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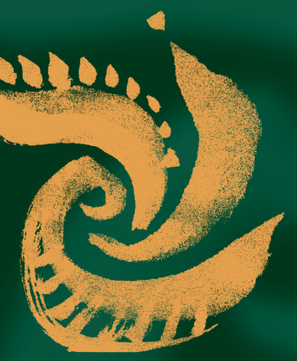

6th Global Conference on Health Promotion, Bangkok, August 2005

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Editors

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EDITORIAL

Ottawa to Bangkok — Health promotion's journey from principles to '*glocal*' implementation

In 1986, a group of delegates from some 50 countries gathered in Ottawa at the invitation of the World Health Organization, Health Canada and the Canadian Public Health Association to develop and affirm a series of principles and actions framing the value systems and practice of health promotion. The organizers had captured the spirit of the times or '*Zeitgeist*' with great astuteness and foresight: the Ottawa Charter built effectively on a broad range of insights from governments, academia and communities, identifying key areas of concern and further investment for health. The Ottawa Charter thus became a visionary statement profoundly connected to a chain of events such as the world's reorientation towards Primary Health Care, the WHO strategy for Health for All, and people's movements in areas such as women's health, environmental consciousness and human rights.

To many, the Ottawa Charter for Health Promotion became the gospel and foundation stone of a new public health movement (which was, indeed, the subtitle of the statement itself). Further global health promotion conferences in Adelaide, Sundsvall, Jakarta and Mexico City refined the principles and action areas laid out in the original Charter. Its various Statements and Declarations became a powerful force and inspiration for investing in health promotion beyond an individual, disease-oriented, behaviour-change model. Rather it focused attention on work at different levels of society (from the individual, through family and community to national strategies), and in a variety of settings (workplaces, markets, neighbourhoods and cities, schools, etc.). In addition, it more intelligently honed an analytical approach to behavioural, social and environmental determinants of health.

In a mere two decades, though, the world has changed fundamentally. In 1986, a nascent internet just started to emerge from the US Defense Advanced Research Projects Agency. Very early adopters could send electronic mail around the globe using systems called bitnet or jnet. Only in 1989, a first world standard for mobile telephony (GSM) was established. This was also the year when the global balance of power between two ideological blocks started to crumble. A machine for gene sequencing only became available in 1995, around the same time that first massive protests against globalization hit the streets.

Back in 1986, the United Nations Conference on Environment and Development in Rio de Janeiro (also known as the Earth Summit) was still six years away. Since 1986, urbanization and environmental change have become a legitimate concern of the public health community. Disasters, emergency management and the consequences of various forms of terrorism entered the health promotion remit. World trade and particularly its impact on health have also been put under the blowtorch and is high on the health promotion agenda. Health as a global public good has also increasingly become a focus of the international health promotion community.

In less than a generation, both the shape and our understanding of the determinants of the health landscape have changed dramatically. Most current students of health promotion have never lived in a world without internet that allows for high-speed communications on virtually every aspect of human life and its qualities, including health. At the same time, we have become aware of the nexus between poverty, debt and health in a world where health issues transcend the traditional

governance systems of nation states. An Ottawa Charter adept, in 1986, may have been struggling to reconcile individual health behaviour change with the need to develop healthy public policy. In 2006, the struggle is now about connecting global phenomena with everyday life.

The Ottawa Charter shifted principles for health promotion from individual foci to determinants of health. Although the more proximal determinants of health (those *directly* impacting on individual and community health) have hardly changed, the patterns of *distal* determinants of health (those factors that set the parameters for proximal determinants), as outlined above, have. For example, the connection between education and health has never been stronger. But the context in which education is shaped, though, is increasingly determined by multinational publishing corporations, globally operating internet providers, the need to be internationally competitive in tertiary education and international aid requirements.

The impact on local health of these global changes is demonstrable: brain drains lead to diminished local capacity for health; 'one size fits all' teaching texts ignore unique and valuable local cultural and value systems for health; and globalized communication channels project an unwarranted desirability of 'western' lifestyles. To manage the challenges and opportunities of globalization at global, national and local levels, collaboration and engagement of all sectors are required to ensure that the benefits for health from globalization are maximized and equitable, and the negative effects are minimized and mitigated. This has been the remit of the development and acceptance of the Bangkok Charter.

Building on the Ottawa Charter, the Bangkok Charter for Health Promotion adds value to health promotion practice worldwide. Four new commitments were identified: to make the promotion of health central to the global development agenda, a core responsibility for all of government, a key focus of communities and civil society and a requirement for good corporate practices. The participants of the Sixth Global Conference on Health Promotion also reviewed the original five action areas, and found that building capacity to promote health goes beyond community and skills development, into the generation and sustenance of health promotion capacity in both global and local ('*glocal*') policy, public/community/corporate partnerships and alliances, finance and information systems and trade considerations.

The Conference was structured around four thematic tracks: the new context, health-friendly globalization, partners, and sustainability. Each track was introduced through plenary presentations, upon which a series of technical papers was discussed in parallel workshops.

In this Special Issue, 10 of these technical papers are published and they can be grouped under three broad categories: challenges in the new context, globalization for health and capacity building for health promotion.

In three papers, current and emerging health issues to which health promotion can make considerable contribution are highlighted. McMichael and Butler look at emerging and re-emerging infectious diseases, declining regional life expectancy, global environmental changes and the impact of globalization of trade on health. Östlin and colleagues examine the links between gender differences and causes, consequences and management of diseases and ill health. Sturgeon argues for greater attention for mental health in the field. The articles not only describe what the issues are but also discuss what action can be taken.

To harness globalization for health, Lee reviews the initiatives on breast milk substitutes, healthy cities, tobacco control and diet and nutrition. She argues that existing institutions are often unprepared in their capacity to tackle global health issues. She recommends ways for strengthening governance and building effective strategies for global health promotion in terms of the process of enabling people to increase control over, and to improve, their health within an increasingly global context. Fidler explores and substantiates the explicit link between health promotion and foreign policy set out in the Bangkok Charter. This link has been strengthened by the recent UN reform proposals to elevate public health as a foreign policy priority to support the four governance tasks served by foreign policy: security, economic well-being, development and human dignity. The emergence of health as a domain for foreign policy presents opportunities and risks for health promotion that can be managed by emphasizing that public health is a public good that benefits all those governance tasks.

Trade liberalization is now at the forefront of debates about globalization. Health services and the diet and nutrition transition in the

context of trade liberalization are examined, respectively, by Arunanondchai, and Fink and Rayner and colleagues. Implications for policy development and practice are discussed and recommendations to public health and health promotion practitioners are made.

The final three papers lead the way towards making the thrust of the Bangkok Charter a reality. All of these review contemporary health promotion capacity and reframe the resulting evidence in terms of changing global contexts. Jackson *et al*. looks at the evidence base for the integrated health promotion strategies that the Ottawa Charter has called for. This evidence base, according to the authors, now needs to be transposed to meet more effectively the health promotion challenges in a globalizing world. Eight key lessons from their review are connected to a global context.

Raeburn and colleagues look at a critical element of integrated health promotion: community capacity. They provide a truly global review of the literature and case studies and demonstrate that the evidence of effectiveness of community capacity building (CCB) is beyond doubt, and that CCB may well be the only sane way ahead towards a sustainable, equitable and just world. Mittelmark and colleagues, finally, address a range of approaches to mapping national capacity for health promotion. These include reviews of the physical and social infrastructure of countries, their policy-making traditions, institutional designs, training options, and workforce and professionalization issues. Although the different maps that have been produced in different regions and countries seem to yield different types of information, Mittelmark *et al.* argue that globalization will be able to lend a crucial helping hand to an important endeavour: global networks of health promoters, fast global communications technologies, and advances in software and data management. For the first time in history, these would provide an opportunity to produce maps for health promotion capacity and its development, which are globally valid and comprehensive, yet locally relevant and responsive.

The Bangkok Charter provides leadership and directions for the health promotion community worldwide. The focus now is on its implementation. To implement the Bangkok Charter effectively, the participants at the Sixth Global Conference also urged WHO and its Member States, in collaboration with others, to initiate plans of action, monitor performance through appropriate indicators and targets and to report on progress at regular intervals. In response, WHO intends to work with key stakeholders through a global partnership to provide health promotion practitioners at the country and local levels with know-how for implementation of the Charter. An important element in this is the development of a global framework for health promotion strategy to fulfil the commitments and execute the action strategies. The framework will include models and methods for practice among practitioners worldwide and a set of priorities for action, indicators and mechanisms to monitor progress.

A key task for the future in implementing the Charter is to build institutional capacity. Not only do health promotion practitioners need to be equipped with the knowledge and skills to tackle the social and economic causes of poor health, the organizations that they work for must also be able to provide a conducive environment. Most importantly practitioners need to be supported with other dimensions of capacity such as information, financing, partnership and policies (Catford, 2006; Tang *et al*., 2006).

The Bangkok Charter and the 10 articles in this volume show that the further development and implementation of health promotion in a global context requires sustainable, resilient and persistent action at all levels—local, regional, national and international. Perhaps, most excitingly, the authors demonstrate that this is not a rhetorical call for action but a journey of '*glocal*' development that is both feasible and necessary.

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OPENING ADDRESSES

Opening address by Dr Lee Jong-wook, Director-General, World Health Organization

Welcome to the Sixth Global Conference on Health Promotion, entitled 'Policy and Partnership for Action: Addressing the Determinants of Health'.

I would like to thank our co-host, the Ministry of Public Health of the Kingdom of Thailand for the excellent preparations they have made. I would also like to thank the many participants who have travelled here for this event—more than 700 from over 100 countries. Your presence and your discussions here this week will bring great strength to our common global effort to improve the health of all people, especially the most disadvantaged.

Health promotion has a leading role to play in this effort. The Bangkok Charter, drafted after a process of extensive consultation, is now ready for you to discuss and finalize. The action you take in the light of this charter can radically improve the prospects for health in communities and countries around the world.

The Ottawa Conference of 1986 is widely recognized as a watershed in the history of health promotion and has had a profound influence on the development of health policy in many countries.

Initially, the interest came mostly from industrialized countries, for example:

- the Swedish national goals for public health are strongly influenced by the Ottawa Charter and the global conferences that followed. These include the Sundsvall Conference in 1991 which stressed the importance of sustainable supportive environments;
- in North Karelia, Finland, improved diet and physical activity have contributed to a reduction in mortality due to heart diseases among men by 73% over a period of 25 years;
- in California, USA, a comprehensive tobacco control programme has reduced the incidence of lung cancer by 14% over a 10-year period, compared to a reduction of only 3% in the rest of the USA; and
- in Australia, road safety promotion contributed to a reduction of 31% in road traffic deaths between 1989 and 1994.

More recently, successful health-promoting initiatives have been seen in a wide variety of settings in Asia and in many other developing countries. For example, they have resulted in:

- a fall in new HIV infections in Brazil, Thailand and Uganda;
- increased participation in sports activities in Singapore; and
- reduced incidence of diarrhoeal diseases as a result of increased handwashing in many low-income countries.

Worldwide interest in health promotion reflects awareness of the need to tackle the root causes of ill-health. These go far beyond the scope of the health sector. That is why the Charter you will be working on this week calls for the active participation of partners across the spectrum of government, international organizations, the private sector and non-governmental and community organizations.

To increase our understanding of the specific ways in which health can be improved by modifying living and working conditions, I launched the Commission on Social Determinants of Health

earlier this year. I am delighted to see that the Chairman and other Commissioners will be speaking here this week. Their expertise will make a valuable contribution to your discussions.

Likewise, your own expertise and involvement in many areas of health promotion have an important role to play in shaping and supporting the work of the Commission and putting its recommendations into practice.

There are never enough human and financial resources for health promotion, but there are always new approaches and methods to increase our options. The global health promotion foundation network, which has its origins in the Victoria Health Promotion Foundation of Australia, is a good example, which has now spread to many other countries. The Thai Health Promotion Foundation, funded directly by a tax on tobacco and alcohol, is another.

Those who recognize the importance of health promotion have played and continue to play a vital role in tobacco control. Their vigorous support was a key to success in the adoption and ratification of the WHO Framework Convention on Tobacco Control. The Convention entered into force in February of this year and now has 74 states parties, including Thailand. We expect that number to reach 100 early in 2006.[1] This is an encouraging trend and we must do everything we can to keep up the momentum. We all share the responsibility over the coming months and years of ensuring that the provisions of the Convention are fully met. Further opportunities for effective action in health promotion are set out in the WHO Global Strategy on Diet, Physical Activity and Health, adopted by the World Health Assembly in May 2004. The WHO report on *Preventing Chronic Disease*, which comes out this October, will provide additional information and inspiration.

The Bangkok Charter for Health Promotion will be the product of many organizations, networks, groups and individuals in many countries. It will urge all stakeholders to work together in a worldwide partnership to fulfill its commitments and carry out its strategies.

WHO wholeheartedly supports the principles outlined in the draft Charter and its bid to gain recognition for health as a top priority for government, business, communities and individuals.

What is really important about the Charter, though, is the creative action for health it can lead to. There is much work for all of us to do to implement its proposals. WHO will do all it can to support the next steps in strengthening health promotion globally.

I wish us all every success in the work that lies ahead. It is our opportunity to make a vital contribution to health in all settings for all people. Let us make the most of it.

[1]The number of 100 parties was achieved in November 2005, and there are now 140 parties as on 26 September 2006.

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TRIBUTE

A tribute to Dr Lee Jong-wook, Director-General of WHO

Dr Lee Jong-wook, Director-General of the World Health Organization, died on 22 May 2006 following a short illness.

Dr Lee, a national of the Republic of Korea, was unfalteringly committed to WHO's mission, to help all people to attain 'the highest possible level of health'.

Dr Lee supported health promotion efforts. He said: 'health promotion draws its sprit from the Alma-Ata Declaration of 1978, which stressed the responsibility of all members of the community for a healthy and rewarding life. We are more than ever in need of that spirit now in our fight against preventable and unacceptable epidemics of our time'. His support to health promotion was reflected in his attendance at both the 18th IUHPE World Conference on Health Promotion and Education in 2004 and the WHO 6th Global Conference on Health Promotion in 2005. Dr Lee also initiated the formation of the Commission on Social Determinants of Health. Operating for three years from March 2005, the Commission is charged with recommending interventions and policies to improve health and narrow health inequalities through action on social determinants

Dr Lee also took the fight against HIV and the threat of pandemic influenza to a new level. He said: 'There can be no "comfort level" in the fight against HIV. We must keep up the pressure to get prevention, treatment and care linked and working. A key outcome of "3 by 5" was the commitment to universal access to treatment by 2010. But what does universal access mean? To me, this means that no one should die because they can't get drugs. It means that no one will miss being tested, diagnosed, treated and cared for because there aren't clinics'. In his global effort to tackle avian influenza, he had a simple message: 'Prepare for a pandemic now, before it is too late'. World leaders took it to heart and acted. Because of his conviction, the world is now better prepared for pandemic influenza than it has ever has been in history.

He preferred to lead by example, rather than instruction. He led a healthy life, and embraced life in Switzerland to its fullest. He loved skiing, mountain biking and walking. He also set an example across the United Nations, with strict rules against tobacco use, and the conversion of the fleet of WHO cars to small, environmentally friendly fuel/electric vehicles.

Dr Lee was the first UN agency head from the Republic of Korea. He began his five-year term as Director-General of WHO on 21 July 2003.

Christine McNab
World Health Organization
Geneva

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OPENING ADDRESS

Opening address by His Excellency Thaksin Shinawatra, Prime Minister of Thailand

On behalf of the Royal Thai Government and the people of Thailand, I would like to say that it is a great pleasure and honour to welcome all of you to this Sixth Global Conference on Health Promotion.

It is clear that good health is a key to progress. In those societies where people are healthy, such communities are sure to progress in many ways. Building health has thus become a priority on national and global agendas. As a key instrument to foster healthy well-being, health promotion received a major boost during the years from the First International Conference on Health Promotion held at Ottawa in 1986 through the fifth in the series of global conferences; the one that was held in Mexico in 2000. At the Mexico conference, high-level political commitment to health promotion was manifested by the adoption of the Ministerial Declaration of Mexico for Health Promotion: A Platform for Action, signed by more than 80 of the World Health Organization Member States. The Member States committed themselves to strengthening their planning for health promotion activities, positioning this issue higher on the political agenda and recognizing it as priority in local, regional, national and international programmes. This commitment was taken forward into the governing bodies of both WHO and Pan American Health Organization. All our countries have thus committed themselves to reduce the burden of diseases and risk factors, while promoting supportive determinants in order to extend healthy life.

With intentions as strong as yours in promoting health, I am pleased to inform you that Thailand has shifted its health paradigm to emphasize 'building' rather than 'repairing' health. We declared in 2002 the policy of 'Building Health for All Thais'. By following the Ottawa Charter and other recommended strategies, Thailand today has achieved a level of success which includes a reduction in malnutrition by promoting a healthy diet, coupled with implementing a food safety programme that we refer to as 'from the farm to the fork'.

Thailand also has launched a campaign to promote exercise for better health. You may have even seen some news about this on CNN. In November 2002, some of you may have seen 46, 824 active participants joining in an attempt that successfully broke the Guinness World Record for the 'largest aerobic display'. We are involving more and more people from every district and village all over the country in a variety of exercises. If you have a chance to tour around Bangkok, you will see for yourselves a variety of exercise activities in different places, such as in public parks, parking lots of many department stores, government offices, elevated roads and private workplaces, and even in the space underneath many expressways. Despite our hectic city life, Thais are making healthy physical activities a familiar part of their daily routines.

In addition, various legal measures are strictly enforced to promote healthy behaviours among Thais. Among them are campaigns against drunk driving and controls on tobacco use such as a prohibition on smoking in public places. Thailand is committed to reducing substance abuse and related production and distribution. Financial measures support the legal measures; for instance, 'sin taxes' on alcohol and tobacco products are used to limit the use of these

substances. The Thai Health Foundation serves as a focal point in providing financial support to governmental and non-governmental organizations as well as public sector and local organizations operating health-promotion activities.

Starting in 2001, the Thai government launched the Universal Health Scheme which provides insurance coverage for every Thai. It is widely known as the '30 baht insurance scheme', under this scheme, 47 million Thai people who are not covered by any other form of health insurance are entitled to receive health promotion, disease prevention and treatment and health rehabilitation with the co-payment of only 30 baht per visit; 30 baht is less than 75 cents US. This means that every Thai enjoys the right and has the means to access health care. This year, the government is emphasizing the prevention of illness with a new slogan: '30 baht helps keep diseases away'.

Apart from individual health promotion, the government also has joined hands with every social sector to build up healthy settings in public places, such as day-care centres, schools, hospitals, factories and workplaces. In our attempt to bring sustained health to all Thais, the Royal Thai Government is combating illicit drugs and narcotics and fighting against poverty, all of which are crucial determinants detrimental to health and national security.

This year marks the launch of our 'Healthy Thailand' policy. As you have just heard, Health is high on the national agenda. Different social dimensions are taken into account, including the environment, intellectual strength and peace of mind. We are emphasizing six important aspects of good health: food, exercise, environmental health, emotional balance, absence of diseases and refraining from destructive behaviours. The programme covers every age and population group and every setting. This year we expect to involve a total of 876 subdistricts, eventually covering every subdistrict throughout Thailand within 5 years. We firmly believe that we will be able to achieve a Healthy Thailand and progress towards attaining the targets set under the Millennium Development Goals by 2010.

To give you first-hand experience of what Thailand is doing, I am pleased that you will be able to witness our tangible activities and outcomes in a study tour on the 11th of August during the afternoon session.

During the last few decades, our world has endured a number of sudden national disasters, as well as political and economic crises, growing threats from communicable diseases and risk behaviours and threats from commercial profiteers, without considering the tremendous impacts on people's health. However, I still believe that we can benefit from giving respect to nature and fostering compassion among mankind. With clear wisdom and impartiality, we will be able to overcome difficulties and bring peace and well-being to our people. I strongly believe that as long as we join our hands and our hearts, there is nothing that cannot be done for our people.

