"BACK TO THE FUTURE" - A PERSPECTIVE ON ENVIRONMENTAL CHANGE, ENVIRONMENTAL HEALTH AND CREATING SUPPORTIVE ENVIRONMENTS FOR HEALTH

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1.0 Introduction

The Earth's physical environment has undergone considerable change in recent decades. Some of these changes have seemingly occurred outside the control of humankind, while others are directly attributable to human activity. Many of these changes negatively impact health and well-being. They range from changes in global climate that affect the nature and extent of the incidence of vector borne diseases to increased urbanization and associated slums that nurture the spread of emerging and re-emerging diseases; from, what is at least perceived to be, an increase in the incidence of natural disasters to unplanned growth and development that are depleting natural resources at an alarming rate.[1] While the causes of these changes are widely debated, finding sustainable solutions to the related public health problems is proving elusive and challenging.

Narrow attempts to "quick fix" these problems abound, with the focus often being on providing short-term relief that gives the appearance of solution but fails the long-term test of sustainability. Environmental health-related intellectual frameworks that support broader-based approaches directed at the forces that drive these changes have been developed, widely discussed and endorsed by stakeholders (e.g., the WHO Driving Forces-Pressures-State-Exposure-Effects-Action {DPSEEA} model). The successful application of such frameworks in real-life, real-time settings to solve priority problems, however, has been, itself, problematic. While this can be attributed to many factors, two of the most important, particularly in low-income countries, are: 1) the failure of decision makers to implement, in practice, the "integrated" and "inter-sector" approaches suggested by the frameworks, despite much talk about them; and, 2) the reluctance of key stakeholders to take on the inherent issues of governance that are critical to bringing about meaningful and sustainable change.

Health promotion interventions are essential components of efforts to overcome these failures, especially in relation to advocacy and the development of health leaders. Also, partnerships between environmental health, health promotion, and their relevant constituencies are critical to effectively meeting the complex public health challenges posed by environmental change. These partnerships need to be exercised within frameworks that integrate the range of ecological, social, economic and human determinants that shape the health of people.[2,3]

2.0 The challenges posed by environmental change

Some of the changes to the Earth's environment seemingly occur outside the control of humankind, while many others are directly attributable to human activity. Dramatic environmental events in 2004 provide a vivid illustration. Heavy monsoons in Bangladesh, India and Nepal caused massive flooding; China suffered its worst drought in 50 years; a record 10 typhoons hit Japan; and, most dramatically, an earthquake-generated tsunami off the coast of Indonesia killed more than 200,000 people and caused billions of dollars in damage across Indonesia, Malaysia, Sri Lanka, Thailand and other Asian countries. Poorly planned development exacerbated the death and destruction associated with many of these events; vulnerable populations (e.g., the aged, the very young and the poor) were the most heavily impacted; and, in the case of the

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[1] Reid WV, et al. *Millennium Ecosystem Assessment Synthesis Report.* Pre-publication Final Draft Approved by MA Board on March 23, 2005. www.millenniumassessment.org , downloaded 2 May 2005.

[2] Hancock T. People, partnerships and human progress: building community capital. *Health Promotion International.* September 2001, 16, 3.

[3] Galea S, Freudenberg N, Vlahov D. Cities and population health. *Social Science & Medicine.* 2005, 60: 1017-1033.

tsunami, available technological innovation that could have provided early warning was not operating where it was needed.[4]

October 04, 2004

"Ramping Up CNG for Transportation in India

...Air quality in Delhi has improved significantly since a Supreme Court order mandating its bus fleets to convert to run on cleaner-burning compressed natural gas (CNG) came into effect in 2002. More cities are expected to follow Delhi in adopting natural gas as a vehicle fuel." [http://www.greencarcongress.com/2004/10/cummins_westpor.html, accessed 18 June 2005]

"Bhopal gas tragedy lives on, 20 years later

Evidence of contaminated water in Indian city mounts.

By Scott Baldauf | *Staff writer of The Christian Science Monitor*

BHOPAL, INDIA – Nearly 20 years after an accident at a Union Carbide chemical plant killed thousands here, there are signs that a second tragedy is in the making. New environmental studies indicate that tons of toxic material dumped at the old plant have now seeped into the groundwater, affecting a new generation of Bhopal citizens." [*Christian Science Monitor*, May 4, 2004]

Sometimes we seem to make progress; sometimes our past catches up with us.

The recent Millennium Ecosystem Assessment Synthesis Report[5] clearly documents that over the past 50 years "humans have changed...[the Earth's ecosystems]...more rapidly and extensively than in any comparable period of time in human history." It indicates that poor ecosystem management is already causing significant harm to some people, and highlights three major problems:

1. Approximately 60% of the ecosystem services examined during the Assessment are being used unsustainably;
2. Changes being made in ecosystems are increasing the likelihood of nonlinear changes; and,
3. "The harmful effect of the degradation of ecosystem services[6]... are being borne disproportionately by the poor."

It is further noted that there are no simple fixes to these problems; that they pose significant barriers to the achievement of the Millennium Development Goals; and, that effective responses require "changes in institutions and governance, economic policies and incentives, social and behavior factors, technology and knowledge."

The public health challenge associated with environmental change and the degradation of ecosystems is complex; resources are scarce; and people are often overwhelmed. There continues to be a critical need to address the dynamics of these changes with integrated

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[4] *WHO Centre for Health Development Annual Report 2004.* Kobe, Japan, WHO Centre for Health Development, 2005.

[5] Reid WV, et al. *Millennium Ecosystem Assessment Synthesis Report* Pre-publication Final Draft Approved by MA Board on March 23, 2005. www.millenniumassessment.org , downloaded 2 May 2005.

[6] **The Report characterizes "ecosystem services" as "the benefits people obtain from ecosystems," noting that "changes in these services affect human well-being through impacts on security, the basic material for a good life, health, and social and cultural relations."**

approaches that encompass the related components of socio-economic development, the environment, demographic change and health. This is particularly true in relation to climate change and increasing urbanization.

Climate change

> "...today the world population is encountering unfamiliar human-induced changes in the lower and middle atmospheres and world-wide depletion of various natural systems (e.g., soil fertility, aquifers, ocean fisheries, and biodiversity in general). Beyond the early recognition that such changes would affect economic activities, infrastructure and managed ecosystems, there is now recognition that global climate change poses risks to human population health." [*Climate Change and Human Health – Risks and Responses - SUMMARY*. WHO,WMO and UNEP. World Health Organization, 2003]

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The health-effects issues associated with climate change and variability are summarized in Table 1. The relative importance of these issues to human health and well-being, particularly in low- and medium-income countries has been the subject of intense discussion and debate for some time now.

A series of 1993 articles published in *The Lancet* highlighted the increasing awareness that climate change is a significant public health issue. Among other things, these articles discussed climate change and health from the perspectives of the changing character of emerging and re-emerging diseases in a warmer world; decreasing biodiversity; stratospheric ozone depletion; marine ecosystems; and food supply. Particular attention was also given to impacts on cities and critical regions of the world. In looking to the future, one of the articles (Haines A, Epstein P, and McMichael J) concluded:

- "A global health monitoring network is essential not only to determine the impact of climate change but also to shape strategies to prevent climate change as far as possible and mitigate those effects which do occur."[7]

The 1995 report on the State of the Environment in Asia and the Pacific also visited the subject of climate change and pointed to adverse impact of human-related activities such as rapid industrial expansion, increasing energy consumption and deforestation on the atmosphere. In the chapter on Human Health, the report concludes that while a number of countries have developed environmental health policies:

- "...primary emphasis has always been on curative, rather than preventive measures. This is usually because the majority of sectoral ministries, which could implement these preventive measures, are not effectively involved in policy and programe development. Furthermore, health system research is geared more to epidemiology rather than to procedural initiatives within communities and multi-sectoral research."[8]

[7] Health and Climate Change – a *Lancet* series reprint. *The Lancet Ltd*, Devonshire Press, 1994.
[8] *1995 State of the Environment in Asia and the Pacific*. Economic and Social Commission for Asia and the Pacific, and the Asian Development Bank. New York, the United Nations, 1996.

Table 1: Global Health Effects from Climate Change and Variability[9]

Health and well-being issues	Examples of health issues
Temperature-related morbidity and mortality	Cold and heat-related illnesses, mental health; respiratory and cardiovascular stress, and occupational health stress.
Health effects of extreme weather events	Mental health; preparedness and population displacement; damaged public health infrastructure; and occupational health hazards.
Air pollution-related health effects	Respiratory diseases; cardiovascular diseases; cancer; asthma and allergens; changed exposure to indoor air pollutants.
Water- and food-borne contamination	Enteric diseases and contaminants; food safety and security.
Vector-borne infectious diseases	Changed patterns for vectors, pathogens and transmission rates.
Population vulnerabilities in cities and communities	Rural and urban health; seniors, children, homeless and low income, traditional cultures, disabled, and immigrant populations.
Health and socio-economic effects	Changed determinants of environmental health and well-being, global burden of disease; health and social co-benefits; health risks of greenhouse gases mitigation technology and policy.
Health effects of stratospheric ozone depletion	Cancer; cataracts; immune suppression.

In a 2002 meeting on "Climate Change and Health," the World Health Organization (WHO) noted its growing concern regarding climate change and human health issues because of, among other things:

- "...their potentially serious health consequences, their disproportionate expected impact on poor countries and their disproportionate impact on the poor and vulnerable groups in general. Climate change may, therefore, contribute to an increase in health inequalities within and between countries."[10]

In charting a course for developing responses to climate change, WHO, the World Meteorological Organization and the United Nations Environment Programme have particularly noted the importance of "policy-focused assessment" and "communicating assessment results" to raise public awareness.[11]

Urbanization

> "A radical process of change is underway in large urban conglomerations. This process is unregulated and places extreme strains on health, natural resources and social equilibrium. It is a process that requires a new way of thinking about the health and welfare system, and how to respond more effectively to the growing pressures of a rapidly expanding urban population." [*Report of the Driving Force Sub-Group on Urbanization and Health.* Kobe, Japan, WHO Centre for Health Development, 2004.]

[9] *Meeting Report – Planning Meeting for Ministries of Health to Address Climate Change and Health* Geneva, Switzerland, World Health Organization, 2002.
[10] *Meeting Report – Planning Meeting for Ministries of Health to Address Climate Change and Health.* Geneva, Switzerland, World Health Organization, 2002
[11] *Climate Change and Human Health – Risks and Responses - SUMMARY* WHO,WMO and UNEP. World Health Organization, 2003

The participants in the Driving Force Sub-Group on Urbanization and Health referred to in the box above coined the term "new urban setting" to describe the complex processes, the relationships and the geography that encompass the radical process of change that is underway in large urban conglomerations. The Sub-Group also introduced the notion of "glocalization" to reflect the merging of traditional global and local perspectives on urbanization and health, and to recognize the central role that urban municipalities play as key drivers of modernization and social change. In this context, cities were seen as "fundamental local platforms for finding equitable and efficient solutions to a range of global problems, including those related to health."[12] From the perspectives of environmental health and health promotion, the critical impacts of urbanization on health have been recognized for some time.

One of WHO's main inputs to HABITAT II was the background document, *Creating Healthy Cities in the 21st Century.*[13] This document presented the Organization's 1996 perspective on urbanization and health in the coming century in the context of five themes, highlighting, among other things, the following:

- **Building healthy cities –** Highlighting the fact that people's health can be as much the result of conditions where they work, go to school, live and play as the quality of health care available to them.
- **Emerging and re-emerging diseases –** Understanding that these diseases are "one component of a complex and changing global ecology which is shaped ... by economic, social, environmental, demographic and technological changes...."
- **Environmental health –** Emphasizing that inadequate provision for water and sanitation is "arguably the single most serious environmental problem in cities in terms of its health impact."
- **Child health –** Noting that the potential for implementing relatively low-cost measures to make cities safe for children is high.
- **Women's health –** Recognizing the disadvantages for health faced by women in most urban centers – the hazards of bearing and giving birth to children in the absence of "a healthy, secure home and good quality health services;" discrimination in education, labor markets and resource allocations; and, violence.

More recent assessments of the urban condition continue to reinforce the critical nature of these issues, depicting a rapidly deteriorating situation, especially for the urban poor.[14] New perspectives are needed on dealing with these issues in the context of "new urban settings." With respect to environmental issues, Hardoy, Mitlin and Satterthwaite[15] note that: "most environmental problems have underlying economic and political causes," and reflect a failure of government to plan effectively, control pollution and promote environmental health. In looking to the future, they suggest: "It is remedying these failures of government within cities and city districts and addressing the reasons that underlie them that should be central to any new urban environmental agenda."

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[12] *Health in Development – Healthier People in Healthier Environments. A Proposed Research Framework for the WHO Centre for Health Development.* Kobe, Japan, WHO Centre for Health Development, 2004.
[13] *Creating Healthy Cities in the 21st Century.* Geneva, World Health Organization, 1996.
[14] *A Home in the City.* The UN Millennium Development Project Task Force on Improving the Lives of Slum Dwellers. London, Earthscan, 2005.
[15] Hardoy J, Mitlin D, Satterthwaite D. *Environmental Problems in an Urbanizing World. Finding Solutions for Cities in Africa, Asia and Latin America.* London, Earthscan Publications Ltd., 2001.

Thus, one of the major tasks for the future is to undertake truly holistic, integrated approaches to complex problem-solving that address critical issues of governance. This is a task that has always been easier to 'say' than 'be.' [16]

3.0 The environmental health – health promotion alliance

Environmental health-related frameworks that support broad-based approaches directed at the forces that drive environmental changes have been developed, widely discussed and endorsed by stakeholders. For example, the WHO Driving Forces-Pressures-State-Exposure-Effects-Action {DPSEEA} model is one such framework. It provides a unifying framework for describing the potential causal pathways and preventive or remedial actions for improving health. As designed in the 1990s, the model depicts how driving forces impose different kinds of pressure on the environment. These pressures can lead to changes in the state of the environment, potentially leading to exposures among humans that can result in a variety of health effects. Actions are possible at any point in the chain to prevent or treat adverse health effects.

Although the DPSEEA model was designed for use in the analysis of environmental health indicators, its general structure makes it possible to apply it to a variety of health problems and the socio-economic or behavioral determinants that lie behind them. Within this broader construct, driving forces create pressures in society that alter the state of health in development and lead to changes in exposures and health outcomes. The basic DPSEEA framework can also be used as a guide in developing and classifying public health interventions (Figure 1). It provides common conceptual ground for public health action among programmes such as environmental health and health promotion.

Effectively applying such frameworks in practice, however, has been problematic. Two of the most important factors in this regard are: 1) the failure to actually implement approaches that are truly "integrated" and "inter-sector," despite much talk to the contrary; and, 2) the reluctance of stakeholders to tackle the issues of governance that are critical to bringing about meaningful change and success. For example, environmental health practitioners, as stakeholders, often retreat to the comfort of "we only provide technical solutions" in the face of these challenges when a strategic alliance with health promotion stakeholders could offer a more hopeful response.

Health promotion practitioners need only look at the Ottawa Charter to find clear links to the task of dealing with these factors in the context of "environmental change," including recognition of the importance of: 1) building healthy public policy; 2) creating supportive environments for health; 3) strengthening community action; and, 4) developing personal skills.[17] These are natural bridges between health promotion, environmental health and the many other public and private sector stakeholders who need to contribute to resolving environment-related public health issues, as well as broader development-based issues such as the Millennium Development Goals. If used effectively, they can support partnerships that develop creative and holistic approaches to solving complex public health problems that could benefit from environmental health and health promotion interventions. A good example of this is found in the experience of WHO and its partners with "healthy settings" approaches.

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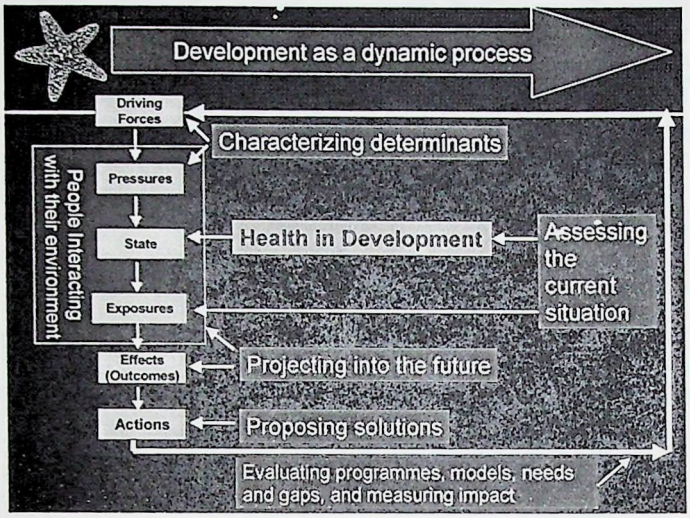
[16] Takano T, Ed. *Healthy Cities & Urban Policy Research*. London and New York, Spon Press, 2003.
[17] *Ottawa Charter for Health Promotion*. First International Conference on Health Promotion, Ottawa, CAN, 21 November 1986. WHO/HPR/HEP/95.1.

Figure 1: A modified DPSEEA framework for public health action[18]



"Healthy Cities" emerged in WHO in the 1980s as a response to deteriorating health conditions in urban settings. Based on the principles of Health-for-All adopted at Alma Ata[19] and embodied in the Ottawa Charter,[20] it was characterized as a new public health movement.[21] Healthy Cities' projects are intended to reflect holistic approaches to problem solving; emphasize the importance of inter-sector collaboration; engage political leaders and decision-makers; encourage and facilitate community participation; and, create supportive environments for health.[22]

"Healthy Cities" has flourished in Europe, met with significant success throughout Asia, as well as in the Pacific (where it was re-invented as "Healthy Islands" in the 1990's), and has been applied with region-specific success in the Americas and elsewhere. It is an integrating mechanism that has significant potential for effectively addressing health governance-related issues. On a smaller and more focused scale, the approach and attendant health-promoting principles have been successfully applied in other "settings" such as villages, schools, workplaces, marketplaces, and hospitals.

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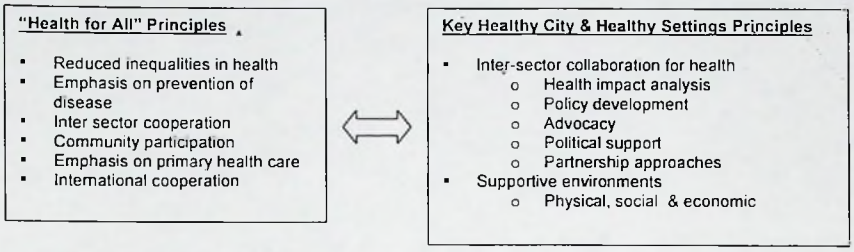
[18] *Health in Development – Healthier People in Healthier Environments. A Proposed Research Framework for the WHO Centre for Health Development.* Kobe, Japan, WHO Centre for Health Development, 2004.
[19] World Health Organization. *Managerial Process for National Health Development – Guiding Principles.* Geneva, World Health Organization, 1981.
[20] *Ottawa Charter for Health Promotion.* First International Conference on Health Promotion, Ottawa, CAN, 21 November 1986. WHO/HPR/HEP/95.1.
[21] Kickbusch I. Healthy Cities: a working project and a growing movement. *Health Promotion*, 4: 77-82.
[22] World Health Organization. *Building a Healthy City: A Practitioners' Guide.* [WHO/EOS/95.10], and *WHO Healthy Cities: A Programme Framework.* [WHO/EOS/95.11] Geneva, World Health Organization, 1995.



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4.0 Effective partnership approaches

What is a partnership anyway?

Since partnerships are considered important in public health problem solving, we would do well to better understand the nature of partnerships. In recent years, there has been a significant increase in the numbers and diversity of public-private partnerships (PPPs) in public health.[23] This is reflected in actions such as the World Bank encouraging partnerships as part of its comprehensive development framework;[24] the World Health Organization (WHO) promoting partnerships;[25] and, non-governmental organizations (NGOs) establishing relationships with for-profit organizations. Included among the reasons for this are the increasing influence of NGOs on public health concerns; and, the inability of public or private organizations to resolve complex public health problems on their own.[26]

There is a general lack of consistency and consensus in terminology used to describe PPPs. A variety of terms are used to describe the spectrum of such partnerships involving both not-for-profit and for-profit stakeholders. Terms such as partnerships, collaborations, collectives, alliances, and joint ventures are all used and interchanged.[27] The United Nations Development Programme (UNDP) has described PPPs very broadly as "a spectrum of possible relationships between public and private actors for the cooperative provision of infrastructure services."[28]

What are the ingredients that make a partnership effective?

Collaboration is a critical element in PPPs. The degree to which it is effectively achieved determines to a great extent whether the partnership works or fails. In examining the challenges of collaboration between non-profit organizations and businesses, J. Austin[29] enumerates "seven

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[23] Roussos ST, Fawcett SB. A Review of Collaborative Partnerships as a Strategy for Improving Community Health. *Annual Review of Public Health*. 2000. 21:369-402, ProQuest Medical Library.

[24] World Bank, Africa Regional Office. Project Appraisal Document on a Proposed Development Credit ... to the Republic of Ghana for a Health Sector Program Support Project II. Report No.: 24842-GH, January 2003.

[25] Lucas AO. Public-Private Partnerships: Illustrative Examples. Massachusetts, Harvard University, Workshop on Public-Private Partnerships in Public Health, April, 2000.

[26] Nishtar S. Public-private partnerships in health – a global call to action. PubMed Central, published online July 2004 (http://www.pubmedcentral.nih.gov).

[27] Linder S. Coming to terms with the public-private partnership: a grammar of multiple meanings. In: Rosenau PV, ed. *Public-Private Policy Partnerships*. Cambridge, Massachusetts, MIT Press, 2000: 19-35.

[28] http://undp.org/pppue/images/graphics-what1.gif

[29] Austin J. *The Collaboration Challenge. How Nonprofits and Businesses Succeed Through Strategic Alliances*. Jossey-Bass, 2000; and, an associated Workbook – Tools of Collaboration, 2002.

C's" of effective collaboration that also mirror the characteristics of successful Public-Private Partnerships (PPPs)

1. Connection with Purpose and People
2. Clarity of Purpose
3. Congruency of Mission, Strategy and Values
4. Creation of Value
5. Communication Between Partners
6. Continual Learning
7. Commitment to Partnership

In discussing some of the factors that determine the rate at which collaborative partnerships affect community and system change, S.T. Roussos and S.B. Fawcett[30] note the importance of similar characteristics:

- Having a clear vision and mission;
- Action planning for community and systems change;
- Developing and supporting leadership;
- Documentation and ongoing feedback on progress;
- Technical assistance and support,
- Securing financial resources for the work; and,
- Making outcomes matter.

Such characteristics are also reflected in the views of PPP practitioners regarding the key factors that cause PPPs to succeed or fail. A recent report to the WHO Centre for Health Development, Kobe, Japan, highlights the importance of the following:[31]

- *Building relationships*
- *Agreeing on goals and objectives*
- *Being sensitive to the local context and environment*
- *Identifying "Champions"*
- *Promoting good governance and transparency*
- *Supporting the strengthening of national and local systems and priorities*

How can effective partnerships be developed?

The key question in establishing a partnership is: "Why are we doing it?" The answer to this question is essential for establishing an effective relationship, and a participatory approach that involves all key stakeholders is essential in coming up with the answer. While there are many ways to go about this, Z. O'Leary has developed a stepwise approach[32] that is reflected in a recently suggested "10-Step Protocol Framework" for developing PPP evaluation protocols.[33] The "10-Steps" noted in the Framework" (see Box 1 below) can also be adapted to the process of building partnerships. The Framework and the associated Steps recognize that a "one-size-fits-all" approach will not work and offers a progressive, consultative, participatory process for developing settings- and problem-specific relationships that engages key stakeholders and decision makers and responds to their needs and interests.

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[30] Roussos ST, Fawcett SB. A Review of Collaborative Partnerships as a Strategy for Improving Community Health. *Annual Review of Public Health*. 2000. 21:369-402, ProQuest Medical Library.
[31] Tamplin S, O'Leary Z. *Report on Refining and Testing a Research Protocol for Evaluating the Effectiveness of Private-Public Partnerships in Enhancing Health and Welfare Systems Development.* Kobe, Japan, WHO Centre for Health Development, 2005.
[32] O'Leary Z. *Researching Real-World Problems: A Guide to Methods of Inquiry.* London, Sage, 2005.
[33] Tamplin S, O'Leary Z. *Report on Refining and Testing a Research Protocol for Evaluating the Effectiveness of Private-Public Partnerships in Enhancing Health and Welfare Systems Development.* Kobe, Japan, WHO Centre for Health Development, 2005.

In taking the "10 Steps" and exercising the resulting partnership, Tamplin and O'Leary note that a number of guiding principles are important:[34]

- Building relationships and trust are most important – this takes time.
- A co-learning approach with an "in partnership with" mentality is preferable.
- The process needs to be participatory and inclusive.
- A concerted effort needs to be made to embed capacity building in the process.
- Integrity and transparency are critical to success.
- Clarity of purpose is crucial – everyone needs to be on the same page.

Box 1: Ten steps to building effective partnerships

1. Gain support for the partnership from key stakeholders
2. Come to an agreement on purpose
3. Negotiate an appropriate operational team
4. Agree on evaluation priorities
5. Negotiate and operationalize indicators of success
6. Design methods
7. Collect and analyze data
8. Draw conclusions
9. Produce 'deliverables'
10. Disseminate and facilitate result utilization

How might we best use partnership approaches to solve real-life, real-time problems?

There is a wide range of examples of proven partnership approaches that attest to the soundness of the characteristics, principles and steps noted above. Among many others, these include initiatives related to:

National policy and programme development, such as -

In Fiji, the adoption of a National Environmental Health Action Plan (NEHAP) in Fiji 1998 [see Box 2] might, on the surface, seem like a rather straightforward event. In reality, it was far from that, representing the culmination of 15 years of partnership effort involving the Government of Fiji, the Fiji School of Medicine, the World Health Organization, several external support organizations and, most importantly, local communities. Along the way, Fiji's environmental health service was professionalized and a sustainable relationship was developed between health promotion and environmental health practitioners. In the final analysis, the development of the NEHAP was effectively driven from the bottom up with the full participation of all relevant stakeholders.

[34] Tamplin S. O'Leary Z. *Report on Refining and Testing a Research Protocol for Evaluating the Effectiveness of Private-Public Partnerships in Enhancing Health and Welfare Systems Development.* Kobe, Japan. WHO Centre for Health Development. 2005.

Box 2: Shaping Fiji's Healthy Islands

"In...1998, Fiji produced it first National Environmental Health Action Plan (NEHAP). This document began by setting out frameworks for Environmental Health and Healthy Islands. It did four things:

- Aligned Fiji's Environmental Health programme with Agenda 21;
- Gave shape to the Healthy Islands vision of the Yanuca Island Declaration;
- Acknowledged the Jakarta Declaration on Health Promotion; and
- Reinforced the Raratonga Agreement on Healthy Islands.

The document provided a blueprint for reshaping the old reactive Health Inspectorate, as a much more pro-active and collaborative Environmental Health Service. It also paved the way for a productive partnership with the emerging National Centre for Health Promotion." [*Shaping Fiji's Healthy Islands – Strategies for transforming national policy into local practice.* Fiji, Ministry of Health, 2001.]

In the United States, the struggle for smoke-free passenger airplanes began in the United States in the 1970s. It was only in 1990 that a ban on smoking on all passenger airplanes took effect. The success of this long campaign is attributed to the partnership of organized labor (the flight attendants and their unions) with health advocacy groups and key members of the United States Congress around a single-focus issue. The dynamics of the partnership went well beyond the obvious concern over the health impacts of secondhand tobacco smoke.

Population-specific issues, such as -

In Asia and the Pacific, hospitals are traditionally viewed as the cornerstone of the system that provides health care services to the community. However, in practice, services are focused more on providing technical solutions to the curative aspects of ill health. Less effort and time are spent on preventive interventions, health promotion and health protection. At San Lazaro Hospital in Manila (the Philippines' major infectious disease hospital) the establishment of an Extended Child Care Centre, in 2001, is an innovative programme that responds to this need. Children (together with parents and caregivers) receive on-going support, nurture, protection and or stimulation while they are in the hospital environment.

This initiative is making a significant contribution to the development of a national extended childcare policy in the Philippines, and providing new knowledge about the development of public-private partnerships to combat poverty and support children's health and wellbeing. This initiative is partnership venture among San Lazaro Hospital, the Philippine Department of Health, the World Health Organization and a not-for-profit non-governmental organization, Precious Jewels Ministry (PJM). The lessons learned in this on-going initiative will be relevant to enhancing child health and related policies and programmes in other settings and countries. A significant factor in making this initiative successful has been the 15-year relationship building work undertaken by PJM in the communities served by San Lazaro Hospital, as well as in the hospital itself.[35]

[35] Ireland J, Tamplin S. Case Study Report on the First Year of Operation of the San Lazaro Hospital Extended Child Care Centre. University of Western Sydney, Hawkesbury, The Centre of Environmental Health Development, a WHO Collaborating Centre for Environmental Health, 2003.

Settings-based approaches,[36] such as –

- The WHO "Healthy Cities" movement [including "Healthy Islands" in the Western Pacific Region, "Healthy Municipalities and Communities in the Region of the Americas, etc.), and the related "Healthy Settings" approaches;
- The Local Agenda 21 initiative of the United Nations Division for Sustainable Development and its partners;
- The Sustainable Cities Programme of UN-HABITAT; and,
- Cities Alliance launched by the World Bank and the United Nations Centre for Human Settlements.

5.0 "Back to the Future"

In looking to the future, how might "health promotion" and "environmental health" build on these types of successful partnership experiences to effectively address emerging issues of environmental change? Or, from Asian perspective, how might we honor the past while meeting the challenges of the future?

A challenging opportunity provides a context

In March 2005, in Santiago, Chile, the World Health Organization launched its Commission on Social Determinants of Health (CSDH). This Commission will "work to recommend the best ways to address health's social determinants and safeguard the health of poor and marginalized populations, and to break the 'poverty equals ill-health' cycle."[37] Among the ways in which the work of Commission will be supported is through the use of several "knowledge networks"[38] of leading scientists and practitioners to assemble evidence to underpin actions on social determinants of health. In the words of Dr. J.W. Lee, Director-General, WHO:

> "The goal is not an academic exercise, but to marshal scientific evidence as a lever for policy change – aiming toward practical uptake among policymakers and stakeholders in countries."[39]

One of the Knowledge Networks is being organized around the theme of "urban settings." The "Hub" that has been selected to manage the work of this Network is the WHO Centre for Health Development, located in Kobe, Japan. The Scope of Work for the Urban Settings Knowledge Network suggests an interesting conceptual framework for considering health and well being, identifying "health governance" as the critical causal pathway. This identification of governance as a critical factor in determining health outcomes and the need to focus on it in achieving sustainable improvements in health and well being is well-documented [for example, S Burris (2004);[40] E Sclar, et al (2005);[41] S Galea, et al (2005);[42] I Kickbusch (2002);[43] and the

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[36] **Referring to areas such as cities, islands, communities, villages, neighborhoods, schools, hospitals, workplaces, markets, etc.**

[37] News Release WHO/13, 18 March 2005.

[38] **These Knowledge Networks will be organized around the themes of social exclusion, urban settings, employment conditions, early child development, priority public health conditions, health systems, globalization and measurement.**

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Millennium Project Task Force on Improving the Lives of Slum Dwellers (2005)[44]]. However, this Knowledge Network effort to focus on analyzing what's working on the ground in relation to health governance and to look for creative ways of "scaling up" as a major public health initiative is unique.

A historical concept suggests a methodological focus

In a paper based on his participation at the Second Annual Belfast Healthy City Lecture (1999), Trevor Hancock introduces the notion of "community capital."[45] He characterizes health as "a form of wealth, a resource, an asset; in short, a form of capital." In developing the idea of community capital, Hancock speaks of total wealth as consisting of four forms of capital:

- *Human capital* - consisting of "healthy, well educated, skilled, innovative and creative people who are engaged in their communities and participate in governance;"
- *Natural capital* - comprised of "high environmental quality, healthy ecosystems, sustainable resources and the conservation of habitat, wildlife and biodiversity;"
- *Social capital* – constituting "the 'glue' that holds our communities together...[consisting of]...an informal aspect related to social networks and a more formal aspect related to our social development programs," and,
- *Economic capital* – constituting "the means by which we can attain many of our human and social goals."

Hancock offers the challenge: "What communities require is a new form of capitalism: one that will simultaneously increase all four forms of capital. This can be considered to be the creation of community capital." This idea of needing to simultaneously increase all four forms of capital resonates well with the findings of the *Millennium Ecosystem Assessment Synthesis Report*,[46] as well as with the experience of others involved in "Healthy Cities" and other similar approaches.[47]

Experience provides a mechanism for honoring the past in meeting the challenges of the future

A framework for responding to the challenges of environmental change would do well to incorporate the collaborative strengths of health promotion and environmental health. For the most part, this grows out of their experience in relation to "healthy settings," where the litany of integrated, inter-sector, participatory approaches to public health problem solving abounds. This experience is particularly relevant to the work envisioned for the CSDH Knowledge Network on Urban Settings. In this regard, the Scope of Work for the Network notes the following:

"...at present, a significant number of economic, social and political factors find their expression in two major trends of global restructuring: globalization and urbanization. These two major forces are intertwined which has led some analysts to speak of a 'global' phenomenon. Therefore, as urbanization and its impacts on health are analyzed, the related global dimension and its impact cannot be neglected."[48]

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[43] Kickbusch I. Influence and opportunity: Reflections on the US role in global public health. *Health Affairs*. Chevy Chase: Nov/Dec 2002. Vol. 21, Is. 6

[44] *A Home in the City*. The UN Millennium Development Project Task Force on Improving the Lives of Slum Dwellers. London, Earthscan, 2005.

[45] Hancock T. People, partnerships and human progress: building community capital. *Health Promotion International*. September 2001, 16, 3.

[46] Reid WV, et al. *Millennium Ecosystem Assessment Synthesis Report*. Pre-publication Final Draft Approved by MA Board on March 23, 2005. www.millenniumassessment.org , downloaded 2 May 2005.

[47] Price C, Tsouros A, Eds. *Our Cities, Our Future: Policies and Action Plans for Health and Sustainable Development*. Copenhagen, WHO Healthy Cities Project Office, 1996.

[48] *Scope of Work for the Knowledge Network on Urban Settings*. Kobe, Japan, World Health Organization Centre for Health Development, June 2005

Similarly, national-level policy and governance dimensions cannot be neglected either. As characterization of the "globalization" phenomenon suggests, consideration of the social determinants of health in the context of urbanization and urban settings needs to take traditional cities and health approaches to a new level. The idea of "new urban settings" encompasses much more than a city's generally recognized geographic and political boundaries. "New urban settings" have local, national and global impacts. In this context, national governments face significant health, environment and development challenges in relation to urbanization, globalization and environmental change. They need to be intimately involved in policy development that creates immediate and sustainable responses to these challenges in urban settings. Also, at both the national and local levels, external support organizations (in both the public and private sectors) need to be engaged as partners.

The key word in all of this is "partnerships" – partnerships that are built on a well-considered, step-wise approach and reflect the "seven C's" of effective collaboration.

Articulating a Grand Challenge

"Healthy urban settings partnerships" (encompassing the related initiatives of external support agencies – e.g., Cities Alliance, Healthy Cities, Local Agenda 21, Sustainable Cities, etc.) are potentially powerful mechanisms for influencing health governance.

The grand challenge for the Knowledge Network on Urban Settings and the future collaborative work of health promotion and environmental health and their partners is to influence health governance in ways that create and sustain community capital and reduce health inequity.

In taking on this Grand Challenge, partners should be mindful of the need to simultaneously enhance human, natural, social and economic capital, and Hancock's admonition that:

> *"There are no quick-fix solutions to the creation of healthier cities and communities, instead a long-term commitment to multiple small steps must be taken. In essence, a healthy community and a healthy city is created one household at a time, one street at a time, one block at a time, one neighborhood at a time and one day at a time."*
> [Hancock T. People, partnerships and human progress: building community capital. *Health Promotion International.* September 2001, 16, 3.]

6.0 Conclusions

- Finding sustainable solutions to environmental change-related public health problems is elusive and challenging.
- The public health problems associated with environmental change are complex; resources to deal with them are scarce; and people are overwhelmed.
- Environmental health-related frameworks that support broad-based approaches directed at the forces that drive environmental changes are available, but effectively using them is sometimes problematic.
- Holistic approaches to environmental health problem solving often require health promotion interventions; and, holistic approaches to health promotion problem solving often benefit from environmental health interventions.
- Effective partnership approaches can help overcome complexity and contribute to achievement of the Millennium Development Goals. The experience of health promotion and environmental health practitioners in the "healthy settings" approach bears this out.
- "Health governance" is a critical pathway to affecting health and well being.
- Creating and sustaining "community capital" is critical to enhancing health and well being in urban settings.
- "Healthy urban settings partnerships" are potentially powerful mechanisms for enhancing health governance in ways that create and sustain community capital.
- Grand challenges are to be embraced, not feared.

