HPR/HEP/4ICHP/PT/97.1
Distribution: limited
English only

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

PARTNERSHIPS FOR HEALTH PROMOTION

PARTNERSHIPS FOR HEALTH IN THE 21st CENTURY:
2 + 2 = 5

- conference working paper -

DRAFT

provided by:
Working group on partnerships at WHO Headquarters
in the context of the Health for All Renewal

This paper is being made available at the 4th International Conference on Health Promotion, Jakarta, 21-25 July 1997, for discussions in order to benefit from additional input and suggestions by the conference participants.

The views expressed in this document by named authors are solely the responsibility of these authors.

PARTNERSHIPS FOR HEALTH IN THE 21ST CENTURY

1. Introduction

> ***"Today more than ever public health institutions world wide.... need to redefine their mission in the light of the increasingly complex environment in which they operate."***
>
> Julio Frenk

Partnerships for health have become an increasingly important mechanism in implementing the WHO Health for All Strategy. This paper argues that the importance of partnerships will continue to grow and that partnerships for health must constitute a core component of the new WHO Health for All policy for the 21st century (HFA). Acting as a catalyst and honest broker for health partnerships must become a dominant function of WHOs work.

In the course of WHOs work partnerships for health have provided new opportunities for health creation and for putting across health messages. They have allowed for a wider ownership of health throughout society and have added a new dimension to intersectoral action for health. They can be practical expressions of solidarity, provide opportunities to help the most disadvantaged through new approaches and can open new channels of communication and implementation.

The opportunities for partnerships have increased. Over the last decade the role of non-governmental organizations in health has increased significantly and has gained more recognition through the strong NGO involvement in the UN summits. Corporate interest and involvement in health issues has also increased. New players have entered the health arena: UN agencies in general are more active in health matters and frequently measure their progress in health terms, development banks are increasing their health investments, new regional groupings (such as the European Union or ASEAN) are developing health agendas, we are witnessing the expansion of the private health industry as well as of other industries that impact health such as the lifestyles and leisure industries (Softdrinks, sports, leisure, tourism, food, fitness, etc.) and the information and communications industry. Finally we see new types of advocacy NGOs and associations representing consumer interests at local, national and global level.

Partnerships for health are evolving at all levels of society. While this paper makes reference to these, its main focus remains the potential of partnerships within the work of WHO in order to provide input to the HFA renewal process. WHO has a long tradition of working with others: with *UN-organizations* through working agreements and joint commitments, with the *academic community* through the Collaborating Centres and *with NGOs* through the mechanism of formal relationships. A range of partnerships have also existed with the *private sector*, in particular the pharmaceutical industry. Over time new partnerships have been created, for example with *local authorities* through the WHO Healthy Cities Project. There are now many indications and examples which show that new types of partnerships for health are both necessary and possible and this paper argues that WHO must strengthen its mechanisms for partnership building.

2. Partnerships for Health

Partnerships for health bring together a set of actors for the common goal of improving the health of populations based on mutually agreed roles and principles.

Partnerships imply that a balance of power and influence is maintained between the partners and that each partner can maintain its core values and identity. They are built on:

- ❒ common interest
- ❒ mutual respect
- ❒ clear manageable objectives
- ❒ commitment to contribute time, resources and energy
- ❒ trust

A *variety of types* of partnerships are possible - ranging from alliances, coalitions, networks, consortiums, collaboration, cooperation and sponsorships.

Partnership building is a process, where already the negotiations towards the establishment of a *"formal"* partnership for health can lead to new opportunities for health creation as the partners involved evolve and learn. Frequently one partner takes the initiative because it perceives a partnership approach the more effective way of achieving its goals. This has certainly been the case with many of the partnerships that WHO has entered - where it has actively sought out others.

Through the *synergy* created by the partnership each respective partner gains strength to fulfill its existing mandate. Each partner contributes *"what it does best"* to the partnership: for example WHO can bring its technical expertise and credibility, business its managerial expertise, marketing competence and logistics, NGOs their knowledge of local culture. In terms of delivery and outcomes, partnerships aim for the most productive delivery for maximum benefit. While partners share a common interest they will each have a different agenda. Well *managed* partnerships lead to shared benefit and added value for all partners involved. As one advisor expressed succinctly: they make 2 plus 2 add up to 5.

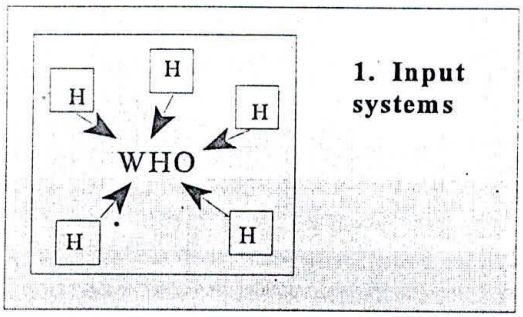
2 + 2 = 5

Thinking in terms of partnerships for health requires *a different mind set* compared to more traditional approaches whereby the health department made all decisions on management of health programmes. WHO will need to move beyond the existing mechanisms and approaches towards a wider range of partners and new ways of working together.

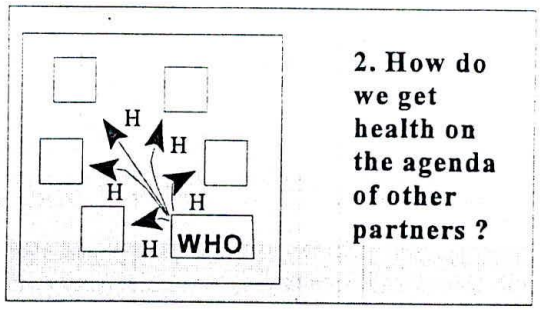
"Partnerships for health" have **two important dimensions**:

(1) through putting health on the agenda of other actors/sectors the health sector can significantly increase social momentum for health improvement.

(2) in doing so it can also increasingly help other sectors/actors understand, how health can support them in reaching their own expressed goals and combine health with other benefits.



1. Input systems



2. How do we get health on the agenda of other partners ?

Looking at partnerships in a new way moves WHO beyond an input model without reciprocity (usually a financial or donor mode of operation) to increasing the attempts to make health an attractive partnership option. The increased interest in health within the UN system, with business and with NGOs opens tremendous opportunities to broker resources and commitments. This leads to a much more diversified approach. For example the mechanism "NGO in official relations with WHO" requires that the NGO concerned have as its major purpose health. It is becoming increasingly necessary and possible to partner with NGOs whose primary purpose is not health, but who are keen to contribute to the health agenda, for example sports organisations or media groups. The recent approach to work with major football associations to "Kick polio out of Africa" is one such example.

A *changing* context implies *changed* and new partnerships.

2.1 The new environment

Strengthening partnerships for health is a practical response to the changed environment at the end of the 20th century. Traditional development resources are declining, privatization of government functions is increasing and private resource transfers to developing countries are expanding. The understanding that health is a critical factor in development - indeed a benchmark for development - is gaining ground and opening up opportunities for partnerships that address the broad range of health determinants and health needs. New information technology offers access to communication, information sharing and networking not possible before. The health industry itself has become a major development factor. Civil society organizations are increasingly actors (and watch dogs) in the development process.

WHO must increasingly see its role as one of mustering support for health from these many players for its health development agenda -both the unfinished business such as child survival and the new challenges such as ageing of societies. It cannot tackle the immense threats to health - such as poverty - alone and through the health system. It needs strong partnerships between public bodies, civil society and the private sector to make health everybody's business. It would be a serious misunderstanding of the importance of partnerships for health if they were simply seen as a way out of the financial stringency

faced by the public sector or by NGOs, they are not synonymous with financing or sponsorship.

Within a large organization new ideas and visions may be difficult to implement, or may be subverted and incorporated into routine approaches. Having an external partner may assist an organization such as WHO in the task of altering its mode of operation, which is a very difficult thing for a UN agency. In a complex, rapidly changing environment old mechanisms do not always provide solutions, indeed they can become counterproductive. It is essential therefore that WHO establish a set of clear principles, criteria and guidelines for partnerships and motivate staff to seek partnerships. This paper makes some suggestions of direction, but recommends that the proposals put forward be further explored. An approach similar to that used by FAO to establish its new guidelines could be recommended.

2.2 New players

The relations between WHO and its partners will not be as predefined and straight forward as in the past. The two approaches described above will increasingly be replaced by an open systems model that requires a very different mind set and management approach. In a rapidly changing environment a certain amount of opportunistic and highly flexible responses will be necessary, speed will be of the essence, information and knowledge management will be at the core. WHO would expand and strengthen its role as a broker for health - mediating, advocating and enabling partnerships for health development.

