FOR REFERENCE ONLY

REPORTS OF HEALTH PROMOTION MEETINGS

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Sundsvall Statement on Supportive Environments for Health

Third International Conference on Health Promotion, Sundsvall, Sweden, 9-15 June 1991

The Third International Conference on Health Promotion: Supportive Environments for Health - the Sundsvall Conference - fits into a sequence of events which began with the commitment of WHO to the goals of Health For All (1977). This was followed by the UNICEF/WHO International Conference on Primary Health Care, in Alma-Ata (1978), and the First International Conference on Health Promotion in Industrialized Countries (Ottawa 1986). Subsequent meetings on Healthy Public Policy, (Adelaide 1988) and a Call for Action: Health Promotion in Developing countries, (Geneva 1989) have further clarified the relevance and meaning of health promotion. In parallel with these developments in the health arena, public concern over threats to the global environment has grown dramatically. This was clearly expressed by the World Commission on Environment and Development in its report Our Common Future, which provided a new understanding of the imperative of sustainable development.

Third International Conference on Health Promotion: Supportive Environments for Health - the first global conference on health promotion, with participants from 81 countries - calls upon people in all parts of the world to actively engage in making environments more supportive to health. Examining today's health and environmental issues together, the Conference points out that millions of people are living in extreme poverty and deprivation in an increasingly degraded environment that threatens their health, making the goal of Health For All by the Year 2000 extremely hard to achieve. The way forward lies in making the environment - the physical environment, the social and economic environment, and the political environment - supportive to health rather than damaging to it.

This call for action is directed towards policy-makers and decision- makers in all relevant sectors and at all levels. Advocates and activists for health, environment and social justice are urged to form a broad alliance towards the common goal of Health for All. We Conference participants have pledged to take this message back to our communities, countries and governments to initiate action. We also call upon the organizations of the United Nations system to strengthen their cooperation and to challenge each other to be truly committed to sustainable development and equity.

A Call for Action

A supportive environment is of paramount importance for health. The two are interdependent and inseparable. We urge that the achievement of both be made central objectives in the setting of priorities for development, and be given precedence in resolving competing interests in the everyday management of government policies. Inequities are reflected in a widening gap in health both within our nations and between rich and poor countries. This is unacceptable. Action to achieve social justice in health is urgently needed. Millions of people are living in extreme poverty and deprivation in an increasingly degraded environment in both urban and rural areas. An unforeseen and alarming number of people suffer from the tragic consequences for health and well-being of armed conflicts.

Rapid population growth is a major threat to sustainable development. People must survive without clean water, adequate food, shelter or sanitation.

Poverty frustrates people's ambitions and their dreams of building a better future, while limited access to political structures undermines the basis for self-determination. For many, education is unavailable or insufficient, or, in its present forms, fails to enable and empower.

Millions of children lack access to basic education and have little hope for a better future. Women, the majority of the world's population, are still oppressed. They are sexually exploited and suffer from discrimination in the labour market and many other areas, preventing them from playing a full role in creating supportive environments. More than a billion people worldwide have inadequate access to essential health care. Health care systems undoubtedly need to be strengthened. The solution to these massive problems lies in social action for health and the resources and creativity of individuals and their communities. Releasing this potential requires a fundamental change in the way we view our health and our environment, and a clear, strong political commitment to sustainable health and environmental policies. The solutions lie beyond the traditional health system.

Initiatives have to come from all sectors that can contribute to the creation of supportive environments for health, and must be acted upon by people in local communities, nationally by government and nongovernmental organizations, and globally through international organizations. Action will predominantly involve such sectors as education, transport, housing and urban development, industrial production and agriculture.

The Sundsvall Conference identified many examples and approaches for creating supportive environments that can be used by policy-makers, decision-makers and community activists in the health and environment sectors. The Conference recognized that everyone has a role in creating supportive environments for health.

Dimensions of Action on Supportive Environments for Health

In a health context the term supportive environments refers to both the physical and the social aspects of our surroundings. It encompasses where people live, their local community, their home, where they work and play. It also embraces the framework which determines access to resources for living, and opportunities for empowerment. Thus action to create supportive environments has many dimensions: physical, social, spiritual, economic and political. Each of these dimensions is inextricably linked to the others in a dynamic interaction. Action must be coordinated at local, regional, national and global levels to achieve solutions that are truly sustainable.

The Conference highlighted four aspects of supportive environments:

- The social dimension, which includes the ways in which norms, customs and social processes affect health. In many societies traditional social relationships are changing in ways that threaten health, for example, by increasing social isolation, by depriving life of a meaningful coherence and purpose, or by challenging traditional values and cultural heritage.
- The political dimension, which requires governments to guarantee democratic participation in decision-making and the decentralization of responsibilities and resources. It also requires a commitment to human rights, peace, and a shifting of resources from the arms race.
- The economic dimension, which requires a re-channelling of resources for the achievement of Health for All and sustainable development, including the transfer of safe and reliable technology.
- The need to recognize and use women's skills and knowledge in all sectors - including policy-making, and the economy - in order to develop a more positive infrastructure for supportive environments. The burden of the workload of women should be recognized and shared between men and women. Women's community-based organizations must have a stronger voice in the development of health promotion policies and structures.

Proposals for Action

The Sundsvall Conference believes that proposals to implement the Health for All strategies must reflect two basic principles:

1. Equity must be a basic priority in creating supportive environments for health, releasing energy and creative power by including all human beings in this unique endeavour. All policies that aim at sustainable development must be subjected to new types of accountability

procedures in order to achieve an equitable distribution of responsibilities and resources. All action and resource allocation must be based on a clear priority and commitment to the very poorest, alleviating the extra hardship borne by the marginalized, minority groups, and people with disabilities. The industrialized world needs to pay the environmental and human debt that has accumulated through exploitation of the developing world.

2. Public action for supportive environments for health must recognize the interdependence of all living beings, and must manage all natural resources, taking into account the needs of future generations. Indigenous peoples have a unique spiritual and cultural relationship with the physical environment that can provide valuable lessons for the rest of the world. It is essential, therefore, that indigenous peoples be involved in sustainable development activities, and negotiations be conducted about their rights to land and cultural heritage.

It Can be Done: Strenghthening Social Action

A call for the creation of supportive environments is a practical proposal for public health action at the local level, with a focus on settings for health that allow for broad community involvement and control. Examples from all parts of the world were presented at the Conference in relation to education, food, housing, social support and care, work and transport. They clearly showed that supportive environments enable people to expand their capabilities and develop self-reliance. Further details of these practical proposals are available in the Conference report and handbook.

Using the examples presented, the Conference identified four key public health action strategies to promote the creation of supportive environments at community level.

1. Strengthening advocacy through community action, particularly through groups organized by women.
2. Enabling communities and individuals to take control over their health and environment through education and empowerment.
3. Building alliances for health and supportive environments in order to strengthen the cooperation between health and environmental campaigns and strategies.
4. Mediating between conflicting interests in society in order to ensure equitable access to supportive environments for health. In summary, empowerment of people and community participation were seen as essential factors in a democratic health promotion approach and the driving force for self-reliance and development.

Participants in the Conference recognized, in particular, that education is a basic human right and a key element in bringing about the political, economic and social changes needed to make health a possibility for all. Education should be accessible throughout life and be built on the principle of equity, particularly with respect to culture, social class and gender.

The Global Perspective

People form an integral part of the earth's ecosystem. Their health is fundamentally interlinked with the total environment. All available information indicates that it will not be possible to sustain the quality of life, for human beings and all living species, without drastic changes in attitudes and behaviour at all levels with regard to the management and preservation of the environment.

Concerted action to achieve a sustainable, supportive environment for health is the challenge of our times.

At the international level, large differences in per capita income lead to inequalities not only in access to health but also in the capacity of societies to improve their situation and sustain a decent quality of life for future generations. Migration from rural to urban areas drastically increases the number of people living in slums, with accompanying problems - including lack of clean water and sanitation.

Political decision-making and industrial development are too often based on short-term planning and economic gains which do not take into account the true costs to people's health and the environment. International debt is seriously draining the scarce resources of the poor countries. Military expenditure is increasing, and war, in addition to causing deaths and disability, is now introducing new forms of ecological vandalism.

Exploitation of the labour force, the exportation and dumping of hazardous substances, particularly in the weaker and poorer nations, and the wasteful consumption of world resources all demonstrate that the present approach to development is in crisis. There is an urgent need to advance towards new ethics and global agreement based on peaceful coexistence to allow for a more equitable distribution and utilization of the earth's limited resources.

Achieving Global Accountability

1. The Sundsvall Conference calls upon the international community to establish nw mechanisms of health and ecological accountability that build upon the principles of sustainable health development. In practice this requires health and environmental impact statements for major policy and programme initiatives. WHO and UNEP are

urged to strengthen their efforts to develop codes of conduct on the trade and marketing of substances and products harmful to health and the environment.

WHO and UNEP are urged to develop guidelines based on the principle of sustainable development for use by Member States. All multilateral and bilateral donor and funding agencies such as the World Bank and International Monetary Fund are urged to use such guidelines in planning, implementing and assessing development projects. Urgent action needs to be taken to support developing countries in identifying and applying their own solutions. Close collaboration with nongovernmental organizations should be ensured throughout the process.

The Sundsvall Conference has again demonstrated that the issues of health, environment and human development cannot be separated. Development must imply improvement in the quality of life and health while preserving the sustainability of the environment. Only worldwide action based on global partnership will ensure the future of our planet.

Document resulting from the Third International Conference on Health Promotion* 9-15 June 1991, Sundsvall, Sweden

*Co-sponsored by the United Nations Environment Programme, the Nordic Council of Ministers, and the World Health Organization

Adelaide Recommendations on Healthy Public Policy

Second International Conference on Health Promotion, Adelaide, South Australia, 5-9 April 1998

The adoption of the Declaration of Alma-Ata a decade ago was a major milestone in the Health for All movement which the World Health Assembly launched in 1977. Building on the recognition of health as a fundamental social goal, the Declaration set a new direction for health policy by emphasizing people's involvement, cooperation between sectors of society and primary health care as its foundation.

The Spirit of Alma-Ata

The spirit of Alma-Ata was carried forward in the Charter for Health Promotion which was adopted in Ottawa in 1986. The Charter set the challenge for a move towards 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:

- build Healthy Public Policy,
- create supportive environments,
- develop personal skills,
- strengthen community action, and
- reorient health services.

These actions are interdependent, but healthy public policy establishes the environment that makes the other four possible.

The Adelaide Conference on Healthy Public Policy continued in the direction set at Alma-Ata and Ottawa, and built on their momentum. Two hundred and twenty participants from forty-two countries shared experiences in formulating and implementing healthy public policy. The following recommended strategies for healthy public policy action reflect the consensus achieved at the Conference.

Healthy Public Policy

Healthy public policy is characterized by an explicit concern for health and equity in all areas of policy and by an accountability for health impact. The main aim of health public policy is to create a supportive environment to enable people to lead healthy lives. Such a policy makes

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health choices possible or easier for citizens. It makes social and physical environments health-enhancing. In the pursuit of healthy public policy, government sectors concerned with agriculture, trade, education, industry, and communications need to take into account health as an essential factor when formulating policy. These sectors should be accountable for the health consequences of their policy decisions. They should pay as much attention to health as to economic considerations.

The value of health

Health is both a fundamental human right and a sound social investment. Governments need to invest resources in healthy public policy and health promotion in order to raise the health status of all their citizens. A basic principle of social justice is to ensure that people have access to the essentials for a healthy and satisfying life. At the same time, this raises overall societal productivity in both social and economic terms. Healthy public policy in the short term will lead to long-term economic benefits as shown by the case studies presented a this Conference. New efforts must be made to link economic, social, and health policies into integrated action.

Equity, access and development

Inequalities in health are rooted in inequities in society. Closing the health gap between socially and educationally disadvantaged people and more advantaged people requires a policy that will improve access to health-enhancing goods and services, and create supportive environments. Such a policy would assign high priority to underprivileged and vulnerable groups. Furthermore, a healthy public policy recognizes the unique culture of indigenous peoples, ethnic minorities, and immigrants. Equal access to health services, particularly community health care, is a vital aspect of equity in health.

New inequalities in health may follow rapid structural change caused by emerging technologies. The first target of the European Region of the World Health Organization, in moving towards Health for All is that:

"by the year 2000 the actual differences in health status between countries and between groups within countries should be reduced by at least 25% by improving the level of health of disadvantaged nations and groups."

In view of the large health gaps between countries, which this Conference has examined, the developed countries have an obligation to ensure that their own policies have a positive health impact on developing nations. The Conference recommends that all countries develop healthy public policies that explicitly address this issue.

Accountability for Health

The recommendations of this Conference will be realized only if governments at national, regional and local levels take action. The development of healthy public policy is as important at the local levels of government as it is nationally. Governments should set explicit health goals that emphasize health promotion.

Public accountability for health is an essential nutrient for the growth of healthy public policy. Governments and all other controllers of resources are ultimately accountable to their people for the health consequences of their policies, or lack of policies. A commitment to healthy public policy means that governments must measure and report the health impact of their policies in language that all groups in society readily understand. Community action is central to the fostering of healthy public policy. Taking education and literacy into account, special efforts must be made to communicate with those groups most affected by the policy concerned.

The Conference emphasizes the need to evaluate the impact of policy. Health information systems that support this process need to be developed. This will encourage informed decision-making over the future allocation of resources for the implementation of healthy public policy.

Moving beyond health care

Healthy public policy responds to the challenges in health set by an increasingly dynamic and technologically changing world, with is complex ecological interactions and growing international interdependencies. Many of the health consequences of these challenges cannot be remedied by present and foreseeable health care. Health promotion efforts are essential, and these require an integrated approach to social and economic development which will reestablish the links between health and social reform, which the World Health Organization policies of the past decade have addressed as a basic principle.

Partners in the policy process

Government plays an important role in health, but health is also influenced greatly by corporate and business interests, nongovernmental bodies and community organizations. Their potential for preserving and promoting people's health should be encouraged. Trade unions, commerce and industry, academic associations and religious leaders have many opportunities to act in the health interests of the whole community. New alliances must be forged to provide the impetus for health action.

Action Areas

The Conference identified four key areas as priorities for health public policy for immediate

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action:

Supporting the health of women

Women are the primary health promoters all over the world, and most of their work is performed without pay or for a minimal wage. Women's networks and organizations are models for the process of health promotion organization, planning and implementation. Women's networks should receive more recognition and support from policy-makers and established institutions. Otherwise, this investment of women's labour increases inequity. For their effective participation in health promotion women require access to information, networks and funds. All women, especially those from ethnic, indigenous, and minority groups, have the right to self-determination of their health, and should be full partners in the formulation of healthy public policy to ensure its cultural relevance.

This Conference proposes that countries start developing a national women's healthy public policy in which women's own health agendas are central and which includes proposals for:

- equal sharing of caring work performed in society;
- birthing practices based on women's preferences and needs;
- supportive mechanisms for caring work, such as support for mothers with children,
- parental leave, and dependent health-care leave.

Food and nutrition

The elimination of hunger and malnutrition is a fundamental objective of healthy public policy. Such policy should guarantee universal access to adequate amounts of healthy food in culturally acceptable ways. Food and nutrition policies need to integrate methods of food production and distribution, both private and public, to achieve equitable prices. A food and nutrition policy that integrates agricultural, economic, and environmental factors to ensure a positive national and international health impact should be a priority for all governments. The first stage of such a policy would be the establishment of goals for nutrition and diet. Taxation and subsidies should discriminate in favour of easy access for all to healthy food and an improved diet.

The Conference recommends that governments take immediate and direct action at all levels to use their purchasing power in the food market to ensure that the food-supply under their specific control (such as catering in hospitals, schools, day-care centres, welfare services and workplaces) gives consumers ready access to nutritious food.

Tobacco and alcohol

The use of tobacco and the abuse of alcohol are two major health hazards that deserve immediate action through the development of healthy public policies. Not only is tobacco directly injurious to the health of the smoker but the health consequences of passive smoking, especially to infants, are now more clearly recognized than in the past. Alcohol contributes to social discord, and physical and mental trauma. Additionally, the serious ecological consequences of the use of tobacco as a cash crop in impoverished economies have contributed to the current world crises in food production and distribution.

The production and marketing of tobacco and alcohol are highly profitable activities - especially to governments through taxation. Governments often consider that the economic consequences of reducing the production and consumption of tobacco and alcohol by altering policy would be too heavy a price to pay for the health gains involved.

This Conference calls on all governments to consider the price they are paying in lost human potential by abetting the loss of life and illness that tobacco smoking and alcohol abuse cause.

Governments should commit themselves to the development of healthy public policy by setting nationally-determined targets to reduce tobacco growing and alcohol production, marketing and consumption significantly by the year 2000.

Creating supportive environments

Many people live and work in conditions that are hazardous to their health and are exposed to potentially hazardous products. Such problems often transcend national frontiers.

Environmental management must protect human health from the direct and indirect adverse effects of biological, chemical, and physical factors, and should recognize that women and men are part of a complex ecosystem. The extremely diverse but limited natural resources that enrich life are essential to the human race. Policies promoting health can be achieved only in an environment that conserves resources through global, regional, and local ecological strategies.

A commitment by all levels of government is required. Coordinated intersectoral efforts are needed to ensure that health considerations are regarded as integral prerequisites for industrial and agricultural development. At an international level, the World Health Organization should play a major role in achieving acceptance of such principles and should support the concept of sustainable development.

This Conference advocates that, as a priority, the public health and ecological movements join together to develop strategies in pursuit of socioeconomic development and the conservation of our planet's limited resources.

Developing New Health Alliances

The commitment to healthy public policy demands an approach that emphasizes consultation and negotiation. Healthy public policy requires strong advocates who put health high on the agenda of policy-makers. This means fostering the work of advocacy groups and helping the media to interpret complex policy issues.

Educational institutions must respond to the emerging needs of the new public health by reorienting existing curricula to include enabling, mediating, and advocating skills. There must be a power shift from control to technical support in policy development. In addition, forums for the exchange of experiences at local, national and international levels are needed.

The Conference recommends that local, national and international bodies:

- establish clearing-houses to promote good practice in developing healthy public policy;
- develop networks of research workers, training personnel, and programme managers to help analyse and implement healthy public policy.

Commitment to Global Public Health

Prerequisites for health and social development are peace and social justice; nutritious food and clean water; education and decent housing; a useful role in society and an adequate income; conservation of resources and the protection of the ecosystem. The vision of healthy public policy is the achievement of these fundamental conditions for healthy living. The achievement of global health rests on recognizing and accepting interdependence both within and between countries. Commitment to global public health will depend on finding strong means of international cooperation to act on the issues that cross national boundaries.

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This Conference calls on all governments to consider the price they are paying in lost human potential by abetting the loss of life and illness that tobacco smoking and alcohol abuse cause.

Governments should commit themselves to the development of healthy public policy by setting nationally-determined targets to reduce tobacco growing and alcohol production, marketing and consumption significantly by the year 2000.

Creating supportive environments

Many people live and work in conditions that are hazardous to their health and are exposed to potentially hazardous products. Such problems often transcend national frontiers.

Environmental management must protect human health from the direct and indirect adverse effects of biological, chemical, and physical factors, and should recognize that women and men are part of a complex ecosystem. The extremely diverse but limited natural resources that enrich life are essential to the human race. Policies promoting health can be achieved only in an environment that conserves resources through global, regional, and local ecological strategies.

A commitment by all levels of government is required. Coordinated intersectoral efforts are needed to ensure that health considerations are regarded as integral prerequisites for industrial and agricultural development. At an international level, the World Health Organization should play a major role in achieving acceptance of such principles and should support the concept of sustainable development.

This Conference advocates that, as a priority, the public health and ecological movements join together to develop strategies in pursuit of socioeconomic development and the conservation of our planet's limited resources.

Developing New Health Alliances

The commitment to healthy public policy demands an approach that emphasizes consultation and negotiation. Healthy public policy requires strong advocates who put health high on the agenda of policy-makers. This means fostering the work of advocacy groups and helping the media to interpret complex policy issues.

Educational institutions must respond to the emerging needs of the new public health by reorienting existing curricula to include enabling, mediating, and advocating skills. There must be a power shift from control to technical support in policy development. In addition, forums for the exchange of experiences at local, national and international levels are needed.

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Commitment to Global Public Health

Prerequisites for health and social development are peace and social justice; nutritious food and clean water; education and decent housing; a useful role in society and an adequate income; conservation of resources and the protection of the ecosystem. The vision of healthy public policy is the achievement of these fundamental conditions for healthy living. The achievement of global health rests on recognizing and accepting interdependence both within and between countries. Commitment to global public health will depend on finding strong means of international cooperation to act on the issues that cross national boundaries.

Future Challenges

1. Ensuring an equitable distribution of resources even in adverse economic circumstances is a challenge for all nations.
2. Health for All will be achieved only if the creation and preservation of healthy living and working conditions become a central concern in all

public policy decisions. Work in all its dimensions - caring work, opportunities for employment, quality of working life - dramatically affects people's health and happiness. The impact of work on health and equity needs to be explored.

3. The most fundamental challenge for individual nations and international agencies in achieving healthy public policy is to encourage collaboration (or developing partnerships) in peace, human rights and social justice, ecology, and sustainable development around the globe.
4. In most countries, health is the responsibility of bodies at different political levels. In the pursuit of better health it is desirable to find new ways for collaboration within and between these levels.
5. Healthy public policy must ensure that advances in health-care technology help, rather than hinder, the process of achieving improvements in equity.

The Conference strongly recommends that the World Health Organization continue the dynamic development of health promotion through the five strategies described in the Ottawa Charter. It urges the World Health Organization to expand this initiative throughout all its regions as an integrated part of its work. Support for developing countries is at the heart of this process.

Renewal of Commitment

In the interests of global health, the participants at the Adelaide Conference urge all concerned to reaffirm the commitment to a strong public health alliance that the Ottawa Charter called for.

EXTRACT FROM THE REPORT ON THE ADELAIDE CONFERENCE * HEALTHY PUBLIC POLICY, 2nd International Conference on Health Promotion April 5-9, 1988 Adelaide South Australia

* Co-sponsored by the Department of Community Services & Health, Canberra, Australia and the World Health Organization Regional Office for Europe, Copenhagen, Denmark.

New Players for a New Era

Leading Health Promotion into the 21st Century

4th International Conference on Health Promotion
Jakarta, Indonesia 21-25 July 1997

Conference Report

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Annexes

Foreword

The Fourth International Conference on Health Promotion: 'New Players for a New Era - Leading Health Promotion into the Twenty-first Century', Jakarta, 21-25 July 1997

The spirit of Alma-Ata was carried forward in the Ottawa Charter developed at the First International Conference on Health Promotion (1986) in Ottawa, Canada. The Ottawa Charter, with its five independent action areas, has since served as the blue print for health promotion worldwide. The subsequent Second and Third International Conferences on Health Promotion in Adelaide, Australia (1988) and in Sundsvall, Sweden (1991), examined two major action strategies of health promotion, resulting in the adoption of the Adelaide Recommendations on Healthy Public Policy and the Sundsvall Statement on Supportive Environments.

The Fourth International Conference on Health Promotion was the first to be held in a developing region. It provided the opportunity to exchange experiences, for developing and developed countries to share and to learn from each other. In view of the major changes which have taken place since the Ottawa Conference in 1986, it provided the opportunity to evaluate the impact of health promotion globally and its priorities in today's world.

It is essential to review and evaluate the impact of health promotion globally, to take stock, to provide vision as to the most desirable future scenarios for world health and to try and identify the approaches, partnerships and alliances which will be required to achieve the desired goal.

Consequently, the Jakarta Conference had three objectives:

a) to review and evaluate the impact of health promotion;
b) to identify innovative strategies to achieve success in health promotion; and
c) to facilitate the development of partnerships in health promotion to meet the global health challenges.

Preparations for the Conference, which formed the central focus in 1997 of the WHO Five-Year Plan for health promotion, served as a catalyst to stimulate action in capacity build capacity for health promotion at local, national and international levels in both developing and developed countries. A series of planned preparatory activities were carried out jointly with the WHO Regional Offices and/or through WHO Collaborating Centers and NGOs in all regions, including intercountry meetings, workshops, and consultations.

These preparations contributed to three major inputs, each addressing one of the specific Conference objectives, namely: I) review and evaluation track; II) scenario/futures track; III) partnership track.

I) The review and evaluation track was developed following a global literature analysis of all evaluated health promotion and education projects. Case studies, published or unpublished, on successful health education and health promotion action were collected and analyzed on a region by region basis through specially appointed focal points. The overall state of health promotion research was reviewed. A number of WHO Collaborating Centers held symposia on the effectiveness of health promotion and prepared papers on health promotion evaluation and research. The results of these efforts provided convincing evidence that health promotion strategies can develop and change lifestyles, and have an impact on the social, economic and environmental

conditions, that determine health (a book with selected papers is available as part of proceedings).

II) The scenario/futures track provided a set of health promotion futures papers and practical guidelines in scenario development. Guidelines for developing scenarios and a global scenario for health promotion in 2020 were specially prepared. Detailed review for health promotion futures in selected topics areas were also prepared, including health promoting schools, workplace health promotion, tobacco free society, ageing and health, sexual health, women's health, healthy cities, and food and nutrition.

III) The third input was on building partnerships for which a series of five papers were prepared outlining the possible way forward, including one on partnerships for health in the 21st Century, and a working paper on partnerships for health promotion. Also, a series of six specific issue papers were prepared for review at the conference as part of the health promoting school global initiative.

The Jakarta Declaration confirmed the five action areas of the Ottawa Charter :

- build healthy public policy;
- create supportive environments;
- strengthen community action;
- develop personal skills;
- reorient health services.

Research and case studies from around the world provided convincing evidence that health promotion is effective and confirmed its continuing validity and relevance. It placed health promotion at the centre of health development. In calling for a global alliance it widened the emphasis to include all sectors of society to work together for the health and well-being of all peoples and societies. The Jakarta Declaration set out the global priorities for health promotion as we enter the new century - health promotion is a key investment.
The success of the 4 ICHP is due to the active contribution of many, the host country, WHO, HQ and the Regional Offices, WR Country Offices, WHO CCs, UN, IGOs and NGOs.

Special gratitude is extended to all; to the countries, institutions and bodies whose support enabled the Conference to take place and assistance to be given to many participants who would otherwise have been able to attend. We are most grateful to all who have contributed to this collective global effort.

Since the Jakarta Conference there has been active follow-up. In May 1998 the World Health Assembly (WHA) has passed the first ever Resolution on Health Promotion confirming the priorities as identified in the Jakarta Declaration and to report back to the WHA in two years time on the progress achieved. This challenge has now to be met.

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Fourth International Conference on Health Promotion
Report

Conference Format

The Fourth International Conference on Health Promotion (4ICHP) took place in Jakarta, it was the first in the series to be hosted by a country from the South, with a majority of participants coming from the South. But this was not the only thing that made *'Jakarta'* unique. It was the first conference of the four to deal with three *different* but intricately connected themes:

- The Conference was to review critically the achievements in the area of health promotion since the adoption of the Ottawa Charter;
- The meeting was to explore possibilities and commitments towards the involvement of new players in partnerships and alliances for health promotion;
- It was to formulate the challenges that are ahead of us, as well as the responses and strategies which health promoters in their partnerships and alliances could employ.

First Truly Global Health Promotion

Achievements
Partnerships
Strategies

These objectives made the conference very much a working meeting. Plenaries provided food for thought, to be expressed in a daily symposia series. Morning plenary sessions were followed by *'Leading Change'* symposia in which insights on new work styles, health promotion skills, the economics of health promotion, ethical conduct, new technologies and much more were shared. In this report, *'Leading Change'* symposia will not be reported on, as they were conceived to be training-like sessions; information on sessions can be obtained through their facilitators. Further, networking time was scheduled every day in order to facilitate further exchange around themes felt important to participants; every late afternoon participants were found all over the conference venue, involved in debates. The core of the conference process was found in *'Partnership in Action'* symposia, which will be reported on below.

Indonesia Day on Health Promotion

The centre of the programme was constituted by *Indonesia Day*, during which the host country's health promotion policy was unveiled and national and local health promotion programmes were presented. Indonesia has committed itself formally to the theme of the conference, and presented an overview of the most innovative health programmes in the country.

The commitments formulated around the above-mentioned themes were ultimately reflected in the *Jakarta Declaration*, the development of which was a continuous participatory process throughout the conference.

Structure of the Report

Rather than following the structure of the conference, this part of the report takes a more evolutionary perspective. The next section describes developments that made a 4ICHP on *'New Players for a New Era'* timely. It contains a review of political and scientific advances in the field.

The *'Where are We Now?'* section takes stock of the current state of health promotion in settings, contexts and stages of life. *'The Road Ahead'* takes an overall view of health promotion challenges in the new era, supplemented by findings of a second set of Symposia on contexts and settings. Partnerships are dealt with in the subsequent section: *'With Whom do we Travel?'*. The *'Conclusion'* deals with health promotion tradition, future challenges, evidence of health promotion working, and partnership issues.

Throughout the report, the global commitment to health promotion in the next millennium will become obvious. In *'A Global Commitment'* representatives of some of the major political global constellations will be presented.

The Road to Jakarta

'Jakarta' should be viewed in the context of a health promotion development process that was started with the adoption of the *Ottawa Charter* in 1986. This conference was followed in 1989 by a conference in Adelaide dealing with *Healthy Public Policy*. The third international conference on health promotion dealt with *Supportive Environments for Health*, and was organised in Sundsvall, 1991.

Dynamic forward-looking development

The Fourth Conference is not only significant because we are on the brink of the next millennium (a symbolic threshold which stimulates the imagination), but also because the world seems to be changing at an ever increasing pace.

Neither of the above developments can be separated from the context of *Primary Health Care* (Alma Ata, 1978) and the rejuvenated strategy *Health for All by the Year 2000*. These major initiatives constitute a strong global commitment to public health.

Particularly globalization of communication, trade, and norms and values was referred to by many as being the most recent challenges. The WHO/SEARO Regional Director (Dr Uton Muchtar Rafei) said during the very first plenary session that *'the New Era has already begun.'*

Globalization of communication, trade, norms and values

Two leading policy makers also took stock of the advances of health promotion in the changing context of their countries. Mr I. Potter (Assistant Deputy Minister for Health) demonstrated the Canadian commitment to working on prerequisites for health (particularly the distribution of wealth), and the need for intersectoral collaboration in the development of healthy public policy. And even though economically adverse conditions abound, health promotion has been growing. Hungarian Minister for Health Dr M. Kökeny also dealt with economic and political changes. He explained that the launch of the Ottawa Charter, in 1986, came both too early and too late for his country. Because of a deteriorating economy, health promotion at that time was not

perceived to be feasible; once the former socialist block (1990) had disappeared, it seemed that health promotion could no longer claim a place on the political agenda. Yet, in spite of a decrease in GDP and the actions driven by market forces, health promotion is back on the agenda. Health Promoting Schools and Healthy Cities are very much integrated in the Hungarian health domain.

Mr J. Mullen, of the 'Private Sector for Health Promotion', suggested that indeed the conference was a landmark, acknowledging the important contributions that the private sector has already made and will make in the future. He showed that the private sector is already collaborating intensively with the health sector in a number of regions. Further global partnerships can be developed, he asserted.

A review of the effectiveness of alliances and partnerships for health promotion presented by Prof P. Gillies (Health Education Authority, London) examined evidence of the success of health promotion. Two approaches to the study were chosen: a literature review using bibliographies of peer-reviewed journals, and snowball sampling through a network of global focal point consultants who were asked to provide further case studies.

Significant behaviour change. Yet: more emphasis on *'Social Capital'* in studies

Following a validated search protocol, 16 randomised controlled trials, 15 comparison studies, and 12 pre-post test evaluations were found. They generally reflected a narrow focus on behaviour change alone, although some highlighted process and policy development outcomes. The focal point consultants provided a further 46 examples of health promotion alliances and partnership programmes. These were predominantly from developing regions in the world.

Significant health behaviour change has been reported. The concept of 'social capital' would potentially add a crucial dimension to the understanding of social influences on health, and would take into account the broader contexts in which health is produced. The approach would focus attention on the mechanisms connecting people with public institutions and with power at local level. The idea of social capital may therefore have much to offer to health promotion research in future, particularly those studies that aim to understand and evaluate the impact of alliances or partnerships for health promotion.

Where Are We Now?

The Monday series of Symposia was to take stock of health promotion developments in a number of settings, contexts and stages of life, important for the further development of the realm. In this section these developments are being summarised; a conclusion will lead into responses to future challenges in these areas.

Settings, contexts and stages of life

Healthy Cities/villages/islands/communities

Being started as a health promotion demonstration project in the European Region of WHO in 1986, the Healthy Cities initiative is now an established global movement. Three case studies were presented, from Kuching (Malaysia), Queensland (Australia), and Samoa. One of the very first agreements the participants established was that *'Healthy City'* is the catch phrase for a wide variety of health promotion programmes related to larger scale contained living arrangements. Therefore, healthy islands, communities, and villages -in spite of their unique social and geographic set-ups- would all fall under the one slogan. The approach has become an umbrella for many other setting approaches, e.g. in schools, hospitals and market places. It contributes to the establishment of high quality physical infrastructures, psychosocial environment, and sustainability of health action. It effectively combines the 'art' and 'science' dimensions of public health, linking ideas, visions, political commitment and social entrepreneurship to the management of resources, methods for infrastructure development, and the establishment of procedures to respond to community needs. Intersectoral work is an integral part of the movement, with many partnerships already in place.

Link ideas, visions, political commitment and social entrepreneurship to health

Nevertheless, further strategic considerations and evaluations on capacity building (including political commitment), process development and implementation and outcome measures will be as crucial in the future as they are now.

Whatever the size of the target population (be they inhabitants of mega-cities or of small islands), the importance of action at the local level is identified as essential.

Health Promoting Schools

Schooling is of course one of the best investments in the future. National and international experiences now show that schools provide also the best opportunities for investment in health. Examples from China, India, Russia, USA, Indonesia, Bangladesh, Pakistan, most European countries including Romania, Zimbabwe, Thailand, Samoa, Australia, Brazil, and Sri Lanka showed the immense potential that schools have in comprehensive health promotion. Collaboration between schools and local health services, with parents and local communities, with teachers also becoming aware of health issues,

The best investment in the future

with pupils, through intergenerational activities, and with professional sports associations or the food industry shows that the concept is easy to apply, stirs the imagination in and beyond schools, and has both direct benefits as well as longer-term health benefits. Some direct benefits are improvement of the overall curriculum and active student participation in both curricular and extra-curricular activities. Also, Health Promoting Schools offer a comprehensive package of behavioural and structural interventions that is most appropriate for children in school-ages. Even children not in school, as evidence from Samoa and India demonstrates, could well be reached through the programme.
The major strength of, Networks of Health Promoting Schools, is its network building, the designation of national focal points, involvement of experts in the field of school health, and the mobilisation of resources at a regional level.

Healthy Workplaces

Workplace health promotion until quite recently seems to have been a largely European and North-American approach. The Conference created an excellent opportunity to take stock of experiences elsewhere in the world.
Two models were considered innovative. A German example was used in more than seventy organisations, nationally and internationally. This 'Health Circle Approach' is based on the availability of problem-solving tools at the management level, but employees decide on need and feasibility of interventions during eight work-time sessions. The approach connects with future-oriented management, is flexible and yet broad in its scope, and is easily implemented on the work floor as it is precisely there where the programme is designed in operational terms.

' If you can't manage safety, you can't manage anything '

Another model was that of accident prevention in Scandinavia, starting at the workplace, but extending to every setting of everyday life. The assumptions were that

- if a company cannot manage safety, it cannot manage anything;
- all accidents can be prevented.

The approach involved industry, the municipality, and the community.
Several other examples were presented during the session, demonstrating that workplace health promotion is a global effort. A notable programme was presented from Shanghai, where a number of factories engaged in innovative approaches to enhance the health and well-being of workers and their communities.
Successful workplace health promotion requires the following:

- The support for programmes by company leadership and top management is essential;
- 'Investment in workers' health is a good investment' is a message that has to be communicated to businesses more unequivocally.
- The community around the workplace must be involved in a coalition with an interest in workplace health promotion; incentives are part of the coalition formation.
- Mental health and stress prevention among workers merits special attention.

Healthy Ageing

Ageing has become a development issue. An ageing population should not be considered a burden on society, but as a challenge and an opportunity. The vast majority of old people

are independent and in good health. They are productive (though not only in economic terms) and contribute to their communities in a variety of ways.

Ageing is a development issue

The healthy ageing message can best be heard by establishing networks. Such networks are interdisciplinary, flexible, informed, and dynamic. Synergy creates an enhanced approach, much better than isolated projects by individual organisations. Evidence now shows that health promotion action could lead to, e.g. sustained or increased levels of physical activity leading to decreased levels of cholesterol and morbidity.

Active Living/Physical Activity

Accumulated scientific evidence shows that daily moderate activity enhances health. Physical activity contributes to mental health, and to the reduction of risks related to, e.g. obesity. Modern lifestyles, however, make it increasingly difficult and provide less and less incentive for people to remain physically active.

Active living should start at an early age, and schools offer in that respect more effective, efficient and equal opportunities than any other setting to get young people interested in physical activity, and enjoy it.

Activity good for mental health

Experiences so far suggest three pathways to successful development and implementation of active living programmes:

- A sound scientific base, providing valid assessment tools, social and clinical diagnoses, and trends in active living;
- Development and evaluation of community interventions, including the joint development of behavioural components, policy development, and the creation of appropriate facilities;
- Effective dissemination and communication of information both to professionals and the general public.

Sexual Health

Sexual health has increasingly become a key public health issue. The HIV/AIDS epidemic has spurred this attention. Recent experiences show that foci on sexual health can build upon the worldwide investments in HIV/AIDS prevention programmes, in order to build a broader sexual health approach. Scandinavian experiences also showed that embedding sexual health issues in social development (e.g. taking into account changing roles of families and women, and integration of sexual health in wider public education programmes) was an example of a successful approach.

Respectful of values

Such an approach would include the following:

- More comprehensive, integrated, culturally specific policies and programmes for sexual health;
- A range of partners will be involved in the establishment and implementation of these policies and programmes;
- 'Openness' (and yet respectful of cultural and religious values of the community) towards sexual health;
- Professional education to avoid judgmental attitudes towards sexuality among health

service providers.

Tobacco free societies

Tobacco use is one of the major threats to health. It is on the increase in most countries from the South, and in Western countries there are examples of youth smoking more, in spite of intensive health education.

The major threat to health

A number of approaches were suggested to deal with the tobacco issue:

- Legislation is of essential importance, but needs to be complemented with
- Public awareness. This can be accomplished by conveying a positive message about tobacco free societies, the marketing of legislation, the formulation and implementation of legislation with a wide range of stakeholders, the need for a phased implementation of smoke-free environments (as people not to adjust), and eliciting support from the mass media;
- Involvement of prime movers (role models, prominent people, etc.);
- Incentives are important in the establishment of behaviour change;
- Community involvement, and mobilisation of a range of partners are essential to the sustainability of programmes;
- Education on a tobacco free society should start at an early stage of life, involving peer pressure and parental support, and;
- Financing of health promotion through tobacco taxes.

Promoting women's health

Women's health remains an issue of considerable concern. Discrimination, unequal opportunities, rape, violence, social taboos and unnecessary medicalization of the female body all create barriers to health.

Stock was taken of a number of projects dealing with training, education and empowerment of women, as well as support of women's health workers. An example from India suggested that empowerment of women, including opportunities for credit and saving and freedom of movement significantly contribute to health status.

Industry: Outstanding Midwives Award

Support of midwives, and gender-specific services, was provided through a number of schemes. They included industry support that recognised the importance of these overworked and underpaid women. The industry established an 'Outstanding Midwives Award', establishing the image of midwifery in the community; two award-winners have now been elected to public office.

A strong need is felt to advocate women's health interests at key international meetings. The Global Alliance on Women's Health is among many organisations doing just that, by producing and dissemination of a compendium containing women's health concerns.

Healthcare: unhealthful conditions

Health promoting healthcare settings

Healthcare settings are not necessarily conducive to health. Waiting lists, occupational stress among staff, and inadequate integration of

health promotion and public health in service delivery create unhealthful conditions.
In order to enhance the health promoting capacities of healthcare settings it is important to involve the community in needs assessments and the quality of service delivery.
A number of initiatives are under way to review and improve conditions conducive to health in healthcare settings, for example the "health promoting hospital-project" not only focussing on patients, but also on health of healthcare staff, patients' families and communities.

Healthy homes/families
Nutrition and safety are among the issues which could be addressed through families and homes. Much has already been learnt from experiences in the past. Health promotion in these settings turns out to be successful if the following considerations are brought together in a comprehensive package:

- a behavioural component through which parents as well as children are reached. Examples are manuals on food, environment and health in Indonesia, and audio-visual materials in the field of mother and child health in Africa. Behavioural components need to be supplemented and supported by
- implementation of programmes through intersectoral work, in which education and training are further enhanced by the provision of facilities, and access to relevant services. Examples include the provision of impregnated mosquito bednets in Africa, in addition to information on the transmission of malaria. However, both health education and facilities need to be
- culture-specific and technologically simple. Boiling of water over wood fires may be appropriate in Indonesia, whereas a country with a critical fuel situation (like Nepal) may follow a different solution to that condition.