GENDER AND HEALTH PROMOTION: A MULTISECTORAL POLICY APPROACH

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Abstract

Women and men are different as regards their biology, their roles and responsibilities that society assigns to them, and their position in the family and community. These factors have a great influence on causes, consequences and management of diseases and ill-health. This is confirmed by evidence on male-female differences in cause-specific mortality and morbidity and exposure to risk factors. Health promoting interventions and policies aimed at ensuring safe and supportive environments, healthy living conditions and lifestyles, community involvement and participation, access to essential facilities and to social and health services, need to address these differences between women and men, boys and girls in an equitable manner in order to be effective. The aim of this paper is to (a) demonstrate that health promotion policies that take women's and men's differential biological and social vulnerability to health risks into account are more likely to be successful and effective compared to policies that are not concerned with such differences, and (b) discuss what is required to build a multisectoral policy response to gender inequities in health through health promotion and disease prevention. The requirements discussed in the paper include 1) the establishment of joint commitment for policy within society through setting objectives related to gender equality and equity in health as well as health promotion, 2) an assessment and analysis of gender inequalities affecting health and determinants of health, 3) the actions needed to tackle the main determinants of those inequalities, and 4) documentation and dissemination of effective and gender sensitive policy interventions to promote health. In the discussion of these key policy elements we use illustrative examples of good practices from different countries around the world.

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Introduction

In most countries, resources allocated by government to health promoting activities are very limited compared to investments in medical care[1]. This imbalance is evident also in the richest countries of the world. For example, in the US approximately 95 percent of the health expenditure goes to direct medical care services, while only 5 percent is allocated to prevention activities.[2] In Canada, the medical care systems absorbs the majority of health sector resources, with less than 3 percent of health spending allocated towards health promotion.[3] Therefore, it is of utmost importance to invest these limited resources in preventive activities with high potential for success and cost-effectiveness.

In the first section of this paper we argue that health promotion policies that take women's and men's differential biological and social vulnerability to health risks into account are more likely to be successful and cost-effective compared to policies that are not concerned with such differences.

Examples of common gender biases in health promotion programmes are discussed in the second section and, in the third section, we discuss what is needed to counteract gender biases in health promotion interventions and what is required to build a strong multisectoral policy response to gender inequalities in health through health promotion and disease prevention. We emphasize that health promotion actions need to take place within the broader social and economic arena (e.g. finance, labour market, education) where the unequal distributions of power, wealth and risks to health between men and women are generated, beyond the reach of the health care sector.

1. Why should health promotion and disease prevention policies and interventions pay attention to gender?

There is increasing evidence from all fields of health research that women and men are different as regards their biology, their access to and control over resources and their decision-making power in the family and community, as well as the roles and responsibilities that society assigns to them. These factors have a great influence on causes, consequences, management and outcomes of diseases and ill-health.

Biological differences (*sex differences*) between men and women, such as muscular strength, proportion of fat tissue, body size, hormonal makeup, and reproductive functions result in differential susceptibility to diseases. For example, women are biologically more vulnerable to morbidity from malaria during pregnancy.[4] Women are at risk of acquiring HIV through hetero sexual contact due to the larger surface area of the mucous membrane exposed during sexual intercourse and the fragility of the mucosal membrane among girls under the age of 18.[5] Even for non-communicable diseases, studies show that there are biological differences in the impact on health.[6] Because of biological factors, women (or men) may experience worse health effects, even when exposed to the same degree to certain risk factors. For example, women are at greater risk of harm from fat-soluble chemicals because of their greater proportion of fat tissue, thinner skin and slower metabolism.[7] As regards sex-specific morbidity, studies show that men who smoke have decreased fertility and sexual potency[8], while smoking women are at higher risk for cardiovascular disease, infertility, cervical cancer, premature labour, early menopause and increased risk for fractures[9]. Women also appear to be more vulnerable than men to many adverse consequences of alcohol use. Women absorb and metabolize alcohol differently than men and they achieve higher blood alcohol concentrations after drinking equivalent amounts of alcohol.[10]

Differences between men and women due to social and cultural factors (*gender differences*), such as power relations, social position, accepted roles and behaviours, division of labour as well as living and working conditions result in differential exposure to risk factors. These social

arrangements differentially affect men's and women's chances to remain healthy. For example, because of the strongly gender segregated labour market women and men are often found in different type of jobs - with different social benefits and in different work environments - and, consequently, they are exposed to different kinds of health-promoting and health damaging factors.[11] Gender constructed roles and norms around masculinity that include risk taking and aggressive behaviour, risky alcohol consumption and other psychoactive substance use puts men at greater risk of road traffic accidents.[12] The construction of femininity may also provoke health damaging behaviours. For example, body weight perceptions and the use of weight control behaviours are significantly associated with predictors of smoking among adolescent females.[13]

Neither biological nor social factors act alone to determine health inequalities between women and men. Biology and social factors interact in complex ways: For example, evidence suggests that women's lower social status and autonomy exacerbate their susceptibility to HIV and other diseases.[14] Little attention has been paid in health promotion research, as well as in policy, to the interaction between gender and other social factors (e.g. class and ethnicity).[15] For example, gender and poverty often combine to create multiple barriers to the well being of women: apart from being biologically more vulnerable when pregnant, poor women are also more vulnerable to morbidity from malaria (than both rich women and poor men) due to poorer access to quality health services, adequate nutrition and education.[16]

Health promotion as well as disease prevention needs to address these differences between women and men, boys and girls in an equitable manner in order to be effective. There is emerging evidence that integrating gender considerations into interventions has a positive effect on health outcomes across various domains.[17]

2. Gender bias in health promotion policies and interventions

During the last few decades there has been an emerging recognition among health professionals — researchers and policymakers alike, of the widespread and profound implications of gender-based inequities in health. There is growing body of scientific evidence that women and men face distinct health risks and have different health needs due to biological differences as well as socially constructed inequalities or gender differences. Even though knowledge of gender differences in health is increasingly available, it does not always translate easily into realities of health planning and programme implementation. The field of health promotion is no exception: gender bias in far too many health promotion interventions leads to misallocated resources and weakened potential for success.

2.1 Gender blindness

When planning and implementing health promotion and disease prevention strategies, gender is an issue that is often neglected.[18,19,20] Generally, there seems to be an assumption that interventions will be just as effective for men as for women. Many health promotion programmes are gender blind and based on research where the sex of the study participants is not made explicit. Gender-neutral expressions, such as 'health care providers', 'children', 'adolescents' or 'employees' are often used in programme descriptions and reports.[21] As a result, collection, analysis and presentation of data are often not sex-disaggregated.

2.2 Gender' as a proxy for 'women'

While talking about health promotion, it needs to be recognised that health promotion involves the agent of promotion and the beneficiary of it. In this context the social construction of gender roles come into play as many of the promotional measures are put into action by women being the care guarantor of every individual in the household. Consequently, health promotion messages often target women in their assigned role as caregivers in the family.[22] Since women's ability to make decisions about implementing health promotional measures is often limited in many countries due

to their lower status in the household, the positive health effects of the promotional measures may be less than expected. When health promotion campaigns are addressed to the family as a whole, health programmes can be considerably improved. In Ghana, for example, information about the importance of child immunization was directed to both fathers and mothers. As a result, men have taken greater responsibility for their children's health, leading to increased vaccination rates and earlier immunization.[23]

2.3 Focus on behavioural change

Many health promotion strategies aim at reducing risk behaviours, such as smoking, while ignoring the social and psychological conditions within which the targeted behaviours are embedded. Critics have argued that gender roles and health-related behaviours linked to those roles in many health promotion programmes have led to a focus on behavioural change at the individual level, rather than on policy change at the societal level.[24, 25] For example, prevention strategies to reduce harmful stress among working women often include measures where the onus is put on women to develop their own personal stress coping strategies to balance competing gender roles. Targeted women feel often accused of not being able to cope with multiple pressures arising from their responsibilities as mothers, wives, housekeepers and workers. To avoid this, complementary measures to ease women's burden through e.g. provision of day-care centres for children and introduction of more flexible working hours should also be introduced.

Similarly, many men may experience extraordinary pressures from unemployment and material hardship, which constrain them to fulfil their assigned gender role as "breadwinners".[26] Those who try to cope with stresses through behaviours, such as smoking, drinking or drug abuse, are accused of risking their health by their own personal choice. Strategies that aim at changing the life-styles of these men would probably be more effective if combined with measures to change the social environment in which the health damaging life-styles are embedded.

According to a study from Thailand, while the nationwide "100% condom programme" to prevent HIV infection has led to a decrease of the infection among men, young women who were engaged in commercial sex have not been protected from the infection to the same degree as men.[27] The authors of the study call for additional measures to protect young women. Obviously, there is a need for policies that recognise and address the gender differences of status and power that structure sexual relationships and counteract women's lack of assertiveness to insist on condom use.

2.4 Lack of multisectoral approach

Traditionally, the health field has been predominantly the domain of medical professionals and the health care sector, where the main focus is on individual health and individual risk factors. Therefore, health promotion and disease prevention strategies within the health care sector are often limited to individual health advice, e.g. on smoking cessation. One limitation of this is that certain groups of people, such as the poor who cannot afford user fees, or women who cannot without permission from their husbands visit health clinics, will be excluded from health advice and information. Another limitation is that the promotional measures within the health care sector are unable to tackle the root causes of health disparities. Many of the health determinants need to be tackled by policies outside the health sector, e.g. the labour market, social services, education system, housing, environmental protection, water and sanitation, transport, road safety and security. These policies have direct and indirect health impacts, which may differ between men and women.[28] Thus, health promoting policies and interventions should be a concern for several societal sectors. Any such initiative should take into account the involvement of key stakeholders in communities and needs to be acceptable at individual, household as well as societal level.

2.5 Top-down approach

The traditional public health approach is top-down rather than bottom-up, i.e. experts identify problems and formulate interventions while the problems and solutions as perceived by those at particular risk rarely constitute the base for action.[29] The power of change is then defined primarily in political and professional terms without the possibility of the targeted people to influence and control various determinants of health. Because of power imbalances, and because of the low representation of women in decision-making bodies, women can seldom make their voices heard. As a result, health promotion programmes designed in top-down manner will not necessarily correspond to women's health needs. Health promotion policies and activities are most meaningful when target communities and groups are involved in all aspects of policy and programme development, implementation and evaluation. For example, "The Blue Nile Health Project" in Sudan with the objective to control water associated diseases was perceived as very successful, thanks to the particular emphasis in the programme on gender-related aspects that defined women's role and participation.[30] The study urges health planners to persuade the subordinated communities of women in many African countries, like Sudan, to play a more active role in the health programmes.

3. The way forward: multisectoral policy response to gender inequities in health through health promotion and disease prevention

Building on past experience from successful and less successful health promotion strategies from a gender equity perspective, we discuss in the following some minimum requirements for gender-sensitive health promotion and disease prevention policies and programmes. These include 1) the establishment of joint commitment for policy within society through setting objectives related to gender equality and health as well as health promotion, 2) an assessment and analysis of gender inequalities affecting health and determinants of health, 3) the actions needed to tackle the main determinants of those inequalities, and 4) documentation and dissemination of effective and gender sensitive policy interventions to promote health.

3.1 Joint commitment

Through international agreements, such as the Ottawa Charter of Health Promotion and the WHO Health For All Strategy[31], many countries have already committed themselves to health promotion. Likewise, most countries in the world have committed themselves to promote gender equity. These agreements state that all women and men have the right to live without discrimination in all spheres of life, including access to health care, education, and equal remuneration for equal work.[32,33]

Most recently, the internationally agreed Millennium Development Goals identified "Gender equality and empowerment of women" as the third of eight goals and a condition for achieving the other seven. Although, these and similar commitments[34] have been ratified by most United Nations Member States, action by governments to bring national laws, policies and practices in line with the provisions of the ratified conventions has lagged behind. Moreover, these commitments have not been pursued in the health sector.

The Beijing Declaration and Platform for Action in 1995 as well as the UN Economic and Social Council (ECOSOC) in 1997 have clearly established "gender mainstreaming" as the global strategy for promoting, among other things, women's health. In the field of public health, this strategy means the integration of both women's and men's concerns into the formulation, monitoring and analysis of policies, programmes and projects. In relation to health promotion, it entails taking into account gender issues that have implications for individual and community health.

Setting international, national and local objectives for gender equity in health is the first step in establishing a joint commitment. These objectives need to be measurable and translated into policies and actions.

A good example of translating international objectives to promote gender equity and health into national objectives comes from Lao PDR. The Lao Ministries of Health and Education have signed, in response to the need to meet the targets of the MDGs, a memorandum of understanding to collaborate in developing health promotion programmes in Lao primary schools which address all 8 targets including MDG 3 to promote gender equity. In combination with the Lao Women's Union, village health committees, NGOs and international organizations, the Lao government ministries have also developed a multi-sectoral national development plan to mainstream gender into all areas of health and wellbeing.

3.2 Assessment and analysis of gender inequities in health

In order to maximize efficient use of resources, health promoting strategies and actions, in general, need to be based on an assessment of the size, nature and root causes of gender inequalities in health. More specifically, health promotion relating to certain issues e.g. HIV/AIDS, malaria. nutrition or smoking, needs to be designed with an understanding of how women and men differ in relation to the issue's causes, manifestations and consequences. Indicators of health, wellbeing and quality of life need to be sex and gender sensitive. Collection, analysis and reporting of data disaggregated by sex, age, socioeconomic status, education, ethnicity, and geographic location, where relevant and possible, should be performed systematically by individual research projects or through larger data systems at regional, national and international levels. Attention needs to be paid to the possibility that data may reflect systematic gender biases (e.g. in exposure levels to health risks) due to inadequate methodologies that fail to capture women's and men's different realities.[15] The promotion of gender sensitive-research to inform the development, implementation, monitoring and evaluation of health promotion policies and programs is also desirable. Although many data bases which are available within international and national health institutions have the potential for being analysed by sex with a gender perspective, such analysis is seldom done. This is clearly a lost opportunity for identifying and understanding gender and sex related differences which may benefit from specific actions.

One good example of recording sex disaggregated, gender sensitive and gender specific health data comes from Malaysia. In 2000, the Asian-Pacific Resource & Research Centre for Women (ARROW) published 'A Framework of Indicators for Action on Women's Health Needs & Rights after Beijing'.[35] This publication was developed as a tool for all government, non-government and international organisations to use in monitoring implementation of the Beijing Platform for Action. The framework presents selected Beijing recommendations on women's health and rights, sexual and reproductive health, violence against women and gender-sensitive health programmes, which are then operationalised into quantitative and qualitative indicators. These can be measured to assess progress particularly in women's health status; health service provision, use and quality; and national laws, policies and plans.

Another good practice in analysing data by gender to inform implementation of a health promotional intervention has taken place in São Paulo in Brazil. The Agita São Paulo Programme to promote physical activity is a multi-level, community-wide intervention. Gender analysis of sex-disaggregated data revealed important differences between adolescent boys and girls concerning patterns of physical activity.[36] Firstly, girls were more involved in vigorous physical activity than boys, which was a surprise because literature from well-developed countries suggested the opposite. Further analysis showed that the main reason behind this was girls' involvement in strenuous housekeeping (42% of girls versus 6% of boys). On the other hand, boys utilised more active transportation to and from school (100% of boys versus 57% of girls). This was a very important source of information for the programme managers for the design and kind of intervention to increase physical activity among girls and boys.

3.3 Actions needed to tackle the main social and environmental determinants of gender inequities in health

The prime determinants of gender inequities in health are social and economic disadvantages related to factors such as decision-making power, income, employment, working environment, education, housing, nutrition and individual behaviours. As mentioned previously, women and men are exposed to various risk factors to different degrees due to differences in gender roles and living and working conditions. These differences are crucial to recognize, estimate and monitor when designing interventions, programmes and population-wide risk reduction strategies. Many determinants of gender inequities in health can be influenced by health promoting measures and risk reduction strategies ranging from micro to macro public policy levels.[37]

(a) Actions to strengthen individuals

Many health promoting interventions with a gender perspective have focused mainly on strengthening women's and girl' capacity to better respond to, and control determinants of, health in the physical and social environment. The most effective interventions are those with an empowerment focus.[38] They aim to help women to gain their rights, improve their access to essential services, address perceived deficiencies in their knowledge, acquire personal skills, and thereby improve their health. Empowerment initiatives aim to encourage both sexes to challenge gender stereotypes. Such actions can include, for example, training boys and men to reduce gender biases by promoting gender-sensitive behaviour and reducing violence. Another example of such initiatives is raising awareness among young girls and their families about unfair discrimination against girls and thereby promoting the status and a value of the girl child. The Girl Child Project in Pakistan has for example made girls aware that unequal food allocation in the family is wrong.[39]

(b) Actions to strengthen communities

Strengthening communities can cover a wide spectrum of strategies aimed at strengthening the way deprived communities function collectively for mutual support and benefit. These range from helping to create meeting places and facilities for social interaction to supporting communities' defence against health hazards, such as substance abuse, crime and violence or environmental pollution. For example, several innovative and gender-sensitive community level initiatives have emerged in Africa over the past decade in response to the devastating effects of the AIDS epidemic in the region.[40] One of these initiatives is the Community Life Project in Lagos, Nigeria which is a unique example of how synergistic partnerships between activists, community and religious organizations, local institutions, involving men, women, and children simultaneously, can help to effectively break the silence on sexuality issues.[41] The project is working with 23 community groups to increase and sustain HIV/AIDS awareness in the community; addressing HIV/AIDS within the broader framework of sexual and reproductive health through sexuality education sessions; and increasing community ownership and participation by training representatives of the groups as volunteers and family life educators. Thus, the initiative places sexuality education on the community's agenda, thereby creating a supportive environment for advancing women's reproductive and sexual health.

(c) Actions to promote gender equity in access to essential facilities and services

In both industrialized and developing countries improvements in living and working conditions and access to services have been shown to bring substantial health improvements to populations. Public health initiatives influencing living and working conditions include measures to improve access to clean water, adequate nutrition and housing, sanitation, safer workplaces and health and other welfare services. Policies within these areas are normally the responsibility of separate sectors and there is a need for them to co-operate in order to improve the health of the population. Health promotion policies and interventions aiming at improving living and working conditions and access to services need to be particularly gender sensitive due to the fact that women and men

face distinct health risks in their living and working environment and have different health needs. For example, many developing countries suffer from weak health services, infrastructures and unaffordable services, a situation that disproportionately affects women as they require more preventive reproductive health services. The inadequacy and lack of affordability of health services is compounded by physical and cultural barriers to care. At the national level some attempts have been made to tackle cost and affordability barriers in health services to women. For example, South Africa and Sri Lanka provide free maternal and infant health services. In some cultures, women are reluctant to consult male doctors. The lack of female medical personnel is an important barrier to utilization of health services for many women.[42] To overcome this barrier, the Women's Health Project in Pakistan works with the Ministry of Health to improve the health of women, girls and infants in 20 predominantly rural districts in four provinces through measures, such as the expansion of community-based health care and family planning services through the recruitment and training of thousands of village women as Lady Health Workers, a 'safe delivery' campaign, and the promotion of women's health and nutritional needs and family planning.[43] The project assumes that a female health care provider could better understand the problem of another woman.

(d) Actions to encourage social and economic policy change

Policies at the structural level include economic and social policies spanning sectors such as labour market, trade environment, and more general efforts to improve women's status. These policies have a great potential to reduce or exacerbate gender inequality, including inequities in health. Influencing factors affecting social stratification is therefore a key for the improvement of women's social position relative to men. This requires policies that influence opportunities women have to improve their capabilities. Policies aimed at improving women's education, increasing their possibilities to earn an income within the labour market and family welfare policies are all measures for improving women's social status in the family and in the society. Improved social status for women relative to men may improve women's control over household resources and their own lives. For example, development policies in Matlab (Bangladesh) included strategies, such as micro-credit schemes linked to employment and provision of more places in school for daughters of poor families, which successfully increased the status of the poorest women. Equity-oriented policies in a social context in which women had traditional matrilineal rights to property and girls were valued as much as boys have resulted in considerable health gains in Kerala, India. Women could benefit from improvements in health care provision and to achieve high levels of literacy. Kerala is the only state in India where the population sex ratio has been favourable to women throughout the twentieth century and it is not plagued by the problem of "missing women".[44] Increasing the participation of women in political and other decision-making processes - at household, community and national levels and ensuring that laws and their implementation do not discriminate against women are measures that have a great potential to improve gender equality and health equity.

3.4 Documenting and disseminating effective and gender sensitive policy interventions to promote health

There is a paucity of information on cost-effective and gender sensitive health promoting strategies and interventions that have successfully addressed social determinants of health, and little concrete guidance is available to policymakers. Developing an international reporting system to collect such information in order to increase the accessibility for policy-makers to relevant information needs to be encouraged. Monitoring and evaluation of strategies and interventions are also important for informing future processes and track progress towards gender equality.

Indicators and methods should be developed urgently for systematic integration of gender dimensions in health impact assessments that assess not only a policy's impact at an aggregate level, but on different population groups, including the marginalized and vulnerable; such an

assessment should be applicable not only to health systems policy, but also to policy in other sectors.[45,46]

Conclusion

Recognizing gender inequalities is crucial when designing health promotion strategies. Without such a perspective their effectiveness may be jeopardized and inequities in health between men and women might even increase. Although, the dynamics of gender inequalities are of profound importance, gender biases in health research, policy and programming, and institutions continue to create a vicious circle that downgrades and neglects gender perspectives in health.

The country case study examples presented in this paper suggest that it is feasible and beneficial to integrate gender in health promotion policies. However, greater efforts are needed to sensitize stakeholders including health professionals - policymakers and researchers alike - to its importance. Many lessons have been learnt which can be used as building blocks for adaptation to ensure that health promotion policies are contextual in nature taking into account gender specific factors that can impinge on the promotion of health among a given community. Effective health promotion policies and programmes are those based on joint commitment and a multisectoral approach and are based on evidence gathered with gender dimensions in mind.

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Health Promotion in an Urbanizing World

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1 The Urbanization Challenge

United Nations projections suggest that over the next thirty years virtually all of the world's population growth will occur in the urban areas of low- and middle-income countries. In 1950, only 30% of the world was urbanized; and by 2001, it was estimated that 47.5% of the world's population live in urban areas. This level of urbanization will rise to 56.7% by 2020, with all of the urban growth occurring in developing countries. At the beginning of the 20th century, just 16 cities in the world contained at least a million people, the vast majority of which were in industrially advanced economies. Today, at the beginning of the 21st century, there are around 400 cities around the world that contain over a million residents, and about three-quarters of these are in low- and middle-income countries. This dramatic transition of world population growth is unprecedented in human history, as more people will live in urban areas of the world. Another distinctive feature is that most of the urban growth will be a result of natural population increase and the structural transformation of formerly rural areas on the periphery of urban areas, and not due to rural-to-urban migration as is commonly understood.

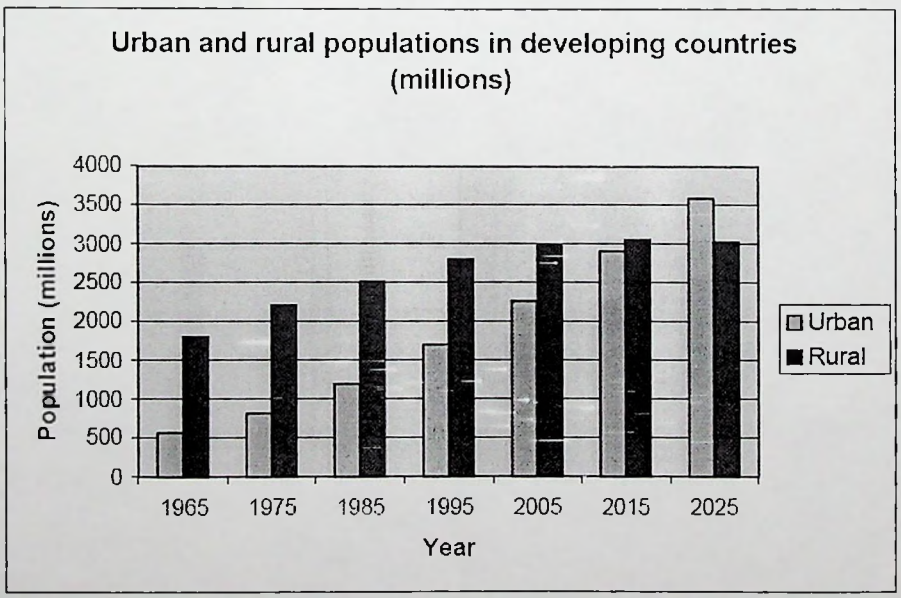

Fig. 1 The urban population in developing countries will soon surpass the rural population.

Significant regional differences continue to define worldwide urbanization trends. Latin America continues to be the most urbanized region, with almost 76% of its population already urbanized, and an anticipated 81% by 2020. In Latin America there is now a deconcentration process seen by more rapid growth of small and medium sized cities. In Asia, there are large population concentrations and almost half of the total world urban population is in this region. It is anticipated that by 2020, 54% of Asia will be urbanized. Sub-Saharan Africa will also experience a dramatic reversal of demographic trends. Africa will cut through the rural-urban divide by 2015 and be 53% urbanized by 2020.[1] However, Africa is also been the one region that has been characterized by dramatic urbanization and very low economic growth.

Historically, urbanisation process was stimulated by economic development. The reason was that economic development involved the transformation of an agricultural based economy to an industrial-service based economy. Production of manufacturing and services is much more efficient when concentrated in dense business-industrial locations in cities. Close spatial proximity, or high density, promoted information spillovers amongst producers, more efficiently functioning labour markets, and savings in the transport costs. This was the experience of Europe in the nineteenth century and Latin America in second half of twentieth century. Today in many parts of the world, urbanization is being accelerated by (and is accelerating) a new global economy that is literally changing the face of the planet. Increasingly, urban growth is being influenced by continued global economic integration and the struggle for countries—and indeed individual cities—to be competitive in the global marketplace. Managing urban growth has increased in both scope and complexity and has become one of the most important challenges of the 21st century.[1]

In a world of liberalized trade and finance, cities are focal points for investment, communication, commerce, production and consumption. Along with the prosperity that such investments bring to cities, in developing countries there are associated problems of poor infrastructure, lack of basic services, increasing pollution, and increasing number of poor people. For developing countries, meeting the challenge of health in new urban setting is difficult for many reasons. Currently, information is limited on the extent to which changes in migration, size and density of cities and characteristics of the urban physical and social environments affects individual and population health. Intra-urban differentials in health outcomes is unavailable for most urban areas, but information from a few cities suggest that situation in urban poor neighbourhoods is often worse than rural areas. This paper discusses some of the available evidences that demonstrate health conditions for the urban poor in developing countries and suggests possible ways to promote health in urban setting.

[1] Barney Cohen (2004), "Urban Growth in Developing Countries: A Review of Current Trends and a Caution Regarding Existing Forecasts", World Development Vol. 32, No. 1, pp. 23–51, 2004

2. Urbanisation of Poverty and Slums

Just as the world is becoming increasingly urban, there is also an increase in the number of poor people in the world. UNDP's 1999 Human Development Report demonstrates that despite the significant advances in human development in previous decades, extreme poverty persists. In developing countries there are still 60 percent more illiterate women than men. An estimated 1.3 billion people live on incomes of less than $1 per day.[2] In his "Millennium Report," United Nations Secretary-General Kofi Annan declared that "extreme poverty is an affront to our common humanity," and called on the international community, "to adopt the target of halving the proportion of people living in extreme poverty... by 2015."[3]

The World Development Report 2001, estimated that while both the share of population and the number of people living on less than a dollar a day declined in the mid-nineties, this decline was exclusively due to a reduction in the number of poor people in East Asia, most notably China. In South Asia, the absolute number of poor has been rising steadily since 1987. Africa is now the region with the largest share of people living below $1/day. In Latin America, the share of poor people remained the same and the absolute number has increased. And in the countries of the former Soviet bloc, poverty rose markedly, both in terms of share and absolute number.

Do more poor people are now in urban areas than ever before? Using the best available survey data from WHO and the World Bank, Haddad, Ruel, Garret (1999) find that for a majority of countries not only has the absolute number of the urban poor and undernourished increased in the last 15-20 years but they have done so at a rate that outpaces corresponding changes in rural areas: in other words, the share of the poor and undernourished that come from urban areas is increasing.[4] While the estimates of exact number of urban poor is not available, given the problems of definitions and measurement of poverty, on a dollar per capita basis, it is estimated that nearly 400 million poor live in urban areas. If the multi-dimensional aspect of poverty is considered, related to access to basic services such as water, sewage, health and education, then the extent of urban poverty incidences are considerably higher.

Slums as manifestation of urban poverty:

The Millennium Declaration, adopted in September 2000 by member states, commits to "achieve a significant improvement in the lives of at least 100 million slum dwellers by 2020", is linked to the primary goal of urban poverty reduction. The focus on slums in the Millennium Declaration has revived the interest in urban poverty reduction policies and programmes, as the slums are the most visible manifestation of urban poverty.

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[2] 1987 purchasing-power-parity; See UNDP 1999 Human Development Report 1999, pages 25 and 28.
[3] "We the Peoples: The Role of the United Nations in the 21st Century," paragraphs 70 and 73.
[4] Haddad, L., Ruel, M. T., Garrett, J. L. (1999). "Are urban poverty and under nutrition growing? Some newly assembled evidence." *World Development* 27(11), 1891-1904.

UN-HABITAT estimates that 946 million people live in slums in urban areas of developing countries.

Table 1: Slum Population in Developing Countries[1]

	1990	2001	2005
Developing Regions:			
North Africa	21719	21355	21224
Sub-Saharan Africa	100973	166208	199231
Latin America & Caribbean	110837	127566	134257
Eastern Asia	150761	193824	212368
Eastern Asia excluding China	12831	15568	16702
South Asia	198663	253122	276432
South Eastern Asia	48986	56781	59913
Western Asia	28641	40726	46288
Oceania	350	499	568
Total	**660,929**	**860,081**	**946,529**

UNHABITAT has developed a household level definition of a slum household in order to be able to use existing household level surveys and censuses to identify slum dwellers among the urban population. A slum household is a household that lacks any one of the following five elements:

- **Access to improved water** (*access to sufficient amount of water for family use, at an affordable price, available to household members without being subject to extreme effort);*
- **Access to improved sanitation** (*access to an excreta disposal system, either in the form of a private toilet or a public toilet shared with a reasonable number of people);*
- **Security of tenure** (*evidence of documentation to prove secure tenure status or de facto or perceived protection from evictions*)

- **Durability of housing** (*permanent and adequate structure in non-hazardous location)*
- **Sufficient living area** (*not more than two people sharing the same room).*

[1] UN-HABITAT (2003). The Challenge of Slums: Global Report on Human Settlements 2003. London: Earthscan Publications.

The Millennium Development Goals have been accepted internationally as a common global development framework. At its core, the Millennium Development Goals are about bringing the vast majority of the world's population out of a poverty trap that robs them of their health, dignity and aspirations for fulfilling their human potential. Although, the slums target is the only target of the MDGs that specifically addresses the issue of urban poverty, it is important to recognise that by improving the lives of slum dwellers, governments are also combating HIV, improving environmental sustainability, addressing gender inequality (and all the MDGs) in the most efficient manner. In other words, as the world becomes more urban, the integration and synergies emerging from the potential of comprehensively addressing the MDGs in a specific, dense location are best achieved in the very settlements where slum dwellers live.[6]

3. Health in Urban Settings

In general, urban residents in developing countries do have better health outcomes. This is attributed to availability of better health care facilities, both from public and privates sector. If this is indeed the case, why should one focus on health promotion in urban areas? While it is true that, on an average, heath outcome in urban areas is better than national average, the intra-urban differentials suggest a worsening of health outcome for the urban poor. We examine below some available statistics, both at aggregate level, and the intra-urban differentials for a few urban locations.

Aggregate urban health outcomes:

Wang (2003)[7] using DHS data from over 60 low-income countries between 1990 and 1999 showed that there is a significant gap in child mortality between urban and rural areas, with rural population having a much slower reduction in mortality compared with their urban counterpart.

Table 2: Urban/Rural Gaps in Mortality Rate:

		IMR		U5 MR	
	Year	Rural	Urban	Rural	Urban
Global All DHS Countries	Early 1990s	87	67	143	105
	End 1990s	77	58	126	89
	Decline rate (% per annum)	1.7	2.1	2.1	2.6

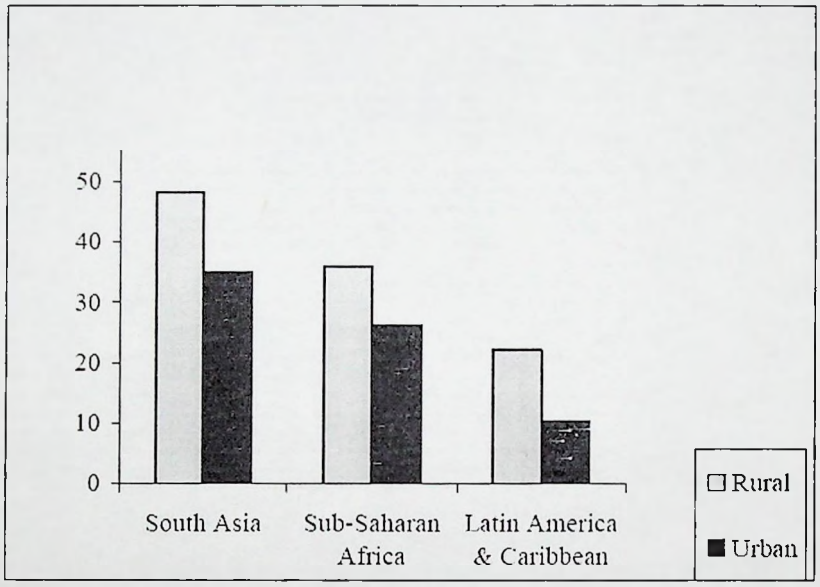
Source: Limin Wang (2003)

[6] A Home in the City, Report of Task Force on improving lives of Slum Dwellers, UN Millennium Project, 2005

[7] Limin Wang (2003), "Health Outcomes in Low-Income Countries and Policy Implications: Empirical Findings from Demographic and Health Surveys", Research working paper series: no. WPS 2831, World Bank

A recent study by International Food Policy Research Institute (IFPRI) also corroborates such findings. Smith et.al (2004) demonstrate that the extent of malnourishment in urban areas of developing countries is lower than in rural areas.

Figure 1—Stunting prevalences across urban and rural areas, by region



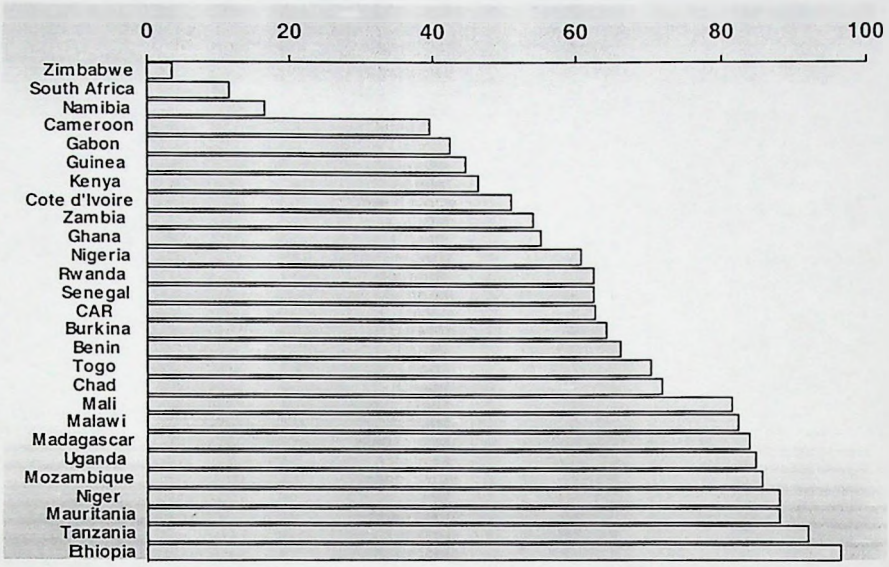
Source: Smith. Ruel. and Ndiaye (2004)[6]

4. Intra-Urban Differentials in Health Outcomes:

While aggregate health statistics suggest that the urban dwellers have better health status compared to those living in rural areas, there is a large and growing gap between the health status of the upper/middle class urban residents and those living at the margins of poverty. The 940 million urban residents, live in slum that are characterized by high density. overcrowded unsanitary conditions often lacking access to basic health. water and sanitation services. This has serious implications on their health status. (See Figure 2 for data on access to sanitation and Figure 3 for links between lack of improved sanitation and infant mortality).