Partnerships are becoming increasingly common in the health arena. The *pharmaceutical industry* is showing a growing interest in matters of health promotion and working with patient groups on issues of disease management and patient education (Press Release WHO/80 and 86 1996); *FAO* has recently restructured its external relations unit and now pursues an openness towards other partners through its new Unit for Cooperation with the Private Sector and NGOs (Annex N°6). The *World Bank* fosters private and public partnerships for health development and has hosted a series of conferences to strengthen this approach. *UNAIDS* is now working with the World Economic Forum, the Prince of Wales Business Leaders Forum and Rotary International to encourage business leaders to take an active role in the global response to HIV/AIDS.

The boundaries between sectors and between public and private, for profit and non profit are also becoming less clearly drawn. Of course WHOs first allegiance is to its governmental members the Member States - but increasingly there is a strong need to move beyond Ministries of Health, a move that is not always understood or supported at the national level. For tobacco control Ministries of Finance and Trade are as important, for rehabilitation issues Ministries of Social Affairs and welfare are crucial, for schools health the Ministries of education are key. These issues needs to be addressed head on in the governing bodies of WHO and mechanisms for regular and systematic dialogue with these other parts of the public sector need to be established.

Increasingly national health agendas are influenced by *regional groupings* and arrangements. No systematic approach to dealing with these entities has yet been established -particularly since it involves different levels of the organization - the regional

offices and headquarters. Also the impact on health of the work of new organizations such as the WTO (World Trade Organization) calls for new types of agreements.

On the other end of the spectrum increased *decentralization* brings new responsibilities for health to the regional and local level - and these bodies frequently do not have access to the international health debate and decision making. The mechanisms for WHO to work with a state/regional government in a federal state system needs clarification and the information system to reach these levels must be improved significantly. WHO has shown creative approaches to this challenge such as the *Regions for Health Network* in Europe, special agreements as with the State of Maryland and of course the WHO Healthy Cities network.

Finally both the private sector and the NGO world are becoming more diversified. We find both for profit and not-for-profit organizations, and we find a range of mixed arrangements and networks that bring together business partners under an NGO umbrella or new types of forums, such as the DAVOS summit. Social insurances and health funds are frequently *not for profit* but also do not fall under the NGO category. On the other hand some NGOs are umbrella organizations for a business-orientation. Other types of "new" partners that need consideration but do not easily fall under established categories are parliamentarians, trade unions, political parties, issue based global NGO such as GREENPEACE , strong national groups such as the AARP (the American Association of retired persons), foundations, religious groups and organizations.

Partners appear in great diversity and in varied contexts, they cannot all be treated in the same fashion. A wide range of partners have not been tapped and present WHO procedures do not allow for a deeper involvement and recognition of their contribution. This must change in order to allow for the implementation of the new Health Policy for the 21st century.

2.3 Characteristics of partnerships

One possible method to introduce a more systematic approach is to group health partnerships according to different characteristics such as,

- ❒ product based partnerships
- ❒ product development partnerships
- ❒ services based partnerships
- ❒ systems and settings based partnerships
- ❒ issue based partnerships
- ❒ health message based partnerships
- ❒ knowledge based partnerships

❒ **product based partnerships**: for example deworming drugs in children, nicotine replacement therapy, aspirin post-MI, cell phones for remote clinics.

Insecticide-treated Mosquito Nets

A potential partnership could exist between WHO, a national government and the corporate sector producing mosquito nets and insecticide to ensure an efficient procurement system which will enable speedy procurement of quality assured materials at lesser costs. Furthermore all partners could promote the appropriate use and treatment of the materials by organizing training sessions or distribution of illustrated instructions.

- **product development partnerships**: for example designing a refrigerator for vaccine for use in developing countries.

(2) Refrigerator for vaccine in developing countries: **WHO and Electrolux**

WHO sent letters to 13 companies asking them to develop a refrigerator for vaccine adapted for use in tropical climates. Three companies answered and finally two companies continued to discuss possible designs. WHO provided the knowledge about circumstances, and the companies designed the product at their own cost and risk. Elektrolux was the only company to continue this process to production and they sold many thousands for use as vaccine refrigerators and other uses. WHO controlled regularly if the product fulfilled its function. Today, well adapted refrigerators for use I tropical climate are available to conserve the vaccine and for other purposes.

- **systems and settings based partnership:** for example the complex and multiple partnerships sought in creating supportive environments for health, i.e. Healthy Cities, safe workplaces, health promoting schools

Healthy Cities Project is a intersectoral collaboration and a supportive environment for health.

The goal is to improve urban health and urban environment in cities, through a new coalition of local governments, community organizations, universities, NGOs and the private sector. The programme focuses on the development of urban policies and management practices that attach importance to health as a goal of sustainable development at a local level, and not only at the national level.

This programme facilitates greater effectiveness of WHO objectives through decentralization. Today the Healthy City Project is a network all around the world, which includes not only WHO-Healthy Cities. The communities exchange plans, ideas, mutual support and experiences characteristic for the region or size of town,. But they are also linked to Collaborating Centres, Ministries of Health and WHO/RO. It also must be emphasized that in Europe not every WHO Healthy City was able to keep its title after the first period, as same had not fulfilled certain criteria. This is an important mechanism to guarantee the standard of the title and to have some model cities motivating further improvement of health.

Through these networks WHO has set up a widespread awareness in health policy, information and knowledge. WHO and the Ministries of Health are relieved and can concentrate on monitoring and the input of new issues. Health improves by a new combination of global and local actions.

- **issue based partnerships**: for example polio eradication, tobacco control, food fortification

Polio-eradication: WHO and Rotary International

In the late seventies Rotary International was looking for a bigger international project to be involved with. A Member of the Club met a staff member from WHO, who suggested that Rotary could focus on polio, being a disease that was well known in the industrialized countries and could be eradicated from the world. Rotary International decided that they focus initially on fundraising and they raised over US $ 200 million.

WHO participated with technical advice and knowledge on vaccines and immunization. Rotary International brought ideas to action with money, manpower, initiatives and lobbying. The relationship developed into a partnership, which grew even stronger in 1989 when the World Health Assembly adopted a resolution to eradicate polio by the year 2000. Rotary International had themselves by this time set their own goal, namely eradication of polio by the year 2005, their 100th anniversary. Some time was needed for the two large organizations to find a common way to work together. But with work, frequent communication and understanding on both sides a way of working was established. Close contact, continuing development process, trust and confidence became key elements in the partnership and it was nourished when results began to show and one success followed another.

- **health message based partnerships**: for example joint campaigns for healthy lifestyles, against drunk driving, for road safety etc. There would seem to be enormous scope for such partnerships with the communications industry.

WHO / UNESCO join together to fight malaria

In recognition of the role that education can play in malaria prevention, WHO and UNESCO signed a Memorandum of Understanding on 2 May 1997 by which the two organizations will collaborate in assisting countries to implement the Global Malaria Control Strategy.

Malaria is preventable and curable. Through health education, WHO and UNESCO aim to mobilize schools, children, parents and the community to play their part in promoting malaria-safe behavior. UNESCO will develop educational materials, train teachers and other educational personnel and elaborate communication materials for the media.

Through personal protection measures, early diagnosis and treatment and community-based preventive measures the mortality rates among young children and morbidity rates among schoolchildren can substantially be reduced. Studies by UNESCO in rural Africa have shown that over one-sixth of primary school children have had two or more attacks of malaria in the current school term, typically missing a week or more of school with each attack.

- **knowledge based partnerships**: knowledge exchange is the major part of partnerships, especially in a partnership with an intersectoral approach.

The WHO Collaborating Centres in Occupational Health and Health Promotion in Shanghai carried out a joint three year project (1992-1995) called the Workplace Health Promotion Project. In four enterprises affiliated to the metallurgical, shipbuilding, textile and chemical industries in Shanghai they increased awareness of occupational health and the necessity of health promotion at the working place for employees and employers.

Another way of framing partnerships could include:

- **A WHO "seal of approval/endorsement** " of a product, service or system. For example, airlines could be rewarded for going smoke free and serving health food by having a special health logo (such as the Blue Angel) awarded which they could use in their advertising campaign,
- **A range of "signing up" approaches**: for example WHO sets criteria / an index for a "healthy company", a "healthy city", etc. - and partners would join a WHO initiative/network that helps them move towards these criteria. League tables could be considered especially in relation to health and related service provision.
- Regular **"Benchmark Health Surveys"** could be undertaken together with key partners, similar to the "Benchmark Corporate Environmental Survey" conducted by the UNCTAD Programme on Transnational Cooperations. The goal of such a project would be to develop awareness for health in different sectors and parts of society.