In line with the theme of this Conference, I am confident that your deliberations will be productive and lead to the adoption of the Bangkok Charter to suit the current and future global situation.

In conclusion, I would like to congratulate the Honourable Ministers and distinguished participants attending this conference for their strong commitment to the health of their people. I hope the conference will be a successful one. I wish you a comfortable and enjoyable stay in Bangkok.

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BANGKOK CHARTER

The Bangkok Charter for Health Promotion in a Globalized World

INTRODUCTION

Scope

The Bangkok Charter identifies actions, commitments and pledges required to address the determinants of health in a globalized world through health promotion.

Purpose

The Bangkok Charter affirms that policies and partnerships to empower communities, and to improve health and health equality, should be at the centre of global and national development.

The Bangkok Charter complements and builds upon the values, principles and action strategies of health promotion established by the *Ottawa Charter for Health Promotion* and the recommendations of the subsequent global health promotion conferences which have been confirmed by Member States through the World Health Assembly.

Audience

The Bangkok Charter reaches out to people, groups and organizations that are critical to the achievement of health, including:

- governments and politicians at all levels
- civil society
- the private sector
- international organizations, and
- the public health community.

Health promotion

The United Nations recognizes that the enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without discrimination.

Health promotion is based on this critical human right and offers a positive and inclusive concept of health as a determinant of the quality of life and encompassing mental and spiritual well-being.

Health promotion is the process of enabling people to increase control over their health and its determinants, and thereby improve their health. It is a core function of public health and contributes to the work of tackling communicable and noncommunicable diseases and other threats to health.

ADDRESSING THE DETERMINANTS OF HEALTH

Changing context

The global context for health promotion has changed markedly since the development of the *Ottawa Charter*.

Critical factors

Some of the critical factors that now influence health include:

- increasing inequalities within and between countries
- new patterns of consumption and communication
- commercialization
- global environmental change, and
- urbanization.

Further challenges

Other factors that influence health include rapid and often adverse social, economic and demographic changes that affect working conditions, learning environments, family patterns and the culture and social fabric of communities.

Women and men are affected differently. The vulnerability of children and exclusion of marginalized, disabled and indigenous peoples have increased.

New opportunities

Globalization opens up new opportunities for cooperation to improve health and reduce transnational health risks; these opportunities include:

- enhanced information and communications technology, and
- improved mechanisms for global governance and the sharing of experiences.

Policy coherence

To manage the challenges of globalization, policy must be coherent across all:

- levels of governments
- United Nations bodies, and
- other organizations, including the private sector.

This coherence will strengthen compliance, transparency and accountability with international agreements and treaties that affect health.

Progress made

Progress has been made in placing health at the centre of development, for example through the Millennium Development Goals, but much more remains to be achieved; the active participation of civil society is crucial in this process.

STRATEGIES FOR HEALTH PROMOTION IN A GLOBALIZED WORLD

Effective interventions

Progress towards a healthier world requires strong political action, broad participation and sustained advocacy.

Health promotion has an established repertoire of proven effective strategies which need to be fully utilized.

Required actions

To make further advances in implementing these strategies, all sectors and settings must act to:

- *advocate* for health based on human rights and solidarity
- *invest* in sustainable policies, actions and infrastructure to address the determinants of health
- *build capacity* for policy development, leadership, health promotion practice, knowledge transfer and research and health literacy
- *regulate and legislate* to ensure a high level of protection from harm and enable equal opportunity for health and well-being for all people
- *partner and build alliances* with public, private, nongovernmental and international organizations and civil society to create sustainable actions.

COMMITMENTS TO HEALTH FOR ALL

Rationale

The health sector has a key leadership role in the building of policies and partnerships for health promotion.

An integrated policy approach within government and international organizations, as well as a commitment to working with civil society and the private sector and across settings, are essential if progress is to be made in addressing the determinants of health.

Key commitments

The four key commitments are to make the promotion of health:

(i) central to the global development agenda
(ii) a core responsibility for all of government
(iii) a key focus of communities and civil society
(iv) a requirement for good corporate practice.

1. Make the promotion of health central to the global development agenda

Strong intergovernmental agreements that increase health and collective health security are needed. Government and international bodies must act to close the health gap between rich and poor. Effective mechanisms for global governance for health are required to address all the harmful effects of:

- trade
- products
- services and
- marketing strategies.

Health promotion must become an integral part of domestic and foreign policy and international relations, including in situations of war and conflict.

This requires actions to promote dialogue and cooperation among nation states, civil society and the private sector. These efforts can build on the example of existing treaties such as the World Health Organization Framework Convention for Tobacco Control.

2. Make the promotion of health a core responsibility for all of government

All governments at all levels must tackle poor health and inequalities as a matter of urgency because health is a major determinant of socioeconomic and political development. Local, regional and national governments must:

- give priority to investments in health, within and outside the health sector
- provide sustainable financing for health promotion.

To ensure this, all levels of government should make the health consequences of policies and legislation explicit, using tools such as equity-focused health impact assessment.

3. Make the promotion of health a key focus of communities and civil society

Communities and civil society often lead in initiating, shaping and undertaking health promotion. They need to have the rights, resources and opportunities to enable their contributions to be amplified and sustained. In less developed communities, support for capacity building is particularly important.

Well organized and empowered communities are highly effective in determining their own health and are capable of making governments and the private sector accountable for the health consequences of their policies and practices.

Civil society needs to exercise its power in the marketplace by giving preference to the goods, services and shares of companies that exemplify corporate social responsibility.

Grass-roots community projects, civil society groups and women's organizations have demonstrated their effectiveness in health promotion, and provide models of practice for others to follow.
Health professional associations have a special contribution to make.

4. Make the promotion of health a requirement for good corporate practice

The corporate sector has a direct impact on the health of people and on the determinants of health through its influence on:

- local settings
- national cultures
- environments, and
- wealth distribution.

The private sector, like other employers and the informal sector, has a responsibility to ensure health and safety in the workplace, and to promote the health and well-being of their employees, their families and communities.

The private sector can also contribute to lessening wider global health impacts, such as those associated with global environmental change by complying with local, national and international regulations and agreements that promote and protect health. Ethical and responsible business practices and fair trade exemplify the type of business practice that should be supported by consumers and civil society, and by government incentives and regulations.

A GLOBAL PLEDGE TO MAKE IT HAPPEN

All for health

Meeting these commitments requires better application of proven strategies, as well as the use of new entry points and innovative responses.

Partnerships, alliances, networks and collaborations provide exciting and rewarding ways of bringing people and organizations together around common goals and joint actions to improve the health of populations.

Each sector—intergovernmental, government, civil society and private—has a unique role and responsibility.

Closing the implementation gap

Since the adoption of the *Ottawa Charter*, a significant number of resolutions at national and global level have been signed in support of health promotion, but these have not always been followed by action. The participants of this Bangkok Conference forcefully call on Member States of the World Health Organization to close this implementation gap and move to policies and partnerships for action.

Call for action

Conference participants request the World Health Organization and its Member States, in collaboration with others, to allocate resources for health promotion, initiate plans of action and monitor performance through appropriate indicators and targets, and to report on progress at regular intervals. United Nations organizations are asked to explore the benefits of developing a Global Treaty for Health.

Worldwide partnership

This Bangkok Charter urges all stakeholders to join in a worldwide partnership to promote health, with both global and local engagement and action.

Commitment to improve health

We, the participants of the 6th Global Conference on Health Promotion in Bangkok, Thailand, pledge to advance these actions and commitments to improve health.

11 August 2005

Note: This charter contains the collective views of an international group of experts, participants of the 6th Global Conference on Health Promotion, Bangkok, Thailand, August 2005, and does not necessarily represent the decisions or the stated policy of the World Health Organization.

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HEALTH PROMOTION CHALLENGES

Emerging health issues: the widening challenge for population health promotion

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SUMMARY

The spectrum of tasks for health promotion has widened since the Ottawa Charter was signed. In 1986, infectious diseases still seemed in retreat, the potential extent of HIV/AIDS was unrecognized, the Green Revolution was at its height and global poverty appeared less intractable. Global climate change had not yet emerged as a major threat to development and health. Most economists forecast continuous improvement, and chronic diseases were broadly anticipated as the next major health issue.

Today, although many broadly averaged measures of population health have improved, many of the determinants of global health have faltered. Many infectious diseases have emerged; others have unexpectedly reappeared. Reasons include urban crowding, environmental changes, altered sexual relations, intensified food production and increased mobility and trade. Foremost, however, is the persistence of poverty and the exacerbation of regional and global inequality.

Life expectancy has unexpectedly declined in several countries. Rather than being a faint echo from an earlier time of hardship, these declines could signify the future. Relatedly, the demographic and epidemiological transitions have faltered. In some regions, declining fertility has overshot that needed for optimal age structure, whereas elsewhere mortality increases have reduced population growth rates, despite continuing high fertility.

Few, if any, Millennium Development Goals (MDG), including those for health and sustainability, seem achievable. Policy-makers generally misunderstand the link between environmental sustainability (MDG #7) and health. Many health workers also fail to realize that social cohesion and sustainability—maintenance of the Earth's ecological and geophysical systems—is a necessary basis for health.

In sum, these issues present an enormous challenge to health. Health promotion must address population health influences that transcend national boundaries and generations and engage with the development, human rights and environmental movements. The big task is to promote sustainable environmental and social conditions that bring enduring and equitable health gains.

Key words: sustainability; transitions; globalization; health promotion

INTRODUCTION

The Ottawa Charter (1986) was forged only 8 years after the historic Alma Ata meeting, which had declared *Health for All by 2000*. With hindsight, the goal of shaping a new and healthier world was already in jeopardy (Werner and Sanders, 1997). Perhaps, aware of this nascent weakening of the prospects for population health, the global health promotion community called for the revitalization of ambitious large-scale thinking. New strategies were devised to energize healthy individual and community behaviours, reflected in phrases such as 'healthy choices should be easy choices' and 'healthy public policy'.

Nevertheless, over the ensuing two decades, the adverse social, economic and environmental trends that were already beginning to jeopardize, Health for All in 1986 have strengthened. Further, economic globalization, with increasingly powerful transnational companies shaping

global consumer behaviours, has tended to make unhealthy choices the easier choices, including cigarettes, fast-food diets, high-sugar drinks, automated (no-effort) domestic technologies and others. These changes have occurred despite an increased understanding of the fundamental determinants of population health. Some of these foundations of health are at risk, and in some regions, hard-won health gains have recently been reversed. Recent attempts to re-focus attention on global public goods, such as in the Millennium Development Goals (MDGs), are weak in comparison to the scale of today's problems.

There is an urgent strategic need for health promotion to engage with the international discourse on 'sustainability'. To date much of the discussion and policy development addressing 'sustainable development' has treated the economy, livelihoods, energy supplies, urban infrastructure, food-producing ecosystems, wilderness conservation and convivial communal living as if they were *ends* in themselves: the goals of sustainability. Clearly, those are all major assets that we value. But their value inheres in their being the foundations upon which the health and survival of populations depend. The ultimate goal of sustainability is to ensure human well-being, health and survival. If our way of living, of managing the natural environment and of organizing economic and social relations between people, groups and cultures does not maintain the flows of food and materials, freshwater supplies, environmental stability and other prerequisites for health, then that is a non-sustainable state.

In this paper, we discuss several of the emerging health issues. Lacking space to be comprehensive, we focus upon infectious diseases, the decline in life expectancy in several regions, the increasingly ominous challenge of large-scale environmental change and how globalization, trade and economic policy relate to indices of public health. Other emerging health issues not discussed here also reflect major recent shifts in human ecology. They too pose great environmental or social risks to health. They include urbanization, population ageing, the breakdown of traditional culture and relations and the worldwide move towards a more affluent diet and its associated environmentally damaging food production methods (McMichael, 2005).

There are two fundamental causes for the selected emerging health risks. First, most important, is the global dominance of economic policies which accord primacy to market forces, liberalized trade and the associated intensification of material throughput at the expense of other aspects of social, environmental and personal well-being. For millions in the emerging global middle class, materialism and consumerism have increased at the expense of social relations and leisure time. The gap between rich and poor, both domestically and internationally, has increased substantially in recent decades (United Nations Development Program, 2005). Inequality between countries has weakened the United Nations and other global institutions. Foreign aid has declined, replaced by claims that market forces will reduce poverty and provide public goods, including health care and environmental stability.

The second fundamental threat to the improvement and maintenance of population health is the recent advent of unprecedented global environmental changes. The scale of the human enterprise (numbers, economic intensity, waste generation) is now such that we are collectively exceeding the capacity of the planet to supply, replenish and absorb. Stocks of accessible oil appear to be declining. Meanwhile, the global emissions of carbon dioxide from fossil fuel combustion, and of other greenhouse gases from industrial and agricultural activities, are rapidly and now dangerously altering the global climate. Worldwide, land degradation, fisheries depletion, freshwater shortages and biodiversity losses are all increasing. The human population, now exceeding 6500 million, continues to increase by over 70 million persons per annum. The number of chronically undernourished people (over 800 million) is again increasing, after gradual declines in the 1980s and early 1990s (Food and Agricultural Organization, 2005). Famines in Africa remain frequent, and 300 million undernourished people live in India alone. Meanwhile, hundreds of millions of people are overnourished and, particularly via obesity, will incur an increasing burden of chronic diseases, especially diabetes and heart disease.

The scale of these health risks is unprecedented. The global food crises of the 1960s were averted by the subsequent Green Revolution. Today, a broader-based revolution is required, not only to increase food production (again), but also to promote peace and international cooperation, slow climate change, ensure environmental protection, eliminate

hunger and extreme poverty, quell resurgent infectious diseases and neutralize the obesogenic environment. This enormous population health task goes well beyond that envisaged by the MDGs.

It is, of course, difficult to get an accurate measure of these emerging risks to health. Some, such as climate change, future food sufficiency and the threat from weapons of mass destruction, may prove soluble. However, because of the inevitable time lag in understanding, evaluating and responding to these complex problems, the health promotion community should now take serious account of them. There is an expanding peer-reviewed literature on these several emerging problem, areas. To constrain health promotion by sidestepping them would be to risk being 'penny wise but pound foolish'.

EMERGING AND RE-EMERGING INFECTIOUS DISEASES

In the early 1970s, it was widely assumed that infectious diseases would continue to decline: sanitation, vaccines and antibiotics were at hand. The subsequent generalized upturn in infectious diseases was unexpected. Worldwide, at least 30 new and re-emerging infectious diseases have been recognized since 1975 (Weiss and McMichael, 2004). HIV/AIDS has become a serious pandemic. Several 'old' infectious diseases, including tuberculosis, malaria, cholera and dengue fever, have proven unexpectedly problematic, because of increased antimicrobial resistance, 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 annually (Bryce *et al.*, 2005). Mortality rates among children are increasing in parts of sub-Saharan Africa (Horton, 2004).

The recent upturn in the range, burden and risk of infectious diseases reflects a general increase in opportunities for entry into the human species, transmission and long-distance spread, including by air travel. Although specific new infectious diseases cannot be predicted, understanding of the conditions favouring disease emergence and spread is improving. Influences include increased population density, increasingly vulnerable population age distributions and persistent poverty (Farmer, 1999). Many environmental, political and social factors contribute. These include increasing encroachment upon exotic ecosystems and disturbance of various internal biotic controls among natural ecosystems (Patz *et al.*, 2004). There are amplified opportunities for viral mixing, such as in 'wet animal markets'. Industrialized livestock farming also facilitates infections (such as avian influenza) emerging and spreading, and perhaps to increase in virulence. Both under- and over-nutrition and impaired immunity (including in people with poorly controlled diabetes—an obesity-associated disease now increasing globally) contribute to the persistence and spread of infectious diseases. Large-scale human-induced environmental change, including climate change, is of increasing importance.

These causes of infectious disease emergence and spread are compounded by gender, economic and structural inequities, by political ignorance and denial (particularly obvious with HIV/AIDS in parts of sub-Saharan Africa). Iatrogenesis (as with HIV in China and partial tuberculosis treatment in many developing countries), vaccine obstacles and the '10/90 gap' (whereby a minority of health resources are directed towards the most severe health problems) add to this unstable picture.

We inhabit a microbially dominated world. We should therefore frame our relations with microbes primarily in *ecological* (not military) terms. The world's infectious agents, perhaps with the exceptions of smallpox and polio, will not be eliminated. But much can be done to reduce human population vulnerability and avert conditions conducive to the occurrence of many infectious diseases. This is an important focus for health promotion.

DECLINING REGIONAL LIFE EXPECTANCY

The upward trajectory in life expectancy forecast in the 1980s has recently been reversed in several regions, especially in Russia and sub-Saharan Africa (McMichael *et al.*, 2004b). These could, in principle, be either temporary aberrations or unconnected to one another. However, identifiable factors appear to link these declines.

The fall in life expectancy since 1990 in Russia is unprecedented for a technologically developed country. Many proximal causes have been documented, including alcoholism, suicide, violence, accidents and cardiovascular disease. Multiple drug-resistant tuberculosis is widespread in Russian prisons. Collectively, these factors reflect social disintegration and crisis (Shkolnikov *et al.*, 2004).

In sub-Saharan Africa, HIV/AIDS has combined with poverty, malaria, tuberculosis, depleted soils and undernutrition (Sanchez and Swaminathan, 2005), deteriorating infrastructure, gender inequality, sexual exploitation and political taboos to foster epidemics that have reduced life expectancy, in some cases drastically. Adverse health and loss of human capital, caused by disease and the out-migration of skilled adults, have helped to 'lock-in' poverty. More broadly, indebtedness and ill-judged economic development policies, including charges for schooling and health services, have also impaired population health in Africa, following decades of earlier improvement. The intersectoral implications for health promotion are clear.

Conflict, most notoriously in Rwanda (André and Platteau, 1998), has also occurred on a sufficient scale to temporarily reduce life expectancy for some populations in sub-Saharan Africa. Age pyramids skewed to young adults have almost certainly played a role in this violence (Mesquida and Wiener, 1996), together with resource scarcity, pre-existing ethnic tensions, poor governance and international inactivity when crises develop.

GLOBAL ENVIRONMENTAL CHANGE

Sustainable population health depends on the viability of the planet's life-support systems (McMichael *et al.*, 2003a). For humans, achieving and maintaining good population health is the true goal of sustainability, dependent, in turn, on achieving sustainable supportive social, economic and environmental conditions. Today, however, human-induced global environmental changes pose risks to health on unprecedented spatial and temporal scales. These environmental changes, evident at worldwide scale, include climate change, biodiversity loss, downturns in productivity of land and oceans, freshwater depletion and disruption of major elemental cycles (e.g. environmental nitrification) (McMichael, 2002). In coming decades, these long-term change processes will exact an increasing health toll via physical hazards, infectious diseases, food and water shortages, conflict and an inter-linked decline in societal capacity.

We currently extract 'goods and services' from the world's natural environment about 25% faster than they can be replenished (Wackernagel *et al.*, 2002). Our waste products are also spilling over (e.g. carbon dioxide in the atmosphere). Hence, there is now little unused global 'biocapacity'. We are thus bequeathing an increasingly depleted and disrupted natural world to future generations. Although the resultant adverse health effects are likely to impinge unequally and, often, after time lag, this decline could eventually harm, albeit at varying levels, the entire human population.

Global climate change now attracts particular attention. Fossil fuel combustion, in particular, has caused unprecedented concentrations of atmospheric greenhouse gases. The majority expert view is that human-induced climate change is now underway (Oreskes, 2004). The power of storms, long predicted by climate change modellers to increase (Emanuel, 2005), appears (in combination with reduced wetlands and failure to maintain infrastructure) to have contributed to the 2005 New Orleans flood. WHO has estimated that, globally, over 150 000 deaths annually result from recent change in the world's climate relative to the baseline average climate of 1961–1990 (McMichael *et al.*, 2004a). This number will increase for *at least* the next several decades.