Focus on homes

The Road Ahead

The conference clearly stated that the New Era has already begun. Both Dr. Sujudi (Indonesian Minister for Health) and Dr Uton Muchtar Rafei (WHO/SEARO Regional Director) demonstrated that socio-political changes in Indonesia and the region have stimulated new ways of dealing with health. All should be mobilised for health, and respect for and humility in regard to the potential of community action and involvement of new partners for health have become an essential concern.
Dr Boladuadua (Director of Primary & Preventive Health Services of Fiji) described the vast variety of Pacific nations. In spite of a generally perceived emptiness in the Pacific, some countries are facing population pressures. Inequities in health exist within countries and between countries. Most significant, though, is the diversity in health problems. On the one hand, health problems associated with poverty and socioeconomic deprivation are putting a burden on the health care system, whereas in the very same countries diseases of affluence are dominant. The goal of health promotion, therefore, must be to curb both non-communicable disease as well as infectious disease. The development of healthy public policy and the establishment of adequate infrastructures for health promotion is a crucial challenge for the future.

The situation was affirmed by Dr F. Manguyu (President, Medical Women's International Association); diversity is as large in Africa as it is in the Pacific. However, large social unrest, wars, and ethnic and population pressures create complex situations for partnerships between government, NGOs, and the private sector. Particularly NGOs play an essential role in the development of health promotion and health services; they are often the voice of the voiceless. Government should recognise their role, and create conditions for effective partnerships: *"No responsibility without authority,"* as Dr F. Manguyu phrased it. Within such more relevant partnerships NGOs can take on roles of health promotion advocacy, resource development, and creation of policies through a commitment to the public dimension of health.

'No responsibility without authority' good governance is essential

On Tuesday, these issues were particularly affirmed by Dr A. Mukhopadyay (Director of Voluntary Health Association India), who saw an immense role for grassroots organisations that should be respectful of local technologies for health, and not only rely on the immense technological advances of the recent decade; in some cases, puppeteering could be a more powerful communication tool than the Internet.

Think Health

The Tuesday tune was set by Dr I. Kickbusch (Director, Division Health Promotion, Education and Communication). In her keynote she stressed the inextricable link between health and human development. Although much has been accomplished, there are considerable imbalances in, among others, health spending, rates of growth, and consumerism.

Dr I. Kickbusch introduced some concepts to describe and operationalise the achievements and challenges presented throughout the conference. They are in many ways paradoxical. The idea of 'socially toxic environments' would indicate that those that are to benefit from sustainable development in the next generation are deeply hurt socially as they grow up. Similarly, many countries are now suffering from a double burden of disease (conditions of poverty as well as communicable and non-communicable diseases), whereas at the same time 84% of the global population lives in countries where together only 11% of global health budgets are spent.

The foremost challenge would therefore be to combine strategies for social capital with strategies that build intellectual capital for health. The notion of 'health literacy' becomes important: understanding individual, social, societal and global health conditions and their impact. Of course these conditions are intricately interdependent. Another challenge is to deal with them in a coherent way. One way of describing the complexity is using indices like 'social capital', the 'human development index', or a measure called the 'ecological footprint'.

Dealing with the global paradox in health and development would require:

- harnessing some of the *new driving forces* that have emerged more clearly since Ottawa to support health;
- advocacy to make health promotion as much part of the *social and human health* agenda as part of the health agenda;
- to position health promotion as a key element of *good governance* - thus opening avenues for health governance, financing and accountability; and
- to fully understand the changes in the global system of health production and work towards a more systematic *global response*.

"The future is something you build as you move into it," Dr O. Shisana (Director-General of Ministry of Health in South-Africa) added in her presentation. Indeed, although the future is unavoidable, it can be shaped. Dr T. Hancock found that the future is only useful and interesting when it affects what we do and how we live today. For that reason, out of the distinction between possible, plausible, probable and preferable futures, the latter is driving the Conference debate.

Although wild scenarios around preferable health promotion futures can be imagined, the futures presented were realistic. They were illustrated by Dr R. Vaithinathan (Ministry of Health, Singapore). She envisaged futures in which new alliances were forged between authorities, communities and social sectors (such as industry), jointly working towards health.

People central, not disease

Dr S.T. Han (Regional Director, WHO/WPRO) saw a future for the Western Pacific region in which people were at the centre of activity, and no longer Disease. Stages of life, and living arrangements, thereby will become essential focal points of policy and action. Specifically, a focus on early years would emphasise Health Promoting Schools, but also the shaping of lifestyles. The middle years of life would be linked, in action and policy terms, to healthy cities, workplaces, markets and islands. The later years, finally, will become the main priority of the region. Vast numbers of people will be over the age of 65; although they are an essential source of wisdom and experience, their health needs will have to be dealt with as well. The family has a crucial position in that respect.

The same future, but from a family planning perspective, was foreseen by Dr Suyowo (Deputy-Minister of Population, Indonesia). In his policy view, population activities will become owned by families which are empowered towards healthy choices.

Literacy and volunteer action were mentioned as two more issues on which a preferable future vision could be formulated. Dr E. Jouen (Education International) once more illustrated the link between literacy and health. As 25% of the world's working population is illiterate, the health problem becomes dramatic too. Stronger political will to link schools, families, and government in combatting illiteracy is a preferable, if not essential, future. Voluntarism can play a major role in health promotion, according to Dr R. Scott (Rotary, Canada). Rotary assistance to health projects is the glue of partnerships. With a solid foundation in both business and professional communities, as well as connections with populations in need, voluntarism will be able to play a proactive role in finding sustainable solutions to local problems, which in turn contribute to global solutions.

The future: literacy and volunteer action

The *'Leading Change'* Symposia during the second half of Tuesday, Wednesday and Thursday mornings provided valuable insights into future challenges and responses. Conference participants valued these sessions particularly because of their action oriented nature. Questions like *'How to finance health promotion'*, or *'What kind of evaluation methodologies can be applied to a variety of health promotion issues, settings and questions'* were explored, and on many occasions answered. Part II of this publication lists all conveners and papers prepared for the various symposia.

Skills and action

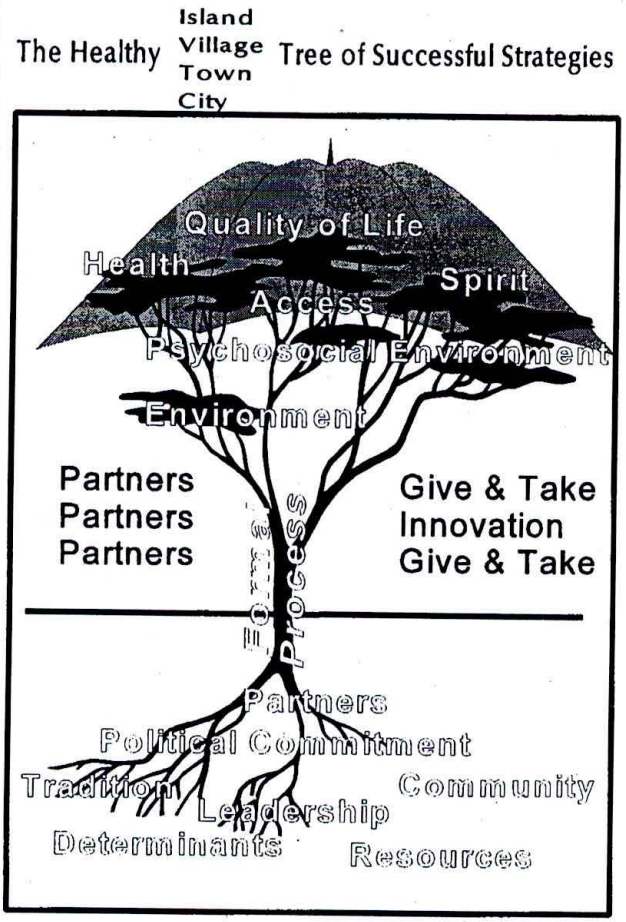
Tuesday and Thursday *'Partnerships in Action'* Symposia on healthy settings, stages

of life, and health conditions were exploring different ways of moving ahead, and operating modes of strengthening and broadening partnerships with a range of both old and new partners; again, a list of facilitators and presentations can be found in Part II of the current volume. Findings are presented below.

Healthy Cities/villages/islands/communities

As participants in this Symposium came from Healthy Cities from all over the world, a debate started on common values and approaches. It soon turned out that, where industrialised nations structure their ideas in terms of 'plans' and 'strategies', countries from South-East Asia, for instance, would speak of 'hope' and 'tradition'. The overriding characteristics of these complementary world views, though, are its interconnectedness and integral vision.

The group built a *'Healthy City Tree of Successful Strategies'* which is rooted in political commitment, a connection with the past and traditions, community engagement, inspired leadership, allocation of resources, work on the determinants of health, and establishing relations with key partners. The trunk of the tree is made up by the formal process, in which good governance and good management are reflected. Both the art and science of running a programme come together in the trunk. The canopy of the tree is constituted by enhanced health, spirituality, quality of life, psycho-social environment, access to determinants of health, and physical environment. Naturally, the canopy is an umbrella; the umbrella approach of healthy cities facilitating other settings-based health promotion activities was therefore reaffirmed.



The following future challenges lay ahead of Healthy Cities:

- Most important is the community agreement on the shape of the future. People will agree on a vision, then move ahead ready to share, adapt and change.
- Healthy Cities were affirmed to be the **hope** for reaching high quality of life; the role of health promotion cannot be one of 'instruction'. Health promotion is to encourage, facilitate, and network with other movements towards the establishment of **one** preferred future.

Invest in school environment

Health Promoting Schools

Already operational in many countries, Health Promoting Schools (HPS) could be further enhanced through the establishment of local, national and international networks between schools, and health and education

sectors, as well as through the development of partnerships and alliances with appropriate other sectors.

Participants in the Symposium identified the following priorities for the further success of HPS:

- Community involvement, and the facilitation of involvement by students in the development of education and health;
- Health sector support for the education sector's efforts to improve quality and substance of education;
- Collaboration among ministries of health and education, as well as international bodies, to create enhanced conditions for health promoting schools;
- An integrated approach to policy processes, curriculum development and evaluation; and
- Maintaining a very practical focus in the key in successful development of HPS.

Healthy Workplaces

Workplaces are the natural environments for effective partnerships. In order to guide such partnerships, the discussions around scenarios and strategies came up with the following priorities:

- Given the great disparity of working conditions and health of workers, there is a need to advocate for global unity and partnership to promote and protect the health of working populations. To this end, international coalitions must be built in order to share values, resources, and responsibilities;

Global unity and partnership for work health

- Policies and action plans in relation to workers health must be future-oriented, taking into account foreseeable population trends and other issues of the working life, e.g. high rate of unemployment, ageing, work patterns, social, economic and technological changes and their impact on health, including mental health;
- There is an urgent need to promote awareness of the benefits of workplace health promotion, as a healthy workforce is vital for the success of global, national and local economies.
- Alliances must be built between various stakeholders and organisations involved in the promotion and protection of workers' health, especially health promotion, occupational health and safety, environmental health and human resources management;
- Finally, there is no shortage of work, only of jobs. We have to reconsider our values, and combine economic development with human development, taking full account of the various trends in the working world.

Active Living/Physical Activity

Participants in the Symposium reviewed a number of large-scale physical activity promotion programmes. The experiences are in line with findings from numerous scientific studies and practical projects and point out several important issues in physical activity promotion:

- Begin today: there is a need, and there are possibilities for success;
- Act locally, even in national projects; then you can tailor the programme to correspond to real needs, expectations, and opportunities;

- **Begin today**
- **Tailor programme**
- **Commit partners**
- **Simple sophistication**

- Find responsible committed partners, and make use of the local culture, traditions, attitudes, and values;
- Make the realisation simple even if the foundation is sophisticated. This is possible when you use the vast range of knowledge and experience that has been gathered.
- If you can afford to direct the effort to only part of the population, consider children as a first priority group. They need physical activity and they like it;
- Strengthen existing opportunities such as physical activity in schools in and outside school hours;
- Another priority area would be women, as they are often underserved in terms of motivation and needs;
- Document anything you do and account for what you did. This serves our own learning process and that of others.

Sexual Health

UNAIDS, brings together six UN Agencies (WHO, UNFPA, UNICEF, UNDP, UNESCO, World Bank) on sexual health. The presentation, and subsequent discussions with Symposia participants, brought up a range of issues that seem determinants of future success in the realm.

Social and economic implications of sexual health

First of all, the HIV/AIDS epidemic has major social and economic implications. Although prevention works, there remains some indolence regarding political commitment, leadership, and a global view on the issue. In those cases where HIV/AIDS prevention has proven to be cost-effective, it was because of the following factors. These constitute the context in which sexual health programmes will have to further develop in the future:

- Recognition of the socio-economic impact of sexual health problems, including HIV/AIDS, will have to lead to a political position in which investments in health become a priority;
- Subsequently, openness and transparency in public health functions has been, and will continue to be, critical to the success of countries in the prevention of the spread of HIV/AIDS;
- The global determinants of the spread of HIV/AIDS and other STDs are travel, tourism (particularly sex tourism), transportation and trade, 'transcultural sexual liberation', and illicit drug trading. Industries and agencies involved in these sectors can be involved in dealing with the spread of the epidemic;
- Increasingly, the business sector is becoming involved in HIV prevention programmes, notably in countries where government fails to act. A global cosmetics chain, e.g., is marketing is some countries the cheapest available condom plus

public education on its use. In collaboration between health and private sectors, though, it is found that only philanthropy is not enough. Work health promotion would be a further road to travel;

- A sector that has also a role in the realm is that of religious leaders. Involvement of key leaders can make or break programmes in this field.
- Yet, a code of (ethical) conduct is required to legitimise and structure partnerships.

Tobacco free societies

Tobacco use may be the one single most addressed issue in public health and health promotion. Therefore, Symposium participants could focus more unequivocally on the future.

In addition to the already existing range of interventions, the following recommendations would guide future action on tobacco use:

- Legislation should always be complemented by other interventions and activities;
- Adoption and implementation of legislation requires a phased approach in order to effect gradual change;

Complement interventions

- Public awareness of the smoking problem and available legislative opportunities is of crucial importance;
- Popular support and further availability of data enables a second round of more stringent legislation;
- Partners, such as the media and employers' organisations, need to be involved in the legislative process and be mobilised to that end.
- Sustainability of programmes, interfacing with community participation;
- There is a definite need to take into account global developments; a country may ban smoking, but not ban export of tobacco products. This is inconsequential. Part of this perspective would also be to provide viable alternatives to tobacco production and processing; the economic impact of a reduction of agricultural output and shifts in industrial processing may not facilitate moves towards tobacco-free societies.

Promoting women's health

Participants in the women's health Symposium reviewed presentations by Education International (a World Trade Union organisation representing 23 million teachers) and BBC (British public radio and television). The first agency reviewed progress on health literacy among women and girls since the Jomtien education (1990) and Beijing women's (1996) international meetings. In spite of recommendations and declarations very little seems to have happened. Yet, education is a basic human right; by 2000, 148 million children (among which 86 girls) will still have no access to primary education. BBC ran a multimedia programme over a week on men's health, making men more sensitive to women's health issues. The programme was a success, both in terms of ratings as well as responses. A consequence was that new partnerships between BBC and other actors need to be established for effective follow-up. Television turns out to be not the only medium: drum, dance and music can be vehicles for subtle passing on of information.

Men sensitive to women's health

Participants discussed Action Steps for further enhancement of global women's health:

- A new concept of women's health for all stages of a woman's life cycle from maternal and child health;
- Adult education and Health Education covering the lifespan should be promoted;
- There should be specific and measurable objectives for implementation of women's health from WHO on education, budget and other issues;
- It is important to emphasise positive values, empowering elderly women (such as TBA's, aunts, grandmothers), giving them the opportunity to teach young women;
- WHO should create partnerships, including with the media, other UN Agencies, NGO's, etc. to increase the dissemination of knowledge and information about women's issues, rights and recommendations from international conventions, like Beijing, Jomtien, etc.;
- We need to have mutually reinforcing programmes with WHO resulting in sustained partnerships with NGO's;
- Governments should treat women's NGOs as real partners, providing support and opportunities and including them in policy and decision making;
- In promoting the health of women and girls, WHO needs to take a strong role in encouraging Governments, Foundations and others to allocate resources, and muster the political will needed for implementation;
- WHO needs to expand its involvement with civil society, creating more partnerships with NGO's;

Health promoting healthcare settings

Healthcare settings are at the core of health care and development. In order to continue to play this role, they must broaden its horizons. Symposium participants generally agreed that there is considerable potential in forging new partnership between relevant actors and healthcare settings. Instruments and perspectives to deal with that challenge are:

- To mobilise patient and consumer organisations to play an active joint role in health promotion;
- Share information and data with the partnership;
- Build an infrastructure, within and beyond the healthcare setting, for health promotion;
- Reorient resource allocation towards health promotion;
- Open up a dialogue and establish joint commitments with health insurance companies and businesses, all health professionals including traditional and alternative healers as well as allied health professionals (nurses, technicians), social and business entrepreneurs, and religious leaders; and
- To argue strongly for healthcare dedicated tax on health-damaging industries, most notably tobacco and alcohol industries.

Infrastructure toward commitment between industry, patients, healthcare

With Whom Do We Travel?

No single sector can meet the challenges of health promotion in splendid isolation. Success will come through an alliance between the private, public and non-governmental sectors. The conference demonstrated through many examples of good practice that health promotion already thrives on joint working. Of course, such joint working can materialize in many different shapes. Alliances, partnerships and collaborative actions are just a few ways of indicating work done together. Work can be governed through contracts, memoranda of understanding, or rather simple mutual recognition. Working together can be done on a bilateral basis, or with the involvement of many different constituencies and legal bodies. The conference demonstrated the wide range of possibilities. Dr A. Malaspina discussed the work of ILSI, the *International Life Sciences Institute*. ILSI is a public, non-profit foundation sponsored by industry, private foundations, and government funding. Its goal is to sponsor and carry out research in food safety and nutrition. The Institute has a membership of over 350 companies, with a global network of 3000 scientists working for ILSI's 12 branches around the world. To facilitate collaboration, ILSI acquired NGO status with WHO. An ILSI scientist is located in WHO Headquarters to facilitate speedy and effective exchange of work.

No single sector can meet challenges

The contribution of the private sector proved to be a major focus for debate at the conference. Representatives of commercial and industrial companies identified a number of issues which would assist in their involvement. At the international level, for example, facilitation is essential in bringing together these two sectors which have traditionally had little contact. WHO, and other United Nations organisations, could play a valuable role in this process, and in actively managing and monitoring the developing relationship. WHO should also provide a clearing house for examples of successful private/public sector partnerships.

A genuine desire for joint community-based programmes

In addition to the obvious potential for sponsorship, private sector organisations expressed a genuine desire for joint, community-based programmes. They acknowledged that such an involvement would not only be in the interests of improved public health, but would also be good for their companies. They stressed that solid, ethical business was also successful business, and that such an involvement would present a positive company image. Moreover, workplace health programmes not only benefited employees, they also contributed to better productivity and positive industrial relations. Private sector colleagues argued strongly, however, for an involvement in partnership programmes right from the outset as this would develop a joint sense of ownership and cement the process of collaboration.

There are also many examples of health promotion contributing to safer commercial and industrial practices which ultimately were of benefit to consumers. The development of increasingly comprehensive food hygiene and nutrition programmes in the food industry was but one example cited at the conference.

NGOs also have a growing desire to work more closely with private sector partners, not only out of a desire for commercial sponsorship, but also on issues such as training and management development. Conference participants agreed to establish a joint database of interested NGOs and commercial organisations, through the auspices of the International

Union for Health Promotion and Education (IUHPE), as the basis for fostering future partnerships.
All parties acknowledged that such partnerships were not without potential pitfalls. A clear statement of ethical principles would be essential as a basis for growing trust and co-operation. This would help to protect the interests of the public, and provide a sound basis for joint development. The road towards healthful alliances and partnerships will not be an entirely smooth one. Participants raised concerns as to matters of control and industrial (hidden) agendas. It was agreed that any networking for health would have to recognize interdependencies and unique expertise of each partner. Openness and mutual respect are essential ingredients of successful collaboration.

A Global Commitment

As stated in the introduction to this report, the conference was very much a working meeting. This characteristic did not just apply to health promotion professionals. There was substantial political commitment to health promotion in its many dimensions. Representatives from many countries described the achievements already accomplished. High-level professionals and politicians also pledged their commitment to the road ahead. Prof Sujudi, Minister of Health of Indonesia, presented the conference with the strong commitment to health promotion of the 13,000 island nation stretched along the Equator like an emerald string. Mr I. Potter (Canadian Assistant Deputy Minister for Health) and Hungarian Minister for Health Dr M. Kökeny were already mentioned earlier.
Other significant presentations were formulated by strong players in international health promotion development. Prof Lu Rushan (Minister of Health of the People's Republic of China) described both the accomplishments of his country as well as the double face of challenges that lay ahead of China. Whereas the country is sharing many of the problems of other countries (such as globalization, ageing, urbanization, etc.), the most populous nation of the world is still having to deal with a large rural population and its more traditional health problems. *'In China, health care services cannot be dealt with in a way developed countries have done in the past - with too high costs. Nor should they be treated the way China did in the past - not appropriate to the current socio-economic development'*, Prof Lu stated. The country regards health promotion as a major contributing instrument to solving its problems. Pilot projects involving a network of health promoting schools, workplace health promotion, and healthy cities demonstrated that health promotion will be the future point of reference. Partnerships are crucial to its success. Prof Lu described a partnership between four ministries (Health, Agriculture,

Broadcasting, Television and Cinema and the National Committee of Patriotic Health Campaign) and further NGOs and academia in the implementation of the *Health Education for the 900 Million Peasants* programme.

Dr M. Rajala of the European Union described the increased efforts of the Union in public health and health promotion. The Maastricht Treaty opened up new venues and opportunities in European health promotion. In addition to substantial and longer-term programmes such as *Europe Against Cancer* and *Europe Against AIDS*, health promotion development is acquiring a prominent position on European political agendas. Naturally, the Union operates in a strong partnership with the World Health Organization, and constitutionally has to work with numerous other partners from its member states. Such collaboration only strengthens the scope and vision of health promotion.

Prof D. McQueen, on behalf of Dr D. Satcher the Director of the Centers for Disease Control and Prevention (United States of America), described CDC's perspective on health promotion. *'CDC's vision of a "Healthy People in a Healthy World - Through Prevention" conveys the agency's global perspective. The concept of the global village has traditionally guided CDC activities in global health,'* he stated. CDC is an esteemed inhabitant of that village. The organization is committed to improving global health by strengthening and facilitating efforts of other international health organizations, by provision of consultancies, by conducting capacity development programmes (e.g. in response to infectious disease outbreaks, an important staple of its international work), and by the application of its global mission which is the promotion of health and quality of life by preventing and controlling disease, injury and disability. Prof McQueen emphasised that the United States itself is benefiting from international collaborative activities as well; its understanding of global health issues is enhanced and would led to further improvements in domestic and global activities. It is also for this reason that CDC is involved in the *Mega Country Health Promotion Network* (cf. below).

Partnerships and Alliances

Thursday symposia were to take stock of existing partnerships and alliances, and explore the potential for new such collaborative efforts. The following reflects the debate.

The Global Healthy Cities Network

The group has worked collaboratively during this with week; discussion offered an opportunity to initiate new dialogues and partnerships among themselves and thereby reached to state a *Declaration on Partnerships For Healthy Cities.*

Declaration on partnerships for Healthy Cities

"The global Healthy Cities movement, which now incorporates islands, villages, communities, towns, municipalities, cities, and megacities around the world, has been a very successful application of the Ottawa Charter's strategies. Healthy Cities embodies healthy schools, workplaces, health care facilities, markets and other settings. Healthy Cities is on the balance of people's spirit and technologies. The process of creating healthier cities is a practical example of the effectiveness of partnerships between local governments involving different departments, residents, NGOs, private sectors, community organisations, and academics.

Commitment to build successful partnerships for Healthy Cities rests on action at local level. Partnerships at several levels with various partners widen diversity in alliance. They include partnerships within the health sector, within the public sector, between cities, and across sectors. This requires participation from health, environment, economy, ecology, education, urban planning fields. Decentralisation expedites influential partnerships.

There is no single standard formula to build up effective partnerships for Healthy Cities. The leadership and managerial skills affect its outcome. Social pressure is a key to stimulate leaders to make partnerships with the concerned organisations and people to enhance the health promotion in places where people live. Health plans developed through partnerships contribute to health gain.

Mechanisms to constitute influential partnerships are to tackle hot local issues, to build on cultural and historical backgrounds, to employ holistic approach, to build on mutual success, to work step by step, to keep conscious in generating additional financial resources to sustain good partnerships, and to involve decision makers of communities.

We need to enable people of various sectors to build partnerships at the local level. People need skills to find partners, work with different partner, mediate, create participatory platform, and work towards the same goal. We need to increase partnership literacy.

This commitment to building Healthy Cities movement is for the health of the people".

Global School Health Initiative

The WHO Global School Health Initiative is a concerted effort by international organisations to help schools improve the health of students, staff, parents and community members. The network is a consolidating initiative, gathering knowledge and understanding about health promotion in the school setting.

Six international HPS Networks

Prior to Jakarta four regional HPS networks

were in place and moving forward strongly: Latin America, Europe, South Africa, and West Pacific. The development of two new networks has been reinforced in Jakarta, and will be formally started in the months following, namely: Central Africa, and South-East Asia. In 1998, two more regional networks are also planned in West Africa and the Middle East. In the USA, CDC in Atlanta is a WHO Collaborating Centre for Health Promotion and Education for School-aged Children. CDC provides technical support to WHO on school matters.

Participants from the above-mentioned networks met in Jakarta with 'New Players', in particular from the private sector, private voluntary agencies, Ministries of Health, international networks of schools, and NGOs.

After debating priority areas the Jakarta participants agreed to elaborate networking modes to enhance further collaboration.

Healthy Work Initiative

The third Symposium on the theme examined the possibility for different organisations and agencies to meet and negotiate with various health promotion initiatives and networks on potential joint health promotion action.

The first presentation drew attention to the need for a healthy work initiative, which included the identification of resources, development of marketing strategies, establishment of a system for the co-ordination of activities, and the reinforcement of information support and research. The second presentation highlighted the UNAIDS workplace AIDS Programme as an example of a partnership initiative in response to the AIDS epidemic. The UNAIDS served as a catalyst for partnerships among NGOs, governments and private sector through public awareness, HIV prevention and resource mobilisation.

The subsequent discussions and responses to the presentations highlighted the following points:

- collect and disseminate data concerning the workers' health so that workers can formulate their demands;
- conduct workshops to create awareness among partnerships on the importance (in economic as well as in health terms) of workplace health promotion;
- involve top decision makers in the public and private sectors;
- encourage corporate involvement in the community;
- equal partnership is important;
- social marketing is a mechanism to engage corporate partnership;
- partnership is complex. Be aware of the different levels for partnership dialogues, from the work floor to national level. As a consequence, partnership negotiation takes different shapes at different levels;
- strategic partnership can be established on the basis of holistic issue-based programmes;
- partnerships thrive within stable social and political contexts;
- partnerships on a micro-level are built on the joint establishment of basic values, development of criteria, methods and tools for the development and implementation of action, and establishment of a system of co-ordination and information support and research;
- global partnership and alliance building will be based on equity and mutual trust.

Catalysts for workplace health

Healthy Ageing Initiative

Healthy older persons are resources for their families, their communities and for society. Rapid population ageing worldwide requires investments on healthy ageing at all levels. The return to economy will be immediate.

Embracing these principles, a multisectoral healthy ageing initiative has been launched under WHO leadership. Partners include NGOs, academic and governmental agencies. It emphasises the unprecedently rapid ageing of developing countries populations.

Old age should not be compartmentalised but is an integral part of the life cycle

The framework of this initiative is based on a life course perspective: *old age should not be compartmentalised but is an integral part of the life cycle*. The emphasis is on the adoption of Health Promotion principles applied to the ageing process. Complementary dimensions include gender specificity, promotion of intergenerational cohesion, establishment of community-based programmes and consideration of cultural values as well as ethical issues.

The initiative comprises a cycle consisting of information-base strengthening and dissemination of the information through multiple means. This re-enforces the initiative's key advocacy role leading to an "informed" research agenda and redefinition of training needs. All this is ultimately translated into the development of policies and interventions to be appropriately evaluated.

The launching of a world-wide movement to celebrate the International Day of Older Persons with a strong "active ageing" message is an example of the actions triggered by this initiative. Partnerships coalitions in this movement include NGOs, local government, academic institutions, the International Olympic Committee, the media and the private sector. This movement followed another outcome of this initiative: the Guidelines for Promoting Physical Activity in Older Age developed by WHO in collaboration with the scientific community and NGOs in 1996. Altogether these examples illustrate the importance being given to physical activity as a key contributor to physical, social and mental well-being. Action on this is strong in the USA where the manufacturers of sports' equipment and clothing have launched a nation-wide campaign targeting ageing individuals.

Active Living Initiative

The WHO Active Living Global Initiative was presented as an illustration of a global intersectoral and multidisciplinary activity which requires a broad partnership including both traditional and new partners to give sufficient momentum for this initiative.

Active Living: outstanding public health issue

The challenge of this Initiative is to promote health-enhancing physical activity as an outstanding public health issue. Its objectives are the following :

- To strengthen the world-wide advocacy of the health benefits of Physical Activity for all, and in various life settings.
- To foster the development of national policies and programmes on Physical Activity as part of social and health for all policies.
- To promote/stimulate actions directed to the community, with particular attention to activities in favour of children, youth, older persons, and persons with disabilities and

belonging to economically vulnerable groups.
- To develop international support to Physical Activity and health.

The strategy to attain these objectives and the targets based on them relies on a broad network of committed partners. These include organisations and institutions from governmental, and non governmental sectors, national public health, educational, social, sport, transport and environment agencies/institutions, and relevant private companies. It is necessary to include among the partners organisations and groups which are interested in fostering the possibilities for increased participation of all girls and women.
The realisation of the activities will be implemented and carried out by community networks of promotional, health, and sociocultural services and associations. This approach is necessary to appreciate the need for culturally appropriate actions and to combine traditional and innovative activities that meet the needs and motivations of the people.

Mega-Country Initiative
The Mega Country Health Promotion Network is a component of the WHO 5-year action plan on health promotion. The goal of the network is to mobilise the world's most populated countries to promote health in a concerted, collaborative effort. There are ten countries with a population of at least 100 million. Together, these countries make up approximately 60% of the world's population. They are: Bangladesh, Brazil, China, India, Indonesia, Japan, Nigeria, Pakistan, Russian Federation, United States of America. By the year 2000, Mexico will also have a population of 100 million.

Mobilise at least 1,000,000,000 people for health

The objectives of the Mega Country Health Promotion Network include:
- Improving each country's own national capacity to promote health;
- Identifying priority areas on which the Network can focus, which can be centred around health issues (e.g. chronic and infectious diseases, mental health, and environmental health). population groups (e.g., youth/ children, women/mothers, and the ageing population) and settings (e.g. communities, schools, and worksites);
- Selecting action areas and activities to work on together;
- Providing support to the nations in the region or world; and
- Building partnerships with governmental and non-governmental agencies, universities, and private industry.
- Criteria for participation in the Mega Country Health Promotion Network include:
- Demonstrating a government commitment to health promotion;
- Providing adequate communication technology;
- Identifying country focal points to facilitate communication and ensure continuity.

Health Promotion Foundations Initiative
The Symposium addressed the dire need to establish organisational structures for health promotion. Such structures have been developed, a.o., in Australia. Similar initiatives are to be launched shortly in Bangkok and Vietnam.

Organisational structures crucial for financing health promotion

Organisational structures for health promotion are important for financing the domain; analysis and dissemination of health and health findings are to be important tasks of such structures.
Dedicated tobacco-taxation is an important and effective way of establishing a financial basis for health promotion structures. Integrated health promotion programmes should be the result.

Health Promotion for Chronic Health Conditions

Patient Groups need to be an integral part of WHO as policy influencers because chronic diseases are increasing and many chronic diseases are hereditary. They have a crucial role to play in improving health care and the health of individuals with chronic disease by encouraging and supporting self help and personal responsibility for life style.
Patient Groups strongly believe that partnerships are the future and can be sooner achieved by using patients at a political level. Patient Groups can educate and advocate.
Patient/Doctor partnerships are critical to good health management. Many people with chronic disease are now living longer (thanks to new drugs and new developments) - many into middle age, hence the need for education, support, coping skills and life style information to maintain quality of life.

Patient - Doctor partnership critical for health management

The group were concerned about the marginalisation of people with chronic disease, especially those with diseases that carry stigma, and were also concerned that the move towards self responsibility may lead to a blaming culture, and an abdication of responsibility by health services for providing support and treatment.
The dynamism, commitment, skills and experience demonstrate by the achievements of patient groups in the 20 th century can be built on to support new initiatives in the 21 st century.
Patient Groups were also concerned that existing negative attitudes towards the pharmaceutical industry were detrimental to patients, who are often dependent on the drugs which industry produce for their quality of life, and sometimes life itself. They feel they have a duty to their members to have good relations with industry to ensure the continued availability of their treatments, as well as pressing for new and improved drugs. They can also work together to produce better information and develop understandings about the non medical issues of living with chronic disease.

Health Promoting Hospitals Initiative

The group looked at:
- Project Hope work, giving management training of health care practices in Eastern Europe. This was the examination of a project in Poland initially funded by a partnership of corporate giving and routed via a charity, US state aid, and local government departmental funding. Now requested by and extended into the Czechoslovakia republic and taught in the Czech language.
- A Community based approach Initiative in Africa, where there was a change from the more centralised specialist services to a basic community based approach again with multi sector funding including the private sector .
- Health 2020. An approach in Thailand which looked at scenarios in health situations and

future trends, so as to inform policy makers and planners and facilitate long term development planning.

- A strategic project which considered important aspects of the prevention of chronic non communicable disease. This project argued for a reversal of the process of marginalisation of the medical staff in health development, suggesting that a stronger lead was necessary .
- The WHO healthy hospital project in Europe.

Healthcare settings require health policy

The main outcomes and action steps are as follows :

- Existing health care settings could benefit from an integration across other sectors. This could also involve multiple partnering with both existing and new partners to a greater extent.
- In some cases, the sector could probably also be extended both horizontally into similar areas and also vertically up and down the process into related areas. More integration with other projects could also occur, e.g. hospitals have not only "in patients", but also
  - Staff (mainly female) - so there are women's health
  - Staff and ancillary workers - so its a workplace
  - Visitors and Out patients - so it could reach out into a community setting
- More emphasis could be given to :
  - Staff professional development and training - so it needs to become a learning organisation
  - Extension of the Healthy hospital concept into existing hospitals who are not members of the healthy hospitals network, including related organisation's in the community.
- New Partners with specialist skills could be involved in this sector in providing expertise for:
  - Training and professional development improve quality standards.
  - Management training - Improving staffs skills and competencies in management practices
  - Infrastructure and organisational development, re engineering internal processes and stronger project management.
  - Health Policy development at both local and national levels.

Health Promoting Media Settings

The technologies and delivery systems of the media have changed dramatically; it is no longer a case of distributing bits of information. To be effective we need to encourage informed dialogue in order to change behaviour to create health and well-being. This is a much harder job.

Two reports were cited by Warren Feek (UNICEF) to illustrate this more complex situation: Demographic and Health Survey Report (UNICEF) and the Soul City Evaluation.

The first assessed the impact of mass media on sexual health. It demonstrated a clear relationship between expose to various media and positive choices.

Access makes the difference especially if health issues are discussed by a wide range of

media news media, soaps and DJ's on radio. The Soul City Evaluation also revealed the importance of a positive cycle of reinforcement i.e. a number of media reinforcing each other resulted in a dialogue amongst friends and family much more effectively than when a person was exposed to only one media.

To be effective Health Promotion should have PUBLIC APPEAL and be presented to media professionals in a user friendly form.

Sherrie Connelly emphasised the importance of selecting appropriate technology. For example there is no point choosing television shows if children's improvisation in school work as well. It is important to ask the following questions:

- What are the communication assets
- What works
- What can you learn from other countries

Communication assets; what works; what can be learned?

Attitudes of health promoters are important. It should not be co-opting the media but getting to know the media.

Alliance building need not be so hard if you begin with those that are already involved in doing good things.

She outlined the following approach based on problem solving:

Scan the media for media professions and business leaders for those people who are already doing 'good things'

- Get the media professionals to teach WHO how to apply attitude change
- Encourage communications leaders to learn more about WHO.
- Prepare a strategy to get everybody on line.

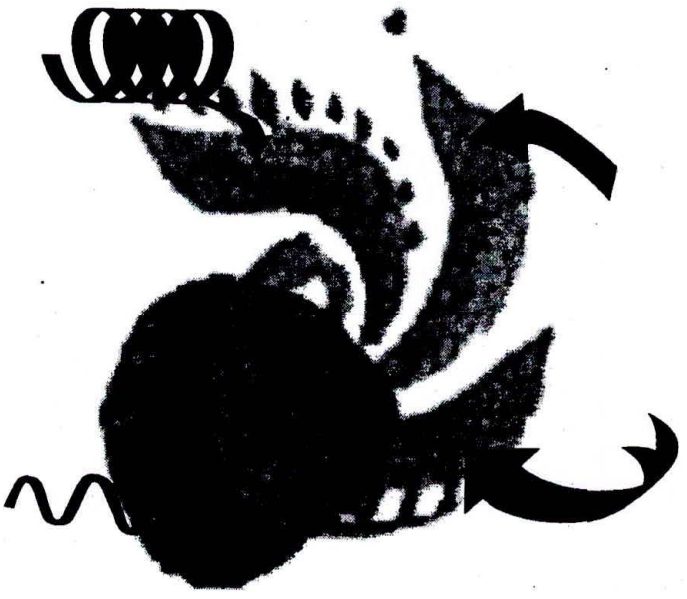
Sonny Fox disagreed with only contacting those already converted. It is important to contact many people simply because of the pressures of media business they may not have given the topic much thought. As well as understanding the media it is important not to be adversarial. The approach should be "we need your help" which empowers the media professionals. Soaps send out messages everyday sometimes carelessly, but by understanding and respecting what programme makers tend to be more willing to act responsibly.

The issues of soap operas (US, UK, Australian, Mexican and Brazilian) being important was raised. A participant from Kenya said this cultural imperialism could be overcome by encouraging local talent. The result may not be as sophisticated as Hollywood but it could have a bigger impact.

Other issues which were raised by the group were the need not just to concentrate on soap but seek to build partnerships in other entertainment areas such as interactive games. The need to maintain a comprehensive list of resources as a service to the media. The need to maintain a topical outlook and new messages to keep alive long running issues such as anti-smoking campaigns.

Conference Conclusions

In summarising the findings of the conference, De Leeuw followed the format of the logo of the conference. Throughout the conference, intense debates showed that health promotion now reflects *'Unity in Diversity'*, a slogan that also happens to be the Indonesian national motto.



Tradition

The Ottawa Charter was reaffirmed as having established a health promotion tradition. Integral dimensions of that tradition are foci on community action, supportive environments, intersectoral action and social change.

Participants throughout the conference shared the values associated with the health promotion tradition. They determined not only a committed working atmosphere, but also the chance to advance knowledge and understanding in specific health promotion areas. Over a hundred papers presented in the various symposia provided ample opportunity to exchange views on both the practical and more abstract implications of the established health promotion tradition to face future challenges.

Future

The conference found that indeed the future starts today. Developments in realms of globalization and demography determine the challenges to health promotion and its responses. Trade, communications and new trends in society all have an impact on health. The double burden of disease many countries face (traditional infectious disease patterns on the one hand, diseases of affluence on the other) requires innovative health promotion action. Ageing, and changing roles of previously marginalized groups would determine new and important priorities for public health and health promotion.

Yet, these future developments also hold a promise. New (high tech, and yet high touch) technologies, and increased understanding of health literacy and social capital for health create challenging new prospects for health promotion.

The conference demonstrated that a wealth of information is already available. Networking, particularly in South-South contexts, would further facilitate adequate responses to global future challenges.

Evidence

Health promotion works; throughout the conference it was demonstrated that it is an

essential and effective investment in society. Many presenters highlighted the fact that over the years a wide range of methods, methodologies and theoretical insights have become available in support of the many modalities of health promotion. Be it community action, environments for health, policy development, or organisational change, it became clear that an increasing part of the academic community is committed to providing evidence that it is sensible to undertake health promotion action.
Yet, convincing evidence of the relevance of health promotion also pervaded the practice-oriented sessions of the conference. Workers in field positions showed that health promotion has much more to offer to communities, and partners in the realm, than mere health enhancement. Health promotion forges improved awareness of organisational and policy determinants of well-being and social conditions, thereby setting the stage for concerted action.

Partnerships

'Evidence presented to the Conference outlining the "crisis of suffering" facing the populations of the world clearly indicates the need for the private sector to play a full and responsible part in working with WHO and governments, in both developed and developing countries, to meet the challenges ahead', read part of the commitment made by the sector during the closing session of the conference.
Although a serious concern was expressed by some that new partnerships with other sectors (particularly industry) might be driven by other motivations than health and well-being, the private sector agreed on the necessity to establish general protocols for successful partnerships. Such protocols would include transparancy, accountability, mutual benefits, and ethics. Particular partnership protocols could also include commitments to the highest standards of professional and scientific conduct.
It became clear that already many partnerships are in place; not just between public and private sectors, but specifically between either of these and Non-Gouvermental Organizations. Many examples were provided that show the feasibility and success of an expansion in partnerships for health promotion.