The growing number of such partnerships for health would help to isolate products or services clearly damaging to health. Consumer groups and the media could play a key role in advocating the best practice. It would allow WHO to systematically expand its role as a broker for significant health development challenges.

2.4 Networks

Increasingly partnerships are organized through networks. WHO has created and is actively involved in many such networks. They thrive on partnerships at all levels of their implementation - between the members of the networks, between the networks and WHO, between one network with other WHO networks. The potential of this "asset" has not been fully exploited by WHO, networks are frequently still seen as a chance effect rather than as a management tool for partnerships. Networks reflect the non hierarchical style of partnership building and perhaps best represent the power shift we are witnessing at the end of this century.

A network is described as a "grouping of individuals, organizations and agencies, organized generally on a non-hierarchical basis, around some common theme or

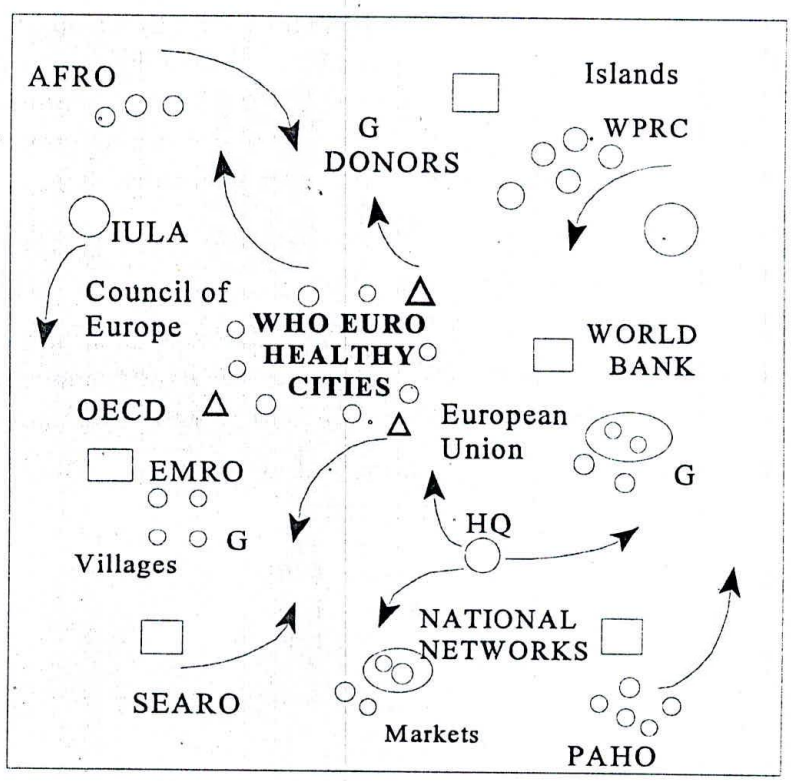
concerns". Networking for health implies interlinking individuals, groups, institutions and organizations which have an interest in health. Their purpose is usually to exchange information and experience; to work together for a common aim; or to advocate a specific position or action. At their best they jointly develop and provide solutions so that the knowledge developed in one part to the network becomes a joint resource and a public good. In recent years WHO has build a number of new setting-based networks.

Settings for Health Projects

are being implemented all over the world and some linked officially to WHO networks, such as

- Healthy Cities
- Healthy Villages
- Healthy Islands
- Health Promoting Hospitals
- Baby-friendly Hospitals
- Healthy Schools Project
- Healthy Prisons
- Healthy Market Places
- Healthy Workplaces
- Sports Venues
- Countrywide Integrated Noncommunicable Disease Intervention Programme (CINDI)

Networking may be as informal as the exchange of electronic messages between experts and the exchange of information and know-how in face-to-face meetings. It may also be promoted through formally established networks, with agreed rules and regulations for their operation. An interesting example for network building and growth is the WHO Healthy Cities Programme.



2.5 Consequences for WHO

- **Role of the health sector**: It is essential for WHO to accept that within a changed environment, one of the key roles of the health sector is to initiate partnerships that leverage health. WHO will need to enter into partnerships at different levels within each "partner-category" in addition to the existing relations, such as Collaborating Centres, NGOs in official relations etc.
- **WHOs organisational culture** needs to be more responsive to lateral relationships and networking among many actors. The present vertical organization is not conductive to information sharing and network building. Successful partnership building does not enjoy the same status as successful fundraising of a classical nature. Staff need to understand the power of partnerships and be trained in partnership building.
- **An information base** listing all WHO partners, their nature, characteristics of the special partnerships, action plans and related subjects is essential, model contracts and agreements should be easily accessible. A partnership unit should help monitor partnerships, help analyse and evaluate them and provide assistance in partnership building. For a successful protection of WHO's reputation a internal database of unaccepted partners and failed partnerships must be established, listing the reasons for failure. Such an information base could assure unified approaches and procedures.
- **Mission and assets.** To achieve the maximum use of knowledge and facilities by the partner for common health goals, WHO has to adapt its own mission and assets. This is already underway as part of the WHO reform process.
- **A strategic entity** (ie a partnerships unit) needs to help develop new partnerships based on HFA and help maintain and strengthen existing partnerships as well as providing new impulse. This unit would actively help programmes to build, cultivate and coordinate networks. This will be the coordinating centre of the new broader spectrum of external relations. It would help prevent duplication of effort, confusion and waste and assist with networking the networks. Some internal working groups to this effect already exist such as the WHO HQ working group on healthy cities.
- **Guidelines for partnerships** must be developed together with potential partners and presented to the governing bodies.
- **Annual "HFA partnership meetings"** that assess progress in partnerships for health in the 21st century should be established beyond individual programmes, donors should be advised of the experiences gained with a network and partnership approach.
- **Publications** can summarize process and successes of a partnership and motivate other institutes to contribute resources to partnerships.

3. Principles and Criteria for Partnerships with WHO

Principles and criteria are needed within WHO in order to build partnerships and to set a firm basis for cooperation that will lead to the attainment of health development goals.

These principles and criteria must provide the basis for all partnerships that WHO enters, be they with international organisations, governments, NGOs, the corporate or academic sector.

3.1 Principles

Partnerships with WHO must respect the value system of HFA and be based on transparency, equal access, protection of WHO's reputation and recognition that partnerships can be terminated when necessary. All partnerships imply a risk and the rewards and costs of the partnership (rather than going it alone) must be clear to all partners.

(1) The value system of WHO implies a commitment to:

- ❒ Human rights
- ❒ Health security
- ❒ Equity
- ❒ Ethics
- ❒ Gender perspective

Partnerships with WHO will respect this value system and where possible advocate for its acceptance.

(2) operational guidelines: For each partnership commonly agreed guidelines would include clear reference to HFA principles and how they are made operational within a specific partnership. The development of a **plan of action** is a critical element in every partnership.

(3) Transparency: The partnership should always be made public at the outset and its progress should be reported regularly in order to ensure maximum transparency. Where financial transfers are involved, a separate audited account should be maintained to ensure that public scrutiny of how funds are used is possible.

(4) Protection of WHO's reputation: Partners must agree not to use the WHO name or reputation for private gain. The WHO logo, name, or reputation should not be used to promote goods and services. The exception to this might be the *seal of approval* or *corporate benchmark* approaches listed above (see point 2.3.), in which the objective is specifically to use the force of WHO to promote healthy goods, services, or practices. Otherwise the Partners could create a specific action based logo, like such as those already done by the healthy cities or vaccination programmes. Possibly a special "in partnership with WHO logo" could be developed.

(5) Termination of partnerships: while sustainability should be a key goal for partnerships rules must be established for the termination of partnerships. WHO must retain the right to terminate partnerships which are not achieving the anticipated health gains, which no longer meet the above criteria, or which threatens WHO's reputation as an impartial upholder of health values. The possibilities of termination by the partner have to be included in the negotiation and guidelines. Clear time frames and benchmarks must identify key stages of implementation and set objectives. The termination must include an evaluation of the partnerships from both parties.

(6) The issue of equal access possibilities for all potential partners to work with WHO must be addressed. WHO cannot be seen to exclude a certain partner or privileging another. The replicability of partnerships must also be explored.