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, storms and floods. Climate-sensitive biotic systems will also be affected. This includes: (i) the vector–pathogen–host relationships involved in transmission of various infections, vector-borne and other, (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 (Lindgren and Gustafson, 2001), cholera outbreaks in Bangladesh (Rodó *et al.*, 2002) and, possibly, malaria in the east African highlands (Patz *et al.*, 2002)—may partly reflect regional climatic changes.

Changes in the world's 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 are likely to increase, potentiating violence, injury, infectious diseases, malnutrition, mental disorders and other health problems.

These and other categories of global environmental changes, often acting in combination, pose serious health risks to current and future human societies (Figure 1). The important message here is that, increasingly, human health is influenced by socio-economic and environmental changes that originate 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 intergenerational health impacts.

EMERGING HEALTH ISSUES AND THE MDGS

In 2000, UN member states agreed on eight 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 shows how the MDG topic areas relate to the emerging health issues discussed here.

Many of the MDG targets are already in jeopardy. Although all are inter-linked, the 'environmental sustainability' MDG has fundamental long-term importance. Without it, the other concomitants of sustainability—economic productivity, social stability and, most importantly, population health—are unachievable. An additional reason to advance the MDGs is because that will slow population growth rates

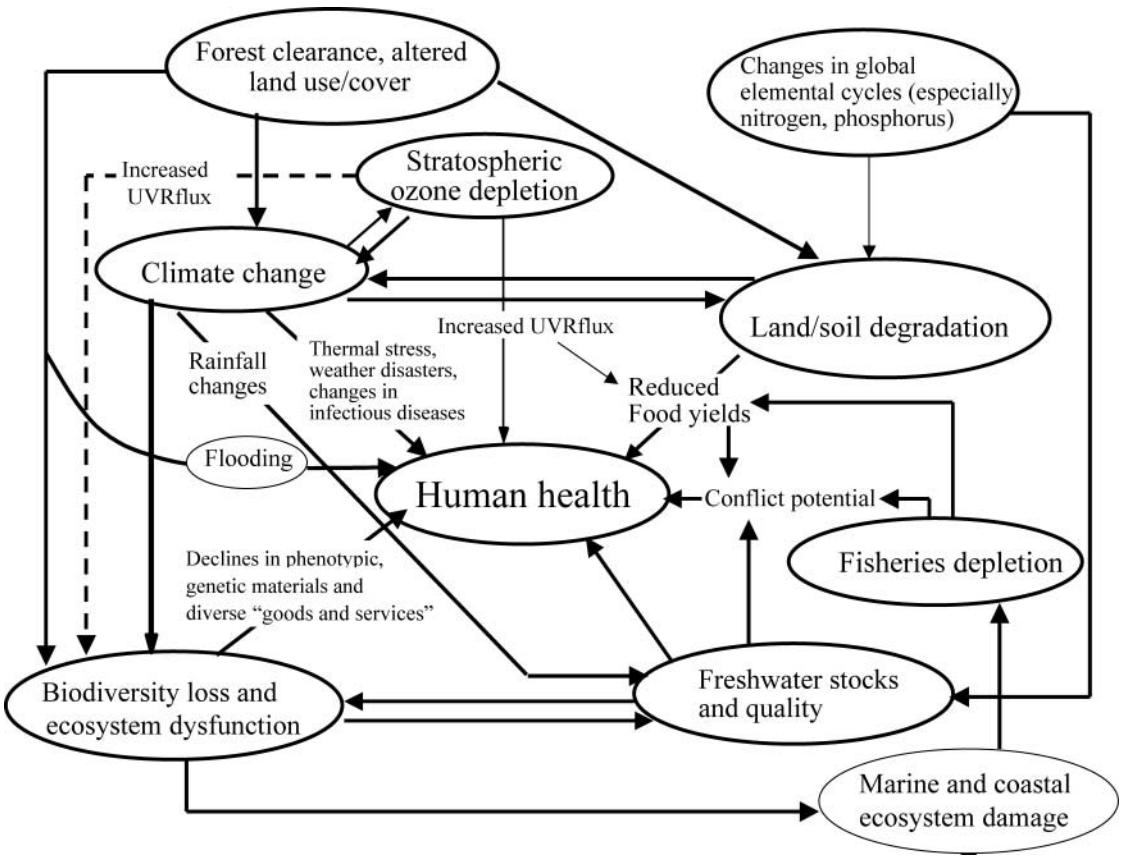

Fig. 1: Major pathways by which global and other large-scale environmental changes affect population health (based on McMichael *et al.*, 2003b, p. 8).

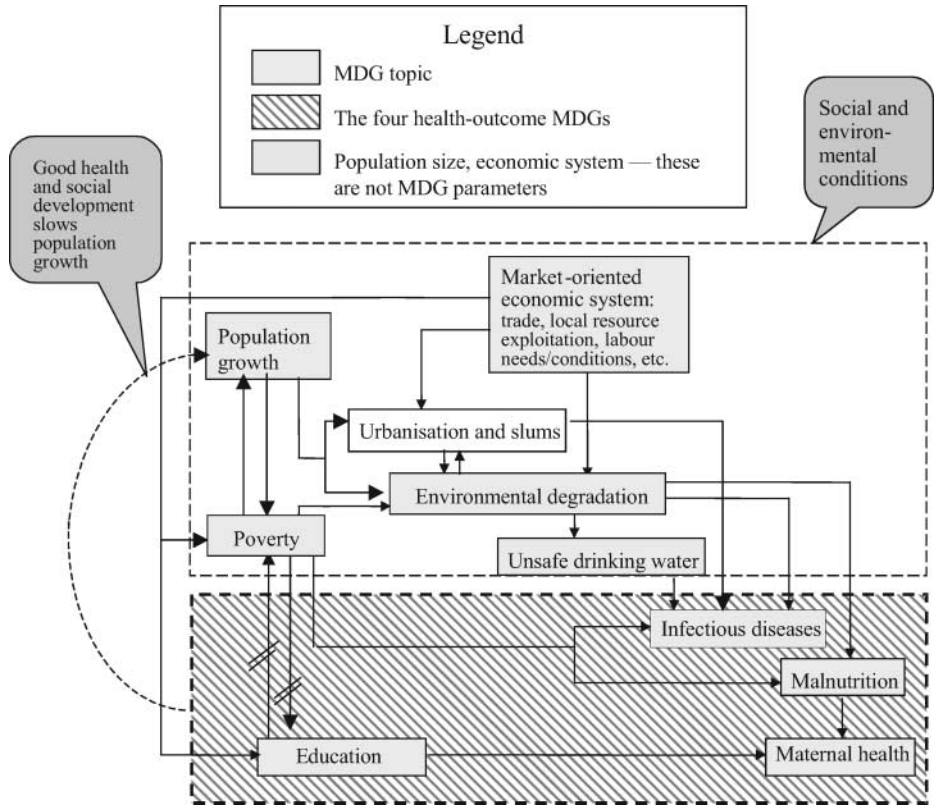

Fig. 2: Relationships between: (i) social and environmental conditions and their underlying economic and demographic influences and (ii) the MDG topics. (Two of this paper's main issues, environmental changes and infectious diseases, are explicitly represented as boxes.)

and thus reduce our collective ecological footprint (Wackernagel *et al.*, 2002).

THE FALTERING DEMOGRAPHIC AND EPIDEMIOLOGICAL TRANSITIONS

Both the demographic and epidemiological transitions are less orderly than predicted. In some regions, declining fertility rates have overshot the rate needed for an economically and socially optimal age structure. In other countries, population growth has declined substantially because of the reduced life expectancy discussed earlier (McMichael *et al.*, 2004b). Relatedly, the future health dividend from recent reductions in poverty may be lower than that once hoped because of the emergence of the non-communicable 'diseases of affluence', including those due to obesity, dietary imbalances, tobacco use and air pollution.

In the 1960s, there was widespread concern over imminent famine, affecting much of the developing world. This problem was largely averted by the 'Green Revolution' during the 1970s and 1980s. Meanwhile, the earlier view that unconstrained population growth had little adverse impact upon environmental amenity and other conditions needed for human well-being gained strength. However, in the last few years, this position has been re-evaluated (United Nations Department of Economic and Social Affairs Population Division, 2005). There is an increasing recognition of the adverse effects of rapid population growth, especially in developing countries, including from high unemployment when population increase outstrips opportunity.

Some argue that unsustainable regional population growth is characterized by age pyramids excessively skewed to young age, high levels of under- and unemployment and intense

competition for limited resources. These circumstances jeopardize public health. Where there is also significant inequality and/or ethnic tension, catastrophic violence can result (André and Platteau, 1998; Butler, 2004).

Although Russia and parts of sub-Saharan Africa have vastly different demographic characteristics, there are important similarities in their recent declines in life expectancy. Both regions have a significant scarcity of public goods for health (Smith *et al.*, 2003). In Russia, there is a lack of equality, safety and public health services. In many parts of sub-Saharan Africa, there is inadequate governance and food security as well as public safety and public health services. Viewed on an even larger scale, the miserable conditions for millions of people in these regions accord with a global class system, in which privileged groups in both developed and developing countries act (often in concert) to protect their own position at the expense of others (Butler, 2000: Navarro, 2004).

The growth of the global population and its environmental impact means that we may now be less than a generation from exhausting the biosphere's environmental buffer, unless we can rein in our excessive demands on the natural world. If not, then the demographic and epidemiological transitions, already faltering, will be further affected. Population growth may then slow not only because of the usual development-associated fertility decrease but also because of persistently high death rates elsewhere.

Meanwhile, the growing awareness of these issues, the publicity of 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 (McCoy *et al.*, 2004) affords new potential resources and collaborations to the global health promotion effort. These should be welcomed and acted upon.

GLOBALIZATION, TRADE, ECONOMIC POLICY AND FALTERING GLOBAL PUBLIC HEALTH: TOWARDS A UNIFYING EXPLANATION

The health benefits of the complex social, cultural, trade and economic phenomena that comprise 'globalization' are vigorously debated. Although differing viewpoints (Bettcher and Lee, 2002) are inevitable, the strength of this debate signifies that the net gain for population health from globalization is uncertain.

Several important health dividends often attributed to globalization have plausible alternative explanations. Many health gains in developing countries may be the time-lagged result of development policies and technologies introduced *before* the era of structural adjustment and partial economic liberalization, which heralded modern globalization. The accelerated demographic transition in China is a greatly under-recognized role in that country's rapidly growing wealth, as were China's earlier investments in health and education.

Proponents of gobalization assert that free trade, via 'comparative advantage', will benefit all populations. In reality, wealthy populations have long tilted the economic and political playing field in ways that ensure a disproportionate flow of trade benefits towards privileged populations (Mehmet, 1995). A powerful realpolitic impediment to the complete removal of trade-distorting national subsidies is that this would probably entail a relatively greater loss for wealthy populations than for the poor. In contrast, the economic disadvantages incurred to date through partial market deregulation have largely been confined to relatively poor and politically weak populations in developed countries.

The pre-eminence of modern economic theory presents a major obstacle for health promoters. The narrow focus of the World Trade Organization, which largely discounts the often adverse social, environmental and public health impacts of trade, underscores the problem. Dominant economic theory evolved when environmental limits were considered remote (Daly, 1996). These theories assume that increased per capita income will offset the non-costed losses, whether these affect social welfare, environmental resources or public health. Critiques of these theories 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.

Mobility of capital brings development, but capricious capital flight can create great hardship, including for public health. Deregulated labour conditions facilitate cheap goods, but they concentrate occupational health hazards among powerless workers. Increased labour mobility and steep economic gradients weaken

family and community structures, contribute to 'brain drain' and promote inter-ethnic tensions. Many indices of inequality, including in health, income and environmental risk, have risen in recent decades (Butler, 2000; Parry *et al.*, 2004).

Most critical commentary of globalization (George, 1999) is conceptual, emphasizing the adverse experiences of the disadvantaged and unborn. In contrast, the experiential feedback of the main beneficiaries of modern economic policy is largely positive. A major challenge for the promoters of health (and other forms) of justice is to adduce stronger evidence to convince policy-makers (themselves largely beneficiaries of globalization) to promote public goods, even though this may diminish the relative privilege of policy-makers and their constituencies. This is a difficult but essential task for health promotion.

EMERGING HEALTH ISSUES: THE CHALLENGES FOR HEALTH PROMOTION

In sum, global and regional inequality, narrow and outdated economic theories and an ever-nearing set of global environmental limits endanger population health. On the positive side of the ledger, there have been some gains (e.g. literacy, information sharing and food production, and new medical and public health technologies continue to confer large health benefits). Overall, though, reliance on economic, especially market-based, processes to achieve social goals and to set priorities and on technological fixes for environmental problems is 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 (Raskin *et al.*, 2002). Population health can be a powerful lever in that process of social change, if health promotion can rise to this challenge.

Many of these contemporary risks to population health affect entire systems and social–cultural processes, in contrast to the continuing health risks from personal/family behaviours and localized environmental exposures. These newly recognized risks to health derive from demographic shifts, large-scale environmental changes, an economic system that emphasizes the material over other elements of well being and the cultural and behavioural changes accompanying development. Together, these emerging health risks present a huge challenge to which the wider community is not yet attuned. The risks fall outside the popular conceptual frame wherein health is viewed in relation to personal behaviours, local environmental pollutants, doctors and hospitals. In countries that promote individual choice and responsibility, there are few economic incentives for the population's health.

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 socio-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 (Yach *et al.*, 2005) at community, national and international levels, via an expanded repertoire of bottom-up, top-down and 'middle-out' approaches to health promotion.

CONCLUSION

The essential principles of the Ottawa Charter remain valid. However, today's health promotion challenge extends that foreseen in 1986 and requires work at many levels. There is need for proactive engagement with international agencies and programs that bear on the socio-economic fundamentals in disadvantaged regions/countries. Many low- and middle-income countries require financial aid from donor countries to achieve the health-related MDGs, to deal with emerging and re-emerging infectious diseases and to counter the emerging health risks from human-induced global environmental problems. Linkages between the health sector and civil society, including those struggling to promote development, human rights, human security and environmental protection, should be strengthened.

We need to understand that 'sustainability' is ultimately about optimizing human experience, especially well-being, health and survival. This requires changes in social and political organization and in how we design and manage our communities. We must live within the biosphere's limits. Health promotion should

therefore address those emerging population health influences that transcend both national boundaries and generations. The central task is to promote sustainable environmental and social conditions that confer enduring and equitable gains in population health.

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HEALTH PROMOTION CHALLENGES

Gender and health promotion: A multisectoral policy approach

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SUMMARY

Women and men are different as regards their biology, the 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 and on the efficacy of health promotion policies and programmes. This is confirmed by evidence on male–female differences in cause-specific mortality and morbidity and exposure to risk factors. Health promoting interventions 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 (i) demonstrate that health promotion policies that take women's and men's differential biological and social vulnerability to health risks and the unequal power relationships between the sexes into account are more likely to be successful and effective compared to policies that are not concerned with such differences, and (ii) 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 i) 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, ii) an assessment and analysis of gender inequalities affecting health and determinants of health, iii) the actions needed to tackle the main determinants of those inequalities and iv) 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.

Key words: gender and health promotion; gender inequality; multisectoral policy response

INTRODUCTION

In most countries, resources allocated by government to health-promoting activities are very limited compared to investments in medical care (McGinnis *et al.*, 2002). This imbalance is evident also in the richest countries of the world. For example, in the USA, approximately 95% of the health expenditure goes to direct medical care services, whereas only 5% is allocated to prevention activities (Centers for Medicare and Medicaid Services, 2000). In Canada, the medical care systems absorbs the majority of health sector resources, with less than 3% of health spending allocated towards health promotion (Hylton, 2003). 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 (as well as their unequal access to power) into account are more likely to be successful and cost-effective compared to policies that are not concerned with such differences. Examples of the lack of gender perspectives in health promotion programmes are provided and discussed in this section.

Illustrated by examples of good practices from different regions of the world, we discuss in the second section what is needed to counteract gender insensitivity in health promotion interventions and what is required to build a strong multisectoral policy response to gender inequities in health through health promotion and disease prevention. We emphasize the need for upstream health promotion actions 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.

WHY SHOULD HEALTH PROMOTION AND DISEASE PREVENTION POLICIES AND INTERVENTIONS PAY ATTENTION TO GENDER?

There is overwhelming evidence from all fields of health research that women and men are different as regards their biology (sex differences), 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 (gender differences). Together gender and sex, often in interaction with socioeconomic circumstances, influence exposure to health risks, access to health information and services, health outcomes and the social and economic consequences of ill-health. Recognizing the root causes of gender inequities in health is crucial therefore when designing health system responses. 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 (for a more detailed discussion and examples, see Keleher, 2004).

Today, there is a growing recognition, among health professionals, researchers and policymakers, of the widespread and profound implications of gender-based inequities in health. There is also emerging evidence that integrating gender considerations into interventions has a positive effect on health outcomes across various domains (Boerder *et al.*, 2004). 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: the lack of translation of knowledge about gender inequities in health into health promotion interventions leads to misallocated resources and weakened potential for success. For example, violence against women, arguably the most extreme phenomenon of gender inequality, affects millions of women. Until recently, the magnitude and health consequences of domestic violence against women have been neglected in both research and policy (Garcia-Moreno, 2002). We have now clear evidence (WHO/WHD, 1996; WHO/WPRO, 1998; Astbury and Cabral, 2000; WHO, 2002; ARROW, 2005; WHO, 2005) that gender-based violence causes physical and psychological harm. In addition, it undermines the social, economic, spiritual and emotional well-being of the survivor, the perpetrator and society as a whole, but it also compromises the trust relationship between men and women. The social, economic, psychological, physical, emotional and relationship harm to individuals from gender-based violence constitutes a major health concern that requires creative and imaginative responses from the plethora of policymakers and intervention agencies dealing with health promotion and prevention of violence. In particular, lack of attention to the hidden emotional outcome of gender-based violence, loss of trust, loss of dignity and a deeply compromised self-esteem need to be addressed alongside housing, economic support, social welfare and legal issues as part of an integrated health promotion strategy (Eckermann, 2001).

Gender blindness

When planning and implementing health promotion and disease prevention strategies, gender is an issue that is often neglected (Cristofides, 2001; Östlin, 2002; Roses Periago, 2004). 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 (Ekenvall *et al.*, 1993). As a result, collection, analysis and presentation of data are often not sex-disaggregated and no gender analysis is undertaken.

Terminology is crucial in framing gendered responses to health promotion challenges. For example, the WHO (2005) Multi-country Study authors recommend using the term 'gender-based violence' to replace the commonly used descriptive terms: intimate partner violence (denotes relationship to perpetrator), domestic violence (denotes location of the abuse) and violence against women (denotes the sex of the survivor). This ensures that the cause of the violence is not forgotten. Violence is regularly the product of socialized but mutable gender relationships, and this is written into the term 'gender-based violence'. Relationship problems take centre stage with risky behaviour, social disadvantage, environmental degradation and germs in the aetiological chain of events that lead to ill-health and compromised well-being (Eckermann, 2006). Health promotion initiatives need to recognize the importance of good gender relationships in promoting health and well-being.

Gender' as a proxy for 'women'

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 (Doyal, 2001). 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 and to the relationships between males and females of all ages, 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 (Brugha *et al.*, 1996). In Lao PDR, an outreach health promotion programme attached to the Bolikhan District Maternity Waiting Home targeted men in 11 remote Hmong and Lao villages to encourage them to take an active role in reproductive health. Interactive sessions addressed male and female anatomy and function, fertilization, physiology of pregnancy, birth spacing including responsibility of men, sexually transmittal infections and HIV prevention, the importance of antenatal and postnatal care, nutrition and relaxation during pregnancy. Attendance rates were over 80% of the men in each village. Before the programme, only 18% of participants said they had a very good knowledge of reproductive health issues. At the end of the programme, 72% of participants reported very good knowledge. Thus gendered knowledge barriers to health improvement were greatly reduced in all 11 villages (Eckermann, 2005).