The beginning of the future

The *Fourth International Conference on Health Promotion* proved to be a milestone in health promotion development. It brought together a range of organizations and individuals reaffirming old commitments and pledging new commitments to the goal of joint promotion of global health.
Statements from virtually every corner of the world, and presentations by both health promotors engaged in everyday work with communities, as well as high-level politicians demonstrated that the challenges of the future shall be met, because health promotion *works*, and offers a tangible and effective investment in people's health and well-being.
Recognition of this position in the *Jakarta Declaration* means that the Conference was not an end-point of a decade of development since the adoption of the *Ottawa Charter*, but the beginning of a future. A future which features health promotion prominently as a driving force in the enhancement of global social capital.

The Jakarta Declaration on Leading Health Promotion into the 21st Century

Preamble

The Fourth International Conference on Health Promotion: New Players for a New Era - Leading Health Promotion into the 21st Century, meeting in Jakarta from 21 to 25 July 1997, has come at a critical moment in the development of international strategies for health. It is almost 20 years since the World Health Organization's Member States made an ambitious commitment to a global strategy for Health for All and the principles of primary health care through the Declaration of Alma-Ata. It is 11 years since the First International Conference on Health Promotion was held in Ottawa, Canada. That Conference resulted in proclamation of the Ottawa Charter for Health Promotion, which has been a source of guidance and inspiration for health promotion since that time. Subsequent international conferences and meetings have further clarified the relevance and meaning of key strategies in health promotion, including healthy public policy (Adelaide, Australia, 1988), and supportive environments for health (Sundsvall, Sweden, 1991).

The Fourth International Conference on Health Promotion is the first to be held in a developing country, and the first to involve the private sector in supporting health promotion. It has provided an opportunity to reflect on what has been learned about effective health promotion, to re-examine the determinants of health, and to identify the directions and strategies that must be adopted to address the challenges of promoting health in the 21st century.

The participants in the Jakarta Conference hereby present this Declaration on action for health promotion into the next century.

Health promotion is a key investment

Health is a basic human right and is essential for social and economic development. Increasingly, health promotion is being recognized as an essential element of health development. It is a process of enabling people to increase control over, and to improve, their health. Health promotion, through investment and action, has a marked impact on the determinants of health so as to create the greatest health gain for people, to contribute significantly to the reduction of inequities in health, to further human rights, and to build social capital. The ultimate goal is to increase health expectancy, and to narrow the gap in health expectancy between countries and groups.

The Jakarta Declaration on Health Promotion offers a vision and focus for health promotion into the next century. It reflects the firm commitment of participants in the Fourth International Conference on Health Promotion to draw upon the widest possible range of resources to tackle health determinants in the 21st century.

Determinants of health: new challenges

The prerequisites for health are peace, shelter, education, social security, social relations, food, income, the empowerment of women, a stable eco-system, sustainable resource use, social justice, respect for human rights, and equity. Above all, poverty is the greatest threat to health.

Demographic trends such as urbanization, an increase in the number of older people and the high prevalence of chronic diseases pose new problems in all countries. Other social, behavioural and biological changes such as increased sedentary behaviour, resistance to antibiotics and other commonly available drugs, increased drug abuse, and civil and domestic violence threaten the health and well-being of hundreds of millions of people.

New and re-emerging infectious diseases, and the greater recognition of mental health problems, require an urgent response. It is vital that approaches to health promotion evolve to meet changes in the determinants of health.

Transnational factors also have a significant impact on health. These include the integration of the global economy, financial markets and trade, wide access to media and communications technology, and environmental degradation as a result of the irresponsible use of resources.

These changes shape people's values, their lifestyles throughout the lifespan, and living conditions across the world. Some have great potential for health, such as the development of communications technology, while others, such as international trade in tobacco, have a major negative impact.

Health promotion makes a difference

Research and case studies from around the world provide convincing evidence that health promotion is effective. Health promotion strategies can develop and change lifestyles, and have an impact on the social, economic and environmental conditions that determine health. Health promotion is a practical approach to achieving greater equity in health.

The five strategies set out in the Ottawa Charter for Health Promotion are essential for success:

- build healthy public policy
- create supportive environments
- strengthen community action

- develop personal skills
- reorient health services.

There is now clear evidence that:

- **comprehensive approaches to health development are the most effective.** Those that use combinations of the five strategies are more effective than single-track approaches.

- **particular settings offer practical opportunities for the implementation of comprehensive strategies.** These include mega-cities, islands, cities, municipalities, local communities, markets, schools, the workplace, and health care facilities.

- **participation is essential to sustain efforts.** People have to be at the centre of health promotion action and decision-making processes for them to be effective.

- **health learning fosters participation.** Access to education and information is essential to achieving effective participation and the empowerment of people and communities.

These strategies are core elements of health promotion and are relevant for all countries.

New responses are needed

To address emerging threats to health, new forms of action are needed. The challenge for the coming years will be to unlock the potential for health promotion inherent in many sectors of society, among local communities, and within families.

There is a clear need to break through traditional boundaries within government sectors, between governmental and nongovernmental organizations, and between the public and private sectors. Cooperation is essential; this requires the creation of new partnerships for health, on an equal footing, between the different sectors at all levels of governance in societies.

Priorities for health promotion in the 21st Century

1. Promote social responsibility for health

Decision-makers must be firmly committed to social responsibility. Both the public and private sectors should promote health by pursuing policies and practices that:

- avoid harming the health of individuals

- protect the environment and ensure sustainable use of resources
- restrict production of and trade in inherently harmful goods and substances such as tobacco and armaments, as well as discourage unhealthy marketing practices
- safeguard both the citizen in the marketplace and the individual in the workplace
- include equity-focused health impact assessments as an integral part of policy development.

2. Increase investments for health development

In many countries, current investment in health is inadequate and often ineffective. Increasing investment for health development requires a truly multisectoral approach including, for example, additional resources for education and housing as well as for the health sector. Greater investment for health and reorientation of existing investments, both within and among countries, has the potential to achieve significant advances in human development, health and quality of life.

Investments for health should reflect the needs of particular groups such as women, children, older people, and indigenous, poor and marginalized populations.

3. Consolidate and expand partnerships for health

Health promotion requires partnerships for health and social development between the different sectors at all levels of governance and society. Existing partnerships need to be strengthened and the potential for new partnerships must be explored.

Partnerships offer mutual benefit for health through the sharing of expertise, skills and resources. Each partnership must be transparent and accountable and be based on agreed ethical principles, mutual understanding and respect. WHO guidelines should be adhered to.

4. Increase community capacity and empower the individual

Health promotion is carried out ***by*** and ***with*** people, not ***on*** or ***to*** people. It improves both the ability of individuals to take action, and the capacity of groups, organizations or communities to influence the determinants of health.

Improving the capacity of communities for health promotion requires practical education, leadership training, and access to resources. Empowering individuals demands more consistent, reliable access to the decision-making process and the skills and knowledge essential to effect change.

Both traditional communication and the new information media support this process. Social, cultural and spiritual resources need to be harnessed in innovative ways.

5. Secure an infrastructure for health promotion

To secure an infrastructure for health promotion, new mechanisms for funding it locally,

nationally and globally must be found. Incentives should be developed to influence the actions of governments, nongovernmental organizations, educational institutions and the private sector to make sure that resource mobilization for health promotion is maximized.

"Settings for health" represent the organizational base of the infrastructure required for health promotion. New health challenges mean that new and diverse networks need to be created to achieve intersectoral collaboration. Such networks should provide mutual assistance within and among countries and facilitate exchange of information on which strategies have proved effective and in which settings.

Training in and practice of local leadership skills should be encouraged in order to support health promotion activities. Documentation of experiences in health promotion through research and project reporting should be enhanced to improve planning, implementation and evaluation.

All countries should develop the appropriate political, legal, educational, social and economic environments required to support health promotion.

Call for action

The participants in this Conference are committed to sharing the key messages of the Jakarta Declaration with their governments, institutions and communities, putting the actions proposed into practice, and reporting back to the Fifth International Conference on Health Promotion.

In order to speed progress towards global health promotion, the participants endorse the formation of a global health promotion alliance. The goal of this alliance is to advance the priorities for action in health promotion set out in this Declaration.

Priorities for the alliance include:

- raising awareness of the changing determinants of health
- supporting the development of collaboration and networks for health development
- mobilizing resources for health promotion
- accumulating knowledge on best practice
- enabling shared learning
- promoting solidarity in action
- fostering transparency and public accountability in health promotion

National governments are called on to take the initiative in fostering and sponsoring networks for health promotion both within and among their countries.

The participants call on WHO to take the lead in building such a global health promotion alliance and enabling its Member States to implement the outcomes of the Conference.

A key part of this role is for WHO to engage governments, nongovernmental organizations, development banks, organizations of the United Nations system, interregional bodies, bilateral agencies, the labour movement and cooperatives, as well as the private sector, in advancing the priorities for action in health promotion.

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STATEMENT ON HEALTHY AGEING

4TH INTERNATIONAL CONFERENCE ON HEALTH PROMOTION, JAKARTA, JULY 1997

Ageing is currently the most important demographic trend worldwide. Further ageing of societies in developed countries is now accompanied by unprecedentedly rapid ageing of populations in developing countries.

The challenges and opportunities for society are multiple and universal. Investments for health throughout life ensure that individuals reach old age enjoying increasing levels of health. This life-course perspective is essential. Health in old age depends on investment in health from childhood. Further major benefits are gained from interventions in adult life - to include those targeting individuals already in old age.

There is a clear evidence that health promotion interventions in relation to ageing work. Data from a number of countries indicate that older people are enjoying better physical and mental health leading to improved social well-being.

A "healthy ageing" initiative has been launched under WHO leadership. It promotes a cycle of activities: the strengthening of information bases; dissemination of information; advocacy; informed research; training; and policy development. It encourages community-based and inter-generational activities. It emphasizes gender and ethical issues.

Successful projects depend on multi-sectoral involvement. The participation of older people themselves as active players and role models, reinvesting in health as they continue to age, greatly strengthens the process. Firm partnerships are needed with many other agencies and sectors - NGOs, governments, educational bodies, the media and the private sector. Projects should be evaluated to identify models of good practice. Only through evidence of effectiveness will decision-makers be convinced and policy development influenced.

Health is the building block which enables individuals to continue to contribute to society. "Healthy older people are a resource for their families, their communities and the economy" *(Brasilia Declaration on Ageing, WHO, July 1996),*

25 July 1997

STATEMENT ON HEALTH PROMOTING SCHOOLS

4TH INTERNATIONAL CONFERENCE ON HEALTH PROMOTION, JAKARTA, JULY 1997

Every child has the right and should have the opportunity to be educated in a health-promoting school. The participants of the 4th International Conference on Health Promotion call upon international and national agencies, governments, communities, nongovernmental organizations and the private sector to support the development of Health Promoting Schools. They urge governments, groups and individuals to promote the concept of the health-promoting school as a sound investment in the future, when considering policies, priorities and expenditures. They call upon all agencies to support the integration of health-related issues into a comprehensive approach that enable schools to use their full potential to promote the physical, social and emotional health of students, staff, families and community members.

25 July 1997

STATEMENT ON HEALTHY WORKPLACES

4TH INTERNATIONAL CONFERENCE ON HEALTH PROMOTION, JAKARTA, JULY 1997

The participants attending the Symposium on Healthy Workplaces at the 4th International Conference on Health Promotion (Jakarta, July 1997) underlined the great importance of work settings for the promotion of health of working populations, their families and friends, the community and society at large. A healthy workforce is vital for sustainable social and economic development on global, national, and local level.

The globalization of business life, technological developments and changes in the demographic structure of populations are leading to new types of employment patterns, such as temporary and part-time work, self-employment and telework. High rates of unemployment are becoming one of the major social problems all over the world. The participants of the symposium stated that "there is no shortage of work, only of jobs. We have to reconsider our values and combine economic development with human development."

The various trends foreseeable in society have to be taken into account for the development of policies and action plans influencing workers' health. Until now most investments for health of working populations have been made in large-scale enterprises. However, informal work settings, small-scale and micro enterprises are becoming increasingly important as new venues for work, national stability and economic growth. This poses considerable challenges to all sectors of society, and calls in line with the Jakarta Declaration for partnership between non-governmental organizations, all branches of the public and private sector, educational bodies and the media.

Comprehensive workplace approaches are essential which take into consideration physical, emotional, psychosocial, organizational and economic factors both within work settings and all other settings, in which people fulfill their multiple life roles. Among other things, this means that strong links to existing setting approaches such as Healthy Cities, Health Promoting Hospitals and Health Promoting Schools have to be established.

In the face of these future challenges, WHO has developed a new initiative, called *WHO's global Healthy Work Approach (HWA)*, which serves as a catalyst for partnership between the different stakeholders. This approach is based upon the following four complementary principles: 1. health promotion, 2. occupational health and safety, 3. human resource management, and 4. sustainable (social and environmental) development. Together, these fundamental principles make it possible to deal with the impact of a wide variety of factors on working people, the surrounding community and society at large.

To strengthen such a global initiative the participants of the symposium at the Jakarta Conference stressed the importance to advocate for global unity and solidarity to promote and protect the health of employed and unemployed people. Priority areas, criteria and key strategies have to be specified in every region of the world through an open dialogue between the different sectors of society. This process will have to be supported by a strong investment in research on the impact of workers health on social and economic development.

25 July 1997

STATEMENT ON PARTNERSHIPS FOR HEALTHY CITIES

"HEALTHY CITIES, VILLAGES, ISLANDS, COMMUNITIES" WORKING GROUP
4TH INTERNATIONAL CONFERENCE ON HEALTH PROMOTION, JAKARTA, JULY 1997

The global Healthy Cities movement, which now incorporates islands, villages, communities, towns, municipalities, cities, and megacities around the world, has been a very successful application of the Ottawa Charter's strategies. Healthy Cities embodies healthy schools, workplaces, health care facilities, markets and other settings. Healthy Cities is the balance of people's spirit and technologies. The process of creating healthier cities is a practical example of the effectiveness of partnerships between local governments involving different departments, residents, NGOs, private sectors, community organizations, and academics.

Commitment at local level

Commitment to build successful partnerships for Healthy Cities rests on action at local level. Partnerships at several levels with various partners widens diversity in alliance. They include partnerships within the health sector, within the public sector, between cities, and across sectors. This requests participation from health, environment, economy, ecology, education, and urban planning fields. Decentralization expedites influential partnerships.

Tailor-made effectual formula

There is no single standard formula to build up effective partnerships for Healthy Cities. The leadership and managerial skills affect its outcome. Social pressure is a key to stimulate leaders to make partnerships with the concerned organizations and people to enhance health promotion in places where people live. Health plans developed through partnerships contribute to health gain.

Key mechanisms

Mechanisms to constitute influential partnerships are to tackle hot local issues, to build on cultural and historical backgrounds, to employ a holistic approach, to build on mutual success, to work step by step, to be aware of generating additional financial resources to sustain good partnerships, and to involve decision makers of communities.

Enablement

We need to enable people of various sectors to build partnerships at the local level. People need skills to find partners, work with different partners, mediate, create participatory platforms, and work towards the same goal. We need to increase partnership literacy.

This commitment to building the Healthy Cities movement is for the health of the people.

25 July 1997

STATEMENT OF MEMBER COMPANIES AND GROUPS

AD HOC PRIVATE SECTOR GROUP

4TH INTERNATIONAL CONFERENCE ON HEALTH PROMOTION, JAKARTA, JULY 1997

Private sector companies and groups attending the Jakarta Conference warmly welcomed the opportunity afforded to them by the WHO for full participation in the ongoing health promotion discussions, with the central theme of building effective partnerships involving new players.

Evidence presented to the Conference outlining the "crisis of suffering" facing the populations of the world, clearly indicates the need for the private sector to play a full and responsible part in working with WHO and government, in both developed and developing countries, to meet the health challenges ahead.

Private sector companies and groups represented at Jakarta are committed to working with WHO, governments and NGOs to help inspire similar commitment from other responsible private sector companies and groups. We share the view that the issue of greater health expectancy is as important to companies and the communities they serve, as was the issue of the environment in the 1980s and early 1990s. We further believe that best practice in the workplace involves a comprehensive and holistic approach to the promotion of physical, mental and emotional well-being for workforces and families. We are also fully aware of the continuing need for companies to be vigilant as to the health impact of their products and services, as well as to the way they are produced, delivered and marketed.

The private sector at large has spent billions of dollars over the last decade in health promotion programs, stimulated in part by the ground-breaking Ottawa Charter. However, for millions of people in both developed and developing countries the private sector's crucial contribution to health promotion is as wealth creators and job providers. The eradication of poverty through the provision of opportunities to work is a crucial, yet undervalued, contribution to health promotion provided by the private sector. Yet there is more to be done. Our view is that health promotion programs in the corporate sector, whether philanthropic or commercial, will become more effective if they are delivered through practical, balanced and transparent partnerships.

Having taken the first steps in creating such partnerships during our time here in Jakarta, the private sector companies and groups would wish
to maintain a regular dialogue with the new partners and WHO, leading to agree partnership
protocols and commitments. General protocols for successful partnerships must include transparency, accountability, mutual benefit and ethics. Other protocols must be tailored to particular partnerships, such as commitment to the highest standards of professional and scientific practice.

The private sector seeks to ensure successful partnerships by reaching agreement on commitments to:

- Regular measurement of goals and objectives;
- Sharing fully and openly all information relevant, and wherever possible, sharing resources be they managerial, technological, training or financial;
- Maintaining open dialogue in the spirit of understanding with an aim to reach agreement on joint values, joint responsibilities and joint action plans;
- Open acknowledgement of the contribution of each partner, and the responsibilities of both new and "old" players in health promotion.

The Scope and Purpose Document prepared by WHO for the 4th International Conference, outlined the expected outcomes of the Jakarta meeting. We believe that our statement addresses directly many of those outcomes, particularly those regarding alliances and partnership principles.

Private sector companies and groups at Jakarta warmly welcome the Jakarta Declaration and commit themselves to participate fully in its implementation.

25 July 1997

	Day 0	day: 21 July	day 2: 22 July	day 3: 23 July	day 4: 24 July	day 5: 25 July	day 6
8.30-9.00		***transportation to palace***	NEWS	NEWS	NEWS	NEWS	***Optional :***
Plenary 9.00-10.30		OFFICIAL OPENING (presidential palace Istana Negara)	CHALLENGE II: New Mindsets Think Health: What makes the difference? 3	CHALLENGE IV: New Policies New Policies for Health Promotion 7	CHALLENGE V: New Tools & Technologies Soaps for Health: health promotion through entertainment 9	CHALLENGE VI Partnerships for Health Promotion Plenary Discussion Jakarta Declaration 13	***HP Site visits***
Break: 10.30-11.00			***Break***	***Break***	***Break***	***Surprise Speaker***	
Symposia 11.00-12.30		*tranport to Conference venue - Hotel Horison -*	LEADING CHANGE I Think Health 4	LEADING CHANGE II Challenges & Responses 8	LEADING CHANGE III Leadership skills for health promotion 10	***Break***	
12.30-	***Registration DAY***	LUNCH	LUNCH	LUNCH	LUNCH	LUNCH	
Plenary 14.00-16.00		CHALLENGE I: Health Promotion : A global challenge 1	CHALLENGE III: Health Futures Health 2020 5	INDONESIA DAY	LEADING CHANGE IV HP towards the 21st century 11	LEADING CHANGE V New Players for a New Era - Final Commitments Adoption of Jakarta Declaration 14	
Break: 16.00-16.30		***Break***	***Break***		***Break***	Closing Ceremony	
		Review & Evaluation	Health Promotion Futures				
Symposia 16.30-18.00		PARTNERSHIPS IN ACTION I Health Promotion in Action 2	PARTNERSHIPS IN ACTION II Moving Ahead 6	PARTNERSHIPS IN ACTION III Indonesian experiences	PARTNERSHIPS IN ACTION IV Partner dialogues strengthening commitments 12		
18.00-	***Welcome Cocktail hosted by WHO***	NETWORKING	NETWORKING	NETWORKING	NETWORKING		
EVENING EVENTS		Welcome Dinner: hosted by Ministry of Health Indonesia	FREE	Dinner & Cultural Evening hosted by Governor of Jakarta	FREE		

Sunday 20 July 1997 12.00 - 20.00 16.30 - 18.00	Registration at Lobby of Krakatau Room Welcome Cocktail hosted by WHO

MORNING EVENTS	DAY 1 Monday 21 July 1997
7.30-8.30	• Transport to Presidential Palace
9.00-10.30 11:00-12:30	**Official Opening** *Presidential palace* • Official opening "Welcoming address from Indonesia" "Welcoming address from World Health Organization" ▸ *Transportation to the conference venue*
12:30-14:00	LUNCH
14.00-15.30	*Multi - Media Introduction* Session 1 — CHALLENGE I — Plenary **Health Promotion - a Global Challenge** *Chair:* *H.E. Prof Dr Sujudi, Minister of Health, Indonesia* ▸ Welcoming address *Dr Uton Muchtar Rafei, Regional Director, WHO/ SEARO* ▸ Keynote speech: *" Looking back...Looking Ahead: Health Promotion a Global Challenge!" - Dr I.Potter, Assistant Deputy Minister of Health, Canada* ▸ Opening Panel: Health Promotion: A Global Challenge! "Challenge in Hungary & Eastern European countries" - *H.E. Dr M.Kökény, Minister of Welfare, Hungary* "Challenge in the pacific islands" - *Dr A.U.Boladuadua, Director Primary & Preventive Health Service,Fiji* "Challenge for NGOs in Africa"- *Dr F.Manguyu, President Medical women's International Association, Kenya* "Challenge for private sector"- *Mr J.Mullen, Chairman, Private Sector for health promotion, USA*
15.30-16.00	**Introduction to programme of 4ICHP** ▸ Introduction to programme of 4ICHP — *Dr D. O'Byrne, Chief HEP, WHO* ▸ Introduction to "health promotion in action" (S2) — *Prof P. Gillies, Director Research, HEA*
16:00-16:30	**Break**
16.30-18.00	Session 2 — PARTNERSHIPS IN ACTION I — Symposia **Health Promotion in Action** 10 Symposia Symposia on successful Health Promotion strategies and approaches (advocating, enabling, mediating, intersectoral action, strengthening community action, etc.) illustrated by case studies. These case studies reflect a wide range of health promotion in action. The outcomes of this session will provide important input, particularly into session 6 "Moving Ahead" and session 12 "Partner dialogues". • What makes health promotion approaches successful? • What are supportive environmental conditions? • Which partners make a difference?
	2.1 Healthy Cities/ villages/ islands/ communities; 2.2 Health Promoting Schools; 2.3 Healthy Workplaces; 2.4 Healthy Ageing; 2.5 Active Living/ Physical Activity 2.6 Sexual Health; 2.7 Tobacco free societies; 2.8 Promoting women's health; 2.9 Health Promoting Healthcare Settings; 2.10 Healthy homes/ families
18.00-19.30	NETWORKING
EVENING EVENTS	Welcome Dinner, hosted by H.E. Prof Dr Sujudi, Minister of Health, Republic of Indonesia

MORNING EVENTS	DAY 2 Tuesday 22 July 1997
8.30-9.00	NEWS
9.00-10.30	*Multi - Media Introduction* Session 3 CHALLENGE II: New Mindsets Plenary **Think Health: What makes the Difference?** *Chair:Mr J.Mullen, Chairman, Private Sector for health promotion* *Key-Note speech:* "Think Health: What makes the Difference?" Dr I.Kickbusch, Director HPR, WHO The panel discusses how to place health promotion in the centre of development. How can health promotion address the determinants of health in different economic, historic, social and cultural contexts? *Panel-presentations:* - *'addressing health determinants in the United States'* - *Dr D.McQueen, USA* - *'addressing health determinants- grass-roots perspective'* - *Dr A.Mukhopadyay, India* - *'addressing health determinants- African perspective'* - *Dr W.Mwanyenge, Bostwana* - *'addressing health determinants- private sector perspective'* - *Dr M. Knowles, Belgium*
10:30-11:00	***Break***
11.00-12.30	Session 4 LEADING CHANGE I Symposia **Think Health** 10 symposia The question 'how do we create health' leads to new approaches policymaking, financing and evaluation. The symposia will provide examples of innovative action.
	4.1 *Intersectoral Action* | 4.2 *Healthy public policies* | 4.3 *Investing in health* | 4.4 *Investing in equity* | 4.5 *City Health Plans*
	4.6 *Evaluating policies* | 4.7 *Evaluating settings* | 4.8 *Evaluating community health programmes* | 4.9 *Ensuring human rights* | 4.10 *Think globally, act locally*
12:30-14:00	LUNCH

14.00-15.30

Multi - Media Introduction

Session 5 — CHALLENGE III: Health Futures — Plenary

Health 2020

Chair: *Dr F.Manguyu, President Medical Women's International Association, Kenya*

Keynote speech: "Demographic trends: health & population responses" - *H.E. Prof H.Suyowo, Minister of Population, Indonesia*
"Global Health Trends & Health Potentials" - *Dr O. Shishana, South Africa*

While moving into the 21st century, health promotion must respond to major challenges. This panel introduces global health trends and selective responses.

Panel-presentations:

- 'Western pacific scenarios: New Horizons in Health' -*DrS.T.Han, Regional Director, WHO/WPRO*
- 'Illiteracy & Educational Responses' - *Dr E. Jouen, Belgium*
- 'Tobacco Trends & Health Responses' - *Dr S.Omar, Egypt*
- 'Building Effective Networks: in the Community and Around the World' - *Dr R. Scott, Canada*

15.30-16.00

Health Promotion Futures

- HP Futures- introduction to 'Moving ahead' (S6)
  - Dr R.Vaithinathan, Director, Training & Health Education Department, Ministry of Health Singapore, WHO Collaborating Centre
  - Dr T. Hancock, Health Promotion Consultant

16:00-16:30

Break

16.30-18.00

Session 6 — PARTNERSHIPS IN ACTION II — Symposia

Moving Ahead

10 Symposia

This series of symposia will focus on different entry points for health promotion action most likely to lead to significant gains in health and well-being by 2020.
Participants will be engaged in proposing priority approaches and action steps based on the most effective strategies as results of session 2 "Health Promotion in Action" incorporating the trends laid out in session 5. Proposals from these symposia will lay the basis for partner dialogues such as in session 12.

- What are key priorities leading to health gain into the 21st Century?
- What action steps today guide the direction to a preferred health promotion future?
- What partnerships will make a difference?

6.1 Healthy Cities/ villages/ islands/ communities	6.2 Health Promoting Schools	6.3 Healthy Workplaces	6.4 Healthy Ageing	6.5 Active Living/ Physical Activity
6.6 Sexual Health	6.7 Tobacco free societies	6.8 Promoting women's health	6.9 Health Promoting healthcare settings	6.10 Healthy Homes & Food & Nutrition

18.00-19.30

NETWORKING

EVENING EVENTS

DAY 3 Wednesday 23 July 1997

MORNING EVENTS	
8.30-9.00	NEWS
9.00-10.30	*Multi - Media Introduction* Session 7 — CHALLENGE IV — Plenary **New Policies for Health Promotion** This plenary focuses on how 3 countries and one interregional group use the integrative health promotion approach to maintain and enhance health. Three of the most populated countries will outline their response to the challenges to lead change in promoting the health of the people. *Chair: H.E. Dr M.Kökény, Minister of Welfare, Hungary* "Health Promotion towards the 21st century: Indonesian policy of the future" - *H.E. Prof Dr Sujudi, Minister of Health, Indonesia* "Global health inequity and the role of Mega-countries" - *Dr D.Satcher, USA* "How is the most populated country facing the future health challenges?" - *Dr Lu Rushan, China* "European policies for health promotion" - *Dr M.Rajala, Luxembourg*
10:30-11:00	***Break***
11.00-12.30	Session 8 — LEADING CHANGE II — 10 Symposia **Challenges & Responses** The world is changing rapidly, and many global trends have an impact on health. The parallel symposia in this session will feature global trends and the discussions will represent challenges and responses. The participants are challenged to define future action and strategies through which health promotion can bend global trends to enhance health and equity.

8.1. *New Ethical: Challenges & HP Responses*	8.2. *Global Health: Global Alert & Surveillance*	8.3. *Global Movements: Tourism*	8.4. *Information Highway: Challenges & HP responses*	8.5. *Trade & Health: Challenges & HP Responses*
8.6. *Mega Cities: Challenges & HP Responses*	8.7. *The Changing Social Fabric: Challenges & Responses*	8.8. *New Consumers: Challenges & HP Responses*	8.9. *Food Production & Safety*	8.10. *Forgotten people: Challenges & HP Responses*

12:30-14.00	LUNCH			
14.00-14.30	Operette - INDONESIA DAY			
14.30 - 16.00	Session I ** Detailed programme of Indonesia Day: see separate booklet*	*ID1 Theme I a:* Religion and Health Development in Indonesia	*ID2 Theme II:* Woman and Health Development in Indonesia	*ID3 Theme III:* Nation Wide Community Action for Health
		ID4 Theme IV: Local Specific Community Action for Health	*ID5 Theme V:* Intersectoral collaboration and Private Sector	*ID6 Theme VI:* Managed Care in Indonesia
14.30 - 16.00	Session II	*ID1 Theme I b:* NGO's Health Activities in Indonesia	*ID2 Theme V:* Woman and Health Development in Indonesia	*ID3 Theme III:* Nation Wide Community Action for Health
		ID4 Theme IV: Local Specific Community Action for Health	*ID5 Theme V:* Intersectoral collaboration and Private Sector	*ID6 Theme VI:* Managed Care in Indonesia
16:00-16:30	***Break*** PARTNERSHIP IN ACTION III			
18:00-19:30	NETWORKING			
EVENING EVENTS	Dinner & Cultural Evening, hosted by the Governor of the metropolitan city of Jakarta			

MORNING EVENTS	DAY 4 Thursday 24 July 1997
8.30-9.00	NEWS
9.00-10.30	*Multi - Media Introduction* Session 9 CHALLENGE V: New Tools & Technologies Plenary **Soaps for Health: health promotion through entertainment** The rapid spread and development of Information systems and communication infrastructures have a major impact on our everyday life. Health promotion can benefit from the fact that nearly all communities in the world and large numbers of individuals have access to communications technology including entertainment on television. This session will show examples of broadcasting health in soap-operas from different parts of the world. *Chair:* *Dr A.U.Boladuadua, Director Primary & Preventive Health Services, Fiji* *Key-Note Speech:* "Soaps for Health", *Dr S. Fox, USA* "Trends in Health and in Communication: Opportunities & Strategies to mobilize Partners"- *Dr W.Feek, USA* *Panel Presentations:* - *Ms Roma Pereira, India* - *Dr Kimani Njogu, Kenya* - *Ms S. Ward, South-Africa*
10:30-11:00	***Break***
11.00-12.30	Session 10 LEADING CHANGE III Symposia **Leadership for health promotion** The symposia in this session challenge the participants to integrate different approaches which are the basis for leading health promotion ahead. Building on the best practices in health promotion strategies, we can learn from diverse leadership skills. 10.1 Leadership through advocacy 10.2 Leadership through communications for health 10.3 Leadership through partnershipbuilding I 10.4 Leadership through Partnership building II 10.5 Global Leadership through conventions 10.6 Leadership through policy frameworks 10.7 Acquiring leadership skills through training 10.8 Economic accountability for HP 10.9 Leadership through coordinating the HP- Networks 10.10 Positioning HP in health care reform
12:30-14:00	LUNCH
14:00-16:00	Session 11 LEADING CHANGE IV Plenary **Health Promotion towards the 21st century** *Chair: H.E. Dr M.Kökény, Minister of Welfare, Hungary* In anticipating a rapidly changing world, this session summarizes and synthesizes the challenges, key strategies and priority areas for future health promotion action. The session allows for the plenary discussion of the draft Jakarta Declaration. *Panellists:* - *Dr D. Nyamwaya, Kenya* - *Dr D. Nutbeam, Australia* - *Ms N. Mattison, Switzerland* - *Drs Dachroni, Indonesia* Discussions of the draft Jakarta Declaration in 10 parallel groups

16:00-16:30	***Break***
16.30-18.00	Session 12 PARTNERSHIPS IN ACTION IV Symposia **Partner dialogues: strengthening commitments** 10 Symposia This afternoon session offers the possibility for different organizations and agencies to meet and negotiate with various global (WHO) Health Promotion initiatives and networks on potential joint health promotion action. Outcomes of the partnerdialogues are presented in plenary session 13 "Partnerships for health promotion". • How can we build new partnerships and alliances to reduce the health gap and promote Health for All in the 21st century? • What new players are willing to form a global alliance for Health Promotion? • How can we capture the positive momentum from partnerships and alliances for a dynamic Health Promotion future?
18.00-19.30	NETWORKING
EVENING EVENTS	

12.1 Healthy Cities Network	12.2 Global School Health Initiative	12.3 Healthy Ageing Initiative	12.4 Healthy Work Initiative	12.5 Active Living Initiative
12.6 Mega-country Initiative	12.7 Health Promotion Foundations - Initiative	12.8 Health Promotion for Chronic Health conditions	12.9 Health Promoting Hospitals- Initiative	12.10 Health Promoting Media settings

MORNING EVENTS	DAY 5 Friday 25 July 1997
8.30-10.30	*Multi - Media Introduction* Session 13 Plenary ***Partnerships for Health Promotion*** *Chair:* *Dr F.Manguyu, President Medical Women's International Association, Kenya* Plenary discussion on Jakarta Declaration proposal
11:00-11:30	*Panellists:* - *Dr D.Mukaji, India* - *Dr A.Malaspina, USA* - *Dr J.Catford, Australia* - *Dr R.Davies, USA*
11:30-14:30	***Break***
14:30-16:00	*Multi- Media Introduction* Session 14 Plenary ***New Players for a New Era - Final Commitments*** *Chair: H.E. Prof. Dr Sujudi, Minister of Health, Indonesia* Presentation of the Conference Report Regional follow-ups - short presentations (5 minutes each) from each WHO Region Reading of the Jakarta Declaration Closing Ceremony

MORNING EVENTS	DAY 6 *(optional)* Saturday 26 July 1997
8.00-8.30	Busses are waiting in front of the lobby Hotel Horison
8.30-10.00 10:00-12:30	3 Site Visits: 1. Taman mini Indonesia indah (the garden of wonderful Indonesia in Minature) 2. Kebun Raya Bogor (the Bogor botanical garden) 3. Taman safari Cisarua (the safari garden, Cisarua) Site Visits to health promotion actions in Indonesia
12:30-14:00	LUNCH
14.30-16.00	Back to Hotel Horison

Introduction to Symposia

The conference programme features on two tracks of symposia:
- 'Leading Change'-symposia in the mornings
- 'Partnership in Action'-symposia in the afternoons

'Leading Change' symposia
The symposia in the 'Leading Change' track are structured as learning sessions. The items addressed in these symposia trigger discussion and debate between the participants with a new reconciling to different perspectives and adopting a stronger, more united approach to health promotion.
The following three 'Leading Change' sessions are discussed in detail in the next pages:
- Session 4, Think Health
- Session 8, Challenges & Responses
- Session 10, Leadership skills for health promotion

Tuesday 22 July 1997 11.00 - 12.30	Wednesday 23 July 1997 11.00 - 12.30	Thursday 24 July 1997 11.0 - 12.30
LEADING CHANGE I Think Health 4	LEADING CHANGE II Challenges & Responses 8	LEADING CHANGE III Leadership skills for health promotion 10

'Partnerships in Action' symposia
The symposia in the 'Partnership in Action' track give the participants the opportunity to work in depth in one of ten health promotion areas.
Within 'Health Promotion in Action' session 2, the participants will illustrate successful Health Promotion strategies, methods and approaches by presenting selected case studies. Building on these successful strategies, participants will identify future Health Promotion action areas. In the 'Challenges & Responses' symposium key action steps to reach the greatest health gain by the year 2020 will be discussed. The focus of 'Partnerdialogues - strengthening commitments' is the enhancement of the commitment on joint action among "old and new players" interested or involved in the respective health promotion initiatives.

Monday 21 July 1997 16.30 - 18.00	Tuesday 22 July 1997 16.30 - 18.00		Thursday 24 July 1997 16.30 - 18.00
PARTNERSHIPS IN ACTION I Health Promotion in Action 2	PARTNERSHIPS IN ACTION II Moving Ahead 6		PARTNERSHIPS IN ACTION IV Partner dialogues strengthening commitments 12

Session 4: *Think Health* - Tuesday 22 July 1997, 11.00-12.30

LEADING CHANGE- symposia *(Sessions 4-8-10)*

Symposia	Speaker	Respondents	Facilitator
4.1 *Intersectoral Action*	Dr N.Kotani, Canada	- Dr M.Szatmari, Hungary - Ms R.Bonner, Switzerland	Dr J.Mwanzia, Kenya
4.2 *Healthy public policies*	Dr N.Ngwenya, Zimbabwe Dr D.McVey, UK	- Dr R.Parish, UK - Dr C.Colin, Canada	Dr H.Hagendoorn, Netherlands
4.3 *Investing in health*	Dr E.Ziglio, Denmark Dr A.Rütten, Germany	- Ms J.Jett, USA	Ms R.Tennyson, UK
4.4 *Investing in equity*	Dr G.Dahlgren, Sweden	- Dr M.Danzon, France - Dr G.Perez, South-Africa	Dr A.Mukhopadhyay, India
4.5 *City Health Plans*	Dr A.Kiyu, Malaysia	- Dr C.Daniel/ Dr J.Goepp, USA - Dr T.Ohta, Japan	Dr J.Urbino-Soria, Mexico
4.6 *Evaluating policies*	Dr I.Rootman, Canada (Dr S. Jackson)	- Dr M. Ahmed, Bangladesh	Dr C.Kelleher, Ireland
4.7 *Evaluating settings*	Dr J.Pelikan, Austria	- Dr J.Adeniyi, Nigeria - Dr Ramji Dhakal, Nepal	Dr J.Catford, Australia
4.8 *Evaluating community health programmes*	Prof P.Gillies, UK	- Dr D.Nyamwaya, Kenya - Dr D.McQueen, USA	Ms C.Hamilton, New Zealand
4.9 *Ensuring human rights*	Dr R.Gurr, Australia	- Dr A.Etsri, Togo	Dr D.Mukarji, India
4.10 *Think globally, act locally (integrate perspectives)*	Dr Chowdhury, Bangladesh	- Dr Boon Yee Yeong, Singapore - Dr F.Lostumbo, USA	Dr B.Petterson, Sweden

The question 'how do we create health' leads to new approaches in policymaking, financing and evaluation. The symposia will provide examples of innovative action.

Symposia Goal

- To address different key approaches to create health

Symposia Objectives

- to learn about new and innovative approaches in creating health;
- to introduce the health promotion perspective on policymaking, financing and evaluation;
- to integrate new perspectives of innovative action into existing approaches.

Symposia Outcomes

- identified new and innovative approaches in creating health;
- identified ways how new perspectives of innovative action can be integrated into existing approaches.

Symposia Structure

- introduction of topic and speakers by facilitator and designation of a rapporteur;
- keyspeaker: presentation on an innovative health promotion approach of policymaking, financing or evaltuation in "creating health" (15 minutes),
- one or two speakers responding to the presentation providing new perspectives on the health promotion approach (5 minutes each);
- discussion along questions prepared by the facilitator and key speaker;
- summary of the discussion by the facilitator;
- written report developed by a designated rapporteur.

Background material

- key speaker to provide all participants with input/material (if possible specific prepared paper) for the symposium.

Session 8: *Challenges & Responses* - Wednesday 23 July 1997, 11.00-12.30

LEADING CHANGE- symposia *(Sessions 4-8-10)*

Symposia	Speaker	Respondents	Facilitator
8.1. *New Ethical Challenges*	Prof H.Hannum, USA	- Ms M.Modolo, Italy - Dr Egwu, Nigeria	Dr H.Hagendoorn, Netherlands
8.2. *Global Health: Global Alert & Surveillance*	Dr Hapsara, WHO/HST (global health trends)	- Dr L.Kuppens, WHO/EMC (global alert & surveillance)	Dr B.Petterson, Sweden
8.3. *Global Movements:tourism*	Ms E.Simon, Switzerland (global Hospitality Industry)	- Ms D.D'Cruz-Grotte, UNAIDS (AIDS - tourism)	Dr J.Catford, Australia
8.4. *Information Highway: Challenges & HP responses*	Dr S.Connelly, USA	- Ms C.Herman, UK (internet) - Ms B.Kabre, Cote d'Ivoire	Dr J.Mwanzia, Kenya
8.5. *Trade & Health: Challenges & HP responses*	*cancelled*		
8.6. *Mega Cities: Challenges & HP responses*	Dr T.Takano, Japan	- Dr C.De Sa, India - Mrs M.Broglia, USA	Dr F.Memon, Pakistan
8.7. *The Changing Social Fabric: Challenges & responses*	Dr J.Davies, UK	- Dr D.Mukarji, India - Dr V.Naweya, Kenya	Dr J.Urbino-Sario, Mexico
8.8. *New Consumers: Challenges & HP responses*	Dr Z.Mirzar, Pakistan		Dr C.Kelleher, Ireland
8.9. *Food Production & Safety*	Dr M.Edmundson	- Ms J.Koch, Switzerland - Mr A.Gueniffey, France	Dr D.Mukarji, India
8.10. *Forgotten people: challenges & HP responses*	Dr P.Makara, Hungary (Gypsies)	- Dr R.Mihi, New Zealand (Maori) - Dr C.Ten Haeff, Netherlands	Dr A.Mukhopadhyay India

The world is changing rapidly, and many global trends have an impact on health. The parallel symposia in this session will feature global trends as challenges for health promotion and the discussions will represent challenges and responses. The participants are challenged to define future action and strategies through which health promotion can bend global trends to enhance health and equity.