3.2 Basic Criteria for Partnerships

Partnerships should meet three basic criteria:

- ❒ The partnership should lead to significant health gains.
- ❒ The health gains should be worth the effort involved in establishing and maintaining the partnership.
- ❒ The partnership should strengthen WHOs role as a catalyst for health development

Because developing partnerships requires human and usually financial resources, a judgement must be made early in the process as to whether the added value of the partnerships (potential health gains) will be worth the effort involved in establishing and maintaining the partnership.

3.2.1 Criteria for Partnerships with NGO

In addition to the present mechanisms of working relationships between WHO and NGOs there is a need of a wider spectrum of NGO-relations, including an evaluated and institutionalized dialogue. The types of NGOs differ considerably and provide alternative views to those of governments. This diversity is important for an effective improvement of health. New types of NGOs need to be included as for example urban leagues and associations of Mayors in order to promote the urban health agenda.

Different types and levels of relationship between NGOs and WHO are needed in order to reflect the different types of NGOs. While there can be significant differences between action oriented NGOs and industry umbrella groups there is often excellent scope for cooperation on specific population health issues. The cooperation of WHO with the food industry in promoting global food safety shows this.

NGOs that are business umbrella groups should be approached with the criteria for partnerships with the corporate sector (point 3.2.3).

Otherwise the following criteria may be helpful:

- NGOs work at all levels, but presently an international scope is regarded as necessary in order to be in official relations with WHO. This has been a source of deep frustration to some major national NGOs. It seems to us an unnecessary criteria. It presently excludes many NGOs that provide rich experience. Not always are national or community based NGOs affiliated to an international NGO, but many would like to have easier access to dialogue, advice and information exchange with WHO. It seems that the development of a network approach could provide solutions for affiliation.
- A difference could be made between affiliation to WHO and to a certain WHO programme. Such a partnership in relation to a certain project or subject, in which the NGO has helpful experience could be established for a determinate period, but this would not exclude a long-lasting partnership. Such recognition and legitimacy seems only appropriate.
- The NGO must be of a certain status of organization, reflective of the accountability/ legal status, services provided, recipient/ users, funds.

A range of proposals has been documented in the recent meeting of WHO with NGOs in the context of the HFA policy for the 21st century. The recommendations in that report (existing in a draft version) should be carefully studied and linked to the proposals in this paper.

3.2.2 Criteria for Partnerships with the academic sector

The academic sector represents a source of expertise, technology transfer, and training of the human resources of tomorrow.
There is a need to make maximum use of the existing collaborative arrangements with the Collaborating Centres, which primarily provide access to the academic sector and research community. Much can be done to maximize this very important resource network, through out-sourcing, competitive bids etc. But the approach to designating Collaborating Centres should be revised and made more effective, and the achievement of the criteria should be controlled carefully every four years to protect a good collaboration and the well-deserved title. Furthermore the academic sector could also be included beyond the health area, in education, management, economics, law; policy sciences, communication and promotion. Moreover the fact that many academic institutions are rather private than public raises the question about independent and authoritative advice, and about general access to health information.
Criteria for these partnerships could be:

- scientific and technical standing in a certain field.
- centres of excellences reflecting the "state of the art".
- quality of technical and scientific leadership.
- relations and research cooperations with other institutions on a national, regional and international level.
- Ability, capacity, readiness, also to assists centres throughout the world in working towards the same high standards and to be member of a global community of centres. They will explore new ways of working together, new types of comparative and global analysis and are involved in the search for common solutions.
- readiness for an *ongoing* exchange of knowledge two way communication process.

- in the academic sector successful collaboration depends strongly on a certain personality. With the change of major personalities in a project evaluation of further promising collaboration is needed.

The role of collaborating centres is being looked at more closely in a study for the discussions at the upcoming Executive Board. Also a recent network meeting of the US collaborating centres has made very useful suggestions for better use of collaborating centres. These recommendations should be linked to this report.

3.2.3. Criteria for Partnerships with the corporate sector

Partnerships with the corporate sector at all levels from global to local are essential. The public health sector has not and cannot make sufficient health gains on its own. Developing partnerships with the corporate sector is a matter of balancing the potential benefits to be gained against risks. The stakes are not trivial: If WHO is unable to engage powerful private development forces in the struggle for better health, WHO may risk a diminution in its relevance and role. Any potential negative impact of corporate sector partnerships must be balanced against the cost of not having this type of partnership.
In considering "health related activities that the corporate sector carries out", the reference is not only to occupational health and safety, or the minimization of pollution and the ecological impact of the industry, but also to the promotion of health values and a public service role for private industry. For the advantages look also above 2.3.
The **risks** in developing partnerships with the corporate sector include the possibilities that,

(a) the WHO reputation will be used to sell goods and services for corporate gain, thus diminishing WHO's reputation as an impartial holder of health values,
(b) WHO's judgment on a particular product, service, or corporate practice may be compromised by financial support provided by the involved company or industry, and
(c) WHO involvement with an industry or company is perceived as acceptance by WHO of unhealthy products, services, or practices.

To maximize the health benefits of partnerships with the corporate sector, while minimizing risk, **three questions** must be addressed when considering such partnerships:

(1) What is WHO's policy toward the particular industry involved?
(2) Is the individual company a suitable partner for WHO?
(3) Is the individual activity appropriate for a WHO partnership?

(1) WHO policy toward the industry involved

The involved industry must be a suitable partner for WHO. The following questions which must be asked when developing a policy toward a specific industry:

- Are the major products or services of the industry harmful to health?
- Does the industry engage on a large scale in practices which are detrimental to health?
- Is the influence of WHO's role in the partnership likely to do more good than the damage done by harmful practices, products or services?

Health provider organizations, the pharmaceutical industry, health care technology industries and similar organizations are generally quite suitable partners. The tobacco and arms industries, which have indisputably negative health impacts, are clearly not suitable partners. Many industries such as transportation industry, fast food industry, and chemical industry have both a positive and a negative impact on health .

For those industries it is essential that WHO formulate a specific policy on the industry. Should a public challenge be made about a WHO partnership with a specific industry, the policy would serve to clarify WHO's position on the industry and its views on the net health benefit of working with the industry.

In several instances, WHO has a history of engagement with a particular industry. Past contact with an industry **should not** be taken as a *de facto* policy. This is especially true if the WHO unit initiating a partnership is different from the unit most familiar with the adverse health consequences of the industry or potential for conflicts of interest. In such instances, an explicit WHO policy is needed.

(2) Suitability of the individual company

Even when an individual industry is a suitable partner, individual companies may not be. Additional factors to consider in evaluating partnerships with individual companies are:

- ❒ the occupational health conditions on which products or services are produced
- ❒ the environmental commitment of the company
- ❒ the marketing and advertising practices of the company
- ❒ the research and development policy and practice of the company
- ❒ the regulatory compliance of the company
- ❒ But also the subsidiary / combine has to be looked at.
- ❒ no past activities(not to exceed 3 Years) which might affect objectivity, credibility of WHO.

These criteria are similar to those already being applied by a range of public agencies. They would need to be interpreted against the backdrop of approved standards for best practice. A screening could be done also by public agencies and media archives. If one company produces at extreme low prices could this be a indicator of bad working conditions.

(3) Appropriateness of the individual activity

Partnerships often focus on a specific activity or set of activities. Most categories of activities proposed in the context of a WHO partnership will be appropriate, since they will aim at specific health policies or health practices. However, the following categories of activities are **not appropriate** within a WHO partnership:

- ❒ Activities which involve **conflict of interest** or **perceived conflict of interest.**
- ❒ Activities which benefit the corporate partner, but provide **no clear health benefit,** benefit to WHO or benefit to Member States.

Conflict of interest is of particular concern for WHO programmes involved in setting regulatory standards and other norms which may affect product costs, market demand, or profitability of specific goods and services. Examples include norms for quality, safety, efficacy, promotion practices, and information accuracy for pharmaceuticals; norms for

registration of herbal and other traditional medicines; chemical safety standards; and nutritional guidelines.

To avoid conflict of interest -- real or perceived -- the concerned WHO programmes must establish procedures which ensure that

(a) final normative decisions are free from undue influence,

(b) industry funding is not used for salaries of staff involved in normative decisions, and

(c) consultations and other normative activities never have their majority financing from the concerned industry.

In the context of an on-going partnership, some proposed activities may service public relations and other interests of the external partners, but have no clear health benefit. In general, such activities should be avoided.