Focus on behavioural change

Many health promotion strategies aim at reducing risky behaviours, such as smoking, while ignoring the material, social and psychological conditions within which the targeted behaviours are embedded. For example, in many countries there is a strong association between material hardship, low social status, stressful work or life events and smoking prevalence (Bobak *et al.*, 2000; Osler *et al.*, 2001). 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 (Kabeer, 1994; Stronks *et al.*, 1996). 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 often feel 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, such as the universal provision of accessible and affordable day-care centres for children and the 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' (Möller-Leimkühler, 2003). 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 lifestyles of these men would probably be more effective if combined with measures to change the social environment in which the health damaging lifestyles are embedded.

According to a study from Thailand, although 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 (Kilmarx *et al.*, 1999). Obviously, there is a need for policies that recognize 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. Again the issue of trust in the relationships between men and women is a key factor for health promotion programmes to take into account.

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 in sectors where health is created, such as 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 (Benzeval *et al.*, 1996). The understanding that both women's and men's health is dependent on several societal sectors is critical to upstream, multisectoral health promoting policies and interventions. 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 levels. In many traditional communities, traditional chiefs, or village leaders, act as gatekeepers in all educational and community-based activities, so it is essential to incorporate these key stakeholders in any health promotion policies and interventions designed to reduce gender inequities.

Top-down approach

The traditional public health approach is top-down rather than bottom-up, with experts identifying problems and formulating interventions while the problems and solutions as perceived by those at particular risk rarely constitute the base for action (Dahlgren, 1996). 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 a 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 (A Rahman *et al.*, 1996). 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.

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.

Joint commitment

Through international agreements, such as the Ottawa Charter for Health Promotion and the WHO Health For All Strategy (World Health Organization, 1981), 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[1]. The recently adopted Bangkok Charter for Health Promotion states that health promotion contributes, among other things, to reducing both health and gender inequities.

Some major achievements in working towards gender equity are evident. For example, the Multi-country Study on Health and Domestic Violence against Women acknowledges the 'combined efforts of grass-roots and international women's organizations, international experts and committed governments' in producing 'a profound transformation of public awareness' (WHO, 2005:1) about gender-based violence. Since the World Conference on Human Rights (1993), the International Conference on Population and Development (1994) and the Fourth World Conference on Women (1995), the perception of gender-based violence as purely a welfare and justice issue has changed significantly to the point where violence against women is 'now widely recognized as a serious human rights abuse' as well as 'an important public health problem that concerns all sectors' (WHO, 2005:1). However, as the 10-year reviews of the ICPD Plan of Action and the Beijing Platform for Action have highlighted (ARROW, 2005; WHO, 2005), all countries still have a long way to go to achieve gender equity in all areas of health and well-being.

The internationally agreed Millennium Development Goals (MDGs) 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[2] 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 (United Nations, 2005). 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 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.

[1] The United Nations International Covenant on Economic, Social and Cultural Rights, Article 12 and the United Nations International Covenant on Civil and Political Rights, Article 2.1 and Article 3. The United Nations Economic, Social and Cultural Rights, Article 2.2, Article 3, Article 7(a)(i), Article 12.2(d) and Article 13.

[2] For example, Article 25 of the Universal Declaration of Human Rights in 1948; the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW) in 1973, the Declaration on the Elimination of Violence against Women of 1993, the Programme of Action of the International Conference on Population and Development (ICPD) in Cairo in 1994, the World Summit for Social Development in Copenhagen and The Beijing Declaration and Platform for Action in 1995; the Declaration of Commitment on HIV/AIDS adopted at the UN General Assembly Special Session on HIV/AIDS (UNGASS) in 2001.

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 eight 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 multisectoral national development plan to mainstream gender into all areas of health and well-being.

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, for example, gender-based violence, 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. Collection, analysis and reporting of data disaggregated by sex, age, socioeconomic status, education, ethnicity and geographic location should be performed systematically by individual research projects or through larger data systems. Attention needs to be paid to the possibility that data may reflect systematic gender biases due to inadequate methodologies that fail to capture women's and men's different realities (Östlin *et al.*, 2004). The promotion of gender-sensitive research to inform the development, implementation, monitoring and evaluation of health promotion policies and programs is also desirable.

One good example of recording sex-disaggregated, gender-sensitive and gender-specific health data comes from Malaysia. In 2000, the Asian-Pacific Resource and Research Centre for Women (ARROW) published 'A Framework of Indicators for Action on Women's Health Needs & Rights after Beijing' (ARROW, 2000). This publication was developed as a tool for all government, non-government and international organizations 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 operationalized 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. This will be reviewed in a publication to be released in late 2006. Meanwhile, ARROW (2005) has applied a similar framework in its 'Monitoring Ten Years of ICPD Implementation'. Eight countries in the Asia Pacific region were examined in detail, using indicators derived from the ICPD recommendations, to 'assess progress in policies, laws and services and changes in women's health, status and lives' over the past 10 years and to 'identify the main barriers and facilitating factors in implementing commitments made in the Programme of Action, ICPD' (ARROW, 2005:17). The Report reveals that 10 years after ICPD, 'women's lives have seen only minimal improvement' and 'violence against women is on the rise, as is HIV/AIDS transmission for women and men' (ARROW, 2005:17). The Report argues that 'one of the best indicators of real change in power relations between men and women is a decrease in domestic violence and rape' yet 'only two of the eight countries (Cambodia and Malaysia) had ever had a national prevalence survey on domestic violence' (ARROW, 2005:43) let alone put prevention strategies in place.

The health promotion recommendations that emerge form the 2005 ARROW Report suggest a major rethinking of intervention to deal with key challenges. These challenges include: deeply embedded patriarchy, early marriage and early first parity, declining commitment of service providers, lack of political will and stability, social inequities, religious fundamentalism in some areas, trends to privatization, liberalization and globalization and persistent low levels of literacy among women and girls. Key recommendations for health promotion include niche planning by governments, rather than the use of uniform 'one size fits all' health promotion programmes, using NGOs as clearing houses for up-to-date dissemination of data and community-based workshops on a variety of health issues and using traditional authority processes (such as village chief authorization)

to run campaigns to promote female literacy and education.

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 (Matsudo *et al.*, 2002). First, girls were more involved in vigorous physical activity than boys, which was a surprise because literature from several 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 utilized 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 of intervention to increase physical activity among girls and boys.

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 (Dahlgren and Whitehead, 1991). Keleher (2004) emphasizes the need for sustainable upstream strategies that address the economic, social and cultural obstacles that prevent women from fulfilling their potential. She argues that such strategies are much more likely to bring about sustainable change than a continual reliance on midstream and downstream strategies.

Actions to strengthen individuals

Many health promoting interventions with a gender perspective have focussed mainly on strengthening women's and girls' capacity to better respond to, and control determinants of, health in the physical and social environment. They include gaining access to economic capital as well as social and cultural capital. The most effective interventions are those with an empowerment focus (Sen and Batliwala, 2000). They aim to help women to: gain knowledge about, and access to, their rights; access microcredit to start their own businesses; improve their access to essential services; address perceived deficiencies in their knowledge (including literacy and secondary education); 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 (Craft, 1997).

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 (Iwere, 2000). 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 (Ojidoh and Okide, 2002). 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.

In the Woorabinda Aboriginal community in rural Queensland, Australia, the community has organized sanctions around the weekend Australian Rules Football match related to gender-based violence. Any player who has been identified as having abused his partner during any week is banned by the team committee from playing in the football match at the weekend. This reinforces community and shared abhorrence of gender-based violence and acts as a public endorsement of good relations between men and women in the community (ABC, 2000; Queensland Government, 2000).

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 cooperate in order to improve the health of the population. Health promotion policies and interventions aimed 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 (Zaidi, 1996). 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 (Asian Development Bank, 2005). The project assumes that a female health care provider could better understand the problem of another woman.

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. Policies aimed at improving women's education, increasing their possibilities to earn an income within the labour market, giving women access to micro-credit to start small businesses 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 achieve high levels of literacy. Kerala is the only state in India where the population sex ratio has been favourable to women throughout the 20th century, and it is not plagued by the problem of 'missing women' (Östlin *et al.*, 2001). 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.

The examples presented earlier suggest that most successful interventions are those that combine a wide range of intersectoral and upstream approaches as well as downstream interventions to tackle a problem. For example, interventions at the individual level to empower women to deal with the threats to their mental and physical health from violence are important. However, interventions are also needed at the structural level, where governments have a central role in policy and legislation and in mandating organizational change to ensure that women are in the position to be empowered. The establishment of societal freedoms from discrimination and violence must sit alongside other efforts to increase women's access to economic resources and social inclusion. These economic, legal, social and cultural assets are fundamental to generating and maintaining women's health and well-being but they also benefit men.

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 policymakers 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 (Lehto and Ritsatakis, 1999; Whitehead *et al.*, 2000).

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 are likely to 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.

In some countries, such as Canada (Status of Women Canada, 2001) and a number of European countries (Pollack and Hafner-Burton, 2000), considerable work is underway to integrate gender perspectives in policy and practice. 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 centred on joint commitment and a multisectoral approach and which are based on evidence gathered with gender dimensions in mind.

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HEALTH PROMOTION CHALLENGES

Promoting mental health as an essential aspect of health promotion

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SUMMARY

This paper advocates that mental health promotion receive appropriate attention within health promotion. It is of great concern that, in practice, mental health promotion is frequently overlooked in health promotion programmes although the WHO definitions of health and the Ottawa Charter describe mental health as an integral part of health. It is suggested that more attention be given to addressing the determinants of mental health in terms of protective and risk factors for both physical and mental conditions, particularly in developing countries. Examples of evidence-based mental health programmes operating in widely diverse settings are presented to demonstrate that well designed interventions can contribute to the well-being of populations. It is advocated that particular attention be given to the intersectorial cooperation needed for this work.

Key words: mental health; promotion; advocacy

INTRODUCTION

It is of great concern that mental health promotion is frequently overlooked as an integral part of health promotion (Desjarlais *et al.*, 1995; WHO, 2001; Lavikainen *et al.*, 2000).

This is surprising because, in theory, mental health is accepted as an essential component of health (WHO, 2001), the close relationship between physical and mental health is recognized (WFMH, 2004) and it is generally known that physical and mental health share many of the same social, environmental and economic determinants (WHO, 2004). We know that facilities for those with mental health problems are more poorly resourced than those for physical illness in many parts of the world (Desjarlais *et al.*, 1995; WHO, 2001) and it is important that mental health promotion does not get similarly affected.

THE RELATIONSHIP BETWEEN HEALTH PROMOTION AND MENTAL HEALTH PROMOTION

Health is defined by the World Health Organization (WHO) as 'a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity' [(WHO, 2001a), p. 1] and health promotion is understood as 'actions that support people to adopt and maintain healthy lifestyles and which create supportive living conditions or environments for health' [(WHO, 2004), p. 5].

In these definitions it is clearly recognized that mental health promotion is an integral component of health promotion. Not only are there complex interconnections between physical and mental health, they share many of the same determinants (Raphael *et al.*, 2005). Therefore, while mental health promotion will focus more specifically on the determinants of

mental health and the creation of conditions that enable optimum psychological and psychophysiological development, these efforts will impact positively on physical health (Herrman *et al.*, 2005).

Two of the five strategies set out in the Ottawa Charter for Health Promotion 'strengthen community action' and 'develop personal skills' (WHO, 1986)—essentially refer to mental health promotion activities: for example, programmes aimed at reducing social inequality and building social capital (WHO 2004). It is also recognized that strategies that maximize the active ownership and participation of people in health promotion initiatives contribute positively to the sustainability of the programmes (WHO, 1997). In this sense health promotion is facilitated by mental health promotion. Conversely, when the focus of the intervention is more directly on the promotion of mental health, physical health issues must not be ignored.

Mental health can be understood as:

> a state of well-being in which the individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her own community [(WHO, 2001b), p. 1].

Other definitions of mental health refer to the individual's subjective feelings of well-being, optimism and mastery, the concepts of 'resilience', or the ability to deal with adversity, and the capacity to be able to form and maintain meaningful relationships (Lavikainen *et al.*, 2000). Although the expression of these qualities will differ contextually and individually from culture to culture, the basic qualities remain the same.

THE RELATIONSHIP BETWEEN PHYSICAL AND MENTAL HEALTH

The artificial division of 'physical health' from 'mental health' common in the western developed world is not shared by many traditional cultures in which physical conditions have long been considered as being closely related to the emotional, social or spiritual health of the person (Swartz, 1998).

The reciprocal relationship between physical and mental health now is widely recognized (Raphael *et al.*, 2005). It is known that mental well-being, social support and social networks are protective factors for physical health. Positive mental health significantly assists people to deal with physical conditions. Conversely, the promotion of physical health impacts positively on mental health, for example, in older people (Li *et al.*, 2002; WFMH, 2004). It is recognized that diabetes, cancer, cardiovascular disease and HIV/AIDS affect and are affected by the mental state of individuals, and particularly by depression (Raphael *et al.*, 2005). Heart disease is found to double in people with depression and approximately one-half of people with heart disease suffer an episode of major depression (WFMH, 2004).

Clearly, to be effective, promotion and prevention programmes addressing health conditions should take mental health factors into account, and mental health and health programmes are best implemented together.

THE BURDEN OF MENTAL ILL-HEALTH

Apart from aiming to increase positive mental health, mental health promotion has an important role to play in relation to mental disorders, in that positive mental health is a strong protective factor against mental disorders (WHO, 2004a). Mental health promotion includes 'strategies to promote the mental well-being of those who are not at risk, those who are at increased risk and those who are suffering or recovering from mental health problems' (WHO 2004a).

The size and cost of the burden of mental and behavioural disorders is perhaps not fully appreciated. Mental and behavioural disorders (expressed in disability adjusted life years, or DALY'S) represented 11% of the total disease burden in 1990, and this is expected to rise to 15% by 2020 (WHO, 2001c). Five of the 10 leading causes of disability worldwide in 1990 were mental or behavioural disorders. Depression was the fourth largest contributor to the disease burden in 1990 and is expected to rank second after ischaemic heart disease by 2020. It is estimated that one in four people will develop one or more mental or behavioural disorders in their life-time and that one in four families has one member suffering from a mental or behavioural disorder (Murray *et al.*, 1996; WHO, 2001c).

The social and economic costs of only attempting to deal with these issues through individual and treatment paradigms is not only prohibitive, but impossible in many parts of the world where there are few mental health professionals (Desjarlais *et al.*, 1995). A public health approach to mental health promotion is imperative, in which, in addition to treatment, efforts are made to support the factors that have been shown to promote mental health and address the factors that constitute risk factors for mental disorders (VicHealth, 1999; Herrman *et al.*, 2005). Unless this is done, the burden of mental illness will continue to grow (Desjarlais *et al.*, 1995).

THE EVIDENCE BASE FOR MENTAL HEALTH PROMOTION

Determinants

The evidence-based determinants of mental health in terms of risk and protective factors include individual, social and societal factors and their interaction with each other. Social and economic disadvantage, giving rise to poverty and lack of education, constitute risks for mental illness, and often create and interact with other known risk factors such as displacement, racial injustice and discrimination, poverty, unemployment, poor physical health, access to drugs and alcohol, violence and delinquency (Desjarlais *et al.*, 1995; Herrman *et al.*, 2005; WHO, 2004; Patel and Kleinman, 2003).

It is these known risk factors that are addressed in effective mental health promotion programmes. If not addressed, these conditions create the 'poverty traps' all too frequently found in developing countries, in countries with civil unrest and in deprived communities worldwide. The mental health of a community is mutually dependent on the mental health of its citizens. Clearly, the promotion of mental health and the protection of human rights are closely associated. Protective factors include integration of ethnic minorities, empowerment, social participation, social services and social support and community networks (WHO, 2004).

Evidence based mental health promotion programmes

Evidence exists for the effectiveness of a wide range of exemplary mental health promotion programmes and policies. Their outcomes show that mental health promotion is a realistic option within a public health approach across the lifespan and across settings such as perinatal care, schools, work and local communities. In many fields of life, well-designed interventions can contribute to better mental health and well-being of the population. [(WHO, 2004), p. 34].

Examples will be given of such mental health promotion programmes addressing issues throughout the life cycle and on individual and community levels that are aimed at removing structural barriers.

There are evidence-based mental health programmes that target early childhood through home visiting, which have positive outcomes well into the children's adolescence. The most well known of these is the Prenatal and Infancy Home Visiting Programme, which impacts successfully on a range of behaviours including child abuse, conduct disorders and substance abuse. (Olds, 1997; Olds, 2002; Olds *et al.*, 1998). Parent training programmes, such as 'The Incredible Years' (Webster-Stratton and Reid, 2003) and the Triple P Positive Parenting Programme in Australia (Sanders *et al.*, 2002) improve parent–child interaction. The Perry Preschool Project combines home visiting and preschool intervention to produce impressive long-term results in deprived communities regarding cognitive development and conflict with the law (Schweinhart and Weikart, 1997).

Other programmes directly or indirectly address the mental health of communities. Communities that Care (CTC) is a programme, replicated in many countries, that mobilizes communities to use multiple interventions to prevent violence and aggression (Hawkins *et al.*, 2002). Programmes that address economic insecurity, human rights and empowerment issues are shown to impact positively on mental health, for example the poverty alleviation programme run by BRAC in Bangladesh (Chowdhury and Bhuiya, 2001) and adult literacy programmes (Cohen, 2002). When communities can be effectively mobilized to address issues such as substance abuse, the outcomes often indicate improvements in other areas as well, such as domestic violence (Bang and Bang, 1991; Wu *et al.*, 2002).

Schools are obvious locations for mental health promotion programmes that target issues such as improving problem-solving abilities and the reduction of substance abuse, bullying

and aggression. There are many examples of effective programmes such as 'I Can Problem Solve' (Shure, 1997), the Improving Social Awareness-Social Problem-Solving Programme (Bruene-Butler *et al.*, 1997), the Good Behaviour Game (Kellam *et al.*, 1994), the Linking the Interests of Families and Teachers (LIFT) Programme (Reid *et al.*, 1999) the Seattle Social Development Project (Hawkins *et al.*, 1991) and the Positive Youth Development Programme (Caplan *et al.*, 1992).

Programmes that target unemployment and impact successfully on re-employment, mastery and depression include the JOBS Programme (Caplan *et al.*, 1989; Vinokur *et al.*, 2000), which has been tested and replicated in large-scale randomized trials in several countries (Vuori *et al.*, 2002). The Care Giver Support Programme, also evaluated in a large-scale randomized trial, increased various work behaviours and enhanced the mental health and job satisfaction of the participants (Heaney *et al.*, 1995).

With regard to older people, controlled trials have demonstrated that exercise improves general mental well-being (Li *et al.*, 2001), and there is some evidence that befriending (Stevens and van Tilburg, 2000) and early screening (Shapiro and Taylor, 2002) also have positive outcomes, although more evidence is required. Information regarding other evidence-based programmes can be accessed from data bases such as those provided by the USA Center for Disease Control and Prevention (CDC), the Collaborative for Academic, Social and Emotional Learning (CASEL), the Substance Abuse and Mental Health Services Administration (SAMHSA) and Implementing Mental Health Promotion Action (IMHPA).