Symposia Goal

- to analyse challenges for health development and how health promotion can best respond to these challenges

Symposia Objectives

- to learn about global trends in terms of their challenge that they pose for health promotion;
- to analyse these trends in terms of their challenge that they pose for health promotion;
- to discuss and develop future strategies of action for addressing these trends.

Symposia Structure

- introduction of topic and speakers by facilitator and designation of a rapporteur;
- key speaker: presentation of global trends and its impact on health (by an expert in the field - keyperson) with emphasis on the health promotion response (15 minutes);
- one or two speakers responding to the presentation providing new perspectives on the health promotion challenges and responses (5 minutes each);
- discussion along questions prepared by the facilitator and key speaker;
- summary of the discussion by the facilitator;
- written report developed by a designated rapporteur.

Symposia Outcomes

- identified global trends that are a challenge for health promotion;
- Identified responses and future strategies of action for addressing these trends.

Background Material

- key speaker to provide all participants with input/material (if possible specific prepared paper) for the symposium

Session 10: *Leadership for health promotion* - Thursday 24 July 1997, 11.00-12.30

LEADING CHANGE- symposia *(Sessions 4-8-10)*

Symposia	Speaker	Repondents	Facilitator
10.1 Leadership through Advocacy	Dr F.Lostumbo, USA	- Dr H.Aroyo, Puerto Rico - Mr D.Boddy, UK	Ms C.Hamilton, New Zealand
10.2 Leadership through communications for health	Dr J.Yadava, India	- Mr P. Mitchell, UK	Dr J.Urbino-Soria, Mexico
10.3 Leadership through partnershipbuilding I	Ms R.Tennyson, UK		Dr Kawaguchi, WHO (Dr J.Miller - rapp.)
10.4 Leadership through Partnership building II	*cancelled*		
10.5 Global Leadership through conventions	Dr N.Mboi, Indonesia (child rights)	- Dr S.Omar, Egypt (tobacco free societies)	Dr C.Kelleher, Ireland
10.6 Leadership through policy frameworks	Dr J.Bennett, Australia	- Dr N.Enyimany, Ghana - Dr L.Parsons, UK	Dr F.Memon, Pakistan
10.7 Acquiring leadership skills through training	Dr H.Saan, Netherlands	- Ms L.Ong Pool - Dr K.Hyu, Korea	Dr J.Catford, Australia
10.8 Economic Accountability for HP	Dr J.Van der Horst, Netherlands	- Dr S.Geddes, Australia	Dr D.Mukarji, India
10.9 Leadership through coordinating Networks	Dr P.Chandran John, India	- Ms H.Macdonald, Australia - Ms I.Dinca, Romania	Dr B.Petterson, Sweden
10.10 Positioning HP in health care reform	Dr J.Castro, Mexico	Dr C.Connolly, Canada	Dr J.Mwanzia, Kenya

The symposia in this session challenge the participants to integrate different health promotion strategies which are the basis for leading health promotion ahead. Building on the best practices participants get the chance to explore diverse leadership skills.

Symposia Goal

- to explore and identify diverse leadership skills for health promotion;

Symposia Objectives

- to learn about key health promotion strategies;
- to integrate diverse leadership activities and skills into existing ones;
- to enhance leadership skills of participants.

Symposia Structure

- introduction of topic and speakers by facilitator and designation of a rapporteur;
- key speaker: presentation of successful strategy and leadership (15 minutes);
- one or two speakers responding to the presentation providing new perspectives of leadership (5 minutes each);
- discussion along questions prepared by the facilitator and key speaker;
- summary of the discussion by the facilitator;
- written report developed by a designated rapporteur.

Symposia Outcomes

- identified diverse models of good practice of leadership skills;
- identified ways to integrate diverse leadership activities and skills into existing ones;

Background Material

- key speaker to provide all participants with input/ material (if possible specific prepared paper) for the symposium

PARTNERSHIP IN ACTION - symposia *(Sessions 2-6-12)*

SYMPOSIA	SESSION 2 - Monday 21 *'Health Promotion in Action'*	SESSION 6 - Tuesday 22 *'Moving Ahead'*	SYMPOSIA	SESSION 12- Thursday 24 *'Partner dialogues'*
1. Healthy Cities/ villages/ islands/ communities	- *"Healthy City Kuching"* - *"Queensland Healthy Cities"* - *"Healthy Island activities"* - *"Evaluating Healthy Cities & Health Promotion"*	- *"Health Promotion Futures: Healthy Cities"* - *"Future Directions for Healthy Cities"* - *"Future Directions for Healthy Cities"*	12.1Healthy Cities Network	*"Partnerships for the Global Healthy City Network"* Panel of Healthy City experts
2. Health Promoting Schools	- *"A Health Promoting School"* - *"National strategies improving school health programmes in Megacountries"* - *"European Network of Health Promoting Schools"*	- *"HP Futures-Health Promoting Schools"*	12.2 Global School Health Initiative	*"Partnerships building for School Health"* Panel discussions
3. Healthy Workplaces	- *"Working Conditions and Quality of Working Life: The Health Circle Approach"* - *"Workplace Initiative- public/private partnership"*	- *"Future Strategies for Effective Workplace Health Promotion in Europe"* - *"Health Promotion Futures: promoting health at work"*	12.3 Healthy Work Initiative	*"Healthy Work Initiative"* *"Partnership building for Healthy Work"*
4. Healthy Ageing	- *"Health Promotion in Action":* - Ms I. Hoskins, USA - Dr T. Setoabudhi, Indonesia - Dr K. Kawahara, Japan	*"Health Promotion Futures":* - Dr Andrea Prates, Brazil - Ms Maria Stefan, USA	12.4 Healthy Ageing Initiative	*"The WHO perspective on Ageing and Health"* *"Partnership building for Healthy Ageing"*
5. Active Living/ Physical Activity	- *"Active Living"* - *"Tongan Weight Loss Campaigns"* - *"Active Living - casestudy Japan"*	- *"Future through/with Active Living"* - *"Future through/with Active Living"* - *"Future steps through Activity"*	12.5 Active Living Initiative	*"Global Partnerships for Active Living"*
6. Sexual Health	- *"Family Planning Project"* - *"HIV/AIDS Prevention in private sector"* - *"Sexual Health - Casestudy"*	*"Global Business Council on HIV/AIDS"*	12.6 Mega-country Initiative	
7. Tobacco free societies	- *"Tobaccofree Thailand"* - *"Tobacco free Finland"* - *"No Smoking Islands in the Maldives"*	*"Health Promotion Futures: tobacco free Societies"* *"Health Promotion Futures: USA policies"* *"Tobaccofree futureplans for Australia"*	12.7 Health Promotion Foundations - initiative	
8. Promoting women's health	*"Women's Health in India"* *"Promoting Women's Health: private sector Case-study"* *"Promoting Women's Health: NGO case"*	*"Education - the right to a better way of life"* *"Men's Health impact onWomen's Health"*	12.8 Health Promotion for Chronic Health conditions	

9. Health Promoting Healthcare Settings	*'Project 'HOPE' in Poland"* *'Health Promoting Healthcare in Africa"* *"Anesthesia Patient Safety - Casestudy"*	*"Health 2020"* *"Health Promotion Futures: responses to Non Communicable Diseases"*	12.9 Health Promoting Hospitals- Initiative
10. Healthy homes/ families	*'Healthy Homes"* *'Healthy Homes & Families"*	*"Development of food-based dietary guidelines"* *"Healthy Homes & Families: a future perspective"*	12.10 Health Promoting Media settings

Session 2: *Health Promotion in Action*

Monday 21 July 1997, 16.30-18.00

Symposia on successful Health Promotion strategies and approaches (advocating, enabling, mediating, intersectoral action, strengthening community action, etc.) illustrated by case stories. These case stories reflect a wide range of health promotion in action. The outcomes of this session will provide important input, particularly into session 6 "Moving Ahead" and session 12 "Partnerdialogues".

Symposia Goal

- to illustrate successful Health Promotion strategies, methods and approaches by presenting selected case studies

Symposia Objectives

- to learn about two models of "good practice" in Health Promotion at different levels of society; incorporating different players;
- to identify indicators for success of Health Promotion action;
- to identify ways in which the different players in Health Promotion are successfully applying Health Promotion strategies to implement and strengthen programmes;

Key Questions

- What are successfull approaches to implement and strengthen HP programmes and/or to improve health at different levels of society?
- What environmental conditions were indicators for success of Health Promotion action?
- Which partners made a difference in health promotion action (public/NGO/private sector; researchers/professionals, groupings of people such as self-help or other groups; etc.?)

Symposia Outcomes

- Models of good practice of strategies/ approaches in creating health: a list of strategies/ approaches;
- Models of good practice within the respective HP area: list of successfull casestudies;
- identified indicators for success of Health Promotion action (HP outcomes).

Symposia Structure

- introduction of topic, rapporteur and speakers by facilitator;
- presentation of two to three case studies covering a range of international, national and local Health Promotion action with emphasis on intersectoral partnership approaches;
- discussion along key questions prepared by technical adviser and the facilitator;
- summary of the discussion by the facilitator, including statement for Jakarta Declaration;
- written report developed by rapporteur.

Background Material

- Technical Adviser and facilitator to decide and distribute on the material that should be available for participants (50 copies)
- Speakers to provide all participants with input/ material (if possible specific prepared paper) for the symposium (50 copies)

Session 6: *Moving Ahead*

Tuesday 22 July 1997, 16.30-18.00

This series of symposia will focus on different entry points for health promotion action most likely to lead to significant gains in health and well-being by 2020.
Participants will be engaged in proposing priority approaches and action-steps based on the most effective strategies as results of session 2 "Health Promotion in Action" incorporating the trends laid out in session 5. Proposals from these symposia will lay the basis for partner dialogues such as in session 12.

Symposia Goal

- to identify future Health Promotion action areas and key action steps to reach the greatest health gain by the year 2020

Symposia Objectives

- to learn about a vision of "potential futures in 2020" in various Health Promotion action areas;
- to identify action steps that need to be taken today to reach the "preferred future in 2020";
- to identify three action steps for TODAY.

Key Questions

- What are key future priorities for global/international, national, and local level action to reach a state of achievement of greatest health gain?

- What key action steps need to be taken today, in 1, 3 and 5 years, to reach that "preferred future by 2020"?
- Which different partners (Public, NGO, private) and which (public/NGO/private) partnerships can support future health promotion action?

Symposia Outcomes
- identified priority action areas to reach a "preferred future by 2020" (i.e. action in partnerships and at global level);
- identified key action steps which need to be taken today, in 5, 10 and 15 years;

Symposia Structure
- introduction of topic and speaker by facilitator;
- presentation of potential futures in various Health Promotion action areas and proposal of an action plan how to reach the preferred future (8 areas will have scenario-paperfrom Singapore);
- one or two responses to the presentation;
- discussion along key questions prepared by the facilitator and technical adviser;
- summary of the discussion by the facilitator n written report developed by rapporteur.

Background Material
- Technical Adviser and facilitator to decide and distribute on the material that will be available for participants (50 copies)
- Speakers to provide all participants with input/ material for the symposium 50 copies each(Specific Health Promotion Scenarios (8 areas) by Singapore available)

Session 12: *Partner dialogues: strengthening commitments*

Thursday 24 July 1997, 16.30-18.00

This afternoon session offers the possibility for different organizations and agencies to meet and negotiate with various global (WHO) Health Promotion initiatives and networks on potential joint health promotion action.

Symposia Goal
- to reach and enhance commitment on joint action among "old and new players" interested or involved in the respective health promotion initiatives

Symposia Objectives
- to communicate the interests of the partners;
- to develop and strengthen the commitment of partners on health promotion action;
- to decide upon key action steps in leading health promotion initiatives forward
- to enhance partnerships around the health promotion initiatives.

Key Questions
- How can we build new partnerships and alliances to reduce the health gap and promote Health for All in the 21st century?
- What new players are willing to form a global alliance for Health Promotion?
- How can we capture the positive momentum from partnerships and alliances for a dynamic Health Promotion future?

Symposia Outcomes
- identified partnerships to strengthen health promotion action in the respective area;
- commitments on action steps by different partners (Public, NGO, private) and in (public/NGO/private) partnerships;
- identified ways to build maintenance for partnerships.

Symposia Structure
- presentation of partner interests;
- facilitator moderates the discussion;
- summary of the discussion by the facilitator;
- preparation of a statement of committment for joint action (a letter of intent);
- designate a representative to present the statement in the plenary panel in session 13;
- written report developed by rapporteur.

Background Material
- Technical Adviser and facilitator to decide and distribute on the material that will be available for participants (50 copies each)
- Speakers to provide all participants with input/ material (if possible specific prepared paper) for the symposium (50 copies)

Partnerships in Action-1	"Healthy Cities/ Villages/ Islands/ Communities"
2.1 Health Promotion in Action **Monday 21 July 1997** **16.30-18.00**	• *"Healthy City Kuching"* - Dr A.Kiyu, Malaysia • *"Queensland Healthy Cities"* - Dr P.Davey, Australia • *"Healthy Island activities"* - Dr P.Toelupe, Samoa • *"Evaluating Healthy Cities & Health Promotion"* - Dr F.Baume, Australia
6.1 Moving Ahead **Tuesday 22 July 1997** **16.30-18.00**	• *"Health Promotion Futures: Healthy Cities"* - Mrs S.Thanarajah, Singapore • *"Future Directions for Healthy Cities"* - Dr T.Hancock, Canada • *"Future Directions for Healthy Cities"* - Dr G.Gurevitsch, Denmark
12.1 Healthy Cities Network **Thursday 24 July 1997** **16.30-18.00**	• *"Partnerships for the Global Healthy City Network"* - Dr G.Goldstein, WHO Panel of Healthy City experts, will include: • Dr El Din Mustafa A'Alla, Sudan • Dr Y.Paisachalapong, Thailand • Dr T.Hancock, Canada • Dr F.Baume, Australia • Dr G.Gurevitsch, Denmark
Facilitator session 2-6-12:	*Dr F.Perkins, Canada*
Rapporteur session 2-6-12:	*Dr K.Nakamura, Japan* *Dr M.Chulavachana, Thailand*
Technical Adviser:	*Dr G.Goldstein, WHO* *Dr R.Erben, WHO/WPRO*

Partnerships in Action-2 "Health Promoting Schools"	
2.2 Health Promotion in Action **Monday 21 July 1997** **16.30-18.00**	• *"Health Promoting Schools"* - Dr Kan Xuegui, China • *"National strategies improving school health programmes in Megacountries"* - Dr L.Kolbe, USA • *"European Network of Health Promoting Schools"* - Ms V.Rasmussen, WHO/EURO
6.2 Moving Ahead **Tuesday 22 July 1997** **16.30-18.00**	• *"Health Promotion Futures: Health promoting schools"* - Ms V.Prema, Singapore
12.2 Global School Health Initiative **Thursday 24 July 1997** **16.30-18.00**	Panel will include: • Dr M.Ahmed, Bangladesh • Dr I.Capoor, India • Mr E.Jouen, Belgium • Ms M. Bell Broglia, USA • Dr V.Pollesky, Russian Federation • Dr L.Pfieffer, USA • Dr L.Rowling, Australia • Dr Ye Guang-Jun, China
Facilitator session 2-6-12:	*Dr P.Reddy, South Africa*
Rapporteur session 2-6-12:	*Ms A.Bunde-Birouste, France* *Mr D.Rivett, WHO/EURO*
Technical Adviser:	*Mr J.Jones, WHO/HEP*

Partnerships in Action-3 "Healthy Workplaces"	
2.3 Health Promotion in Action **Monday 21 July 1997** **16.30-18.00**	• *"Working Conditions and Quality of Working Life: The Health Circle Approach"* - Dr G.Breucker, Germany • *"Workplace Initiative- public/private partnership"* - Dr W.Bjerke, Norway
6.3 Moving Ahead **Tuesday 22 July 1997** **16.30-18.00**	• *"Future Strategies for Effective Workplace Health Promotion in Europe"* - Dr H.Kloppenburg, Luxembourg • *"Health Promotion Futures: promoting health at work"* - Dr J.Koh, Singapore
12.3 Healthy Work Initiative **Thursday 24 July 1997** **16.30-18.00**	• *"Healthy Work Initiative"* - Dr J.Järvisalo, Finland • *"Partnership building"* - Dr J.Llados, Dr E.Noehrenberg, Switzerland
Facilitator session 2-6-12:	*Dr C.Chu, Australia*
Rapporteur session 2-6-12:	*Dr J.Järvisalo, Finland* *Dr J.Koh, Singapore*
Technical Adviser:	*Dr E.Ziglio, WHO/EURO* *Ms A.Stitzel, Germany*

Partnerships in Action-4 'Healthy Ageing'	
2.4 Health Promotion in Action **Monday 21 July 1997** **16.30-18.00**	*"Health Promotion in Action":* • Ms I. Hoskins, USA • Dr T. Setoabudhi, Indonesia • Dr K. Kawahara, Japan
6.4 Moving Ahead **Tuesday 22 July 1997** **16.30-18.00**	*"Health Promotion Futures":* • Dr Andrea Prates, Brazil • Ms Maria Stefan, USA
12.4 Healthy Ageing Initiative **Thursday 24 July 1997** **16.30-18.00**	*"The WHO perspective on Ageing and Health"* • Dr A. Kalache, WHO • Dr H. Noack, Austria
Facilitator session 2-6-12:	*Dr J. Crown, UK*
Rapporteurs 2-6-12:	*Ms L. Daichman, Argentina* *Ms A. Prates, Brazil*
Technical Adviser:	*Dr A. Kalache, WHO* *Dr Al Khateeb (WHO/EMRO)*

Partnerships in Action-5 "Active Living"	
2.5 Health Promotion in Action **Monday 21 July 1997** **16.30-18.00**	• *"Active Living"* - Dr F.Trowbridge, USA • *"Tongan Weight Loss Campaigns"* - Mr M Ofanoa, Tonga • *"Active Living - casestudy Japan"* - Dr S.Kato, Japan
6.5 Moving Ahead **Tuesday 22 July 1997** **16.30-18.00**	• *"Health Future through/with Active Living"* - Dr V.Matsudo, Brazil • *"Health Future through/with Active Living"* - Dr J.Miller, Australia • *"Health Future through Activity"* - Mr M.Knowles, Belgium
12.5 Active Living Initiative **Thursday 24 July 1997** **16.30-18.00**	• *"Global Partnerships for Active Living"* - Dr L.Vuori, Finland
Facilitator session 2-6-12: *Rapporteur session 2-6-12:* *Technical Adviser:*	*Dr L.Vuori, Finland* *Dr K.Chan, Hongkong* *Ms M.C. Lamarre, France* *Dr H.Benaziza, WHO (not attending)* *Dr Jadamba, WHO/SEARO*

Partnerships in Action-6 "Sexual Health"	
2.6 Health Promotion in Action **Monday 21 July 1997** **16.30-18.00**	• *"Family Planning Project"* - Dr L.Aaro, Norway
6.6 Moving Ahead **Tuesday 22 July 1997** **16.30-18.00**	• *"Global Business Council on HIV/AIDS"* - Dr J.Llados, Dr E.Noehrenberg, UNAIDS
Facilitator session 2-6:	*Dr N.Uddin, Bangladesh*
Rapporteur session 2-6:	*Dr P.Lincoln, United Kingdom*
Technical Adviser:	*Dr M.T.Cerquiera, WHO/PAHO*

Partnerships in Action-7 "Tobacco Free Societies"	
2.7 Health Promotion in Action **Monday 21 July 1997** **16.30-18.00**	• *"Tobaccofree Thailand"* - Dr B.Ritthipakdee, Thailand • *"Tobacco free Finland"* - Dr T.Piha, Finland • *"No Smoking Islands in the Maldives"* - Dr M.Osei
6.7 Moving Ahead **Tuesday 22 July 1997** **16.30-18.00**	• *"Health Promotion Futures: tobacco free Societies"* - Dr R.Vathinaithan, Singapore • *"Health Promotion Futures: USA policies"* - Ms S.Asma, USA • *"Tobaccofree futureplans for Australia"* - Mr A.Carrol, Australia
Facilitator session 2-6:	*Dr J.Chideme-Maradzika, Zimbabwe*
Rapporteur session 2-6:	*Dr B.Büchel, Thailand*
Technical Adviser:	*Dr M.Osei, WHO/SEARO*

Partnerships in Action-8 "Promoting Women's Health"	
2.8 Health Promotion in Action **Monday 21 July 1997** **16.30-18.00**	• *"Women's Health in India"* - Dr C.de Sa, India • *"Promoting Women's Health: private sector Case-study"* - Dr M.Harrison, USA • *"Promoting Women's Health: NGO casestudy"* - Dr E.Wolfson, USA
6.8 Moving Ahead **Tuesday 22 July 1997** **16.30-18.00**	• *"Education - the right to a better way of life"* - Ms M.Fouilloux, Belgium • *"Men's Health impact on Women's Health"* - Ms S.Hines
Facilitator session 2-6:	*Dr E. Howze, USA*
Rapporteur session 2-6:	*Dr M.Westphal, Brazil* *Ms J.Koch, Switzerland*
Technical Adviser:	*Dr Hafez, WHO/EMRO*

Partnerships in Action-9 "Health Promoting Healthcare Settings"	
2.9 Health Promotion in Action **Monday 21 July 1997** **16.30-18.00**	• *"Project 'HOPE' in Poland"* - Mr J.Mullen, USA • *"Health Promoting Healthcare in Africa"* - Dr F.Namisi, Kenya
6.9 Moving Ahead **Tuesday 22 July 1997** **16.30-18.00**	• *"Health 2020"* - Dr P.Siriwanarangsun, Thailand • *"Health Promotion Futures: responses to Non Communicable Diseases"* - Dr M.Tsechkovsky, WHO/NCD
12.9 Health Promoting Hospital - Initiative **Thursday 24 July 1997** **16.30 - 18.00**	• *"Health Promoting Hospitals"* - Dr J.Pelikan
Facilitator session 2-6-12:	*Dr P.Trowell, United Kingdom*
Rapporteur session 2-6-12:	*Dr G.Perez, South Africa*
Technical Adviser:	*Dr G.Fernando, WHO/SEARO* *Dr M.Tsechkovsky, WHO/NCD*

Partnerships in Action-10 "Healthy Homes/ Families"	
2.10 Health Promotion in Action **Monday 21 July 1997** **16.30-18.00**	• *"Healthy Homes"* - Dr T.Godal, WHO/TDR • *"Healthy Homes & Families"* - Dr A.Usfar, Indonesia
6.10 Moving Ahead **Tuesday 22 July 1997** **16.30-18.00**	• *"Development of food-based dietary guidelines"* - Dr R.Florentino, Philippines • *"Healthy Homes & Families: a future perspective"*, - Dr F. Lostumbo, USA
Facilitator session 2-6:	*Dr C.Deutsch, USA*
Rapporteur session 2-6:	*Dr J.Hashim, Malaysia*
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12.6 Mega-country Initiative	
Facilitator:	Ms K, Douglas, USA
Rapporteur:	Dr D.McQueen, USA
12.7 Health Promotion Foundations - initiative	
Facilitator:	Dr R.Galbally, Australia
Rapporteur:	Dr Suprakorn, Thailand
12.8 Health Promotion for Chronic Health conditions	
Facilitator:	Ms C. Funnell. UK
Rapporteur:	Ms A. Hayes, UK
12.9 Health Promoting Hospitals- initiative	
Facilitator:	Dr P. Trowell, UK
Rapporteur:	Dr G. Perez, South Africa
Speaker:	Dr J.Pelikan, Austria
12.10 Health Promoting Media settings	
Facilitator:	Dr C. Deutsch, USA
Rapporteur:	Mr C. Powell, WHO/INF
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Annex 2 - Conference Secretariat

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Annex 3 - Conference Advisory Group

4th INTERNATIONAL CONFERENCE ON HEALTH PROMOTION
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Annex 4 - List of Background Papers

REVIEW AND EVALUATION OF HEALTH PROMOTION

Conference Working Papers

4th International Conference on Health Promotion - Jakarta, 21-25 July 1997

1. Desmond O'Byrne (1997) Foreword for the Folder with key background papers on "Review & Evaluation of Health Promotion". ref.HPR/HEP/4ICHP/RET/97a

2. WHO (1997): Evaluating Health Promotion: Progress, Problems and Solutions; Conference working paper. WHO, Geneva, ref. HPR/HEP/4ICHP/RET/97.1

3. Suzanne F. Jackson, Rick Edwards, Michael Goodstadr, Irv Rootman (1997): Report of the International Health Promotion Indicators Project. Ref. HPR/HEP/4ICHP/RET/97.2

4. World Health Organization, Regional Office for Europe, Health Promotion and Investment for Health Programme (1997): Auditing Health Promotion Capacity: An Action Framework. WHO/EURO, Copenhagen, ref. HPR/HEP/4ICHP/RET/97.3

5. Cheryl Vince-Whitman, Alice Jones, Tania Garcia, Nicole Hagen (1997): Rapid Assessment and Action Planning Process (RAAPP): A means to build capacity and infrastructures for promoting health through schools. WHO, Geneva, ref. HPR/HEP/4ICHP/RET/97.4

6. WHO (1997): "Research for Health Promotion: A Challenge for the 21st Century"; Conference working paper. WHO, Geneva, ref. HPR/HEP/4ICHP/RET/97.5

7. WHO (1997), The Effectiveness of Alliances or Partnerships for Health Promotion, A global review of progress and potential consideration of the relationship to building social capital for health; Conference working paper. WHO, Geneva, ref. HPR/HEP/4ICHP/RET/97.6

7.1 Annex A: "Case Studies", Overview table "Health Promotion Case Studies from around the world". WHO, Geneva, ref: HPR/HEP/4ICHP/RET/.A/97.a

8. WHO (1997): International Comparisons of the Key Factors Affecting Health: An analysis of international databases on health; Conference working paper. WHO, Geneva, ref. HPR/HEP/4ICHP/RET/97.7

9. Greg Goldstein, Yasmin von Schirnding (1997): Environmental Health Indicators in Evaluation of Health Cities Programmes. WHO, Geneva, ref. HPR/HEP/4ICHP/RET/97.8

10. Irving Rootman, Michael Goodstadt, Louise Potvin, Jane Springett (1997): Towards the Framework for Health Promotion Evaluation. World Health Organization, Regional Office for Europe, Copenhagen

11. World Health Organization, Regional Office for the Western Pacific (1996) Regional Guidelines: Development of Health Promoting Schools. A framework for action. WHO/WPRO, 1099 Manila, P.O. Box 2932, Philippines

12. M. Van den Cruijsem, J.T. Jones, V. Barnekow Rasmussen, E.J.J. de Leeuw (1997): An Examination of Two Large-Scale Approaches for Promoting Health through Schools. WHO, Geneva, ref. HPR/HEP/4ICHP/RET/97.9

HEALTH PROMOTION FUTURES

Conference Working Papers

4th International Conference on Health Promotion - Jakarta, 21-25 July 1997

1. Desmond O'Byrne (1997) Foreword for the Folder with key background papers on "Health Promotion Futures". ref. HPR/HEP/4ICHP/FT/97a

2. WHO (1997) Guidance memo: Regional/National/Local Options for Health Promotion Scenario Development. WHO, Geneva, ref: HPR/HEP/4ICHP/FT/97.1

3. WHO (1997) World Health 2020: Global Scenarios for Health Promotion. WHO, Geneva, ref. HPR/HEP/4ICHP/FT/97.2

4. Rose Vaithinathan (1997) Introduction: Development of Eight Specific Health Promotion Futures. WHO, Geneva, ref. HPR/HEP/4ICHP/FT/97.3

5. Sivanesvary Arulanandam, André Shi-Lin Wansaicheong, Chng Chee Yeong, Mohammed Jais bin Ahmad (1997) Health Promotion Futures: Tobacco Free Societies. WHO, Geneva, ref. HPR/HEP/4ICHP/FT/97.4

6. Audrey Tan, Sivanesvary Arulanandam, Lee Yee Cheong, Sarojini Thanarajah (1997) Health Promotion Futures: Healthy Cities. WHO, Geneva, ref. HPR/HEP/4ICHP/FT/97.5

7. Mabel Yap, Julie Lau, Petrina Lim, Sue Pritchard (1997) Health Promotion Futures: Food and Nutrition. WHO, Geneva, ref. HPR/HEP/4ICHP/FT/97.6

8. Foo-Koh Yang Huang, Chang Yin Wuan, Clare Tan, Sarojini Thanarajah, Yvonne Sum (1997) Health Promotion Futures: Promotion Health at Work. WHO, Geneva, ref. HPR/HEP/4ICHP/FT/97.7

9. Lik Sing Yong, Alice Leong, Florence Law, Prema V, Yueh-ti Wong (1997) Health Promotion Futures: Health Promoting Schools. WHO, Geneva, ref. HPR/HEP/4ICHP/FT/97.8

10. Chuo-Ng Peck Hiang, Mei Fen Chan, Elaine Yap, Lim Lian Ching, Teo Kiok Seng, Wong Kee Wan (1997) Health Promotion Futures: Promotion Health of the Elderly. WHO, Geneva, ref. HPR/HEP/4ICHP/FT/97.9

11. Chris Chean Hean Aun, Chia Siok Hoon, Vivian Heng, Rashida Bte Yah Kathier, Martin Lee, Jeannie Thng (1997) Health Promotion Futures: Sexual Health. WHO, Geneva, ref. HPR/HEP/4ICHP/FT/97.10

12. Shirley Wan, Cheng Chui Fui, Jayakumari d/o Govindasamy, Lee Soek Ee Joyce, Lim Su Ling Grace, Mary Kurian, Thilakavathi R (1997) Health Promotion Futures: Women's Health. WHO, Geneva, ref. HPR/HEP/4ICHP/FT/97.11

PARTNERSHIPS FOR HEALTH PROMOTION

Conference Working Papers

4th International Conference on Health Promotion - Jakarta, 21-25 July 1997

1. Desmond O'Byrne (1997) Foreword for the Folder with key background papers on "Partnerships for Health Promotion". ref. HPR/HEP/4ICHP/PT/97a
2. WHO (1997) "Partnerships for Health in the 21st century: 2+2=5", draft paper. ref. HPR/HEP/4ICHP/PT/97.1 (distr.: Limited)
3. WHO (1997) "A New Global Health Policy for the 21st Century: an NGO Perspective". ref. HPR/HEP/4ICHP/PT/97.2
4. Ros Tennyson (1997) The Partnership-building process. ref. HPR/HEP/4ICHP/PT/97.3
5. Peter Makara (1997) Partnerships for Health Promotion. ref. HPR/HEP/4ICHP/PT/97.4
6. Ilona Kickbusch (1996) New Players for a New Era: How to date is Health Promotion ? Editorial for HPI, vol. 11, N°4. ref. HPR/HEP/4ICHP/PT/97.5

OTHER PUBLICATIONS/ SOURCES

4th International Conference on Health Promotion - Jakarta, 21-25 July 1997

1. WHO (1997) Jakarta Declaration, WHO/HPR/HEP/4ICHP/BR/97.4, WHO, Geneva
2. WHO (1998) Health Promotion Glossary. WHO/HPR/HEP/98.1. WHO, Geneva
3. WHO/HEP & WHO Collaborating Centre on Health Promotion, Toronto, Canada (1997) Health Promotion Bibliography (pre-publication). HPR/HEP/4ICHP/RS/97.2
4. Bosse Haglund and Gordon McDonald (1997) Resources for Health Promotion, Inventory on Education and Training for Health Promotion: A Global Survey. HPR/HEP/4ICHP/RS/97.3 *
5. WHO (1997) World Health Magazine N°3, May-June 1997, New Players for a New Era

Annex 5 - Follow-up Activities

HEALTH PROMOTION - Follow-up activities in 1998

The Jakarta Conference served as a catalyst to stimulate action to build capacity for health promotion at local, national and international levels in both developing and developed countries. Follow-up activities in 1998 based on the HEP 5-Year Plan of Action are being planned and carried out in all WHO Regions, jointly with the Regional Offices and through Member States, WHO Collaborating Centres, NGOs and other partners in health promotion. Such activities include:

- Health promotion in the ten most populous countries (Mega Country Health Promotion Network);
- Further strengthening of the Global School Health Initiative;
- Developments of the "Health Promoting Workplaces" concept;
- Developing tools for health promotion review and evaluation;
- Co-sponsoring two international conferences: the XVI World Conference on Health Promotion and Health Education in San Juan, Puerto Rico, June 1998; and the "Working together for better Health", International conference, Cardiff, United Kingdom, September 1998;
- Implementing the 51st World Health Assembly Resolution on Health Promotion (WHA51.12).

The WHA Resolution endorsed the call to break through traditional boundaries between government sectors, between governmental and nongovernmental organizations, and between the public and private sectors. WHO is called on to take the lead in elaborating a Global Alliance for Health Promotion, while all Member States are urged to implement the five priorities of the Jakarta Declaration and to adopt an evidence-based approach to health promotion policy and practice. In 2000, a progress report will be submitted to WHO's Executive Board and World Health Assembly, and it will also provide input into the Fifth Global Conference on Health Promotion, to be held in Mexico City, on June 2000.

Annex 6 - World Health Assembly 51, Resolution on Health Promotion

(WHA51.12 Health Promotion) 1998

The Fifty-first World Health Assembly,

Recalling resolution WHA42.44 on health promotion, public information and education for health and the outcome of the four international conferences on health promotion (Ottawa, 1986; Adelaide, Australia, 1988; Sundsvall, Sweden, 1991; Jakarta, 1997);

Recognizing that the Ottawa Charter for Health Promotion has been a worldwide source of guidance and inspiration for development of health promotion through its five essential strategies to build healthy public policy, create supportive environments, strengthen community action, develop personal skills, and reorient health services;

Mindful of the clear evidence that: (a) comprehensive approaches that use combinations of the five strategies are the most effective; (b) certain settings offer practical opportunities for the implementation of comprehensive strategies, such as cities, islands, local communities, markets, schools, workplaces, and health services; (c) people have to be at the centre of health promotion action and decision-making processes if they are to be effective; (d) access to education and information is vital in achieving effective participation and the "empowerment" of people and communities; (e) health promotion is a "key investment" and an essential element of health development;

Mindful of the new challenges and determinants of health and of the need for new forms of action to free the potential for health promotion in many sectors of society, among local communities and within families, using an approach based on sound evidence;

Appreciating the potential of health promotion activities to act as a resource for societal development and the clear need to break through traditional boundaries within government sectors, between governmental and nongovernmental organizations, and between the public and private sectors;

Noting the efforts made by the 10 countries with a population of over 100 million to promote the establishment of a network of most-populous countries for health promotion;

Confirming the priorities set out in the Jakarta Declaration for Health Promotion in the Twenty-first Century,

1. URGES all Member States:

   (1) to promote social responsibility for health;

   (2) to increase investments for health development;

   (3) to consolidate and expand "partnerships for health";

   (4) to increase community capacity and "empower" the individual in matters of health;

   (5) to strengthen consideration of health requirements and promotion in all policies;

   (6) to adopt an evidence-based approach to health promotion policy and practice, using the full range of quantitative and qualitative methodologies;

2. CALLS ON organizations of the United Nations system, intergovernmental and nongovernmental organizations and foundations, donors and the international community as a whole:

   (1) to mobilize and to cooperate with Member States to implement these strategies;

(2) to form global, regional and local health-promotion networks;

3. CALLS ON the Director-General:

(1) to enhance the Organization's capacity and that of Member States to foster the development of health-promoting cities, islands, local communities, markets, schools, workplaces, and health services;

(2) to implement strategies for health promotion throughout the life span, with particular attention to vulnerable groups, in order to reduce inequities in health;

4. REQUESTS the Director-General:

(1) to take the lead in establishing an alliance for global health promotion and in enabling Member States to implement the Jakarta Declaration and other local or regional declarations on health promotion;

(2) to support the development of evidence-based health promotion policy and practice within the Organization;

(3) to give health promotion top priority in WHO in order to support its development within the Organization;

(4) to report on progress to the Executive Board at its 105th session and to the Fifty-third World Health Assembly.

(Tenth plenary meeting, 16 May 1998
Committee A, fourth report)

Acknowledgements

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Japan, Ministry of Health and Welfare

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Singapore, Ministry of Health

Switzerland, Pharmaceutical Partners for Better Healthcare

Switzerland, Swiss Development Agency

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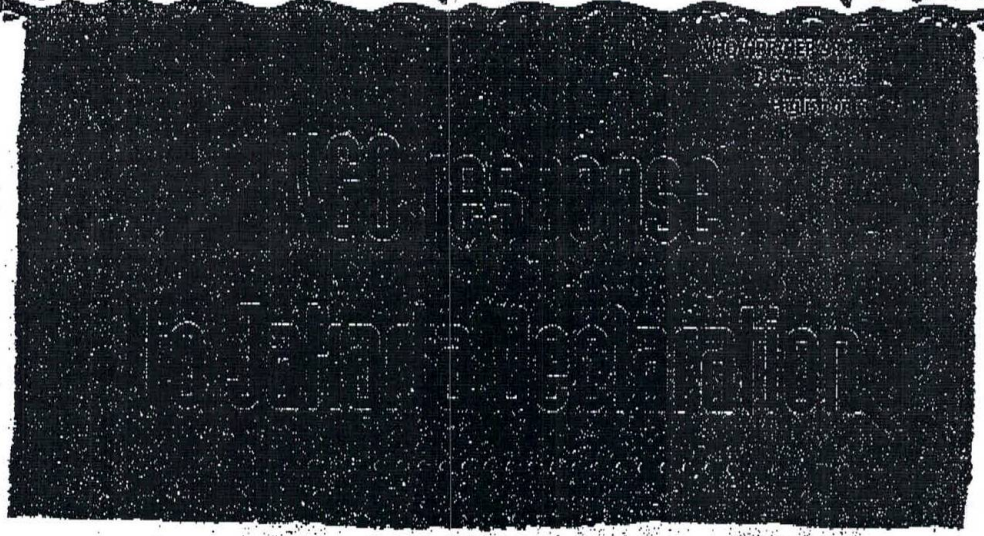

Report of the NGO Briefing held at the World Health Assembly, Geneva, 13 May 1998

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NGO RESPONSE TO JAKARTA DECLARATION

This report is the record of an NGO briefing held during the 1998 World Health Assembly, in Geneva, 13 May 1998. The aim of the briefing was to highlight some of the ways NGOs are participating in the follow up to the Jakarta Declaration, whilst at the same time collaborating with other NGOs, UN Agencies or the Governments.

NGO RESPONSE TO JAKARTA DECLARATION

Berhane Ras Work – Moderator of the Briefing

(President, Inter-African Committee)

It is my privilege to moderate this afternoon's briefing on the Jakarta Declaration and the response made by NGOs, WHO and Governments.

This is a very important occasion for us all. It is well accepted in the field of health promotion that partnership is vital. Too often the intention to co-operate with a broad spectrum of public opinion is there but the reality is something different.

NGOs are being asked for their advice and support more and more andNGOs themselves are constantly looking for ways to relate to United Nations Agencies and Governments. We are particularly fortunate to work with Dr. Desmond O'Byrne and WHO. Dr. O'Byrne has our special thanks for organising this Briefing and keeping us all involved and informed about the follow up to the Jakarta Conference.

The new Director General, Dr. Gro Brundtland has sent the following message:

"Dr. Brundtland sees the importance of establishing close-co-operation with NGOs working in the field of health. The WHO Transition Team, together with Dr. Brundtland is doing in-depth studies on how to improve collaboration with key players, like NGOs in the health sector."

At the international level, with support from the UN Secretary General and the UN Secretariat, it is becoming easier to see the importance of partnership with NGOs. This understanding is the first step toward implementing cooperative agreements that bring results in areas such as health promotion.

Major problems still remain at the national and local level where the promotion of health education is essential. It is here that cooperation between WHO officials and grassroots organisations is so important. WHO country representatives at this Briefing could offer important insights.

In bringing the Briefing to a close, Mrs. Berhane Ras-Work hoped that the present dialogue would be the first of many linking stakeholders, both large and small, in the Jakarta Declaration in a joint effort to promote health education.

The Inter-African Committee works on traditional practices affecting the health of women and children, with a network of affiliates in 26 African and 4 European countries. The IAC also represents thousands of volunteers from high African government officials to traditional leaders and young women in rural African villages who are determined to ensure the health and well being of women and children.

NGO RESPONSE TO JAKARTA DECLARATION

Dr. Halfdan Mahler, M.D.
(former WHO Director General)

You have one big problem with health promotion, namely that it is very gender insensitive. Health promotion requires very horizontal thinking and action, and most men are very bad at that. I speak from my own childhood experience where the women in my village knew exactly how to think multisectorally. The males, all of them, always were like the experts who have a lot of fun telling you why nothing can be done. This is in my opinion a real problem.