No similar meeting has yet taken place with the private sector to discuss partnership as has been undertaken with the NGOs (see above). Private sector comments on this paper were solicited but this paper strongly recommends the establishment of a mechanism for regular dialogue with the broad scope of the private sector with an interest in health. One such attempt is under way in the health promotion division where a "private sector for health promotion" group has been established.

4. The Process of Building and Maintaining Partnerships

Partnerships do not just come about. They need to be built with skill, care and mutual trust. A partnership strategy needs to constantly keep in mind each of the following steps:

- ❒ identifying opportunities
- ❒ identifying potential partners
- ❒ selecting the most suitable partners
- ❒ negotiating /reaching a clear partnership agreement
- ❒ maintaining the partnership
- ❒ regularly evaluating the partnership.

Step 1: identifying opportunities

WHO is in a unique position to identify opportunities for partnerships in health development. It has a global overview of priorities and needs, is already in contact with a wide range of actors and has the standing and authority to approach new players. This is the crucial step for all partnership building which requires the new type of mind set referred to above.

Step 2: identifying potential partners

In identifying partners WHO should always try to be inclusive instead exclusive. Equal access possibilities for different partners should be provided whenever possible. WHO should maintain an open and fair process in developing partnerships with partners on similar projects.

If a partner approaches WHO, the joint areas of interest should be carefully examined. While legal considerations are essential they cannot constitute the only element of decision

making: political concerns, long term gains, strategic/tactical considerations must enter the equation.

Step 3: Selecting the most suitable partners.
The criteria mentioned under point 3.2. and particularly the compatibility with HFA and the commitment to the partnership serve as an standard to select a partner.

Step 4: Negotiating /reaching a clear partnership agreement, with guidelines
Establishing partnerships is very time and resources consuming at the initially beginning. But the added forces will save time and resources once the partnership is underway and is maintained. The partners may not underestimate the effort needed before the starting point of the partnership. Every partner has to analyse his starting position, objectives and means of achieving them. Plans of action are a well-established procedure used with WHO Collaborating Centres and, for example, with the WHO Healthy Cities "City Health Plan." The work contained in such a plan often represents a substantial bonus for health, with relatively small investment of WHO resources. This stage is important in establishing mutual trust, therefore the negotiator should not be exchanged. The negotiations are terminated by a letter of agreement which includes:

- a clear cut goal of the partnership
- measurable project objectives
- human and financial resources and other contributions
- responsibilities of each partner
- organizational structure
- duration of the agreement
- communication during the partnership
- possible benefit-sharing
- conditions and mechanisms for amendments or termination of the agreement
- method and timing of evaluation The agreement should include a timetable for action and methods for evaluating the added value of the partnership, as well as its contribution to improved health. Measurable objectives can help facilitate the reaching of an understanding and provide better accountability. The guidelines must include an agreement how to handle possible problems, conflicts or misunderstandings

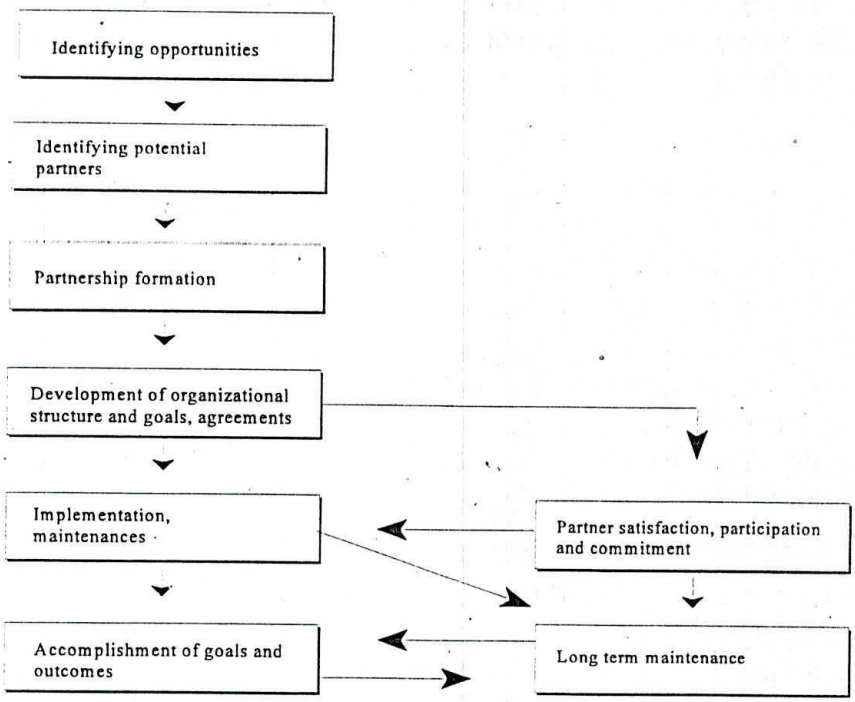
As mentioned above WHO must build an institutional capacity for recording and evaluating partnerships so it can advise on new efforts.

Step 5: Maintaining the partnership:
Regular communication, training and close monitoring increase trust, coordination and avoid misunderstanding. This guarantees common approaches and further commitments. Maintaining the Partnership is a crucial momentum to assure the success of the partnership.

Step 6: Evaluating the partnership:
The parties agree in advance how to evaluate and to which criteria/indicators will be used to measure progress, success or failures. A small task force should begin with developing a set of general indicators and analytic categories that can be adapted for specific partnerships.

The above can be illustrated in the following graph:

Partnership development and maintenance



5. Conclusions

Partnerships for health will result in joint action that will lead to the attainment of common predefined goals. Additional benefits are likely over time as a culture develops of "all" being involved in HFA. A partnership for health approach also has consequences for both training and research in public health. Training institutions must teach the skills needed to form and maintain partnerships and a future oriented research agenda must study existing (and failed) partnerships with a view to developing evaluation tools. If the partnership is structured appropriately from the start and the principles accepted by all partners, it is likely that legislative approaches and formal codes of conduct will be less important.

Increasingly the health sector at all levels will be called upon to play a motivational and brokerage role for new types of partnerships for health development. It is only appropriate that WHO should take the lead in such a development.

During the preparation of this paper, we recognized many existing types of partnership at WHO.
Unfortunately there is insufficient space to elaborate these projects any further in this paper. We were able to include only a few examples, mainly at WHO /HQ. But the range is so diverse that we propose to edit a book on partnerships in the last 50 years on the occasion of the 50th anniversary.

Members of the Working Group

Dr C.M. Chollat-Traquet, Director PPE
Dr N.E. Collishaw, TOH
Mr S.S. Fluss, HPD
Dr T. Godal, Director TDR
Dr G. Goldstein, UEH
Dr M. Jancloes, Director SSC
Dr F. Käferstein, Director FSF
Dr Y. Kawaguchi, Director INA
Dr I.Kickbusch, Director HPR (Chair)
Dr J.D. Martin, SSC
Ms A. Möhrle, HPR
Dr D. O'Byrne, Chief HEP
Dr J. Quick, Director, DAP
Dr J.L. Tulloch, Director CHD
Dr D. Yach, Chief PAC

Note: This paper is based on the deliberations of the HQ working group set up in the context of Health for All Renewal. It has been reworked based on comments from the members of the group, and a range of external advisors, from the NGO, government and corporate sector. The chair would like to thank all members for their input. She would also like to thank Ms. Anne Möhrle who helped produce the final version of this paper during her internship with WHO.

Resource list

Published documents:

Health Education Authority: *Promoting health in partnerships with the Health Education Authority;* An invitation to the pharmaceutical industry. London, 1997.

Kerr, Melville: *Partnering and Health Development; The Kathmandu Connection.* University of Calgary Press/ International Development Research Centre, Calgary/ Ottawa, 1996

Gaag van der, Jacques: *Private and Public Initiatives; Working Together for Health and Education*. The World Bank, Washington, 1995

Green, Andrew/ Matthias, Ann: *How should governments view nongovernmental organizations?* In: World Health Forum, Volume 17, page 42. 1996

The Prince of Wales Business Leaders Forum/ Tennyson, Rosalind: *Tools for Partnership-building*, 1994

Richards, Ronald W. (editor): *Building Partnerships; Educating health professionals for the communities they serve*. Jossey-Bass Publishers, San Francisco, 1996

Ritchie, Mark A./ Minsek, Marianne/ Conner, David W.: *Roles and approaches of nongovernmental organizations in health development*. In: World Health Forum, Volume 16, page 36, 1995.