The level of evidence is more forthcoming from better-resourced developed countries. A challenge to the health sector is to document and disseminate the mental health promotion programmes currently being offered, often at very low cost, by a wide variety of sectors and to facilitate improved levels of evidence (Jane-Lopis *et al.*, 2005; Herrman *et al.*, 2005; Herrman and Jane-Lopis, 2005). A recent joint publication by the WHO and the World Federation for Mental Health is another example of such an initiative (WHO, 2004b). It is significant to note the variety of organizations involved in the programmes and that in most cases the programmes were managed by partnerships between several organizations.

THE WAY FORWARD

As many determinants of health, and particularly mental health, largely lie outside the health sector, addressing promotion requires an understanding and commitment from stakeholders from many constituencies. In a public health approach, the health sector requires the knowledge, attitudes and skills to advocate, persuade and collaborate with these other sectors to engage in activities that enhance mental health.

> The activities of mental health promotion are mainly socio-political: reducing unemployment, improving schooling and housing, working to reduce stigma and discrimination of various types... The key agents are politicians, educators, and members of nongovernment organizations (WHO, 2004), p. 26].

The main motivation for these other sectors to engage in promotion programmes may not be their impact on health or mental health *per se*, but outcomes of the programmes more closely connected to their own disciplines and interests. If they are carrying the cost, this is understandable and acceptable. They need to be convinced that these programmes would address their own needs. In order to persuade other sectors to adopt policies and programmes conducive to mental health promotion, the health sector needs to be able to communicate with them in their own language and to see the policies and programmes from their perspective. This applies whether engaging in policy development at the national level, encouraging non-governmental organizations to initiate programmes or engaging with service user groups. In addition, the mental health outcomes of programmes not primarily aimed at mental health promotion need to be evaluated.

Working with other sectors is particularly important in developing countries where a wide range of initiatives, including community and social development programmes, are needed to address the multiple factors associated with poverty that impact negatively on health and mental health. The process followed in addressing these multiple factors is guided by the principles of advocacy, participation and empowerment, which are intrinsic to the promotion of mental health (Patel, 2001; WHO, 2004). The positive mental health outcomes of these programmes suggests that maximum use

of these partnerships will further the cause of mental health promotion.

CONCLUSION

It is advocated that mental health assume its rightful place in health promotion. The significant number of evidence-based mental health programmes concerned with well-being from early childhood to old age, aimed at individuals, groups or at community structural issues demonstrate that well designed interventions contribute significantly to the well-being of populations. Efforts need to be made to strengthen this evidence, particularly in developing countries. A further challenge is for mental health professionals to become more skilled in the process of advocacy in order that such evidence is used to maximum effect in ensuring that mental health promotion is recognized as an integral and central component of health promotion.

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GLOBALIZATION FOR HEALTH

Global health promotion: how can we strengthen governance and build effective strategies?

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SUMMARY

This paper discusses what is meant by 'global health promotion' and the extent to which global governance architecture is emerging, enabling people to increase control over, and to improve, their health within an increasingly global context. A review of selected initiatives on breast-milk substitutes, healthy cities, tobacco control and diet and nutrition suggests that existing institutions are uneven in their capacity to tackle global health issues. The strategic building of a global approach to health promotion will draw on a broad range of governance instruments, give careful attention to implementation in the medium to longer term, reflect on the nature and appropriateness of partnerships and develop fuller understanding of effective policies for harnessing the positive influences of globalization and countering the negatives.

Key words: global health governance; globalization; public–private partnerships

INTRODUCTION

As globalization increasingly impacts on diverse aspects of our lives, we are beginning to understand how factors that go beyond the national borders of individual countries are influencing the determinants of health and health outcomes. This paper discusses what is meant by 'global health promotion' in terms of the process of enabling people to increase control over, and to improve, their health (WHO, 1986) within an increasingly global context. The focus of this paper is the extent to which global governance architecture is emerging for health promotion. After briefly reviewing the concepts of global health governance (GHG), this paper draws lessons from selected examples of global health promotion initiatives and concludes with suggested strategies for building a global approach to health promotion.

FROM INTERNATIONAL TO GLOBAL GOVERNANCE FOR HEALTH PROMOTION

Governance concerns the many ways in which people organize themselves to achieve common goals. Such collective action requires agreed rules, norms and institutions on such matters as membership within the cooperative relationship, distribution of authority, decision-making processes, means of communication and resource mobilization and allocation. *Health governance* concerns the agreed rules, norms and institutions that collectively promote and protect health (Dodgson *et al.*, 2003).

Importantly, while government can be a central component of governance, governance more broadly embraces the contributions of other social actors, notably civil society organisations (CSOs) and the corporate sector.

Moreover, governance embraces a variety of mechanisms, both formal (e.g. law, treaty and code of practice) and informal (e.g. norms and custom) (Finkelstein, 1995). Formal instruments with the strongest regulatory powers can be legally binding and backed by punitive measures (e.g. fines or imprisonment). Informal mechanisms may rely on self-regulation and voluntary compliance, as well as less tangible forms of censure, such as public opinion.

Global health governance GHG can be distinguished from *international* health governance (IHG) in three ways. First, IHG involves *crossborder* cooperation between governments concerned foremost with the health of their domestic populations. Infectious disease surveillance, monitoring and reporting, regulation of trade in health services and protection of patented drugs under the Agreement on Trade-Related Intellectual Property Rights (TRIPS) are examples of IHG. However, changes being brought about by globalization mean that many health determinants and outcomes are becoming increasingly difficult to confine within a given territorial boundary (i.e. country) and, in some cases, are becoming de-linked from physical space (deterritorialised) (Scholte, 1999). As such, it has been argued that the current IHG architecture alone is inadequate to deal with *transborder* flows that impact on health, such as people trafficking, global climate change and internet pharmaceutical sales (Lee, 2003).

Second, the mechanisms of IHG are, by definition, focused on governments in terms of authority and enforcement. Examples include the International Health Regulations (IHR) and Framework Convention on Tobacco Control (FCTC). In contrast, GHG embraces both governmental and non-governmental actors and a wider range of formal and informal governance mechanisms. These include voluntary codes of practice, quality control standards, accreditation methods and consumer monitoring and reporting. These mechanisms vary widely in their jurisdiction, purpose, scope and associated resources.

Third, while IHG is traditionally focused on the health sector, GHG seeks to address the broad determinants of health, extending its reach to health impacts from non-health sectors, such as trade and finance, and environment across multiple levels of governance. As Collin *et al.* (Collin *et al.*, 2005) write,

> In a world where many health risks and opportunities are becoming increasingly globalised, influencing health determinants, status and outcomes cannot be achieved through actions taken at the national level alone. The intensification of transborder flows of people, ideas, goods and services necessitates a reassessment of the rules and institutions that govern health policy and practice.

The three distinct features of GHG described above can be understood through the example of efforts to control dengue fever across multiple countries. An IHG approach would concentrate on a coordinated effort by ministries of health in affected countries to tackle environmental factors (e.g. spraying and reducing potential breeding sites), distribute bed nets and increase the use of insect repellents. Reporting of data on incidence might be shared among the appropriate public health authorities. In contrast, a GHG approach would consider the role of transborder factors, such as documented and undocumented migration, and migration of the Aedes aegypti mosquito. In addition to government, there might be cooperation among a wide range of relevant stakeholders such as non-governmental organizations (NGOs), private companies, research institutions and local communities. Finally, the impacts on the social and natural environment from changes to agricultural practices (e.g. agribusiness), terms of trade, or conflict and political instability would be taken into account.

To the extent that globalization requires global governance architecture for health, there is a need to rethink traditional approaches to health promotion. There is a need to understand how globalization, defined as changes that are intensifying crossborder and transborder flows of people and other life forms, trade and finance and knowledge and ideas, is impacting on the process of enabling people to increase control over, and to improve, their health. For example:

- The promotion of sexual health may require greater attention to changing patterns of population mobility within and across countries in the form of migration, tourism, displaced populations and migrant workers.
- The promotion of healthy diets may require measures to counter the marketing of global brands by transnational corporations.
- The promotion of tobacco control may require measures to tackle the availability of

contraband cigarettes, and the targeting of emerging markets in low-and middle-income countries by transnational tobacco companies (TTCs).
- The promotion of healthy living environments may require greater attention to the impact of large-scale agricultural production on urbanization and land availability.

In summary, *global health promotion* can be defined as the process of enabling people to increase control over, and to improve, their health within an increasingly global context. The challenge lies in creating effective forms of governance that support such efforts. In principle, there is an emergent architecture for global health promotion, as shown in the examples below. By definition, health promotion is broadly conceived to involve a range of social institutions, from governmental bodies to individual families. In practice, however, initiatives to date that seek to tackle global health issues have reflected the uneven quality of existing institutions and shortfalls in how they operate together. In briefly reviewing these examples, particular attention is given to the institutions and mechanisms involved, the effectiveness of these efforts (strengths and weaknesses) and lessons learned for future action.

LESSONS TO DATE: SELECTED EXAMPLES OF GLOBAL HEALTH PROMOTION

International code of marketing of breast-milk substitutes

Adopted in May 1981 by WHO member states, following years of concern about the general decline in breastfeeding in many parts of the world, the International Code of Marketing of Breast-Milk Substitutes represented the culmination of a prominent global health promotion campaign by WHO, UNICEF and NGOs led by the International Baby Food Action Network (IBFAN). The code was highly successful at drawing worldwide public attention to the health consequences of the marketing practices of infant formula manufacturers, with NGOs mounting a successful boycott of Nestlé. Despite non-support by the US government, the code was adopted by national health systems around the world and corporations were made acutely aware of the power of consumer action.

The implementation of the code during the past 20 years has seen mixed success. Despite the high-profile adoption of the code, and efforts in some countries to align national law to its provisions, it remains largely a voluntary code. Widespread violations in many low-and middle-income countries have been reported (Taylor, 1998), and there remain few formal means of enforcement beyond public censure. Efforts to raise the issue within the Food and Agriculture Organization (FAO), Codex Alimentarius, World Trade Organization (WTO) and other relevant international forums have sought to embed the code within nutritional guidelines and trading principles. Amid a renewed Nestlé boycott, NGOs also accuse the company of engaging in new marketing tactics to circumvent provisions, including the use of a corporate social responsibility initiative (i.e. ombudsman scheme) to placate public concerns. Meanwhile, NGOs monitoring companies report that 4000 babies continue to die each day from unsafe bottle feeding (International Baby Food Action Network, 2004).

This example suggests that reliance on voluntary codes alone to regulate the behaviour of powerful and well-resourced transnational corporations, without sufficient attention to implementation and enforcement, is likely to be ineffective. While NGOs can effectively campaign to draw public attention to an issue, public pressure can be difficult to sustain in this way in the longer term without the support of more formal governance instruments. This is especially so given the worldwide scale of the issue. A voluntary code can be seen as an initial effort to raise awareness and improve public education. If ongoing monitoring shows non-compliance (Allain, 2002), stronger governance instruments may be necessary in time.

Healthy cities programme

The idea of 'healthy cities' took off in the mid-1980s, following a Canadian conference 'Beyond Health Care Conference' that focused on community health promotion. The idea was quickly taken up by WHO which launched an initiative in 1988 to protect and promote the health of people living in urban environments. With over half the world's population living in large cities and towns by 2007, and rapid

urbanization continuing apace, the Healthy Cities Programme soon became a worldwide movement.

The Healthy Cities Programme is widely described as a success story. Each phase of the movement has seen a steady increase in the number of supporting cities to over 3000 worldwide in 2003. Regional networks, in turn, have also been formed to support the work of local communities. This is reinforced globally by the International Health Cities Foundation and an international conference held regularly since 1993. The distinct features of the Healthy Cities movement, in terms of governance, have been its holistic approach to health promotion and its partnerships with a diverse range of actors at multiple policy levels. Building on the principles of Health for All, and the concept of environmental sustainability, the initiative recognizes that:

> A healthy city is one that is continually creating and improving those physical and social environments and expanding those community resources which enable people to mutually support each other in performing all the functions of life and in developing to their maximum potential (Hancock and Duhl, 1988).

Based on this vision, WHO set a common agenda that could be used for promoting local action by individuals, households, communities, NGOs, academic institutions, commercial businesses and governments.

While Healthy Cities has proven effective at mobilizing diverse interests around an agreed health goal, Awofeso (Awofeso, 2003) argues that this success so far 'has largely been confined to industrialized countries'. It is argued that larger scale health risks such as poverty, urban violence and terrorism, skeletal urban infrastructure in poor countries, and impacts of 'capitalist globalization' have as yet been inadequately addressed. Moreover, the evidentiary base and generalizability as a global movement to local contexts remain unclear. As such, Awofeso concludes that the 'Healthy Cities approach is unlikely, in its present form, to remain a truly effective global health promotion tool this decade'.

This example suggests that global health promotion can be successfully initiated with a clear and shared vision and effectively built through engagement with relevant stakeholders. Unlike the baby milk code, powerful vested interests were not overtly challenged in this case. Achieving truly global impact, however, may require careful reflection on its relevance to diverse and underserved populations. A further progression of the movement might then be launched, with adapted evidence-based goals, resources and actions.

Framework convention on tobacco control

The scale of the emerging tobacco pandemic (predicted 10 million deaths annually by 2030) led WHO to initiate the FCTC in 1998. While ostensibly an international treaty between national governments, the increasingly global nature of the tobacco industry and the consequent shift of the health burden to 'emerging markets' in the developing world (70% of expected deaths by 2030) convinced WHO of the need for a global approach to health promotion. As Yach (Yach, 2005) describes, 'The rationale for the FCTC was to address the transnational aspects of tobacco control as it strengthens and stimulates national actions. Issues such as illicit trade, controls on cross border marketing and international norms for product regulation...' Similarly, the then WHO Director-General Gro Harlem Brundtland (Brundtland, 2000) stated,

> The Framework Convention process will activate all those areas of governance that have a direct impact on public health. Science and economics will mesh with legislation and litigation. Health ministers will work with their counterparts in finance, trade, labour, agriculture and social affairs ministries to give public health the place it deserves. The challenge for us comes in seeking global and national solutions in tandem for a problem that cuts across national boundaries, cultures, societies and socio-economic strata.

One of the key governance innovations during the negotiation and implementation process has been the contribution of civil society groups. These inputs have been largely organized around the Framework Convention Alliance, a

> heterogeneous alliance of non-governmental organizations from around the world who are working jointly and separately to support the development, signing, and ratification of an effective Framework Convention on Tobacco Control (FCTC) and related protocols. The Alliance includes individual NGOs and organizations working at the local or national levels as well as existing coalitions and alliances working at national, regional, and international levels (Collin *et al.*, 2005).

As well as accelerating accreditation of NGOs with 'official relations with WHO', the scope of involvement widened to allow access to open working groups. Perhaps more important than the formal terms of participation has been the ability of NGOs to play a number of key supporting roles. These include informing delegates (e.g. seminars and briefings), lobbying, publishing reports on key issues (e.g. smuggling) and even serving on national delegations.

The focus since the FCTC came into effect in February 2005 has been on subsequent implementation within countries. The evidence to date suggests that the treaty, so far signed by 192 countries and ratified by 60, has been an effective catalyst for putting tobacco control much higher than ever before on policy agendas in many countries. The sustained effort to achieve this over the past seven years, culminating in the FCTC, has more recently been followed by a potential decline in interest due to a perception that tobacco control is now 'done'. With individual protocols to negotiate and the actual implementation of policies in member states, the task is clearly far from complete.

> Unfortunately, governments and international agencies run the risk of becoming complacent. For many, the FCTC is done, tobacco control has an answer and the rest will follow. Nothing could be more dangerous than that premise. In fact, if we are not alert and active, the FCTC could turn into yet another treaty gathering dust in ministries and academic institutions around the world (Yach, 2005).

The decision by Gro Harlem Brundtland to step down as WHO Director-General in 2003, after a single term, has invariably meant a loss of global leadership on the issue, despite reassurances by her successor, the late J. W. Lee, that tobacco control remains a high priority. Tobacco control advocates worldwide now face the challenge of keeping the attention of the donor community from shifting to the next 'priority' on an already crowded global health agenda.

This example suggests that, like the Healthy Cities Programme, a worldwide health promotion movement requires strong high-level leadership and clearly defined goals. WHO was successful, perhaps even more so than for the baby milk code, in taking on a powerful industry despite strong opposition from vested interests. The role of civil society was critical to the FCTC negotiation process, mobilized into an effective global social movement. Efforts were made to include pharmaceutical companies (manufacturers of nicotine replacement therapy), although involvement by the tobacco industry itself was restricted to submissions to public hearings along with other stakeholders. The industry's production and marketing of tobacco as harmful products, its rapid and unapologetic spread into 'emerging' markets, along with evidence of covert efforts to undermine WHO and the FCTC process, precluded the acceptability of 'partnership'. How sustainable the FCTC will be, as a pillar of GHG around which governmental organizations and NGOs can rally, will depend on the degree to which this global initiative can now become entrenched in regional, national and local level institutions.

Global strategy on diet and nutrition

Lessons learned during the FCTC negotiations have begun to be applied to tackle another major contributor to the looming non-communicable disease burden (60% of deaths worldwide)—poor diet and nutrition. Similar to tobacco control, health promoters face powerful vested interests who dominate world food production and consumption. A draft WHO Global Strategy on Diet, Physical Activity and Health, endorsed by the WHA in 2004, was supported by a range of organizations including the International Union Against Cancer (UICC), International Diabetes Federation and World Heart Federation. However, the US government, reportedly under pressure from the domestic food lobby led by sugar producers, argued against stronger regulation, citing the importance of individual responsibility for lifestyle choices.

The document eventually adopted in May 2004 was described as 'a milder final draft' resulting from 'a diplomatic high-wire act to silence its critics and win worldwide support' (Zarcostas, 2004). In defending its need to consider almost 60 new submissions, WHO officials described the need for a 'balanced' approach that 'takes into account political realities' (Zarcostas, 2004). While parallels were drawn with the FCTC, as Yach Yach, 2003 stated, 'food is not tobacco. The food and beverage industries are a part of the solution'. Fuelling the political battle has been a perception of scientific uncertainty. Despite alarming upward trends in obesity and diet-related ill-health, the

evidentiary base for underpinning global guidelines on diet and nutrition has remained keenly fought over. The multiplicity of factors contributing to poor diet and nutrition, and the need for a better understanding of what policy interventions are most effective to address them, has made policy discussions fraught with complexity compared to tobacco control. This task has been made more difficult by industry-funded claims that recommended daily intakes of salt, sugar and fat are unnecessary. As Yach *et al.* (Yach *et al.*, 2005) advise, 'Undertaking research necessary to close the remaining knowledge gaps is therefore important to eliminate any persistent uncertainty, particularly with regard to the health effects of obesity'.

The ongoing tussle over a global dietary strategy contrasts with the Move for Health Initiative adopted by the World Health Assembly (WHA) in 2002 to promote increased physical activity. Described as 'driven by countries', implementation has sought to involve a wide range of 'concerned partners, national and international, in particular other concerned UN Agencies, Sporting Organizations, NGOs, Professional Organizations, relevant local leaders, Development Agencies, the Media, Consumer Groups and Private Sector' (WHO, 2003). The initiative is described as offering core global messages to partner organizations, but allowing flexible implementation at local, national and regional levels.

Importantly, unlike the FCTC and guidelines on diet, this initiative does not face strong vested interests in the same direct way. This has allowed public health organizations to engage a wider range of partners than available to tobacco control advocates, for example. Indeed, many private companies have begun to support the initiative, possibly as a means of demonstrating corporate social responsibility (Figure 1), but ostensibly to prevent stronger regulation and product liability litigation (Mello *et al.*, 2003). Such 'partnerships' have not been without criticism. In the UK, with the fastest growing obesity rates in Europe, it was reported that the food industry agreed in 2004 to contribute millions of pounds to the creation of a National Foundation for Sport 'if they want to avoid stricter regulation' of food advertising, marketing and labelling (Winnett and Leppard, 2004). The supermarket chain Sainsbury's has introduced the Active Kids voucher scheme to provide schools with sports equipment. However, Cadbury's Get Active initiative, supported by the British sports minister, has been criticized for requiring schoolchildren to spend over £2000 on chocolate (almost one and a quarter million calories) to earn a set of volleyball posts (Food Commission, 2003). The use of sports personalities to promote unhealthy food options has also been criticized.