Emotionally, I have always had a "feel" for health promotion, since tuberculosis was my professional background. The resistance against health promotion is still strong in the traditional health professions though the nurses are coming much more naturally to it than the medical profession. But, the medical profession has so much more power in most countries than the nursing profession has. You have my true admiration for having come from a very small beginning to as far as you have come with health promotion, not only at Ottawa, Adelaide, Sundsvall and Jakarta, but in practical applications.

The NGOs are beautiful and powerful when they come to big international conferences, in Cairo, Copenhagen, Vienna etc. But, when they come back to their own countries they don't get together in national networks. If you want to have political clout then the NGOs have to learn that horizontalism also when they come home from the big international conferences. I am sure all of you have done "something" but much more is required. Because, when it comes to health promotion, then it is really true what I always have been obsessively saying **health is politics and politics is health on a large scale. If you really want to move healthy public policies forward in a big manner then you have to have the political dynamite that is necessary** to move these immovable mountains that politicians normally are.

So I have always been wondering how you get such ammunition. How would you be able to make all this abstract horizontalism reasonably concrete.

Many intellectual people can speak for days about human rights but when you stand in an Indian village, as I did the other day, and there was a woman who asked me "We have heard that health and human rights go together, could you please explain that" I found it very difficult. The same thing goes for health promotion. In order to make it truly concrete for both ordinary and sophisticated people **you need to find a way of having a programme from the global to the local level and from the local to the global level which is based on getting a constant feedback from "some operations research".** That sounds fanciful but you need to have something done with scientific discipline so you are sure and can show that it works, and that you can fight on from that level of ammunition. I am grateful that I am allowed to be here today.

NGO RESPONSE TO JAKARTA DECLARATION

Olive Shisana, Sc.D
(Director-General of Health, Government of South Africa)

Collaboration between NGOs and Government

(speech delivered by Rose Mazibuko, Chief Director, Northern Province, South Africa, winner of the Sasakawa award)

The South African Department of Health works in partnership with **non-governmental** organisations in a number of areas in order to **promote and protect the health** of South Africans.
We start from a point of view that government does not have a monopoly to deliver all the services It is therefore necessary to have partners, who are the non-governmental organisations, the statutory councils and the community. We consider a National Health System as including the participation of all these partners in aspects of service delivery, health promotion and protection of citizens.
With this premise in mind, we have set up formal structures to consult NGOs to contribute to policy development, conduct scientific research and participate in planning, and where necessary to deliver services.

Policy

We have established the national consultative health forum, whose mission is to consult with a variety of stake holders in health. The Forum includes labour organisations, progressive health organisations, statutory councils, political organisations as represented by Parliamentary Standing Committees, the private health sector, national, provincial and local government representatives. The Forum considers major health policy initiatives before they become government policy. The Forum has sub-committees which discuss possible new policy areas to ensure that input is obtained early. It is certainly not easy to co-ordinate such a massive organisational structure, hence there may be some issues that slip through the cracks and are not consulted upon adequately.
There are many other fora where NGOs provide input on a routine basis. These include the Health Promotion Forum, the HIV/AIDS Advisory Committee (which is being restructured to be consistent with our white paper on the

transformation of the health care system), and the Human Resource Forum, etc. These fora give input to specific policy areas and also help to draw up particular health plans and ensure the smooth introduction of health policy.

Service Delivery

The Department of Health funds more than 200 NGOs to deliver health services on its behalf. Most of these NGOs are in the HIV/AIDS area. Some of the NGOs have contractual arrangements with national and provincial government to deliver hospital services. We also have a major NGO which is dealing with TB.

Advocacy

We also fund NGOs to do advocacy work for us, particularly in areas where government is weakest. For example, we have an NGO dealing with Anti-Smoking campaigns. This NGO has been extremely effective in convincing government to increase excise tax on tobacco. It successfully advocated for the introduction of warning labels on cigarettes, and assists the Department of Health in monitoring compliance with these labels. The NGO also monitors the rate of cigarette smuggling into South Africa.

We fund many AIDS advocacy organisations in South Africa. Their role is to ensure there is a focus on HIV/AIDS at governmental and private sector levels.

To work with social partners it is necessary to ensure there is a clear national policy on the involvement of such groups in health activities. It is also necessary to ensure that donor funds are not provided to NGOs to initiate activities that generate a demand for services that will not be met when donor funds dry up.

However, working with NGOs and other social partners is not easy, as each has its own niche to fulfil. It is therefore necessary that roles be defined and each one understands the respective functions.

In the health promotion area, it is even more crucial to define these roles because a potential for conflict exists between government and NGOs. This is so, particularly where the two have different policy positions.

NGO RESPONSE TO JAKARTA DECLARATION

Dr Desmond O'Byrne
(Chief Health Education and Health Promotion Unit, WHO, Geneva)

This meeting is the result of the initiative of a group of NGOs responding to the challenge of the Jakarta Declaration. The new framework document on Health for All (HFA) in the 21st Century fully recognises the important role to be played by NGOs and that HFA strategies in our changing world would need to "recognize the expanded role of civil society in health."
Our newly-elected Director General, Dr Gro Harlem Brundtland, in her message to this meeting sees the importance of establishing close collaboration between WHO and NGOs.

I wish to express my thanks to all those NGOs who are actively following up on Jakarta, and in particular all those who have arranged this meeting. Also, I wish to express on behalf of all present our appreciation to Dr. H. Mahler, former Director-General of WHO, and one of the leading figures in public health of this century, for giving his valuable time to come and to address our meeting. The challenge of Jakarta is to form networks, a global health promotion alliance.

Dr Mahler has drawn our attention to the many difficulties of translating into horizontal collaboration the many good intentions generated at meetings and conferences. Today's meeting is a positive indication that such difficulties can be overcome.

The Jakarta Conference and Declaration (July 1997) was not just for the few, but for all sections of society. **It is through the NGOs in particular that all levels, especially the grass root level will be able to contribute towards meeting the priorities identified in the Jakarta Declaration.**

The five priorities for health promotion in the 21st Century are:

- **promote** social responsibility for health;
- **increase** investment for health development;
  (including investments that reflect the needs of particular groups such as women, children, older people, and indigenous, poor and marginalized populations;)

- **consolidate** and expand partnerships for health;
- **increase** community capacity and empower the individual;
- **secure** an infrastructure for health promotion.

In relation to each of these priorities, NGOs through their advocacy role, and/or through their direct contact with the community have an important contribution to make; health promotion wants to mobilize all sections of society to work together towards the goals of HFA. Civil society, NGOs and the co-operatives have , through their many networks and practical knowledge and outreach to the community, a unique resource to contribute in mobilizing the community and society for health.

Our colleagues on the platform representing many different NGOs, including the Inter-African Committee, International Council of Nurses, International Baccalaureate Organisation, International Co-operative Alliance, the Associated Country Women of the World, and the Global Alliance for Women's Health, are a clear demonstration of networks, and of networking of networks towards a common goal; in this instance in response to the Jakarta Declaration.

Health promotion needs to build bridges and collaboration with all sectors of society, this very definitely includes the medical profession and the health care professions who have such an important role both in their own professions but also as strong partners and advocates for promoting and protecting health.

We need to have a common vision and a common goal. The HFA 21st Century provides a framework for that goal, now we need to work together as partners towards its realization. Civil society, NGOs, co-operatives, have a special contribution to make towards the realization of that goal. As we proceed in our work, we need to monitor our progress, and to assess how it is going in order to learn both from our successes as well as our failures. When we look back in the year 2000, we will be able to see how our work has progressed and be able to document the valuable contributions made by NGOs and be able to learn and build for even greater efforts towards health promotion in the 21st Century.

I would like to end by thanking you all for your good work to date and look forward to our ongoing and strengthening collaboration.

IBO RESPONSE TO JAKARTA DECLARATION

Dr Ian Hill
(Regional Director for Africa/Europe/Middle East, International Baccalaureate Organisation)

The IBO starts with a premise that youth is our future in relation to many things, including health education; educating youth is really the key to forming good habits - good health habits and attitudes. We need to explain why good health is important to people and give young people responsibility for their own well-being. These things are basic to our own health education programme. We also include mental and social health, as well as physical health. In a school situation children are not always dealing with physical health problems but also with mental and social health.

We want to collaborate with WHO and anyone or any organisation which is serious about the promotion of health. We do not, of course, just deal with health; we deal with other issues, but health is important and mandatory in our Middle Years Programme for children from 11 – 16 years of age.

I was very pleased to take part in the Partners in Health Conference that was held in Dakar, Senegal in February this last year. It was an excellent conference which showed the value of networking. One of the things I remember very much at that conference was that as NGOs we sometimes are very critical of government institutions and of huge UN organisations like WHO, UNESCO, and so on. It is very easy to be critical. But I remember Dr Samba saying at that Conference: "Be wary, because there is an African saying that if you point the finger at somebody, there will be three fingers that are pointed back at you". I think it is very true. We have to look at both sides of what we do, and be wary about being too critical. Government organisations, particularly huge organisations like WHO, have many different people to contend with and many different countries; I think we have to respect that.

Internal IBO Network

I want to talk about how we try to network and reach out to other people; we are hoping other people will also come to us. We have two aspects - an internal networking which is via the curriculum for health education and so here we simply have the IBO schools. There are over 800 of them in 95 countries. This is

our own internal network through health and social education and a service component to the community which is compulsory. This means that young people are involved in various activities throughout the curriculum.

For example, in geography they deal with health problems near coal power plants. In physics they talk about burns caused by sun and steam. In language classes there is discussion about peer pressure in relation to drug abuse, poor nutrition. In maths there is analysis of statistics related to health problems. In history: who invented alcohol, cigarettes, etc. In drama they perform and write short plays related to social problems including health.

Network External to IBO

Then there is the external network. This comes from any single IB school which could be in any part of the world, and it reaches out to different people. We have students involved in local villages, local hospitals, elderly peoples' homes, local schools.

Let me give you a couple of examples. One of the schools which teaches our programme in Swaziland has contact with the WHO local office in that country and in fact the children there raise money in Mbabane to buy equipment for the Government Health Department in conjunction with WHO to enable testing in State primary schools for hearing and sight. The Government did not have money to buy this equipment; students raised the money even better, these people who were 17, 18, 19 years actually went to the schools; they were trained to do the testing and gave the results back to WHO which transmitted them to the Government. This was an excellent initiative. And, so the young children would not be frightened, the IB students performed little plays to show them why they were doing this testing, because sometimes this can be quite daunting.

Two other very quick examples follow.

In a school in Ghana we had a group of students who decided to create a pipeline to bring fresh water to a village where the women were carrying the water for two km and of course it was not good water anyway. So the students dug a pipeline, laid it, and actually the water now goes through to the village. They did it with the villagers. On their own, the villagers might not have done this.

The final example is a school in Europe which helps with blind children; once a month they play football in the dark at night with the blind children. The blind children always win but for the development of their mental and social health this is an amazing thing. The blind are put into a context where their disability is of no consequence.

These are some of the things we are trying to do and we are looking for other partners.

ICN RESPONSE TO JAKARTA DECLARATION

Dr. Tesfamicael Ghebrehiwet
(Consultant, Nursing & Health Policy, International Council of Nurses)

Mobilizing Nurses for Health Promotion

Introduction

Founded in 1899, the International Council of Nurses (ICN) is a federation of national nurse associations in 118 countries and this number is constantly growing. ICN's mission is to develop nursing's special contribution to society with respect to health and quality of life. ICN's goals are to influence nursing, health and social policy, assist nurses to improve nursing standards and promote strong national nurses' associations. ICN achieves its goals by working with and through its member associations, UN agencies such as WHO and NGOs.

ICN Activities in Health promotion

The ICN Code for Nurses first adopted in 1953 identifies four fundamental responsibilities of the nurse one of which is health promotion. Think of the millions of nurses working in schools, workplaces, health centres, and hospitals world wide. One of ICN's goals is to mobilise the millions of nurses for health promotion and disease prevention. Health promotion is central to the activities of ICN and much of the health promotion agenda is integrated or mainstreamed into the main programme areas. Often the health care delivery system gets distorted and tends to focus on cure and caring rather than on health promotion and disease prevention. ICN works with its member associations to align or balance that focus so that health promotion and primary health care become vital components of health care services.

Health promotion in ICN focuses on a number of areas:

Smoking and health aims to enable nurses become effective in reducing the demand for tobacco and promote tobacco free lifestyle especially in young people. Nurses working in schools are strategically located to promote healthy lifestyles and growing up tobacco free.

Women's health. The social and economic position of women puts them at increased health risks and ICN lobbies for promoting women's health, and putting women's health issues on the agenda.

Child health including the Girl Child. ICN has through its position statements and guidelines focused on promotion of child health, human rights of children and the role of nurses working with communities, in multidisciplinary health teams and other sectors.

Young peoples' health. This is an issue which is increasingly of concern to ICN. In 1997 ICN had a special issue for the International Nurses Day which focused on young peoples health. Under the theme of healthy young people = a brighter tomorrow, ICN disseminated a resource kit to its member associations.

Healthy Ageing. ICN promotes the notion of healthy ageing through its publications such as the International Nurses Day Resource Kit and other guidelines.

School Health. ICN promotes school health initiatives that focus on healthy environments and monitoring of children's health.

HIV/AIDS and STDs. Since the early years of HIV/AIDS coming into the picture, ICN has been working actively with member associations and WHO to mobilise nurses for HIV/AIDS prevention and care. ICN continues to lobby and advocate for quality of care for people living with HIV/AIDS (PWA) and to fight any discrimination against PWA or people considered to be at risk such as commercial sex workers, intravenous drug users, etc.

Mental Health. ICN promotes health in its holistic sense of which mental health is a vital aspect that is inseparably linked to physical, social and spiritual health.

Health of Special Populations. ICN is concerned with the health of migrants and refugees and the health of indigenous populations and has position statements and guidelines on promoting the health of these vulnerable groups.

More broadly ICN lobbies for healthy public policy to ensure that health becomes a vital agenda in the work of all the sectors not just the health sector. ICN working in partnership with its member associations, UN agencies such WHO and NGOs is in a strategic position to promote health. ICN also lobbies for elimination of harmful cultural practices such as female genital mutilation, nutritional taboos that discriminate the female child, boy preference and sex selection.

ICN Strategies for Health Promotion

ICN strategies for health promotion include:

- Advocacy
- Lobbying
- Enabling
- Training of Trainers
- Partnerships
- Networking/linkages

Jakarta and Beyond

Since the Fourth International Conference on Health Promotion and the Jakarta Declaration, ICN has:

- disseminated the Jakarta Declaration to its member associations in 118 countries and called on them to translate it into action;
- endorsed the Jakarta Declaration at the 101st WHO Executive Board in January 1998;
- selected health promotion as a theme for International Nurses' Day 2000;
- consolidated health promotion as a priority area for international nursing research;
- revisited PHC and community development concepts to integrate health promotion into nursing education and nursing practice.

ICN believes that health promotion is a unifying agenda for all health professionals and other sectors. ICN is committed to health ideals that promote "healthy futures" for all.

IHCO RESPONSE TO JAKARTA DECLARATION

Mats Ahnlund, Secretary General
(International Health Co-operative Organisation)

There is a "Call for Action" in the Jakarta Declaration and this Call for Action includes co-operatives. That is the first time Co-operatives were singled out in that way in a WHO document. One can ask why now ?

One reason they are now mentioned could be that there are a lot of health co-operatives growing around the world. I was not aware of that when I started to work as Secretary-general of IHCO. I come from the Consumers Co-operative sector and I ended up learning about health co-operatives just recently. The United Nations published this year a big report on health co-operatives in the world and it turned out, which was a surprise for most of us, **there are more than 100 million households in the world served by health co-operatives, in 53 countries.** It is probably even more than that, but this is what is documented in the UN report. The report is available in the UN bookshop here, for 25 dollars.

What are we talking about ? Here are some examples:
It could be the clients who own their hospitals. Like the health co-operative movement in Japan, that, like in many other cases started the fact that the public sector could not satisfy the needs of the Japanese after the war. In Japan those health co-ops are still a growing part of the health sector.

The members in a Japanese health co-op meet for mutual check-up

But a co-operative could also be created and owned by doctors or other providers. For example in Brazil we have a huge doctor-co-operative with 70 thousand doctors that joined together in a co-operative serving especially the

countryside. They run their own helicopters, planes etc... A co-operative could also be run by *both* clients and doctors together in a multi-purpose or mixed co-operatives like the Espriu Foundation in Spain which is another large health co-operative.
There could also be small health co-operatives. I come from Sweden and I recently visited a very small health care centre owned by the staff there. It was the community, the public sector, that had found they could not afford to run this, so they decided to privatise it. The staff wanted to buy it and they did and they have now created a new co-operative. The chairman of the co-operative is an auxiliary nurse so she is bossing over the doctors now. That has by the way surprised several visitors from other countries.

What is a co-operative? Here is a basic definition:

- They are not for profit. People in there don't own them primarily to make money but because they are involved.
- Co-operatives are owned by the involved. It could be the consumers, the clients, or the providers.
- A real co-operative is always independent from state. There are some created and ruled by the state in some countries but we don't really recognise these as real co-operatives from the international co-operative movement.
- There is always concern for the community. This is written into the basic co-operative principles. Actually as late as 1995, even if it very often also previously been the concern of most co-ps.

There are other types of co-ops which are very appropriate for health promotion. If we talk about enabling people to create the essential conditions for health, which is a part of the Ottawa Charter, another WHO document, we can very well include housing co-operatives that are creating good housing or simply creating any housing at all in many countries. Food co-operatives concerned with nutritious food. Worker's co-operatives and the working conditions, always better in a co-operative owned by the people working there, than in most private companies. All these mentioned co-operatives are not in the health sector but could be a part of the health promotion.

Two years ago the health co-operatives created a new international NGO, the International Health Co-operative Organisation (IHCO). Our message is that we are prepared to be a partner in this "Jakarta Declaration Call for action" and we are also prepared to participate in this network that WHO will create with different partners.
We are part of the NGO sector and we want to go on with this WHO-NGO collaboration.

GAWH RESPONSE TO JAKARTA DECLARATION

Dr. Elaine Wolfson
(President, Global Alliance for Women's Health)

Thank you very much for inviting me to speak. I am delighted to be able to talk about the Jakarta Declaration and our response to it. I was privileged to attend the July meeting in Jakarta last year and the energy was truly exciting.

The Global Alliance of Women's Health is focused on many issues as they relate to women's health throughout the life span. The organisation is four years old and is committed to advancing women's health through all phases and stages of life. The mission includes public policy formation as well as implementation and monitoring of services. We were very pleased that in the Jakarta Declaration there was a specific mention of the "empowerment of women". Indeed in the section on the determinants of health, the empowerment of women was listed. **We think that it is very critical to have recognised that this half of the population of the world is still not empowered equitably and does not receive parity in terms of health care services and research.**

We have been working on a number of areas in health promotion. Since my academic field is public policy and I have been involved for the past 30 years on formation of public policy, we attempted to influence the action documents of the Beijing Conference and the Social Summit in Copenhagen. We developed partnerships with many NGOs in order to produce a compendium of women's health provisions. More than 70 international and national NGOs who had come to New York for various meetings joined in consultations providing suggestions that were incorporated into the more than 200 provisions of the Compendium. We distributed more than 20,000 copies of the Compendium through 1994 and 1995 to NGOs around the world.

In the past year, we have focused on promoting women's health through publications, mobilising NGOs through information and establishing

to draw your attention to one of our most popular publications, *Depression and the Mature Woman.* We invited social workers, geriatricians and NGOs to speak. What we tried to do in the edited proceedings was to capture the exchange between the audience and the experts talking about issues of women's health, comparing mature women's issues of mental health and depression across many cultures. In addition to African American women, the other women who were the subjects of these talks, were mainly immigrants to the United States, for example Latina women, Indian women, and women from Eastern Europe. We were fortunate to get funding from Pfizer to produce this book. We brought the *Depression* book to the NGO meeting in Dakar. The women at the meeting were very impressed with the book and asked whether it could be translated into French.

We have also worked on women's health issues and promotion with foundations. At the request of the Edna McConnel Clark Foundation, we were asked to place trachoma in the framework of women's health. In other words, we looked at an infectious eye disease from a women's health perspective in the context of the issues that were being addressed by the women's health movement nationally and internationally. With the assistance of graduate students from Colombia University School of Public Health, we reviewed the medical and social science literature and wrote a position paper for the Foundation. It was well received and we were granted additional support for publishing this work as a booklet.

In this publication, *Trachoma: A Women's Health Issue*, we make some recommendations on how the World Health Organisation's efforts on behalf of trachoma elimination could be linked with the Jakarta Declaration. **The effort to promote SAFE strategies in communities where trachoma is endemic is fundamentally an educational and promotional undertaking.**

Finally, we are promoting women's health through linkages with NGOs and governments. We have been circulating a proposed draft resolution on "Women's Health throughout the Lifespan", and have been holding briefings in New York and Geneva. We believe that, if this resolution is passed by the General Assembly at the United Nations, it will help WHO and NGOs who are promoting health in the regions and the countries of the world.

NGO RESPONSE TO JAKARTA DECLARATION

Discussion and comments from the floor

After the Panel Speakers, the floor was opened and a lively discussion took place with questions directed to the Panel and contributions made by those present.

One NGO showed how they introduced the care of the new born child into the Safe Motherhood Initiative, and had helped to bring about the much needed partnerships between obstetricians, neonatologists, and nursing staff. They have a global partnership programme to prevent childhood blindness, bringing in the community, which is sometimes a neglected partner.

A Youth Organisation stressed the importance of involving the youth and young professionals and that they need to be supported and strengthened and helped to develop their professional abilities. Other NGOs underlined the importance of participation with the youth and young professionals, the need to promote young leadership, and in particular to include them in national or official delegations.

A question was raised about involvement with the private sector and the impact of alliances with transnationals. In reply Dr O'Byrne said that the private sector were present in Jakarta in their personal capacity. He said that all partners need to work openly and transparently, and that it is essential to protect the independence and good status of the UN and of WHO when working with different partners from the private sector.

Mats Ahnlund (IHCO) said that his organisation has no official standpoint as it is very decentralised and every cooperative has the right to discuss with any partner. We are all very different and this meeting is about how we asNGOs can contribute to partnerships.
Elaine Wolfson (GAWH) noted that some pharmaceutical companies had taken the lead in instituting research on women's life span health issues, particularly middle life and ageing and have thereby provided a service for women's health. They had donated resources and filled the gap to combat river blindness , trachoma and lymphatic filorisias, and other gender related diseases. She noted that it would be good to have more socially responsible corporations helping

women's health.

A question was raised about the need for reform in legal issues and national laws. The hope was expressed that the Jakarta Declaration on Health Promotion should look at legal issues, property law, etc. which sometimes put women into a very marginalised situation. Elaine Wolfson recalled that CEDAW (the Convention on the Elimination of all Forms of Discrimination against Women) and the Beijing Platform of Action are two legal instruments for use by the international community. Unfortunately, ratification and monitoring of the conventions do not always take place. Tesfa Ghebrehiwet (ICN) said that it is important to go beyond legislation to implementation and action, and that the medical profession needs to be empowered and sensitised when treating victims of violence.

Two NGOs talked about the importance of involving human rights in health promotion, and that the application of human rights can achieve empowerment. Three NGOs supported the idea of establishing an NGO Human Values Caucus in Geneva which could focus on and reawaken human values to translate them into daily life.

The International Alliance of Women explained that their organisation had developed a family planning component through another established project, and had initiated education programmes for adults and youth, and then established a dispensary for delivering services. This had required additional funding and she explained that NGOs are sometimes able to facilitate funding resources from a third party.

The rapporteur for the briefing was Joanna Koch, representing Associated Country Women of the World (ACWW), the only international organisation of rural women and farming women. ACWW aims to promote international goodwill and to help raise the standard of living and education of rural women and their families. The organisation works through training programmes and community development projects in health, HIV/AIDS, income generation, nutrition, water management, and other agricultural issues.

LIST OF PARTICIPANTS

Organisation	Name
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Int. Council Jewish Women	Rebecca Muhlethaler
Int. Council of Nurses	Tracy Terminsley
	Louise Sanchez Seatman
	Ursula Klein
	T. Ride
	Tesfa Ghebrehiwet
Int. Council Social Welfare	Nils Dahlquist
	Michelle Greuter
Int. Federation of Red Cross and Red Crescent Societies	Maria Nonova
	Juja Kim
	Leila Passah
	Brian Rawson
Int. Federation on Ageing	Grace Iijima
Int. Federation Medical Students Association	A. Hoffmann
	Tigran Vilotijevic
Int. Peoples' Health Council	David Saunders
ILO	Herman Raus
	Jacquier Christian
Int. Ass. Agriculture, Medicine & Rural Health	Ashok Patil

Int. Health Cooperative Organisation	Mats Ahnlund
	Won-Sik Noh
ISRRT, Wales	P. Yule
ISRRT, Canada	D. Yule
La Leche League Int.	Giselle Laviolle
Medical Mission Sisters	Velasco Dulce Corazhon
Medical Womens International Association	Dorothy Ward
	Vibeke Jorgensen
Ministry of Health, Health Promotion, Mexico	Javier Urbina Soria
Ministry of Health, Hesse, Germany	Christian Luetkens
Ministry of Health, Namibia	Maggie Nghatanga
Ministry of Health and Social Welfare, Swaziland	Shongwe
Ministry of Health, Burundi	Bakanibuna Renovat
Ministry of Health, South Africa	Rose Mazibuko
National Council for Int. Health	Debra Smith
	Margaret Gwynne
	Ron Wilson
NGO WG on Nutrition	Gilberte van Haelst
N.O.W.	Jean Harris
Pan Pacific and South East Asia Womens Ass.	Clarissa Starey
Rotary International	Gunter Hermann
SCORP, (IFMSA) Egypt	Hazem Wafa
SINAN, Swaziland	Dlamini Tyler
Swiss Nurses Association	Magali Bertholet
UNICEF, Pakistan	Maaike Arts
World Ass. of Societies of Pathology and Lab. Medicine	William Zeiler
World Federation of Poison Centre	J.F. Deng
World Fed. Methodist & Uniting Church Women	Renate Bloem
World Organisation Scout Movement	Mateo Jover
WHO	Yu Sen-Hai
	Peter Iverson
	Ursel Broesskamp-Stone
	P. Nordet
	Jack Jones
	Merri Weinger
	Desmond O'Byrne
	Isolde Birdthistle
	Petra Heitkamp
	Irene Hoskins
	Roberta Ritson
	Gina Cheatham
	André Chirondel
	Marilyn Rice
	Katharina Hauck
World Union of Catholic Women Org.	Ursula Barter-Hemmerich
Womens World Summit Foundation	Elly Pradervand
Zonta International	Danielle Bridel
"Die Tageszeitung", Berlin	Andreas Zarmach, Journalist

NGO Activities before and after

the Fourth International Conference
on Health Promotion
"New Players for a New Era,
Leading Health Promotion into the Twenty-first Century"
Jakarta, Indonesia, 21-25 July 1997

NGOs based in Geneva which participated in the Fourth International Conference for Health Promotion held in Jakarta in July 1997, have been working closely with the Health Education and Health Promotion Unit (HEP) of WHO since before the Conference and in follow-up activities.

We have organised a number of informal briefings to sensitise Geneva based NGOs about the Conference and to become involved in the follow up, and we have shared the Jakarta Declaration, approved by the Conference participants. This Declaration has been translated into a number of languages and copies are available from the HEP Unit of WHO.

Following Jakarta, we have distributed Information Sheets, reported about the Conference at national and international fora, included articles in Newsletters for our membership, and incorporated health promotion ideas in ongoing work and future programmes. Statements made at the WHO Executive Board meetings in January 1998 pointed to the importance of NGO participation in health promotion in all aspects of life including healthy schools, healthy cities and countries, healthy workplaces, and so on.

Mindful of the dedicated members of the health profession who would be present for the World Health Assembly in May, we were keen to arrange an NGO Briefing on the NGO Response to the Jakarta Declaration. This was done with the help of WHO. The purpose of the briefing was to show how Governments, WHO and NGOs can work together on health promotion. The aim was to encourage others to become involved, in as many different ways as possible, through their organisations, and through their different mandates and programmes. This report records the highlights of that Briefing.

We invite NGOs and others to exchange information and ideas on how to translate the Jakarta Declaration into action, and to share with us their hopes as we move towards the Fifth International Conference on Health Promotion which will take place in Mexico in June 2000.

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Call for action

The participants in this Conference are committed to sharing the key messages of the Jakarta Declaration with their governments, institutions and communities, putting the actions proposed into practice, and reporting back to the Fifth International Conference on Health Promotion.

In order to speed progress towards global health promotion, the participants endorse the formation of a global health promotion alliance. The goal of this alliance is to advance the priorities for action in health promotion set out in this Declaration.

Priorities for the alliance include:

- raising awareness of the changing determinants of health
- supporting the development of collaboration and networks for health development
- mobilizing resources for health promotion
- accumulating knowledge on best practice
- enabling shared learning
- promoting solidarity in action
- fostering transparency and public accountability in health promotion

National governments are called on to take the initiative in fostering and sponsoring networks for health promotion both within and among their countries.

The participants call on WHO to take the lead in building such a global health promotion alliance and enabling its Member States to implement the outcomes of the Conference. A key part of this role is for WHO to engage governments, nongovernmental organizations, development banks, organizations of the United Nations system, interregional bodies, bilateral agencies, the labour movement and cooperatives, as well as the private sector, in advancing the priorities for action in health promotion.

from the Jakarta Declaration on Leading Health Promotion into the 21st Century, July 1997

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The Fifth Global Conference on Health Promotion
Health Promotion: Bridging the Equity Gap
5-9th June 2000, Mexico City

1. Introduction

The Fifth Global Conference on Health Promotion (5GCHP) – *Health Promotion: Bridging the Equity Gap* – was held 5-9th June, 2000 in Mexico City. This conference built on the advances of the previous four International Health Promotion Conferences, particularly taking forward the priorities of the last International Conference on Health Promotion held in Jakarta, Indonesia in 1997.

The First International Conference on Health Promotion held in Ottawa, Canada, in 1986 created the vision by clarifying the concept of health promotion, highlighting the conditions and resources required for health and identifying key actions and basic strategies to pursue the WHO policy of Health for All. *The Ottawa Charter for Health Promotion* identified prerequisites for health including peace, a stable ecosystem, social justice and equity, and resources such as education, food and income. Key actions to promote health included building healthy public policy, creating supportive environments, strengthening community actions, developing personal skills, and reorienting health services. The Ottawa Charter thus highlighted the role of organizations, systems and communities, as well as individual behaviours and capacities, in creating choices and opportunities for the pursuit of health and development.

Building healthy public policy was explored in greater depth at the Second International Conference on Health Promotion in Adelaide in 1988. Public policies in all sectors influence the determinants of health and are a major vehicle for actions to reduce social and economic inequities, for example by ensuring equitable access to goods and services as well as health care. The *Adelaide Recommendations on Healthy Public Policy* called for a political commitment to health by all sectors. Policy-makers in diverse agencies working at various levels (international, national regional and local) were urged to increase investments in health and to consider the impact of their decisions on health. Four priority areas for action were identified: supporting the health of women; improving food security, safety and nutrition; reducing tobacco and alcohol use; and creating supportive environments for health.

This latter priority became the focus of the Third International Conference on Health Promotion in Sundsvall, Sweden, in 1991. Armed conflict, rapid population growth, inadequate food, lack of means of self determination and degradation of natural resources are among the environmental influences identified at the conference as being damaging to health. The *Sundsvall Statement on Supportive Environments for Health* stressed the importance of sustainable development and urged social action at the community level, with people as the driving force of development. This statement and the report from the meeting were presented at the Rio Earth Summit in 1992 and contributed to the development of *Agenda 21*.

The Fourth International Conference on Health Promotion held in Jakarta, Indonesia, in 1997 reviewed the impact of the *Ottawa Charter* and engaged new players to meet global challenges. It was the first of the four International Conferences on Health Promotion to be held in a developing country and the first to involve the private sector in an active way. The evidence presented at the conference and experiences of the previous decade showed that health promotion strategies contribute to the improvement of health and the prevention of diseases in developing and developed countries alike. These findings helped to shape renewed commitment to the key strategies and led to further refinement of the approaches in order to ensure their continuing relevance. Five priorities were identified in the *Jakarta Declaration on Leading Health Promotion into the 21st Century*.

These were confirmed in the following year in the *Resolution on Health Promotion* adopted by the World Health Assembly in May 1998:

1. Promoting Social Responsibility for Health
2. Increasing Community Capacity and Empowering the Individual
3. Expanding and Consolidating Partnerships for Health
4. Increasing Investment for Health Development
5. Securing an Infrastructure for Health Promotion

At the start of the new century, two challenges remain: to better demonstrate and communicate that health promotion policies and practices can make a difference to health and quality of life; and to achieve greater equity in health. Concern for equity is at the core of the health promotion concept and a thread that runs through the previous conferences and their declarations. Our understanding of the root determinants of inequities in health has improved significantly. Yet inequalities in social and economic circumstances continue to increase and erode the conditions for health. For these reasons, the Fifth Global Conference on Health Promotion focused on bridging the equity gap both within and between countries.

Conference objectives, structure and processes

The Fifth Global Conference on Health Promotion had as its **overall goal** an examination of the contribution made by health promotion strategies to improving the health and quality of life of people living in adverse circumstances. The joint organizers were the World Health Organization (WHO), the Pan American Health Organization (PAHO/AMRO) and the Ministry of Health of Mexico.

The **conference objectives** were:

- To show how health promotion makes a difference to health and quality of life, especially for people living in adverse circumstances;
- To place health high on the development agenda of international, national and local agencies;
- To stimulate partnerships for health between different sectors and at all levels of society.

The conference brought together a wide range of **participants** from about 100 countries, reflecting the various groups and sectors of society that are responsible for or influence the determinants of health. These included Ministers and other major policy- and decision-makers from both health and other sectors; representatives from international and national development agencies, non-governmental organizations, community-based organizations; the private sector; and scientists and practitioners from various fields, including experts in evaluation and communication.

The conference had two **programme components**: a five day technical programme and a two day ministerial programme. These were linked by two joint sessions. At the end of the ministerial programme, several political delegations joined the technical programme.

The preparation of the **ministerial programme** involved the development of the *Mexico Ministerial Statement for the Promotion of Health: From Ideas to Action*, signed at the conference by 86 Ministers of Health or their representatives - a clear sign of political commitment to health promotion. The Ministerial Statement is available in the Annex of this report.

The Statement:

- affirms the contribution of health promotion strategies to the sustainability of local, national and international actions in health, and
- pledges to draw up a country-wide plan of action to monitor progress made in incorporating health promotion strategies in national and local policy and planning.

The **technical programme** was structured around the priorities for health promotion set out in the Jakarta Declaration (1997) and confirmed in the World Health Assembly Resolution on Health Promotion (1998)[1]. The six technical sessions addressed areas Member States and societies as a whole are urged to act upon:

- Strengthening the Evidence Base for Health Promotion
- Increasing Investments for Health Development
- Promoting Social Responsibility for Health
- Increasing Community Capacity and Empowering Individuals and Communities
- Securing an Infrastructure for Health Promotion
- Reorienting Health Systems and Services with Health Promotion Criteria

Each of the six thematic sessions consisted of a plenary followed by breakout sessions allowing discussion of the key elements in smaller groups. In each plenary three case studies and one technical report were presented, then the floor was opened for questions and comments. The technical reports were presented in final draft form to allow for a peer review process during the conference. These are published separately from this report[2].

The conference provided several **mechanisms for active participation** of all participants.

After each plenary, up to 15 breakout sessions were held. These were supported by a facilitator and rapporteur who worked as a team throughout the week (see Annex 6).They guided the debate along pre-defined questions, as well as considering the issues that emerged out of the plenary debates. Breakout sessions provided participants with the opportunity to both:

- give input into the conference report being written during the event, and
- provide targeted feedback towards the finalisation of the technical reports.

A writing team (see Annex 6) was established to ensure a participatory writing process of this conference report on the technical programme[3]. Breakout session rapporteurs met regularly with this team to provide feedback from participants' discussions. In addition, two drafts of the conference report were circulated during the course of the week, allowing all participants to provide further comments in writing.

A similar process was set up for participants' work towards the *Framework for Country wide Plans of Action for Health Promotion*. The intention of this framework was to provide countries that signed the *Mexico Ministerial Statement for the Promotion of Health: From Ideas to Action*, with a tool that guides and supports their efforts to develop and implement country specific action plans. This framework is also available separate from this report[4].

All **products of the conference**,

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[1] See Annex for WHO Document WHA 51.12, May 1998
[2] See Annex for information on how to obtain this document
[3] See Annex regarding the report of the Ministerial Programme see Annex
[4] See Annex for information on how to obtain this document

- the six technical reports
- the case studies
- the Mexico Ministerial Statement for the Promotion of Health: from ideas to action
- the framework for country wide plans of action for health promotion, and
- this conference report

are being made widely available beyond the group of 5GCHP participants via various communication channels, including print media and the WHO website[5].

2. The Opening Ceremony

The opening ceremony was held at the National Anthropological Museum, Mexico City on Monday 5th June. The conference audience was addressed by Lic. Jose Antonio Gonzalez, Minister of Health, Mexico; Dr Gro Harlem Brundtland, Director General, World Health Organization; and Dr George A.O. Alleyne, Director, Pan American Health Organization.

Participants witnessed the signing of the *Mexico Ministerial Statement for the Promotion of Health: from Ideas to Action*. The conference audience was then addressed by Dr Ernesto Zedillo Ponce de Leon, President of Mexico.

Some selected quotes are provided below.

> "Considering that the commitment for health goes beyond the boundaries of the health sector, the Conference is a platform to discuss the character of a Global Alliance for Health Promotion to harness the potential of the many sectors of society, and create new partnerships in equal footing among the different sectors and at all levels of government." *(Lic. Jose Antonio Gonzalez, Minister of Health, Mexico)*

> "WHO's overall strategy helps to set priorities. It lays out four strategic directions: reducing excess mortality and disability, reducing risks to human health, developing health systems that equitably improve health outcomes, and putting health at the centre of economic and development policy. All these four directions have elements of health promotion. Each involves us in disseminating knowledge, establishing consensus on how knowledge can be implemented, and encouraging healthy public policies that encourage people to implement the knowledge for themselves." *(Dr Gro Harlem Brundtland, Director-General, World Health Organization).*

> "It is not enough to look at the health outcomes. One must look at those social conditions that determine health outcomes – the determinants of health..... During this week we must look at the disparities in these determinants of health and determine to what extent they are distributed so unequally as to produce health disparities. It is of fundamental importance that in discussions on equity we understand the difference between disparities in health status and disparities in the determinants of health that cause these health inequalities or inequities." *(Dr George A.O. Alleyne, Director, Pan American Health Organization)*

> "Health is a collective responsibility that necessarily implicates the active participation of the population especially in preventive action and in health promotion action like those

[5] See Annex for information on how to obtain these documents

that will be analysed during this conference." *(Dr Ernesto Zedillo Ponce de Leon, President of Mexico.)*

The complete speeches of Dr Brundtland and Dr Alleyne are provided in Annex 1 and 2.

3. Joint Technical-Ministerial Sessions

The technical and ministerial programmes combined on two occasions. The **first** occasion was on Monday 5th June on the theme **setting the stage**. Presentations were given by:

- Dr Achmed Sujudi, Minister for Health, Indonesia, who spoke of the Jakarta Declaration and Indonesia's progress in implementing its national plan for health promotion;
- Professor Michael Marmot, University College London, United Kingdom, who gave the keynote speech on determinants of health with special emphasis on social and economic factors and inequities in health;
- Dr Alex Kalache who described the new organizational arrangements for health promotion in WHO, Geneva.

Professor Marmot's speech is published jointly with the six technical reports of this conference.

The **second** joint technical-ministerial session was held on Tuesday 6th June and provided an opportunity for feedback between the two programmes and **sharing conclusions** from the Ministerial meeting. This session was structured around the four key **themes addressed at the Ministerial meeting**, namely:

- Healthy Public Policies: Equity, Investment for Health and Development;
- Social Responsibility for Health Promotion: Community Participation and the Involvement of all Sectors;
- Re-Orienting Health Systems and Services;
- Mental Health and Healthy Life Conditions: Major Challenges for Health Promotion.

The main outcomes and conclusions from the Ministerial Programme are published separately from this report[6].

4. The Technical Themes and Case Studies

This section summarizes the discussions that took place in the breakout sessions following the six plenaries. The technical reports and case studies presented in the plenaries are available in separate documents and are not covered in detail in this report[7].

Technical Theme 1 : Evidence Base for Health Promotion

The nature of evidence in the context of health promotion was the focus of the first plenary. The technical report "Strengthening the Evidence Base for Health Promotion" was written and presented by Dr David McQueen. This technical session was unusual in that no case studies were presented and no breakout sessions followed the plenary. However, the issue of evidence

[6] See Annex for information on how to obtain this document

[7] See Annex: Conference products/documents.

was discussed as a cross-cutting theme during all other technical sessions and was taken up in all breakout sessions. This is referred to below in the relevant sections. In addition, a special 5GCHP Ad Hoc Working Group on Evaluation in Health Promotion met on several days during the networking time.