Sheldon, Tony: *Call for European cooperation in research*. BMJ 3. May 1997, p.1300

Slater, Sharon (UNICEF)/ Saadé, Camille (BASICS): *Mobilizing the Commercial Sector for Public Health Objectives*, 1996

Soilver, Cary: *Rotary's PolioPlus*. In: World Health, 48th Year, No. 1, 1995

UNCTAD (United Nations Conference on Trade and Development Programme on Transnational Corporations): *Environmental Management in Transnational Corporations; Report on the Benchmark Corporate Environmental Survey*. United Nations, New York, 1993

UN Non-Governmental Liaison Service (NGLS): *The United Nations, NGOs and Global Governance*; Challenges for the 21st Century. UNCTAD/NGLS/64. Geneva, 1996

UNRISD (United Nations Research Institute for Social Development): *States of Disarray*; The social effects of globalization. London, 1995

Uusitalo, Teuvo/Chowpradith: *Internet as a tool for distribution of occupational health and safety information*. In: Asian-pacific Newsletter on Occupational Health and Safety, 1995, volume 2, page 54-55

Wilson Larry/ Wilson Hersch: *Stop Selling , Start Partnering*. John Wiley & Sons, Inc.,New York, 1997.

WHO, D. Bettcher: *Think and act globally and intersectorally to protect national health*. (WHO/PPE/PAC/97.2) Geneva, 1997

WHO: *Collaborating Centres*; General Informations. Geneva, 1987

WHO: Division of control of tropical Diseases; *Progress report 1996*. (CTD/PR/97.1) Geneva, 1997

WHO/ Global Programme for Vaccines and Immunization: *Vaccine Supply and Quality; Global Training Network*. Geneva, 1997

WHO: *Global Strategy on Occupational Health for All*. (WHA 49.12) Geneva, 1996

WHO/ RO for Europe, edited by Tsouros, Agis D.: *WHO Healthy cities Project*; A Project becomes a Movement; Review of Progress 1987-1990. Copenhagen. 1991

WHO/ UNICEF: *State of the world's vaccines and immunization*.(WHO/GPV/96.04) Geneva, 1996

WHO: *WHO Global Partnership Initiatives for health development*. (WHO/INA/97.2) Geneva, 1997

WHO: *Principles governing Relations between WHO and NGOs*. (WHA 40.25)

WHO: *Renewed health-for-all strategy: draft policy for the twenty-first century*. (EB100/2) Geneva, April 1997

WHO: *WHO and EMORY University Collaborative Support for Health development in Africa*. (WHO/INA/96.3). Geneva, 1996

WHO: *WHO and University of California, Los Angeles (UCLA) Collaborative Support for Health Development*. (WHO/INA/97.1) Geneva, 1997

WHO: WHO/ World Bank Partnership; *Procedural strategies for implementation of recommendations for health development*. (WHO/INA/96.1) Geneva, 1996

Unpublished documents:

Centre of Disease Control and Prevention (CDC): *Guidance for Collaboration with the Private Sector*. Atlanta, 1997

Heitkamp, Petra I.: *Global Health Promoting Partnerships in WHO's Organizational Perspective*. Final Thesis for Maastricht University. Maastricht, 1996

Health Programs and Services Branch *CANADA*: *Guidelines for working with the private sector. OTTAWA*, 1995

IMO (International Maritime Organization): *Strengthening and expanding the resource base of IMO's integrated technical co-operation programme (ITCP)*. (A6/A/19) London, 1994

ILO/ Minet, G.: *Draft discussion paper on the relationship between the UN system and civil society*, March 1997

Makara, Peter/ Büchel, Bettina/ Hagard, Spencer: *Partnerships for Health Promotion*; Background Paper prepared in the context of the 4th International Conference on Health Promotion, April 1997

NGO Forum for Health: *Statement to the 50th World Health Assembly*. Geneva, May 1997

The Prince of Wales Business Leaders Forum: *Notes from the meeting of the international partnership Advisory Group (IPAG) and other colleagues* at World Bank, Washington, 23rd May 1997

The Prince of Wales Business Leaders Forum/ Tennyson, Ros: *Training Session: Building Partnerships;* Corporate Citizenship Conference at World Bank, Washington 22nd May 1997

UNAIDS: Draft; The Expanded Response to HIV/AIDS: Working in Partnerships with the Private Sector.Geneva, April 1997

UNESCO: *Directives concerning UNESCO's co-operation with private extra-budgetary funding sources and their right to use UNESCO's name , emblem or any other type of representation of the Organization's corporate entity.*

WHO: Division of control of tropical diseases and Regional Office for Africa: *Draft Guidelines for Implementation of Insecticide-treated Mosquito Nets for the Prevention and Control of Malaria in Africa.* (CTD/MAL/AFRO/97.4) Geneva, 1997

WHO: Kickbusch, Ilona: *Creating a Global Web for Health; Challenges for WHO and its Collaborating Centres.* (Washccs.97).Presentation prepared for the 1st Meeting of US Collaborating Centres Washington, June 1997

WHO: Kickbusch, Ilona: *Intersectoral Action for Health. Health for All Rernewal Meeting, Halifax, Canada,* April 1997

WHO: Kickbusch, Ilona: *Global Experiences in Health Promotion since the Ottawa Charter and Future Actions for International Collaboration Based on Its Framework;* Special lecture given on the occasion of the International Forum on Health Promotion '96 Tokyo, September 1996

WHO: *A New Global Health Policy for the Twenty-first Century: an NGO Perspective. Outcome of a Formal Consultation with Nongovernmental Organizations. Geneva, 2 - 3 May 1997.* (WHO/PPE/PAC/97.3), Geneva, 1997

WHO/ UNICEF; World Summit for Children: *21 health and health-related goals 1990-2000;* Review of progress at mid-decade and preparations for the year 2000. Geneva, 1996

WHO: Lehtinen, Suvi/ Mikheev, Mikhail: *WHO Workers' health programme and Collaborating Centres in Occupational Health.*(WHO/OCH/95.2), Geneva, 1995

Press releases:

97th session of the Executive Boards Opens in Geneva. Diversifying Alliances: A new Challenge for WHO. WHO/3, 15 January 1996

Rotary and UNAIDS; Working with New Generations for a Safer World.Press Release UNAIDS, 8 July 1996

WHO and the Pharmaceutical Industry Join Forces to Combat Antibiotic Resistance. WHO/80, 15 November 1996

International Alliance Formed for Elimination of Trachoma. WHO/82, 26 November 1996

Vaccine Industry Boots Global Polio Eradication. WHO/86, 9 December 1996

The Campaign against Polio: Sports Joins in; Kick Polio out of Africa. WHO Press Release, 26 April 1997

WHO, UNESCO Join Together to Fight Malaria. WHO/38, 7 May 1997

WHO Links With ASEAN to Promote Health. WHO/39, 12 May 1997

WHO,UNICEF Agree on Joint Strategy to Improve Water Supply and Strengthen Local Health Systems. WHO/43, 23 May 1997

The Children's Vaccine Initiative; "Working Together to Protect Children from Infectious Diseases". Fact Sheet N° 169, June 1997

List of Annexes

1. Requirements for the designation of cities in the 1993-1997 phase of the WHO Healthy Cities project
2. Network of WHO Collaborating Centres in Occupational Health
3. Principles of Cooperation among the Beverage Alcohol Industry, Governments, Scientific Researchers and the Public Health Community
4. List of Partners in Health through 1996 of the Division of Control of tropical Diseases
5. FAO's new policy on the private sector, in FAO contact, January 1997

Annex 1

Requirements for the designation of cities in the 1993-1997 phase of the WHO Healthy Cities project

All project cities should establish a widely representative intersectoral policy committee with strong links to the political decision-making system, to act as a focus for and to steer the project. All cities should appoint a person to be politically responsible for the project.

All project cities should establish a visible project office which is accessible to the public, with a coordinator, full-time staff and an operating budget for administration and management.

All project cities should develop a health for all policy based on the European targets for health for all and prepare and implement a city health plan (or adapt an existing one) that addresses equity, environmental, social and health issues, within two years after entering the second phase for old project cities and within four years for new cities. Cities should secure the necessary resources to implement the policy.

All project cities should establish mechanisms for ensuring accountability, including presentation to the city council of short annual city health reports that address health for all priorities.

All project cities should take active steps to take on the strategic action priorities of the WHO Regional Office for Europe, particularly implement the European Tobacco Action Plan and the European Alcohol Action Plan.