[6] Lisa C. Smith, Marie T. Ruel, and Aida Ndiaye (2004), Why Is Child Malnutrition Lower in Urban Than Rural Areas? Evidence from 36 Developing Countries, FCND Discussion Paper No. 176, International Food Policy Research Institute, Washington

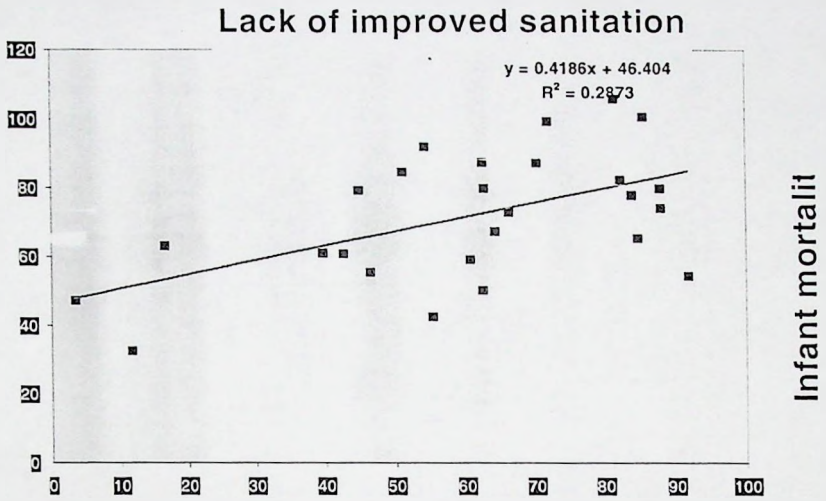
Figure 2: Percentage of urban households that lack access to improved sanitation, urban areas



Source: Gora Mboup (2003)[9]

Though the slum dwellers constitute over one-third of the global urban population, there is very little data on the health status of this population. Compiling data on health in urban slums poses serious problem. Existing data are rarely disaggregated according to intra-urban location or socioeconomic criteria. Data sets such as DHS and MICS are disaggregate by "urban" and "rural," but go no further. Nonetheless, UN-HABITAT has been making concerted efforts to reanalyze large data sets where the geographic origins of the data can clearly be identified as "slum" and "non-slum."

[9] Gora Mboup (2003), **Improving health conditions of slum communities:** Health Interventions versus slum upgrading, presentation at ***Urban Poverty and Health in Sub-Saharan Africa***, Nairobi, April 14-15, 2003

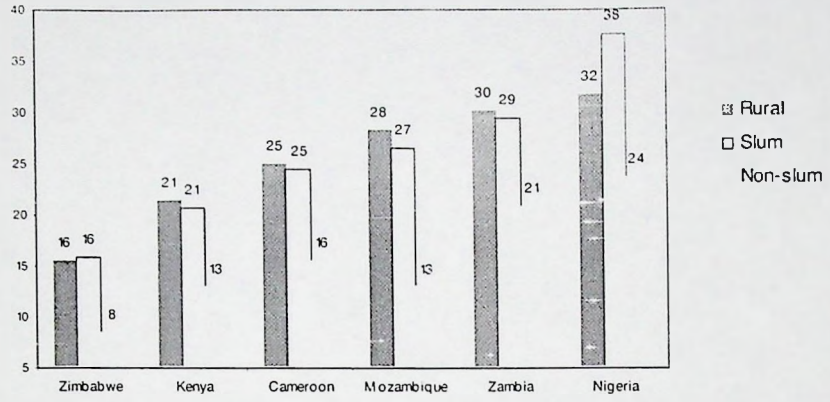


Source: Gora Mboup (2003)

4.1 Malnourishment in urban slums:

Urban residents, while better nourished on average, are extremely vulnerable to macroeconomic shocks that undermine their earning capacity and lead to substitution towards less nutritious, cheaper foods. The urban poor are particularly vulnerable. The nutritional vulnerability of the urban poor is evidenced by the fact that, where data is available, the number of children that show evidence of malnutrition amongst the urban poor is higher or equal to the rural poor. Respiratory infections from both indoor and outdoor air pollution and diarrhoeal diseases, two of the world's greatest challenges to child survival, are also daunting challenges in urban areas.

Percentage of children 0-59 months underweight
source: G.Mboup, 2004. Impact of slum upgrading on health



4.2 Infant and Child Mortality in urban slums:

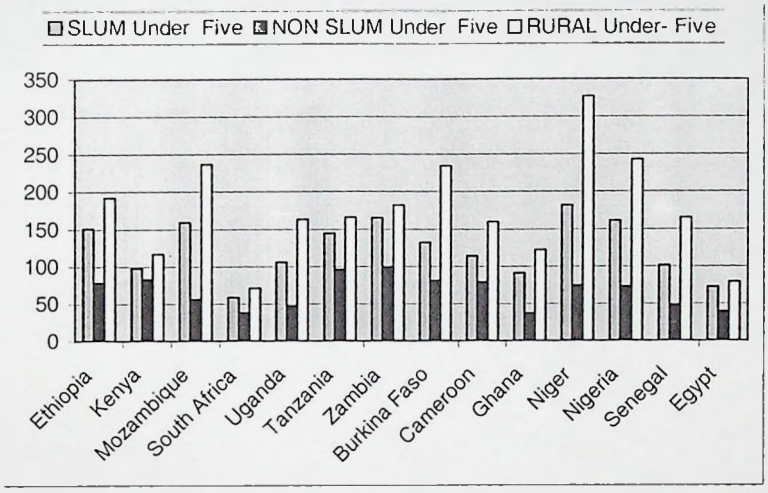
While urban residents in developing countries have better health outcomes on average than their rural counterparts, these averages often hide large intra-urban inequities in disease and injury burdens and premature death. In some cities the urban poor may fare worse than residents of rural areas. (Montgomery et al 2003)[10]. High barriers to accessing good-quality water, sanitation, health services, and emergency services, especially for slum dwellers, often make it difficult for poor urban residents to prevent and treat debilitating health problems. In Dhaka infant mortality rates are higher in urban slums than in rural areas (Harpham and Tanner 1995, see Figure)[11] In São Paulo 1992 infant mortality rates in municipalities ranged from 18 to 60 per 1,000 live births, with slums and poorer communities experiencing the worst outcomes (Stephens and others 1994)[12].

[10] Montgomery, Mark R, Richard Stren, Barney Cohen, and Holly Reed, eds. 2003. Cities Transformed: Demographic Change and Its Implications in the Developing World. Washington. D.C.: National Academy Press.

[11] Harpham, Trudy, and Marcel Tanner, eds. 1995. Urban Health in Developing Countries: Progress and Prospects. London: Earthscan Publications.

[12] Stephens, C., I. Timaeus, M. Ackerman, S. Alve, P.B. Maia, P. Campanario, B. Doe, L. Lush, D. Tetteh, and T. Harpham. 1994. "Environment and Health in Developing Countries: An Analysis of Intra-Urban Differentials Using Existing Data." London School of Hygiene and Tropical Medicine.

Figure 4: Under Five Mortality by human settlement types in the Sub-Saharan Africa



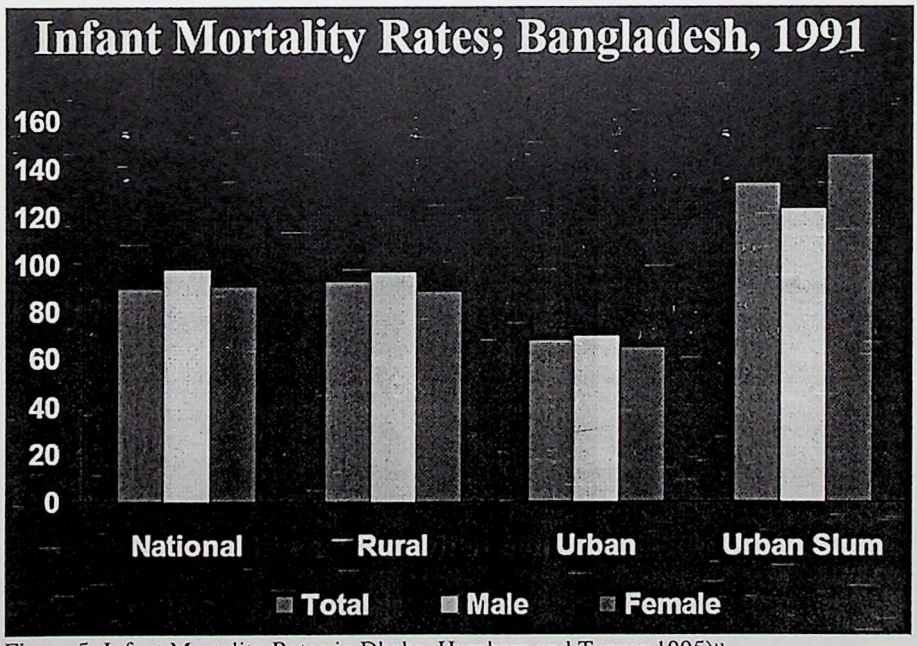


Figure 5: Infant Mortality Rates in Dhaka, Harpham and Tanner 1995)[13]

[13] Harpham, Trudy, and Marcel Tanner. eds. 1995. Urban Health in Developing Countries: Progress and Prospects. London: Earthscan Publications.

Studies from Slums in Nairobi show that Infant and Child mortality in urban slums are highest in Kenya. A comprehensive 1998 survey of Nairobi slums found that residents who lacked basic services, adequate housing, and health services and who lived among similarly disadvantaged people had worse health outcomes in almost every dimension than other Nairobi residents, rural Kenyans, and Kenyans overall (APHRC 2002). This survey also showed that under-five mortality rates in Nairobi's slums were 151 per 1,000 live births—much higher than the average for Nairobi (62) or the average for rural areas (113). The very poor living conditions in slums, including the lack of provision for water and sanitation and high levels of overcrowding, contribute much to the health status of the poor. Adequate health services to prevent and treat illnesses remain inaccessible to these communities, because of price, quality of care, and treatment-seeking behaviour.

Infant and Child (under 5 yrs) Mortality Rates in the Urban Slums of Nairobi

(compared with other areas of Kenya).

	Infant Mortality (per 1000 births)	Under-five Mortality (per 1000 births)
NCSS[xx]		
Nairobi Slums	91.3	150.6
National[x]	73.7	111.5
Rural [x]	75.9	113.0
Other Urban[x]	56.6	83.9
Nairobi[x]	38.7	61.5

[x] Based on 1998 KDHS data - Kenya Demographic and Health Surveys
[xx] NCSS - National Cross Sectional Slums Survey, 2000

4.3 Diarrhoea in urban Slums

Prevalence of diarrhoea among urban slum children is also more pronounced. Firkee (2004)[11] cites information from Egypt to show that diarrhoea prevalence among urban slum children is higher than in rural areas. (See Fig 6) Though the difference in Egypt is not very significant, the information for Nairobi, as presented by Gora Mboup (2003)[12] shows the effect of income on diarrhoea incidence in Nairobi slums. Studies from other African countries also show higher diarrhoea prevalence in urban slum areas (see Figure 5).

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[11] Fariyal Firkee (2004), A Global Perspective: Cross National Pressures on Urban Health, presentation Fikree3rd International Conference on Urban Health Boston, October 21, 2004

[12] Gora Mboup (2003), **Improving health conditions of slum communities:** Health Interventions versus slum upgrading, presentation at ***Urban Poverty and Health in Sub-Saharan Africa*** Nairobi, April 14-15, 2003

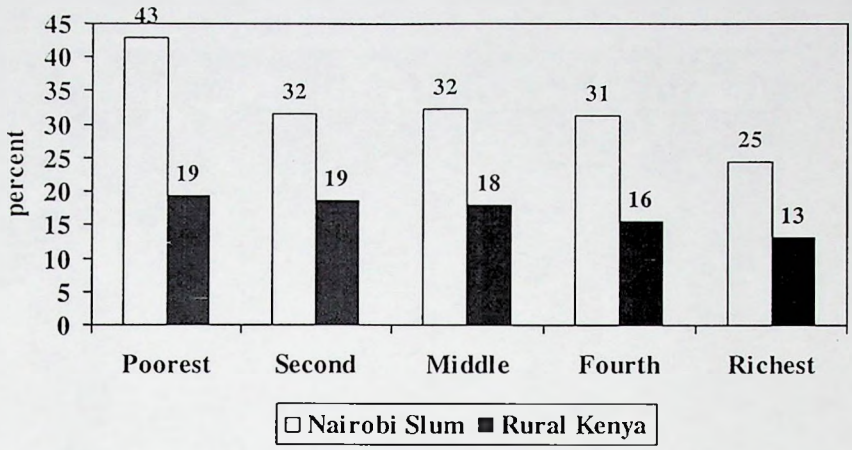
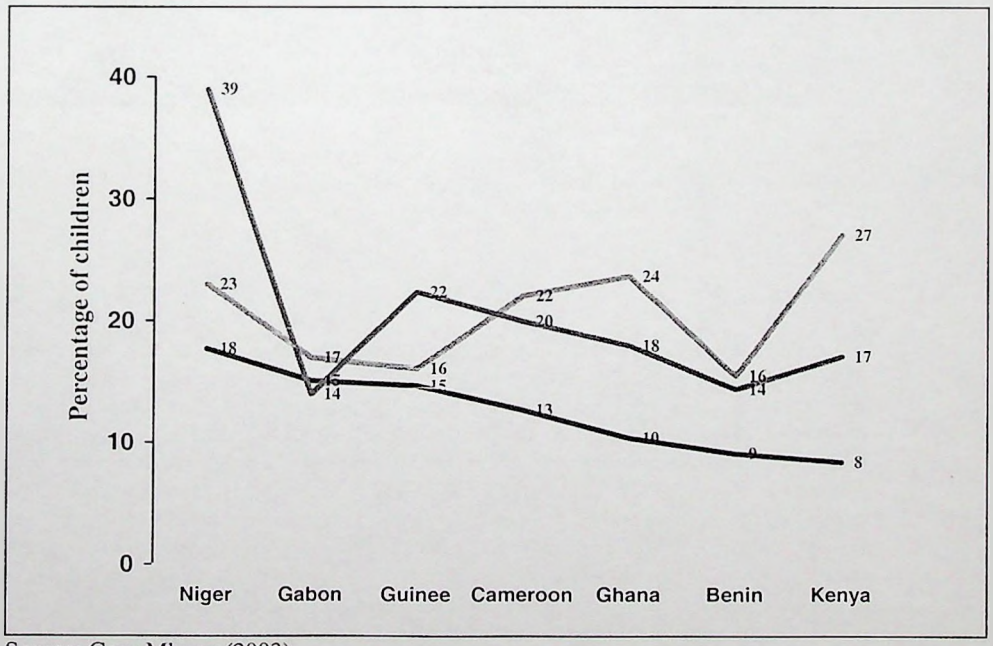


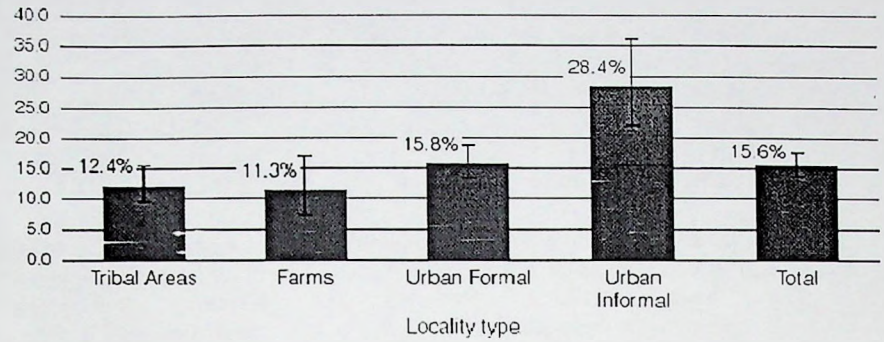
Figure 4: Diarrhea in the Last Two Weeks by Wealth Index Quintiles and Residence
Source: NCSS, 2000 & KDHS 1998

Figure 5 : Prevalence of diarrhea among children



Source: Gora Mboup (2003)

HABITAT 2004)[16]. Like all other health indicators, we see higher prevalence of HIV among the urban slum residents. (See Fig 7 for South Africa).



HIV prevalence among persons aged 15-49 years by locality type, South Africa 2002[33]

5. Health Promotion Programmes in Urban Settings

Healthcare facilities are overwhelmingly concentrated in urban areas. Urban health services are typically provided by a patchwork of entities, including public hospitals and clinics, private physicians, laboratories, pharmacies, and NGOs. As a result, urban populations - on average - have greater access to formal healthcare services. These services are, however, not accessible to the urban poor for a variety of reasons. High cost of these services is one of the reasons, but even where free public health services are available in urban areas; these are not specifically oriented to serve the urban poor. Often, the urban poor are unaware of availability of free health care services. Even when they are aware, it is difficult for them to use these services as they have to spend a great deal of time to avail these services.

Specific programmes for promoting health in urban slums did exist in the past. The WHO's Healthy Cities Programme, and UNICEF's Urban Basic Services Programme (UBSP) was quite active in 80's and 90's and contributed significantly to promote health and provide primary health care services in slums. The Healthy Cities Programme (HCP) was first implemented in developed regions, but was extended to lower income countries in the late 1990s. The main activities of the projects were awareness raising and environmental improvements, particularly solid waste disposal and home and neighbourhood hygiene. An evaluation of the project, undertaken in 1998-9 showed that City leaders had little political commitment to Healthy Cities Projects. As a result, HCPs have limited influence on municipal health policies. WHO support for HCP enabled project co-ordinators to network at national and international levels, but did not necessarily build capacity of their institutions. The evaluation report also warned that end

[16] UN-HABITAT (2004), Challenging the Challenge: Shelter Dimensions of HIV/AIDS and Orphans in Urban Slums of Sub-Saharan Africa, Draft December 2004

of WHO funding and the absence of alternative sources of finance have threatened the sustainability of HCPs. [17]

Without global funding, both Healthy Cities Programme of WHO, and the Urban Basic Services Programme (UBSP) of UNICEF have curtailed its activities in developing countries. A few countries have, however, continued with similar programme for health promotion among the urban poor, but clearly greater effort at global level is required.

6. Need for a New Programme on Health Promotion for Urban Poor:

The MDG Goal 7 on environmental sustainability and the target 11, "of improving lives of at least 100 million slum dwellers by 2020", has been instrumental in focusing attention on issues related to urban poverty. UN-HABITAT along with many other UN agencies and partner organisations have agreed that 'improving the lives of slum dwellers' means not only improvement in shelter conditions of the urban poor, but must also include improvements in health status of the urban poor.

- Intra-urban inequities need to be documented by disaggregating information by slum and non-slum population
- Appropriate technologies need to be provided for sustainable shelter design that provides for adequate ventilation, safe disposal of wastes, easy access to clean and safe drinking water and sanitation, improved drainage, increased safety and appropriate fuel options.
- Improving lives of slum dwellers requires that high quality health interventions are brought to slum neighbourhoods. Urban slums have to be targeted with well-focused education campaigns designed to spread important information about the prevention, diagnosis and treatment of disease.
- Promotion of health in urban setting requires a multi-sectoral approach involving a range of stakeholders. Health promotion campaigns for urban poor must include strengthening of capacity of local governments and other stakeholders.
- Lessons from Healthy Cities Programme and UBSP programme have highlighted the need for commitments of local government leaders and for active engagement of community based organisations in urban slums in health promotion programmes.
- Strengthen local institutions (private and public) and find ways to link them to resources and facilities that can help them gain the attention and collaboration of policy makers who can affect their long-term status in the community.

More recently, the report by the "Commission on Africa", popularly known as the Blair commission on Africa, cites rapid urbanisation and poverty in urban areas of Africa as an important issue. The WHO's Commission on Social Determinants of Health has decided that one of its foci is on urban settings as a social determinant of health and inequities in health. The WHO Center for Health Development in Kobe Japan has been selected to lead the learning in this area towards synthesizing what is known on how to address various aspects of urban settings as a social determinant of health and developing

[17] 'Health city projects in developing countries: the first evaluation' by T. Harpham, S. Burton and I. Blue, Health Promotion International 16 (2001)

recommendations that include what and how to address these issues and scale up existing successful programs/policies.

It is expected that through this renewed focus on urban poor, national and local governments will reorient the health services and public health infrastructure, with the explicit intention of reaching the slum dwellers UN-HABITAT with in partnership with other UN agencies has begun a programme to collect intra-urban data on morbidity and mortality, for selected cities. Such data are important for better directing health resources to the neediest groups. But greater research effort is needed to learn more about treatment-seeking behaviour of the urban poor, the quality of various urban health services, and perceptions of such care by users.

As of 10 August 2005

6th Global Conference on Health Promotion, "Policy and Partnership For Action: Addressing the Determinants of Health"

7-11 August 2005
UNCC, Bangkok

Updated Provisional List of Addresses

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Contribution of Health Promotion to the Achievement of Millennium Development Goals.

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Abstract

The Millennium Development Goals (MDG) adopted by the United Nations in year 2000 provide an opportunity towards improved global health, through harmonised efforts of the developing and developed world. The MDG process involves critical review of the current innovative practices, prioritised policy reforms, identification of frameworks for implementation and monitoring, as well as evaluation of financial options. Goal number 1-7 are outcomes related, whereas MDG 8 is concerned with process. Out of the eight set MDGs four are directly health related, while the other four have important indirect relationship with health.

This paper shows linkages between health promotion and MDGs. There is a brief description of the eight MDGs as adapted in year 2000, highlighting how each goal relates to health. Main issues and challenges are explained under each goal. More attention is given to the health goals and related targets. Health promotion contribution towards MDG achievements and as an important tool for advocating effective global, national and community partnership is demonstrated. There is an emphasis on ways of tackling future health challenges. Some examples of innovative and good practice across regions and countries are given. In addition, relevant equity and cultural issues have been addressed.

In conclusion, the paper shows that health promotion could potentially contribute in accelerating the progress, especially towards achievement of the health related MDGs. Recommendations for the way forward are provided. Specific strategies that could be adapted as part of health promotion initiative are also given, including strategies for disease prevention and management; epidemic prevention and control; information, education and communication; as well as monitoring and Evaluation strategies.

Health Overview of MDG Goals and Targets

Goal	Target
1: Eradicate extreme poverty and hunger	Halve the proportion of people whose income is less than one dollar a day and the proportion of people who suffer from hunger by year 2015
2: Achieve universal primary education	Ensure that by 2015, children everywhere, boys and girls alike, will be able to complete a full course of primary schooling.
3: Promote Gender equality and empower women	Eliminate gender disparity in primary and secondary education, preferably by 2005, and to all levels of education no later than 2015
4: Reduce child mortality	Reduce by two-thirds between 1990 and 2015, the under-five-mortality rate
5: Improve Maternal Health	Reduce by three quarters, between 1990 and 2015, the maternal mortality ratio.
6: Combat HIV/AIDS, malaria and other diseases	i) Have halted by 2015 and begun to reverse the spread of HIV/AIDS ii) The target of halting and reversing malaria incidence by 2015. iii) Halting and reversing Tuberculosis
7: Ensure Environmental sustainability	By integrating the principles of sustainable development into country policies and programmes and reversing the loss of environmental resources; by halving by 2015 the proportion of people without sustainable access to safe drinking-water and basic sanitation ; and by having achieved, by 2020, a significant

	improvement in the lives of at least 100 million slum dwellers.
8: Global Partnership for Development	Develop further an open, rule-based, predictable, non-discriminatory trading and financial system; address the special needs of the least developed countries; address the special needs of landlocked countries and small island developing States; deal comprehensively with the debt problems of developing countries through national and international measures in order to make debt-relief sustainable in long term.

Present Status with Relation to Health Related MDGs:

Main and Cross Cutting Issues.

It has been acknowledged that progress towards meeting several goals is too slow especially with relation to health indicators in sub-Saharan Africa (UN, WHO, WB, UN/MP).

A main cross-cutting issue is whether and how countries adapt MDGs more closely to their level of development since feasibility of goals especially for the very poor countries is constrained by inadequate human, financial and other resources

Debt relief and Highly Indebted Poorest Countries funds (HIPC) in support of poverty reduction plans increase potential for meeting the goals; however donors are not fully living up to their commitments, while trade and aid policies remain unfair.

Financial and Human Resource for Health (HRH) constraints (shortage in numbers and skills), as well as poor infrastructure and inadequate supply systems explain why health systems fail to respond. The massive exodus of professionals from poor to richer countries and HIV/AIDS continue to drain the already scarce human resources.

The interconnectedness of the problems should be recognised, for example the linkage of childhood mortality with rapid population growth and lack of family planning, HIV/AIDS, poor water and sanitation status. Poverty breeds ill health while ill health breeds poverty. In sub-Saharan Africa HIV/AIDS compounds the situation, increasing the workload while weakening the system at the same time. Fast population growth, urbanization, migration and global climate change are further crucial in relation to water, sanitation and hygiene in health and development. There is further a direct relationship between poverty, Tuberculosis (TB), gender and women health while linkage of health with water and fuel inaccessibility is also evident. The lack of harmonisation strategies is therefore worrying for instance with relation to non-communicable diseases that are missing from most poverty reduction strategies and MDG needs assessment reports. Greater emphasis need to be placed on cross-government thinking, establishment of synergies across sectors/goals, integrated planning and inter-sectoral action.

A selection of issues specific to individual goals is presented in the table below.

There are issues that contribute to the progress of each specific goal. However, as noted in the previous section, it is more important to consider the interconnectedness of issues, as well as key health determinants across the eight goals. For example, ill health as related to poverty, gender, poor education and illiteracy, HIV/AIDS, fast growing population, environmental issues, migration, urbanization and other related factors.

Goal	Issues
1:Eradicate extreme poverty and hunger	• Rapidly growing populations • Impact of increasing urbanisation and unemployment • Climate changes affecting agriculture • Farmers in poor countries affected by HIV/AIDS and malaria • Unfair competition from subsidised farmers in richer countries • National and international disaster un-preparedness
2:Achieve universal primary education	• Socio-economic barriers hindering access especially for girls. • Poor teacher motivation and retention • In-availability of free school meals, safe water and sanitation • Curricula relevance, for self reliance or for global markets? • Risk of substance abuse, teenage pregnancies and HIV/AIDS. • Lack of investment in new distance learning technologies and the problem of 'education' miles for rural communities
3:Promote Gender equality and empower women	• Poverty has a greater impact on women • Gender equality and empowerment of women still far of target • Socio-cultural, legal, religious, political and employment barriers • Vulnerability of women during conflicts • HIV/AIDS, maternal and non maternal conditions. • Poor data on the progress of women empowerment
4:Reduce Child Mortality	• 4 million babies die yearly before the age of one month. • Nearly 99% of child deaths occur in developing countries, • WHO estimates that two-thirds of child deaths could be prevented by interventions which are already available, which are also feasible to implement in low-income countries. • Nutrition interventions, including appropriate breast feeding, complementary feeding, zinc, Vitamin A, could save 2-4 million children or 25% of the total child deaths, while • Management of infections like diarrhoea, malaria and neonatal sepsis could save 3.2 million or 33% of total child deaths. • low-quality of care and in -accessibility of essential drugs and vaccinations
5:Improve Maternal Health	• The lifetime risk of dying from maternal causes in sub-Saharan Africa is 1 in 16, 1 in 160 in Latin America and 1 in 4,000 in Western Europe. • 830 maternal deaths per 100,000 live births in Africa. • Each year, nearly 1 m children die due to death of their mother. • More than 70% of all maternal deaths are caused by haemorrhage, infection or sepsis, unsafe abortion, eclampsia and obstructed labour (WHO 2003, 2004). Worsened by increased fertility rates, lack of family planning, harmful traditions (such as Female Genital Mutilation -FGM) and high illiteracy rate among women. • human resources constraints a controversial issue • It is estimated that globally only 62% of births are attended by a skilled attendant. In developing countries the average is 53%, in some countries as low as 34%.
6: Combat HIV/AIDS, malaria and	**HIV/AIDS** • WHO and UNAIDS (2004) reports that HIV/AIDS has killed more than 20 million people and is now the leading cause of death and

other diseases	lost years of productive life for adults aged 15–59 years worldwide. • At the end of 2003 estimated 40 million people were living with HIV/AIDS. Without treatment, all of them will die a premature. • In 2003, three million people died and five million became infected. • Almost 6 million people in developing countries need antiretroviral treatment, but only 440.000 were receiving it by end of 2003. • HRH insufficient and inadequate for scaled-up response **Malaria in Africa** • Accounts for 20% of all deaths in children under 5. • Severe malaria causing maternal deaths directly and from malaria-related severe anaemia. • In malaria endemic areas of Africa infection during pregnancy is estimated to cause an estimated 75 000 to 200 000 infant deaths each year (WHO 2004). • Recently (2004/05) conducted MDG needs assessment in 4 African countries (Kenya, Ethiopia, Ghana and Senegal) show slow progress towards reaching Abuja coverage targets of 60%. For example, ITNs less than 10% coverage for the target groups: • Malaria control is hampered by poverty, drug resistance, HIV/AIDS, climate and environmental change, lack of resources and breakdown of control programmes. **Tuberculosis** • TB kills 2 million people yearly. • South-East Asia Region; 33% of incident TB cases globally. However, per capita TB incidence in sub-Saharan Africa is nearly twice that of the South-East Asia, at 350 cases per 100 000 population (WHO 2004) • There is direct relationship between poverty, TB, gender and women health. • TB and HIV co-infection posing a great challenge. • Inadequate funding for TB calls for greater partnership. • TB control needs stronger general health systems **Important non-communicable diseases (NCD)** • Tobacco and smoking related illness, stroke, cancer, diabetes and chronic respiratory diseases, mental illness, substance abuse. • NCD not sufficiently addressed in MDG needs assessment and poverty reduction strategies in countries
7: Ensure Environmental sustainability	• Environmental sustainability is directly linked with health. • Many lack access to clean water and sanitation, causing 5.5% of the global burden of disease. • 1.6 million people die every year from diarrhoeal diseases (including cholera) attributable to lack of access to safe drinking water and basic sanitation and 90% of these are children under 5, mostly in developing countries (WHO/WSH 2005) • Health depends on combined access to water and fuel. • Solid fuel use is responsible for approximately 2.7% of the global burden of disease. • Fast population growth, urbanization, migration and global

	climate change relate to water, sanitation and hygiene in health and development.
8: Global Partnership for Development	• The Commission on Macroeconomics and Health has estimated requirements for investments, primarily in the health sector, to a total annual figure of US$ 27 billion, at least a four-fold increase in current donor spending on health. • Only a few donor countries have made significant progress towards the 0.7% GNP target. • However, spending on health and combating AIDS has increased. For example through The United States Millennium Challenge Account and the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM). • There are also issues of Trade- Related Aspects of Intellectual Property Rights (TRIPS) agreement and public health; trade in health services. • There is also a need to address other areas of inter-sectoral co-operation.

Promotion for MDGs

Health should be promoted at individual, family, community, institutional as well as national and international policy levels. Partnership is a key requirement because of the interconnectedness of the benefits, problems and the solutions. Research and monitoring of indicators through functional health information systems, integrated with a health promotion strategy is further essential to ensure that health promotion interventions are rational, evidence based and cost-effective.

Reduction of Poverty and Hunger
Advocating for fair trade of agriculture products from poor countries at global level, sustainable agriculture production, targeted welfare benefits and promotion of greater partnership with communities, civil society across sectors and with development agencies will have impact not only on reduction of poverty and hunger but also on child and maternal health, better sanitation and reduction of communicable and non-communicable diseases.

Universal Primary Education
The link between health and the goal of universal primary education is evident.
Supportive health promotion programmes for the children and adolescents in and out of school are crucial for the promotion of life-skills for adulthood and the principles of health promoting schools, personal and environmental hygiene, sexual and reproductive health. HIV/AIDS prevention, anti-tobacco campaigns, prevention of substance abuse, and promotion of sports as an important aspect of health.

Gender Equality
The socio-cultural and religious barriers that contribute to gender inequality need to be addressed through strengthened advocacy and accelerated implementation of gender equity strategies, as well as reinforcement of relevant legislations to protect women from domestic and other types of violence.

Advocacy is required to get gender related interventions with matching budgets included in the national poverty reduction and health strategic plans. Gender related campaigns should be conducted to discourage harmful traditions such as FGM and to enact laws.

Reduction of Child Mortality

Health promotion should show the link between child mortality and poverty, while emphasising that most under five children deaths are caused by preventable interventions that can be implemented in low-income countries. For example. Integrated Management of Childhood Illness Package which should be promoted and expanded for wider coverage of under five populations.

Community based health promotion strategy can prevent childhood diseases through child immunization campaigns, advocacy on the use of long lasting insecticide treated nets (LLITNS), access to safe drinking water and childhood nutrition, control on marketing of breast milk substitutes, greatly reducing child mortality. Such interventions could further be backed up through promotion of children's rights policies and laws and promotion of inter-sectoral collaboration and partnership for child health at various levels.

Tanzania Essential Health Intervention Project (TEHIP) has reported significant reduction in the mortality of children under the age of 5 years through evidence based approach to health planning and interventions. Community – level information systems provided the basis for bringing about more rational allocation of existing district level funds, and personnel to better focus on resources on highest diseases burden with dramatic reduction in for example the mortality of under-five children (55% decline between 1998 and 2003)

Maternal Health

Most interventions for reduction of maternal mortality are feasible at community levels, and may be facilitated through appropriate health promotion interventions (see box below)

Health promotion interventions for reduction of maternal mortality

- Community IEC on family planning, ante-natal care, improved nutrition during pregnancy, malaria prevention through use of LLITNs and other measures;
- Prevention of mother to child transmission of HIV/AIDS and
- importance of attended child birth by skilled health workers;
- Preparedness and timely response to obstetric emergencies and establishment of functional referral system through strong inter-sectoral partnership;
- Addressing socio-political and cultural barriers that contribute to maternal mortality
- Developing and reinforcing implementation of policies and laws to protect girls and women from early marriages, ensuring the rights to family planning, and protection from Female Genital Mutilation (FGM), war and domestic violence

Combating HIV / AIDS

Health promotion approaches, are crucial in ongoing global, and national efforts to combat HIV/AIDS, tackling major barriers to HIV/AIDS control. Prevention and care programmes for HIV/AIDS need to take into consideration underlying determinants

of the epidemic, including poverty, gender, inequality, and social dislocation and vulnerability.

The following HIV/AIDS interventions could benefit from health promotion:

- IEC on social stigma and discrimination.
- Education and behaviour change campaigns
- Promoting gender equity in HIV/AIDS and related programmes.
- Campaigning for global, national and community level support to the orphans.
- Harm reduction, behaviour change and condom promotion programmes, focused on vulnerable population
- IEC on Voluntary testing and counselling, control of sexually transmitted diseases (STIs)
- Advocating for prenatal testing and increased coverage of Anti-Retroviral treatment (ARVs) to prevent mother-to-child transmission (PMTCT)
- Promoting health systems precautions and blood safety
- Advocating for the rights to have access to treatment and care and social support for people living with HIV/AIDS.
- Support the harmonisation of prevention and treatment messages, in the communities and other levels.
- Advocate for greater partnership and commitments towards strengthened health systems, in response to HIV/AIDS
- Mobilisation of greater partnership in support of poor nations with high diseases burden due to HIV/AIDS and related conditions with one agreed HIV/AIDS action framework, one national AIDS coordinating authority and one agreed country-level monitoring and evaluation system
- Campaigning for accelerated action, which will enhance accessing and using the pledged vital resources for combating HIV/AIDS, including the GFTAM, US President's Emergency Plan for HIV/AIDS Relief (PEPFAR) and the World Bank.
- Promoting multi-sectoral response to HIV/AIDS.
- Campaigning for supportive policies and legal environment
- Promoting HIV research towards effective diagnostics and possible vaccine and traditional medicines through global and regional partnerships.

Uganda (in East Africa) has demonstrated a good example, whereby through strong partnership with national and international communities, PLWA, Government Civil Society Organisations, development partners, across sectors (multisectoral response). HIV/AIDS prevalence has been drastically reduced from over 30% in the 90s to 6.5% in 2005. (Uganda National HIV seroprevalence survey 2005).

The Government of Botswana began providing ART services in January 2002 and 29 months later a of 24, 087 patients were covered. The trend shows that more than 40,000 patients will be covered by end of 2005, which is nearly half of the 110,000 total patients needing ART country wide. Strong collaboration with international and local partners, between health facilities, support for PLWAs, improved health infrastructure, adequate HRH, decentralized ART services are among main enhancing factors (WHO/AFRO 2004).

Combating Malaria

Health Promotion in the implementation of the proposed integrated package for malaria control should address disease prevention through promotion of: (LLITNs), indoor residual spraying (IRS), anti-larval measures and malaria prevention in Pregnancy.

Malaria disease management should be backed up by IEC on the need for prompt and accurate malaria diagnosis, advocacy for increased access to effective and affordable antimalarials (e.g. Artemisinin Combination Therapy - ACT) and increased access to basic health care services, including home –based malaria management in underserved areas.

Successful scaled –up malaria control programmes have been reported from Ethiopia, Eritrea, Madagascar, Vietnam, South Africa and Tanzania. Experience from these countries shows that sustained reduction in the malaria burden can be achieved through well- coordinated efforts and strong partnership with communities and all stakeholders.