This example suggests that global health promotion on diet and nutrition faces difficult challenges. It must improve the evidentiary base and build necessary but appropriate partnerships with the food and beverage industry. The public health community should be aware of

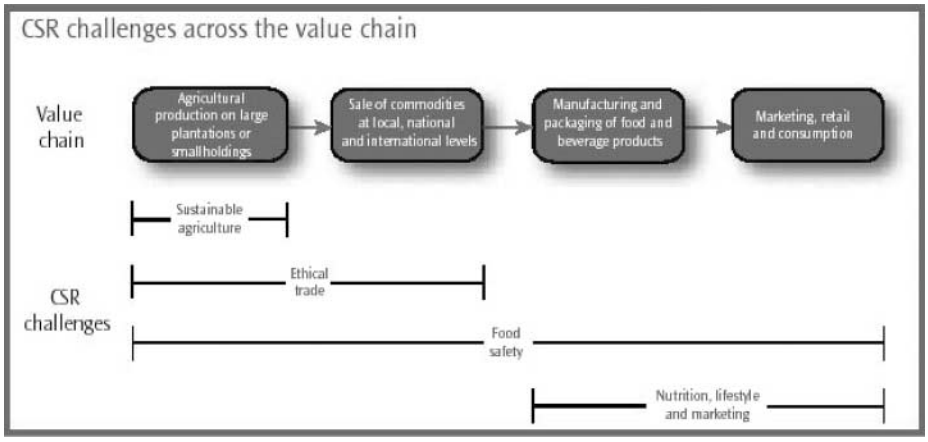

Fig. 1: Corporate social responsibility challenges across the food and beverage industry value chain. *Source:* Prince of Wales International Business Leaders Forum, *Food for Thought: Corporate social responsibility for food and beverage manufacturers*. London, 2002.

strategies to undermine such efforts by vested interests, with some parallels to the FCTC process. Nonetheless, there are limitations to applying the interventions used in tobacco control to a global strategy on diet. Most notably, tobacco is inherently harmful to health, while food intake is necessary to life. Excluding the food and drink industry from policy development and implementation would therefore seem inappropriate. Fuller understanding of effective health promotion activities is needed, accompanied by efforts to build a broad global network of supporting institutions, with clearly agreed criteria of acceptable collaboration.

STRATEGIES FOR BUILDING A GLOBAL APPROACH TO HEALTH PROMOTION

This brief overview of global health promotion offers a number of lessons for future action.

First, *a global approach to health promotion should seek to draw on a wide range of governance instruments, from voluntary codes to binding legislation.* Not all of these instruments will be available at various policy levels. For instance, legally binding regulations at the regional and international level require careful negotiation vis-à-vis principles of state sovereignty. Where agreement to binding measures are not possible, 'softer' forms of governance (e.g. declarations of principles or codes of practice) may need to be relied upon to draw public attention to an issue, lend symbolic value to a health promotion movement or serve as the basis for public education. In some cases, stronger regulatory measures may unavoidably be needed, with 'teeth' to ensure compliance, when dealing with strong vested interests. Moreover, different instruments or combinations of instruments will be appropriate for different contexts and at different points in time.

Second, *ensuring the effectiveness of governance instruments for global health promotion requires careful attention to implementation in the medium to longer term*. High-profile global initiatives are increasingly numerous, but have stumbled over insufficient attention to ensuring sufficient capacity, political will, resources and leadership to implement from the local level upwards. The 'eight capacity wheel' (Catford, 2005) for assessing national capacity for health promotion, supported by the Bangkok conference, suggests stark shortfalls in many countries, as well as at the global level. The existing picture is highly fragmented. If global health promotion initiatives are to prove effective, far greater attention to supporting them through skilled personnel, an authority base and social agreement about the need and approaches for implementation are essential.

Third, *careful reflection on the nature and appropriateness of partnerships for global health promotion is needed.* In principle, 'broad based, well networked, vertical and horizontal coalitions' (Yach *et al.*, 2005) are intuitively attractive. The building of 'partnerships' for global health promotion across a broad spectrum of institutions and interests has been an important and popular development (Wemos Foundation, 2004). However, the process of formulating such partnerships requires critical reflection. Partnerships can become overly inclusive, hampered by complex working relationships and an insufficient basis for working together. Conversely, partnerships can be too exclusive, failing to recognize the need for a broad social movement or policy advocacy. The abundance of partnerships created to date offer fertile ground for drawing wider lessons. For example, Thomas and Weber (Thomas and Weber, 2004) describe recent efforts to mobilize global resources for HIV/AIDS as 'focused on piecemeal investments based on loans, discounts, or donations'.

> The piecemeal approach...is often presented in the language of partnerships. A key problem with these 'partnerships' is that they are not based on substantive conceptions of equality that underpin, for instance, the health for all ideal, and that those in whose interests they are avowedly developed are in general excluded from their negotiation. For serious partnerships to develop, developing countries must be fully involved in deliberations with companies and UN organizations.

In other words, if partnerships are critical to addressing the challenges posed by globalization to health, there is a need to understand when such partnerships are appropriate, what the membership should be, how partners should work together and what governance instruments are needed to regulate them.

Fourth, *there is a need for better understanding of effective policies for harnessing the positive influences of globalization, and countering the negatives.* This must be based on better knowledge of the interconnections between global

(macro) level influences and everyday lives at the individual and community levels. This should include understanding of the ways global forces influence decisions about lifestyle and health. This is well understood, for example, by large transnational corporations employing powerful marketing techniques to build global markets (e.g. branding and sponsorship). Health promotion policies could harness such strategies and use them to create counter influences.

Fifth, and related to the above points, *there are a number of research areas that require attention to underpin a global approach to health promotion.*

- A fuller assessment of what governance instruments have been used, in what contexts, and their degree of effectiveness than can be provided in this brief analysis is needed. When is it necessary and possible to apply certain instruments? Should instruments used be changed over time and when is this appropriate?
- The ingredients for effective implementation of global health promotion initiatives require fuller understanding. What does capacity for global health promotion mean in terms of resources, skills, leadership and political will? How can we build capacity for global health promotion at various levels of health governance?
- A critical review of partnerships for global health promotion is needed. What partners are (in)appropriate for which issues? What roles should partners play in such collaborations? How can partnerships improve their transparency and accountability?
- A broader review of how well health governance is working to address the challenges of globalization is needed. While there has been some limited analysis of specific governance mechanisms, an overall assessment of the system as a whole (GHG architecture), and how it can be improved, is needed to take account of significant governance changes since the early 1990s.

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GLOBALIZATION FOR HEALTH

Health as foreign policy: harnessing globalization for health

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SUMMARY

This 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 Secretary-General's United Nations (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.

Key words: global public goods; global governance; foreign policy; United Nations reform

INTRODUCTION

The Sixth Global Conference on Health Promotion held in Bangkok, Thailand, in August 2005 reaffirmed the values, principles and purposes of the health promotion movement that stretches back nearly two decades (Bangkok Charter, 2005). As the Bangkok Conference and Charter recognized, 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 paper focusses on one transformation that affects health promotion—public health's rise as a foreign policy issue in international relations.

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' (Ottawa Charter, 1986). 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.

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

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.

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' (Ottawa Charter, 1986).

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 (Kickbusch, 2003; Lee and Zwi, 2003), treating it as a non-political matter best left to technical specialists (Haas, 1964). 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 increasingly interdependent world.

HEALTH PROMOTION AND FOREIGN POLICY: THE NEW CONTEXT

The decision to focus attention on foreign policy at the Bangkok Conference, and to include in the Bangkok Charter an express linkage between health promotion and foreign policy (Bangkok Charter, 2005), 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.

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 (Adelaide Recommendations, 1988). 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 (Table 1).

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 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

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 policy-making 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

Table 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 against 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
WHO negotiation, adoption and entry into force of the Framework Convention on Tobacco Control
WHO global strategy on diet and nutrition
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
World Bank emerging as major player in global health
Commission on Macroeconomics and Health
Public health and human rights issues
Re-invigoration 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 (MDGs)
Global Fund to Fight AIDS, Tuberculosis and Malaria
Roll Back Malaria Campaign
Stop TB Partnership
WHO's '3 by 5' Initiative
US President's Emergency Plan for AIDS Relief
Doha Declaration on the TRIPS Agreement and Public Health
Global Health Security Initiative
Revision of the WHO's International Health Regulations (IHR)

policy—policy that organizes the state's relations with other sovereigns.

Historically, public health has predominantly been a domestic policy concern (Cheek, 2004); 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

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.

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.

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 (Weber, 1997), 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 (Figure 1). 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.

Public health's subordination in foreign policy 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.

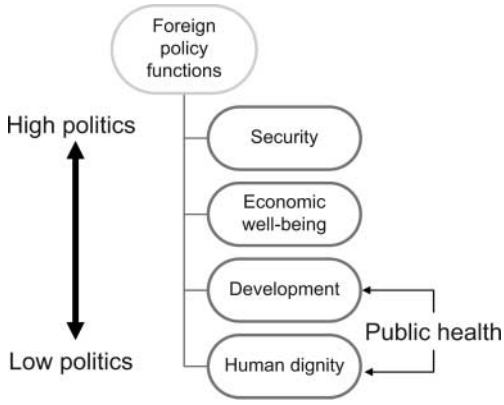

Fig. 1: Traditional hierarchy of foreign policy governance functions.

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 (Commission on Macroeconomics and Health, 2001). 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 (Table 2).

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.

UNITED NATIONS REFORM, FOREIGN POLICY AND HEALTH PROMOTION

One can appreciate this transformation by examining the United Nations (UN) Secretary-General's proposals for UN reform. Reform of the UN 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* (UN Secretary-General, 2005).

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), three of which

Table 2: Public health examples with respect to each foreign policy governance function

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 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's MDGs 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

target specific health problems (child mortality; maternal health and HIV/AIDS, malaria and other diseases) and four of which seek improvement in key health determinants (poverty and hunger, universal primary education, gender equality and environmental sustainability) (UN Millennium Development Goals, 2000). The eighth MDG (develop a global partnership for development) targets cooperation with pharmaceutical companies to provide access to affordable, essential medicines in developing countries (UN Millennium Development Goals, 2000).

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 (UN Secretary-General, 2005). Strengthening global infectious disease surveillance and increasing research on the special health needs of the poor are global priorities in realizing freedom from want (UN Secretary-General, 2005).

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' (UN Secretary-General, 2005, para. 105).

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' (UN Secretary-General, 2005, para. 148). 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' (UN Secretary-General, 2005, para. 15).

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, economic well-being, 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

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.

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.

Opportunities do not come without risks, and health as foreign policy is no exception (Table 3). One danger is that states will use

Table 3: Opportunities and risks: the Framework Convention on Tobacco Control and the new IHR

Opportunities	Risks
Framework convention on tobacco control The WHO Framework Convention for Tobacco Control (FCTC) (World Health Organization, 2003), which entered into force in 2005, constitutes a seminal effort to use treaty law for health promotion purposes. The FCTC, and the process that produced it, have elevated prevention and control of tobacco-related diseases on public health and foreign policy agendas around the world. Further, the Bangkok Charter itself highlighted the FCTC as a leading example of how to make health promotion central to the global development agenda.	The negotiation and adoption of the FCTC highlighted tensions that health as foreign policy faces. The FCTC process had to address concerns from powerful states concerning the potential impact of the FCTC on trade rules in the World Trade Organization. In addition, WHO and its FCTC partners had to deal with the tobacco industry's cooperation with certain states to defeat or dilute the treaty. Finally, concerns have been expressed that, with the FCTC now in force, the global movement on prevention and control of tobacco-related diseases has lost momentum and has been overshadowed in foreign policy by threats from communicable diseases.
New international health regulations The new International Health Regulations (IHR), adopted in May 2005 by the World Health Assembly (World Health Assembly, 2005), also illustrate the opportunities 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.

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. Producing what Yach and Bettcher (1998) called the convergence of self-interest and altruism will remain a difficult challenge.

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, whereas health promotion remains neglected.

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.

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.

HEALTH PROMOTION AND FOREIGN POLICY

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.

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 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 (Figure 2).

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.

Health as foreign policy offers health promotion opportunities to engage non-governmental

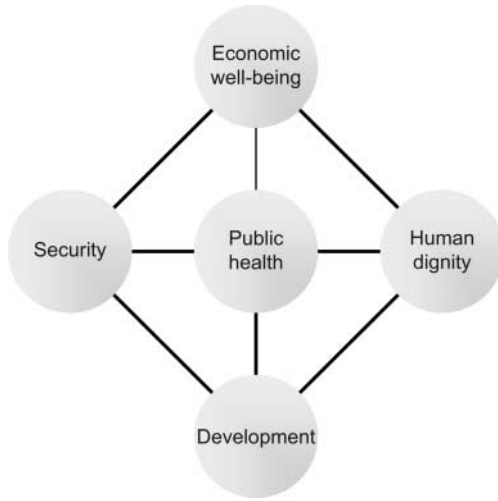

Fig. 2: Public health as an integrated public good.

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

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, and the Bangkok Charter's call for health promotion to 'become an integral part of … foreign policy and international relations' (Bangkok Charter, 2005) recognizes the new context and reality in which health promotion must operate.

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.

The increased intersections between public health and foreign policy generate risks for the health promotion effort, which include the need for the health promotion community to work to help solidify public health's development into an integrated public good. This task will not be easy because it represents a significant shift in emphasis, but comprehensive implementation of the Bangkok Charter requires meeting this challenge. 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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GLOBALIZATION FOR HEALTH

Trade in health services in the ASEAN region

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SUMMARY

Promoting quality health services to large population segments is a key ingredient to human and economic development. At its core, healthcare policymaking involves complex trade-offs between promoting equitable and affordable access to a basic set of health services, creating incentives for efficiencies in the healthcare system and managing constraints in government budgets. International trade in health services influences these trade-offs. It presents opportunities for cost savings and access to better quality care, but it also raises challenges in promoting equitable and affordable access. This paper offers a discussion of trade policy in health services for the ASEAN region. It reviews the existing patterns of trade and identifies policy measures that could further harness the benefits from trade in health services and address potential pitfalls that deeper integration may bring about.

Key words: healthcare services; international trade; ASEAN economic integration; labor mobility

INTRODUCTION

The performance of a country's health sector is critical for the well-being of its citizens. Caring for sick workers preserves a country's stock of human capital, laying the foundation for sustained economic growth. The provision of health services also has important public good characteristics, in particular when it comes to containing the spread of infectious diseases such as HIV/AIDS, tuberculosis and malaria.

Given the centrality of health to human well-being, policy reform discussions in the health sector tend to be of a sensitive nature. Many countries have inscribed a basic right to healthcare in their constitutions, sometimes mandating the provision of services free of charge. Health services are not viewed as a tradable commodity that can be subject to global market forces.

Notwithstanding these sensitivities, healthcare policy does involve serious economic choices. Few countries can afford state-of-the-art healthcare for every citizen. Choices about what kind of health services are provided to which segments of the population have to be made—explicitly or implicitly. At their core, these choices involve complex trade-offs between promoting equitable and affordable access to a basic set of health services at minimum quality, creating incentives for efficiencies in the healthcare system, and managing constraints in central and state-level government budgets. International trade in health services influences these trade-offs. It can present opportunities for cost savings and access to better quality care, but it can also raise challenges in promoting equitable and affordable access.

Against this background, this paper offers a discussion of trade policy in health services for the ASEAN region. It draws on a set of national research studies that were conducted by researchers of the ASEAN Economic Forum. These studies covered seven of the 10 ASEAN countries: Cambodia (Chea, 2005), Indonesia, Laos (Leebouapao, 2004), Malaysia (Akhmad, 2005; Abidin *et al.*, 2005), the Philippines, Thailand (Avila and Manzano, 2005; Arunanondchai, 2005) and Vietnam

(Thang, 2005). In view of its economic importance, Singapore is also included in this paper, drawing on information available from the seven country studies as well as publicly available data.

Trade in health services is already an important phenomenon in the ASEAN region. To a large extent, this trade occurs outside the framework of existing trade agreements. At the same time, ASEAN governments have established a framework for progressively liberalizing trade in services and, in particular, have identified healthcare as a priority sector for region-wide integration. Therefore, a key aim of this paper is to identify the policy measures that would harness the benefits from trade in health services and address potential pitfalls that deeper integration may bring about.

The paper is structured as follows. The next section will introduce the concept of international trade in health services and review the patterns of existing trade in the region. The section the gains and pitfalls from trade in health services will outline the gains that further trade liberalization could offer and also point to possible pitfalls that expanded trade may hold. The following section discusses several policy implications and makes several recommendations for policy initiatives that ASEAN countries could pursue. The final section offers concluding remarks.

CURRENT TRADE PATTERNS IN THE ASEAN REGION

Trade discussions in services typically adopt a wide definition of what constitutes trade, involving the following four modes of supply.

- *Mode 1: cross-border supply*. This mode of supply is akin to traditional goods trade, whereby suppliers and consumers are located in different countries.
- *Mode 2: consumption abroad*. International trade also takes place when the consumer moves to the country of the supplier.
- *Mode 3: commercial presence*. This mode of supply describes the situation whereby producers, in the form of juridical persons (or companies), move to the country of the consumer.
- *Mode 4: movement of individual service providers*. Similar to Mode 3, this mode of supply describes the situation whereby the producer moves to the country of the consumer, but the producer takes the form of a natural person (or individual). Mode 4 trade typically captures the movement of service workers that is of a temporary nature and does not involve permanent migration.

Remarkably, current trade patterns of countries in the ASEAN region involve all four modes of supply.

Mode 1: cross-border supply

In the ASEAN region, Philippines have started to export medical transcription services to the USA. Philippine's comparative advantage in medical transcription is explained mainly by its pool of educated English-speaking workers. Transcriptionists are usually medical school college graduates who work part time while preparing for Philippine's board exams. Interestingly, the majority of the 25 companies exporting these services in 2004 were owned by US investors. Indeed, the Philippine Government offers special incentives for foreign direct investment (FDI) in this sector. Although exports are still small in absolute value ($10 million in 2004 by a rough estimate), they hold substantial growth potential. For example, current exports to the USA still account for less than 1% of the $13 billion spent on medical transcription in the USA per year.

Mode 2: consumption abroad

Several ASEAN countries have become significant exporters of 'health tourism' services. These are chiefly Malaysia, Singapore and Thailand. Table 1 presents information on export revenues and the number and origin of foreign patients for these countries. Thailand is the largest exporter in the region, followed by Malaysia and Singapore. Interestingly, in the case of Singapore and Malaysia, the majority of foreign patients come from other ASEAN countries (mainly Indonesia), whereas in the case of Thailand only 7% of foreign patients are from the ASEAN region. For Thailand, Japanese nationals account for the largest share of foreign patients.

The competitiveness of Malaysian, Singaporean and Thai hospitals primarily stems from two factors. First, they can offer medical

Table 1: Export of health tourism services

	Export revenues	Number of patients	Origin of patients
Malaysia (2003)	RM 150 million ($40 million)	More than 100 000	60% from Indonesia, 10% from other ASEAN countries
Singapore (2002)	$420 million	210 000	45% from Indonesia, 20% from Malaysia, 3% from other ASEAN countries
Thailand	Around 20 billion baht in 2003 ($482 million)	470 000 (2001) 630 000 (2002)	42% from the Far East (mostly Japan), 7% from ASEAN countries

Sources: Singapore Tourism Board, Abidin *et al.* (2005), Arunanondchai (2005).

services at significantly lower price compared to developed countries (Table 2). Differences in labor costs are likely to account for much of the observed price differences. Second, hospitals in Malaysia, Singapore and Thailand have established a reputation for high quality services. In Thailand, service quality has been explicitly promoted by an accreditation system administered by a dedicated government agency. A related aspect is that Malaysian, Singaporean and Thai hospitals can offer specialized services not available in other, especially poorer, ASEAN countries.

