method/technique: is an iterative process used to collect and distil the judgments of experts using a series of questionnaires interspersed with feedback. Each subsequent questionnaire is developed based on the results of the previous questionnaire. The Delphi method is widely accepted throughout the world in many sectors including health care, defence, business, education, information technology and engineering. (26)

Experts: people who have an above average knowledge in a specific field of significance. They usually have experience, training, education, and/or an enthusiasm for the subject being explored. (27)

Inequity/Inequality: The concept of **inequity** has been considered synonymous with the concept of **inequality**; however, while inequality implies differences between individuals or population groups, inequity refers to differences which are unnecessary and avoidable but, in addition, are also considered unfair and unjust. Not all inequalities are unjust, but all inequities are the product of unjust inequalities. The definitions of *just* and *unjust* are subject to various interpretations. In the context of health, one of the more accepted definitions of "just" refers to equal opportunities for individuals and social groups, in terms of granting access to and using the health services, in accordance with the needs of the various groups of a population, regardless of their ability to pay. (28)

Partner: the individual and/or organisation with which one collaborates to achieve mutually agreed upon objectives. (24)

Partnership: a collaborative relationship of individuals and/or organisations within which partners set aside personal or organisational agendas to achieve the agenda of the partnership. In a partnership, the partners engage as equals in the decision-making process. In effective partnerships, partners share a vision, are committed to the integrity of the partnership, agree on specific goals, and develop a plan of action to accomplish the goals. (29)

Stakeholder: those groups or individuals: (a) that can reasonably be expected to be significantly affected by the project's activities, products, and/or services; or (b) whose actions can reasonably be expected to affect the ability of the project to successfully implement its strategies and achieve its objectives. They can be an individual, community or organisation that affects, or is affected by, the operations of the project. Stakeholders may be individuals, interest groups, government agencies, or corporate organisations. (24)

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