In Vietnam: 144 malaria outbreaks in 1991 triggered Government increased investment in malaria control including free distribution and treatment of bed nets in annual and biannual campaigns; application of IRS; deploying of new antimalarial medicines, including artemisinin derivatives; training and supervision of voluntary health workers to improve health seeking behaviours at community level. As result

- *number of people protected by vector control methods (ITNS, IRS) increased from 4 million in 1991 to 12million in 1998.*
- *number of people using ITNs rose from 300,000 to more than 10 million*
- *morbidity and mortality rates were reduced by 97% and 60% respectively*
- *local malaria outbreaks were eliminated (WHO 2000).*

Combating Tuberculosis

Health promotion initiatives may contribute significantly to the Global Plan to stop TB including advocating for actions to reduce stigma, promoting increased access to Directly Observed TB Treatment (DOTS) and care, promoting integrated TB, HIV/AIDS interventions and advocating for Global partnership and national commitments towards increased percentage of resource allocation for combating TB. Special attention to be given to the 22 high-burden countries which account for 80% of all TB cases, as well as Sub-Saharan Africa because of poverty and HIV-related TB.

Combating Non-Communicable Diseases

Advocacy should aim at more attention for non-communicable and chronic diseases and their consequences, promoting an integrated strategy for chronic disease prevention and control, mobilisation of global, regional and national partnership and additional funding. Research should remain as key function of Health Promotion, to generate more evidence on NCD and their impact on health and development. However, emphasis needs to be given to research on implementation, not just epidemiology. Although there are gaps in the evidence, enough is known to enhance necessary action now.

***WHO supported World Health Days (WHD)** have been useful as an entry point in campaigning for the control of NCD, especially, control of tobacco use, mental health, and other related conditions. It has proved quite effective in mobilising target groups at national and lower levels and could be considered as a good practice. However, there is a need to strengthen and support local ownership of this initiative towards sustainability.*

Summary of Health Promotion Approaches for Combating Diseases

a) **Disease prevention through promotion** of relevant preventive measures for example, increased access to ITNs to prevent malaria and condoms to prevent HIV/AIDS.

b) **Back up of disease management strategies** including

- IEC on the need for prompt and accurate diagnosis
- Advocating for increased access to effective and affordable drugs (e.g. ACT for malaria, ARV for HIV/AIDS and DOTS for TB)
- Advocate for increased access to basic health care services, including home –based care in underserved areas.

c) **Backing epidemic prevention and control** strategies including:

- Studies towards early detection of outbreaks
- Early warning and effective surveillance systems
- Addressing social and environmental factors, such as war, migration, change in local vector ecology etc.

d) **Promoting Information, education and communication** Strategies through

- IEC that is sensitive to local socio-cultural and environmental factors
- IEC on integrated disease control approaches (e.g. integrated malaria/HIV/AIDS/ TB. IMCI and safe motherhood), to foster effective and horizontal communications
- IEC that encompass broad exchange and adapt implementation measures to the needs of community

e) **Supporting Monitoring and Evaluation** (M&E) through:

- Monitoring trends in morbidity and mortality, resistance to medicines, coverage rates of prevention and management interventions etc
- Developing indicators to be used in monitoring, chosen according to local transmission conditions
- Ensuring availability of high-quality data for the chosen indicators.
- Developing capacities in health information systems as priority to enhance effective M&E of disease control programme

Environmental Sustainability

Health promotion is also important for alleviating the problems of water scarcity, pollution and related issues of environmental risks to child health, the fast population growth, urbanization, migration and global climate change. There is a need for strong health promotion to protect the poor, including advocating for legislation to protect human rights to safe and sustainable environment. Continuous generation of relevant data to monitor progress towards the water and sanitation targets and country support in the assessment of impact of water management activities are important health promotion interventions. Selective interventions should benefit "un-served" populations, such as slum areas. Also there is a need to empower and support local communities, especially the low-income and vulnerable groups, through strong advocacy and greater partnership.

Good practices have been reported from a number of countries through ***Healthy Cities Projects*** *(Thailand, Dar es Salaam in Tanzania, Cairo etc.). Healthy cities project includes among other interventions, promotion of healthy living styles integrated with poverty alleviation programmes in various settings. For example, through healthy market places, promoting food safety among street food vendors, healthy school, 'healthy communities' focusing on the poor and vulnerable groups, such as adolescents, People Living With AIDS (PLWA), women and orphans.*

Promoting Partnership

Health Promotion approaches are crucial for sstrengthening partnership and joint commitments, at local (community), national, regional and global levels in support of MDG achievement, including partnership with and among donors, international agencies, trade organizations, civil society, the private sector and local community.

Health Promotion could support the dissemination of good practices including experiences and learned lessons from countries that have adapted effective partnership approaches in MDG-PRS processes and Sector Wide Approaches (SWAp), which encourages joint donor/government/private sector/community planning, pooling of resources, joint implementation, monitoring and evaluation. Other forms of partnership that could be supported through health promotion include partnership across sectors (multi-sectoral approach), partnership with various groups in the society, including youth and women groups, partnership among professionals from various disciplines, also among various health programmes and partnership between Government and the private sector (public/private partnership).

The Piloting of MDG-PRS processes under the UN Millennium Project in selected countries (Kenya, Ghana, Senegal, Ethiopia, Tanzania, Tajikistan, Yemen, Cambodia and The Dominican Republic), has demonstrated good examples of strengthened partnership in the context of MDGs. The process involves partnership actions among Government, UN country teams, bilateral and multilateral agencies, the civil society, private sector, the community, training and research institutes. It includes close linkages between goals and sectors to ensure necessary synergies, to avoid unnecessary overlaps and reduce costs. The conducted MDG needs assessment has covered each of eight MDGs. The process involves five major steps: developing generic list of interventions; specifying targets for each set of interventions; estimating synergies across interventions/sectors; developing investment model, estimating resource needs and developing financing strategy.

It focuses on alignment with the national development policies and strategies, especially the PRS and supports capacity building for local ownership, greater partnership and sustainability. The end result is MDG-based national plans/PRS and responding Medium term Expenditure Frameworks (MTEF) and national budgets, all geared at MDG attainment.

Conclusion:

There is general slow progress towards MDGs achievements. Health promotion could potentially contribute in accelerating the progress, especially for the Health related MDGs.

Recommended way forward through Health Promotion

- Continue strong advocacy at national, regional and global level, taking the 2015 time-horizon seriously.
- Promote Information, education and communication strategies, sensitive to local socio-cultural and environmental factors, integrated with other health programmes to foster effective and horizontal communications, encompassing broad exchange and adapting implementation measures to the needs of communities
- Emphasis should be placed on underlying determinants of health including poverty, education and illiteracy, gender, environmental sustainability, urbanization, migration and other relevant factors, which calls for strengthened partnership and multi-sectoral action.
- Strengthen partnership, mutual trust and joint commitments, at local (community), national, regional and global level including development partners, international agencies, trade organizations, civil society and the private sector
- Promote social mobilization and community participation
- Promote social and economic development through MDG-based poverty reduction strategies
- Organise donor assistance around achievement of MDG's
- Advocate for increased financing, while streamlining and harmonizing financial and administrative procedures
- Promote proven cost-effective health interventions including "Quick Wins" actions to save and improve millions and to promote economic growth.
- Strengthen health systems to match the required up-scaling of activities to achieve the health MDG's
- Advocate for strong attention to human resources for health issues including motivation, migration, innovative training and flexibility in deployment
- Provide information and clear guidelines to countries on MDG-based poverty reduction (MDG-PRS) strategies aiming at achieving healthy populations
- Support MDG-PRS networking across regions and countries, and dissemination of lessons and best practices from the piloting countries.
- Improve required knowledge and information by promoting relevant research and strengthening MDG / Health information management systems
- Give special attention to sub-Saharan Africa because of its disproportional heavy burden of disease

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EMERGING HEALTH ISSUES:

THE WIDENING CHALLENGE FOR POPULATION HEALTH PROMOTION

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Abstract

There is a widening spectrum of tasks for health promotion in today's world. Since the Ottawa Charter (1986), substantial political, social, economic and environmental changes have occurred. While many broadly-averaged measures of population health are improving, various other indices of health and its determinants are faltering. There are emerging risks to health from demographic shifts, large-scale environmental changes, the cultural and behavioural changes accompanying national development, and an economic system that emphasises the material over other elements of well-being.

Reinforcement of inter-sectoral health promotion is needed (including engaging with the development, human rights and environmental movements). Not only must health promotion often transcend the health sector, but, increasingly, it must engage beyond national boundaries. The Ottawa Charter argued for "healthy public policy" – yet that was in a world that largely predated HIV/AIDS and a surge of other infections, unyielding widespread poverty and under-nutrition, worldwide declines in freshwater and soil fertility, recognition of climate change as a health threat, and escalating chronic disease burdens in developing countries. The need for that policy-level approach has heightened.

Examples of emerging health risks and trends include:

- Infectious diseases: Many diseases have emerged since the late 1970s, while others have unexpectedly increased. Reasons include persistent poverty, urban crowding, environmental changes (mobilising new microbes), altered sexual relations, intensified food production, increased mobility and trade, and tardy vaccine development.

- Regional life expectancy declines: Life expectancy has unexpectedly declined in various countries. Factors linking these declines suggest that others could follow. Relatedly, the demographic and epidemiological transitions have faltered. In some regions, declining fertility has overshot that needed for optimal age structure, while elsewhere mortality increases have reduced population growth rates despite continuing high fertility.

- Millennium Development Goals, health and sustainability: Several health-related MDGs appear unlikely to be achieved. Most policy-makers do not understand the link between environmental sustainability (MDG #7) and health. Sustainability entails maintenance of Earth's ecological and geophysical systems, and social cohesion, as the basis for health.

These large-scale risks to health present great challenges. Beyond engaging with other sectors, and across levels of society, health promotion must also address population health influences that transcend national boundaries and generations. The *big task* is to promote sustainable environmental and social conditions that bring enduring and equitable health gains.

Introduction

The 1986 declaration of the Ottawa Charter reflected a growing awareness that, in many parts of the world, declines in the social, economic, political and environmental conditions that underpin population health were jeopardising the goal of *Health for All by 2000*, signed 8 years earlier in Alma Ata.[1,2] This awareness stimulated fresh strategies to induce healthier behaviours for both communities and individuals, reflected in phrases such as "healthy choices should be easy choices" and calls for "healthy public policy". The Charter also emphasised the important, but often latent, health-promoting role of informed and empowered communities.

The forces driving the upward trajectory in global health evident in the decades before 1978, including the development and dissemination of improved health technologies, health services, decolonization and foreign aid, gave Health for All credence. But many of the underlying social forces that stimulated to the Ottawa Charter have intensified, despite the efforts of those concerned with health advancement and protection, and despite large increases in formal evidence and understanding of the fundamental determinants of health. Indeed, the foundations necessary to *maintain* current health levels are now at risk, while in some regions hard-won health gains have already been reversed.

Periodic attempts to reverse this trend, such as the Millennium Development Goals (MDGs), have slowed but not reversed this slide. Indeed, the rate of deterioration in the fundamentals needed for good global health appears to be quickening.

Two fundamental causes for these "emerging health risks" are: (i) economic policies that emphasise markets and intensified throughput over other elements of social, environmental and personal well-being, and, relatedly, (ii) Earth's ever-diminishing spare "bio-capacity"[3] available for exploitation. While an economic system that disproportionately benefits the powerful is hardly new, this co-exists with a human population with an expanding capacity and aspiration to appropriate and critically transform nature on a global scale.

The scale of these synergistic problems is unprecedented. If it seems overstated to call this combination "dangerous", bear in mind that the WHO constitution argues that "Unequal development in different countries in the promotion of health and the control of disease . . . is a common danger" for humankind as a whole."[4] To this long-recognised danger of grossly unequal health development must now be added the danger of unprecedented environmental change.

This paper discusses six selected contemporary emerging health issues, all relevant to and reflective of increased global health inequalities. The first four are the challenge of infectious diseases, urbanisation, declines in regional life expectancy, and the relationship between health and global environmental change, including to the climate. The UN's (2000) Millennium Development Goals are then viewed in the context of sustainability and health. Finally, we discuss the faltering of the global epidemiological and demographic transitions. We explore the linkages between these six issues, and conclude that health promoters must give heightened emphasis to population-level influences, and must expand alliances with other government sectors and other social reformers in order to improve population and community health.

Other emerging health issues which cannot be discussed in detail here include: (i) population ageing (including long periods of dementia-based dependency); (ii) the changing nature of work, including employment casualisation and the gulf of economic power separating consumers from workers; (iii) the increasing burden of road traffic accidents in low-income countries; (iv) the increasing likelihood of destructive acts of terrorism and bioterrorism, and (v) the increasing burden of mental health problems.

This paper does not consider in any detail the Health Promotion strategies needed to address these emerging health issues. Rather, the paper reviews the changing health-risks which highlight how today's world differs from that of the Ottawa Charter in 1986. However, we identify a systems-based understanding and a capacity to think on a larger scale and longer term as an underlying principle needed.

1. Emerging and re-emerging infectious diseases

In the early 1970s, it was widely assumed that infectious diseases would continue to recede: sanitation, vaccines and antibiotics were at hand. The subsequent generalised upturn in infectious diseases was unexpected. Worldwide, at least 30 "new" infectious diseases have been recognised since 1975.[5] HIV/AIDS has become a serious pandemic. Several "old" infectious diseases, including tuberculosis, malaria, cholera and dengue fever have proven unexpectedly problematic, including because of increased antimicrobial resistance,[6,7] new ecological niches, weak public health services and activation of infectious agents (e.g., tuberculosis) in people whose immune system is weakened by AIDS.

Diarrhoeal disease, acute respiratory infections and other infections continue to kill more than seven million infants and children every year.[8] In parts of sub-Saharan Africa mortality rates among children are now increasing.[9] While persistent poverty has preceded and shadowed most of these conditions the spread of some, such as SARS and West Nile Fever, have been promoted by trade, affluence and air travel.

This recent upturn in range and burden of infectious diseases reflects a general increase in opportunities for entry into the human species, transmission and long-distance spread. The underlying influences include increases in population size and density, greater mobility (including for air-travellers, migrants and refugees), population age-distributions unfavourable to development[10] and conducive to violence,[11] persistent poverty – especially in overcrowded and unhygienic slums, encroachment on undisturbed ecosystems and human-induced large-scale environmental changes (such as ongoing changes to the world's climate system. These causes are further complicated by conflict and warfare, gender-based violence, political ignorance, denial (as has occurred with HIV/AIDS in parts of sub-Saharan Africa), iatrogenesis (as with HIV in China) and vaccine obstacles.

While specific new infectious diseases cannot be predicted, there is now improved understanding of the conditions favouring disease emergence and spread: (i) new human-microbe contacts, as in animal domestication and forest clearance;[12,13] (ii) disturbance of natural ecosystems and their various internal biotic controls;[14] and (iii) poverty, crowding, social disorder and under-nutrition – and, at the other end of the nutritional spectrum, people with impaired immunity due to poorly controlled diabetes (an obesity-associated disease on the increase globally).

The apparent failure of WHO's Roll Back Malaria program[15] shows the risk of stand-alone (vertical) approaches to disease and the difficulties in operating outside older institutions. Yet the program raised new funds, increased high-level awareness, and led to political pledges of support. This encapsulates a dilemma for health promotion. Enthusiasm, while necessary, is insufficient. Technical advice, attention to detail and genuine collaboration are essential.

Finally, this is a microbially-dominated world, and we must understand and approach our relations with microbes primarily in *ecological* (not military) terms. We cannot banish the world's infectious agents; but we can eliminate some, control many, and we have knowledge of how to reduce human population vulnerability and avert conditions conducive to infectious disease occurrence – both of which should be foci of health promotions strategies. We would thus achieve a more sustainable approach to human-microbe co-existence.

2. Urbanisation: gains and losses for population health

Most of the recent global population increase has been absorbed by towns and cities in developing countries. The urban environment is rapidly becoming the dominant 'human habitat'. Few cities have been able to adequately plan and provide social and material infrastructure essential for health, resulting often in un- and under-employment,[16] slums and other high-risk environments. Rapid urbanisation transforms many values and behaviours, alters social relations, and leads to various health gains and losses. In recent decades, rural-to-urban migration yielded a net health gain in many developing countries (as in European countries in the nineteenth century). This is no longer assured. Losses include breakdown in family and community relations; amplified violence and drug-abuse; readier spread of many infections; road trauma; air pollution; a distorted daily energy-balance in an 'obesogenic' urban environment;[17] and, for many, a search for meaning and spiritual connection unfulfilled by consumerism.[18]

Empirical evidence and understanding of how some health risks are embedded in urban design, infrastructure (especially transport systems), housing, marketing strategies and retail choices have recently increased – as has the understanding of how these 'urban' health risks are modulated by socioeconomic and other disparities. This growing awareness of the urban environmental and social contextual influences on health risks, in contrast to a focus on personal behaviours and consumer choices, underscores the important *ecological dimension* that health promotion strategies must embrace if enduring health gains are to be achieved.

3. Declines in regional life expectancy: Reflecting what?

The upward trajectory in life expectancy forecast in the 1980s[19] has been challenged by recent major reversals in several regions, especially in Russia [20] and sub-Saharan Africa.[21] Although these could either be temporary aberrations or be unconnected to one another, identifiable factors appear to link these declines – declines that may presage other falls in life expectancy.

The dramatic decline in life expectancy in Russia since 1990 has been unprecedented for a technologically developed country. Many proximal causes have been well- documented, including increases in alcoholism (especially binge drinking), suicide, violence, accidents and cardiovascular disease.[22] These factors suggest a society facing a collective crisis of social disintegration and crisis.[23]. As recognised with malaria and HIV in sub-Saharan Africa, these adverse health consequences are of sufficient consequence to further depress population health.

In sub-Saharan Africa, HIV/AIDS has combined with poverty, malaria, tuberculosis, depleted soils and undernutrition,[24] deteriorating infrastructure, gender inequality, sexual exploitation and political taboos to foster a runaway epidemic that has reduced life expectancy, in some cases drastically. In turn, adverse health and human capital losses, caused both by disease and the out-migration of skilled adults has helped to "lock-in" poverty. In parts of sub-Saharan Africa childhood mortality has increased, not only directly from AIDS but also because of a loss of parents and other carers.[25] More broadly, indebtedness and punitive development policies, including charges for schooling and health services, often introduced as a consequence of structural adjustment programmes, have also hurt population health in Africa, following decades of earlier improvement.[1] The intersectoral implications for health promotion are clear.

Conflict – most notoriously in Rwanda[26] – has also been on a sufficient scale to temporarily reduce life expectancy for some populations. Age pyramids skewed to young adults have almost certainly played a role in this violence,[11] together with resource scarcity, pre-existing ethnic tensions, poor governance and international inactivity when crises develop.

4. Global environmental changes (including climate change)

Sustainable population health depends fundamentally on the viability of the planet's life-support systems – the integrity of the natural environment. For humans, achieving and maintaining good population health and wellbeing is the true goal of sustainability. Human societies have devised social structures, economic systems, technologies and environmental management practices primarily to enhance human security, wellbeing and health.

In today's world, global environmental changes pose new risks to human health, on an unprecedented spatial-temporal scale. Over recent years, evidence has accrued of complex human-induced environmental changes at global/worldwide scales – climate change, stratospheric ozone depletion, biodiversity loss, regional downturns in the productivity of land and oceans, freshwater depletion, and disruption of major elemental cycles (especially sulphur, phosphorus and nitrogen – resulting in environmental nitrification). Over the coming decades, these long-term change processes could exact a great health toll via physical hazards, infectious diseases, food and water shortages, conflict and an inter-linked decline in societal capacity.

Material living standards and life expectancy have increased greatly in most countries during the past half century. However, trends in measures of "inclusive" wealth which account for the true economic costs of the drawdown of natural and social capital (the support systems needed for biological production and social harmony) are less favourable. These data reveal that the true increase in net

income is less than supposed, and in some populous countries is actually declining.[27] More fundamentally, the juxtaposition of regions with declining inclusive wealth may generate harmful synergies, including conflict and health declines.

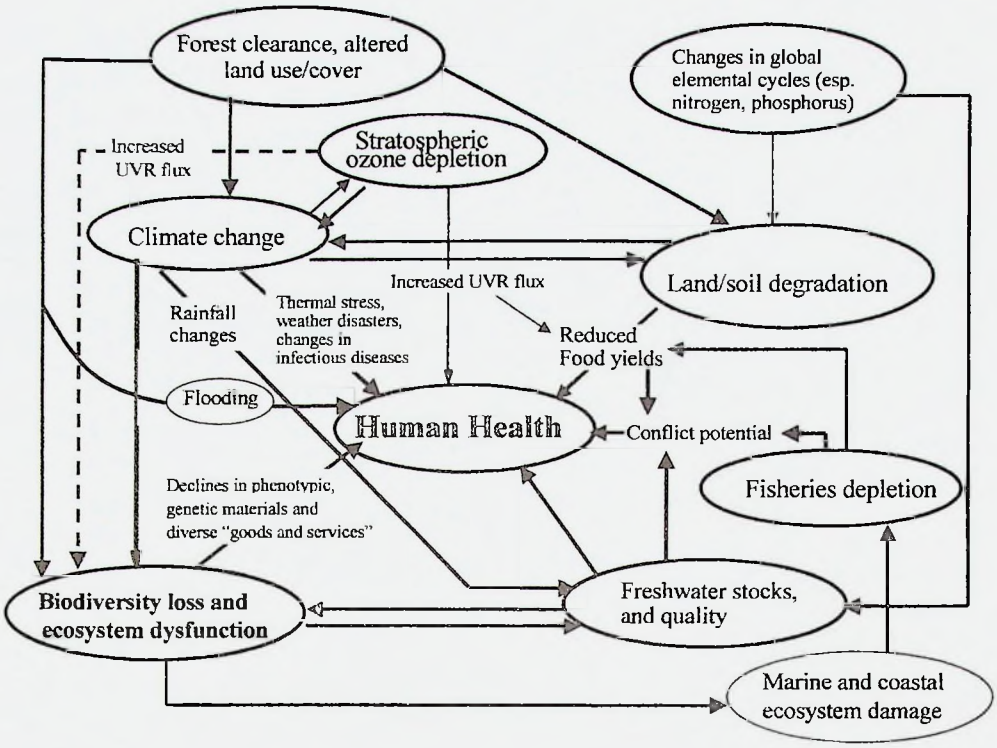
We currently extract "goods and services"[28] from the natural environment about 25 per cent faster than they can be replenished.[3] Correspondingly, there is now little unused "biocapacity" to draw down. In combination, we are therefore transmitting an increasingly depleted natural world to future generations, and this will have inevitably have adverse health consequences. While the distribution of these adverse effects is likely to be unequal, and – for many – lagged, it is not inconceivable that this decline could eventually harm the entire human population.

Global climate change is attracting increasing attention. Fossil fuel combustion for industrial processes, agriculture and transport has caused unprecedented levels of atmospheric carbon dioxide and other heat-trapping gases. The majority expert view is that climate change, which is likely to also involve significant hydrological and agricultural changes[29] is now underway. WHO has estimated that, globally, over one hundred thousand deaths annually result from recent change in the world's climate relative to the baseline average of 1961-1990.[30]

The most direct risks to future health from climate change are posed by heatwaves (exemplified by the estimated 25,000 extra deaths in Europe in August 2003[31]), cyclones and floods. Climate-sensitive biotic systems will also be affected. This includes: (i) the vector-pathogen-host complex involved in transmission of various infections (both vector-borne infections and those due to various bacteria such as salmonella), (ii) the production of aeroallergens, and (iii) the agro-ecosystems that generate food. Recent changes in infectious disease occurrence in some locations – tickborne encephalitis in Sweden,[32] cholera outbreaks in Bangladesh,[33] and, debatably, malaria in the east African highlands[34] – may partly reflect regional climatic changes.)

Altered climate and ecosystems, biodiversity losses, and other large-scale environmental stresses will, in combination, affect the productivity of local agro-ecosystems, freshwater quality and supplies, and the habitability, safety and productivity of coastal zones. Such impacts will cause economic dislocation and population displacement. Conflicts and migrant flows would increase, and, variably, a mix of violence, injury, infectious diseases, malnutrition, mental disorders and other health problems would result.

Figure 1. Major pathways by which global and other large-scale environmental changes affect population health.

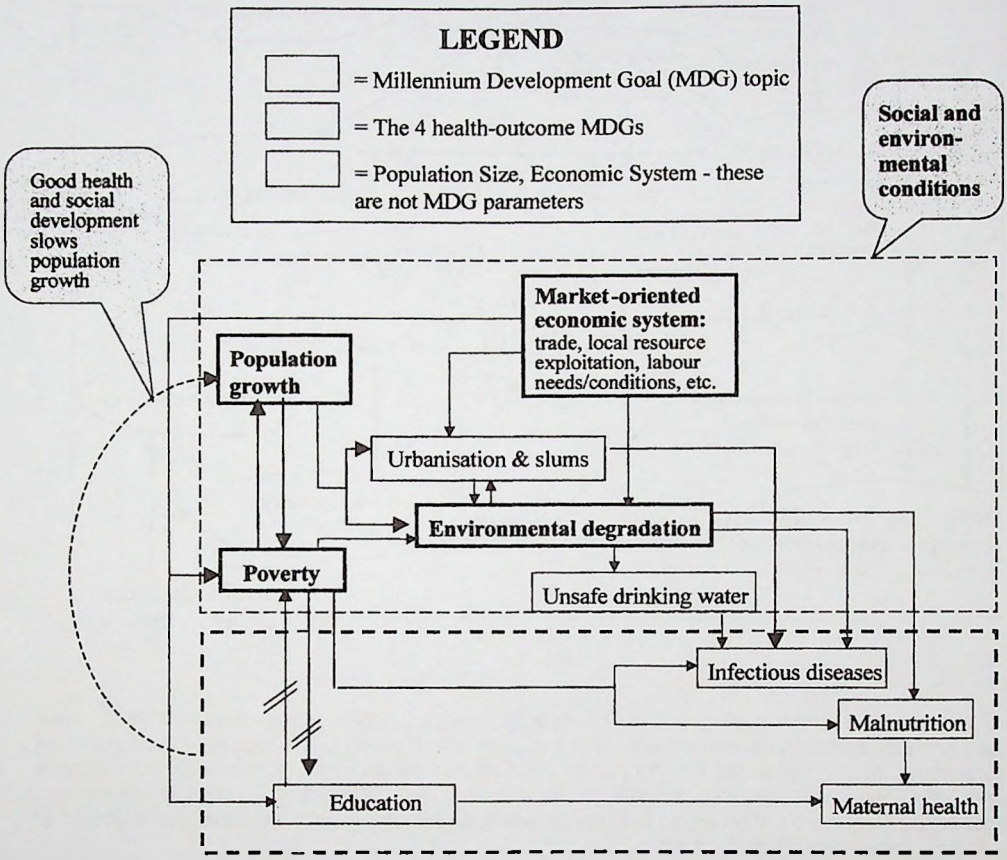


These and other categories of global environmental changes, often acting in combination, pose serious health risks to current and future human societies (see Figure 1). The important message from this diagram is that, increasingly, human health is influenced by social-economic and environmental changes originating well beyond national or local boundaries. The major, perhaps irreversible, changes to the biosphere's life-support system, including its climate system, increase the likelihood of adverse inter-generational health impacts.

5. Emerging health issues and the Millennium Development Goals

In 2000, UN member states agreed on eight Millennium Development Goals (MDGs), with targets to be achieved by 2015. Four MDGs refer explicitly to health outcomes: eradicating extreme poverty and hunger; reducing child mortality; improving maternal health; and combating HIV/AIDS, malaria and other infectious diseases. Figure 2 indicates the relationships of the MDG topic areas to the emerging health issues discussed in this paper.

Figure 2. Relationships between: (i) social and environmental conditions and their underlying economic and demographic influences, and (ii) the Millennium Development Goal topics. (Three of this paper's main issues – urbanisation, environmental changes, infectious diseases – are explicitly represented as boxes.)



Many of the MDG targets are already in jeopardy. While all MDGs are inter-linked, the 'environmental sustainability' MDG has fundamental long-term importance.[35] Without it, the other concomitants of sustainability – economic productivity, social stability and, most importantly, population health – are unachievable.

Striving for sustainability should not, however, overshadow tackling the existing, immediate, social and environmental problems that directly affect the health-related MDGs.[35] But, by similar token, we cannot ignore the connections of population size and economic growth with health status, poverty and environmental sustainability. The burgeoning environmental impact of humanity's collective 'ecological footprint' reflects the ongoing increases in both the levels of per capita consumption and population size.[3] Therefore, an additional reason to advance the MDGs is because that will help slow population growth rates, and that will reduce our collective ecological footprint.

6. The faltering demographic and epidemiological transitions

Both the demographic and epidemiological transitions have become less orderly than previously predicted. In some regions (including parts of Europe, Russia, Japan, and possibly China) declining

fertility rates have overshot the rate needed for an economically and socially optimal age structure,[36] while in other countries population growth has declined substantially because of the reduced life expectancy discussed above.[21] Further, the health dividend from a reduction in poverty may still be only partial because of the emergence of "diseases of affluence", including those due to obesity, tobacco use and air pollution.

During the Green Revolution (which coincided with the period before the drafting of the Ottawa Charter) a prevalent view was that unconstrained population growth has little impact upon environmental amenity and other conditions needed for human well-being. This view has recently been re-evaluated,[37,38] signifying a return to an earlier, more cautious approach to the benefits and costs of rapid population growth. There is increasing recognition of the likely adverse effects, including high unemployment when population increase outstrips growth of opportunity. Hence, unsustainable regional population growth is characterised by age pyramids excessively skewed to young age, high levels of under- and un-employment, and intense competition for limited resources. These circumstances predispose to a social milieu inimical to public health. Indeed, if there is also significant inequality and/or ethnic tension, catastrophic violence can result.[26,39]

Although they have vastly different demographic characteristics, there are links between the life expectancy declines in Russia and parts of sub-Saharan Africa, particularly the erosion of public goods. Viewed on an even larger scale, these set-backs accord with certain elements of a global class system,[40-42] in which privileged groups in both developed and developing countries act (often in concert) to protect their own position at the expense and health of others.

While inequality is intrinsic to all human societies, its current scale and accelerating growth, in the context of a declining stock of spare "bio-capacity" (the capacity of the Earth's biological and other natural processes to provide, replenish and absorb – see above)[3] jeopardises the already faltering demographic and epidemiological transitions. Hence, future population growth may slow not only because of a decreased fertility linked to increased life expectancy (in some regions), but because of persistently high death rates elsewhere.

On the other hand, the resurgent awareness of these related issues, the publicity surrounding the MDGs, the ongoing campaigns against poverty and Third World debt, calls for public health to address political violence, and the renewed vigour of social movements for health (e.g., the People's Health Movement)[43] afford new potential resources and collaborations to the global health promotion effort.

Globalisation, trade, economic policy, and public health: Towards a unifying explanation for faltering health

There is intense debate about the health benefits of the complex social, cultural, trade and economic phenomena that comprise "globalisation".[44-46] Well-informed advocates have differing viewpoints[47] – perhaps inevitably, given the complex mix of factors that allow alternative explanations of heath consequences that might otherwise be attributed to globalisation. The debate itself, however, indicates that the net gain or loss for population health from globalisation is unclear.

As described above, the rate of gain in average global life expectancy has recently slowed, as has the 'classical' epidemiological transition associate with 'development'. These changes to a blunt but powerful indicator of population health question the proposition that globalisation confers widespread health benefit. Further, many of the health (and other) dividends that might be attributed to globalisation have alternative explanations – for example, health gains in many developing countries may actually be the time-lagged result of development policies and technologies introduced *before* the era of structural adjustment and partial economic liberalisation. The accelerated demographic transition in China has also played an under-recognised role in that country's rapidly growing wealth,[10] as did China's earlier investments in health and education.

In theory, free trade, via the mutual benefits of comparative advantage, can benefit all populations. In reality, wealthy populations are likely to continue tilting the economic and political playing field so that the theoretical shared gains of free trade (as, indeed, was predicted by some 19th-century trade theorists).[48] Indeed, a powerful real-politic impediment to the complete removal of trade-distorting national subsidies is that this *would* probably entail a greater relative economic loss for wealthy

countries than for the poor. The economic disadvantages incurred to date through partial market deregulation have largely been confined to relatively poor, politically weak, populations. Any suggestion of broadening these economic stringencies to more powerful populations, especially to their subsidised agricultural sectors, provokes great opposition.

The current dominance of economic theory and criteria, in government, presents a major challenge to health promotion in tackling fundamental impediments to wide and enduring gains in health. The narrow focus of the World Trade Organization, in largely discounting the adverse social, environmental and public health impacts of its championing of 'free-trade' policies, underscores the problem. Today's dominant economic theory evolved when environmental limits were considered remote.[49] Besides, these theories assume that increased per capita income will offset the non-costed losses ("negative externalities"), whether those affect social welfare, environmental resources, or public health. Critiques of these theories[27,49] consistently note that the harshest costs of modern economic practices fall upon ecosystems and populations with little current economic power or value – including generations not yet born.

Many indices of inequality, including in health, income, and the risks from climate change, have risen in recent decades.[29,50] To date, much of the critical commentary on this[51] has been largely *conceptual*, emphasising the adverse experiences of the disadvantaged and unborn. Meanwhile, the *practical* feedback actually received by the main beneficiaries of modern economic policy is mostly positive – and hence misleading. Hence, a major challenge for the promoters of health (and other forms of justice) is to adduce *stronger evidence* to convince policy-makers to promote these public goods, even though this may diminish the *relative* privilege of those policy-makers and their constituencies.

This is a tall order – but an essential task for health promotion. The diverse challenges of modern globalisation cannot be ignored. Mobility of capital brings development, but its fickleness risks capricious flight, with consequent economic and public health hardship. Deregulated labour conditions facilitate cheap goods, but concentrate occupational health hazards among powerless workers.[52] Increased labour mobility and steep economic gradients weaken family and community structures, contribute to "brain drain" (including of many health workers)[53] and promote inter-ethnic tensions. All these endanger or erode the health of vulnerable populations.

In summary, global and regional inequality, narrow and outdated economic theories and their misleading price signals, and an ever-nearing set of global environmental limits are endangering population health. On the positive side of the ledger, there have been gains in literacy, information sharing, and food production (environmental costs notwithstanding) and access to food in some regions, and new medical and public health technologies continue to confer large health benefits. Overall, though, reliance on economic processes to achieve social goals and to set priorities, and on technological fixes for environmental problems, are poorly attuned to the long-term improvement of global human well-being and health. For that, a transformation of social institutions and norms, and, hence, of public policy priorities is needed.[54] The criterion of population health should be a powerful lever in that process of change. That is part of the modern task of health promotion.

Emerging Health issues: The challenges for health promotion

This paper has explored the widening spectrum of tasks for health promotion in today's world. Since the Ottawa Charter (1986), substantial political, social, economic and environmental changes have occurred. While many broadly-averaged measures of population health are improving, various other indices of health and its determinants are faltering.

The sources of many contemporary risks to population health are of large spatial and temporal scale; they affect whole systems and social-cultural processes (in contrast to the many continuing health risks from personal/family behaviours and localised environmental exposures). These newly recognised risks to health derive from demographic shifts, large-scale environmental changes, the cultural and behavioural changes accompanying national development, and an economic system that emphasises the material over other elements of well-being.

These emerging risks to health present a huge challenge. The wider community, including most governments, are not yet well attuned to understanding or responding to these larger-scale influences on health. They fall outside the popular focus on health risks in relation to personal behaviours,

specific environmental pollutants, doctors and hospitals. In countries where the prevailing ethos promotes individual choice and responsibility, there are few economic incentives to promote the population's health or other public goods.

Health promotion must, of course, continue to deal with the many local and immediate health problems faced by individuals, families and communities. But to do so without also seeking, to guide social-economic development and the forms and policies of regional and international governance is to risk being "penny wise but pound foolish". Tackling these more systemic health issues requires multi-sectoral policy coordination[55] at community, national and international levels, via an expanded repertoire of bottom-up, top-down and "middle-out" approaches.[56] The essential task is that of *population health promotion.*

Reinforcements for the work of population health promotion must come from:

1. Research: Better understanding of large-scale sources of health risks, and intervention strategies, requires a capacity for systems-level interdisciplinary analyses, informed by an ethical framework. The UN's Intergovernmental Panel on Climate Change provides a good model of interdisciplinary research that incorporates assessment of health risks.[57] The research gaps exploited by proponents of unhealthy products and practices to oppose health-promoting reform should be filled, though some scientific uncertainty is inevitable and should not be used to excuse inaction.[55] There is also need for better monitoring of indicators of wellbeing, social development and equity.

2. Education: The rising generations must understand better the ecological envelope within which the human species lives. We are a part of, not apart from, nature – and are ultimately accountable in nature's currency. Hence, the essence of "sustainability" is that we must learn to live on the natural world's terms, not on our own presumptuously detached (and ultimately destructive) terms. That requires changes in educational curricula and social norms.

3. Politics and governance: Our nineteenth-century political legacy of narrowly self-interested nation-states can be described (with some poetic licence) as a modern analogue of ancestral warring tribes. This self-centred short-termism appears to have been 'programmed' into the human species by the primordial evolutionary struggle for survival. Its downside, in an increasingly interconnected and inter-dependent world, is that it now threatens humanity with the adverse consequences of self-interested, non-sustainable, social, economic and environmental behaviours. We must deploy our (largely latent) ability to anticipate and shape the distant future, in order to override these counter-productive drives.