A number of major initiatives concerning this issue have been undertaken in North America and Europe. These were outlined in the plenary presentation. Overall, the concept of evidence was a source of considerable debate throughout the conference. Traditional scientific, and particularly medical, definitions of evidence were felt by many conference participants to be too limiting. It was felt that health promotion is a form of participatory action that requires participatory research leading the development of evidence. Traditional scientific convention does not allow for this. Participants felt that evidence needs to be derived from the full range of experiential knowledge. Moreover, the focus of health promotion on the determinants of health and on personal and social change requires relevant measures and indicators. It was the view of many that we are currently not measuring the right things.

Further discussion took place in **the 5GCHP Ad Hoc Working Group on Evaluating Health Promotion** that was initiated by WHO to help clarify and define the role of health promotion evaluation, and identify those gaps that need to be addressed further. In a series of meetings, **the working group** participants discussed and challenged the evidence debate presented in the plenary session on evidence and the related draft technical report. Major points of the lively and sometimes heated discussions were:

- the distinction between purposes for evaluation and types of evidence to be collected for each purpose;
- the evidence debate from a *global* perspective, and the yet missing voices and approaches, such as those from developing countries;
- the differences between evidence and evaluation, and the issues of measuring complex systems of change;
- the need for partnerships with stakeholders and for measuring both processes and outcomes.

The working group developed **the following** *core set of concrete recommendations* for WHO:

- to continue the discussions and work, across regions and schools of thought, started by this 5GCHP evaluation working group, and
- to assist in the development of an infrastructure and core set of techniques for health promotion evaluation.[8]

Several experts expressed that their institutions may be interested in becoming part of a global infrastructure to be created in support of health promotion evaluation.

Technical Theme 2 : Investment for Health

The theme of Investment for Health was explored in the second plenary session, presented by Dr Erio Ziglio and Professor Spencer Hagard. The connection between health and human development was explored with particular reference to the Investment for Health approach adopted by the European region of WHO. This is a vehicle which, through benchmarking, enables governments, regions and localities to explore the contribution of each sector to the creation and maintenance of health. The strong connection between social, economic and

[8] See Annex for a more detailed description.

human development, and health was highlighted. Case studies from Trinidad and Tobago, Gaza and Germany were presented[9].

Five broad themes emerged from the discussions amongst conference participants:

- investing in human and social development;
- achieving integrated, multi-sectoral investments for health;
- improving understanding of the relationship between investment and health;
- improving the quality of indicators used to assess development in countries.

Investing in human and social development

Through the breakout sessions, the conference participants strongly expressed the view that Investment for Health is not about economics, but about human and social development. If the prerequisites for health do not exist, social and economic development will be stalled. To the prerequisites identified by the *Ottawa Charter* should be added democracy and political stability. Specifically, it was felt that countries need to re-negotiate their external debt relations to include good health and social development conditions, alongside those concerned with economic development. Human resource and social development should be the cornerstone of any countrywide development plan.

Achieving integrated, multi-sectoral investments for health

Conference participants felt there was extensive evidence to show that integrated, multi-sectoral approaches to investment for health are effective in contributing to both health and economic development. Much of this evidence is of a historical and comparative nature, but provides a compelling case for investing in health.

Improving understanding of the relationship between investment and health

One fundamental step in this process is to make people aware of the relationship between different forms of investment and health. Through such understanding, people are far more likely to relate to and take ownership of health as a public good.

Examples from the case studies and wider discussion indicated that understanding and ownership depend on the reference points of those receiving the message. Not everyone sees the relationship between human and social development and health in a broader sense. Most fundamentally, the concept of health held by those in key political positions is crucial.

For example, the municipalities in all parts of the world that have made greatest progress in taking actions to promote health and achieved a more holistic/integrated approach, are those in which the mayor holds a more broadly based concept of health. This demonstrates both the importance of engaging people and the impact of individual decision-makers on progress. Sharing experiences, stories and case studies as "evidence", alongside more traditional forms of evidence is important. Stories influence decision-makers as well as scientific evidence. The political and technical dimensions interact. Disseminating case studies in a consumable form (like the videos shown at the conference) can generate political change. This approach can also address the issue of public accountability.

[9] See Annex

Improving the quality of indicators used to assess development in countries

Conference participants were also concerned that there was still a paucity of health indicators (as distinct from disease indicators) used at the global and local level. Such health indicators may include measures relating to the determinants of health. Moreover, given the close links between socio-economic development, inequities in access to resources and health, health in itself becomes an indicator of development. Similarly, participants felt the prerequisites for health and major determinants of health should be *the* focus of indicators. There is also a need to develop indicators on *equity* separate to the measures of *inequality* which now exist.

Technical Theme 3 : Social Responsibility for Health

The issue of social responsibility emerged during the Jakarta Conference with particular reference to the role of the corporate sector as potential new partners in promoting health. The technical paper *Promoting Social Responsibility for Health: Progress, Unmet Challenges and Prospects* was written and presented by Professor Maurice Mittelmark in this plenary. In his presentation, Professor Mittelmark focused more on community level issues and concerns. The concept of equity-based health impact assessment was presented. Case studies were presented from Gujarat and Calcutta in India, and Henan in China[10].

Five broad themes emerged from the discussions amongst conference participants:

- What constitutes social responsibility for health?
- How do you measure it?
- Issues of equity and gender
- The case studies and what they reflected in terms of the prerequisites of success
- Cultural diversity

What constitutes social responsibility?

It was clear from the feedback received from participants that social responsibility, like health, means different things to different people. Defining it becomes particularly important when identifying who is responsible for what. In working together people need to be clear about rights and responsibilities and need to go through a process of defining social responsibility for health in their own terms so that there is collective ownership.

Different levels, as well as different sectors, need to be clear on roles and responsibilities. Participants identified that Governments are socially responsible for the promotion of democracy, for mobilizing key players and bridging the gap between human rights and social rights at the community level. Some participants felt that Governments too often sign up to Human Rights but fail to follow through and support them at the local level.

However, if social responsibility is devolved, governments too often give up their own responsibilities. A key challenge is to link the different levels of society and develop a dialogue to overcome the inherent tensions.

Some participants pointed out that both workplaces and trade unions have a role to play. Trade unions in particular are currently under-utilised allies. However, some participants felt that in the private sector, social responsibility only signifies economic self-interest.

[10] See Annex

To some participants social responsibility for health is also about the ability to respond - and that implies skill development and capacity building. To others it is seen as a right.

Participants also identified the development of social responsibility for health as a political process and a potentially dangerous one for its advocates. In at least two breakout groups, this led to a discussion on the barriers to its development

Finally, conference participants pointed out that at the centre of social responsibility lies the issue of respect, respect for the social fabric of a community.

How do we measure social responsibility for health, and is there an evidence base

It was felt by conference participants that little evidence is currently collected on the mechanisms through which social responsibility is related to health improvement. Indeed it is an important dimension missing from current research, particularly in relation to sectors other than health. The key challenge is to come up with appropriate benchmarks for different levels of government and society.

Gender and equity

In many parts of the world, women currently play a prominent role in social responsibility for health at community level. The issue of equity in relation to women emerged as an important issue, which some felt had been neglected, in contrast to social structure inequities. Social responsibility is always seen as the primary responsibility of women, thus men currently take only a marginal role. Moreover, there are different perceptions as to what constitutes social responsibility between men and women. Nevertheless, social responsibility needs to be the responsibility of the whole community.

The focus on the community and case studies

The case studies became an important focus of discussion within the breakout groups. They demonstrated multifaceted action, all starting a different point but with long-term and sustainable consequences. They were developed over long periods of time, had political commitment, reflected partnership approaches particularly between expert, community and local government. They used appropriate technology and were examples of the strong link between environment and health. They also showed the importance of good feedback to the community as part of the process.

Cultural diversity

Just as there are different perceptions of what constitutes social responsibility between men and women, participants argued that there is no national or international consensus on its definition. Social responsibility and how it is defined is a culturally specific concept. Discussion and operationalisation of the concept, as well as measurement of social responsibility, must take this into account.

Technical Theme 4: Building Community Capacity and Empowerment of the Individual

Dr Helena Restrepo summarised the key points in her technical paper on Increasing Community Capacity and Empowering Communities for Promoting Health. She argued that community capacity building lies at the heart of health promotion. Drawing on the work of Paulo Friere she

outlined the main characteristics of community capacity building. She also highlighted the challenges to this approach, particularly in the context of general trends towards economic insecurity, corruption, lack of solidarity, and human rights violation. Her presentation was followed by case studies from Nigeria, Colombia and the United Kingdom[11]. Both the case studies and the presentation generated a passionate response from participants.

The debate in the group breakout sessions was equally lively. Five themes emerged, all demonstrating the tensions around community capacity building and empowerment:

- Capturing the evidence of success and value of community capacity building
- The need for capacity building amongst community health promoters
- The keys to successful community capacity building
- Government and health sector perceptions
- The role of women

Capturing the evidence of success and value of community capacity building

All participants felt that there was a long and established history of community development involving varied and innovative experiences. The systematic documentation of these is crucial. This implies the development of research skills amongst practitioners as well as the development of a greater number of opportunities to communicate work in this area, including publication in journals. One scientific challenge is to find ways, using appropriate qualitative data, of describing the growth and change that takes place in people and communities through empowerment-oriented health promotion strategies. A simple measure of the outcome of community capacity building could be the actions that people take in response to adversity. The systematic relationship between community capacity building, social capital and health needs more and better documenting.

The need for capacity building amongst community health promotion workers

A consistent theme that came through in all the group discussions was the need for better training of community health promotion workers to ensure good practice. Advocacy skills were seen as particularly important. There also needed to be greater investment in network infrastructures. A suggestion from one group was a global website on community capacity building, including guidance on best practice.

The keys to successful community capacity building

Some discussion took place around defining the keys to successful community capacity building. Fundamental to this process is that control of decision-making rests with the community concerned – with little or no outside involvement. Where governments or outside agents are involved, they should take the role of facilitator, not provider. Process is at the core of community capacity building. That process is often slow, and generally needs to be slow to ensure relevance to community aspirations, cultural sensitivity, and to improve the chances of sustainability. Participants also emphasised the importance of systematic planning and good facilitation.

Government and health sector perceptions

[11] See Annex

Participants expressed concerns that both government and the health sector still do not understand community-based health promotion. Indeed it was emphasised that many top-down, governmental interventions in the past have cut across existing community strengths and undermined existing, locally relevant activity. This danger still remains, especially in some countries where, according to some participants' perception, there is a return to centralisation of health promotion within health services. Community capacity building requires considerable skills and these should be addressed in the training of health professions and public servants in order to avoid or minimise the chances of such practices in the future.

The role of women

As in previous discussions, participants again emphasised the role of women at the core of health development and capacity building initiatives. Some participants felt that this issue comes up repeatedly because of the inherent skills of women which still do not receive proper recognition. Women who are already organised can transfer skills and enhance their own capacity with new skills.

Technical Theme 5 : Securing an Infrastructure for Health Promotion

In presenting his paper on *Infrastructure to Promote Health: The Art of the Possible*, Dr Rob Moodie stressed the need both to build on and improve existing infrastructures to promote health and create a core of dedicated infrastructures for Health Promotion. In light of the barriers identified, he stressed that Health Promotion does not happen by chance. This presentation was followed by two case studies[12] from South Africa and Mexico and one case study illustrating the global movement for active ageing[13].

The debates in the breakout sessions highlighted four main themes:

- Appropriate infrastructures for health promotion
- Equity
- Development of human resources
- Building collaboration

Appropriate infrastructures for health promotion

There was a general discussion on the importance of having an infrastructure that reflects health promotion concepts and principles. That implies not developing new bureaucratic infrastructures or centres but building on what already exists. This means strengthening the capacity to act and developing the mechanisms to do this, and in turn, moving away from traditional vertical structures to networking type structures. It also means recognising that responsibility is not just with government, but involves a whole range of sectors. Appropriate structures are those which strengthen democracy and provide sustainable, continuing support at all levels, particularly at the community level. There should also be mechanisms that provide leverage on resources, and clear benchmarking of standards.

There was much discussion and little agreement on whether a national body dedicated to health promotion was required. Points of view depended very much on the situation in a country.

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[12] See Annex for a more detailed description.
[13] See Annex

Equity

As with discussions on the other topics, the issue of equity was a consistent theme that ran through the consideration of infrastructures for health promotion. Ensuring that any infrastructure pays attention to encouraging equity is fundamental. Such infrastructures also encompass the global dimension. At this level, new forms of mentorship need to be developed between regions and countries. It is also important to recognise that differences in access to technology such as the internet have the potential to increase inequity in access to information. This needs to be addressed in any communication infrastructure.

At all levels, attention to equity means reallocation and redeployment of resources. Any infrastructure needs to have capacity to apply leverage on government policy to ensure that equity considerations remain to the fore. Such an infrastructure also requires equality in top-down and bottom-up elements for delivery of all the elements of health promotion to be successful.

Development of human resources

Participants discussed the need for capacity building in human resources as an essential element of any infrastructure for health promotion. An infrastructure for effective training should be in place and some specific skills are essential. Skill development in democratic planning was highlighted as particularly important. Closer integration between universities and community members was also felt to be important. More fundamentally, there should be basic education for all in what constitutes a health-promoting society.

Building Collaboration

It was reiterated by participants that multi-sectoral collaboration lies at the heart of health promotion and of any infrastructure needed to support it. Communication must be encouraged and credibility established with existing organizations by building coalitions to develop an effective agenda, with emphasis on good practice. Such coalition building takes health promotion beyond the sole remit of the health sector.

Technical Theme 6 : Reorienting Health Services

Dr Daniel Lopez Acuña presented the major findings of the technical report on *Reorienting Health Systems and Services with Health Promotion Criteria*, co-written by five authors[14]. He expressed the need to integrate health promotion and prevention as an integral part of the health care delivery process and to incorporate health promotion principles into health services management. He laid out several strategies to achieve this and outlined steps towards a "second wave of health sector reform". The three key steps highlighted in the paper were to reorient health systems and services with health promotion criteria to increase the effectiveness of health interventions, to promote the quality of care, and to improve public health practice.

His presentation was followed by presentation of case studies from Ecuador, the USA and Pakistan[15].

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[14] See Annex

[15] See Annex for a more detailed descritpion.

The crucial role of communities in evaluating the quality of health care services was highlighted. A core question raised was that of the role of governments or the state in the reorientation of health systems and services.

The breakout session consisted of very lively discussions which focused on four main themes:

- Making the case for reorientation
- Equity
- The public/private mix
- How to move things forward.

Making the case for reorientation

A number of participants felt that the reorientation of a health system should involve the integration of health promotion at every stage of the system. The challenge in doing this was in making the case for change. Inevitably, systems are resistant to change. There is a need for clear arguments that can persuade people of the need for change from inside and outside the system. This includes presenting the evidence in such a way as to make it meaningful to politicians. A central role was proposed for WHO in setting up a committee to explore such a reorientation and how it should be implemented. Overall government leadership and political will are most important for any reorientation.

The public/private mix

The case studies provided examples of the reorientation of health care services rather than the larger issue of the reorientation of a health system. Moreover, they reflected only the example of nongovernmental organisations (NGOs). This led to considerable debate as to who is responsible for what within any health system.

There was also a general debate on the role of the state in the provision of the public health function. This is especially important in countries where health service delivery is increasingly managed by the private sector. Issues were also raised relating to universal access to health services in a health care system predominantly managed by the private sector .

In some countries, the models that NGOs have developed have allowed better involvement of the community in decision-making. However, participants felt strongly that Governments should take responsibility for reorientation.

Equity

Coverage in terms of access lies at the heart of equitable health systems. There are some examples of successful reorientation of health systems in different countries, and all have made a contribution to equity. Participants commented that, at its best, an equitable system would include health system reorientation in any needs assessment within a community, as well as a community-controlled health committee.

How to move things forward.

Participants had a far-ranging discussion on how to move forward in terms of a "second wave" of health reform. Although reorientation of health systems had been a fundamental element of the Ottawa Charter, development has been patchy and there has been no systematic analysis of

what has happened and what is possible. The technical paper was seen as a first stage in developing a strategy for change.

5. A Framework for Countrywide Plans of Action on Health Promotion

The *Mexico Ministerial Statement for the Promotion of Health: From Ideas to Action* (MMS) was signed by 87 Ministers of Health or their designates at the official opening of the conference. The MMS was the outcome of a carefully planned process of consultation and briefings, which took place throughout the proceeding year. An initial draft statement prepared by the conference organisers was circulated globally to all Ministers of Health for their comments and suggestions. The Statement was modified accordingly and a revised version once more circulated. Two briefing sessions on the draft statement were held for the diplomatic corps accredited to the UN at WHO. The MMS took forward the spirit of the *WHA Resolution on Health Promotion* (WHA51.12). The MMS states that health promotion must be a fundamental component of public policies and programmes in all countries in the pursuit of equity and better health for all and pledges support for the preparation of countrywide plans of action for promoting health. It states that the plans will vary according to national context, but will follow a basic framework agreed upon during the Fifth Global Conference on Health Promotion. In follow-up to this commitment, on arrival at the conference, participants received a first draft of a *Framework for Countrywide Plans of Action in Health Promotion*. This first draft was used as the basis for a plenary presentation on Tuesday 6th June, followed by a breakout session to discuss the content, direction and application of such a framework. Following further discussion and feedback, a revised version was approved by the conference. This final version is available on the conference website.

6. Health Promotion in Mexico

During Mexico Day, Wednesday 7th June, Plenary session D was dedicated to showcasing a range of Mexican experiences of health promotion as a cross-cutting approach applied to disease prevention. The five themes were: an overview of the strategic programmes of the Vice Ministry for Disease Prevention and Control; health promotion strategy of the immunisations programme; health promotion approaches in health of the elderly; the basic health care packages; and the health education components of the free textbook provided by the Ministry of Public Education.

The following initiatives and points were discussed: a programme on health of the elderly with special attention to diabetes and hypertension; a programme to encourage physical activity; the important role of the community in housing improvement and achieving health development goals; communication strategies such as "The Messenger for Health" which provides information via radio to encourage adequate use of health services and self-care; and the "Heart to Heart" campaign for prevention of noncommunicable disease.

Programmes using the Settings approach were also presented. There are 1,483 "Municipalities for Health", a strategy that advocates for healthy public policy, and enables cross sector action to create healthy and supportive environments. This strategy has succeeded in placing health on the local development agenda and on the national agenda. The "Health Promoting Schools" initiative provides socially and culturally relevant life skills and school health activities centred on the development of youth and adolescents. The family health programme "Health begins at home" trains local community health workers as health promotion agents with the purpose of establishing "health-friendly houses". There are 46 indicators to evaluate the impact and process of these programmes.

The Immunisations Programme covers children, youth and pregnant women, and is extending coverage to the elderly. The Health of the Elderly programme carried out by the Mexican Social Security Institute (IMSS) focuses on primary and secondary disease and risk prevention. This programme emphasises self-care and physical activity. An important activity is the establishment of an information system that monitors results and reports on risk factors identified by the surveillance system.

PROGRESA is a programme that provides a basic health care package. Its objective is to extend coverage to health services. A communication strategy using persuasive messages is in place to prevent tobacco use. The programme encourages self-care and provides ongoing training of health workers to deliver the basic health care package. This model of primary health care provides basic services while reducing the costs of health care.

The school health programme of the Ministry of Education has introduced key health concepts which are included in the free textbook programme. Public education provides 3 million children with free textbooks (approximately 160 million books have been distributed). The content centres on the development of life skills, values, attitudes and practices for a healthy and fulfilling life, including self-esteem, self-respect and respect for others, gender equity and tolerance education. Children develop an integral concept of health and development, learn to express and manage their feelings and to establish nurturing relationships, learn about the changes in their own bodies and how to protect the environment.

During the Mexican case study presentations, a variety of experiences were shared that illustrate culturally relevant health promotion at the community level. There were nine simultaneous working groups with approximately 5 presentations in each. Each session centred on a health promotion approach. One session was dedicated to health promotion strategies with different population groups. Another showcased health promotion experiences across the life cycle and with a family focus. Yet another group presented and discussed experiences with the settings approach: schools, municipalities, communities and workplace health promotion. The richness and diversity of experiences illustrated the relevance of health promotion at the local level. This session facilitated a common understanding of health promotion and provided input for many reflections. During the discussions, however, it became apparent that a common understanding of health promotion was lacking and that the existing networks of "Health Promoting Schools", "Healthy Municipalities and Communities" and the "Consortium of Universities", could very well be engaged in promoting a common understanding of health promotion.

7. Key issues arising from the meeting.

Restatement of the relevance of health promotion

Health promotion is the process of enabling people to exert control over the determinants of health and thereby improve their health. As a concept and set of practical strategies it remains an essential guide in addressing the major health challenges faced by developing and developed nations, including communicable and noncommunicable diseases, and issues related to human development and health.

Health promotion is a process directed towards *enabling people* to take action. Thus, health promotion is not something that is done *on* or *to* people, it is done *by*, *with* and *for* people either as individuals or as groups. The purpose of this activity is to strengthen the skills and capabilities of individuals to take action and the capacity of groups or communities to act collectively *to exert control over* the determinants of health and achieve positive change.

In tackling the determinants of health, health promotion will include combinations of the strategies first described in the *Ottawa Charter*, namely developing *personal skills*, strengthening *community action*, and creating *supportive environments for health*, backed by *healthy public policy*. Special attention is also given to the need to *reorient health services* towards health promotion.

Thus, health promotion will include actions directed at both the determinants of health which are outside the immediate control of individuals, including social, economic and environmental conditions, and the determinants within the more immediate control of individuals, including individual health behaviours.

The inputs to the conference in the form of presentations, case studies and posters clearly demonstrate that health promotion remains as powerfully relevant a strategy for social development as it was when it first emerged as a concept at the First International Conference on Health Promotion fifteen years ago. In particular, it remains an important set of strategies to address the factors influencing inequities in health.

Focus on the determinants of health

Health is a resource for life which enables people to lead individually, socially and economically productive lives. It is a positive concept emphasising social and personal resources (physical, mental and spiritual).

It has long been acknowledged that there are certain prerequisites for health which include peace, adequate economic resources (and their distribution), food and shelter, clean water, a stable ecosystem, sustainable resource use, and access to basic human rights. It was clear from the conference that the challenge to meet these fundamental needs must remain a core goal for all action directed towards health, social and economic development.

Recognition of these prerequisites highlights the inextricable links between social and economic conditions, structural changes, the physical environment, individual lifestyles and health. These links provide the key to an holistic understanding of health, and are meaningful to people's lives as they experience them.

Bridging the Equity Gap

A major underlying theme of the conference was to consider ways in which health promotion strategies can be employed to bridge inequitable differences in health status in populations, both between and within countries. The issue of equity in health was considered consistently in the breakout sessions, and addressed directly or indirectly through each of the technical reports. Considerable attention was given to underlying causes of inequity in health, especially regarding access to resources for health, and both social and structural inequities, especially gender inequity. By maintaining a focus on the determinants of health, and by emphasising the importance of empowerment, health promotion strategies also address the fundamental determinants of inequity in health. Thus, health promotion represents a viable, strategic response to inequity in health.

Because of the focus on addressing the determinants of health, health promotion requires political, social and individual actions. These actions need to be scientifically sound, socially relevant and politically sensitive.

Health promotion is scientifically sound

There is no single scientific "discipline" of health promotion. Given the range of strategies that are employed to promote health, the scientific basis for health promotion is drawn from a wide range of disciplines, including the health and medical sciences, social and behavioural sciences, and the political sciences. Health promotion may be considered an integrative discipline, using a systematic process to bring together different disciplinary perspectives to achieve intended outcomes.

For this reason it is difficult to determine a simple and universally agreed set of rules of evidence for health promotion. "Evidence" is inevitably bound to social, political and cultural context, and will be related to the method of action, process of change and measure of outcome which are valued by the population affected by actions to promote health.

Health promotion is scientifically sound. The different inputs to the conference (presentations, case studies, posters) demonstrated that there is a rich experience of practice as well as the traditional scientific literature which continues to guide decision-making in health promotion. This evidence can be used as the foundation for transparent accountability for actions taken. Health promotion actions should be based on a sound analysis of the issue being addressed, and should be informed by established theories and models of change drawn from its broad scientific base. A systematic approach to programme planning will, in many cases, greatly improve the chances of detecting a successful outcome and of being able to link observed outcomes to the actions taken. It is important to emphasise that health promotion strategies translate into more than defined programmes and products. For example, assessment of the value and impact of public policy requires quite different measures and methods to those used in programme evaluation.

It is clear from the deliberations at the conference that much work remains to be done to locate and assemble health promotion experiences from around the world to improve the scope and quality of the scientific basis for action, and contribute to knowledge development. This must include further debate on the methods and measures which can be appropriately used to evaluate health promotion strategies.

Health promotion is socially relevant

All actions to promote health occur within a social context. The strategies adopted to address the determinants of health need to be continually adapted to ensure their social and cultural relevance and to ensure that their effect increases rather than reduces equity in health. This is especially true for actions addressing health determinants in indigenous populations. Health promotion must be socially and culturally relevant.

Many of the case studies presented at the conference demonstrated that strategies to promote health should be grounded in a meaningful assessment of people's needs and aspirations, and should engage people in the process of addressing these. This ensures that social responsibility for health is genuinely shared between people and their government, and public and private interests at all levels.

The report of the Ministerial meeting and the Ministerial Statement make it clear that governments have special responsibilities to guarantee basic and universally accepted human rights, support democratic and participatory processes, and create infrastructures and conditions which support action to address the determinants of health.

The different inputs to the conference also strongly demonstrated the importance of collective action at the local level. Effective action at this level is built on an informed population, equitable participation in decision-making and a sense of belonging. It was also clear from the case studies that health promotion at this level is inextricably bound with economic and social development. In this regard, building the capacity of communities to take action to address locally determined problems is central to health promotion. Part of this process of building community capacity is to create the conditions within which community leadership and social entrepreneurialism can emerge and act as catalysts for change.

Many find the concept of social capital useful in describing both the process and outcome of locally based action for health.

Health promotion is politically sensitive

Health promotion is an inherently political process as it is essentially concerned with individual and community empowerment. Health promotion often necessitates actions which require political processes in the form of resource allocation, legislation and regulation.

The determinants of health are not restricted to the influence of health ministries and health professionals. Addressing these determinants and achieving greater equity in health requires political processes and actions which extend well beyond these boundaries. For these reasons, the role of health ministers and of health ministries is substantially greater than a restricted concern with the provision of essential health services.

Achieving greater investment for health in other sectors, by both governments and the private sector, remains an important goal, and one for which health ministers and ministries have an important advocacy role. As new models of governance emerge it is essential that health ministries retain this important health leadership role.

This responsibility was recognized by the Ministers of Health and their delegates in their report to the technical conference. Emphasis was given to the role of health ministers and ministries as advocates for health within government, and as the organizational mechanism through which health impact assessment of government policies could be managed.

What also emerged from that meeting was a clear request for health promotion actions to be informed by and responsive to prevailing political realities. This included the need for accountability, built on the use of scientifically sound health promotion actions.

Tension exists between emphasising the direct role of government in health promotion and the need to transfer powers and responsibilities to communities to determine their own health.
The continued effects of globalisation reduce the powers of national and local governments, yet also place greater responsibility on them to monitor and manage the health, social and environmental impact of global trade and transnational businesses. Private enterprises have a major influence on health. This influence can be direct in terms of the employment and economic rewards they offer, as well as their impact on working conditions and job security. Other impacts are less direct, for example environmental pollution. At present, the political processes required to manage the health impact of globalisation are not well developed.

The role of women in health development

A continuing theme throughout the conference was the role of women as a cornerstone of health development. The poor living conditions and social status of women lie at the heart of

inequity in health, since women take social responsibility for themselves and for their children in such disadvantaged circumstances. The empowerment of women through economic actions, through education and, importantly, through women's collective action is a crucial element in the resolution of the major inequities in life circumstances. Ensuring women have a voice in decision-making processes, and supporting their participation could have a substantial impact in effective health promotion.

8. Conclusions and Recommendations

The conference process was directed towards addressing some of the fundamental challenges which need to be met to ensure continued progress in addressing inequities in health by drawing upon the concept and strategies of health promotion. The products of these processes include the development of the *Mexico Ministerial Statement for the Promotion of Health: From Ideas to Action* and a *Framework for Countrywide Plans for Action* to support its implementation. These documents provide useful guidance for countries and for their Ministers concerning action to address the determinants of health and to ensure greater equity in health.

The conference also considered the resources and structures needed to develop and sustain capacity for health promotion at local, national and international levels. These are considered below.

Strengthening the "science and art" of health promotion

It was clear from the technical discussions and ministerial meeting that continued efforts need to be made to strengthen the "evidence base" on which health promotion policies and practices are founded. This can be done if all forms of evidence, derived from the full range of experiential knowledge, are included. In addition, this evidence needs to be better disseminated through improved exchanges of information within and between countries. Finally, it was clear that this evidence has to be communicated in ways that are politically, socially and culturally relevant to countries and communities.

This will require:

- continued **investment in appropriate research and evaluation** to improve understanding of the determinants of health, and the effectiveness of health promotion strategies to address these determinants. This will require a broad range of research methods which reflect the values, process and intended outcomes of health promotion policies and practices;

- the **development of indicators** which are more sensitive and relevant to health (as opposed to disease), health determinants, equity in health, and the short-term impact of particular health promotion strategies, and processes of change;

- improved **interaction, co-operation, and participation** among researchers, policy-makers, practitioners, and the communities with whom they work. Through improved interaction there is a greater chance that researchers will answer questions that are valued and valuable for decision-making, and that policy-makers and practitioners will make greater use of research findings;

- identification of practical strategies that can be employed to better **locate, assemble, synthesise and communicate** findings from ongoing research and evaluation, and experiences from case studies. This can be achieved in a variety of ways using established

methods such as through conferences and grass-roots networks, and publication in journals, as well as making use of newer technologies, including the internet;

- greater attention to opportunities to **communicate evidence in ways that are socially and politically relevant**. This has to do, in part, with the timing and orientation of the presentation of evidence.

The case studies presented at the conference were testimony to the extraordinary spirit, creativity and resourcefulness of practitioners and activists, mostly operating at community level. Processes which develop practical skills and capacities for health promotion, which encourage leadership for health, and which support the emergence of social entrepreneurs in communities are vital for the continued development and implementation of health promotion ideas and actions. This will require:

- **solidarity** among practitioners and activists who are often working in adverse circumstances with meagre resources. The development of **networks, alliances and partnerships** for health by concerned individuals and organisations is an important practical strategy for building solidarity;

- **mobilisation of resources** (financial, material and human) to ensure the implementation and sustainability of health promotion policies and practices at all levels. Such resources may come from a variety of government, non-government and private sector sources. Governments at all levels have a responsibility to ensure that the necessary resources are mobilised to implement existing and new policies and programmes, laws and regulations for health;

- the **development of community capacity** which is built on good access to information on the determinants of health and supportive infrastructures, including training;

- the **development of human resources** through education, training and exchange of experience. Universities and other educational institutions have a vitally important role in ensuring exposure of a wide range of professions to health promotion concepts and strategies (including but not limited to the health professions);

- creation of **networks and associations of practitioners** for mutual support and personal development. These associations should avoid exclusivity. Given the multi-disciplinary nature of health promotion there is considerable advantage in opening up such associations to a broad range of people and professions.

Strengthening political skills and actions for health promotion

A strong and consistent theme of the technical meeting concerned the need to work with and through existing political systems and structures to ensure healthy public policy, adequate investment in health, and facilitation of an adequate infrastructure for health promotion. This will require:

- **democratic processes** which emphasise decentralisation of power, resources and responsibilities for health;

- continued **social and political activism** where this is needed to influence government policies and to strengthen powers and responsibilities of communities to determine their

own health;

- use of a system of equity-oriented **health impact assessment** particularly of public policies at all levels of government, and of private sector policies and practices. This is a concrete mechanism to underpin inter-sectoral action for health, and to support social responsibility for health among governments, the private sector, NGOs and communities;

- **reorientation of health services** towards health promotion and primary prevention, and to achieve greater equity in health. A "second wave" of health sector reform may offer an important window of opportunity to achieve this change;

- **improved interactions** between politicians, policy-makers, researchers and practitioners. This will help ensure that, on the one hand, health promotion actions are informed by and responsive to prevailing political realities and scientific advances, and on the other, the importance of investing *for* health, and *in* health promotion is well communicated and widely understood;

- plans and structures which strengthen existing **capacity for implementing health promotion strategies**, and support **synergies between different levels** (local, national, international). These structures may be supported by governments, non-governmental organisations or the private sector. The *Framework for Countrywide Plans of Action for Health Promotion* may be helpful in guiding these actions.

Participants at the conference recognized the need to make progress in advancing the science, the art, and the politics of health promotion. The challenges identified above represent a substantial agenda which is far beyond the responsibilities of any single international organization, government, non-governmental agency, institution, or community. Participants at the conference committed themselves to actions to address these challenges in ways that are feasible and relevant to their circumstances. Participants also recognised that addressing many of these challenges will require continued concerted action and solidarity between the different health promotion actors represented at the meeting.

To ensure progress, participants recommended that WHO, in accordance with the 1998 *World Health Assembly Resolution on Health Promotion* (WHA51.12) take the next steps to establish an alliance for global health promotion to address these challenges, and work to implement the *Mexico Ministerial Statement for the Promotion of Health: From Ideas to Action* and other recommendations from previous international conferences as well as local/regional declarations on health promotion.

9. Annexes

Annex 1. Keynote speech given by Dr Gro Harlem Brundtland at Opening Ceremony

Annex 2. Keynote speech given by Dr George A.O. Alleyne at Opening Ceremony

Annex 3. Conference Programme

Annex 4. 5GCHP Ad Hoc Working Group on Evaluation in Health Promotion

Annex 5. WHA 51.12 Resolution on Health Promotion

Annex 6. Acknowledgements

- Speakers at the plenary sessions
- Facilitators of the plenary sessions
- Rapporteurs and facilitators of the breakout sessions
- Report writing team for the technical programme of the 5GCHP
- Conference organizers

Annex 7. Conference Products and Documents

- Mexico Ministerial Statement (with list of countries that have signed)
- List of 5GCHP case studies presented
- List of 5GCHP technical reports presented

Please check the following web sites
http://www.who.int/hpr/conference

to obtain the documents referred to in this report.

Dr Gro Harlem Brundtland
Director-General
World Health Organization

Fifth Global Conference on Health Promotion
Mexico, 5 June 2000

Your Excellency, President Ernesto Zedillo,
Secretary of Health, José Antonio González Fernández,
Dr Alleyne,
Distinguished Participants,
Colleagues, members of the press,

Last Wednesday, I was at a mass meeting in Bangkok. Standing on a platform I looked out over a sea of blue caps and white T-shirts. Wave upon wave of slogans against tobacco. Ten thousand health volunteers from villages all over Thailand had marched or bicycled to the city to mark the World No Tobacco Day. Health was being promoted on a giant scale. From local level to regional, from regional level to national, people were mobilised.

The speeches, though, weren't just about telling people not to smoke. They were not about local, or even national issues. They were about levels of taxation, about world-wide bans on advertising and the Framework Convention on Tobacco Control. These global responses support a growing national movement in Thailand: a movement against a public health disaster now killing someone in our world every 8 seconds.

What happened that Wednesday morning brought out the essence of health promotion. Promoting health is about enabling people to keep their minds and bodies in optimal condition for as long as possible. That means that people know how to keep healthy. It means that they live under conditions where healthy lifestyles are feasible. It means that they have the power to make healthy choices. Yes, health promotion is about making decisions - within the household, within society, and within the nation state. Its about making decisions within international institutions - whether they are concerned with development, trade, health or finance.

So much has happened since the last global Conference on Health Promotion in Jakarta in 1997. The landscape for international health is changing in fundamental ways. More and more people understand the benefits of good health. We know what needs to be done - in our lives and in our environments. We now understand the links between health, politics and the economy more clearly than ever before. For those of use meeting here in Mexico City, dedicated to promoting health, this really is a powerful moment.

It is a powerful moment because **we know how to benefit from the increasing inter-dependence in our world**. Yes, globalisation frightens some people and causes uncertainty to many more. But it also presents us all with genuine opportunities. New opportunities for global solidarity continue to emerge. There is great convergence - of values, of ideas and of action.

At the same time the search for equity and justice in health now involves more people in effective local-level action than ever before, reflecting our cultural and linguistic diversity.

Bringing the two trends together, we recognise the power of linking global values with local action. This is our responsibility as workers for health, as health promoters. No group is better placed to ensure that greater economic integration brings benefits to those who need them the most. Through encouraging

global solidarity while nurturing diversity, we help to shape events in line with the values of equity and fairness.

Now to a second reason why this is a powerful moment. **Health is very big news** - everywhere. It involves more and more people. Health is no longer a concern only of health professionals. A much wider constituency is engaged.

Let us reflect on what is happening:

- Both national and international health issues are prominent on the agenda when Heads of State, including the G8 leaders, debate the major political issues of our time. Just last week, global health featured prominently within the discussions at the U.S. European summit. (CHECK)

- A month ago, Africa's Heads of State assessed the economic impact of malaria for their continent and their peoples. They took responsibility for a continent wide effort to help people to halve the impact of malaria on their lives. They undertook to promote a series of proven interventions, making them available to people in their homes, when they need them.

- More and more governments see good health as a critical element of Human Security. In some nations this combination of human development and national security has become the basis of foreign policy. It is therefore no surprise that a health issue – HIV/AIDS in Africa – has been taken up by the Security Council of the United Nations.

- The mobilisation of resources to improve national efforts for promoting health is on the agendas of finance ministers as they discuss debt relief with the World Bank and IMF.

- Sustained improvement in International Health is a key theme in the Millennium Report by the United Nation's Secretary-General.

Health has now moved to the heart of domestic and international development agendas. Good health is increasingly recognised as a pre-requisite if communities are to be enabled to fight against poverty.

How can those of us who promote health take advantage of this powerful moment? We have an unparalleled opportunity to make a real difference. Our Mission is clear. We must empower people to make healthy choices for themselves and their families.

When the World Health Organization set out to improve health 50 years ago, there were hopes that antibiotics, vaccines and biomedical technology would provide the tools to achieve health for all.

However, decades of health development have clearly shown that technologies are not enough to guarantee people's health. A range of civil, cultural, economic, political and social conditions have to be addressed as well.

Many of the major determinants of better health lie outside the health system. Knowledge. Made available to people. Clean environments. Access to basic services. Fair societies. Fulfilled human rights. Good government. Enabling people to make decisions relevant to their lives, and to act on them.

Let us agree on the key points: **for people to have the power to be healthy, they first need knowledge**. Accurate, reliable knowledge about how to achieve good health, and about the risks to health that they face in their daily lives. They need knowledge that helps them to make the best choices and to implement them. They need to know how she or he can achieve good health: how the family can stay healthy. As we see from the recent trends of reduction in heart diseases and cancers in several industrialized countries, up to date, applicable knowledge is a pre-requisite for better health.

Knowledge is necessary, but it is not sufficient. **For people to have the power to be healthy, they must be in a position to choose better health**. This means making the right choices, and putting them into practice. If people are not able to do so, the new knowledge leads to frustration. That is why health promotion has focussed extensively on the issues of healthy cities, healthy schools, healthy workplaces and healthy homes. Environments within which people can choose to be healthy, and implement their choices in their daily lives. A good example is this city, which has made great strides to improve its environment over the past decade.

Yet, the combination of knowledge and a healthy environment may not be enough. Many people will still not feel that the power to be healthy is in their hands. **The third element is their being empowered to make the healthy choices for themselves** - and stick to them. This means local, national – and even international – policies that give them the freedom to do what they want, and need, to do.

- Promoting sexual health, among teenagers, often requires those responsible for local or national government to adopt policies that fly in the face of deeply-held beliefs

- Enabling people at risk to protect themselves and their families from the risks of malaria may call for liberalised access to mosquito nets, insecticides with which to coat them, treatment for those affected by malaria.

- Empowering young people to avoid tobacco use involves global action to limit the tobacco industry's attempts to lure children and youth into smoking: knowledge and encouragement are, on their own, insufficient to protect those under 20 from nicotine addiction.

Promoting health means transcending the narrow slot traditionally labelled "health promotion". That is why, when I am asked who is in charge of health promotion at WHO, I answer: "I am." All departmental staff, be they in Geneva, the regional or the country offices, have explicit health promotion responsibilities.

Promoting health means reducing risks to health and modifying behaviour that affects it. Our contribution is clear. We help to provide knowledge about determinants of health, and ensure that it is made widely available. We help to build consensus around ways in which this knowledge can be put into practice - in different settings, among different communities. We encourage public policies that help people themselves to take the action necessary to put this knowledge into practice.

We recognise that this work poses important challenges:

- *How to balance the role of governments in pursuing healthy public policies while, at the same time, enabling individuals to choose what they want to do for themselves as long as it does not harm others?*

- *How can we be sure that the complex debates about interactions between different risks to people's health are comprehensible to the majority who lack specialised knowledge, wherever they live, whatever their circumstances?*

- *How can we help health systems evolve into organisations that work on behalf of all people, reflecting the complex interplay of risks to people's health, and offering advice to individuals, to communities and to local authorities that promote health-seeking and care-seeking behaviour?*

- *Which mechanisms are appropriate - and effective - to take forward trans-national interventions against global health threats, such as tobacco?*

- *What approaches can we use to promote access to public goods - such as essential drugs - when people are unable to access them because of systematic market failures?*

- *How do we ensure that minimum environmental, labour and health standards are followed in a world where investors move assets in a matter of months and capital in a matter of seconds to ensure maximum short-time gains?*

You will be discussing such questions over the coming days. The member states and secretariat of the World Health Organization have a key role to play in helping to find answers.