For a number of medical treatments, hospitals from Malaysia, Thailand and Singapore directly compete with each other. The price comparisons in Table 2 suggest strong competition, in particular, between Thailand and Malaysia.

Interest in developing the health tourism industry has also emerged in Philippines. The country benefits from a pool of well-qualified and English-speaking medical professionals. Hoping to build on these advantages, the Government included health tourism in its 2004 Investment Priorities Plan.

As for the low-income ASEAN countries, Vietnam also exports some health services, mainly to neighboring Cambodia. Nonetheless, most Cambodian patients seeking treatment abroad choose hospitals in Thailand and Singapore. Several private hospitals in Cambodia make a business of facilitating treatment in foreign hospitals. Similar services are also provided by independent agents at Cambodia's borders.

Table 2: Price comparisons (US$, 2001)

	Coronary by-pass graft surgery	Single private hospital room per night
Malaysia	$6 315	$52
Singapore	$10 417	$229
Thailand	$7 894	$55
United Kingdom	$19 700	n/a
United States	$23 938	$1351

Source: Abidin *et al.* (2005).

Mode 3: commercial presence

There is limited foreign participation in the private sector healthcare segment in six of the seven ASEAN countries studied (Laos being the only exception). For example, in Indonesia, foreign hospitals are estimated to account for only 1% of total hospital beds (Timmermans, 2002). In Philippines, only two of 19 Health Maintenance Organizations (HMOs) are foreign-owned. In Thailand, foreign investment is estimated to account for only 3% of total investment in private hospitals in Thailand. Some foreign presence also exists in Cambodia and Vietnam, though no information is available on the market shares of foreign hospitals. Across all countries in the region, foreign-owned healthcare facilities cater to the middle and upper income population segments and are mostly found in urban areas.

Foreign investment appears to originate both from within and from outside the ASEAN region. In Cambodia, most foreign hospitals are of Chinese origin. Among ASEAN countries, Singapore and Thailand, in particular, have emerged as outward investors in the healthcare sector. For example, Parkway Group Healthcare, the biggest investment group in the healthcare sector in Singapore, has set up joint ventures with hospitals in India, Indonesia, Malaysia, Sri Lanka, and the United Kingdom. Bumrungrad Hospital in Thailand has entered

into management contracts with hospitals in Bangladesh and Myanmar and has formed a joint venture with a hospital in Philippines. Bangkok Hospital has established 12 branches in Southeast and South Asia, locating primarily in tourist towns.

Mode 4: movement of individual service providers

The ASEAN region hosts two of the world's largest exporters of healthcare workers. Philippines and Indonesia send large numbers of nurses and midwives to countries around the world. This form of trade is driven by a growing supply of well-educated professionals in these two countries and shortages of healthcare workers in richer economies. Demographic pressures and rapidly rising healthcare costs in developed countries are likely to increase the demand for healthcare professionals from lower wage economies in future.

In the case of Philippines, the number of nurses working abroad is estimated to be around 87 000. Unfortunately, no statistics are available on the number of returning nurses. The main export destinations are outside the ASEAN region. They include Ireland, Kuwait, Libya, Saudi Arabia, the United Arab Emirates, the UK and the USA. Hospitals and specialized recruitment agencies in these countries directly source their nurses from the Philippine's labor market. Over the past few years, there has been a sharp increase in the number of medical schools offering nursing degrees. Several of these schools have adapted their course curricula to the needs of foreign markets. So far, there have been few concerns about domestic shortages of nurses in Philippines, as there has always been a sufficient supply of newly graduating nurses.

For Indonesia, the main export destinations are other Islamic countries, especially countries in the Middle East (Saudi Arabia, United Arab Emirates) but also Malaysia and Singapore. Language and cultural affinity account for this geographic export pattern. Concerns about exports leading to domestic shortages are more pronounced than in Philippines, as Indonesia's healthcare system is chronically understaffed.

Within ASEAN, the main host economies for foreign healthcare workers are Malaysia and Singapore and, to a lesser extent, Thailand. Interestingly, Malaysia is both a recipient and a sender of healthcare workers, with Malaysian hospitals hiring mainly Indian and Filipino nurses and Malaysian nurses working in Singapore and Saudi Arabia. In 2001, there was a net outflow of about 450 nurses, which represented less than 3% of total nurses employed. The same holds for medical doctors. Over the past decade, private and public hospitals have hired several hundred foreign doctors and medical specialists, partly to address a serious domestic shortage of doctors. At the same time, a significant number of Malaysian doctors have moved to higher wage countries—in particular, to Singapore.

THE GAINS AND PITFALLS FROM TRADE IN HEALTH SERVICES

As pointed out in the introduction, trade in health services creates both opportunities and risks. This section will review the key economic effects from greater openness in healthcare. Since these effects depend on the way in which services are supplied internationally, the discussion will proceed along the four modes of supply introduced in the section current trade patterns in the ASEAN region.

Cross-border trade and consumption abroad (Modes 1 and 2)

Patients who seek medical treatment abroad and hospitals which outsource medical transcription to foreign service providers can realize significant cost savings. One recent study, for example, estimated that the USA would save $1.4 billion annually if only one in 10 patients were to go abroad for a limited set of low-risk treatments (Mattoo and Rathindran, 2005). Countries that export health services realize gains from specialization, allowing them to employ their capital and labor where they are most efficient and generating export revenues for the import of other goods and services.

A second important benefit from trade is greater choice. Patients from poorer ASEAN countries and elsewhere are able to undergo treatment for certain conditions not available in their home countries.

Notwithstanding these efficiency and choice gains, trade also has adverse effects. Any economic activity that experiences rapid growth due to export expansion will become dearer in the domestic economy. Even if economies as a

whole gain, export expansion in the health sector may have important distributive consequences for domestic patients. In addition, the public good characteristic of healthcare alluded to in the introduction raises the question of whether economies as a whole could even be worse off by rapidly expanding health tourism exports.

Distributive concerns are particularly relevant for Malaysia and Thailand. In Thailand, private hospitals that treat foreign patients do not participate in social health insurance schemes. Since they generate more revenue per patient, they can offer higher salaries to medical staff. This has diverted medical personnel away from public hospitals and private hospitals that serve Thai patients only (many of which participate in social health insurance schemes). By one estimate, an extra 100 000 patients seeking medical treatment in Thailand leads to an internal brain drain of between 240 and 700 medical doctors (Pannarunothai and Suknak, 2004). This has exacerbated shortages of medical professionals in Thailand, especially in the public sector and in rural areas. A related concern is that tertiary medical education in Thailand is provided by the public sector. Private exporting hospitals hire from the same pool of doctors as public hospitals, yet they do not share the costs of medical education.

Similar concerns exist in Malaysia. The inflow of foreign medical professionals has not alleviated domestic shortages in medical personnel (partly because Malaysian doctors and nurses have gone abroad, too). Greater numbers of foreign patients seeking treatment in Malaysia would put further pressures on the domestic healthcare system.

Commercial presence (Mode 3)

Foreign investment in hospital and related services can contribute in various ways to the reach and quality of health services. It may relax domestic capital constraints and alleviate supply shortages in the domestic healthcare system. Foreign hospitals may bring advanced medical knowledge and specialized equipment, offering new treatments to domestic patients. Foreign entrants may also transfer valuable organizational skills and managerial know how, gained through experience abroad. Being part of multinational hospital networks offers additional benefits. Bangkok Hospital, for example, cites increased bargaining power vis-à-vis suppliers of medical equipment and improved quality control mechanisms as key advantages of operating a large network of hospitals. The contribution of FDI could be especially important in the poorer ASEAN economies with underdeveloped health systems. This explains why Cambodia, Laos, and Vietnam impose few policy barriers to the establishment of foreign hospitals, though the small size of their healthcare market remains a binding constraint to attracting more FDI.

The more controversial aspect is to what extent foreign investment may exacerbate inequalities in the domestic healthcare system. As described above, foreign hospitals typically cater to middle and upper income patients and almost exclusively locate in urban areas. That also means they can offer the most attractive pay package to medical professionals, leading to the internal brain drain phenomenon discussed earlier. There is no evidence, however, whether such adverse effects have been important in the ASEAN economies studied. That may, partly, be because the extent of foreign participation in countries' healthcare sectors has so far been small. In addition, existing healthcare systems are often tilted towards more affluent patients who can afford private medical services. Foreign entry may thus, indeed, worsen inequality, but it would not necessarily affect access to the health system by those patients who rely on public provision or public insurance schemes. A related consideration is that foreign entry may induce domestic patients who in the past sought medical treatment abroad to stay at home. Again, such an outcome would worsen inequitably in the national provision of healthcare, but it would not necessarily worsen inequality in the consumption of health services by domestic patients.

In the end, the net contribution of foreign investment to equity and access also depends on the type of foreign entry and accompanying policy choices. If entry takes the form of acquisition and domestic medical personnel is scarce, internal brain drain effects may be more pronounced. In contrast, if foreigners build new hospitals and bring along doctors and other medical staff, their investment may help alleviate pre-existing shortages.

Movement of healthcare workers (Mode 4)

The movement of health workers from low-wage countries to high-wage countries can

improve economic efficiency. For receiving countries, the benefit usually takes the form of alleviating shortages of domestic medical personnel—a growing problem in many middle and high income countries. For the sending countries, the welfare effects depend crucially on where foreign healthcare workers spend their income. If a significant share of earnings is remitted home, as is the case for Filipino nurses working abroad, the sending country is likely to benefit, too. Otherwise, the sending country will experience a net economic loss.

Another important question is how the outflow of healthcare workers affects the supply of medical personnel in the sending countries. As described in the previous section, the outflow of nurses from Philippines has so far not led to any domestic shortages. In contrast, the net outflow of nurses from Indonesia and Malaysia seems to have exacerbated already existing shortages of nurses in the country.

Finally, a key consideration for the sending country is whether the movement of healthcare workers is of a temporary or permanent nature. If nurses and doctors return to their home countries after a number of years, concerns about domestic supply shortages may be less severe. Returning medical professionals may also bring back with them new skills and capital. If, in contrast, labor movement is permanent, there is the risk of substantial human capital losses with damaging long-term effects on social and economic development.

POLICY IMPLICATIONS

Trade policy in healthcare cannot be considered in isolation from domestic healthcare policy. The latter involves defining the roles or the public and private sectors in providing and financing healthcare. In doing so, governments face difficult choices. In some areas, trade reforms can be helpful in advancing objectives set by governments. In other areas, trade can make existing problems worse. Much also depends on how domestic policy reforms and trade policy reforms are sequenced. With these considerations in mind, what is the role of ASEAN in realizing the gains from deeper integration?

The ASEAN Framework Agreement in Services (AFAS) has so far not contributed to greater liberalization in the region. The four negotiating rounds under AFAS have not resulted in commitments in the health sector. Where ASEAN governments have opted for liberal trade policies, they have done so unilaterally. However, healthcare was identified as one of 11 priority sectors for integration at the 2003 Summit of ASEAN Economic Ministers in Bali.

Indeed, a regional forum may deliver quicker results for countries ready to commit to market opening in services, compared to the prolonged multilateral negotiating process at the WTO. In addition, if service providers from within the region are at an infant stage, regional market opening may, in theory, offer learning externalities that can enable these providers to become more efficient and eventually face global competition. But regional liberalization may also entail economic costs, mainly in the form of second-based service providers entering the domestic market.

There is little doubt that regional agreements can make an important contribution in the area of regulatory cooperation. Although the 10 ASEAN countries are not a homogenous group, there does appear to be scope for increased cooperation in the health sector—as is already happening in many other fields.

The national research studies for the seven ASEAN countries identified a number of specific areas for regulatory cooperation that could be pursued at the ASEAN level:

- *Promoting health tourism exports*. Notwithstanding the need for appropriate policy sequencing as outlined above, there are a number of initiatives that could expand trade within the region. First, an ASEAN-wide framework for the portability of health insurance could be developed, which would seek to address the concerns of public and private insurers in covering medical expenses occurred in other ASEAN countries. Second, the development of rules on the privacy and confidentiality of patient information would help assure patients that foreign hospitals treat such information responsibly. Third, although there is already an ASEAN initiative to promote visa-free travel among its member countries, there is scope to further minimize visa requirement for traveling patients—for example, for patients seeking treatments requiring a

stay longer than the maximum number of days allowed in tourist visas. Fourth, an ASEAN-wide system for the accreditation of high quality hospitals could be developed. This could help hospitals overcome reputational barriers to greater health tourism exports.

- *Managing the movement of healthcare workers*. An ASEAN facility could be created that would monitor shortages and surpluses of medical personnel in different ASEAN countries. This could help policymakers evaluate where the movement of healthcare workers is warranted and where it exacerbates existing shortages. In addition, a special ASEAN visa, not necessarily limited to healthcare workers, could be developed that would be truly temporary in nature. Such a visa could address concerns in host countries that foreign workers will stay permanently and, at the same time, reduce negative brain drain effects in home countries. Where the movement of healthcare workers is considered desirable, it can be actively promoted through the harmonization of professional standards and the conclusion of agreements recognizing foreign qualifications. The short term movement of medical specialists for individual treatments could be promoted by developing a framework for malpractice insurance of out-of-jurisdiction medical personnel.
- *Improving the quality of health services and medical training*. The transfer of medical knowledge could be advanced by encouraging exchanges of hospital staff within the ASEAN region. Transfer of skills could also be promoted by region-wide training initiatives and the harmonization of course curricula, especially for new medical technologies. In the long term, cooperation on training could also contribute to increased mobility of medical personnel in the region. Finally, regulators could exchange best practices in developing and enforcing medical service standards, which could be of particular benefit to the poorer ASEAN countries.

Several of the proposed regulatory initiatives would require the direct involvement of the private sector and medical associations. The role of ASEAN governments in these cases would be to provide the forum and set the direction for cooperation among those entities. Developing regional frameworks for regulatory cooperation could help promote feasible cooperation at the bilateral level and ensure such cooperation could in the longer term be extended to other ASEAN members.

As part of ASEAN's effort to advance integration in the so-called priority sectors, the Government of Singapore has developed a Roadmap to advance the region-wide integration of the healthcare sector. The sectoral initiative in healthcare is not limited to the integration of service markets, but also encompasses the promotion of trade in healthcare goods (e.g. medical equipment, pharmaceutical products) as well as cooperation on questions of technical standards and intellectual property protection. This Roadmap was adopted by ASEAN Trade Ministers in November 2004 and incorporates many of the recommendations outlined above. Interestingly, one area that has received relatively little attention in the Roadmap is the promotion of health tourism exports. In particular, although the streamlining of visa requirements for foreign patients is recognized, no measures are proposed to promote the portability of health insurance.

As a final note, for at least some countries in the region, there are likely to be large pay-offs from pursuing such cooperation with countries outside the region. As described earlier in this paper, health services and healthcare workers are exported in large quantities to the USA, the UK, Japan and countries in the Middle East.

CONCLUDING REMARKS

ASEAN governments have set themselves the goal to progressively liberalize trade in health services in the region. From an economic perspective, opening healthcare markets promises substantial economic gains. Yet it may also intensify existing challenges in promoting equitable access to healthcare. In a way, trade may raise the stakes of domestic policy reforms. It may help focus policymakers' minds and create new opportunities for improving affordable access. But it may also lead to outcomes from which only the better-off will benefit.

Pursuing integration regionally, rather than through unilateral liberalization, holds certain advantages for ASEAN countries. Each one has

something to gain—whether the prospect of greater exports or the promise of regulatory capacity building. Still, delivering on the recently adopted ASEAN Roadmap on Healthcare will be no small feat. ASEAN's past experience in promoting deeper integration points to the difficulties posed by differences in regulatory regimes and levels of economic development. And for at least some countries in the region, there are likely to be large pay-offs from pursuing deeper integration with countries outside the region.

Economic research on the effects of liberalizing trade in health services is still in its infancy. In particular, more studies are needed which empirically assess the impact of trade reforms on key healthcare performance indicators. Such research would improve policymakers' understanding on what works in which circumstances and could thereby contribute to improving the design of trade reforms.

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GLOBALIZATION FOR HEALTH

Trade liberalization and the diet transition: a public health response

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SUMMARY

Trade liberalization remains at the forefront of debates around globalization, particularly around the impact on agriculture and food. These debates, which often focus on how poorer countries can 'trade their way' out of poverty, pay limited attention to dietary health, especially in the light of the WHO's Global Strategy for Diet, Physical Activity and Health (2004), which warned that future health burdens will be increasingly determined by diet-related chronic diseases. This article examines the diet transition as the absent factor within debates on liberalizing trade and commerce. We describe the evolution of trade agreements, noting those relevant to food. We review the association between trade liberalization and changes in the global dietary and disease profile. We illustrate some of the complex linkages between trade liberalization and the 'diet transition', illustrated by factors such as foreign direct investment, supermarketization and cultural change. Finally, we offer three scenarios for change, suggesting the need for more effective 'food governance' and engagement by public health advocates in policy making in the food and agriculture arena.

Key words: globalization; trade; food; non-communicable diseases

WORLD TRADE POLICY, AGRICULTURE AND FOOD

Over the last half-century, the volume of merchandize traded globally increased 17-fold, more than three times faster than the growth in world economic output (FAO, 2003). Agricultural trade has grown at around the same rate as world economic output, but accounts for $<10\%$ of world merchandize exports. The World Food Summit in 1996 made the case that international food trade permits consumption to exceed production and helps modulate fluctuations in supply, but it was also noted that trade competition might disrupt traditional food production systems or introduce negative environmental consequences.

Since 1994, world trade policy has been managed by the World Trade Organization (WTO), a supranational body dedicated to liberalizing (i.e. opening up) commercial interactions between nations. Member states of the WTO negotiate trade deals in a series of 'Rounds', addressing trade issues such as protectionist mechanisms (tariff and non-tariff barriers), subsidies, intellectual property, foreign direct investment (FDI), food safety and other matters once solely the province of nation states or international trade groupings. Trade policy should not be understood as simply the movement of goods across borders, but the rules affecting commerce in the broadest terms.

Until 1994, trade policy was subsumed by the loose trade 'club' of member nations known as

the General Agreement on Tariffs and Trade (GATT). The final GATT Round, the Uruguay Round (1987–1994), established the WTO and brought agriculture and food into the negotiations, leading to the Agreement on Agriculture (AoA).

As a result of the GATT, the average tariff on non-agricultural goods fell from ~40% in 1947 to 4.7% by the end of the Uruguay Round in 1993. When the WTO assumed its responsibilities, agricultural liberalization was high on its agenda. Agricultural trade has indeed increased since the AoA: total world trade in agriculture had risen to US$674 billion by 2003 (WTO, 2004). But, protectionism has actually also risen in both percentage and volume terms: in OECD countries, producers' support had reached US$279 billion by 2004 (OECD, 2005). Some have argued that this level of subsidy represents dumping on a global and systematic scale (Andersona *et al.*, 2001), explaining the decline of food exports from developing countries from ~50% of total world exports in the 1960s to <7% by 2000 (FAO, 2005).

Addressing agricultural protectionism remains prominent on the WTO agenda. The Doha Round of negotiations aimed to promote 'substantial improvements in market access' (http://www.wto.org/english/tratop_e/dda_e/dda_e.htm). Negotiations, however, have proved painfully difficult (the 1999 talks held in Seattle collapsed, as did the Cancun talks in 2003). The recent Hong Kong talks, in December 2005, became mired in complexity, although there was agreement to eliminate export subsidies by 2013.