4. Business: This sector remains a key (potential) partner for population health. This sector can play a key role, for example, in countering emerging infectious diseases and human-induced global environmental problems. There is (at last) a growing acceptance by the pharmaceutical industry of the need to provide cheaper drugs in high-need low-income countries. There is great health promotion potential in relation to health-endangering production processes (e.g. local air pollution and greenhouse gas emissions), and in the distribution and sale of products and services harmful to health such as tobacco and energy-dense food. Business is beginning to respond to the wider health implications of its commercial actions. The sector must be encouraged to recognise that – for both ethical and self-interest reasons – there is an urgent need for *corporate social responsibility* to protect the health of people, workers, environment and social relations.

   Health Promotion should engage effectively with the private sector in three relevant domains: corporate social responsibility, consumer and environmental advocacy, and government stewardship. Meanwhile, it must be alert to how some companies, such as major tobacco transnationals, have sought to corrupt the concept of corporate social responsibility by their actions.

Conclusion

The contemporary challenge for health promotion extends that foreseen in 1986. However, the essential principles of the Ottawa Charter are still valid. Tackling today's systemic population health issues requires working at community, national and international levels. There is need for proactive

engagement with international agencies and programs that bear on the social-economic fundamentals in disadvantaged regions/countries. Many low- and middle-income countries require financial aid from donor countries to achieve the health-related Millennium Development Goals, to deal with emerging and re-emerging infectious diseases, and to counter the emerging health risks from human-induced global environmental problems. Linkages should be strengthened between the health sector, and civil society, including those struggling to promote development, human rights, human security and environmental protection.

We urgently need an increased understanding that "sustainability" is ultimately about optimizing human social and biological experiences – especially wellbeing, health and survival. That requires changes in social and political organization, and in how we design and manage our communities (especially modern urban environments). We must live within the limits of the natural world.

Beyond engaging with other sectors, and across levels of society, health promotion must also now address population health influences that transcend national boundaries and generations. The *big task* is to promote sustainable environmental and social conditions that bring enduring and equitable gains in population health.

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Health of the Marginalized Groups

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Health of the Marginalized

Poverty and ill-health are intertwined, as poor countries tend to have worse health outcomes than better off countries. Within countries itself, the poor and the marginalized have worse health outcomes than the better off. For example, those living in absolute poverty are five times more likely to die before reaching the age of five, and two and a half times more likely to die between the age of 15 and 59, than those in higher income groups. This association between poverty and ill health reflects causality as ill-health may have a substantial impact on household income and may even make the difference between being above and being below poverty line.

Poor countries and the marginalized within these countries suffer from a multiplicity of deprivations that translate into high levels of ill health. The marginalized people are caught in a vicious circle as poverty breeds ill-health and ill-health maintains poverty. Among the marginalized itself, there are those who are doubly burdened such as, the economically depressed indigenous people, refugees and women. Although there has been significant improvement in the health status of the people of the world overall, these groups have remained further marginalized.

The failure of health services to reach the poor and the marginalized in developing countries, despite their disease burden is not just a matter of the better off using their higher income to purchase care from private sector. The marginalized receive less of government subsidies to the health sector, this bias in favour of the rich is especially pronounced in the hospital sector, which benefits from the largest part of the government spending.

Emerging context and its implications on health promotion

The earlier ups and downs

The interest of the international community in health inequality has varied greatly in recent years. The 'Health for All' movement, which was greatly accelerated by the 1978 International conference on Primary Health Care, held at Alma Ata was later displaced by greater concern for health system efficiency and sustainability. As the pendulum began to swings towards what became known as "health sector reform" the attention shifted from the disease burden of the poor to that of the worlds as a whole. More recently the interest in equality, equity and the health of the poor has begun to rise again.

The incipient renewal of concern

As the third millennium began, there was an incipient renewal of concern for poverty and equity in health. Further impetus was provided in statements by WHO's Director-General, Dr. Brundtland in 'World Health Report' stating, "... there is a need to reduce greatly the burden of excess mortality and morbidity suffered by the poor".

As health is now higher on the international agenda than ever before, and concern for the health for the poor people is becoming a central issue in development, three of the Millennium Development Goals (MDGs) call for health improvements by 2015: reducing child deaths, maternal mortality and the spread of HIV/AIDS, Malaria and Tuberculosis. The first MDG to reduce by half the proportion of the population in extreme poverty by 2015 cannot conceivably be accomplished if the health goals are not achieved. The nations of the world have agreed that enjoying the highest attainable standard of health is one of the fundamental rights of every human being, without distinction of race, religion, political belief, and economic or social condition which is also central to overall human development and to the reduction of poverty.

Need for a Paradigm Shift

Health Promotion and Development efforts need a paradigm shift to substantially address the challenges of Health & Development of the marginalized. Let us examine them.

Poverty and Social Justice

The health of all communities specially marginalized is inextricably linked with issues of food, shelter, education and social dignity. While various efforts have been made to tackle these issues, their overall impact has been insignificant. In the coming years, therefore, the governments will have to devise more imaginative and people-centred efforts to deal with these vexing issues. Land reform and minimum wages, in particular, will need to be tackled on a war footing. Economic and social development of the underprivileged must go hand in hand.

Gender Inequity

Gender inequity is another major stumbling block. It must be addressed through state legislation and involvement of women in formal decision making. This must be supported by people awareness, education and income generation if the transition is to be meaningful.

Since health is integral to the overall development of women, a multi-sectoral approach will be needed through development of partnerships with other related sectors. Any group, programme or body aiming to enhance the status of women is a potential partner for health.

Population Stabilization

Factors contributing to population growth include new sources of income, the desire for security in the absence of banking and pension schemes, innovative technologies, improved crops, education and health care. Factors which contribute to a decline in growth rate are high child mortality, the preference for sons, greater awareness of family planning, delayed marriages and the consequent reduction in the number of child bearing years. There are important lessons to be learned from the overall success of Sri Lanka and some pockets of Bangladesh and India with respect to population stabilization.

Compared to the scale of government efforts to tackle this problem in the region, the overall results have been disappointing. Most countries are seized of the need for a fresh approach, and are making the necessary shifts.

Health and Environment

A very high percentage of morbidity of the marginalized population can be traced to the absence of safe drinking water and improper sanitation. Water and sanitation schemes can no longer be viewed simply as engineering projects: the human element has to be recognized and due importance given to involvement and co-operation of intended beneficiaries, particularly women. At the same time, these interventions must be sensitive to local customs governing the position of women in the home and community, as well as their relative seclusion.

Pesticide use and dumping of chemicals are adding a new dimension to health problems. Barring some isolated pockets, these problems have not received adequate attention. Common resources like waterbody, forest on which marginalized are dependant getting polluted, privatized, often making it difficult for them to access causing considerable hardship.

Control of Communicable & Non-communicable Diseases

Most countries are passing through a prolonged phase of epidemiological transition: a phase in which the health problems of the affluent and not-so-affluent co-exist. In other world, these countries must bear a dual burden: of communicable diseases associated with poverty, malnutrition & unhygienic living conditions and non-communicable ones such as ischemic heart disease, hypertension, cancer and diabetes associated with affluence, stress, changes in lifestyles and dietary habits.

It must be stressed that globally, non-communicable diseases are emerging as the leading cause of death. At present, the risk of death from these during adulthood (15-60 years) is considerably higher in the developing world than in established market economies.

Given longer life spans, the health needs of the elderly must be kept in mind as societies evolve. The number of people in the over 65 bracket is growing faster in poor and developing countries than in advanced ones. Although the elderly in many countries now enjoy better health, an ageing population is often associated with a growth in non-communicable diseases and mental and emotional health problems.

Urban Health Strategies

The major health problems identified in the poor urban areas can be summarized as follows: diarrhoeal diseases, respiratory diseases, infectious diseases (preventable by immunization), malnutrition, tuberculosis, malaria, gynecological disorders and infections, sexually transmitted diseases and socio-psychological problems like drug addition, alcoholism, domestic violence and child abuse.

A comprehensive urban health care strategy, if it is to succeed, requires fundamental changes of attitude and approach in city health systems and government agencies. Urban health cannot simple by 'added on' to existing services. Priorities should be set on the basis of the most important causes of mortality and morbidity, prevailing epidemiological and socio-economic conditions. However, the following interventions are almost universally required:

- Provision of primary health care services like immunization, control of diarrhoeal diseases, acute respiratory infections, malaria, tuberculosis and provision of antenatal and postnatal care. While these are important in the short run, interventions that focus on the underlying causes of ill health are much more significant in the long run.
- Decentralized area-bound planning and the management of primary health care and development programmes, with the active, democratic participation of the community, is essential. Broadening the outlook of municipal departments and capacity-building of community workers are necessary supportive steps.
- And above all comprehensive housing policy for the marginalized.

Cooperation and Partnership for Health

Health is a social goal. Hence, responsibility for it has to be shared among all concerned sectors. This was reflected in the principle of primary health care enunciated at Alma Ata in 1978, where WHO Member States endorsed the strategy for intersectoral action to achieve the goal of Health for All.

Outside the boundaries of the health sector exist an array of opportunities, sectors and systems institutions and individuals, as well as organizations engaged in the cause of human development or crucial to it. These are out potential partners for health.

Health is also an attractive entry point for most development programme or change initiatives. This is already evident in the numerous partnerships which have been established. Three such examples are environmental sanitation, immunization and safe motherhood, which have attracted willing partners – NGOs, both national and international, and bilateral development assistance agencies. School health is another area where the ministries of health and education collaborate. Major multisectoral opportunities are also offered by HIV/AIDS prevention and care and by environmental issues. Strengthening of district health systems is an area which has gained the support of UN agencies.

There is a need to develop greater awareness of the responsibility of governments towards ensuring health security for the marginalized people, and to strengthen health systems with allocation of adequate resources for health development, particularly for primary health care benefiting the marginalized and underprivileged population. This needs strong political will and commitment to HFA on the part of decision makers. Efficient and effective utilization of available resources call for sound managerial skills and motivation. Improving the managerial performance of the civil service, including decentralization, is one of the key areas of health sector reform, discussed below:

Government Health Infrastructure

As discussed earlier in this paper, the performance of the health infrastructure is clearly below par. Health sector reform, therefore, is imperative. Such reform calls for fundamental, not cosmetic, changes in health policy and institutional arrangements. The main areas where reform is indicated are:

- Reorientation and restructuring of ministries of health, including publicity financed and organized services.
- Broadening health financing options.
- Improving the performance of the civil service, including decentralization.
- Expanding partnerships.
- Specially focusing to the needs of the marginalized.

In other world, it is imperative that we develop a long term perspective and an altogether new framework for public health action so as to strengthen national capabilities, infrastructure and technologies.

Meanwhile, change will inevitably come about in the way health services are planned, financed and managed. New approaches to health care will be tried out in different countries. Mechanisms to disseminate and share these experiments will need to be worked out.

Private Sector in Health Care

The growing disillusionment with the government's delivery system has fuelled the phenomenal growth of the private sector in health care. The private sector is unusual in its variety and scope, allowing room for various systems of system to co-exist. The emergence of the cadre of registered medical practitioners (RMPs) is an interesting feature and points to the ability of the private sector to respond to felt needs and purchasing power of different segments of society.

Unfortunately, many private doctors resort to unethical and irresponsible practices, not least among them irrational prescription of drugs.

Recent studies show that the private sector is a significant provider of primary health care as well, providing services like immunization across regions and income groups, though their overall quality is debatable. However, given that the sector will continue to be a major player in the health scene, a conscious effort and strategy must be evolved to involve it in overall health care. At the same time, regulatory policies may be needed to improve the quality of private health care services without affecting their accessibility and affordability. A rational drug policy will go a long way in diluting the nexus between the drug industry and medical practitioners making curative resources cheaper.

The time has come to evolve subsidized health insurance scheme for the marginalized. Many studies show this is one of the major cause of indebtedness of the poor.

Voluntary Agencies and Health Care

Voluntary agencies have played a significant role in developing alternative models, as well as providing low-cost and effective health services. They have succeeded in developing village-based health cadres, appropriate educational materials and technologies. These voluntary agencies also play a critical role in filling gaps in the government health services, specially in the area where the marginalized live.

Given their track record, it would be wise to upscale the activities of voluntary agencies. Unfortunately, their work is often hampered for want of a supportive climate and finances. Enabling policies and appropriate government inputs will go a long way in helping NGOs reach out to the innumerable pockets where the health situation continues to be grim.

Likewise, voluntary agencies can play an extremely important role in pioneering research work on issues of public concern, helping communities evolve self-sustaining health care mechanisms, as well as lobbying for policy change.

If they are to realize their true potential, voluntary agencies must widen their scope and concerns by:

- Proactively addressing the health need of the marginalized
- Joining hands with other progressive forces in the broader struggle for social justice
- Tackling issues of socio-economic justice in their areas of operation
- Working towards a viable alternative health strategy
- Generating public awareness on rational and holistic health so as to create a conducive atmosphere for a shift in policy
- Pressing for greater public accountability of the government health machinery
- Building up a consumer movement to ensure affordable, quality health care from the private sector

In their new role, voluntary agencies will often find themselves at loggerheads with the state, medical establishment and drug industry. But then genuine change without conflict is impossible.

Traditional Systems of Medicine

In many countries, traditional systems co-exist alongside modern, mainstream medicine. However, gigantic and multi-tiered efforts are still required to bring these systems to the forefront through research, documentation and policy support. They can be cheaper but viable alternative for the marginalized.

Community Participation and Empowerment

Genuine development is not possible where communities passively receive health care judged appropriate by others, and have no say in assessing their health needs, planning for, providing and evaluating services. For, in their hands are the critical determinants of health: in understanding the nature of problems and in finding solutions to them. In bypassing communities, not only do we undermine their dignity, but we also lose the essential resource for health and development – the people themselves.

Community participation takes many forms, be it village development committees, mothers' clubs, village drug co-operatives, community health based insurance and health care schemes or village funds for nutrition. Community-based approaches are also being attempted while addressing the emerging problems of the elderly and home care for persons with chronic or degenerative diseases.

The mandating of rural development committees in India, with men and women elected by the rural community (Panchayati Raj) through a constitutional amendment, is expected to lead to enhanced community participation in development, including health.

Health Education

Health Education has traditionally been a one-way process, working on the assumption that local communities need to learn from "health educators". In developing countries, their messages often have little to do with local practices which have evolved through centuries of trial and error. Imposed education of this nature usually ends in frustration: it also leads to a gradual erosion of some sound local health practices.

Health education must start with an understanding of local health traditions, habitat and dietary habits. This will ensure that messages conveyed are easily understood and accepted, and also that goals and milestones are set realistically. True health education, therefore, is a two way process: of learning from communities as well as imparting new information to them.

Current mainstream health education relies largely on the written tradition, even though the vast majority of the marginalized in developing countries are illiterate. In a region where the oral tradition has predominated, health educators need to understand how information is traditionally acquired, processed and recorded. Overemphasis on written information and records such as growth charts, family health cards and so on in unlikely to yield the desired results. After all, farmers plan their crop, estimate seed and fertilizer requirements and balance the family budget without a single noting.

Furthermore, these communities have vibrant, entertaining and ever-evolving methods of communication that are visible at local fairs and festivals: puppeteers, folk musicians, street theatre groups, to name a few. These forms are far more interactive, and easier for communities to relate to. These forms must be integrated into the health education strategy.

This is not to deny the importance of the print media, or the immense outreach of radio and television. Health messages have been successfully propagated through the medium of feature films and songs, particularly in India. Radio and television are particularly effective in creating a favourable climate for launching community-based educational efforts.

All to often, health education initiatives prove non-starters, because they are out of sync with the true needs of the community. Take for instance an Eye-Care campaign in an area where people are suffering from Malaria. Health education campaigns must be rooted in the needs of the community.

Similarly, concepts of time, dates and venues vary across societies. In agrarian communities, life is dictated by the agricultural cycle – sowing and harvesting, seasonal changes and festivals. Modern notions of time, like fixing meetings at nine O'clock every Sunday morning, are incongruous. Decisions regarding time are best left to the community. Given the highly stratified nature of societies and caste and other dynamics, venues must be selected with care. Similarly, meetings must be moderated to ensure participation of women and the oppressed.

In short, the entire approach to health education must be thoroughly overhauled if it is to reach out to those for whom it is intended.

Impact of Economic Liberalization

Economic liberalization and privatization are sweeping across the world. Most countries view privatization as an instrument to improve living standards, and thereby promote human welfare. But development is not a guaranteed outcome of economic liberalization. Unintended fallout such as environmental degradation and widening disparities need careful monitoring. Economic liberalization may be necessary, but in the process, governments must not shirk their responsibility of providing safety nets to the vulnerable and protecting their interest.

New Zealand

Maori are the indigenous people of New Zealand and comprise 14% of the total population. At the time of contact with the British, there was already a well-developed concept of public health in New Zealand. But the colonization process progressively undermined these foundations largely due to the impact of infectious diseases, land alienation and political oppression.

In 1937, Nurse Robina Cameron founded the Women's Health League in Rotorua, a central North Island town, this was in response to the concerns about the health of Maori women and children. In terms of health status, Maori women are over-represented in major disease categories like cervical cancer, lung cancer and mental illness. In response to the concerns for the well being of marginalized Maori mothers and their babies, the women's health league established the **Tipu Ora Charitable Trust** in 1990. This initiative was undertaken with the help of Department of Health for an initial period of one year but seeing the positive health outcomes in routine evaluations, funding was secured from the government to carry on the *Tipu Ora* programme.

The philosophy of *'Tipu Ora'* is for "Maori to be healthy as Maori" and is extremely Maori centered. Principles such as interconnectedness, self-determination, Maori identity, quality, whanau (extended family) relationships, caring, community credibility and empowerment have been guiding the *Tipu Ora* programme. It uses cultural affirmations as a mechanism to improve health and thereby seeks to strengthen the Maori identity. Individuals are not viewed in isolation from their whanau, but their participation in the programme is encouraged.

Currently there are 1980 Kaitiaki (caregivers) registered with *Tipu Ora*, almost all of who are Maori Women. Activities such as family support and advocacy; individual and group health education; informal well-child checks; building relationships with health professionals and other support givers; referrals and follow-up care form a part of the *Tipu Ora* programme.

Routine monitoring of the programme provides evidence that it has led to significant health gains and has improved Maori health outcomes. Evaluation has shown that high mortality rate in children due to SIDS earlier, has reduced much more than expected as there were only three deaths due to SIDS. Positive lifestyle changes have been incorporated by the extended families as well.

Netherlands

'The Work & Caring Project', was developed in collaboration between the Social Assistance Department of Amsterdam and the Netherlands Institute of Care and Welfare (NIZW). As a model and experimental project, it lasted from 1996 to 2002, and was promoted as one of the best practice by the Dutch Ministry of Public Health, Social Welfare and Sports on National Television.

This model was evolved and implemented because of various studies done by Dutch Social and Cultural Planning Bureau (SCP) and Dutch Central Bureau of Statistics (CBS) which showed clear-cut links between social and economic status (SES) and health hazards of a predominantly physical nature which were being replaced by welfare diseases and mental health. Research conducted revealed that poorest 20% of the population rate their own health as "not good", more than twice as often as the richest 20% of the population. These marginalized 20 % consist of persons living on an allowance, a state pension, or a marginal income from work or profit. Three-quarters of all families living on public assistance are below the Dutch Poverty line.

Between 1993-95, every one on the disability-from-work allowance was re-examined medically and a substantial number of persons lost their disability allowance. Medically their problems could not be assessed seriously and this implied that a high percentage of this group was having 'vague complaints'. In 1999, 60% of the long –term unemployed on public assistance were facing health problems such as backache/hernia, migraine, depression, addiction and psychosocial problems.

Low-income senior citizens scored high on loneliness and feeling redundant and depressed. The *work & caring* created mutual beneficial relationship between this group, which required simple care services rendered by peers or health providers and in return offered friendship and life experiences and by the end of the project 120 of them were receiving supplementary care regularly.

Many unemployed women had complex problems such as ½ of them were single, ¾ were black or immigrants and ¼ were traumatized by war or violence. With *work & caring*, many women wanted to render services such as work experience within a training course empowering them to get their life organized and preparing them for future jobs or further education, 54% out of them gained jobs, 14% continued education or voluntary work

The *work & caring* project carries out an intense six month training with focuses on enhancing skills such as self-esteem and self-confidence, communicative skills, coping styles etc. health education, health improvements and self care were woven into the programme as well.
At present the *Work & Caring* Project is being implemented at Tilbury, in Netherlands since 2001.

India

Voluntary health Association of India (VHAI) is the worlds largest association of voluntary organizations formed by the federation of state level voluntary health associations linking over 4000 health and development organizations in India.

An experiment was launched by VHAI known as **'KHOJ',** a Hindi word meaning 'search' at a time when the overall situation of the country was at it lowest ebb. Socio-political and economic degeneration had reached a level where hunger and malnutrition were universal, half the children died before the age of 5, primary health care was non-existent and nine-tenths of the population was illiterate.

The philosophy behind *KHOJ* is to search for innovative methods and strategies to combat community health related problems in remote areas. The approach being that community health is a crucial component in the development of a broad base of human capital that can reinforce economic growth. VHAI, aspired to highlight the "areas of light" by incorporating the salient features of path breaking community health programmes in an integrated community health and development package, thus it aspired to make a concerted and conscious effort to do away with the "areas of darkness".

The *KHOJ* projects were initiated in the state of Rajasthan and also subsequently in various parts of rural and underdeveloped India. Currently *KHOJ* projects are being implemented in as much as 30 pockets in India. VHAI understood that women could play the most vital role in keeping the families as well as the societies going. Thus a dialogue was initiated with the community who identified potential women for this crucial role. Subsequently training was imparted to them as most of them were illiterate or semi literate. They were then properly equipped to deal with the day to day health situation of their fellow villagers. The process was further strengthened with the monthly meetings of the community health workers and their supervisors.

These women are playing the most important role of health educators and the impact of *KHOJ* is more than visible. Gradual and sure decline of maternal and infant mortality, lesser number of complex cases of morbidity and almost negation of malaria and vector borne diseases are a sure sign of the contributions of these community health workers.

There has been significant improvement in the general socio-economic development of the beneficiaries of *KHOJ*. With the formation of women, youth as well as farmers groups, decision-making power has remained with the people and with the help of capacity building programmes, income generation has increased.

Philippines

The health of Filipinos has slightly improved in the past decade, however, the progress slowed down during recent years. Infant mortality and maternal mortality are still higher than in comparable countries. Infectious diseases continue to prevail, while lifestyle related chronic and degenerative diseases are becoming more prevalent. The spending of Filipinos is still heavy on family out-of-pocket and greatly affects the marginalized sector.

The three major factors that gravely affect the health sector are the *inappropriateness of the health delivery system*, the *inadequate regulatory mechanisms* the *poor health care financing.*

In 1999, the Department of Health initiated a bold move by launching the Health Sector Reforms (HSRA) which covers the area of health financing. This concept revolves around universal coverage and is aimed at the fact that there will be increased access to health services especially for the poor, which would reduce financial burden on the individual families.

Under the National Health Insurance Act of 1995 the National Health Insurance Program or NHIP was enacted. The **'Philippines Health Insurance Cooperation'** was established with a vision that ensures sustainable, affordable, and progressive social health insurance, which endeavors to deliver accessible quality health care for all Filipinos. One important component of NHIP being the Outpatient Diagnostic Package, which is also referred to as "The Primary Care Package" where, LGUs who enrolled their indigents would be receiving a capitation of P300 (US $6) as advance payment for medical care per family per year.

Health financing, by simultaneously involving the formal as well as the non formal sectors of society has shown that equity in health care can be realized and most importantly has given the local government executives the "battle-cry" and the impetus to seek improvements in health service delivery. *Philhealth* is now the biggest social security agency in the country in terms of membership base covering the big sector of the poor and the marginalized.

The health-seeking behavior of the poor has improved. Health promotion is a major intervention in reaching the marginalized sector. *Philhealth* has successfully aimed at mobilizing partners to become health promoters and payers for premium for the marginalized. Universal access to essential health care is assured by mobilizing resources for health, improving efficiency in the production and allocation of health goods and services, and providing safety nets and addressing inequities specifically among the vulnerable and marginalized groups.

Conclusion

Judging by the innumerable innovative and successful experiments, solutions to the many and varied health and development problems of the marginalized do exist.

Many of these solutions lie in wider areas of socio-political action. This is something that health professionals and activists must take cognizance of. At the same time, we must grapple with a host of emerging health problems which are linked to new modes of human behaviour, social transition and materialism. Solutions to these may be harder to find.

It is a matter of grave concern that the vast government health machineries are operating well below par, and appears ill-equipped to cope with current problems, let alone future challenges. Restructuring and revitalizing this gigantic apparatus is urgently needed.

The involvement of larger civil society, including traditional healers, NGOs and the private sector can make a significant difference to all aspects of health promotion – effort in this direction has so far been lacking.

Health Education too, needs a facelift, and must be rooted in the needs of the community. Forums and modes of communication have to be culturally relevant and suitable if they are to be effective. Similarly, without community participation, health promotion and development efforts are bound to flounder.

There is a dire need for partnerships between nations for health promotion. These must be built with great care and skill, with common interests and goals clearly defined in a spirit of mutual trust. These partnerships must break out of the narrow mould of mere financial or sponsorship arrangements. They could be product based (bed-nets for malaria), service-based (guidance in disease prevention), system-and-settings-based (healthy cities, safe work places, schools), or issue-based (polio eradication).

We must carefully study the traditional health cultures and guard against the pitfalls of Western medicine and health care models while evolving a health strategy. Health care in recent years has become a commodity that can be bought and sold. It is no longer an organic part of community life as it once was. The germ theory needs to be substituted by one where the individual is regarded as central, and helped to regenerate a sense of well-being. Interestingly, most traditional systems approach health from this holistic angle. We obviously need a new paradigm of health care: one that is far removed from the current bio-medical model, and closer to a socio-political and spiritual one.

The health of any nation is the sum total of the health of its citizens, communities and their settlements. A healthy nation, therefore, presupposes the participation of all its citizens in achieving the goal of HFA. Unfortunately, over the last five decades, most parts of the world have followed a pattern of governance in which the State is alienated from the people and their needs. Sadly, development efforts have failed to build on traditional institutions and forms of governance that have evolved over centuries, and are culturally relevant, participatory and self-sustaining. We must tap into our native wisdom before it is too late.

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Regulation of products harmful to health in an era of globalization

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Abstract

This session examines the way globalization has impacted on threats to public health by facilitating the use of tobacco and alcohol products. It also examines the way globalization enables a public health response to these threats; the use of global strategies is illustrated with lessons learned from the WHO Framework Convention on Tobacco Control and its application in the context of Myanmar. These lessons will inform the development of a Global Alcohol Strategy in the coming years.

Globalisation and health

Impacts on health

In the era of globalization, marketing and promotion of harmful products such as tobacco and alcohol have been identified as major transnational determinants of ill-health. The enormous resource of the powerful multinational corporations which are producing and distributing alcohol and tobacco facilitates the use of innovative and sophisticated marketing, sometimes globally themed, sometimes with national emphasis. As Jernigan (Jernigan, 2001) states in relation to alcohol: "What is emerging worldwide is the dominance of a small number of companies, several of which are based in Europe, whose marketed images, created to appeal to young people in the developed countries, increasingly define alcohol and the culture of alcohol use for the world." In a globalised, media-saturated world the commodification of youth culture provides a fertile environment in which the marketing can grow demand for these products, particularly among the young (Hong, 2000, Klein, 2000).

Globalization via trade and economic agreements also have had and have potential to have further impacts on alcohol and tobacco as determinants of ill-health. Globalization restricts the capacity of countries to regulate these products through domestic legislation alone. While aiming to achieve free trade across borders the rules in trade agreements limit governments' regulatory authority over trade and enhance the authority of international financial organizations and trade organizations (Kickbusch cited in Shaffer et al., 2005). The mechanisms which have affected this include GATT (general agreement of Trade and Tariffs), regional free trade agreements and the WTO negotiations on the GATS (General Agreement on Trade and Services). These have meant that national governments have had less ability to control in key policy areas. International trade treaties have already forced changes in many government measures affecting availability and control (Grieshaber-Otto et al., 2000).

The World Health Organisation's Comparative Risk Assessment has determined the contribution made to the global burden of disease of a range of risk factors including alcohol and tobacco. Globally tobacco contributed 4.1% of disability adjusted life years lost in 2000 and alcohol contributed 4% making them respectively fourth and fifth leading cause of the loss of healthy life years (Ezzati et al., 2002). In both developing and developed regions alcohol and tobacco were major causes of disease

burden. However the relative contribution of these products varied in different regions of the world depending on their levels of use and the importance of other risks to health. In developed regions tobacco (12.2%) and alcohol (9.2%) were consistently among the leading causes of loss of healthy life. In high mortality, developing countries tobacco contributed 2% and alcohol 1.6% to loss of healthy life. The role of both alcohol and tobacco is particularly striking in developing countries with low mortality, such as parts of America and Asia Pacific: Alcohol contributed 6.2% to loss of healthy life in these countries, making it the leading cause, and tobacco contributed 4.0% (Ezzati et al., 2002). It is these countries, some with expanding economies and many with yet unsaturated tobacco and alcohol markets, where many of the impacts of globalisation on the production and marketing of these products are yet to be fully experienced.

A global public health response

In response to the globalization of the tobacco epidemic, the 191 Member States of World Health Organization unanimously adopted the WHO Framework Convention on Tobacco Control at the 56th World Health Assembly in May 2003, as a global complement to national actions. THE WHOFCTC is a major global development for addressing the globalization of the tobacco epidemic and an example of emerging global health governance (Dodgson et al., 2002).

In response to similar concerns with regard to the globalisation of alcohol the member states unanimously passed the resolution "Public health problems caused by harmful use of alcohol" at the 58th World Health Assembly in May 2005. The WHO Secretariat has been asked to report back to the World Health Assembly in May 2007 and work on regional strategies is already underway. This signals the beginning of the development of an urgently needed Global Strategy on Alcohol.

This paper describes the involvement of a low income country, Myanmar, in the development of the WHOFCTC and the implications of this at the national level. It then describes some of the health impacts of alcohol and draws on lessons from the Myanmar case study to delineate the key elements of a global public health strategy aiming to reduce harm at the national level and the impact of globalisation on these key determinants of health

Globalization and tobacco in Myanmar – a case study

Tobacco use has long been culturally and socially accepted in most countries of the WHO South-East Asia Region. The Region is also unique in having a diversity of tobacco products being used. Home to one-quarter of the world's population and undergoing significant demographic and socio-economic changes, the Region has become a lucrative market for the tobacco industry. The multinational tobacco companies had intensified their marketing practices in the Region during the last two or three decades through a variety of complex factors with cross-border effects such as advertising, promotion and sponsorship, trade liberalization and foreign direct investment.

Myanmar, like other Member Countries of the Region is a fertile ground for the tobacco habit and a probable scene of tobacco-related morbidity and mortality explosions by the turn of the century. With the opening of the market economy, multinational tobacco companies and a few Indonesian tobacco companies came to invest in the country in the 1990s. New cigarette brands were introduced through vast investments on advertisement; hundreds of cigarette advertising billboards were erected in major cities and gradually expanded to rural areas. The cigarettes were sold at relatively cheaper prices than imported cigarettes and the "foreign" brands with colorful pictures attracted many customers. With the lack of tobacco control legislation, youth had easy access to tobacco products which were sold in loose forms without age limitation. Cigarette consumption increased rapidly among all ages, especially among adolescent males and young adults. The Ministry of Health became seriously concerned about the increasing trends in tobacco use and increased its health education activities on dangers of tobacco.

Myanmar and the global movement for tobacco control

In July 1998, WHO reorganized its tobacco control efforts within a new structure, the Tobacco Free Initiative (TFI) and this movement greatly enhanced the momentum of the anti-tobacco activities in Myanmar. The National Health Committee which is the highest inter-ministerial advisory group of all concerned ministries at the national level issued guidelines for prevention and control of smoking related diseases at its 26th meeting held in September 1998.

The National Programme on Tobacco Control was officially launched in January 2000 with the drafting and approval of the National Policy on Tobacco Control and Plan of action. The National Tobacco Control Committee was formed in March 2002, headed by the Minister for Health and included heads of related departments and chairpersons of several national NGOs as members. The Committee set guidelines for the tobacco control measures to be implemented in the country.

The Ministry of Information prohibited advertisement of tobacco on television and radio and from all electronic media in the year 2000. Tobacco advertising billboards were banned from the vicinity of schools, hospitals, health facilities, sports stadiums and maternity homes in May 2002 and from other places in April 2003. Tobacco advertisement were also been banned from the newspapers, journals and magazines in early 2003. Smoking was prohibited at all hospitals and health departments, at all basic education schools, all sports stadiums and sports fields and at some workplaces.

In May 1999, the World Health Assembly-the governing body of the World Health Organization, adopted a resolution (WHA 52.18) (World Health Assembly, 1999) which paved the way for starting multi-lateral negotiations on the WHO FCTC and possible related protocols. Myanmar along with fellow Member States actively participated in the negotiating process of the WHOFCTC and strongly supported the convention. Myanmar delegates expressed their strong commitment towards comprehensive tobacco control measures and voiced the need for a comprehensive ban on all forms of tobacco advertisement including cross-border advertising. Myanmar proudly hosted the 4th Inter-country Consultation Meeting on Framework Convention on Tobacco Control in August 2002, where the countries of South-East Asia Region issued the "Yangon Declaration" (The Yangon Declaration, 2002).

Myanmar delegates who participated at these negotiations, reported back to the national authorities with strong recommendations to sign and ratify the convention. The theme and provisions of WHOFCTC were put up by the Minister for Health to the 34th meeting of the National Health Committee in April, 2002; the meeting principally agreed the provisions of WHOFCTC and gave the green light for becoming Party to the Convention. Myanmar became a proud signatory to the FCTC on the 23rd of October 2003 and became a Party to the Convention on the 20th of April, 2004; it was the 11th country to become Party to the Convention.

National legislation on tobacco control

Drafting of Tobacco Control Law started in 2002, when Myanmar was actively participating in the negotiating processes of WHOFCTC. The ratification of WHOFCTC increased the momentum of the drafting process and also widened the scope of contents of the legislation as the drafting committee tried to cover the provisions of FCTC as much as possible. An example was prohibition of sale of individual or small packets of cigarettes; this was previously not included in the legislation as it was considered impractical in Myanmar but was later included in the law as one of the FCTC provisions. The legislation has been approved and is in the process of being enacted by the Government of the Union of Myanmar.

Opportunities and challenges

Dedicated personnel at the Ministry of Health and multisectoral collaboration mechanisms among sectors contributed to the achievements in the tobacco control activities of Myanmar. The negotiating processes of WHOFCTC had been successfully used as an advocating tool for tobacco control; becoming a Party to the FCTC further strengthened the dedication and commitment of anti-tobacco advocates.

Reluctance of the decision makers to increase tax and price on tobacco products for fear of increasing the burden on the poor was a major challenge in the drafting process of the legislation. The legislative draft has failed to include any measures on price and tax. More research studies need to be conducted to provide the policy makers with evidence-based information.

The whole process of implementing the tobacco control programme, involvement of multi-sectoral bodies in the national committee, active participation in the FCTC negotiations, signing and ratifying the FCTC, drafting the legislation and having it approved had achieved significant impact on public health measures regarding tobacco in Myanmar.

Framework convention on tobacco

The initiation and adoption of WHOFCTC had an enormous impact on the world-wide anti-tobacco movements. Getting involved in the negotiating process itself moved the tobacco control measures of countries forward; in countries like Myanmar, delegates who had participated in the Intergovernmental Negotiating Bodies reported back to the policy makers with strong recommendations to enhance the momentum of anti-tobacco activities and public awareness campaigns. The whole process of adopting, signing and ratifying the WHO FCTC was a challenging and exciting experience and having the national tobacco control legislation approved was a huge success in the history of public health in Myanmar. In many countries the WHOFCTC has been used as a strong advocating tool to fight against the powerful lobbying of tobacco industries.

Global strategy on alcohol

Lessons can be learned from the Myanmar case study which illustrate the value in the development of a global strategy on alcohol.

The resolution on alcohol harm passed in 2005 was the first WHO resolution solely addressing alcohol since 1982. Unlike both narcotics and tobacco the United Nations system has not identified alcohol as in need of a global response. However, recent data has illustrated clearly the importance of alcohol as a risk factor for ill health. Alcohol is causally related to more than 60 medical conditions (Room et al., 2005). The WHO study on the global burden of disease has illustrated the importance of alcohol in developed and developing regions of the world with the contribution made to loss of healthy life in developing countries with low mortality, where it was the leading cause, of particular concern (Ezzati et al., 2002).

The size of the burden caused by alcohol is likely to be even greater than indicated in these WHO analyses since they take into account primarily health problems related to drinking. The limited evidence available, however, suggests that social problems related to drinking impose as much of a burden (Room et al., 2003). Furthermore, not only the drinker experiences the health and social consequences of alcohol but so do others; the externalities from alcohol use may well exceed those of tobacco.