All project cities should establish mechanisms for public participation and strengthen health advocacy at city level by stimulating the visibility of and debate on public health issues and by working with the media.

All project cities should carry out population health surveys and impact analyses and, in particular, assess and address the needs of the most vulnerable and disadvantaged social groups.

All project cities should ensure full and active participation by the politically responsible person and the project coordinator in the project business meetings at which policy and management decisions are taken. Also attendance by the city delegations at the project's symposia is necessary to the extent (i.e. size of delegation) that is feasible without damaging the primary emphasis which must be on local actions.

All project cities should report back regularly to WHO (according to an agreed five-year plan and as negotiated at subsequent business meetings) on progress achieved and share information and experience with other city partners. All project cities must link up to the WHO Regional Office for Europe electronic mail/bulletin board.

Participation in MCAP work is essential. It is up to the project cities to decide which MCAPs they want to participate in. Participation should be active and the work linked to/integrated with the overall project in the city.

All project cities should explore ways of providing support and resources for overall promotion and development of the Healthy Cities network.

All project cities should take active steps to cooperate locally with other networks and institutions such as schools of public health, departments relevant to urban health and development, medical associations and pharmaceutical associations.

All project cities should develop active working links with the other project cities, through city visits and by fostering technical and cultural exchanges and hosting Healthy Cities meetings and events.

The cities which were members of the network in 1987-1992 and which remain in the 1993-1998 project must recognize that an important part of their role will be to provide advice and support to the new projects cities. This process could include sharing experience on ho to start up the project, running joint technical meetings and assisting in the preparation of project resource materials. WHO could facilitate twinning arrangements between old and new cities.

Annex 2

Network of WHO Collaborating Centres in Occupational Health

The Network of the 58 WHO Collaborating Centre in Occupational Health was created in June 1990, when the national institutes of Occupational Health convened a meeting in Helsinki. The first meeting of the Network member institutes was held in Moscow in September 1992.
The network is a powerful and practical tool in implementing various activities of the WHO/ Workers' Health Programme (WHO) and makes the best possible combination available for the programme.The adoption of the Global Strategy on Occupational Health for All by the 49. WHA 1996, prepared by the Network, was a big success. Furthermore this kind of strong cooperation offers an excellent opportunity for effective use of existing knowledge and for creating synergism in development of Occupational Health at the national level.
Building and coordinating the network *was done by* the OCH Unit The network is strongly coordinated by the WHO/OCH, *but an alternative would be that one Collaborating Centre overtakes the coordination part.*

The Planning group, consisting of 8 Collaborating Centres which meet once a year, serves as an advisory body to the WHO/OCH Unit in deciding a comprehensive strategy plan with the priority programme for the Unit. The strategy offers a basis for the Collaborating Centres to select the topics, targets and forms of their collaborative contributions. Example of priority activities:

- training at different levels, especially in developing countries , including producing training and educational material.
- preparation of guidelines in different aspects of occupational health practice

Mechanisms for exchanging information between the network:

- Meeting of the Collaborating Centres every two years.
- Study groups on selected priority problems to gather the existing knowledge and information available and to find out the gaps in the knowledge. Information is published as WHO Technical Reports.
- Continuous communication of information and feedbacks between WHO and the Collaborating Centres. Consequently/ therefore WHO/OCH has the action plans and accomplished results of the Collaborating Centres and can make full use off their published results, as well as of the joint publications of the Collaborating Centres.
- Publications inform the Collaborating Centres of WHO objectives, priorities and procedures and of each other s' current and planned activities.
- An International Directory of the WHO Collaborating Centres in Occupational Health is available on database and databanks.
- The WHP Newsletter, published three times a year by NIOSH (US National Institute for Occupational Safety and Health), serves as a channel of up-to-date information on current activities of both the WHO /WHP and the Collaborating Centres.
  Another Newsletter on Maritime Occupational Health, published by the Institute of Maritime and Tropical Medicine, in Poland, plays the same role for those Collaborating Centres in dealing with health of seafarers.
- Also exists a electronical board for information exchanges.
- To monitor the WHO Colllaborating Centres' work, each centre is required to present its annual report in a given form not later than February of the following year.

There is now an interdisciplinary approach too: the WHO Collaborating Centres in Occupational Health and Health Promotion in Shanghai carried out a joint three year (1992-1995) of Workplace Health Promotion project. The four entreprises in charge were affiliated to the metallurgical, shipbuilding, textile and chemical industries in Shanghai.

Networking of the Collaborating Centres in Occupational Health

The overall framework of networking is shown in Figure 1.

Annex 3

PRINCIPLES OF COOPERATION AMONG THE BEVERAGE ALCOHOL INDUSTRY, GOVERNMENTS, SCIENTIFIC RESEARCHERS, AND THE PUBLIC HEALTH COMMUNITY

Following extensive consultations with individuals and organizations in many countries, a group of experts met in Dublin on 26 - 28 May, 1997 at the invitation of the National College of Industrial Relations and the International Center for Alcohol Policies. At the end of the meeting, in their individual capacities, they adopted by consensus the "Dublin Principles", and expressed the hope that these Principles will be generally adopted.

Participants included scientists, industry executives, government officials, public health experts, and individuals from intergovernmental and nongovernmental organizations.

Preamble: The Ethics of Cooperation

The common good of society requires all its members to assume their fair share of social responsibility. In areas related to alcohol consumption, individuals and the societies in which they live need to be able to make informed choices. In order to further public knowledge about alcohol and prevent its misuse, governments, the beverage alcohol industry, scientific researchers, and the public health community have a common responsibility to work together as indicated in these Principles.

I. Alcohol and Society: Cooperation among Industry, Governments, the Community, and Public Health Advocates

A. Governments, nongovernmental organizations, public health professionals, and members of the beverage alcohol industry should base their policies and positions concerning alcohol-related issues upon the fullest possible understanding of available scientific evidence.

B. Consistent with the cultural context in which they occur, alcohol policies should reflect a combination of government regulation, industry self-regulation, and individual responsibility.

C. Consumption of alcohol is associated with a variety of beneficial and adverse health and social consequences, both to the individual and to society. Governments, intergovernmental organizations, the public health community, and members of the beverage alcohol industry, individually and in cooperation with others, should take appropriate measures to combat irresponsible drinking and inducements to such drinking. These measures could include research, education, and support of programs addressing alcohol-related problems.

D. Only the legal and responsible consumption of alcohol should be promoted by the beverage alcohol industry and others involved in the production, sale, regulation, and consumption of alcohol.

E. Government and industry both have a responsibility to ensure strict control of product safety.

F. To enable individuals to make informed choices about drinking, all those who provide the public with information about the health and societal impact of alcohol should present such information in an accurate and balanced manner.

1. Advertising of beverage alcohol products should be subject to reasonable regulation, and/or industry self-regulation, and should not promote excessive or irresponsible drinking.
2. Educational programs should play an important role in providing accurate information about drinking and the risks associated with drinking.

II. Alcohol Research: Cooperation among Industry, Governments, and the Scientific and Academic Communities

A. To increase knowledge about alcohol in all its aspects, the academic and scientific communities should be free to work together with the beverage alcohol industry, governments, and nongovernmental organizations.

B. The beverage alcohol industry, governments, and nongovernmental organizations should support independent scientific research which

contributes to a better understanding of the use, misuse, effects, and properties of alcohol and the relationships among alcohol, health, and society.

C. The academic and scientific communities should adhere to the highest professional, scientific, and ethical standards in conducting and reporting on alcohol research, whatever the source of funding for such research.

D. All those concerned in a research undertaking, including funders, should avoid arrangements that might compromise the intellectual integrity and freedom of inquiry fundamental to scientific research and academic institutions.

1. When seeking support, scientific researchers should disclose any personal, economic, or financial interest that might directly and significantly affect the design, conduct, analysis, interpretation, or reporting of any research project.
2. Scientific researchers should acknowledge the source(s) of funding of their research activities in any report of such research.

E. Researchers should be free to disseminate and publish the results of their work. In order to protect proprietary information or trade secrets that do not have public health implications, dissemination and publication may be subjected to reasonable and ethical restrictions agreed in advance.

Annex 4

PARTNERS IN HEALTH

Table 1 lists the Division's Partners in Health through 1996. Further details regarding specific funding to each activity can be obtained in the Division's Financial Report. We should like to thank our contributors for their continuous support and in-kind donations which have greatly assisted our work, and as a result achievements over the past year.