WHO's overall strategy helps to set priorities. It lays out four strategic directions: reducing excess mortality and disability, reducing risks to human health, developing health systems that equitably improve health outcomes, and putting health at the centre of economic and development policy.

All these four directions have elements of health promotion. Each involves us in disseminating knowledge, establishing consensus about how the knowledge can be implemented, and encouraging healthy public policies that encourage people to implement the knowledge for themselves.

In serving as the international technical agency for health, WHO has several core functions through which the directions are pursued.

WHO will set standards and bring forward the evidence. Take the issue of food safety. Our core function is to act as an independent provider of knowledge and evidence.

Yet, providing knowledge is not enough. Evidence must translate into action. We must speak out about the information we possess. Broaden the constituency of organizations that have the power to act. Build coalitions of different partners – nationally and internationally. Working with others will translate ideas and commitments into better and more effective health systems.

Then we must help policy-makers, regulatory authorities and trade bodies make the best decisions possible. The tougher the issue for society, the greater the need for WHO to help decision-makers reach informed judgements.

We in WHO have learnt that programmes and policies are most likely to be sustained and successful if the people they are meant to serve are engaged in their design and implementation. Initiatives that rely on one sector alone are less likely to be effective than multi-sectoral efforts. Local initiatives are more likely to be effective when supported through global efforts.

The issue of tobacco illustrates this. The current annual toll of 4 million tobacco deaths world-wide will rise to 10 million by 2030. Seventy per cent of the increase will damage developing countries. The WHO Framework Convention on Tobacco Control will become one of the most powerful tools to promote health.

Full negotiation on this item will begin in October, and already we see emerging unprecedented global support for strong action. Adoption of the Convention, and its implementation, will be a crucial move by nations of the world to adopt healthy public policies.

Mr President,

Promoting health is a noble pursuit, but is it a goal in itself? Many of you would say yes, and I share that view. But I would like us to widen our ambitions. **Health is important not only for how it lengthens life and improves its quality – it is also an important contributor to economic and social development.**

Poverty perpetuates ill health.

In all our efforts we have to give special attention to the challenge of reducing poverty. The Nobel economics prize laureate Amartya Sen defines poverty as "deprivation of capability". He argues that people are poor not only because their income is low, but because they do not have access to basic services, such as health and education, which would have increased their freedom. Poverty, he says, seriously deprives people of a number of choices they must have available in order to live a satisfying life.

But improvements in health reduce poverty and enable growth.

As in Europe at the end of the 19th and beginning of the 20th century, we have seen that developing countries which invest relatively more, and well, on health are likely to achieve higher economic growth.

In East Asia, for example, life expectancy increased by over 18 years in the two decades that preceded the most dramatic economic take-off in history.

A recent analysis for the Asian Development Bank concluded that fully a third of the phenomenal Asian economic growth between 1965 and 1997 resulted from investment in people's health.

There is solid evidence to prove that investing wisely in health will help the world take a giant leap out of poverty. We can drastically reduce the global burden of disease. If we manage, hundreds of millions of people will be better able to fulfil their potential, enjoy their legitimate human rights and be driving forces in development. People would benefit. The economy would benefit. The environment would benefit.

Our task is no less than this. It is a difficult one. But - at this powerful moment, here in Mexico - we can commit ourselves to its achievement.

Thank you.

Dr George A.O. Alleyne
Director PAHO*

HEALTH PROMOTION—BRIDGING THE EQUITY GAP**
México, D.F., Mexico, 5 June 2000

Mr. President
Mr. Secretary of Health
Madam Director-General of WHO
Ministers of Health
Ladies and Gentlemen.

It is my very pleasant task to join with the Secretary and the Director-General in welcoming you to this Fifth Global Conference on Health Promotion. This is a joyous occasion for me and my colleagues in the Pan American Health Organization as we welcome you to the Americas for this Conference.

First, I must thank the Government of Mexico for its generosity and having shown us the hospitality for which Mexico and Mexicans are famous. There could not have been a better country to host this Conference, which returns to the Americas for the first time since the historic Ottawa conference in 1986 that set health promotion firmly as a priority in the minds of all those who are concerned with the public's health.

It is also very appropriate that this opening ceremony should be held in this museum which has the world's greatest ethnographical collection. Mr. President, every time I come here I am transported back in time and the realism of the exhibits stirs a chord in me. When I was here two months ago this Conference was very much on my mind and for a while I had the strange sensation that the very stones were rising up and the statues were speaking to me. And indeed they spoke of a past that is very relevant to the issues before us this week.

They spoke of the great civilization of Teotihuacan and the glory of Tenochtitlán of the Aztecs, and had me see the latter as a city that was the largest and most beautiful of its time. They spoke of a public policy that was healthy to the extent that the elected rulers were themselves enjoined to set an example in their lives and avoid health-damaging behavior. This public policy in the city that was the umbilicus of the world had public latrines, proper disposal of waste water and public servants who kept the streets clean. The five lakes were mirrors of the sun and moon. Personal hygiene was at a level only dreamed about in most other places.

Community action and responsibility for the local waterways were in part responsible for them being so clean. The orientation of the health services was seen in the delivery of medical treatment based on a welfare system. The network of veterans' hospitals and the quarantine system were fore runners of current public health practice. Moctezuma I had founded the famous botanical and zoological gardens and his herbarium had collections of medicinal plants from all parts of middle America.

These stones and statues would tell me of equality of opportunity, of education for all, which undoubtedly contributed to good health.

And I could not but think that your Tenochtitlán was indeed a healthy city and exemplified many of the basic concepts of health promotion that were so well codified in the First Conference in Ottawa and solidified in other subsequent ones.

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* Pan American Health Organization, Pan American Sanitary Bureau, Regional Office for the Americas for the Americas of the World Health Organization.

** Presented at the Fifth Global Conference on Health Promotion. México, D. F., Mexico, 5-9 June 2000.

I came back to reality with the hope and conviction that this Fifth Conference would indeed light a new fire for health promotion. It would seek to show that equity in health was indeed important and that the strategies for health promotion are essential to bridge the gaps and decrease the disparities that are unjust and unfair and therefore represent inequity.

But why should we be so fixed on the concept of equity in health? Does this idea that is behind the noble goal of Health For All still have currency today? I say it does. There are two concepts that must guide us in our discussions. First there are disparities of health outcomes or disparities in health status, but they are not manifestations of inequity unless we can say that they are unjust or unfair. It is almost intuitively apparent that a good such as health that is universally prized as among the most important attributes in life should not permit of disparities that are unfair. In our lexicon, the concept of equity is translated to mean that the difference that exists should be avoidable, should be beyond the will or volition of the individual or group and ideally there should be an agent to which responsibility can be assigned.

It is not enough to look at the health outcomes. One must look at those social conditions that determine health outcome—the determinants of health. Many of the constitutions of our countries speak to the right to health or as better put by the American Declaration on the Rights and Duties of Man. It is of fundamental importance that in discussions on equity we understand the difference between disparities in health status and disparities in the determinants of health that cause these health inequalities or inequities.

This Conference will address the possibility that the strategies of health promotion will reduce the health disparities that we deem inequities. I have no doubt that you will have examples to share of how public policy has been or can be shaped such that the disparities in health determinants be reduced. One important aspect of such policy relates to the proper balance between maintaining a strong central state authority and yet decentralizing many operations to a more peripheral level. I am pleased to note the progress Mexico has made in this regard and we in the Pan American Health Organization have been witnesses to the universality of coverage in many of your states to which much of the execution has been decentralized.

I hope that this Conference will not ignore the possibility— nay imperious necessity that attention be paid to gender equity. Gender discrimination as a cause of ill health is all too often ignored because its manifestations are so subtle.

The call for re-orienting the health services has been heard clearly in this Region and almost every country is engaged in some reform of the health sector. Every one of them has equity as a desideratum in addition to efficiency and effectiveness. There will be opportunities during this Conference to reflect on how the main constituents of the reform process are being played out in national contexts.

Equity is one of the basic value principles I have espoused loudly and vigorously in the Pan American Health Organization and it represents a basic focus of our technical cooperation. We ask if there are gaps in health outcomes or determinants and can our technical cooperation address them. We have concrete examples to demonstrate that this is possible.

Mr. President, these Conferences are global rather than international and this implies that the business of promoting the public's health is a matter that involves nations yes, but involves a wider constituency. The call for partnership is as clear today as when it was issued in Jakarta at the Fourth Conference and I am pleased to note the many examples of such partnerships that have flourished globally and regionally in favor of health.

Mr. President, Mr. Secretary, let me thank you again for your hospitality and as we go out from this place, I hope that we will indeed hear the voices of some of your gods of years past. And I trust they will give us some of their wisdom such this Fifth Conference will fulfill the high aspirations of those who

have come here from every part of the world to examine how the application of the strategies and principles of health promotion can enhance equity in health.

Again I bid you welcome.

MINISTERIAL PROGRAMME

Sunday 6th June

When	What
14:00 onwards	Participant registration
Late afternoon	Welcome reception
18:00	Briefing of the Ministerial delegations

Monday 5th June

When	What
9:00 – 10:30	**Opening Ceremony** Speakers: Lic. José Antonio González Fernández, Minister of Health, Mexico Dr Gro Harlem Brundtland, Director General, WHO Dr George A.O. Alleyne, Director, PAHO **Signature of the Mexico Ministerial Statement for the Promotion of Health** Welcoming Message: Dr Ernesto Zedillo Ponce de León, President of Mexico
10:30 – 11:00	Return to Sheraton Hotel and Healthy Break
11:00 – 12:30	**Joint Technical-Ministerial session - Setting the Stage** *Overview of Past Accomplishments and Present Challenges* Chairpersons: Lic. José Antonio González Fernández, Minister of Health, Mexico Dr Gro Harlem Brundtland, Director General, WHO Dr George A.O. Alleyne, Director, PAHO Introduction: Dr. Achmad Sujudi, Minister of Health, Indonesia Speakers: Dr Michael Marmot, Department of Epidemiology, University College, London Dr Alexandre Kalache, Acting Director, Department of Health Promotion, WHO Facilitator: Dr. Roberto Tapia C.
12:30 – 14:00	**Lunch**
14:00 – 16:00	**1st Ministerial Session: Healthy Public Policies Equity, Investment on Health and Development** Chairperson: Dr Gro Harlem Brundtland, Director General WHO Secretary: Lic. Mario Luis Fuentes Alcalá, General Director of the Mexican Institute of Social Security, Mexico
16:00 – 16:30	Healthy Break

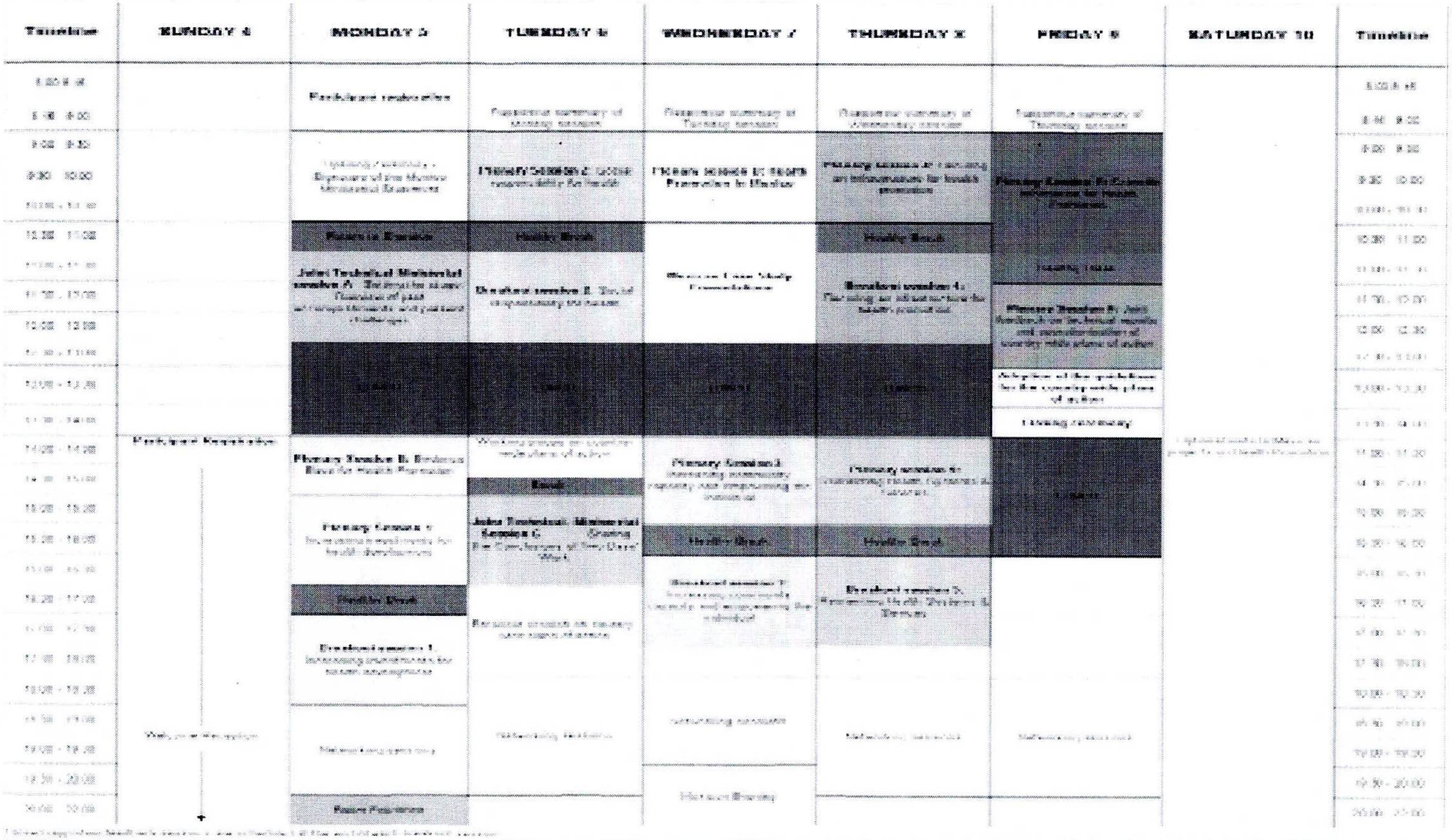
16:30 – 18:30	**2nd Ministerial Session: Social Responsibility for Health Promotion: Community Participation and the Involvement of all Sectors** Chairperson: Dr George A. O. Alleyne, Director PAHO Secretary: Lic. Socorro Díaz Palacios, General Director, Institute of Social Security and Services for State Workers, Mexico
20:00	**Special Performance of the Mexican Ballet**

Tuesday, 6th June

When	What
9:00 – 11:00	**3rd Ministerial Session: Reorienting Health Systems and Services** Chairperson: Dr David Satcher, Surgeon General of the United States of America Secretary: Lic. Enrique Burgos García, General Director of the Programme for the Integral Development of the Family, Mexico
11:00 – 11:30	Healthy Break
11:30 – 13:30	**4th Ministerial Session: Mental Health and Healthy Life Conditions: Major Challenges for Health Promotion** Chairperson: Dr Manuel Urbina Fuentes, Undersecretary, Ministry of Health, Mexico Secretary: Dr Enrique Wolpert Barraza, President of the National Academy of Medicine, Mexico
13:30 – 15:00	Lunch - Buffet
15:00 – 16:30	**Joint Technical-Ministerial Session: Sharing the Conclusions of Two Days' Work** Minister Tim Menakaya, Nigeria Minister Hamza Rafeeq, Trinidad and Tobago Minister Aaron D. Chiduo, Tanzania Minister Fr. Savvides, Cyprus Prof Don Nutbeam – Technical report Synthesis & Facilitator: Dr Julio Frenk, WHO
20:00	**Ministers' Closing Dinner**

ANNEX 3

Technical Conference Programme at a glance



5GCHP Ad Hoc Working Group on Evaluation in Health Promotion[16]

The following text is taken from a summary report by Mary Hall, the working group rapporteur, the major *points and recommendations of which were presented to the 5GCHP conference by David McQueen.*

1. There was general agreement on the distinction between purposes for evaluation, and the types of evidence one collects for each. One purpose is for the benefit of the program and its stakeholders. The evidence gathered in this type of evaluation is used to guide the program and to make improvements. Process measures are used as evidence for this purpose. A second purpose for evaluation is to provide proof to funders and policy makers that the program has an impact, an effect, a value. The types of evidence collected for this purpose are outcome measures that demonstrate the impact of the program or policy.

2. Many voices are still missing from the discussion/debate on evidence. These may be representatives from developing nations, or people who are not typically included in such discussions as they do not tend to hold the type of government offices that allow them at the table. The workgroup must find a way to uncover these voices, and the approaches used by developing nations that are meaningful. These voices and methods must be incorporated into the existing body of evidence.

3. Participants requested further definition of the core techniques for conducting health promotion evaluation. However, before this core can be agreed upon, it is essential to more closely define the term "health promotion." If it is agreed that the heart of health promotion is community and policy change, then health promotion evaluation should include techniques on how to measure that complex system of change.

4. Whatever the context for health promotion evaluation, such evaluations must be conducted in partnership with stakeholders and/or the communities in which programs are taking place. This requires that stakeholders are also involved in program planning, and that evaluation measures chosen will be meaningful to stakeholders/communities. Evaluations should be conducted equitably, both in the process and in applying the outcomes. Resources for evaluation should also be applied equitably.

Recommendations:

WHO should establish an Evaluation Development Workgroup that will be responsible for creating a plan for the development of evaluation globally.

- This Workgroup, which should build on work previously done by the European Workgroup, should consider existing work in this area, and should integrate unpublished work into current evaluation knowledge.

[16] Co-chairs: Ligia de Salazar (Colombia); David Mc Queen (United States) - Core group set up by the 5gchp organisers: the co-chairs of the WG; representatives of major leading initiatives on HP evaluation; the members of the 5GCHP technical review and support group; - WG Participants: invited and welcomed experts from developed and developing nations

- Evaluation approaches should recognize the importance of equity in conducting locally-determined evaluation, and should emphasize the use of participatory approaches and multisectorial involvement in evaluation.

- This Workgroup should have equal representation from developed and developing countries, and diverse cultural representation. Members, to be selected in collaboration with global partners, should have expertise and experience in evaluation and health promotion. The Workgroup should complete its work within one year of being convened.

World Health Assembly Resolution on Health Promotion

FIFTY-FIRST WORLD HEALTH ASSEMBLY **WHA 51.12**

Agenda item 20 16 May 1998

Health Promotion

The Fifty-first World Health Assembly,

Recalling resolution WHA42.44 on health promotion, public information and education for health and the outcome of the four international conferences on health promotion (Ottawa, 1986; Adelaide, Australia, 1988; Sundsvall, Sweden, 1991; Jakarta, 1997);

Recognizing that the Ottawa Charter for Health Promotion has been a worldwide source of guidance and inspiration for health promotion development through its five essential strategies to build healthy public policy, create supportive environments, strengthen community action, develop personal skills, and reorient health services;

Mindful of the clear evidence that: (a) comprehensive approaches that use combinations of the five strategies are the most effective; (b) certain settings offer practical opportunities for the implementation of comprehensive strategies, such as cities, islands, local communities, markets, schools, workplaces, and health services; (c) people have to be at the centre of health promotion action and decision-making processes if they are to be effective; (d) access to education and information is vital in achieving effective participation and the "empowerment" of people and communities; (e) health promotion is a "key investment" and an essential element of health development;

Mindful of the new challenges and determinants of health and that new forms of action are needed to free the potential for health promotion in many sectors of society, among local communities, and within families, using an approach based on sound evidence;

Appreciating the potential of health promotion activities to act as a resource for societal development and that there is a clear need to break through traditional boundaries within government sectors, between governmental and nongovernmental organizations, and between the public and private sectors;

Noting the efforts made by the 10 countries with a population of over 100 million to promote the establishment of a network of most-populous countries for health promotion;

Confirming the priorities set out in the Jakarta Declaration for Health Promotion in the Twenty-first Century,

1. URGES all Member States:

(1) to promote social responsibility for health;

(2) to increase investments for health development;

(3) to consolidate and expand "partnerships for health";

(4) to increase community capacity and "empower" the individual in matters of health;

(5) to strengthen consideration of health requirements and promotion in all policies;

(6) to adopt an evidence-based approach to health promotion policy and practice, using the full range of quantitative and qualitative methodologies;

2. CALLS ON organizations of the United Nations system, intergovernmental and nongovernmental organizations and foundations, donors and the international community as a whole:

(1) to mobilize Member States and assist them to implement these strategies;

(2) to form global, regional and local health promotion networks;

3. CALLS ON the Director-General:

(1) to enhance the Organization's capacity with that of the Member States to foster the development of health-promoting cities, islands, local communities, markets, schools, workplaces, and health services;

(2) to implement strategies for health promotion throughout the life span with particular attention to the vulnerable groups in order to decrease inequities in health;

4. REQUESTS the Director-General:

(1) to take the lead in establishing an alliance for global health promotion and in enabling Member States to implement the Jakarta Declaration and other local/regional declarations on health promotion;

(2) to support the development of evidence-based health promotion policy and practice within the Organization;

(3) to raise health promotion to the top priority list of WHO in order to support the development of health promotion within the Organization;

(4) to report back to the 105th session of the Executive Board and to the Fifty-third World Health Assembly on the progress achieved.

Tenth plenary meeting, 16 May 1998
A51/VR/10

Acknowledgements

The conference organizers, World Health Organization, Pan American Health Organization and the Mexico Ministry of Health, wish to express their warm appreciation of all those who actively contributed to the Fifth Global Conference on Health Promotion.

In this annex to the report of the *technical* programme special thanks are extended to the following groups of persons whose contributions were essential to the success of the conference.

Speakers at the plenary sessions

Rina Alcalay
Keziah Awosika
Parveen Azam Khan
Elizabeth Casey
Indira Chakravarty
Mirai Chatterjee
Gerard d'Abreau
Michael Drupp
Jonathan Fielding
Mariana Galarza
Alonso García Acosta
Mariano García Viveros
Rodolfo Garzón Mendizábal
Pat Graham-Casey
Rebecca Holmes
Alexandre Kalache
Rolf Altmann
Daniel López-Acuña
Michael Marmot
Enrique Martinez
David McQueen
Maurice Mittelmark
Rob Moodie
Antoinette Ntuli
Martín Pacheco
Scott Ratzan
Helena Restrepo
Jonathan Rosenberg
Aown Shawa
Wang Shugeng
Achmad Sujudi
Zhang Zeshu
Erio Ziglio
Elizabeth Zonneveld

Facilitators of the plenary sessions

John Batten
Bryna Brennan
Somsak Chunaras
Gillian Durham
Julio Frenk
Uton Muchtar Rafei
Roberto Tapia

Rapporteurs and facilitators of the breakout sessions

Robert Anderson
Tariq Bhatti
Malinee Chulavachana
Halina Cyr
Richard Horst Noack
Martin Pacheco
Fran Perkins
Bosse Pettersson

Gerard D'Abreau
Ligia de Salazar
Doris Gillis
Martha Lucia Gutiérrez
Nancy Hailey
Piedad Huerta
Josefa Ippolito-Shepherd
Sergio Maresman
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Desmond O'Byrne, WHO
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Julio González, PAHO/WHO Mexico Office
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Amy Maines, WHO
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José Antonio Solís, PAHO
Roberto Tapia, MoH, Mexico
Javier Urbina Soria, MoH, Mexico
Lisa Véron, WHO

FIFTH GLOBAL CONFERENCE ON HEALTH PROMOTION

Health Promotion: Bridging the Equity Gap
Mexico City, June 5th, 2000

Mexico Ministerial Statement for the Promotion of Health : *From Ideas to Action*

Gathered in Mexico City on the occasion of the Fifth Global Conference on Health Promotion, the Ministers of Health who sign this Statement:

1. Recognize that the attainment of the highest possible standard of health is a positive asset for the enjoyment of life and necessary for social and economic development and equity.

2. Acknowledge that the promotion of health and social development is a central duty and responsibility of governments, that all sectors of society share.

3. Are mindful that, in recent years, through the sustained efforts of governments and societies working together, there have been significant health improvements and progress in the provision of health services in many countries of the world.

4. Realize that, despite this progress, many health problems still persist which hinder social and economic development and must therefore be urgently addressed to further equity in the attainment of health and well being.

5. Are mindful that, at the same time, new and re-emerging diseases threaten the progress made in health.

6. Realize that it is urgent to address the social, economic and environmental determinants of health and that this requires strengthened mechanisms of collaboration for the promotion of health across al sectors and at all levels of society.

7. Conclude that health promotion must be a fundamental component of public policies and programmes in all countries in the pursuit of equity and better health for all.

8. Realize that there is ample evidence that good health promotion strategies of promoting health are effective.

Considering the above, we subscribe to the following:

ACTIONS

A. To position the promotion of health as a fundamental priority in local, regional, national and international policies and programmes.

B. To take the leading role in ensuring the active participation of all sectors and civil society, in the implementation of health promoting actions which strengthen and expand partnerships for health.

C. To support the preparation of country-wide plans of action for promoting health, if necessary drawing on the expertise in this area of WHO and its partners. These plans will vary according to the national context, but will follow a basic framework agreed upon during the Fifth Global Conference on Health Promotion, and may include among others:

- The identification of health priorities and the establishment of healthy public policies and programmes to address these.
- The support of research which advances knowledge on selected priorities.
- The mobilization of financial and operational resources to build human and institutional capacity for the development, implementation, monitoring and evaluation of country-wide plans of action.

D. To establish or strengthen national and international networks which promote health.

E. To advocate that UN agencies be accountable for the health impact of their development agenda.

F. To inform the Director General of the World Health Organization, for the purpose of her report to the 107th session of the Executive Board, of the progress made in the performance of the above actions.

Signed in Mexico City, on June 5th 2000, in Arabic, Chinese, English, French, Portuguese, Russian, and Spanish, all texts being equally authentic.

Mexico Ministerial Statement for the Promotion of Health : *From Ideas to Action*

This Ministerial Statement was signed by the following countries:

Algeria
Angola
Argentina
Aruba
Australia
Austria
Bangladesh
Belize
Bhutan
Bolivia
Brazil
Bulgaria
Cameroon
Canada
China
Colombia
Costa Rica
Cuba
Czech Republic
Denmark
Dominica
Dominican Republic
Ecuador
El Salvador
Egypt
Finland
France
Gabon
Germany
Guatemala
Haiti
Hungary
India
Indonesia
Iran
Israel
Jamaica
Korea
Kuwait
Lao PDR
Lebanon
Madagascar
Malaysia
Maldives
Malta
Marshall Islands
Mexico
Morocco
Mozambique
Myanmar
Namibia
Nepal
Netherlands
New Zealand
Nicaragua
Niger
Norway
Oman
Pakistan
Panama
Paraguay
Poland
Portugal
Puerto Rico
Russian Federation
Rwanda
Saint Kitts and Nevis
Saint Lucia
Samoa
Slovakia
Slovenia
South Africa
Spain
Sudan
Swaziland
Sweden
Switzerland
Thailand
Turkey
United Kingdom
United States
Uruguay
Vanuatu
Venezuela
Yugoslavia
Zambia
Zimbabwe

Case Studies presented during the Conference

INCREASING INVESTMENT FOR HEALTH DEVELOPMENT

The case study "Igniting the Fires of Hope", presented by Martín Pacheco and Gerard d'Abreau, told the story of SERVOL, an NGO from Trinidad & Tobago which offers child and youth programmes in community centres.

"Three months after Father Gerard Pantin, walked into Laventille in 1970 he confessed to one of the residents called Chaca that he was getting nowhere and was thinking of giving up. Chaca vehemently protested, 'You cannot do that! It is true that you have done nothing more than get jobs for a few dozen kids; but what you have really done is to bring HOPE to the area. Every morning you walk up the hill, those watching you think: maybe tomorrow it will be my turn to get a job. And once people have hope they will continue the struggle.' "

The case study "Environmental Health Promotion and Solid Waste Management in Gaza City", presented by Mr Aown Shawa, Mayor of Gaza City, and Ms Liesbeth Zonneveld, described how the Gaza City municipality, with EU funding and enthusiastic community participation, cleaned up its garbage- and sewage-filled streets.

" ... the aim was not just regular and affordable waste collection and disposal - project sought to involve citizens and municipal staff in a wider dialogue on 'how to improve living conditions in our city - how to make our city a healthy one', and to engage the entire Palestinian community in the battle to improve their environmental health conditions...."

The case study "Enterprise for Health", presented by Dr Herren Landig and Dr Michael Drupp, described a WHO/EURO-funded initiative on worker health promotion in Lower Saxony, Germany.

"WHO partnered with the regional association of Local Sickness Funds of Lower Saxony to create an incentive for private enterprises to invest in health. Granted 'bonuses' in the amount of one month's payment to the government's social security health insurance (for both employee and employer payments), for those companies willing to commit to comprehensive workplace health promotion."

SOCIAL RESPONSIBILITY FOR HEALTH

The case study "SEWA: Self-Employed Women's Association, Gujarat, India", presented by Mirai Chatterjee described the work of a trade union for poor, self-employed women workers who earn a living through their own labour or small businesses.

"... a Union of 220,000 women workers of the unorganised sector. Self-employed workers constitute 93 percent of the Indian workforce. They do not have regular salaried employment with welfare benefits: no weekly
day off, sick leave, pension, nor any maternity benefits. They are the poorest of workers, and yet, they ... account for 63 percent of gross domestic product in India."

The case study "Street Food Project, Calcutta", presented by Professor Indira Chakravarty, described how Calcutta authorities brought together the mayor, city and police authorities, community workers and street food vendors to improve the safety and nutritional value of street food.

"Street food vendors could be called the nutritionists of the poor. An individual's daily nutritional needs can be met with just a few rupees. However, street food can pose a significant health risk for consumers. Often ignored or tolerated by food control and public health officials, street food in many cities has become a critical concern..."

The case study "Latrine Revolution in the Henan Province", presented by Zhang Zeshu and Wang Shugeng described the project that introduced double-urn latrines to turn human excrement into non-hazardous, high quality fertiliser for use in agriculture.

"... the use of human nightsoil as fertilizer for farming is a fundamental aspect of Chinese culture. The exposed excreta emit offensive smells and serve as a favourable habitat for flies... Unhygienic conditions caused diarrhea and intestinal parasitic infections to run rampant in rural towns and villages. ... Professional health and agricultural workers invented the double-urn, funnel-shaped latrine...The new design allows human excreta to become non-hazardous fertilizer."

INCREASING COMMUNITY CAPACITY AND EMPOWERING THE INDIVIDUAL

The case study "Building Linkages with Democracy and Health" was presented by Ms Rebecca Holmes and Dr Keziah Awosika and described a partnership between 19 Nigerian NGOs and Johns Hopkins University to promote women's empowerment and participation in politics.

"Promoting the active involvement of women in public decision-making processes helps to ensure that practical gender interests are adequately addressed through appropriate policies and programs [including] reproductive and child health, literacy, access to clean water and sanitation, food supplies and prices, increased opportunities for income generation, early marriage, rights to inheritance and property, access to quality health services..."

The case study "Versalles: Healthy Municipality for Peace", presented by Dr Gilda Stella Millán and Mr Alonso García Acosta, Mayor of Versalles, described programmes implemented by this Colombian municipality to address health, education, conservation and development.

"... local development occurs within a health promotion framework and involves the active participation of community members in determining priorities for action as well as the appropriate strategies for addressing the identified needs. Using a methodology that combines analysis, action, and reflection, diverse sectors work jointly for education, community participation, equity, and sustainability."

The case study "Against the odds – Walterton and Elgin, From Campaign to Control" (United Kingdom), presented by Jonathan Rosenberg, described a North London community campaign in the 1980s which fought to prevent the local authority from

redeveloping the area as private housing for sale at prices beyond the reach of local people.

"WECH, a resident-controlled housing association, campaigned to prevent the local authority from redeveloping the area as private housing for sale at prices beyond the reach of local people. The two tower blocks were built out of steel, concrete and fibre glass. The lifts regularly broke down, the rubbish chutes blocked, and residents suffered flooding and water penetration. The worst problem was the wide range of asbestos products used as fire protection."

SECURING AN INFRASTRUCTURE FOR HEALTH PROMOTION

The case study "The Global Embrace: A World-Wide Walk Event for Active Ageing", presented by Dr Alex Kalache, described the highly visible one-day event consisting of a chain of locally organised celebrations and walks in 96 countries, occurring consecutively around the globe over a period of 24 hours.

"The vast majority of people, as they age, continue to live within their local communities. Grass-roots and community-based activities are a natural focus to promote healthy and active ageing. ... walking is not only an excellent form of physical exercise but also enhances social integration as it is a good way to meet people or enjoy the companionship of friends and family."

The case study "Equity Gauge – a tool for monitoring equity in health and health care in South Africa", presented by Antoinette Ntuli, described a project which supports improvement and reorientation of health services with the help of national and provincial lawmakers by setting up benchmarks to measure progress toward equity in health and health care.

"... a national project to help South Africans know if their health is improving and measure progress toward equity in health care provision. A partnership between South African Legislators and the Health Systems Trust to support the transformation of the health system."

The case study "Integration Of The Consensus-Action Group: A Network Of Academic And Social Institutions For Community Health Promotion And Education (Mexico)", presented by Dr. Mariano García Viveros, described the work of an action group formed to strengthen health promotion activities by mobilizing academic institutions to provide scientific support for health priority areas.

"... a network of investigators and educators to provide support to those working in health promotion, closing the gap between theory and practice. Network includes a variety of institutions with established infrastructure and significant potential for mobilizing to strengthen community capacity ..."

REORIENTING HEALTH SERVICES AND SYSTEMS

The case study "Association Vivir: Promoting Daily Health With Community Participation", presented by Dr Mariana Galarza, described how, in response to inadequacies of the existing health system, a private NGO, provides primary and preventive services and training.

"... a non-governmental organization that opened the door to alternative forms of health care in Ecuador. According to Dr. Galarza, the predominant curative approach to health care fails to see the human being in a comprehensive light; ignoring the social, emotional, and environmental causes of illness."

The case study "Community Care Network (CCN) Evaluation Program: A Case Study of An Expanding Private/Public Partnership in Rural United States", presented by Elizabeth Casey and Pat Graham-Casey, described how CCN addresses community health improvements via public/private partnerships to determine community needs, ensure continuum of care, and effectively manage resources.

" ... initially focused on improving cancer screening services for the underserved. It has now effectively expanded its service to include more comprehensive efforts to prevent chronic disease and improve all aspects of health care for the residents of west Texas."

The case study "Drug Abuse Prevention with Young People in Peshawar, Pakistan", presented by Dr Parveen Azam Khan, described the work of the DOST Welfare Foundation in the treatment and rehabilitation of drug addicts and their families and prevention of drug abuse in the community.

"DOST Welfare Foundation responds to the need for effective rehabilitation based on whole person recovery, i.e. physical, psychological, social and spiritual. Treats and rehabilitates drug addicts and, in parallel, works for drug abuse prevention in the community, by strengthening young people to resist the lure of drugs and develop healthy alternatives...."

Technical Reports written for the Fifth Global Conference on Health Promotion

"Strengthening the Evidence Base for Health Promotion"

By Dr David McQueen, USA.

"Investment for Health"

By Dr Erio Ziglio, WHO Regional Office for Europe; Prof. Spencer Hagard, UK; Prof. Laurie McMahon, UK; Dr Sarah Harvey, UK; Prof. Lowell Levin, USA.

"Promoting Social Responsibility for Health: Progress, Unmet Challenges and Prospects"

By Dr Maurice Mittelmark, Norway.

"Increasing Community Capacity and Empowering Communities for Promoting Health"

By Dr Helena Restrepo, Colombia.

"Infrastructure to promote health: the art of the possible"

By Dr Rob Moodie, Australia; Dr Elizabeth Pisani, Australia; Monica de Castellarnan, Australia.

"Reorienting Health Systems and Services with Health Promotion Criteria"

By Drs Daniel López-Acuña, PAHO, WHO/AMRO; Patricia Pittman, USA; Paulina Gomez, Chile; Heloiza Machado de Souza, Brazil; Luis Andrés López Fernández, Spain.

Review/2001/1

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The dynamics of health promotion: from Ottawa to Bangkok

by Ilona Kickbusch, Senior advisor on health policy, Federal Office of Public health, Bern, Switzerland

Kickbush, Ilona. The dynamics of health promotion: from Ottawa to Bangkok. Reviews of Health Promotion and Education Online, 2005. URL:http://www.rhpco.org/reviews/2005/1/index.htm.

The fact, that WHO together with the Thai organizers of the Bangkok Conference has signaled the intention to produce "a Bangkok Charter on health promotion" has sent storms, waves and ripples through the health promotion community. Suddenly, the uniqueness of the Ottawa Charter - a warm blanket that we had come to live with – was questioned. Various options emerged: it could be dismantled, it could be updated and even – as some implied – improved, or Bangkok could lead us to a new vision of public health in the 21st century. Meanwhile the first draft is available for commentary.

I like the fact that the World Health Organization is beginning to take health promotion seriously again and that the process of the Bangkok Conference engages the health promotion community in a dialogue over the value of the Ottawa Charter and any new approaches and innovations that may be necessary. And I am delighted to have been asked to be a part of this process. This is indeed a rare opportunity in a professional career.

Twenty years have passed since those cold days of creation in a conference hotel in Ottawa in 1986 and in looking back I am proud of what we achieved. WHO showed clear leadership and the Charter contributed significantly towards a new public health. The Charter has held up incredibly well in these twenty years – partly because it reflected the many changes that were in the air, partly because it was based on sound research, partly because it was clear about its values and partly because it was very participative in its production. But there is a new world and a new policy environment out there and a new generation of health professionals needs to take over the torch from the Ottawa pioneers in order to move the field forward.

I would like to comment on five issues that I feel we must consider in this process:

Developed – developing countries

Much has been made of the fact that the Ottawa Charter (OC) was for the developed world only and that we now need "something global". Yet the challenge thrown out by Dr. Halfdan Mahler, the then Director General of the WHO, was to make the principles of the Alma Ata Declaration applicable to the developed world – in particular the notion of empowerment. Indeed that concept came as much out of the experiences of the developing countries – Paolo Freire's approach to *conscientization* to name one of the most influential – as it mirrored the global social movements of the times. That has also been reinforced through that fact that it was easier to gain understanding for health promotion and its strategies in many developing countries and with indigenous societies than in the medicalized developed world.

The deliberations at Bangkok could help free the OC and health promotion from this misconception and false dichotomy. In a global world there is no us and them – only us.

Integration – specific areas of action

Others like to indicate that there are big chunks missing from the Ottawa Charter – an area that is mentioned frequently is mental health. Yet the challenge of the OC was to provide an integrative strategy for ALL the dimensions of the WHO definition of health (physical, mental and social – in the debate there was also frequent reference to the spiritual) and to recognize that in real life the three are hardly separable. A simple case in point was the heart disease research of the day which showed that the mental health effects of exercise groups were as

important as the physical. Another key influence on the OC was the research on social support and health, which, given the medicalized mental health approach of the day, needed to find a strategic home as far away from mental health as possible. Even though the OC did all it could to suggest that its five action areas could be applied to more or less any health problem in any part of the world it seems there is a deep psychological need to find "my health issue or problem" or "my vulnerable population group" in policy documents.

I hope the deliberations in Bangkok will be able to steer clear of long lists and reinforce the clear strategic directions of the OC.

The essential core

Health promotion practice has faced many difficult challenges, last not least to find recognition and funding for the kind of approaches it stands for. In consequence many deals have been made pragmatically along the way. The OC became the mantra while practice was something toned down to fit reality. Increasingly the evidence that the OC took from the knowledge base in the social sciences has arrived in the health arena through the research on social determinants, social capital and even macroeconomics. I hardly dare mention that health promotion spoke about investment in health even before the 1993 World Bank report was published.

The deliberations at Bangkok could help clear the air a bit again and bring us back to the essentials: the focus on health not disease, on resources not problems, on social determinants not symptoms, on people not professionals. This includes those new determinants that are now global in reach and need new strategies of response.

The WHO role

WHO has not always been a reliable champion and partner in health promotion. Despite World Health Assembly resolutions as to its importance the organization has had problems with assigning it the importance and budget that the policy documents would indicate and ensuring an organization wide commitment. Changes in staffing and outlook as well as personal preferences (based on the Not-invented-here Syndrome) have led to many up and downs – the most far reaching being the near equation (and at times replacement) of health promotion with non-communicable disease control.

I hope the deliberations in Bangkok can give a clear message to the WHO as to the relevance and scope of health promotion and the very strong contribution it can give to the WHO Commission on Social Determinants. It is a core function of public health and health policy and should be a core function of every government and of a global health organization.

The other partners

The OC is very "nation-state focused" in its approach because it wanted to underline that governments have a responsibility for the health of their people – particularly in the then new area of "lifestyles". The challenge of healthy public policy is now becoming increasingly recognized within governments and in the global arena. Health promotion has also frequently been at the cutting edge of public health thinking beyond the state – for example in relation to civil society involvement in health or public private partnerships. This has not always been well received initially. Health promotion developed this capacity for innovation through its work in the community with people – in short the untidy processes of real life. It remains true that *"health is everybody's business"* and that we should make *"the healthy choice the easier choice"* – finally it seems that this message is reaching more and more policy makers and is being turned into concrete strategies – witness the actions on tobacco or on obesity as well as some of the new health policy initiatives in countries. Finally many strategic approaches heralded by famous management gurus have – for example – been practiced every day in the "settings projects". Indeed health promotion has been a great social laboratory, not only of health but of participation and democracy.