The impacts of alcohol are also importantly related to development opportunities and poverty. While consumption of commercially produced alcohol may remain the prerogative of the elite in low and medium income countries the transfer of money from the local community to global corporation via a product which does not generally aid development efforts make it a relevant issue for health inequalities.

Expansion of alcohol harm

Developing countries, especially those with expanding economies, have been identified as areas for market expansion. Thailand provides a good example of such a country. Thailand has seen a rise in GDP accompanied by a substantial rise in per capita consumption of commercially produced alcohol over the last four decades.

Commercial alcohol consumption doubled in the eight years from 1992 to 2000 (Thamarangsi, 2005).

Harm from alcohol has also become a topic of concern and measurement in Thailand. Calculations of the costs associated with alcohol related traffic crashes have been estimated at between 2 – 3.5% of GDP (Thamarangsi, 2005). Families with a drinking member have been found to have 3.84 times higher rate of household violence (Thamarangsi, 2005).

While there have been expansions in consumption and harm the implementation of effective public health policies has not kept pace (Thamarangsi, 2005). Taxation policies are in place but do not have an explicit health goal; there is little effective restriction on the availability of alcohol and the minimum purchase age of 18 is not enforced. There is legislation to regulate conduct in licensed premises in Thailand, for example, against selling to intoxication, being drunk in public place and being underage in tavern but this is not enforced. With regard to drinking and driving there is a per se law at 0.05% but once again there is little enforcement of this. Finally controls over alcohol promotion are limited and have been subjected to sabotage by the industry.

This lack of enforcement and, in many cases, lack of legislation and regulation for the most effective policies, is common in high income countries (Babor et al., 2003) and also in countries with low and medium incomes.

Need for the development of an international framework for alcohol control

The situation with regard to alcohol is such that a similar process to that engaged in for the development of the WHOFCTC would be likely to assist the development and implementation of more effective policies at the national level and also to assist urgently required regional and international co-operation. Both the process and the elements of the WHOFCTC are relevant to the needs of a Global Alcohol Strategy. The involvement of member states in regional and global strategy development, as illustrated by Myanmar's involvement in the WHOFTC, will have a positive impact on national development.

Elements of a public health framework/global strategy

Surveillance, research and policy analysis

The Myanmar case study illustrated the impact that monitoring of trends in tobacco consumption and noting increases in young and in males had in motivating action by the Ministry of Health.

There is a similar need for surveillance and analysis of alcohol. WHO is currently undertaking the collation of data at a global level on consumption (World Health Organization, 2005) and the policies jurisdiction have in place (World Health Organization, 2004). With regard to data on consumption, countries have often relied on statistics collected for taxation purposes to make estimates of per capita consumption. In countries with developing alcohol markets it is necessary to estimate

among what proportion of the population the alcohol is shared. Taxed alcohol also excludes illicit supply of commercial alcohol and informal, often traditional, beverages. The need to obtain accurate estimates is likely to increase reliance on population surveys to measure and monitor trends in use and makes the issue of appropriate measurement methods very important. Population surveys also allow for monitoring of specific demographic groups, which is important in the context of increased youth drinking, and for the monitoring of patterns of drinking such as episodic, heavier consumption, which are important for harm and policy development.

To a greater extent than is now the case for tobacco, there is a need to measure harms causally related to alcohol use. Alcohol interacts with the cultural setting in ways which influence much of the harm associated with its use. Measurement of alcohol harm needs to cover the full range of social consequences. Current estimates of economic costs lack adequate data in many areas. In countries in which the globalization process is accelerating socioeconomic transition alcohol plays a important, but largely undocumented, role in changing traditional family and community structures and can also have impacts on spiritual values.

The Myanmar case study also described the importance to the policy development process of the analysis of market developments – it was noted that new brands were introduced at cheaper prices, and were being heavily marketed. Analysis of alcohol issues requires economic literacy given the globalized and privatized context.

Finally, there is a need to evaluate in low and medium income countries the implementation of policies. This includes policies which have been shown to be effective in high income countries and new approaches relevant to the country setting. In a country like Myanmar, with high levels of poverty, the adoption of taxation policies in relation to both alcohol and tobacco in order to achieve a public health goal requires clear evidence of effectiveness.

Advocacy

The Myanmar case study illustrated the way in which the drafting of the national tobacco control legislation took place in parallel with the participation by Ministry of Health personnel in the development of the WHOFCTC and showed that there was synergy between these two parallel developments.

While alcohol has come to greater prominence in a number of jurisdictions and regional and international organizations in recent years (GAPA, Eurocare, European Commission, Secretariat of the Pacific Community, 2004), it is apparent that progress on a Global Alcohol Strategy will enhance developments at the national, regional and international level and there will be similar synergies to those which occurred in relation to the WHOFCTC.

The Myanmar case study illustrated the complementary role of the NGO sector. Globally 200 NGOs were engaged in the successful achievement of the WHOFCTC. They came together in a Framework Convention Alliance which included a range of NGOs working at the national, regional and international levels. The work of the NGO network was crucial. The NGO network in alcohol is less well developed globally than is currently the case for tobacco but there are some clear indications that

this is growing (GAPA). The technological developments which have allowed globalization of the markets for alcohol and tobacco also facilitate the global development of public health networks.

Much of the societal level response to alcohol occurs at the community level in the informal sector (eg. women's organizations, religious organizations) and the involvement of these organizations in advocacy on alcohol issues is important.

An important difference in alcohol advocacy compared with tobacco is the salience of the role of the alcohol industry and its associated organizations. Some sectors of the global alcohol industry are actively engaged in lobbying at national, regional and international levels (eg. distilled spirits re economic agreements). They also fund a large number of 'social aspects organizations' which advocate for industry-friendly policies (McCreanor, 2000, Anderson, 2002). One important issue which will be increasingly clarified during the development of a Global Strategy on Alcohol is the appropriate role of industry sectors in policy development and implementation. While local retailers may have an important role in responsible supply of alcohol the interests of alcohol producers conflict with those of public health and their involvement in a policy development process will tend to frustrate public health objectives in favour of more industry friendly approaches (Babor 2000 cited in Anderson, 2002).

Resourcing

In Myanmar resources were provided for the tobacco control work. First there was the establishment of national level committee and then the funding of a national programme in 2000. Myanmar also hosted the WHO meeting resulting in the Yangon Declaration, a significant step towards the WHOFCTC. Such resourcing will also be required to support the development of a Global Alcohol Strategy.

Important here is the resource required for civil society to develop and sustain networks able to be involved in the process of global health governance. At the national level there is a need to ensure resources for policy implementation; in addition to the needs of the health sector there is resource required for cost effective policies such as the enforcement of effective drink-driving legislation, the minimum purchase age, and hours and places of sale. Much of this requires funded community mobilization as well as adequate funding for the relevant sectors.

Implementation of effective policies

The adoption of effective tobacco control policies at the national level was facilitated by the WHOFCTC. Myanmar established controls on marketing tobacco and some smoke free environments in 2000 – 2003. However, the inclusion of the prohibition of sale of single cigarettes was included in national legislation only after Myanmar became a signatory to the WHOFTC which requires it. Taxation remains an area which is a crucial part of the WHOFCTC but is not included in Myanmar's legislation.

There are effective alcohol policies which have been shown in evaluations in higher income countries to reduce harm (Babor et al., 2003, Chisholm et al., 2004). These are

often less popular than the more individually focused approaches and the support of a Global Strategy, by promoting the evidence base on effective implementation, would assist their uptake. The implementation of effective policies requires a legislative framework, enforcement, and media and the resourcing and development of community capacity to sustain their implementation.

Regional and international collaboration

The involvement of Myanmar's Ministry of Health personnel in the development of the WHOFCTC helped in their role as national level advocates. Similarly the involvement of these advocates assisted the momentum of the WHOFCTC. The development of a Global Alcohol Strategy will also require strong input from a range of supportive member states.

Many of the effective policies relating to both tobacco and alcohol increasingly require regional and international response. Effective public health policy for both alcohol and tobacco requires restriction on availability, marketing and pricing. Alcohol policies have generally until now been the concern of national and local governments. In the globalised world there is a need for regional and international support for national efforts to control the alcohol market.

Public health professionals and organizations have rarely participated in trade negotiations or in resolution of trade disputes. The linkages among global trade, international trade agreements, and public health deserve more attention than they have received to date (Shaffer et al., 2005). There is an urgent need for alcohol and tobacco to be excluded from the general trade and services agreement of the WTO and of regional trade agreements (Room et al., 2003).

Some form of global health governance (Dodgson et al., 2002) will also be required if the myriad of new technological possibilities for brand marketing, including the internet, are to be appropriately controlled.

Conclusion

Globalisation has affected the use of alcohol and tobacco and the consequent experience of harm. This has resulted from the growth in global corporations leading to increased marketing and accessibility of commercially produced, branded alcohol products. The globalization of media and youth culture has also facilitated their spread in many countries of the world. The economic agreements which have reduced the barriers to the distribution of these products have facilitated their penetration into new markets. Future agreements in regard to trade and services as well as new regional economic agreements have the capacity to allow greater access and marketing of these products and threaten the capacity of national governments to control access to these products. This requires a strong public health response with much greater analysis of the public health implications of all economic agreements

The WHOFCTC illustrates a strong public health response to the threats of globalization to the health and welfare of the world's citizens. It requires ongoing support, including resourcing of national and community capacity in lower income

countries to ensure that more countries become signatories and to ensure that the WHOFCTC's clauses are implemented at national levels. A similar global response to the threats to health posed by the spread of alcohol is urgently required and many of the key issues to do with the marketing and promotion of the products are very similar to those of tobacco.

Global health governance requires a combination of regulatory frameworks and informal, normative developments (Dodgson et al., 2002). There is a need for an ongoing response to alcohol and tobacco which incorporates the strength of the regulatory framework agreed to by national governments and the informal monitoring and influence which is an essential part of the role of civil society in governance in this area.

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Health as Foreign Policy: Harnessing Globalization for Health

David P. Fidler

The 6th Global Conference on Health Promotion
Bangkok, Thailand, 7-11 August 2005

Abstract

This technical paper explores the importance for health promotion of the rise of public health as a foreign policy issue. Although health promotion encompassed foreign policy as part of "healthy public policy," mainstream foreign policy neglected public health and health promotion's role in it. Globalization forces health promotion, however, to address directly the relationship between public health and foreign policy. The need for "health as foreign policy" is apparent from the prominence public health now has in all the basic governance functions served by foreign policy. The UN Secretary-General's UN reform proposals demonstrate the importance of foreign policy to health promotion as a core component of public health because the proposals embed public health in each element of the Secretary-General's vision for the UN in the 21st century. The emergence of health as foreign policy presents opportunities and risks for health promotion that can be managed by emphasizing that public health constitutes an integrated public good that benefits all governance tasks served by foreign policy. Any effort to harness globalization for public health will have to make health as foreign policy a centerpiece of its ambitions, and this task is now health promotion's burden and opportunity.

Introduction

1. The 6th Global Conference on Health Promotion seeks to reaffirm the values, principles, and purposes of the health promotion movement that stretches back nearly two decades. Reaffirmation of the tenets of health promotion as a core component of public health today unfolds, however, in an environment radically different from the situation prevailing when the Ottawa Charter was adopted in 1986. This technical paper focuses on one transformation that affects health promotion—public health's rise as a foreign policy issue in international relations.

2. Increasing the visibility of health promotion has previously linked health promotion and foreign policy. These linkages tended, however, to be subsumed in advocacy for the larger goal of "healthy public policy."[1] The last decade witnessed relationships between public health and foreign policy intensify, expand, and become more explicit. These developments reveal that a new context and a new reality for health promotion and foreign policy have emerged.

3. Intersections between foreign policy and public health have become critical in analyzing the management of globalization in ways sensitive to health promotion. Thinking about "health as foreign policy" requires understanding the opportunities and challenges this task creates. In addition, health as foreign policy necessitates initiatives that can make foreign policy a more robust channel for health promotion.

The Health Promotion Movement and Foreign Policy

4. The transformation of the relationship between public health and foreign policy should not obscure the long-standing intersections between health promotion and foreign policy. Past conferences framed health promotion in global terms, stressed the need for health promotion to be advanced by all governmental sectors, and called for healthy public policy at all levels. The health promotion vision encompassed foreign policy as an important governance activity.

5. Foreign policy's relevance for health promotion remained, however, implicit and mostly assumed. None of the documents issued by previous health promotion conferences specifically mention foreign policy. Earlier conferences conflated policy categories to emphasize that health promotion "puts health on the agenda of policy makers in all sectors and at all levels[.]"[2]

6. This message did not, however, penetrate mainstream foreign policy. Experts have noted how the study and practice of foreign policy and international relations historically neglected public health,[3] treating it as a non-political matter best left to technical specialists.[4] A gap existed between foreign policy communities, which relegated public health to the "low politics" of foreign policy, and health promotion advocates, for whom public health was among the most important challenges facing countries in an interdependent world.

Health Promotion and Foreign Policy: The New Context

7. The decision to focus on foreign policy at the Bangkok Conference represents recognition that the relationship between health promotion and foreign policy has been transformed. This recognition echoes the realization by foreign policy makers that public health has risen on their agendas in ways that challenge the traditional neglect of this area. Developments over the past decade precipitated a collision of the worlds of public health and foreign policy that is historically unprecedented.

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[1] Ottawa Charter for Health Promotion, 21 Nov. 1986, WHO/HPR/HEP/95.1.
[2] *Id.*
[3] *See, e.g.*, I. Kickbusch, "Global Health Governance: Some Theoretical Considerations on the New Political Space," in *Health Impacts of Globalization* (K. Lee, ed.) (Palgrave, 2003): 192-203, p. 192.
[4] E. B. Haas, *Beyond the Nation-State: Functionalism and International Organization* (Stanford University Press, 1964), pp. 14-17.

8. A key factor producing this collision is globalization. Earlier health promotion conferences identified international interdependencies as one reason why healthy public policy should be a global objective.[5] Assertions about interdependence did not produce robust foreign policy engagement with public health, especially among the great powers. Globalization has, however, expanded, intensified, and transformed interdependence to the point that public health problems cascade across foreign policy agendas and capture the attention of strong and weak countries. See Box 1.

Box 1.

Examples of Public Health Issues and Developments of Foreign Policy Significance

- Emerging and re-emerging communicable diseases
  - → HIV/AIDS pandemic and associated infections (e.g., tuberculosis)
  - → Outbreak of Severe Acute Respiratory Syndrome (SARS)
  - → Outbreaks of avian influenza (H5N1)
  - → Problems with the fight against malaria
- Proliferation of biological weapons by states and the threat of bioterrorism
  - → Breakdown in the negotiations for a compliance protocol to the Biological and Toxin Weapons Convention
  - → Anthrax attacks in the United States in 2001
  - → Development of policies to improve biosecurity
  - → Fears of rapidly advancing science making perpetration of bioterrorism easier
- Global increase in non-communicable diseases
  - → Concerns related to tobacco consumption leading to the WHO-sponsored negotiation and adoption of the Framework Convention on Tobacco Control
  - → Growing problem of obesity worldwide leading to WHO work on a global strategy on diet and physical activity
- Linkages between international trade and public health
  - → Controversies over the protection of patent rights for makers of pharmaceutical products and access to essential medicines in developing countries
  - → Concerns about further liberalization of trade in health-related services adversely affecting the quality, affordability, and accessibility of health services
- Reassessment of the role public health plays in economic development (e.g., Commission on Macroeconomics and Health)
- Public health and human rights issues
  - → Reinvigoration in international interest in the right to health
  - → Renewed concern about respect for civil and political rights in connection with responses to dangerous outbreaks of communicable diseases (e.g., SARS)
- Major diplomatic initiatives on global public health problems
  - → UN's Millennium Development Goals
  - → Global Fund to Fight AIDS, Tuberculosis, and Malaria
  - → Roll Back Malaria Campaign
  - → Stop TB Partnership
  - → WHO's "3 by 5" Initiative
  - → U.S. President's Emergency Plan for AIDS Relief
  - → Doha Declaration on the TRIPS Agreement and Public Health and related initiatives (e.g., Paragraph 6 Agreement and the WHO Commission on Intellectual Property, Innovation, and Public Health)
  - → Global Health Security Initiative
  - → Negotiation and adoption of the WHO's new International Health Regulations

9. Globalization exposed vulnerabilities of countries to public health threats that were previously non-existent, latent, or ignored. Governments faced mounting public health threats with the realization that globalization constrained policy control over many determinants of health, limiting options to the detriment of population and individual health. Globalization also affected the traditional dichotomy between

[5] *See, e.g.*, Recommendations from the 2nd International Conference on Health Promotion, Adelaide, Australia, April 1988 ("The achievement of global health rests on recognizing and accepting interdependence both within and between countries.").

domestic and foreign affairs, blurring the utility of borders to demarcate where and how policy should be made. Interconnectedness between the local and the global produced centralization of policy making at the national level because only at that level could states address the international and transnational contexts of globalized health issues.

Health as Foreign Policy: The New Reality

10. Globalization's impact on public health appears to underscore the need for healthy public policy at all governance levels given the ways in which globalization challenges every level of policymaking within countries. The reality of public health's emergence in foreign policy has been, however, to make foreign policy more important to public health. Globalization has not altered the political structure of international relations—humanity remains organized into nearly 200 territorial states that interact in a condition of anarchy, defined as the absence of any common, superior authority. The dynamics, and many of the foundational norms, of this anarchical structure privilege sovereignty as a governance principle. Intercourse between sovereign states is the essence of foreign policy—policy that organizes the state's relations with other sovereigns.

11. Historically, public health has predominantly been a domestic policy concern;[6] but developments over the last decade have forced public health experts and diplomats to think of health *as* foreign policy, namely public health as important to states' pursuit of their interests and values in international relations. This transformation is complicated and cannot simply be equated with "healthy public policy." This new reality presents opportunities and risks for health promotion.

Foreign Policy Functions and Public Health

12. One way to understand the new reality of health as foreign policy is to see how public health connects with the basic functions of foreign policy. Although foreign policy is complex, states engage in it to fulfill four basic governance functions. First, through foreign policy, states seek to ensure their security from external threats. Achieving national and international security is, thus, a foreign policy function. Second, a country uses foreign policy to contribute to its economic power and prosperity. States promote their interests in international trade and investment through foreign policy.

13. Third, states use foreign policy to support the development of political and economic order and stability in other countries. Such development supplements a state's interest in its security and economic well-being. As a result, political and economic development forms part of foreign policy. Fourth, states make efforts to promote and protect human dignity through foreign policy, as evidenced by support for human rights and the provision of humanitarian assistance.

14. Identifying foreign policy's governance functions does not imply that any given state integrates these functions well or even considers them equally important. Students of international relations have frequently noted a hierarchy in the foreign policy functions,[7] with security and economic power ranking higher than development or human dignity. Public health's traditional place in the "low politics" of foreign policy can be attributed to this hierarchy because public health was generally categorized as a development or human dignity issue. See Figure 1.

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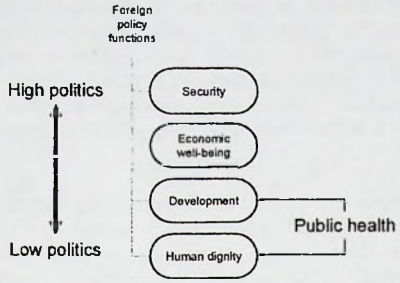
[6] R. Cheek, "Public Health as a Global Security Issue," *Foreign Service Journal* (Dec. 2004): 22-29, p. 23.
[7] *See, e.g.,* Steven Weber, "Institutions and Change," in *New Thinking in International Relations Theory* (M. W. Doyle and G. J. Ikenberry, eds.) (Westview Press, 1997): 229-265, p. 230.

Figure 1.

Traditional Hierarchy of Foreign Policy Governance Functions



15. The health promotion strategy reinforced public health's subordination in mainstream foreign policy. Global conferences on health promotion stressed the health of individuals over the security of states, the right to health over economic interests, and the primacy of global equity and justice over the aggregation of national power.

16. Public health's subordination was entrenched during the 20th century because many states faced military threats to their existence and diplomacy rife with political and ideological hostility about how to organize economic systems, how political and economic development should proceed in developing countries, and what constituted human rights. These problems were acute during the Cold War. Advocacy for healthy public policy based on human rights, equity, and social justice emerged into a foreign policy context inhospitable to health promotion's universalistic ambitions.

17. The emergence of health as foreign policy in the post-Cold War period signals a sea change in public health's relationship with foreign policy's functions. Public health today features prominently in all foreign policy's basic functions. Those concerned with national and international security have realized public health's importance concerning threats from biological weapons proliferation and bioterrorism. Debates concerning the impact of international trade and investment on public health demonstrate public health's importance to the state's pursuit of its economic interests. The traditional trope of "wealth leads to health" that guided economic development's relationship to public health for most of the post-World War II period has been challenged by the "health produces wealth" argument.[8] In addition, rising health care costs in many countries are becoming major macroeconomic factors that can affect a country's global competitiveness and fiscal policy options. Finally, public health's importance to civil and political rights and economic, social, and cultural rights has been a feature of human rights and public health discourse over the last decade. See Table 1.

18. For the first time since health promotion advocacy began, health promotion advances in a context in which the role of public health features prominently in all foreign policy's functions. In terms of foreign policy, public health has a higher profile than ever before.

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[8] *See, e.g.*, Commission on Macroeconomics and Health, *Macroeconomics and Health: Investing in Health for Economic Development* (WHO, 2001).

Table 1.

Foreign Policy Governance Function	**Examples of Importance of Public Health to Each Function**
Security	• Fears about the state proliferation of biological weapons • Concerns about the use of biological weapons by terrorists • Acknowledgment that emerging communicable diseases, such as SARS and avian influenza, can pose direct threats to the security of states, peoples, and individuals • Recognition that the political, economic, and social devastation caused by HIV/AIDS can threaten the security of states, peoples, and individuals • Development by WHO of the concept of "global health security" with respect to communicable disease threats
Economic well-being	• Understanding of the economic damage communicable disease epidemics and pandemics can cause to national economies integrated through globalization • Tensions between states that export products harmful to human health (e.g., tobacco products) and states that import such products and try to mitigate the health effects of the products • Health care costs as increasingly important factors for national economic performance and the dynamics of global economic competition • Controversies over the effect of trade liberalization strategies on national health regulatory powers and capabilities
Development	• Advocacy to put public health at the center of economic development strategies • Centrality of health to the achievement of the UN Millennium Development Goals • Research and analysis that highlights the contributions health makes to macroeconomic and microeconomic development • Linking debt-forgiveness and future international assistance to increased attention on, and investments in, health
Human dignity	• Focus on a human-rights based approach to HIV/AIDS • Human-rights centered arguments in favor of increasing access to essential medicines subject to patent rights under TRIPS • Appointment by the UN of a Special Rapporteur on the Right to Health • Challenge of balancing enjoyment of civil and political rights and addressing dangerous communicable disease outbreaks effectively

United Nations Reform, Foreign Policy, and Health Promotion

19. One can appreciate this transformation by examining the UN Secretary-General's proposals for United Nations reform. UN reform is not new for the foreign policy of UN members; but never before has public health appeared in UN reform proposals as significantly as it did in Kofi Annan's March 2005 report *In Larger Freedom.*[9]

20. Each of the Secretary-General's objectives for UN reform—freedom from fear, freedom from want, and freedom to live in dignity—depends on public health improvements. To achieve freedom from want, the Secretary-General emphasizes fulfillment of the eight UN Millennium Development Goals (MDGs),[10] three of which target specific health problems (child mortality; maternal health; and combat HIV/AIDS, malaria, and other diseases) and four of which seek improvement in key health determinants (poverty

[9] *In Larger Freedom: Towards Development, Security and Human Rights for All,* A/59/2005, 21 Mar. 2005.
[10] *Id.,* ¶¶28-32.

and hunger; universal primary education; gender equality; and environmental sustainability).[11] The eighth MDG (develop a global partnership for development) targets cooperation with pharmaceutical companies to provide access to affordable, essential medicines in developing countries.[12]

21. The Secretary-General also asserts that ensuring access to sexual and reproductive health services, providing safe drinking water and sanitation, controlling pollution and waste disposal, assuring universal access to essential health services, and building national capacities in science, technology, and innovation are national priorities for achieving freedom from want.[13] Strengthening global infectious disease surveillance and increasing research on the special health needs of the poor are global priorities in realizing freedom from want.[14]

22. In terms of freedom from fear, the Secretary-General's new vision of collective security includes addressing threats presented by naturally occurring infectious diseases and biological weapons. These tasks require strengthening national and global public health and potentially involving the UN Security Council in "any overwhelming outbreak of infectious disease that threatens international peace and security."[15]

23. The Secretary-General's conception of freedom to live in dignity also connects to public health. The Secretary-General declared that "[t]he right to choose how they are ruled, and who rules them, must be the birthright of all people, and its universal achievement must be a central objective of an Organization devoted to the cause of larger freedom."[16] Public health feeds this right and attribute of human dignity because "[e]ven if he can vote to choose his rulers, a young man with AIDS who cannot read or write and lives on the brink of starvation is not truly free."[17]

24. The Secretary-General's UN reform proposals constitute a vision in which UN members must elevate public health as a foreign policy priority in order to support security, development, and human dignity. The Secretary-General's UN reform strategy clarifies the importance of states thinking in terms of health as foreign policy. Indeed, this strategy fuses the success of UN reform to the effectiveness of global health promotion.

Opportunities and Risks with Respect to Health as Foreign Policy

25. The prominence the Secretary-General gives public health reveals that health promotion, as a core component of public health, is a strategic necessity for the international community, the fulfillment of which depends on how states organize and implement their foreign policies. Health's rise on foreign policy agendas, and the centrality of public health to UN reform, demonstrates that strengthening foreign policy approaches to public health offers significant contributions to all the governance functions served by foreign policy. These contributions can develop at national, regional, and global levels. Engraining health promotion into foreign policy helps ensure that linkages between health and foreign policy assist states in addressing governance challenges the world faces as globalization accelerates.

26. The number and significance of the links between public health and foreign policy suggest that effective public health has become an independent marker of "good governance" for 21st century humanity and its globalized interactions. Health promotion has long emphasized the need for healthy public policy, and the emergence of public health as an independent marker of good governance opens new opportunities for health promotion as a normative value and a material interest.

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[11] UN Millennium Development Goals, http://www.un.org/millenniumgoals/.
[12] *Id.*
[13] *In Larger Freedom*, ¶¶40-41, 43-44, 46.
[14] *Id.*, ¶¶63-64, 67.
[15] *Id.*, ¶105.
[16] *Id.*, ¶148.
[17] *Id.*, ¶15.

27. Opportunities do not come without risks, and health as foreign policy is no exception (see Box 2). One danger is that states will use public health for ulterior foreign policy motives or purposes that have little to do with health protection and promotion. In other words, health policy becomes another pawn in a power-political game of competition that values public health as a short-term instrument not as a sustainable foundation for good governance nationally and globally. Health policy can, thus, become yet another arena in which states engage in traditional foreign policy conflicts over power, security, and influence.

28. A second danger concerns the possibility that foreign policy interest in specific public health problems, such as the control of infectious diseases and the threat of bioterrorism, subordinates health promotion's emphasis on determinants of health in policymaking. Such subordination would mean that only parts of public health connected to national security and economic power emerge into the "high politics" of foreign policy while health promotion remains neglected.

29. A third danger involves the disequilibrium of power that exists in international relations. This imbalance can create conditions in which more powerful countries pursue foreign policy agendas with respect to public health that do not address the needs of weaker states. Health as foreign policy contains the potential for the mixture of power and epidemiology to create controversies.

30. A fourth danger is gridlock because foreign policy interests of different states concerning public health can produce divergence rather than convergence on appropriate actions. Public health's rise as a foreign policy issue has been accompanied by controversies that have undermined trust and goodwill among states. Even in the realm of public health, producing a harmony of interests among states in their foreign policy pursuits is not easy.

Box 2.

Opportunities and Risks: The New International Health Regulations

The new International Health Regulations (IHR), adopted in May 2005 by the World Health Assembly,[18] provide a case study for the opportunities and risks health as foreign policy presents to health promotion. The new IHR constitute a radically different set of rules from the old IHR and are designed to achieve global health security in the context of the globalization of disease threats. The WHO, its member states, and the UN Secretary-General have embraced the new IHR as a critical instrument in protecting and promoting public health in the 21st century.

The new IHR's negotiation raised, however, risks that health as foreign policy can create. Tensions arose about the new IHR's application to suspected incidents involving biological weapons and the politically sensitive relationship between China and Taiwan. Further, the new IHR concentrate on detecting and responding to public health emergencies of international concern and do not directly address determinants of health that create the conditions conducive for disease emergence and spread. Such determinants are targets of health promotion efforts. Concerns exist, thus, that the attention the new IHR bring to global health security between states might drain resources and interest away from improving determinants of health within countries.

Health Promotion and Foreign Policy

31. Health promotion now faces a context transformed by globalization and public health's emergence as an issue for all the governance functions served by foreign policy. In this environment, health promotion needs to sharpen its focus on foreign policy as an aspect of the larger objective of healthy public policy, which means paying more attention to substantive and institutional aspects of public health as a foreign policy issue.

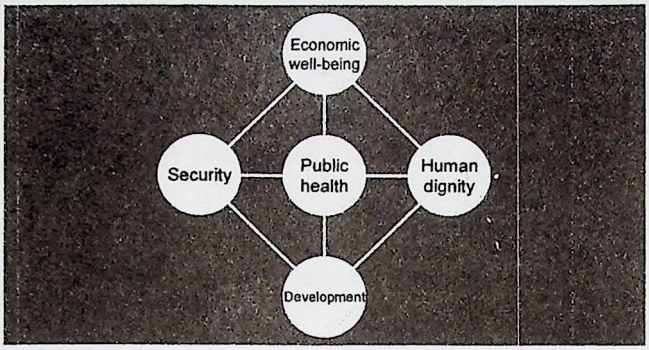
32. Substantively, health promotion's message should be that public health constitutes an *integrated public good* that benefits the state's pursuit of security, economic well-being, development efforts, and

[18] World Health Assembly, Revision of the International Health Regulations, WHA58.3, 23 May 2005.

respect for human dignity. The multiple interests and governance purposes public health supports make it a "best buy" for foreign policy. As such, health as foreign policy allows public health to escape its traditional relegation to the "low politics" of foreign policy. See Figure 2.

Figure 2.

Health as Foreign Policy:
Public Health as an Integrated Public Good



33. Foreign policy pursuit of the integrated public good of public health will necessitate changes to the structure and dynamics of health and foreign policy bureaucracies. Health promotion should focus attention on how governments can better facilitate public health as a foreign policy objective. Pursuing public health as an integrated public good requires health and foreign policy bureaucracies to develop new skills in order to understand the new context in which they operate, promote more effective interagency collaboration, produce policy coherence, and assess progress. Health and foreign ministries could exchange staff more frequently to increase the health competence of foreign ministries and the diplomatic competence of health ministries.

34. Health as foreign policy offers health promotion opportunities to engage non-governmental actors. For example, non-governmental organizations (NGOs), such as universities and schools of public health, could contribute to the pursuit of public health as an integrated public good by deepening understanding of the health-foreign policy dynamic and training prospective public health practitioners to operate in the new environment created by the health as foreign policy transformation. Foreign policy collaboration with NGOs through public-private partnerships may also be a fruitful strategy for health as foreign policy. NGOs may also be valuable in assessing how well countries engage in health as foreign policy.

Conclusion

35. Public health's rise as a foreign policy issue has transformed how health promotion unfolds in the future. This transformation forces health promotion advocates to pay more attention to health as a foreign policy issue rather than subsuming foreign policy in the concept of healthy public policy.

36. Health promotion's challenge is to advance the concept of health as foreign policy defined as the pursuit of public health as an integrated public good across all governance functions served by foreign policy. Advancing this concept of health as foreign policy serves not only each country but also perspectives on how global politics should progressively develop in the 21st century.

37. Although the increased intersections between public health and foreign policy generate risks for health promotion, these risks do not negate the challenge facing health promotion at the Bangkok Conference and beyond. Any effective effort to harness globalization for public health will have to make health as foreign policy a centerpiece of its ambitions. This responsibility is now the health promotion strategy's burden and opportunity.

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WORLD HEALTH ORGANIZATION

FIFTY-FOURTH WORLD HEALTH ASSEMBLY
Provisional agenda item 13.2

A54/8
30 March 2001

Health promotion

Report by the Secretariat

1. Resolution WHA51.12 requests the Director-General to support the development of evidence-based health promotion activities, give health promotion top priority within WHO, and report back to the Executive Board and the Health Assembly. The Executive Board at its 105th session acknowledged the importance of health promotion programmes, particularly the need to implement programmes that are based on evidence, to monitor their effectiveness, and to give priority to the need for health promotion programmes in developing countries. Time did not permit the subject to be fully discussed at the Fifty-third World Health Assembly in May 2000; it was therefore decided that the item should be placed on the agenda of the Fifty-fourth World Health Assembly.[1]

2. Health promotion has a rich history at WHO, and it remains a cornerstone of WHO policies and actions. WHO has designated many collaborating centres, sponsored five international conferences, benefited from significant regional and national conferences, and conducted important programmes and activities on health promotion.

3. The Ottawa Charter for Health Promotion continues to guide the global practice of health promotion and sets out a strategy with five essential actions: building healthy public policy, creating supportive environments, strengthening community action, developing personal skills, and reorienting health services. These remain valid. The most recent meeting – the Fifth Global Conference on Health Promotion (Mexico City, 5 to 9 June 2000) – adopted a Ministerial Statement which affirmed the contribution of health promotion strategies to the sustainability of local, national and international actions in health, and pledged to draw up country-wide plans of action to monitor progress made in incorporating strategies which promote health into national and local policy and planning.

4. Over the past few years, much of the progress in WHO's health promotion programme has been achieved by application of health promotion principles to specific risk factors and diseases in particular populations and settings, and generation of an evidence base of effective practice. After 25 years of effort, community-based health promotion activities in North Karelia, Finland, have reduced age-adjusted mortality due to heart disease among men by 73% and cut all cause mortality for men by 44%. Over a 10-year period in California, United States of America, a comprehensive tobacco control programme has prevented 33 000 heart disease deaths and reduced the incidence of lung cancer by 14%, compared to a reduction of 3% in the rest of the United States. In Belgium, educational efforts on the importance of designated drivers and stringent enforcement of drink driving laws have decreased motor vehicle deaths and injuries by 10% in the year following the launch of the programme. In Thailand, a national HIV/AIDS prevention programme increased condom use and

[1] Document WHA53/2000/REC/3, summary record of the eighth meeting of Committee A, section 3.

decreased sexually transmitted disease and HIV infection rates across the whole population. Many other examples of successful health promotion programmes have been published.

5. Health promotion strategies are not limited to a specific health problem, nor to a specific set of behaviours. WHO as a whole applies the principles of, and strategies for, health promotion to a variety of population groups, risk factors, diseases, and in various settings. Health promotion, and the associated efforts put into education, community development, policy, legislation and regulation, are equally valid for prevention of communicable diseases, injury and violence, and mental problems, as they are for prevention of noncommunicable diseases.

6. Despite the progress made, health promotion needs to be applied more energetically at local, country and regional levels in order to change the factors that influence health and improve health outcomes.

7. In order to strengthen its health promotion programme throughout the Organization, WHO will streamline its efforts, focusing on a specific set of priorities, but with a broad spectrum of involvement. The priorities proposed are young people, health communications, and health systems.

8. Health promotion directed at young people, especially those in early adolescence, has a great potential for advancing the health of the population. Establishing supportive communities, networks and institutions, and encouraging healthful behaviour are the most effective ways to enable young people and their families to increase control over, and improve, their health. It is essential that health promotion activities should be available to all young people, both in and out of school. Of particular importance is the potential role of sports and recreation in providing healthful alternatives to risky youth behaviour and the often counteractive influence of the media and the entertainment industry.

9. Improved health literacy is necessary for people to increase control over their health, and for better management of disease and risk. Communications strategies that increase access to information and build the capacity to use it can improve health literacy, decision-making, risk perception and assessment, and lead to informed action of individuals, communities and organizations. Communications, particularly media advocacy, can be directed at moving public opinion and action toward reforms in policies and regulations of the various social, economic and environmental factors that influence health.

10. In addition, health systems that are integrated and accessible have great potential to promote health, as well as to prevent disease. Health systems have an essential responsibility for primary and secondary prevention, and assist in improving adherence to therapies and treatment regimens. Health systems can be instrumental in involving other sectors as partners in health promotion.

11. In a broader policy context, it is recognized that health promotion is integral to, and can help advance, WHO's corporate strategy. Health promotion helps to reduce excess mortality, address the leading risk factors and underlying determinants of health, helps to strengthen sustainable health systems, and places health at the centre of the broader development agenda.

12. Based on sound evidence, WHO's health promotion efforts will target specific populations at risk, taking account of the interface between health status and the broader determinants of health. Priority will be given to implementation of programmes among disadvantaged populations in specific settings. Too often, it is not proven strategies that are lacking, but vigorous and culturally sensitive application of measures that are known to work.