DONORS	ACTIVITIES
AGFUND (Arab Gulf Programme for UN Development Organizations)	Trypanosomiasis
Agrevo Environmental Health Ltd, UK	WHOPES
Al Ahlia Insurance Company, Kuwait	Dracunculiasis & CTD Activities
Arab Fund for Social and Economic Development	CTD Activities
Australia	Dengue
Babolna Bioenvironmental Control Centre Ltd., Hungary	WHOPES
Bader Al Mulla and Brothers Co., Kuwait	CTD Activities
Bank of Kuwait and the Middle East K.S.C., Kuwait	Leishmaniasis & CTD Activities
Bayer AG, Germany	WHOPES and Training
Behbehani, Aster & Salman, Kuwait	Leishmaniasis
Behbehani, Mohammed Saleh & Reza Yousef, Kuwait	CTD Activities
Belgium	Malaria/CTD Activities/ Trypanosomiasis
Brunei Darussalam	Malaria
Chamber of Commerce and Industry, Kuwait	Leishmaniasis
Cheminova Agro A/S, Denmark	WHOPES
Ciba Geigy AG, Switzerland	Schistosomiasis
Cyanamid International Corporation Ltd., USA.	WHOPES
Danish Bilharziasis Laboratory, Denmark	Training
Denmark	Onchocerciacis
Dow Elanco Ltd, UK	WHOPES
FMC Corporation USA	WHOPES
France	Leishmaniaisis/Trypanosomiasis
Francome Fabrications Ltd., UK	WHOPES

Garton G.A.H., Australia	Malaria
German Pharma Health Fund EV, Germany	Intestinal Parasitic Infection Schistosomiasis/Opisthorchiasis
Germany	Schistosomiasis control
Global 2000 Inc. of The Carter Center, USA	Dracunculiasis
Health and Development International, USA	CTD Activities
Hoechst Shering AgrEvo SA, France	Leishmaniasis
Igeba Geraelebau GMBH, Germany	WHOPES
International Development Association, USA	Malaria
Islamic Organization for Medical Sciences, Kuwait	Dracunculiasis
Italy	Training/Int. Parasites/ Schistosomiasis/Malaria
Japan Pharmaceutical Manufacturers Association	Malaria
Japan	Malaria/Dracunculiasis
Kuwait	Malaria/Schistosomiasis
Kuwait Fund for Arab Economic Development	CTD Activities
Mitsui Toatsu Chemicals Inc., Japan	WHOPES
Dr Nasser Mohamed Nasser Al Sayer	CTD Activities
Netherlands	Malaria/Trypanosomiasis/Vector borne diseases
Organization of Petroleum Exporting Countries (OPEC)	Dracunculiasis
Rhone Poulenc Agrochimie SA, France	WHOPES
Sandouq Zakat-Bait Al Tamweel, Kuwait	CTD Activities
Smithkline Beecham Pharmaceuticals, UK	Training
Spain	Malaria
Sumitomo Chemical Co. Ltd., Japan	WHOPES
Sweden	Malaria
Takeda Chemical Industries, Ltd., Japan	WHOPES
UNICEF	HealthMap
UNDP	Schistosomiasis/Intestinal Parasites
United Kingdom of Great Britain & Northern Ireland	Malaria/Dracunculiasis
United States of America	Malaria
Zeneca Agrochemicals, UK	WHOPES

FAO contact

JANUARY 1997

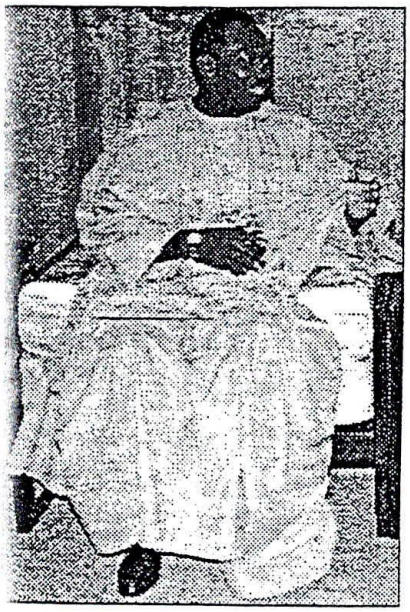
Inside

From the Director-General

FAO's new policy on the private sector

The private sector will provide a large percentage of the investment, new technology and farming and management systems needed to achieve global food security in the 21st century. FAO has therefore initiated a new policy to expand and intensify cooperation with the private sector at national, regional and international levels.

One of my early decisions at FAO was to establish a new Unit for Cooperation with the Private Sector and NGOs (TCDN). The unit provides a focal point for policy relations with the private sector, and a vehicle for promoting and coordinating FAO's overall cooperation with all sectors of civil society.



Director-General Jacques Diouf

A consultative process with key private sector organizations is now under way to help develop strategies and operating guidelines for cooperation in the follow up to the World Food Summit. In fact, I have already met with private sector groups and have made statements to meetings of the International Federation of Agriculture Producers (IFAP) and the International Fertilizer Industry Association (IFA).

An additional US$19 billion in agriculture-related investment per year will be needed from the private sector if food security needs are to be met. This is in addition to US$5 billion from government sources and US$7 billion from official development finance.

Private investment should be drawn primarily from domestic savings at the household level but other national and external private investment sources will be an essential complement. The private sector should also play a leading role in developing and transferring new technologies, systems and skills required to realise food security goals.

I am hopeful that the private sector will take a particular interest in the Special Programme for Food Security, already established in 16 countries with a pilot phase that will test and develop economically viable food production systems. Funds permitting, we intend to extend it progressively to all the 82 low-income food-deficit countries.

The fertilizer, pesticide and agro chemical industries could make a substantial contribution to the Programme, especially in the framework of Integrated Pest Management and Integrated Plant Nutrient systems. In addition, processing and storage technologies need private sector help.

FAO Contact
is published monthly by the Information Division (GII).

The opening section, "From the Director-General", is published in English, French, Spanish and Arabic. The English version is distributed at FAO headquarters but staff may obtain other versions at their registries. Articles in other sections are published in the language in which they are submitted.

Comments, questions, suggestions of topics for future articles and contributions of information are welcome.

Direct them to FAO Contact
E-mail: gii-registry@fao.org
fax: +39-6-5225-3152
mail: GII, Room C124, FAO, Viale delle Terme di Caracalla, 00100 Rome.

FAO data and information are available on Internet at (gopher://gopher.fao.org) and (http://www.fao.org).

I am encouraging governments to involve their national private sectors – including farming, processing, marketing and trading – in Special Programme initiatives. In Kenya, for example, private enterprises are assuming responsibility for seed supply and produce marketing in the pilot phase.

The farmer himself will be the most important source of investment, but the local private sector will also be encouraged to invest in providing agricultural inputs and marketing services. Large national and regional investments in input production and processing will hopefully also be feasible.

FAO is helping member countries create the policy, institutional, legal and investment framework to support the emergence and growth of an effective private sector.

Investment Centre reaches out to new partners

FAO's Investment Centre develops projects for the World Bank and regional banks and will now extend its cooperation to sub-regional and national banks and other private investment institutions.

With the support of FAO technical divisions, the Investment Centre is expanding its private-sector-related activities. For example, in Central and Eastern Europe, the Centre is helping develop wholesale market companies and farmers' marketing networks to replace the former state-operated systems. In another new approach, the Centre is exploring the feasibility of an agribusiness venture capital fund and project development facility in Uttar Pradesh, India.

Other FAO units are carrying out training programmes, developing and distributing software programs for micro-credit organisations and agri-markets with the aim of improving the collection and dissemination of agricultural trade data.

FAO plans to tackle boldly the food and agriculture problems of the 21st century. With the continuing decline in official development assistance for agriculture, we must expand and strengthen the Organization's role as an honest broker for mobilising managerial, technological, scientific, financial and other resources through new alliances with private industry, NGOs, foundations and other key non-governmental actors.

Thanks to the Organization's reputation as "a centre of excellence", its credibility with governments and its ability to help attract complementary partners and resources for such initiatives, I believe that FAO has a comparative advantage for such an honest-broker role.

Private sector was a major contributor to the World Food Summit

The World Food Summit provides a good example of the valuable contributions that can come from sources other than traditional donors. While government contributions were extremely important, donations from other partners such as private companies and their associations, NGOs and foundations were also impressive. A total of 73 companies contributed in cash and kind to the Summit. One national FAO association acted as a conduit for contributions from a further 200 companies.