I hope the deliberations in Bangkok will include many of these other partners – from the public, the private and the NGO sector – and that any document that emerges will reflect their commitment to health and health promotion.

Finally:

In my view there is no need to dismantle, revise or improve the Ottawa Charter – it is a living document with deep vision and practical orientation. We should let it stand.

But at the same time we should look forward. Let us work towards a conference outcome that is both as visionary and as resilient as the Ottawa Charter and complements it in important dimensions. What is should be called is part of the democratic process at the conference.

Beyond a document I hope that a group of committed partners will come together to support the WHO in its work on health promotion – so as to ensure continuity of effort. Many of the disease specific areas have seen the forging of important focused alliances with a good funding base – health promotion should aim to create a global partnership that will support the results of the conference and the implementation of whatever the key action areas of a Bangkok Charter might be.

I hope that by the time we then come together at the IUHPE Conference in Vancouver in 2007 the first policy impacts of such a partnership can be reported.

You want to react to this text? Click here!

expert — community partnership

people + people partnership ⇔ movement

PHM - determinants of health
+ action

policy impact — ↑ com. action
— ↑ com voice
↑ com. control

— uniting people for peace + life

structure of policy making bodies determines who participates

strategies - That address macro determinants
+ com, indi factors.

CG

- universality = health
- GPPIs
- CG - have explicit goals eg health promotion
- Need to function within an evolutionary + spiral way
- Mechanisms connecting people to health resolutions 41CHS 1997, & Jakarta Declaration
  + to power - at local level
- importance of action at local level

7-11th Aug 2005

The Bangkok Charter for Health Promotion in a Globalized World

Introduction

Scope

The Bangkok Charter identifies actions, commitments and pledges required to address the determinants of health in a globalized world through health promotion.

Purpose

The Bangkok Charter affirms that policies and partnerships to empower communities, and to improve health and health equality, should be at the centre of global and national development.

The Bangkok Charter complements and builds upon the values, principles and action strategies of health promotion established by the *Ottawa Charter for Health Promotion* and the recommendations of the subsequent global health promotion conferences which have been confirmed by Member States through the World Health Assembly.

Audience

The Bangkok Charter reaches out to people, groups and organizations that are critical to the achievement of health, including:

- governments and politicians at all levels
- civil society
- the private sector
- international organizations, and
- the public health community.

Health promotion

The United Nations recognizes that the enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without discrimination.

Health promotion is based on this critical human right and offers a positive and inclusive concept of health as a determinant of the quality of life and encompassing mental and spiritual well-being.

Health promotion is the process of enabling people to increase control over their health and its determinants, and thereby improve their health. It is a core function of public health and contributes to the work of tackling communicable and noncommunicable diseases and other threats to health.

Addressing the determinants of health

Changing context

The global context for health promotion has changed markedly since the development of the *Ottawa Charter*.

Critical factors

Some of the critical factors that now influence health include:

- increasing inequalities within and between countries
- new patterns of consumption and communication
- commercialization
- global environmental change, and
- urbanization.

Further challenges

Other factors that influence health include rapid and often adverse social, economic and demographic changes that affect working conditions, learning environments, family patterns, and the culture and social fabric of communities.

Women and men are affected differently. The vulnerability of children and exclusion of marginalized, disabled and indigenous peoples have increased.

New opportunities

Globalization opens up new opportunities for cooperation to improve health and reduce transnational health risks; these opportunities include:

- enhanced information and communications technology, and
- improved mechanisms for global governance and the sharing of experiences.

Policy coherence

To manage the challenges of globalization, policy must be coherent across all:

- levels of governments
- United Nations bodies, and
- other organizations, including the private sector.

This coherence will strengthen compliance, transparency and accountability with international agreements and treaties that affect health.

Progress made

Progress has been made in placing health at the centre of development, for example through the Millennium Development Goals, but much more remains to be achieved; the active participation of civil society is crucial in this process.

Strategies for health promotion in a globalized world

Effective interventions

Progress towards a healthier world requires strong political action, broad participation and sustained advocacy.

Health promotion has an established repertoire of proven effective strategies which need to be fully utilized.

Required actions

To make further advances in implementing these strategies, all sectors and settings must act to:

- **advocate** for health based on human rights and solidarity
- **invest** in sustainable policies, actions and infrastructure to address the determinants of health
- **build capacity** for policy development, leadership, health promotion practice, knowledge transfer and research, and health literacy
- **regulate and legislate** to ensure a high level of protection from harm and enable equal opportunity for health and well-being for all people
- **partner and build alliances** with public, private, nongovernmental and international organizations and civil society to create sustainable actions.

Commitments to Health for All

Rationale

The health sector has a key leadership role in the building of policies and partnerships for health promotion.

An integrated policy approach within government and international organizations, as well as a commitment to working with civil society and the private sector and across settings, are essential if progress is to be made in addressing the determinants of health.

Key commitments

The four key commitments are to make the promotion of health:

1. central to the global development agenda
2. a core responsibility for all of government
3. a key focus of communities and civil society
4. a requirement for good corporate practice.

1. Make the promotion of health central to the global development agenda

Strong intergovernmental agreements that increase health and collective health security are needed. Government and international bodies must act to close the health gap between rich and poor. Effective mechanisms for global governance for health are required to address all the harmful effects of:

- trade
- products
- services, and
- marketing strategies.

Health promotion must become an integral part of domestic and foreign policy and international relations, including in situations of war and conflict.

This requires actions to promote dialogue and cooperation among nation states, civil society, and the private sector. These efforts can build on the example of existing treaties such as the World Health Organization Framework Convention for Tobacco Control.

2. Make the promotion of health a core responsibility for all of government

All governments at all levels must tackle poor health and inequalities as a matter of urgency because health is a major determinant of socioeconomic and political development. Local, regional and national governments must:

- give priority to investments in health, within and outside the health sector
- provide sustainable financing for health promotion.

To ensure this, all levels of government should make the health consequences of policies and legislation explicit, using tools such as equity-focused health impact assessment.

Continued on next page

Commitments to Health for All, Continued

3. Make the promotion of health a key focus of communities and civil society

Communities and civil society often lead in initiating, shaping and undertaking health promotion. They need to have the rights, resources and opportunities to enable their contributions to be amplified and sustained. In less developed communities, support for capacity building is particularly important.

Well organized and empowered communities are highly effective in determining their own health, and are capable of making governments and the private sector accountable for the health consequences of their policies and practices.

Civil society needs to exercise its power in the marketplace by giving preference to the goods, services and shares of companies that exemplify corporate social responsibility.

Grass-roots community projects, civil society groups and women's organizations have demonstrated their effectiveness in health promotion, and provide models of practice for others to follow.

Health professional associations have a special contribution to make.

4. Make the promotion of health a requirement for good corporate practice

The corporate sector has a direct impact on the health of people and on the determinants of health through its influence on:

- local settings
- national cultures
- environments, and
- wealth distribution.

The private sector, like other employers and the informal sector, has a responsibility to ensure health and safety in the workplace, and to promote the health and well-being of their employees, their families and communities.

The private sector can also contribute to lessening wider global health impacts, such as those associated with global environmental change by complying with local national and international regulations and agreements that promote and protect health. Ethical and responsible business practices and fair trade exemplify the type of business practice that should be supported by consumers and civil society, and by government incentives and regulations.

A global pledge to make it happen

All for health

Meeting these commitments requires better application of proven strategies, as well as the use of new entry points and innovative responses.

Partnerships, alliances, networks and collaborations provide exciting and rewarding ways of bringing people and organizations together around common goals and joint actions to improve the health of populations.

Each sector – intergovernmental, government, civil society and private – has a unique role and responsibility.

Closing the implementation gap

Since the adoption of the *Ottawa Charter*, a significant number of resolutions at national and global level have been signed in support of health promotion, but these have not always been followed by action. The participants of this Bangkok Conference forcefully call on Member States of the World Health Organization to close this implementation gap and move to policies and partnerships for action.

Call for action

Conference participants request the World Health Organization and its Member States, in collaboration with others, to allocate resources for health promotion, initiate plans of action and monitor performance through appropriate indicators and targets, and to report on progress at regular intervals. United Nations organizations are asked to explore the benefits of developing a Global Treaty for Health.

Worldwide partnership

This Bangkok Charter urges all stakeholders to join in a worldwide partnership to promote health, with both global and local engagement and action.

Commitment to improve health

We, the participants of the 6th Global Conference on Health Promotion in Bangkok, Thailand, pledge to advance these actions and commitments to improve health.

11 August 2005

Note: This charter contains the collective views of an international group of experts, participants of the 6th Global Conference on Health Promotion, Bangkok, Thailand, August 2005, and does not necessarily represent the decisions or the stated policy of the World Health Organization.

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The 7th WHO Global Conference on Health Promotion - towards integration of oral health (Nairobi, Kenya 2009).

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Since the first World Health Organization (WHO) Global Conference on Health Promotion (GCHP) that produced the Ottawa Charter for Health Promotion, subsequent GCHPs were held in different continents. It was Africa's turn to host the 7th GCHP in Nairobi in October 2009, organised by WHO and Kenya Ministry of Health. The theme of the meeting was *Promoting Health and Development: Closing the Implementation gap.* It was the first time in the GCHP history that oral health received such a high profile and featured in one of the 12 special sub-plenary sessions. This report summarises the proceedings of the sub-plenary session on social determinants of oral health. Strategies for tackling social determinants of oral health and closing the implementation gap were considered, together with specific examples from developed and developing countries from different WHO regions. Oral health promotion implications were discussed based on public health experience and operational research. At the end of the session, input on oral health related issues was prepared for the Nairobi Call to Action adopted by the conference. In follow-up, the WHO Global Oral Health Programme contributes to the newly established WHO initiative *Mainstreaming Health Promotion*, which particularly seeks to build capacity in health promotion in low- and middle income countries. This work is carried out in support of the World Health Assembly Resolution (WHA60.17) on oral health.

Key words: *Capacity building, community empowerment, health policy, health promotion, social determinants, strategies for oral health*

Introduction

In 1986, the Canadian city Ottawa hosted the first World Health Organization (WHO) Global Conference on Health Promotion (GCHP) that established *the Ottawa Charter for Heath Promotion* (WHO, 1986), building on the spirit of Alma Ata (WHO, 1978). The values and principles were consolidated in subsequent meetings on *Healthy Public Policy* in 1988 in Adelaide, Australia (WHO, 1988); *Supportive Environments for Health* in 1991 in Sundsvall, Sweden (WHO, 1991); *New Players for a New Era - Leading Health Promotion into the 21st Century* in 1997 in Jakarta, Indonesia (WHO, 1997); *Health Promotion: Bridging the Equity Gap* in 2000 in Mexico City, Mexico (WHO, 2000) and *Policy and Partnership for Action: Addressing the determinants of Health* in 2005 in Bangkok, Thailand (WHO, 2005a). These conferences contributed significantly to the development of concepts, approaches and strategies in health promotion and several countries have adopted health promotion principles as part of national health policies and programmes.

However, the need persists for strengthening of health promotion globally. Global health is facing unprecedented challenges. These include the threat of global pandemics as well as the inexorable growth of non-communicable conditions in lower and middle income countries (WHO, 2005b). The financial crisis threatens the viability of national economies in general and the financing of health systems in particular. These new challenges compound the problems many countries still have in the attainment of the internationally agreed development goals such as the United Nations Millennium Goals (WHO, 2005c). The burden of ill-health is increasingly recognized to be inequitably distributed, between and within countries, leading the Commission on Social Determinants of Health to conclude that "Social injustice is killing people on a grand scale" (WHO, 2008a). In the face of these new challenges, the attainment of health equity depends on an effective health promotion approach: on individual and community empowerment, on health system leadership and on intersectoral action to build healthy public policy. In this context, health promotion has never been timelier, or more needed. Over the period from the Ottawa Conference (1986) through to the sixth global conference in Bangkok (2005), health promotion has accumulated a large body of knowledge, evidence and experience as an integrative, cost-effective public health strategy and approach, and an essential component of health systems.

The implementation gap

Global health urgently needs to apply the body of evidence based policies, strategies and approaches of health promotion developed over the past twenty years. Two global health promotion charters (Ottawa and Bangkok), conference declarations and WHO Regional Committees and World Health Assembly (WHA) resolutions endorse the importance of health promotion; yet the evidence for their implementation in countries is lacking. These along with a rich body of research and experience from around

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the world provide a resource for guidance and direction for the implementation of health promotion, which is essential in order to *achieve health for all* and to *tackle the issue of inequities in the distribution of health* by gender, social class, income level, ethnicity, education, occupation, and other categories. As emphasized in the World Health Report 2008, Primary Health Care (PHC) is essential element in health promotion (WHO, 2008b); the PHC approach was renewed by setting four broad policy directions: 1. dealing with inequalities by moving towards universal coverage; 2. putting people at the centre of service delivery; 3. multisectoral action and health in all policies; 4. inclusive leadership and effective governors for health. Furthermore, the World Health Assembly 2009, in its resolution on primary health care, including health systems (WHO, 2009a), urged Member States to tackle the health inequities within and across countries through political commitment on the main principles of "closing the gap in a generation" as a national concern, as is appropriate, and to coordinate and manage intersectoral action for health in order to mainstream health equity in all policies, where appropriate, by using health and health equity impact assessment tools. Meeting these challenges cannot be reduced to a technical problem, for example, of finding cases of a specific disease and treating them. These are also significant political challenges. How to ensure that development policies effectively promote health? How to ensure that the work of all sectors contributes to a healthy policy environment that improves the daily living conditions of disadvantaged populations? How can civil society itself help to hold governments and international agencies accountable for their impact on health? What is the role of communities and individuals? How can societies promote positive health and offer social protection? Where, in all this, is the role of the private sector?

Challenges to oral health promotion

The rapidly changing development in the world, intensified by globalisation and urbanization, triggers urgent responses to rising public health challenges to oral health. Evidence-based oral health promotion policy and practice are essential to effectively tackle oral health problems, addressing the widening inequalities in oral health within and between countries (WHO, 2003; Kwan & Petersen, 2010; Petersen 2008, 2009). While action strategies have been identified in previous global health promotion meetings (Tang et al, 2006), critical implementation gaps remain, particularly in developing countries with limited infrastructure and financial resources. There are gaps in health promotion programmes where evidence is not effectively incorporated into public health practice. Evidence on the oral health impacts of social determinants is not adequately considered in public policies. Moreover, there is a lack of capacity in the health systems to promote oral health, particularly in developing countries and countries with economies in transition (Petersen, 2008, 2009).

7th Global Conference on Health Promotion 2009

Against this background, the seventh GCHP *Promoting Health and Development – Closing the Implementation Gap* was convened in October 2009 in Nairobi, Kenya, the first ever global health promotion conference that took place in Africa. Over 600 delegates representing more than 100 countries attended the five-day meeting, together with a large number of virtual participants via a social networking site www.conneet2change.org. The programme - including workshops, case studies and keynotes and sub-plenary sessions - was organised in five tracks addressing major strategic areas of health promotion that promote healthy development (***Box 1***). For the first time in the history of GCHP, oral health promotion was given special attention with a dedicated sub-plenary session, one of the twelve sub-plenary sessions with special themes that cut across tracks and cover a range of application areas. This report summarises the proceedings of the Sub-Plenary Session on Social Determinants of Oral Health.

Box 1. Five key tracks of the 7th Global Conference on Health Promotion

Track 1: Community empowerment
Track 2: Health literacy and health behaviour
Track 3: Strengthening health systems
Track 4: Partnership and intersectoral action
Track 5: Building capacity for health promotion

Social determinants in oral health: building capacity for oral health promotion

Oral health is important component of general health and quality of life. Meanwhile, oral disease is still a major public health problem in high income countries and the burden of oral disease is growing in many low- and middle income countries. Significant numbers of people around the globe suffer from illness and pain related to the mouth. The disadvantaged and poor people suffer most and they often do not receive appropriate oral health care. In addition, disease prevention and oral health promotion are widely neglected area in public health. This is particularly the case in middle and low income countries. In the World Oral Health Report 2003 issued by the World Health Organization (WHO, 2003), and further in a series of WHO publications (WHO, 2005d; Petersen, 2008, 2009; Petersen and Kwan, 2004; Kwan and Petersen, 2010), policies and the necessary actions to the continuous improvement of oral health are formulated.

The global strategy is that oral disease prevention and the promotion of oral health needs to be integrated with chronic disease prevention and general health promotion as the risks to health are linked. Integration of the prevention of specific oral disease manifestations with the control of infectious diseases is particularly relevant in the case of HIV AIDS (Petersen, 2006). The new approaches form the basis for future development or adjustment of oral health programmes at country and community levels. The good news is that most oral

diseases are avoidable. Public health research has shown that a number of individual, professional and community preventive measures, and community oriented oral health promotion are effective in control of oral disease and promoting oral health. However, advances in oral health science have not yet benefited the poor and disadvantaged populations worldwide. Inequalities in oral health still exist. The major challenges of the future will be to translate knowledge and experiences in oral disease prevention and health promotion into action programmes.

Directions as regards to strengthening health promotion, incorporating oral health, and orientation of oral health services towards health are emphasized to countries and communities (Petersen 2008, 2009). Particular attention is given to the following assumptions:

Increasing the global awareness of the significance of oral health to general health and quality of life, and the importance of social determinants to oral health.

National capacity building in oral health promotion and integrated disease prevention is a major platform for public health.

Strengthening of primary health care is vital to closing the gap in oral health and general health between the rich and the poor within countries and across countries.

The sub-plenary session on Social Determinants of Oral Health focussed on the analysis of negative and positive factors in building programmes and developing strategies. The implementation gap in oral health promotion was discussed, taking into account lessons learnt from existing community and national oral health promotion projects and the experience gained by WHO Collaborating Centres (WHOCC) in oral health. In addition to the participation of WHOCCs, the session was attended by the two oral health Non-Governmental Organizations in official relation to WHO, i.e. the International Association for Dental Research (Professor David Williams) and the World Dental Federation FDI (Dr Roberto Vianna). Moreover, Aide Odontologique Internationale, a French non-governmental organization having extensive work relations with the WHO Global Oral Health Programme, took part in the conference.

Dr. Nanna Jürgensen of WHOCC University of Copenhagen, Denmark was appointed Chair for the session and Dr Jayanthi Stjernswärd of WHOCC Malmo, Sweden as reporter. Dr Petersen introduced on the background, the philosophy and the structure of this special WHO session on oral health; seven contributions were then presented with examples from different countries in different regions.

Contribution 1: Social determinants in oral health -strategies for oral health promotion

S. Kwan and P.E. Petersen. WHO Collaborating Centre for Research and Development for Oral Health, Migration and Inequalities, Leeds, United Kingdom, and World Health Organization, Global Oral Health Programme, Geneva, Switzerland.

Good oral health enables people to speak, eat and socialize without active disease, discomfort or embarrassment. However, oral disease is a major burden to populations across countries of the world. According to the World Health Organization Global Oral Health data bank and the World Health Survey 2003, widening social disparities in oral health exist across low-, middle- and high income countries. The influence of education, economic circumstances, material possession, living and working conditions and the environment on health is significant. These social determinants are also responsible for inequities in access to and use of oral health services. The social determinants of health are largely universal, affecting a range of oral health outcomes and the exposure to risk factors. The social gradients appear to be persistent over time. Poor oral health is found among people living in poverty. Proximal risk factors such as unhealthy lifestyles in relation to diet and nutrition, tobacco and alcohol, and poor personal hygiene are related to living conditions as well. The good news is that oral disease conditions are preventable, and social inequality in oral health is avoidable. Oral diseases share the common risk factors of several chronic diseases. Interventions in relation to the socio-economic environment, settings for health, and risk factor approaches are important strategies for promotion of oral health of the whole population. Moreover, evidence exists on promotion of oral health and prevention of oral diseases through public health interventions. Country experiences worldwide show that community outreach primary health care is essential to improvement of oral health, however, a lack of health policy and limited national budgets for oral health are major barriers for implementation of integrated health promotion.

Contribution 2: Common risk factor strategies in oral health promotion for youth - Some experiences from Tanzania.

F.K. Kahabuka and P.E. Petersen. WHO Collaborating Centre for Primary Oral Health Care, Planning and Research, Dar-es-Salaam, Tanzania and World Health Organization, Global Oral Health Programme, Geneva, Switzerland.

Risk factors to poor oral health include unhealthy diet and nutrition, inadequate personal hygiene and lack of regular oral hygiene practices, inadequate sanitation, and insufficient exposure to fluorides, growing tobacco and alcohol consumption, and limited availability and access to dental services. The planning of public health intervention directed towards modifiable risk factors shall be based on available evidence, which has been called upon by the Tanzania Ministry of Health. In a nation-wide school health survey of adolescents, it was shown that adolescents had frequent consumption of sweets, chewing gum with sugar, and sugar containing drinks. Significant proportions of young people performed cigarette smoking and consumed alcohol, and they seldom consulted a dentist for oral health care. On the other hand, most children and adolescents had good general hygiene practices and brushed their teeth daily with a plastic tooth brush utilizing a fluoride tooth paste. Risk behaviours relevant to non-communicable chronic disease are common to oral disease. Experiences from Tanzania show that oral health risk behaviours of children

and adolescents are modifiable. Sustainable behaviour modification is possible through oral health promotion for the young and should start early in life. Risk factors to chronic and oral disease are common and this may call for integrated approaches in general health promotion strategies. Nevertheless, there are several constraints in relation to public health priorities and consequently to implementation of oral health promotion which include: high priority towards prevalent infectious life threatening diseases; low priority by health authorities to oral health problems; low literacy level; poverty; poor infrastructure; incomplete sanitation and clean water; limited number of health personnel; oral health is conceived isolated and independent from general health. Against this, there are positive factors that may facilitate the implementation process, namely;

Existing school health programmes aimed to combat infectious diseases may provide a unique context for incorporation of oral health

The availability of primary health personnel

Contribution 3: Oral health promotion for people living with HIV AIDS - the example of Burkina Faso.

S. Ouattara and P.E. Petersen. Research Centre Muraz, Bobo-Dioualaso, Burkina Faso and World Health Organization, Global Oral Health Programme, Geneva, Switzerland.

HIV AIDS is a disease of poverty which significantly affects populations of Sub-Saharan Africa. Many people are currently living with HIV AIDS; they are likely to suffer from a double burden of disease as they are also often affected by non-communicable chronic disease. Prevention of HIV AIDS may be strengthened effectively through oral health. HIV/AIDS manifest in the oral cavity with several oral lesions such as oral ulcers, bacterial and fungal infections. Oral health promotion and prevention of oral disease however need to be integrated with primary health programmes. Oral health professionals and primary health workers play important roles in this process, particularly; they have great potential in early detection of conditions, provision of essential oral care, health education, and referral for special care. Primary health care (PHC) is an appropriate community platform for control of disease and promotion of oral health. Initiatives of strengthening community intervention against HIV AIDS and their oral manifestations currently take place in Burkina Faso and Tanzania. Community participation and empowerment of people are important and in relation to children/orphans the schools and schoolteachers are essential. The efforts for strengthening of health promotion are supported by public health research to be translated for action and capacity building. Practical experiences from implementing evidence-based community-oriented oral health promotion are given from Burkina Faso.

Contribution 4: Oral health promotion through schools - global experiences.

N. Jürgensen. WHO Collaborating Centre for Community Oral Health Prorammes and Research, University of Copenhagen, Denmark

One of the challenges of health promotion is to identify effective settings for implementation. Schools have globally proven to be ideal platforms. Although the school setting will not be able to reach all children the primary school setting still covers a considerable large and diverse part of many child populations. This provides a unique opportunity to level out the socio-economic and geographical gradients observed in morbidity as well as in modifiable risk factors important for oral health; risk factors such as oral health related knowledge, attitude and behaviour. The idea of health promotion through schools has also been introduced in a number of countries in Southeast Asia. However, developing schools into a health promoting setting often strongly depends on visionary individuals at local level or the support of external resources. This keeps the number of health promoting schools limited/low while the project approach makes them less sustainable. To address this implementation gap and support the scaling up of health promoting schools a number of suggestions should be considered:

As a strategy for healthy public policies health promotion should be integrated permanently into the structure of the educational system and mirrored in teachers training and educational material for all primary schools

Personnel at all levels should develop necessary skills and be responsible for supporting the implementation of activities

Parents and local communities should actively be involved in the creation of the school as a supportive setting for health thereby increasing local ownership and sustainability

The health sector should be involved to assure correct technical input and provision of preventive and basic services

Contribution 5: Barriers and opportunities for community-based oral health promotion in developing countries - lessons learnt in Africa and Asia.

B. Varenne and B. Decroix. Aide Odontologique Internationale, Paris, France.

In many low income countries, oral diseases contribute substantially to the burden of non-communicable diseases and injuries. Oral health remains a neglected public health issue. This is reflected in the lack of organization of oral health promotion, disease prevention and oral health services. Both in urban and rural areas, populations have only limited access to oral health care and the use of fluoride is not widespread. Apart from national budgets for general health and in particular for oral health being very limited, one significant barrier to implementation of community oral health promotion relates to the gap between training offered to oral health professionals and the perceived and real needs of people living in developing countries. A comprehensive project has been established in Burkina Faso and involves the French Non-Governmental Organization Aide Odontologique Internationale. The project is based on the integration of preventive and curative oral health components into health promotion and shows how difficult it is to go from theory to practice if socio economic and oral health manpower requirements are

not met. The opportunity for organization of oral health promotion programmes is illustrated from experiences with capacity building activities. Oral health promotion skills of oral health staff may be achieved through technical, university and institutional networks. Thus, a programme ongoing in Cambodia shows that one of the keys to success is the active role played by local oral health officers capable of implementing and following up innovative and integrated oral health promotion activities, i.e. school health education, primary oral health care and work for population use of affordable fluoridated toothpaste. Research and practical experiences in numerous countries have demonstrated that health promotion should be based on awareness of environmental factors and healthy lifestyles of people. The example of Laos shows how the implementation of salt fluoridation will become an intersectoral programme as planned and developed at community level. At the end, the experiences gained call for a better integration of oral health activities into global health promotion programmes.

Contribution 6: Health Promotion and Oral Health – Japanese Experiences.

H. Miyazaki. WHO Collaborating Centre for Translation of Oral Health Science. Department of Oral Health Science, Graduate School of Medical and Dental Sciences, Niigata University, Japan.

Because of the failure to tackle social and material determinants and incorporate oral health into general health promotion, millions of people still suffer intractable toothache and poor quality of life and end up with few teeth. Health policies should be reoriented to incorporate oral health using socio-dental approaches to assessing needs and to apply the common risk factor approach for health promotion. "Healthy Japan 21" is a 10-year (2000-2010) national campaign intended to promote healthy behaviours of the national population and to build healthy environments through actions of communities, worksites, health professionals and other related organizations. National objectives are established and shared by interested parties. Oral health is included objective to prolong length of healthy life and improve quality of life. Objectives are specified within nine areas for "Healthy Japan 21": 1) food and nutrition, 2) physical activities, 3) mental health, 4) tobacco, 5) alcohol, 6) oral health, 7) diabetes, 8) cancer and 9) cardiovascular diseases. Lessons learnt from the development process of programmes for oral health promotion in Japan are that the continuous sharing of local and national experiences is important factor in effective implementation. Information about the weakness and strengths in identification of health determinants and formulation of policies and action plans are instrumental to oral health intervention.

Contribution 7: Disease prevention, an essential complement to health promotion.

R. Baez. Former Head, WHO Collaborating Centre for Translation of Oral Health Sciences into Clinical and Public Health Practice, San Antonio, Texas, USA.

Health promotion contributes to maintenance of oral health but efforts must be complemented with prevention. In several countries dental caries is on the increase. Fluoride for caries prevention has been recognized as an effective agent and various methods are available for use in public health and private practice.

There are many reasons that these public health measures are not available to populations, particularly in developing countries:

Non-existent or inadequate oral health programmes
Lack of oral health policies on public health prevention
Cost or non-availability of fluoride compounds or equipment
Inadequate human resources
Lack of technical expertise
Absence of on-site training opportunities
Lack of community education and impact of anti-fluoridationists
Poor economy and cost

For example the introduction of water fluoridation requires that the country/community has a reasonably well established economy with a reliable public water supply system. Also availability of equipment and fluoride product is essential. Caries levels should be high enough to justify the cost of the programme and government/legislative support is essential. Similar issues arise if salt or milk fluoridation is contemplated. The cost of fluoride toothpastes can be a barrier to their use; being classified and taxed as cosmetics in some communities contribute to their cost. Gels and varnishes require trained personnel for their application. Finally, use of fluoride supplements and fluoride mouthrinses require considerable compliance. Capacity building in planning and administration of fluoride programmes is essential. Countries are encouraged to ascertain the most suitable strategy to incorporate use of fluoride in community prevention programmes with the ultimate goal of optimizing oral health in the most efficient manner with minimum risks.

Summing up and conclusions

The essential points made by the contributors are presented according to the five conference tracks.

Track 1: Health Literacy and Health Behaviour

Experiences from Tanzania show that oral health risk behaviours of children and adolescents are modifiable. Sustainable behaviour modification is possible through oral health promotion for the young and should start early in life.

Risk factors to chronic and oral disease are common and this may call for integrated approaches in general health promotion strategies.

Constraints to implementation of oral health promotion include high priority given by public health administrators to prevalent infectious life threatening diseases, low priority for oral diseases, lower literacy, poverty, sanitation and clean water and limited health personnel.

Existing school health programmes and the availability of primary health personnel are positive factors in the implementation process of oral health promotion for children (Kwan *et al,* 2005).

Track 2: Community Empowerment.

Schools have globally proven to be ideal platforms for implementation of health promotion.

As a strategy for healthy public policies health promotion should be integrated permanently into the structure of the educational system and mirrored in teachers training and educational material for all primary schools.

Developing schools into a health promoting setting often strongly depends on visionary individuals at local level or the support of external resources.

In several low- and middle income countries dental caries is on the increase. Fluoride for caries prevention has been recognized as an effective agent and various methods are available for use in public health and clinical practice. Automatic fluoridation programmes shall be considered by countries where fluoride in drinking water is sub-optimal.

Initiatives of strengthening community intervention against HIV AIDS and their oral manifestations currently take place in certain countries of Africa. New approaches to improving quality of life of people affected by infection and orphans are developed.

Oral health promotion and prevention of oral disease for people living with HIV/AIDS need to be integrated with primary health care programmes.

Track 3: Strengthening Health Systems.

Apart from national budgets for general health and in particular for oral health being very limited, one significant barrier to implementation of community oral health promotion relates to the gap between training offered to oral health professionals and the perceived and real needs of people living in developing countries.

In the majority of developed countries oral health systems need reorientation towards prevention of disease and health promotion. In developing countries oral health programmes need to be established urgently and policies shall give priority to health promotion and oral disease prevention. Human and financial resources are required to meet the needs for oral health care of the population.

In agreement with the recommendations of the WHO Commission on Social Determinants (WHO, 2008a), oral health services need to be financially fair in order to ensure oral health of poor and disadvantaged people.

Track 4: Partnership and Intersectoral Action.

Oral health promotion skills of oral health staff may be achieved through technical, university and institutional networks. Thus, a programme ongoing in Cambodia shows that one of the keys to success is the active role played by local oral health officers capable of implementing and following up innovative and integrated oral health promotion activities, i.e. school health education, primary oral health care and work for population use of affordable fluoridated toothpaste.

The example of Laos shows how the implementation of salt fluoridation will become an intersectoral programme as planned and developed at community level.

Track 5: Building Capacity for Health Promotion.

Health policies should be reoriented to incorporate oral health using socio-dental approaches to assessing needs and to apply the common risk factor approach for health promotion.

"Healthy Japan 21" is a 10-year (2000-2010) national campaign which has shown effective to promoting healthy behaviour of the national population and to build healthy environments through actions of communities, worksites, health professionals and other related organizations.

Capacity building in health promotion is essential to oral health. Countries are encouraged to study the most suitable strategy to incorporate oral health into national public health programmes with the ultimate goal of optimizing oral health in the most efficient manner.

The Nairobi Call to Action

The oral health presentations focussed different dimensions of community oral health: social determinants; modifiable risk factors; poverty and HIV/AIDS; empowerment of communities for oral health; strengthening of oral health systems; settings for oral health; integrated disease prevention and oral health promotion, and development of oral health promotion in the context of a national health programme. Following the seven presentations, ideas were exchanged and, after much deliberation and constructive discussion, three key oral health messages were drafted for input to the Nairobi Call to Action (***Box 2***). The Nairobi Call to Action, which was developed through expert- and web-based consultation before and during the conference, was officially adopted on the last day of the meeting. It is a strong political statement that urges WHO and United Nations partners, governments, non-governmental organisations, civil society, communities and individuals to consider the key strategies and commitments urgently required for closing the implementation gap in health and development through health promotion (WHO, 2009b).

Global commitments are that all countries – governments and stakeholders- are called urgently to use the untapped potential of health promotion, to make health promotion principles integral to the policy and development agenda, and to develop effective and sustainable delivery mechanisms. According to the call for action, countries are to build capacity in health promotion, to strengthen health systems, to ensure community empowerment, to develop partnerships and intersectoral actions relevant to addressing the determinants of health, and to help improvement of health literacy and healthy lifestyles. Further, the Nairobi Call to Action emphasizes the need for countries to specify the responsibilities for implementation of health promotion, such as strengthen leadership and workforces, mainstream health promotion, empower communities and individuals, enhance participatory processes, and build and apply knowledge. The call to global commitment is presented in ***Box 3.***

WHO- the way forward for promoting oral health

In follow-up of the 7th GCHP, WHO has strengthened its work for country capacity building in health promotion with a focus on low and middle income countries and application to priority public health problems. This initiative includes oral health conditions as well. *Mainstreaming Health Promotion* is a new WHO activity to

Box 2. The three key messages that were formulated in relation to preparation of the Nairobi Call to Action

1. Oral health is a human right and essential to general health and quality of life.
2. Promotion of oral health and prevention of oral diseases must be provided through Primary Health Care and general health promotion. Integrated approaches are the most cost-effective and realistic way to close the gap in implementation of sound interventions for oral health around the globe.
3. National and community capacity building for promoting oral health and integrated oral disease prevention requires policy and appropriate human and financial resources to reduce the gap between the poor and rich.

Box 3. The 7th Global Conference on Health Promotion Call to Action by Governments and stakeholders

GLOBAL COMMITMENT

We, the participants of the 7th Global Conference on Health Promotion, recognising the changing context and acute challenges, call on all governments and stakeholders to respond urgently to this Call to Action and the strategies and actions that follow.

TO USE THE UNTAPPED POTENTIAL OF HEALTH PROMOTION

We pledge, as champions, to:

- ☑ Use the existing evidence to prove to policy-makers that health promotion is fundamental to managing national and global challenges such as population ageing, climate change, global pandemic threats, maternal mortality, migration, conflict and economic crises;
- ☐ Revitalise primary health care by fostering community participation, healthy public policy and putting people at the centre of care;
- ☐ Build on the resilience of communities by harnessing their resources to address the double burden of non-communicable and communicable diseases.

TO MAKE HEALTH PROMOTION PRINCIPLES INTEGRAL TO THE POLICY AND DEVELOPMENT AGENDA

We call on governments to exercise their responsibility for public health, including working across sectors and in partnership with citizens, in particular to:

- ☑ Promote social justice and equity in health by implementing the recommendations of the WHO Commission on the Social Determinants of Health;
- ☐ Accelerate the attainment of national and international development goals by building and redistributing resources to strengthen capacity and leadership for health promotion;
- ☐ Be accountable for improving people's quality of life and well being.

TO DEVELOP EFFECTIVE AND SUSTAINABLE DELIVERY MECHANISMS

We request Member States to mandate WHO to:

- ☐ Develop a Global Health Promotion Strategy and action plans, with regional follow-up that respond to the major health needs and incorporate cost-effective and equitable interventions;
- ☐ Strengthen its internal capacity for health promotion, and assist Member States to develop sustainably funded structures and set up accountable reporting mechanisms for investment in the promotion of health;
- ☑ Disseminate compelling evidence on the social, economic, health and other benefits of health promotion to key sectors.

support the development of an evidence-based, outcome oriented package of health promotion actions. In response to this initiative, the WHO Global Oral Health Programme has intensified its actions for assembling the evidence on community based oral health promotion and integrated disease prevention; the goal is to strengthen the mechanisms for translation of oral health science into country policies and action programmes for oral health.

Health promotion offers a comprehensive range of specific and proven actions. Health promotion actions seek to produce changes in individuals, communities, health services, and environments. Actions for promoting health take a series of forms, including:

Dissemination of information, education and communication to individuals, to change health related behaviour, knowledge, attitudes and beliefs.

Using advocacy, mass communication and social marketing to shift cultural norms.

Legislation and regulation, to reduce population exposure to health risks and encourage health behaviour.

Empowering and supporting communities to take action and control.

Orienting health systems towards universal access, prevention and early intervention, primary health care and optimal patient education, and with a people-centred focus.

Ensuring sustainable health promotion capacity, including financing, training, workforce and leadership, and monitoring the effectiveness of health promotion programmes.

Advocacy and development of healthy public policies, to create healthy physical and social environments.

Such actions are in fact the basis of the WHO global policies for promoting oral health as being emphasized recently by the WHO governing bodies. The World Health Assembly 2007 is a major event in the world history of oral health. At the annual meeting of the WHA, the WHO Member States agreed on a unique Resolution (WHA60.17): ***Oral health: Action plan for promotion and integrated disease prevention*** (Petersen, 2008; Petersen, 2009). Based on a thourogh analysis of the global oral health situation, new strategies and approaches are recommended for countries to adopt. The scope of the Resolution is most comprehensive as it encompasses the major oral health problems and risk factors relevant to public health. Principal actions are suggested for tackling the social determinants in oral health, intervention in relation to risk factors of oral health, disease prevention and effective control of oral diseases through establishment of appropriate national oral health systems.

More information about the work carried out by the WHO Global Oral Health Programme is available on www.who.int/oral_health

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World Health Organization

MINISTRY OF SOCIAL AFFAIRS AND HEALTH
Finland

The 8th Global Conference on Health Promotion, Helsinki, Finland, 10-14 June 2013

The Helsinki Statement on Health in All Policies

Building on our heritage, looking to our future

The 8th Global Conference on Health Promotion was held in Helsinki, Finland from 10-14 June 2013. The meeting builds upon a rich heritage of ideas, actions and evidence originally inspired by the *Alma Ata Declaration on Primary Health Care* (1978) and the *Ottawa Charter for Health Promotion* (1986). These identified intersectoral action and healthy public policy as central elements for the promotion of health, the achievement of health equity, and the realization of health as a human right. Subsequent WHO global health promotion conferences[1] cemented key principles for health promotion action. These principles have been reinforced in the 2011 *Rio Political Declaration on Social Determinants of Health*, the 2011 *Political Declaration of the UN High-level Meeting of the General Assembly on the Prevention and Control of Non-communicable Diseases*, and the 2012 Rio+20 Outcome Document (*the Future We Want*). They are also reflected in many other WHO frameworks, strategies and resolutions, and contribute to the formulation of the post-2015 development goals.

Health for All is a major societal goal of governments, and the cornerstone of sustainable development

We, the participants of this conference

Affirm our commitment to equity in health and recognize that the enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition. We recognize that governments have a responsibility for the health of their people and that equity in health is an expression of social justice. We know that good health enhances quality of life, increases capacity for learning, strengthens families and communities and improves workforce productivity. Likewise, action aimed at promoting equity significantly contributes to health, poverty reduction, social inclusion and security.

Health inequities between and within countries are politically, socially and economically unacceptable, as well as unfair and avoidable. Policies made in all sectors can have a profound effect on population health and health equity. In our interconnected world, health is shaped by many powerful forces, especially demographic change, rapid urbanization, climate change and globalization. While some diseases are disappearing as living conditions improve, many diseases of poverty still persist in developing countries. In many countries lifestyles and living and working environments are influenced by unrestrained marketing and subject to unsustainable production and consumption patterns. The health of the people is not only a health sector responsibility, it also embraces wider political issues such as trade and foreign policy. Tackling this requires political will to engage the whole of government in health.

Health in All Policies is an approach to public policies across sectors that systematically takes into account the health implications of decisions, seeks synergies, and avoids harmful health impacts in order to improve population health and health equity. It improves accountability of policymakers for health impacts at all levels of policy-making. It includes an emphasis on the consequences of public policies on health systems, determinants of health and well-being.

We recognize that governments have a range of priorities in which health and equity do not automatically gain precedence over other policy objectives. We call on them to ensure that health considerations are transparently taken into account in policy-making, and to open up opportunities for co-benefits across sectors and society at large.

[1] Subsequent conferences were held in Adelaide (1988); Sundsvall (1991); Jakarta (1997); Mexico City (2000); Bangkok (2005); Nairobi (2009).


9th Global Conference
on Health Promotion
Shanghai · 21-24 November, 2016
Shanghai Declaration
on promoting health
in the 2030 Agenda
for Sustainable
Development