13. In WHO health promotion is being brought into the mainstream of technical programmes and initiatives. For example, the cluster on Sustainable development and healthy environments deals with the cross-sectoral dimensions of health and coordinates work related to poverty, trade and human rights, all of which affect the underlying determinants of health. Work on healthy cities, islands, or municipalities, which shows how multisectoral approaches to health development lead to improved health, is being undertaken in several regions. The Commission on Macroeconomics and Health will continue to deal with poverty and other determinants of ill health.

14. WHO will cooperate with Member States in strengthening their capacity for health promotion and incorporating it into national plans, with particular emphasis on programme implementation and evaluation. To this end, use is encouraged of WHO's Health promotion glossary,[1] which provides clear definitions and descriptions of health promotion terms. This glossary will be reviewed and revised to include additional relevant terms, as part of the process of obtaining standardized terminology and of the provision of technical assistance to Member States.

15. In order to improve the evidence base for health promotion, WHO will build up a vigorous research and development component, focusing on better dissemination and application of its principles and approaches, especially in developing countries. This will be achieved through existing research partnerships with academic institutions, professional organizations, and WHO collaborating centres. Thus health promotion research will be integrated into the content of WHO programmes in order to achieve coherence and greater relevance, and to ensure applicability of research findings.

16. A mechanism for coordination and planning will be set up, that will serve as a driving force for the continuous development of health promotion throughout WHO. One of its first activities will be to take stock of what has been done worldwide, in order to develop approaches that will speed up implementation of activities in the three areas of priority outlined above, and to advance the practice of health promotion in general.

17. WHO will establish a forum for health promotion dialogue with other organizations of the United Nations system, academic institutions, professional associations, and other nongovernmental organizations, such as the International Union for Health Promotion and Education. Its purpose will be to stimulate joint action, coordinate activities, expand partnerships, especially with nongovernmental organizations and the private sector, and work together on a common agenda. Emphasis will be laid on advancing understanding of the development, delivery and assessment of health promotion programmes, particularly for disadvantaged populations. The activities of each participant in the forum should complement, not duplicate, those of the others.

ACTION BY THE HEALTH ASSEMBLY

18. The Health Assembly is invited to note the report.

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[1] Health promotion glossary, WHO, Geneva, 1998 (document WHO/HPR/HEP/98.1).

2005
RHP&EO is the electronic journal of the International Union for Health Promotion and Education

Charters, Declarations, World Conferences: Practical Significance for Health Promotion Practitioners 'on the ground'

Maurice B. Mittelmark, Professor, University of Bergen and President, IUHPE

Mittelmark, Maurice B., *Charters, Declarations, World Conferences: Practical Significance for Health Promotion Practitioners 'on the ground'*, Reviews of Health Promotion and Education Online, 2005. URL:http://www.rhpeo.org/reviews/2005/3/index.htm.

We are on the cusp of the twentieth anniversary of the Ottawa Charter for Health Promotion. In 2005 in Bangkok, the *World Health Organization* will lead a re-examination of the Ottawa Charter, and the Bangkok Charter on health promotion will have be launched. At the *International Union for Health Promotion and Education's* global conference in Vancouver in 2007, the Ottawa Charter will again be in the spotlight, as will, for that matter, the new Bangkok Charter.

One might wonder about the need for a new Charter, and what impact such documents have on the practical work of health promotion practitioners, if any. The need for a new Charter is the subject of lively debate at the time of this writing, a sign that the Ottawa Charter continues to have significance, even though the world has changed remarkably in the twenty years since its adoption. Perhaps the best test of the Bangkok Charter's impact will be the degree of attention it receives in 2025, when the young readers of this book have aged into the vanguard of health promotion leadership.

That still leaves the question of if, and how, the high level political machinations which culminate in health promotion Charters and Declarations have significance for the day-to-day work of health promotion practitioners. For a start, it is clear that health promotion provides common ground for many health professionals, which enhances the quality and effectiveness of cross-discipline team work. Education in health promotion stimulates and enables cross-discipline dialogue, respect, and eagerness for collaboration. Regardless of a health professional's discipline-specific training, education in health promotion creates bonds with other disciplines. It ensures a high regard for the principles of empowerment and participation. It instils appreciation for the expertise of non-health professionals. It creates commitment to

community-based solutions, and to action in community settings. Health promotion's conferences, continuing education offerings, journals, and newsletters, help maintain the bonds forged in early training.

So, health promotion *does* have practical significance for health professionals. A vital point is that for health promotion to 'deliver' in the ways mentioned, it must have mechanisms of action, it must have infrastructure, and it must have visibility in education, in practice, and in policy arenas. The existence of these essential elements should not be taken for granted. There exists an attractive logic that, since health promotion has relevance to all public health work, it should be diffused in health care systems. To the contrary, health promotion's distinctiveness requires diligent preservation, in no small part because of its almost unique bridge-building capability.

That claim brings me back full circle, to the question of what relevance health promotion's high level political processes, and Charters and Declarations, have for allied health professionals. The answer is that if health promotion is to remain vital, and to serve the practical functions described above, it requires periodic illumination, with critical debate. At the very least, global conferences and the Charters and declarations they spawn *do* illuminate health promotion. They *do* spark much needed debate. Two outcomes of discussion and debate swirling around the Bangkok conference and the Bangkok Charter can be safely anticipated: affirmation of health promotion's foundational values, and agreement on the need for ever more innovative health promotion strategies and more effective collaboration in our rapidly changing times.

Note: This text has been adapted slightly, with authorisation from the Publisher and the Editor, from the Preface to: Scriven, A. (ed) (2005) Health Promoting Practice: The Contribution of Nurses and Allied Health Professions. Palgrave, London. It will also be published in French and Spanish, as well as its original language, in Promotion & Education, Volume XII, Number 1, 2005 (in press).

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2005
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On image, ownership and open space

Hans Saan, NIGZ (Netherlands Institute for Health Education), the Netherlands,

Saan, Hans, *On image, ownership and open space*, Reviews of Health Promotion and Education Online, 2005. URL:http://www.rhpeo.org/reviews/2005/24/index.htm.

It is most interesting to see how we negotiate about the Bangkok Charter. The vigour shows how much many of us are fully engaged in health promotion and are ready to debate their principles and values. That in itself is a good sign of how health promotion is alive and kicking. I would like to add to the debate three arguments, that relate not so much to the content, but to the positioning and style of that declaration.

My first observation has to do with the logo of the conference. The Ottawa logo is a great trade mark and the variations in each of the following conferences added to the impact of that image without destroying it. I liked the curves of the shapes, the escape from the circular form, the beauty of its simplicity. It sends a message on concepts, by putting them in a dynamic pattern. The Ottawa logo had a one to one fit with the charter, so it worked as a didactic tool too. Now the Bangkok conference chooses a logo that overlaps the Ottawa image with a human figure in a green circle. It remains to be seen how that image relates with the content of the statement. It has not yet won a prize in my beauty contest.

The second argument has to do with language. The drafts of the text circulated so far had many boring sentences of a rather abstract language. It seeks to inspire, but it misses the feeling of innovativeness and border crossing that made the Ottawa Charter then such a challenging text. Taken into account the context of the statement being produced, buropolicy language seems unavoidable, but I wonder what would happen if the now final sentence: "We the participants...." like the famous "We the people...." were put first. It might have a refreshing impact on the text if We promise something to Us, to You and to All.

My final argument will embrace the two mentioned. So far the text and the conference have four tracks. Now four is a closed number: it evokes seasons, directions, so rather stable situations. Health promotion deserves a more dynamic approach, so I propose (in line with a book about the Rule of Four) to apply a Rule of

Five. Put in the text and the conference a fifth track labelled Open Space. That area invites innovative approaches that people find not yet covered in the other four tracks. It will help to lower the pressure on the four tracks to be all-inclusive and by putting at the conference a room apart for this fifth track, in which we are ready for the surprise. Health promotion always is on the lookout for the possible, for unexpected knots in a pattern, for opportunities for innovative empowerment. In that open space some workshops may provoke creative approaches to the issues at hand. Agenda setting could be done on the spot, people vote with their feet, the output should be at most five sentences or items, to fit with the format of the other tracks.

My suggestions for workshops: a competition for a Bangkok Logo and a workshop with experienced text writers and journalists on a We the People version of the Charter.

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2005
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The Bangkok Charter: will it be as significant as the Ottawa one ?

Michel O'Neill, Professor, Université Laval, Québec and Vice-President for Communications, IUHPE

O'Neill, Michel, *The Bangkok Charter: will it be as significant as the Ottawa one ?*, Reviews of Health Promotion and Education Online, 2005. URL:http://www.rhpeo.org/reviews/2005/23/index.htm.

On the 11th of August 2005, the Bangkok Charter will be proclaimed in Thailand during the 6th international conference for health promotion sponsored by the World Health Organization (WHO). Whatever the final version looks like, and in my opinion it will not be too different from the preliminary versions that have been circulating for a while, this Charter (or whatever it will end up being called) will necessarily be of the same type than what such conferences generate : values and broad principles as well as noble and generous suggestions that are increasingly difficult to apply by Member States, crippled by less and less freedom of action in our era of globalization. Given the very nature of the WHO, it could hardly be otherwise.

Why did the Ottawa Charter have such an impact then, while the final documents proclaimed at the four other WHO international conferences were much less influential? Because it's content was particularly convincing? Because it was a *Charter* and not like in Adelaide a set of *Recommendations*, or in Sundsvall, Djakarta or Mexico, a *Declaration* (« ministerial » in the case of Mexico)? Is the fact that it will most likely be a *Charter* in Bangkok a guaranteed recipe for success?

I suggest here to explain the success of the Ottawa Charter and the relatively small impact of the final documents of following WHO international health promotion conferences not by their contents nor by the fact that they are labeled a *Charter* or not. I think the key element is the historical and political circumstances in which each of them has been proclaimed. If this analysis is correct, it can already provide us with some interesting indications relating to the possibilities of the new Bangkok Charter. So why were the historical and political circumstances of the Ottawa Charter so special?

First and foremost, there was a novelty factor involved: this Charter was the first of

it's kind, proclaimed at the first of WHO international conferences in health promotion. I would argue that this "first kid on the block" syndrome played a similar role with the famous Lalonde report (1974): it was followed very closely by similar reports from the USA and most of the industrialized countries but with much less international impact. Being the first matters thus.

A second phenomenon of importance : the Ottawa conference was the outcome of almost ten years of work, reflections and exchanges. It was in the wake of the *Health for All* declaration of the World Health Assembly in 1977 and the *Primary HealthCare* conference of Alma Ata in 1978, where lots of people were trying to operationalize all over the world the first major reorientation proposed by the WHO since it's creation in 1948.

Thirdly, we must also recall that in 1986 the WHO, like all the other organizations of the UN system, still had strong credibility and leadership; 20 years of economic conservatism and « new world order » have seriously weakened these two important characteristics. Is today's WHO moral authority, whatever the content of the new charter produced in Bangkok, as strong as yesterday's?

Finally, the leadership in the production of the Ottawa Charter came from northern countries : the WHO European office in Copenhagen in interaction with the Canadian federal government. This charter also benefited from the tenacious efforts of a group of people like Ilona Kickbusch, Ron Draper and several other intellectual visionaries who were very well networked and occupied relatively powerful positions. Even if the international macro-economical leadership in the last 20 years, has somewhat shifted from Europe and North America to South-East Asia, will the proclamation of the Bangkok Charter next August benefit from the same positioning in the global political economy than the Ottawa one in 1986?

Only time will allow to answer the questions above. I nevertheless thought important to point out that it is not necessarily the exact wording nor the name of the Bangkok Charter that will explain the impact (or lack of) of this document on the international health promotion scene but the broader context in which they occur.

Note : a first version of this paper was published in French in the Bangkok Charter electronic discussion group of the Institut national de prevention et d'éducation pour la santé (INPES) *in Paris in February 2005; it was reprinted in the same month in RHPEO. Thanks to Sébastien Courchesne-O'Neill for a first draft of translation in English.*

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2005

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Bangkok Charter: criticizing but backing WHO

Maurice B. Mittelmark, Professor, University of Bergen and President, IUHPE

Mittlemark, Maurice B., *Bangkok Charter: criticizing but backing WHO,* Reviews of Health Promotion and Education Online, 2005. URL:http://www.rhpeo.org/reviews/2005/22/index.htm.

The focus on the wording of the Bangkok Charter, while important, has tended to obscure what I feel are other important issues. As I stated in my previous contribution to this discussion, the test of the Bangkok Charter will be a test of time. Will it excite debate in 20 years? I hope so. Will that in any way diminish the significance of the Ottawa Charter? I think not. However, that there will be a Bangkok Charter at all IS significant. Immediately after the Mexico City conference in the series started in Ottawa, it seemed sure that Mexico City would the last in the series. WHO leadership in Geneva at that time told me there were no plans for continuing, and that upset me. Without question, the WHO health promotion conference series has pumped air into the health promotion balloon at regular and needed intervals.

IUHPE conferences do so, too, but in a different way. At the professionals' conferences, there are many points of activity that energise virtually all who attend -- and the numbers are in the thousands and growing. WHO conferences, with attendance by invitation and with relatively few participants, serve a different function. These WHO 'happenings', including their Charters, Declarations and other pronouncements, provide advocacy opportunities that are priceless. For example, after Mexico, the Norwegian government launched an important in-country review of, and discussion about, the state of its health promotion efforts. That would hardly have happened without Mexico City.

Today, the WHO Director General and senior staff are emphasising health promotion again by holding the Bangkok conference. In this, they need and deserve our support and encouragement. Many of us are helping them with the Bangkok conference, even as we exercise our right to criticise aspects we are uncomfortable with (that Bangkok intends to adopt a 'Charter' seems the main point of contention; issues of wording are mostly being worked out, I think).

I have been ambling along toward my central point, and it is this: WHO in Geneva has far too few resources to accomplish all that its stakeholders, constituents and critics demand. As politics is the sweet science of deciding how too-scarce resources should be distributed, decisions about how much emphasis health promotion will receive in Geneva are political decisions -- influenced by other factors, but political decisions at the core. We in health promotion need to do all we can to influence those decisions. Grumbling about various inadequacies to one another and adopting a confrontive style with WHO will get us nowhere. Only advocacy -- by us -- at the State level has a chance of helping. In our countries, we need to advocate for health promotion with a simple message:

Health promotion is the cutting-edge action arm of public health. It works at low cost, and works well, when done with seriousness of purpose and in a sustained way. A strong core of professional expertise in health promotion at WHO in all its regions and in Geneva can help States do health promotion effectively. Therefore, Member States are committed to investment in a critical mass of health promotion expertise in WHO, that is at present sorely lacking. The very good, but very few, health promotion experts at WHO need more help!

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2005
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What would the Nutbeam Charter look like if it were written with my editing?

By Lawrence W. Green, Visiting Professor, University of California at Berkeley School of Public Health, USA

Green, Lawrence W., *What would the Nutbeam Charter look like if it were written with my editing?*, Reviews of Health Promotion and Education Online, 2005.
URL:http://www.rhpeo.org/reviews/2005/21/index.htm.

Don Nutbeam's very nicely crafted and cogent commentary (2005) on the Ottawa Charter leads with the stage-setting observation that the Charter process was highly consultative, but within a relatively small group. One could add that most of those present from developing or developed countries were not necessarily representing their governments or the leading professional associations or other stakeholders in their countries. They were the people who could attend, among those who were invited. If my invitation was typical, it is easy to appreciate the issue Prof Nutbeam raises concerning the representativeness of consultative process. The other part of Nutbeam's implicit concern here is with the representation of the developing world at the Ottawa conference. In response to this frequent criticism, Ilona Kickbusch pointed out in her commentary in February (2005) that this was the very "challenge thrown out by Dr. Halfdan Mahler, the then Director General of the WHO, ...to make the principles of the Alma Ata Declaration applicable to the developed world..." If Ottawa was the tilting of the balance back toward developed countries, Bangkok may be expected to be the pendulum swing back toward the emphasis of the Alma Ata Declaration on developing countries, but with a greater emphasis on the health promotion issues raised in Ottawa. Or, as Kickbusch suggests, it could be the end of this "false dichotomy."

Nutbeam's section on "Healthy Public Policy" accurately reflects the origins of the concept, its limitations for certain developing countries, and the needs for updating it to give greater weight to decentralized policy-making, the needs of developing countries, and globalization. I would embellish his decentralization to emphasize organizational and institutional policies within communities, because community has such varied geographic meaning across the globe, as witnessed by the need to

rename the "Healthy Cities" initiative of Western Europe "Healthy Communities" in North America, "Healthy Shires" in Australia, and "Healthy Villages," "Healthy Towns," or "Healthy Counties," in some places. What also concerned me with the naming of these things as "healthy" is that the real intent was to make them *healthful* so that people living in them could be healthy. Living things can be healthy. Inanimate or nonliving objects can, at best, be healthful. This is not just a grammatical point, but also a concern that the redirection of focus from the health of people to the "health" of policies, cities, and communities could have the effect of diluting the concern with health outcomes for people. It might have had the effect of reinventing policies, cities, communities, etc in the possibly romanticized or utopian image of what some people (e.g., those attending the Ottawa conference) would hold for an ideal community life or political orientation of policy, but which would not be guaranteed to improve the health of people. What it did contribute toward was the growing interest in reviving ecological approaches to health promotion.

Some of the foregoing issues are addressed in the Nutbeam's following section on "Healthy Environments." Here Nutbeam seems to shift the spotlight onto the physical environment and "settings," which became the "more subtle" way of expressing health promotion's particular interests in social environments. Some reference might be in order here to the shift in emphasis from physical environment in public health history to social environments in the Ottawa Charter's health promotion, to the current emphasis on "social determinants of health" which places less emphasis on settings and more on social inequalities and early childhood or lifetime exposures to socioeconomic conditions harmful to health. Whether health promotion needs to take this additional step toward social inequalities or away from "settings" as a focal concern for the Bangkok Charter needs to be debated. Such a shift, however, must not abrogate the traditional (and now growing) responsibility of public health for the protection of people from exposures to toxins and other threats of the physical environment, which is deteriorating in many places.

Nutbeam's point about the over-reaction of the Charter to simplistic behavioral and individualistic approaches is very important and worthy of a prominent place in this debate leading up to the Bangkok meeting. It was expressed by some during the Ottawa Charter era as disdain for the historical roots in health education and disparagement of those continuing to develop the theoretical and empirical grounding of educational and behavioral components of more ecologically layered, more comprehensive programs. The subsequent maturing of both levels--individual and social--expressed in part in the Ottawa Charter, might give the Charter a different tone, emphasizing the reciprocal determinism of behavior and environment, a central tenet of ecology, if written today. Nutbeam's casting this section of his commentary in the context of health literacy puts a particular spin on one aspect of the issue that for those with a narrow understanding of health literacy could miss the larger ecological context in which the individual-community, behavioral-environmental interplay and dialectic have played out. This would be, ironically, the same fate of those who held a narrow understanding of health

education at the time of the Ottawa Charter.

Nutbeam's observation in the next paragraph that governments have tended to invest in the IEC components of the more comprehensive efforts needed to get at the social determinants and other ecological forces recovers the important point that the combination of both is needed to achieve the goals of health promotion. One could add, perhaps more cynically, that governmental focus on IEC components gives them publicity and visibility when they are doing little to address the determinants over which individuals can exert minimal control, so that IEC sometimes becomes public relations rather than public health education.

In his section on community development, I would add a plea for more participatory research with professionals and other indigenous practitioners, community policy makers, and grass roots residents. This is a concrete example of the point Professor Nutbeam makes here about the richness of experience and literature from developing countries that is only beginning to be reflected in mainstream health promotion literature. Participatory research was not a concept developed in the Ottawa Charter, but one whose time has come.

In short, if Don Nutbeam and I were co-authoring a draft of the next charter, it would likely have (1) a built-in consultative process to assure wider representation of key stakeholders; (2) a more systematic tracing of causal links from population health outcomes to the policies, regulations, and organizational structures that could achieve them, rather than "healthy polices" and "healthy cities" as apparent ends in themselves; (3) a blending of physical and social environmental issues; (4) a rehabilitation of health education (perhaps in the new clothes of health literacy) with its recognition of individual agency and reciprocal determinism between behavior and the environment; (5) recommendations to strike a better balance in the distribution of expenditures of governments on information, education and communications, such that government officials could not misdirect such funds toward their own public relations purposes; and (6) an underpinning of the health promotion enterprise with the development of a science that grows as much out of participatory research on existing needs and local practices as from highly controlled, hypothesis-driven trials in artificially contrived experiments.

These features, of course, would depend on Professor Nutbeam's acceptance or further rewriting of my edits on his virtual, hypothetical, updated redrafting of the Ottawa Charter. It was his prospectus for such an update that inspired me to sign on. We both "retain a strong attachment to the basic concepts and principles of the Ottawa Charter," and we both seem to come back to it with the benefit of our respective revolving-door careers in and out of academia and government service.

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Another world is possible - that is more equitable, just and healthy

Health promotion

6th Global Conference on Health Promotion

"Policy and Partnership for Action: Addressing the Determinants of Health" E Thailand, 7-11 August 2005

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Mr Alok MUKHOPADHYAY, Chief Executive, Voluntary Health Association of India (VHAI), New India

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Conference Committe

1. The Conference C Committee (COC)
2. The Programme C (PC)
3. The WHO Confere Secretariat
4. Conference Orgar Committees in Th
5. Conference Track

6th Global Conference on Health Promotion: 1,2,3,4,5 | Next page

HLM - all these are for the health promotion resource file
23/8/05.

The 6th Global Conference on Health Promotion

"Policy and Partnership for Action: Addressing the Determinants of Health", Bangkok, Thailand, 7-11 August 2005

The 6th Global Conference on Health Promotion, organized by the World Health Organization and the Ministry of Public Health, Thailand, will be held at the United Nations Conference Centre in Bangkok, on 7-11 August 2005.

This conference is the latest in the series which began in Ottawa in 1986 and produced the Ottawa Charter on Health Promotion. This benchmark conference was followed by Adelaide (1988), Sundsvall (1991), Jakarta (1997) and Mexico-City (2000).

Almost 20 years later, many things have changed in the world, including the impact of globalization, the internet, greater moves towards private sector involvement in public health, emphasis on a sound evidence-based approach and cost-effectiveness. The 6th Global Conference has been convened to meet these challenges and to better exploit the opportunities presented for health promotion in the 21st Century.

Latest updates

MEDIA CENTRE

Welcome to the media centre for the 6th Global Conference on Health Promotion
Information for the media: media advisories and releases, agenda
Full text

VIRTUAL CONFERENCE

This will be available during the week of the conference. View daily summaries, keynote addresses and presentations, photo gallery.

Background information

ABOUT THE CONFERENCE

What is the 6GCHP?
Full text

Conference overview
Conference tracks, plenary sessions, technical discussions and outcomes.
Download document [pdf 72kb]
Conference agenda
Download document [pdf 176kb]

SUPPORT DOCUMENTS

Venue
Poster [jpg 219kb]
Committees

PREVIOUS CONFERENCES

Ottawa (1986), Adelaide (1988), Sundsvall (1991), Jakarta (1997) and Mexico-City (2000).
More information

SPOTLIGHT

Bangkok Charter Health Promotion
More information

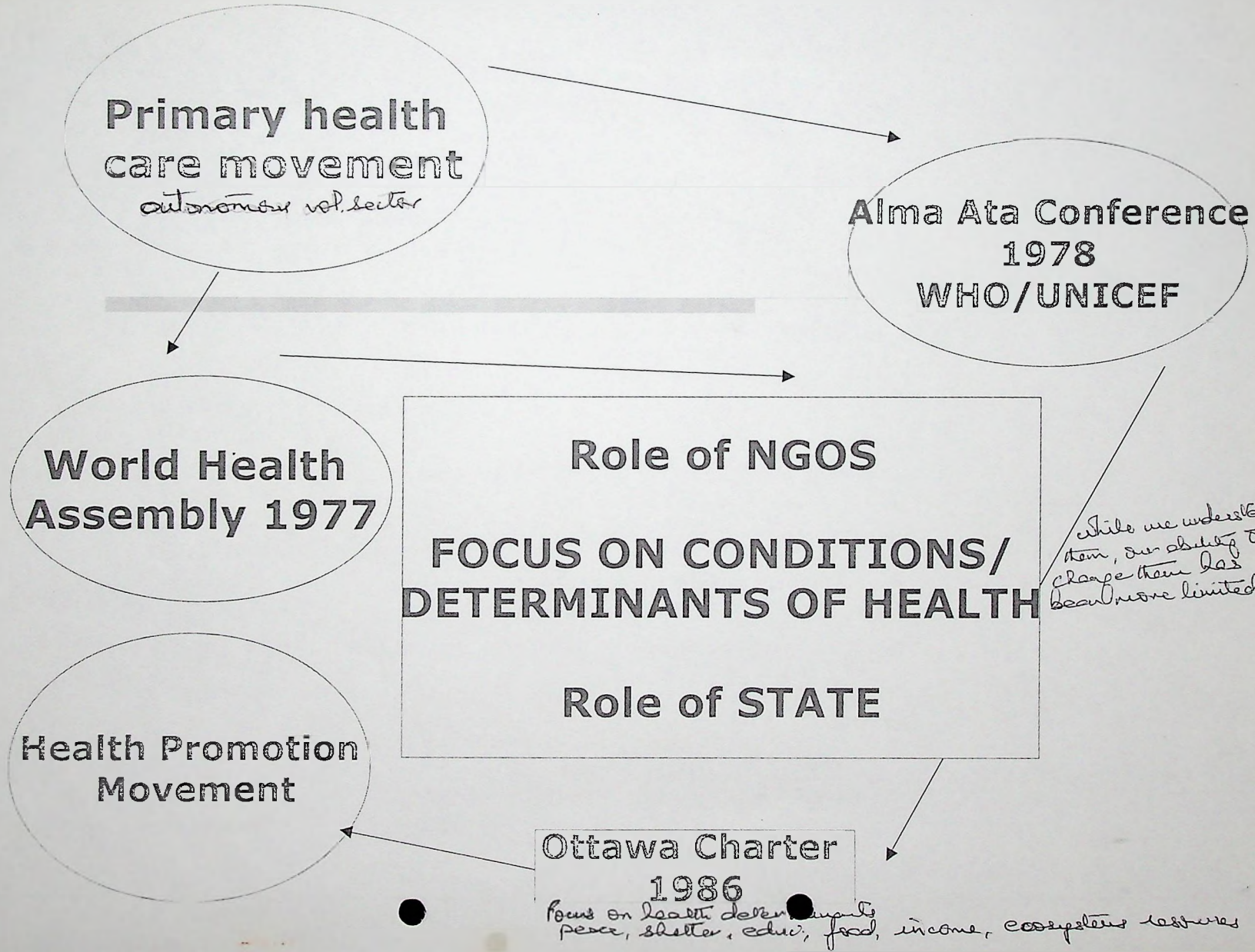
GENERAL WHO INFORMATION

Media centre
News, events, fact sheets, contacts, a multimedia.

Director-General's
Biography of the Director-General, n speeches, and biographies of Assi Directors-General.

Governance
WHO Constitution, policy documentati and Executive Boar and World Health Assembly resolutio and records.

Travellers' health
Vaccination requirements, trave risks and precautio


Primary health care movement
autonomous vol. sector
Alma Ata Conference 1978 WHO/UNICEF
World Health Assembly 1977
Role of NGOS
FOCUS ON CONDITIONS/ DETERMINANTS OF HEALTH
Role of STATE
while we understand them, our ability to change them has been more limited
Health Promotion Movement
Ottawa Charter 1986
Focus on health determinants peace, shelter, educ., food, income, ecosystem, resources

Progress in addressing health determinants: Context in 2005

Increased knowledge

Increased wealth

Information and communication technology

Free flow of ideas

Health a fundamental human right

Adverse effects on:

Livelihoods – agriculture (a primary commodities) & cottage industry, small scale industry
Jobless growth

Purchasing capacity

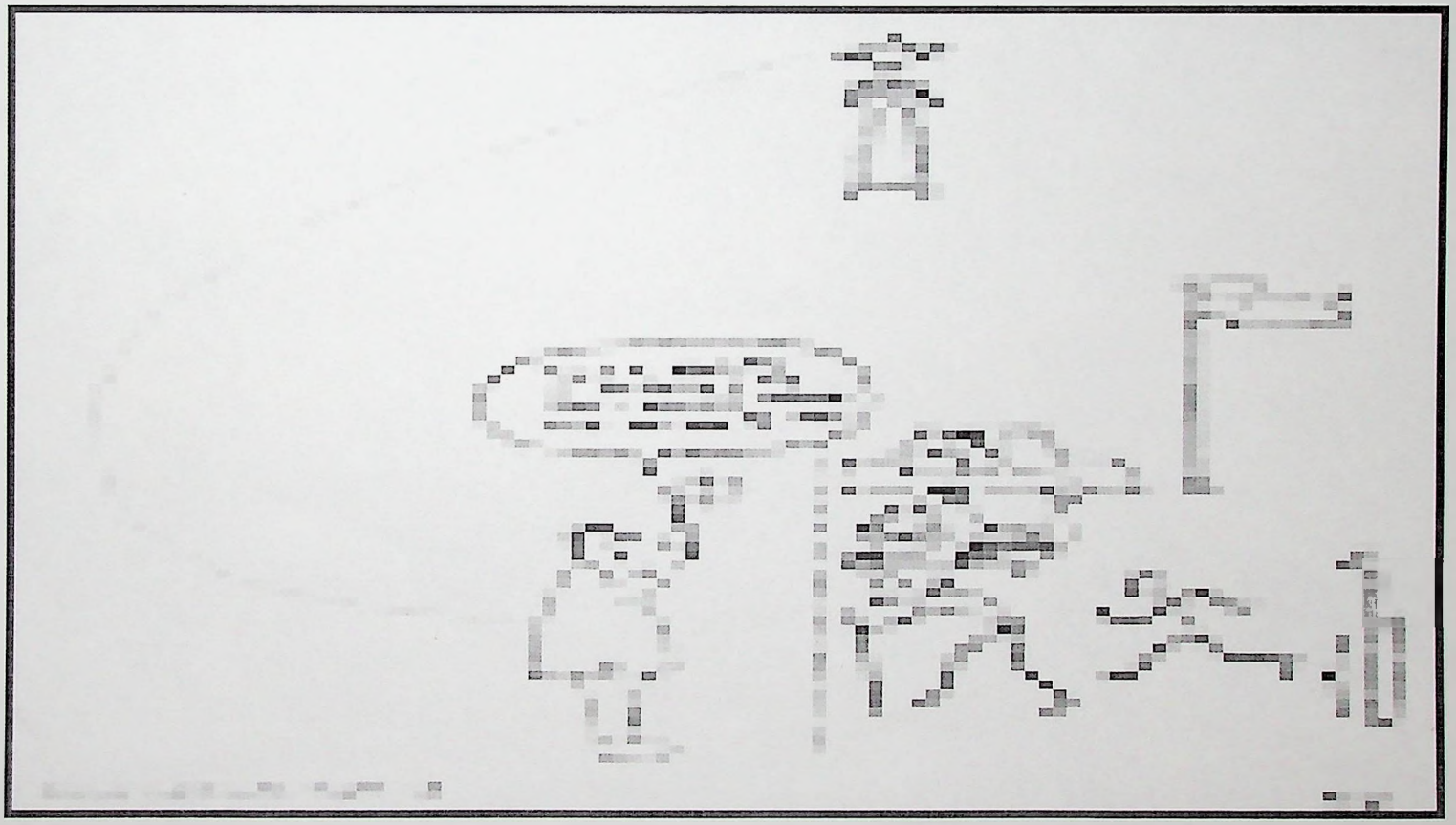
Food + human security

Environment
Macroeconomics, speculative financial flows, global trade policies

Health disparities

Denial of health and access to health care
Privatisation of public resources – water, electricity, health services
Loss of human rights

IS THE HEALTH PROMOTION COMMUNITY ADDRESSING THE CONFILCTS OF INTERESTS THAT UNDERPIN THE SITUATION?



NGO PROFILES

Heterogeneity
Changing profile – ↑ attention, influence + resources
Non-for-profit → subcontracts → corporate/

NGOS
GONGOS
CONGOS

Networks / Associations

International Union for Health Promotion and Education

NGO Ad hoc Advisory Group on Health Promotion

Movements – Peoples Health Movement

Positioning and capacity to address proximal and distal determinants of health?

immediate ● ● underlying

NGO COALITION BUILDING FOR HEALTH PROMOTION

- Social health activism to increase community control over health determinants.
- Needs vision, skill, care, time and resources.
- Selecting partners with shared goals.
- Reaching agreements and evolving strategies.
- Mobilizing resources, setting timeframes.
- Reflections, reviews, SWOT assessments

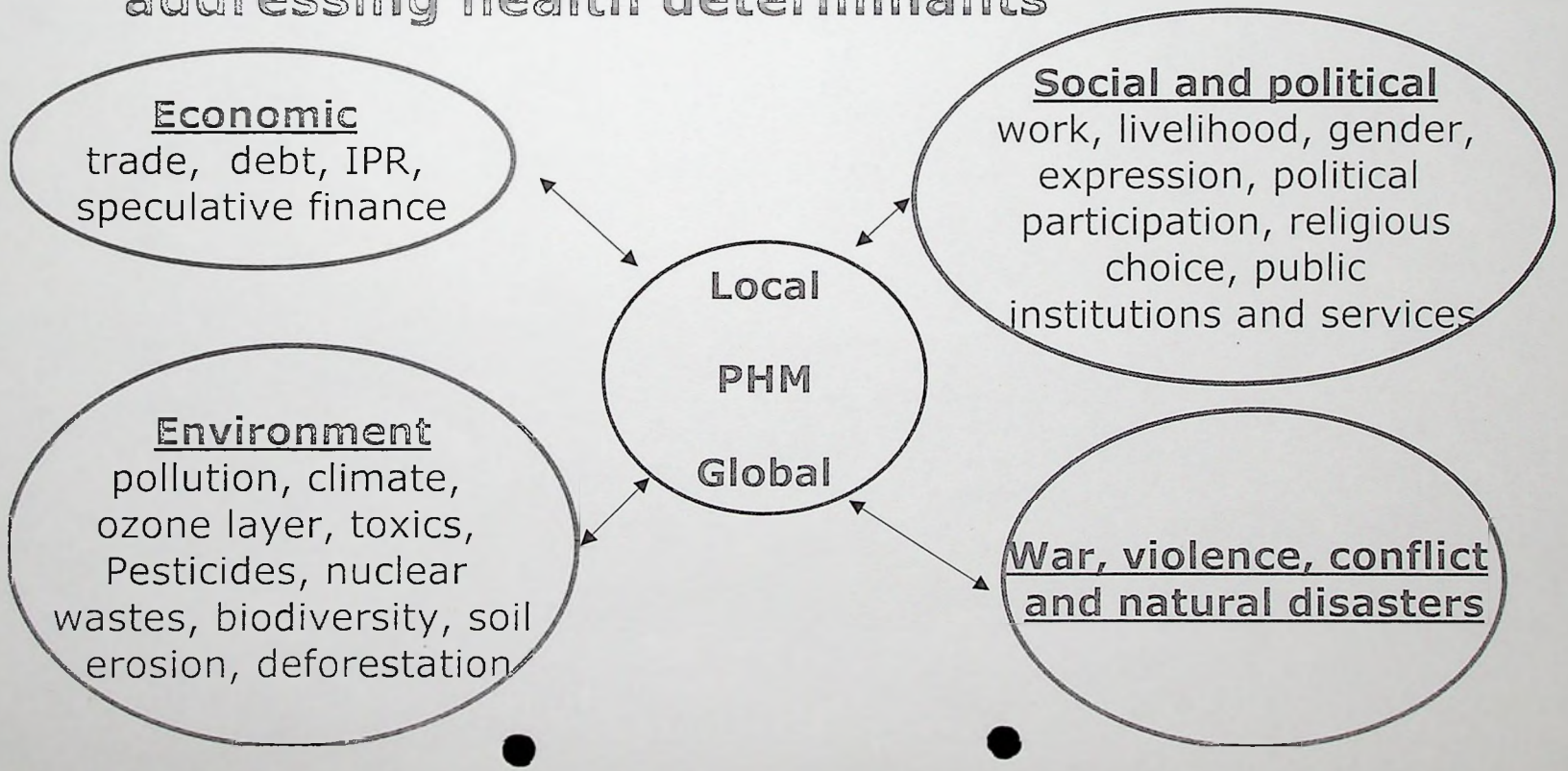
CHALLENGES IN NGO COALITIONS

- Unequal distribution of power and decision making.
- Corporate interests working through governments, international bodies and other means.
- Lack of trust and suspicion between partners.
- Governments to see beyond their term of office.
- NGOs / civil society to see beyond their constituency and reality and engage with wider processes.
- Inadequate cooperation and sense of responsibility

The need to bring in communities as the most effective stakeholders.

The People's Health Movement

The Peoples Charter for Health – addressing health determinants



Peoples Charter for Health

People's Health Movement

- Largest consensus document on health, 50 translations.
- Framework for action – globally.
- Second Peoples Health Assembly – Cuenca, Ecuador, July 18th to 23rd.

PHM ACTION

Global Patents Campaign

No to war

Right to Health Care Campaign

Right to food campaign

Right to water campaign

Dialogue with WHO

Environmental Justice Campaign

Health policy advocacy

Tsunami Watch

Save UNICEF Campaign

Revitalizing Primary Health Care

People's Health Movement

No centralized funding

Loose networking - global and national structures

Strong inputs from the South

Strong community voice and agency

A globalization of solidarity from below addressing health determinants

Final Draft

The Bangkok Charter for Health Promotion in a globalized world

Introduction

The Bangkok Charter identifies the strategies and commitments that are required to address the determinants of health in a globalized world through health promotion. It affirms that policies and partnerships to empower communities, improve health and reduce health inequalities should be at the centre of global and national development.

The Bangkok Charter supports 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. These are shared by activists and practitioners around the world and have been confirmed by member states through the World Health Assembly.

The Bangkok Charter reaches out to people, groups and organizations that are critical to the achievement of health. This includes governments at all levels, civil society, the private sector and international organisations.

Health promotion

The United Nations recognize 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. It offers a positive and inclusive concept of health as a determinant of the quality of life, and of 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. Health promotion is a core function of public health and contributes to tackling communicable and chronic non communicable diseases and emerging threats to health. It is an effective investment in improving health and human development. It contributes to reducing both health and gender inequities.

Addressing the determinants of health

The context for health promotion has changed markedly since the development of the *Ottawa Charter*. Increasing inequities within and between countries, new patterns of consumption and communication, commercialisation, environmental degradation, and urbanization are some of the critical factors that influence health. Rapid and often adverse social change affects working conditions, family patterns and the culture and social fabric of communities. Health and demographic transitions have also contributed to this change. Women and men are affected differently by these developments; the vulnerability of children and exclusion of marginalised and indigenous groups have increased.

Globalization can also open up new opportunities for cooperation to improve health, for example through improved mechanisms for global governance and enhanced information technology and communication, and sharing of solutions. Health promotion strategies can address avoidable transnational health risks by enabling policies and partnerships which ensure that benefits for health from globalization are maximised and equitable, and the negative effects are minimised and mitigated.

To manage this challenge, policy must be coherent across all levels of governments, United Nations bodies and other organizations, including the private sector. This will strengthen compliance, transparency and accountability with international agreements and treaties that affect health. The global commitment to reduce poverty by addressing all of the Millennium Development Goals is a critical entry point for health promotion action. The active participation of civil society is crucial in this process.

Strategies for health promotion in a globalized world

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 utilised. To make further advances all sectors and settings must act to:

Advocate for a rights based approach to health promotion;
Invest in sustainable policies, actions and infrastructure to address the determinants of health;
Build capacity for policy development, leadership, health promotion practice, knowledge and research, and health literacy;
Partner and build alliances with public, private and nongovernmental organizations to create sustainable actions;
Regulate and legislate to ensure a high level of protection from harm, and enable equal opportunity for health and well being for all people.

Commitments to health for all

Make the promotion of health central to the global development agenda
Government and international bodies must act to close the gap in health between rich and poor. Strong intergovernmental agreements that increase health and collective health security need to be in place. Effective mechanisms for global governance for health are needed to address 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 that build on the example of existing treaties such as the World Health Organization Framework Convention for Tobacco Control.

Make the promotion of health a core responsibility for all of government
Health determines socio-economic and political development. Therefore governments at all levels must tackle poor health and inequalities as a matter of urgency. The health sector has a key role to provide leadership in building policies and partnerships for health promotion. Responsibility to address the determinants of health rests with the whole of government, and depends upon actions by many sectors as well as the health sector. An integrated policy approach within government, and a commitment to working with civil society and the private sector is essential to make progress in addressing these determinants. Local, regional and national governments must give priority to investments in health, within and outside the health sector, and 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 health impact assessment and national or local health plans.

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 rights, resources and opportunities so that that their contributions are amplified and sustained, and support for capacity building is important less developed communities. Well organized and empowered communities are not only highly effective in determining their own health, and as partners with others, but are also 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. Successful grass roots community projects, civil society activities, and women's organizations have demonstrated their effectiveness in health promotion, and provide models of practice for others to follow.

Make the promotion of health a requirement for good corporate practices
The private sector has a direct impact on the health of people and on the determinants of health through their influence on local and national cultures, environments and wealth distribution. The private sector has a responsibility to ensure the health and safety, and promote the health and well being of their employees, their families and communities. They also contribute to wider global health impacts, such as those associated with global environmental change. The private sector must ensure that its actions comply with local, national and international regulations and agreements that promote and protect health. Ethical and responsible business practices, and fair trade have been spearheaded by some companies exemplify the type of business practice that should be supported by consumers, and through government incentives and regulations.

A global pledge to make it happen

Meeting these commitments requires better application of existing, 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, government, civil society and the private sector, has a unique role and responsibility. However, progress in addressing the underlying determinants of health in many cases will only occur by working together so that resources can be used more effectively and efficiently to achieve lasting results.

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. The participants of this Bangkok Conference forcefully call on Member States and the World Health Organization to proceed to close this implementation gap and move to policies and partnerships for action.

Conference participants expect the World Health Organization, in collaboration with others, to work with Member States to allocate resources, initiate a plan of action, monitor performance through appropriate indicators and targets, and report on progress at regular intervals.

This Bangkok Charter urges everyone to join in a worldwide health promotion partnership to promote health, with both global and local engagement and action. We, the participants of the 6th Global Conference on Health Promotion in Bangkok, Thailand, pledge to advance these commitments to improve health, and to advocate for the required resources, policies and practices.

11 August 2005

Draft 7

The Bangkok Charter for Health Promotion in a globalized world

Overview

and collective action

Policies and partnerships to improve health, empower communities and reduce health inequalities must be at the centre of global and national development. The Bangkok Charter identifies major challenges, actions and commitments needed to address the determinants of health in a globalized world.

The Bangkok Charter builds upon the principles and values of health promotion established in the *Ottawa Charter for Health Promotion* and the recommendations of the subsequent global health promotion conferences.

The Bangkok Charter reaches out to the many actors and stakeholders that are critical to the achievement of health. This includes international organisations, governments, civil society and the private sector.

Context, challenges and actions

Health promotion

One of the fundamental rights of every human being is the enjoyment of the highest attainable standard of health. Health promotion is based on a positive and inclusive concept of health that emphasizes the quality of life, and 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 an effective investment in improving health and reducing health and gender inequalities.

creating conditions

Global context

Addressing the determinants of health requires continuous adaptation of policies and actions to improve health. The context for health promotion action has changed markedly since the development of the Ottawa Charter. Continued environmental degradation, urbanization and changes to working conditions, as well as political, epidemiological and demographic transitions have all contributed to this changed context.

While globalization can open up new opportunities for cooperation to improve health it can also weaken governmental control over health determinants, increase inequalities in health (particularly for women, for marginalized and indigenous peoples), and subject individuals and communities to rapid and often adverse social change.

A goal of health promotion is to create policies and partnerships to ensure that the positive benefits for health of globalization are maximised, and the negative effects are minimised and mitigated.

To achieve this goal, policy coherence is required between all levels of governments, United Nations bodies and other organizations, to ensure compliance, transparency and

- Equity
- Human rights / universal bodies + others accountable to universal commitments
- Trade, finance - political process + better governance at global, national + local levels
- Social movements, community voice + agency
- analytical work to understand determinants.

accountability with international agreements and treaties that affect health. Of particular importance is the global agreement to poverty reduction and the other Millennium Development Goals; the active participation of civil society is critical in this process.

National Challenges
While primary responsibility for health promotion lies in the health sector, responsibility to address the determinants of health often rests with other parts of government. Policies and practices that improve health are required from both the public and private sectors. A whole of government approach to improving health and a commitment to partnership is essential to make progress in addressing the determinants of health.

Priority Actions
Progress towards a healthier world requires strong political action and active participation by the many stakeholders. Health promotion has an established repertoire of effective strategies which need to be fully utilised in order to ensure this action and participation. To ensure continuing and sustainable progress, four priorities for action across sectors are to:

Invest in sustainable policies, actions and infrastructure to tackle the determinants of health;
Build capacity to promote health, particularly in policy development and practice, health impact assessment, health literacy, community actions, leadership, workforce, monitoring and research
Partner and build alliances with public, private and nongovernmental organizations to create sustainable actions to address the determinants of health
Regulate to ensure a high level of protection from harm, and ensure equal opportunity for health and well being for all people.

New commitments

To meet the wide range of existing, emerging and potential future opportunities and challenges, commitment is required by all stakeholders to:

Make the promotion of health central to the global development agenda
This requires actions to promote dialogue and cooperation among civil society, the private sector, government and intergovernmental bodies to coordinate health promotion actions. Public health considerations need to become an integral part of foreign and domestic policy and international relations, including during times of conflict. National government action and intergovernmental alliances that increase positive health benefits and protect people from the potentially harmful effects of trade, products, services and marketing strategies are essential.

Make the promotion of health a core responsibility of all of government
To ensure that health promotion is an integral part of socio-economic and political development, governments at all levels must tackle the underlying causes of poverty, poor health and inequalities as a matter of priority. Governments need to make the health

impact and consequences of all policies and legislation explicit, and ensure that investments outside the health sector contribute to the achievement of positive health outcomes.

Make the promotion of health a requirement for good corporate practices
Private sector activity has a direct impact on the health of people, and on the determinants of health. The private sector has a responsibility to ensure the health and safety, and promote the health and well being of their employees, their families and communities. The sector must also ensure that production processes, products and marketing strategies comply with local, national and international regulations and agreements that promote and protect health. This includes environmental and trade practices that do not compromise living conditions and health.

Make the promotion of health a key focus of communities and civil society
Non governmental organisations have a crucial role in demanding and creating health. Communities and civil society often lead in initiating, shaping and undertaking health promotion - but they need to be supported so that their contributions are amplified and sustained. Policies and environments need to be strengthened so that individuals and communities are empowered to take action with others and on their own.

Partnerships for health

While each sector - government, private sector and civil society - has a unique role and responsibility, partnerships provide new opportunities and unlock new resources and energy to tackle the major health promotion challenges and meet the key commitments. Formal and informal alliances and networks operate at all levels and can bring people and organisations together around a common goal and joint action to improve the health of populations. Strong partnerships enable stronger and more sustainable approaches to tackle the underlying determinants of health and use resources more effectively and efficiently.

A global pledge

This Bangkok Charter urges all stakeholders to work together in a worldwide health promotion partnership, with global and local engagement and action, to undertake the actions and commitments outlined above for the health and well being of all.

To measure progress on implementation of the Bangkok Charter, Conference participants call upon the World Health Organization, in collaboration with other partners, to work with Member States to develop appropriate indicators, processes and mechanisms.

We, the participants of the 6th Global Conference on Health Promotion in Bangkok, Thailand, pledge to advance the actions and commitments outlined in this Charter.

The Bangkok Charter for Health Promotion

Overview

The Bangkok Charter for Health Promotion in a globalized world highlights the new challenges, the commitments to be made and the actions to be undertaken by all stakeholders to address the determinants of health. This Charter aims to engage and provide guidance to all health promotion stakeholders. The goal is to position health improvement and the reduction of health inequalities at the centre of global and national development agendas.

Health is a human right

One of the fundamental rights of every human being is the enjoyment of the highest attainable standard of health. Health is a "state of complete physical, mental and social well-being and not merely the absence of disease or infirmity".

Values

Health promotion is based on the following values:

- Social justice and gender and health equity within and between countries
- Respect for diversity and human dignity
- Peace and security

Public health and health promotion

Public health action underpins the achievement of Health For All. Health promotion, a core function of public health, is the process of enabling people to increase control over their health and its determinants, and thereby improve their health. It embraces community actions by people and supportive actions by decision-makers to improve the underlying conditions that affect physical, mental, social and cultural aspects of health.

Ottawa Charter and global health promotion conferences

The Bangkok Charter endorses the principles and purposes of health promotion as laid out in the Ottawa Charter and the recommendations of the subsequent global conferences held in Adelaide, Sundsvall, Jakarta and Mexico City. The Bangkok Charter builds on the Ottawa Charter's five Action Areas:

- Build healthy public policy
- Create supportive environments
- Strengthen community action
- Develop personal skills
- Reorient health services

Context, challenges and opportunities

National challenges

While special responsibility for health promotion lies in the health sector, it alone cannot achieve health for all. Health supportive policies from both the public and private sector are required. Therefore the adoption of the whole of government approach and partnership among all stakeholders for health are essential to address the determinants of health. It is crucial to build the capacity for health promotion in all sectors at the local and national levels.

Global changes

Environmental degradation, urbanization and political, epidemiological and demographic transitions, advances in science and information technology, the role of the state and particularly globalization, have markedly changed the context for health since the Ottawa Charter.

Health promotion in a globalizing world

Globalization opens up new opportunities for cooperation and health improvement. It can also:

- Weaken governmental control over a growing number of health determinants
- Subject individuals and communities to rapid and often adverse social change
- Reduce social and economic development prospects particularly for marginalized and indigenous peoples

Policy cohesion is required between all levels of governments, United Nations bodies and other organizations for more equitable globalization. Globalization also demonstrates the central importance of poverty reduction for health improvement and the economic and social development of nations, as emphasized by the importance given to health in the Millennium Development Goals and other international agreements.

Active participation required

Progress towards a healthier world requires strong political action and active participation by many stakeholders including:

- The health sector
- Governments
- International organizations
- The private sector
- Nongovernmental organizations and civil society
- The wider community

New commitments

Four commitments

To meet the wide range of existing, emerging and potential future opportunities and challenges, commitment is required by all stakeholders to ensure that:

- Globalization becomes a positive force for improving the health of populations
- The promotion of health is a core responsibility of all governments
- The promotion of health is a key criterion for good corporate practices
- Environments empower individuals and communities to improve their health

Make the promotion of health central to the global development agenda

The task of ensuring that the promotion of health becomes central to the global development agendas requires actions by all concerned stakeholders to:

- Promote dialogue and cooperation among civil society, the private sector, government and intergovernmental bodies to coordinate public health actions
- Balance the benefits of globalization with the benefits of local action so that the assets of culture are preserved and cultural diversity is enhanced
- Make public health considerations an integral part of foreign and domestic policy and international relations including during times of conflict
- Support national government actions and intergovernmental alliances that increase positive health benefits and protect people from the potentially harmful effects of products, services and marketing strategies
- Address the brain drain of health expertise from developing countries

Make the promotion of health a core responsibility of governments

To ensure that health promotion is an integral part of socioeconomic and political development, governments should use the whole of government approach to:

- Tackle the underlying causes of poverty, poor health and inequalities
- Ensure that the health implications of all government policies and legislation are taken into consideration
- Ensure that investments outside the health sector contribute to the achievement of positive health outcomes
- Develop appropriate legal and regulatory frameworks to promote public–private and intersectoral collaboration
- Invest in health promotion capacity, research and its application to practice

Make the promotion of health a criterion for good corporate practices

The private sector is an important stakeholder in the achievement of population health. This sector needs to:

- Invest in health and safety and promote well-being of employees, their families and communities
- Ensure that production processes, products and marketing strategies do not undermine health
- Foster public–private collaboration and multinational alliances to enhance health through greater corporate social responsibilities
- Undertake collaborate efforts with public sector health care providers to enhance access to basic, good quality and affordable health services

Promote environments that empower individuals and communities

This commitment will include actions that:

- Provide policy environments which enable communities to engage in self-determined health promotion action
- Establish networks and partnerships, particularly with nongovernmental organizations, that strengthen community actions for tackling local, national and global health issues
- Support evidence-based traditional and complementary approaches to health
- Make health-promoting information available to every individual and engage in efforts to ensure high levels of health literacy
- Assist communities to engage in activities that promote mental health especially when they are undergoing rapid transition

Making it happen

Implementation

Support for the Bangkok Charter is an important step in strengthening action-oriented health promotion. This will require:

- Adopting integrated strategies in multiple settings across all age groups.
- Acknowledging the importance of partnerships for health
- Recognizing the urgent need to strengthen health promotion capacity
- Affirming the adoption of the evidence-based approaches to policy development and practice

Implementation guide

To ensure continuing progress on health promotion, the following implementation guide is proposed:

#	Actions	Requirements
1	Invest	Achieve adequate and sustainable financing for investment in actions that tackle the determinants of health and in health systems that are appropriate, affordable and accessible
2	Advocate	Advocate for evidence-based policy development and practices that support and protect health by engaging the political system at all levels, and by working with nongovernmental and community organizations
3	Build capacity	Build capacity to promote health, particularly in the areas of policy development and practice, health literacy, community actions, leadership, workforce and research
4	Enable and mobilize	Enable and mobilize individuals and communities to overcome structural barriers to health, to enhance social support, and to reinforce social norms conducive to health, in particular through information and communication technology
5	Collaborate	Collaborate and build alliances with public, private and nongovernmental organizations to create sustainable actions across sectors to address the determinants of health

Health promotion is result oriented

The health of the population is a key criterion of the success in managing the natural and social environments. To measure progress on implementation of the Bangkok Charter, the World Health Organization, in collaboration with other partners, will encourage, and work with, Member States to develop appropriate indicators, processes and mechanisms.

Benchmarks for measuring progress

The following benchmarks, against which progress can be measured, will enable countries and communities to report on progress in 2009 and at regular intervals:

- Capacity for health promotion
- Investment in health promotion
- Health concerns in international trade agreements
- Policies focusing on health determinants in all sectors
- Stakeholder participation in health promotion policy formulation, planning and implementation
- Trends in health of the population and in health inequalities

A global pledge

This Bangkok Charter urges all stakeholders to work together in a worldwide health promotion partnership, with global and local engagement and action, to undertake the commitments and strategies outlined above for the health and well-being of all.

We, the participants of the 6th Global Conference on Health Promotion in Bangkok, Thailand, strongly support the values, commitments and actions outlined in this Charter.

The Bangkok Charter for Health Promotion

Overview

The Bangkok Charter for Health Promotion in a globalized world highlights the new challenges, the commitments to be made and the actions to be undertaken by all stakeholders to address the determinants of health. This Charter aims to engage and provide guidance to all health promotion stakeholders. The goal is to position health improvement and the reduction of health inequalities at the centre of global and national development agendas.

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Ottawa Charter and global health promotion conferences

The Bangkok Charter endorses the principles and purposes of health promotion as laid out in the Ottawa Charter and the recommendations of the subsequent global conferences held in Adelaide, Sundsvall, Jakarta and Mexico City. The Bangkok Charter builds on the Ottawa Charter's five Action Areas:

- Build healthy public policy
- Create supportive environments
- Strengthen community action
- Develop personal skills
- Reorient health services

Context, challenges and opportunities

National challenges

While special responsibility for health promotion lies in the health sector, it alone cannot achieve health for all. Health supportive policies from both the public and private sector are required. Therefore the adoption of the whole of government approach and partnership among all stakeholders for health are essential to address the determinants of health. It is crucial to build the capacity for health promotion in all sectors at the local and national levels.

Global changes

Environmental degradation, urbanization and political, epidemiological and demographic transitions, advances in science and information technology, the role of the state and particularly globalization, have markedly changed the context for health since the Ottawa Charter.

Health promotion in a globalizing world

Globalization opens up new opportunities for cooperation and health improvement. It can also:

- Weaken governmental control over a growing number of health determinants
- Subject individuals and communities to rapid and often adverse social change
- Reduce social and economic development prospects particularly for marginalized and indigenous peoples

Policy cohesion is required between all levels of governments, United Nations bodies and other organizations for more equitable globalization. Globalization also demonstrates the central importance of poverty reduction for health improvement and the economic and social development of nations, as emphasized by the importance given to health in the Millennium Development Goals and other international agreements.

Active participation required

Progress towards a healthier world requires strong political action and active participation by many stakeholders including:

- The health sector
- Governments
- International organizations
- The private sector
- Nongovernmental organizations and civil society
- The wider community

New commitments

Four commitments

To meet the wide range of existing, emerging and potential future opportunities and challenges, commitment is required by all stakeholders to ensure that:

- Globalization becomes a positive force for improving the health of populations
- The promotion of health is a core responsibility of all governments
- The promotion of health is a key criterion for good corporate practices
- Environments empower individuals and communities to improve their health

Make the promotion of health central to the global development agenda

The task of ensuring that the promotion of health becomes central to the global development agendas requires actions by all concerned stakeholders to:

- Promote dialogue and cooperation among civil society, the private sector, government and intergovernmental bodies to coordinate public health actions
- Balance the benefits of globalization with the benefits of local action so that the assets of culture are preserved and cultural diversity is enhanced
- Make public health considerations an integral part of foreign and domestic policy and international relations including during times of conflict
- Support national government actions and intergovernmental alliances that increase positive health benefits and protect people from the potentially harmful effects of products, services and marketing strategies
- Address the brain drain of health expertise from developing countries

Make the promotion of health a core responsibility of governments

To ensure that health promotion is an integral part of socioeconomic and political development, governments should use the whole of government approach to:

- Tackle the underlying causes of poverty, poor health and inequalities
- Ensure that the health implications of all government policies and legislation are taken into consideration
- Ensure that investments outside the health sector contribute to the achievement of positive health outcomes
- Develop appropriate legal and regulatory frameworks to promote public–private and intersectoral collaboration
- Invest in health promotion capacity, research and its application to practice

Institutionalise HIA procedures & approval control for public & private sector schemes, programs & projects

Make the promotion of health a criterion for good corporate practices

The private sector is an important stakeholder in the achievement of population health. This sector needs to:

- Invest in health and safety and promote well-being of employees, their families and communities
- Ensure that production processes, products and marketing strategies do not undermine health
- Foster public–private collaboration and multinational alliances to enhance health through greater corporate social responsibilities
- Undertake collaborate efforts with public sector health care providers to enhance access to basic, good quality and affordable health services

Promote environments that empower individuals and communities

This commitment will include actions that:

- Provide policy environments which enable communities to engage in self-determined health promotion action
- Establish networks and partnerships, particularly with nongovernmental organizations, that strengthen community actions for tackling local, national and global health issues
- Support evidence-based traditional and complementary approaches to health
- Make health-promoting information available to every individual and engage in efforts to ensure high levels of health literacy
- Assist communities to engage in activities that promote mental health especially when they are undergoing rapid transition

Making it happen

Implementation

Support for the Bangkok Charter is an important step in strengthening action-oriented health promotion. This will require:

- Adopting integrated strategies in multiple settings across all age groups.
- Acknowledging the importance of partnerships for health
- Recognizing the urgent need to strengthen health promotion capacity
- Affirming the adoption of the evidence-based approaches to policy development and practice

Implementation guide

To ensure continuing progress on health promotion, the following implementation guide is proposed:

#	Actions	Requirements
1	Invest	Achieve adequate and sustainable financing for investment in actions that tackle the determinants of health and in health systems that are appropriate, affordable and accessible
2	Advocate	Advocate for evidence-based policy development and practices that support and protect health by engaging the political system at all levels, and by working with nongovernmental and community organizations
3	Build capacity	Build capacity to promote health, particularly in the areas of policy development and practice, health literacy, community actions, leadership, workforce and research
4	Enable and mobilize	Enable and mobilize individuals and communities to overcome structural barriers to health, to enhance social support, and to reinforce social norms conducive to health, in particular through information and communication technology
5	Collaborate	Collaborate and build alliances with public, private and nongovernmental organizations to create sustainable actions across sectors to address the determinants of health

Health promotion is result oriented

The health of the population is a key criterion of the success in managing the natural and social environments. To measure progress on implementation of the Bangkok Charter, the World Health Organization, in collaboration with other partners, will encourage, and work with, Member States to develop appropriate indicators, processes and mechanisms.

Benchmarks for measuring progress

The following benchmarks, against which progress can be measured, will enable countries and communities to report on progress in 2009 and at regular intervals:

- Capacity for health promotion
- Investment in health promotion + health impact assess'.
- Health concerns in international trade agreements
- Policies focusing on health determinants in all sectors
- Stakeholder participation in health promotion policy formulation, planning and implementation
- Trends in health of the population and in health inequalities

A global pledge

This Bangkok Charter urges all stakeholders to work together in a worldwide health promotion partnership, with global and local engagement and action, to undertake the commitments and strategies outlined above for the health and well-being of all.

We, the participants of the 6th Global Conference on Health Promotion in Bangkok, Thailand, strongly support the values, commitments and actions outlined in this Charter.

Cuenca, Ecuador

21 July 2005

Submission from the People's Health Movement on The Fifth Draft, 24 June 2005, of the Bangkok Charter for Health Promotion

Thank you for the opportunity to comment on the draft Bangkok Charter. This submission comes from the People's Health Movement (PHM) and is based on email discussions between PHM members and supporters worldwide and discussions held at the People´s Health Assembly 2 in Cuenca, Ecuador. The People´s Health Movement is a worldwide coalition of people's organisations, civil society organisations, NGOs, social activists, health professionals, academics and researchers that endorse the People´s Charter for Health (http://www.phmovement.org/charter/pch-index.html).

The PHM is strongly focused on the interests of the poor and the marginalized and their struggle for health. The People´s Charter for Health summarises our basic ethos about the struggle to achieve "health for all" as envisioned by the Declaration at Alma Ata. Our comments overall reflect the discrepancies in focus and intent between the draft Bangkok Charter and the People´s Charter for Health

We appreciate the work and expertise that has gone into developing the draft Charter. We are supportive of the intent to address global issues that have arisen since the Ottawa Charter was drafted in 1986. However, we have concerns about many aspects of the draft and hope that our comments will be taken constructively to inform the final draft to represent the interests of those currently marginalised by the global obstacles to "health for all". We would thus like to make the following points:

1. We agree that health is a human right but would like to see this firmly grounded by reference to Article 12 of the International Covenant on Economic, Social and Cultural Rights, and more clearly articulated throughout the document.

2. We see the reduction of inequalities between and within countries as a fundamental aspect of health promotion and would like to see this re-instated explicitly as a principle in the draft (in addition to referring to social justice and health equity).

3. We believe that the increase in poverty and health inequalities since the Ottawa Charter was drafted should be clearly identified.

4. We believe that the Ottawa Charter has been very important in the development of health promotion and that it remains relevant today. We would like to see a stronger endorsement of the Ottawa Charter and more explicit identification that the Bangkok Charter will operate alongside it, as opposed to replacing the Ottawa Charter.

5. We believe that the draft should explicitly identify the serious negative forms and impacts of the processes that may be collectively termed "globalisation". Key elements of current globalisation such as transnational property and land tenure concentration; large-scale

social exclusion, privatisation of public resources; and the loss of human rights resulting from commodification should be identified due to the challenges they pose to health.

6. We believe the draft should also identify that the current processes of globalisation have reduced social and economic development prospects, particularly for marginalised and impoverished peoples, and that they have exacerbated health inequalities. Whilst some members of developing countries have benefited from globalisation, it is important that the overall negative effect of current modes of globalisation on health is noted.

7. We argue that any potential positive health effects of a "globalising world" lie in adherence by all nations to internationalised rights and obligations. The draft should therefore clearly endorse and align with existing international human rights and environmental treaties, and agreements such as the Framework Convention on Tobacco Control and the Millennium Development Goals (MDGs). These treaties offer health promotion potentially powerful frameworks which have the backing of international law.

8. We are concerned that the draft charter is weaker than aforementioned existing international human rights and environmental treaties, the MDGs and other international agreements that promote health. If the draft is not clearly aligned as above, there is the risk that it could be cynically used by corporations, states and international finance institutions to claim that their actions were "health promoting in accordance with the Bangkok Charter" and thus avoid complying with stronger health promoting standards set by the international treaties, agreements and MDGs. If this happened, the Charter would facilitate the equivalent of "greenwash" and have a negative effect.

9. We argue that the potential negative impacts on health of international trade agreements should be identified and that rights which improve health should be asserted as superordinate to the provisions of any such agreements and incorporated as such within all bilateral, regional and multilateral trade agreements.

10. We would like to see the endorsement of equity-focused health impact assessment of trade agreements during their negotiation and the endorsement of assistance from global bodies for poorer countries to undertake this.

11. We reject that the importance of health is for poverty reduction. Rather, the relationship is in the opposite direction whereby the importance of poverty reduction is for health.

12. We suggest several other strategies to make globalisation less negative for health:
    - Trade agreements should be reformed to discriminate positively in favour of economic development of low- and middle-income countries.
    - Debt owed by developing countries should be cancelled due to the negative impact this transfer of wealth has on the health of the poor.
    - Economic conditionalities should be removed from debt cancellation, development assistance or loans/grants from the international financial institutions and other development banks.
    - Financial markets and international taxation systems should be reorganised to ensure equitable cost-sharing of public programs and infrastructures amongst all citizens and corporations.
    - All nations should immediately ratify, and agree on enforcement measures for, the United Nations Convention on Corruption to reduce the negative health effects of bribery and other forms of illegal or unethical practices involving multinational corporations and governments.

13. We strongly advocate the re-instatement of the need to support governments to work for peace in areas of conflict and minimise the health impacts of war on peoples, given the enormous effect that war continues to have on health.

14. We reject the encouragement given to public-private partnerships throughout the draft. Such partnerships do not improve health, particularly for the poor and marginalised peoples that are our focus. Instead they contribute to the commodification of health. We do not believe that advocacy of such partnerships is therefore consistent with health promotion. All references to facilitation of such partnerships should be removed.

15. We would add that a core responsibility of all governments is to develop appropriate legal and regulatory frameworks to protect health from commercial activity and promote appropriate, sustainable and health promoting intersectoral collaborations

16. We strongly advocate the consideration of the health of indigenous peoples in the draft. Currently, this is a serious omission. The Bangkok Charter should aim to be of particular benefit to indigenous peoples given the specific and grave health problems they face.

17. We believe that the draft could achieve this by aligning itself with the 1999 World Health Organisation Declaration on the Health and Survival of Indigenous Peoples, which called for action on the following:
    - Respect for all the rights of indigenous peoples as described in international instruments and other treaties and agreements between governments and indigenous peoples.
    - Recognition for indigenous peoples' concept of health and survival and expressions of culture and knowledge.
    - Policies and programmes in capacity building, research, education, rectifying the inequities and imbalances in globalisation; increased resources; co-ordination between United Nations bodies; the participation of indigenous peoples at all stages of policy development and implementation; and constitutional, legislative and monitoring mechanisms.
    - Action on the broad determinants of the health and wellbeing of indigenous peoples which include the effects of the loss of identity due to removal from family and community, displacement and dispossession of lands, resources and waters, and the destruction of languages and cultures; the impact of environmental degradation; the need for sustainable development; the need for participatory community development; and the effects of war and conflict.

18. We believe that there should be consideration of labour rights in the draft, and support for the need for governments and corporations to respect such rights globally and nationally, including the ratification of International Labour Organisation conventions.

Once more, thank you for the opportunity to make this submission and contribute to the drafting process for the Bangkok Charter. We look forward to the discussions at the 6th Global Conference on Health Promotion and the final document.

The People´s Health Movement

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6TH GLOBAL CONFERENCE ON HEALTH PROMOTION
7TH – 11TH AUGUST 2005 - BANGKOK

"Policy and Partnership for Action:
Addressing the Determinants of Health"

NGO COALITIONS FOR GLOBAL HEALTH PROMOTION

BY

Thelma Narayan, Community Health Cell,
Peoples Health Movement
Marilyn Wise, International Union for Health
Promotion and Education
Tesfamicael Ghebrehiwet, International Council
of Nurses

No	Technical Session	Track	Chair	M/F	Region	Rapporteur	M/F	Region
1	Emerging health issues: the widening challenge for population HP	1 (11:00-12:30)	Julita Maradzika	F	AFR	Francis Namisi	M	AFR
2	"Back to the future" - a perspective on environmental change, environmental health and creating supportive environments for health	1 (11:00-12:30)	Rob Moodie	M	WPR	Katrin Engelhardt	F	WPR
3	Health in new urban settings	1 (11:00-12:30)	Gail Andrews	F	AFR	David Houeto	M	AFR
4	Health of the marginalized groups	1 (11:00-12:30)	Claudia Kessler Bodiang	F	EUR	Hope Corbin	F	EUR
5	Gender and health promotion: a multisectoral policy approach	1 (11:00-12:30)	Rima Afifi-Soweid	F	EMR	Rima Nakkash	F	EMR
6	Promoting mental health as a neglected issue	1 (11:00-12:30)	Thai Health	F	SEAR	Nithat Sirichotiratana		SEAR
7	Health promotion capacity mapping - a global overview	1 (11:00-12:30)	Maurice Mittelmark	M	IUHPE	Catherine Jones	F	EUR
8	Trade agreements and public health	2 (16:00 - 1730)	Nick Drager	M	WHO	Anne Andermann	F	AMR
9	Regulation of products harmful to health in an era of globalization	2 (16:00 - 1730)	Mikael Forss	M	EC	Caroline Costings	F	EUR
10	Health as foreign policy: harnessing globalization for health	2 (16:00 - 1730)	Sirikul Isaranurug	F	SEAR	Simon Carroll		AMR
11	Globalization, workplace and health	2 (16:00 - 1730)	Christer Hogstedt	M	EUR	Sarah Wamala	F	EUR
12	PH emergencies of international concern	2 (16:00 - 1730)	Sylvie Stachenko	F	AMR	Gaelle Picherit-Duthler	F	AMR
13	How to strengthen corporate responsibility and MNC commitment to HP	2 (16:00 - 1730)	Marica Faria Westphal	F	AMR	Jaime Sapag	M	AMR
14	Trade liberalization and the diet and nutrition transition: a public health response	2 (16:00 - 1730)	Jacques Baudouy	M	WB	Mary Amuyunzu-Nyamongo	F	AFR
15	Global health promotion	2 (16:00 - 1730)	Thelma Narayan	F	PHM	Ahmed Afaal	M	SEAR
16	NGO coalition for global health promotion	3 (11:00-12:30)	Michael O'Donnell	M	EMR	Juliana de Paula	F	AMR
17	The role of private sector foundation in health promotion	3 (11:00-12:30)	Rob Moodie	M	WPR	Katrin Enelhardt	F	WPR
18	The role of independent health providers/practitioners in HP	3 (11:00-12:30)	Julita Maradzika	F	AFR	Francis Namisi	M	AFR
19	Contribution of HP to the achievement of MDGs	3 (11:00-12:30)	Nicholas Muraguri	M	AFR	Raymond Mbouzeko	M	AFR
20	Integrated HP strategies	3 (11:00-12:30)	Colin Sindall	M	WPR	Filomena Wilson	F	AFR
21	Setting-based HP: a contribution to tackling current and future health challenges	3 (11:00-12:30)	Maurice Mittelmark	M	IUHPE	Catherine Jones	F	EUR
22	Information and communication for HP - towards a health competent society	3 (11:00-12:30)	Claudia Kessler Bodiang	F	EUR	Ulla-Karin Nurm	F	EUR
23	The whole of government approach to promote health	4 (16:00 - 1730)	Marica Faria Westphal	F	AMR	Jaime Sapag	M	AMR
24	Knowledge management and HP	4 (16:00 - 1730)	Rima Afifi-Soweid	F	EMR	Rima Nakkash		EMR
25	Building the capacity of MOH to promote health	4 (16:00 - 1730)	Ahmed Mohit	M	EMR	Lilla Veto	F	EUR
26	Building community capacity to promote health	4 (16:00 - 1730)	Gail Andrews	F	AFR	David Houeto	M	AFR
27	Sustainable financing for HP: issues and challenges	4 (16:00 - 1730)	Mikael Forss	M	EUR	Caroline costings	F	EUR
28	Integrated HP into health systems	4 (16:00 - 1730)	Linda Milan	F	WPR	Mabel Yap	F	WPR
29	Health impact assessments and the globalization challenges	4 (16:00 - 1730)	Christer Hogstedt	M	EUR	Sarah Wamala	F	EUR

Room 2, 2nd fl
Room 2, "

Attn: KC Tang Room number 2408.

	1st Choice		
1.1	124	3.1	79
1.2	32	3.2	41
1.3	56	3.3	19
1.4	43	3.4	63
1.5	20	3.5	116
1.6	32	3.6	40
1.7	124	3.7	58
		3.8	1
2.1	60	4.1	101
2.2	25	4.2	53
2.3	42	4.3	50
2.4	58	4.4	89
2.5	48	4.5	41
2.6	43	4.6	51
2.7	46	4.7	40
2.8	132	4.8	1

How to strength corporate social responsibility and MNC commitment to Health Promotion

Robert Mallett, Ken Gustavsen, Stella Bialous

The 6th Global Conference on Health Promotion
Bangkok, Thailand, 7-11 August 2005

Abstract

This session will concentrate on the growing role of multi-national corporations (MNCs) in addressing major public health issues by creating effective public-private partnerships. The session begins with an overview of the role of MNCs in addressing health issues to set the stage for a more specific case study. The case study will focus on the Mectizan Donation Program, which is considered a best practice. Spearheaded by MERCK, the successes and challenges of implementing the program and the effectiveness of MNCs in addressing health issues will be discussed. This session will also provide examples from the tobacco industry to illustrate when public/private partnerships are not in the public's interest.

There will be three short presentations by respectively R Mallett, Ken Gustavsen, Stella Bialous

For the manuscript of Stella Bialous, please refer to 6a Manuscripts