Food trade is affected by numerous other trade agreements. The WTO Agreement on Technical Barriers to Trade (TBT) applies to food quality standards and labelling (e.g. of nutrients) and the Trade-Related Intellectual Property Rights Agreement (TRIPS) to seed patents. The agreement on the application of Sanitary and Phytosanitary Measures (SPS) has been notably important in food trade, applying to any trade-related measure taken to protect human health from unsafe food. SPS recognizes the standards set by another important trade-related text: the Codex Alimentarius (the joint WHO/FAO international food code). Reflecting the emphasis placed on food safety, SPS notifications to the WTO increased from 196 in 1995 to 855 in 2003 (Regmi *et al.*, 2005). Diet and nutrition have received negligible attention.

Trade policy is also set through 'regional trade agreements' (RTAs). In the last decade, almost 200 RTAs have been notified to the WTO. RTAs, along with 'bilateral agreements', such as the recent US–Australia Free Trade Agreement and the new Central American Free Trade Agreement (CAFTA), are becoming critically important in the face of tensions at the WTO.

TRADE POLICY AND PUBLIC HEALTH

The assumption behind trade liberalization is that open markets benefit everyone, everywhere, by inducing a virtuous cycle of economic growth. Increased trade lowers prices for consumer goods (notably food, which makes up a relatively larger proportion of the expenditures of poor people), boosts incomes of agricultural producers (comprising large segments of the populations of low-income countries) and increases relative demand for skilled labour, which, in turn, raises demand for education and public goods. It has been suggested that 40% of differential mortality improvements among countries are explained by differences in national income growth; consequently, an income rise of by just 1% in developing countries would avert as many 33 000 infant and 53 000 annual child deaths (Pritchett and Summers, 1996). From this perspective, trade liberalization is 'good for the poor' and 'good for health' (Dollar and Kraay, 2002), and although growth may increase inequality, this is outweighed by positive implications (Ravallion, 2004).

Such suggestions, say critics, have often not been borne out in reality. If some say that insufficient liberalization is to blame, others allege that trade rules favour the powerful and that policy needs to be 'pro-poor' (Oxfam, 2002). According to a former chief economist at the World Bank, the new trade rules, the adjudication process on the rules and the required domestic disciplines reflect the priorities and needs of developed countries more than developing countries (Stiglitz and Andrews, 2004). Even organizations required to promote trade in food have questioned liberalization formula, saying that trade liberalization confuses mechanisms with outcomes. The UN Food and Agriculture Organization of the United Nations (FAO) says that globalization 'does not automatically

benefit the poor' (FAO, 2000) and that market openness should not be viewed as a policy tool to achieve growth but primarily as an economic outcome. (FAO, 2003) Liberalization may prompt reductions in state expenditure in public goods, such as education or health services, which benefit the poor most (Conway, 2004). Population health may worsen if general working conditions deteriorate or if trade facilitates the transfer of disease or unhealthy consumer goods across borders. Some contest that health and social justice would be better achieved through 'deglobalization' or 'localization' (Hines, 2000; Pretty and Hine, 2001; Bello, 2004).

Amartya Sen has observed that debates around globalization often take the form of an empirical dispute about whether the poor who participate in trade are getting richer or poorer. A more fundamental question, he suggests, turns on the distribution of its benefits, which, in turn, raises broader issues about the adequacy of the institutional arrangements that shape global and national economic and social relations (Sen, 2002). Trade and trade agreements for the global food supply chain also have unequal consequences. Given that trade policy is becoming an important driver for the global food supply, national dietary patterns should not be judged by consumption volume alone but much by broader dietary and nutrition considerations, thereby raising the importance of 'food governance'—the scrutiny of the food chain to achieve public benefit.

In 2002, the WHO and WTO prepared a joint report on the public health implications of trade (WHO/WTO, 2002). This noted that trade agreements do take some account of health, permitting national trade-restrictive measures that protect human health—but only those that are the least trade-restrictive relative to any other measure. The report concluded that 'there is common ground between health and trade' (p. 137), but in the face of past disputes between health and trade, it also argued for health and trade policy 'coherence'. Although the report covered matters as diverse as intellectual property rights, food insecurity, infectious disease control and food safety, it failed to address changing diets and the rising global burden of diet-related chronic diseases (DR-CDs).

However, according to WHO Technical Report 916, international trade issues 'need to be considered in the context of improving diets' (WHO/FAO, 2003, p. 140). Certainly, trade policy proved to be one of the most contentious issues during the negotiation of the WHO's Global Strategy on Diet, Physical Activity and Health, suggesting the need for a closer look at trade.

DIET-RELATED CHRONIC DISEASES

Hitherto, public health concerns around food have focused on undernutrition and food safety. Undernutrition decreased from 28% of the global population in the 1980s to 17% in 1999–2001. The subsidies going to agriculture in OECD countries, given rising productivity, have meant that although the world's population doubled between 1960 and 2000, levels of nutrition improved markedly and the prices of rice, wheat and maize—the world's major food staples—fell by 60%. Nevertheless, FAO estimates that more than 800 million people suffer chronic undernutrition. Alongside, food safety issues remain prominent because of bovine spongeform enchphalopathy (BSE) and Avian Influenza. Chronic diseases, in contrast, are influenced by factors urbanization and changing food such as systems. As a result, there is an emerging 'dual burden': continuing malnutrition on one side and rising DR-CDs on the other.

The global burden of DR-CDs, such as obesity, diabetes, cardiovascular diseases, cancer, dental diseases and osteoporosis, is rising (WHO/FAO, 2003). Chronic diseases account for 60% of the 56 million deaths globally, with unhealthy diets being a major contributor to key risk factors (high blood pressure, high cholesterol, low fruit and vegetable intake and overweight and obesity) (WHO, 2002). Over one billion people are now overweight or obese. If the health costs in USA and EU are already massive (Rayner and Rayner, 2003), such diseases would overwhelm poorly resourced healthcare systems.

Omran's theory of the Epidemiological Transition, first promulgated 35 years ago, proposed that as societies develop, chronic diseases substitute for infectious diseases (Omran, 1971). More recently, Popkin has characterized a 'nutrition transition', focusing on diet, nutrition and lifestyle determinants in the explanation of the emergence of DR-CDs (Popkin, 2001). The nutrition transition is conceptually powerful,

but in explaining obesity, for example, it is only one of a number of models—ranging from economic change to genetic factors (Lang and Rayner, 2005). There may be a case for 'unbundling' the nutrition transition from one single process into three, namely, diet, the physical environment and culture, recognizing that each of these transitions overlap, combine and amplify each to the other. Separation may help clarify each conceptual space and strengthen policy responses. The rest of this paper deals with the diet transition.

TRADE LIBERALIZATION AND THE DIET TRANSITION

Dietary change is occurring worldwide: traditional diets with a limited range of staples are being substituted by a diet more composed of livestock products (meat, milk and eggs), vegetable oils and sugar. These three food groups currently provide 28% of total food consumption in the developing countries (in terms of calories), up from 20% in the mid-1960s. Their share is projected to rise to 32% in 2015 (FAO, 2003).

Global trade patterns are immensely complex. Trade policy acts at the macrolevel, affecting households and individuals through complex and poorly understood pathways with potential for unpredictable and unintended effects. There is, moreover, enormous variation in the pace and style of dietary change worldwide. It is thus difficult to trace the precise links between trade and diet, just as it is for globalization's impact on health (Hawkes, 2006). Still, considering the potential importance of trade for dietary health, a starting point is to understand how trade liberalization affects the food supply chain, what this implies for diet and the critical needs for future work in this area.

TRADE LIBERALIZATION AND THE FOOD SUPPLY CHAIN

Trade liberalization affects the food chain at varying levels of complexity that can be characterized as follows: food imports and exports, the local/global balance of the internal dynamics of the food supply chain, FDI in food processing and retail and commercial promotion of food.

The most obvious consequence is the rising importance of food imports. For the 49 least developed countries by the end of the 1990s, imports were more than twice as high as exports. The role of food imports in the Pacific Islands States presents an historical example of potential dietary impacts. Pre-1945, each nation was essentially self-sufficient, but during the subsequent era of 'development', countries became more reliant on imports, with impact on diets and local production systems. In Tonga, for example, meat imports rose from 3389 tonnes in 1989 to 5559 tonnes in 1999, accompanied by a 60% increase in consumption (Evans *et al.*, 2001). Given the highly differentiated impact of trade at a country level, there is an urgent requirement to undertake health impact analysis at national or regional levels in order to unravel this complex trade picture.

Another level of added complexity is the effect of trade liberalization on the internal dynamics of the food supply chain. Although local factors remain critical, changes in the food chain are taking on an increasingly uniform character. In traditional societies, food chains are typically short and focused on locally grown, seasonally available products. As elements of the food chain rise in capital intensity, the task of moving food from farm to table becomes more complex. Localism is displaced, and investments increasingly shifted from basic or seasonal commodities to 'value added' processed foods. Such circumstances are frequently driven by new market players attracted by more open market conditions. From a public health perspective, there is a need to examine the circumstances under which trade liberalization encourages or discourages local production and if this has a dietary impact.

Another layer of complexity is investment. Liberalization of finance is part of trade regulations and encourages FDI. FDI has proved particularly important in the spread of highly processed foods (Hawkes, 2005). Cross-border processed food trade has remained limited since the mid-1990s (Regmi *et al.*, 2005), whereas FDI has mushroomed. Between 1988 and 1997, food industry FDI increased from US$743 million to US$2.1 billion in Asia and from US$222 million to US$3.3 billion in Latin America, far outstripping investments in agriculture (FAO, 2004). US food companies sell five times more (US$150 billion) through FDI sales than through export sales. FDI has stimulated the global spread of

supermarkets, driving sales of packaged foods. The USA has the highest concentration of supermarkets (Table 1), but the largest shopping malls are now in China (Barboza, 2005). It is often assumed that the retail revolution in processed 'convenience' foods delivers dietary gains by widening the choice of foods and lowering price, but the actual impact of these changes requires closer assessment.

A further level of complexity is the role of commerce in changing the cultural expectations of populations via advertising and product marketing. The case of soft drinks illustrates the role of a more liberal operating environment (Bolling, 2002). FDI sales for US soft drink brands were US$30 billion in 1999 in a global market estimated at US$393 billion (whereas US soft drink exports were only US$232 million in 2001). Soft drinks use cheap constituents that are mostly acquired locally with only the critical ingredients are imported. In order to achieve market dominance, foreign brands require large investments in production, distribution and promotional marketing: Coca Cola and PepsiCo spent, respectively, US$2.2 billion and US$1.7 billion on advertising and other forms of promotion in 2004 (more than the WHO's annual budget). The successful marketing of soft drinks and similar products is affected by the global spread of advertising services, which have been bolstered by more liberal trade rules, and has played a significant part in reshaping cultural expectations. However, this marketing effort has not necessarily internalized the costs to health.

FUTURE SCENARIOS FOR TRADE AND DIETARY HEALTH

In nineteenth century Europe, nutrition was a powerful driver for economic growth (Fogel, 1977). In the twenty-first century, global dietary change may be of equal importance. What is the future for trade policy and dietary health? Trade policy used to be dominated by farm and commodity groups. Protectionism remains strong, but the balance of power has shifted towards food processing, retail industries and traders. Despite growing complexity in trade rules, greater liberalization remains likely, although at an uneven pace. From these trends, we discern three possible scenarios on the relationship between food trade and dietary health.

Business as usual. Further development of global and national markets drawing on globalized technology, supermarketization and consumer dietary patterns, but retaining a semblance of regional and national variations in dietary composition. This represents what will happen in the absence of a public health or food industry response to concerns about unhealthy diets.

Fragmentation. Development of processed 'niche' food products designed to appeal to the healthy diet conscious, heavily packaged and advertised, but with limited implications for the rest of the food chain. Stung by the obesity crisis worldwide, some international food companies are already pursuing this scenario, hoping to highlight their products' health benefits.

Table 1: Share of food sales for retailers in selected international markets, 2002 (per cent sales)

Retail outlets	United States	Western Europe	Latin America	Japan	Indonesia	Africa and Middle East	World
Supermarkets/hypermarkets	62.1	55.9	47.7	58.0	29.2	36.5	52.4
Independent food stores	10.0	10.0	33.0	11.3	51.1	27.1	17.8
Convenience stores	7.5	3.8	3.1	18.3	4.8	10.0	7.5
Standard convenience stores	5.7	2.5	1.8	18.2	4.8	9.5	6.4
Petrol/gas/service stations	1.8	1.2	1.3	0.1	0.0	0.5	1.1
Confectionery specialists	0.5	2.0	1.7	0.3	0.1	1.3	1.2
Internet sales	0.2	0.1	0.1	0.4	0.0	0.0	0.2
Chemists/drug stores	0.2	0.3	0.2	0.4	0.2	0.3	0.3
Home delivery	0.4	0.2	0.0	0.0	0.0	0.0	0.1
Discounters	7.4	10.3	0.2	2.2	2.7	6.2	5.7
Other	12.0	17.5	14.0	9.0	11.9	18.6	14.9
Total	100	100	100	100	100	100	100

Source: Euromonitor, 2003 http://www.euromonitor.com.

Health at the centre of trade. Resulting from a strong public health response to dietary concerns, dietary health becomes a key arbiter of food and farming, including trade, with food governance a determining factor. This outcome—an 'ecological public health' approach applied to food and farming—implicates other drivers of change, such as water shortages and climate change.

The first two scenarios are more likely in the short term, but, as health consequences accumulate, attention may be given to the third. How this third scenario might develop is now explored.

PROMOTING GOOD GOVERNANCE

In increasingly obesogenic societies, encouraging people to adopt healthier lifestyles—the 'social marketing' approach (Grier and Bryant, 2005)—is unlikely to work without tackling major upstream forces such as trade. Moving to the third scenario requires a far stronger incorporation of dietary health considerations into trade policy. The public health community would need to take a stronger advocacy role to achieve better oversight on the food chain. Measures might address both the supply and the demand sides, for example, affecting relative prices of healthy and less healthy foods (Haddad, 2003). Lessons could be learnt from attempts to inject sustainability and environmental protection into business activity.

More specifically, we propose a spectrum of actions to address trade-related diet issues, as follows:

- *Strengthen food and health governance.* A central issue is the effectiveness of institutional frameworks for control and monitoring of the food chain from a nutritional balance perspective, alongside food safety, already the major focus of international and national food governance. Globally, the Codex Alimentarius Commission is now beginning to discuss the implementation of the WHO Global Strategy on Diet, Physical Activity and Health. Ministries of health, education and others, particularly in North America and Europe, are beginning to take a far closer interest in food in institutional settings, and one audit of companies' health commitments suggests that this approach is rich in possibilities for improving food governance (Lang *et al.*, 2006).
- *Audit commerce and trade on national diet.* Auditing the impact of trade liberalization on diets is under-researched. Pending further research, some have argued for freezing compliance with liberalization commitments under trade agreements. Monitoring of food industry and agribusiness responses to trade agreements—mergers across borders, growth and marketing trends and efforts to move to a healthier product mix—would be one example. This is also of interest to investment banks, with their concerns about the long run sustainability of the food sector (JPMorgan, 2003).
- *Engage with trade and international agreements to promote good dietary health*. Trade institutions assume that liberalization automatically generates health benefits and note that WTO agreements already have a 'pro-health' clause. However, food is considered only in terms of food safety—irrespective of nutrition. The Framework Convention on Tobacco Control (FCTC) provides some lessons of developing a non-trade treaty that sets a pro-health standard in trade disputes (the FCTC does not specifically refer to trade, but uses language indicating that health should be the prime consideration). The convention contained potentially commerce-restrictive consumer-oriented strategies, including taxes, labelling, advertising, product liability and financing. Food is not tobacco, but the impact of DR-CDs may warrant comparable scrutiny. On product marketing, for example, actions might range from advertising bans to making schools commerce-free (Hawkes, 2004). Such regulations have trade implications, so public health professionals must engage with trade policy professionals to influence any potential adjudication process.
- *Develop national supply side measures to build new markets for healthy foods*. FDI is driving changes in food chain ownership and diet. A way to maintain local patterns of ownership is to encourage cooperatives linking suppliers, retailers and consumers allied with pressure on local government to address employment losses. Building markets for healthy foods could be a focus for cooperatives, while also benefiting local economies.
- *Working with Civil Society*. Civil society activism ranges from consumers wanting low

prices and quality produce to communities defending livelihoods against multinational enterprise (Focus on the Global South, 2003). Nutrition and health professionals can engage with these varied strands and those most affected by trade policies.

- *Public health capacity*. Filling capacity gaps is a necessary precursor to action. The foregoing proposals have little hope of success without the public health community acquiring new expertise, resources and, critically, imagination and political will, to make successful interventions. In many countries, the public health infrastructure—professions, facilities, influence and power—remains weak. Industrial levies or hypothecated taxation, or potentially through marketing taxes or taxes on energy-dense foods, offer potential means of rising finance.

CONCLUSION

Putting good health at the centre of trade policy will require public health advocates to re-think strategies. The impact of liberalizing trade policy on diet is complex, under-researched and poorly understood. Although the World Food Summit in 1996 made a strong case for the advantages of expanding global food trade, it also warned of possible negative consequences. Public health bodies need to improve their monitoring of what the food sector delivers and how it markets products, particularly those foods identified in the Global Strategy for Diet, Physical Activity and Health. Departments of Commerce and Trade ought to have better public health input into their policy making. *Vice versa*, Ministries of Health and the public health movement need to gain a more sophisticated analysis of trade and investment in order to promote the development of healthy diets.

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CAPACITY BUILDING

Integrated health promotion strategies: a contribution to tackling current and future health challenges

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SUMMARY

This paper was presented as a technical background paper at the WHO sixth Global Conference on Health Promotion in Bangkok Thailand, August 2005. It describes what we know about the effectiveness of four of the Ottawa Charter health promotion strategies from eight reviews that have been conducted since 1999. The six lessons are that (i) the investment in building healthy public policy is a key strategy; (ii) supportive environments need to be created at the individual, social and structural levels; (iii) the effectiveness of strengthening community action is unclear and more research and evidence is required; (iv) personal skills development must be combined with other strategies to be effective; (v) interventions employing multiple strategies and actions at multiple levels are most effective; (vi) certain actions are central to effectiveness, such as intersectoral action and interorganizational partnerships at all levels, community engagement and participation in planning and decision-making, creating healthy settings (particularly focusing on schools, communities, workplaces and municipalities), political commitment, funding and infrastructure and awareness of the socio-environmental context. In addition, four case studies at the international, national, regional and local levels are described as illustrations of combinations of the key points described earlier. The paper concludes that the four Ottawa Charter strategies have been effective in addressing many of the issues faced in the late 20th century and that these strategies have relevance for the 21st century if they are integrated with one another and with the other actions described in this paper.

Key words: integrated health promotion; multiple strategies; Ottawa Charter; effectiveness

INTRODUCTION

This paper describes what we know about the effectiveness of health promotion strategies and makes suggestions for the emphasis that is required as we move into the 21st century. The strategies are four of the five key health promotion action areas identified in the Ottawa Charter—building healthy public policy, strengthening community action, developing personal skills and creating supportive environments. Re-orienting health services is a very important strategy that has not been addressed consistently over the last 20 years. However, it was not addressed here because it was addressed independently by another background paper presented at the WHO sixth Global Conference on Health Promotion.

EFFECTIVENESS OF HEALTH PROMOTION INTERVENTIONS, STRATEGIES AND ACTIONS

In this section, we outline some of the key findings of eight reviews written in the last 6 years, which have assessed the effectiveness and cost-effectiveness of health promotion interventions. There is a significantly larger body of

published evidence assessing the effectiveness and cost-effectiveness of chronic disease and particularly non-communicable diseases and their risk factors. We chose this selection of reviews because together they reflected health promotion interventions addressing chronic disease (i.e. mental health and injury), other health issues (i.e. HIV/AIDS and maternal and child health) and various social determinants of health (i.e. poverty, food security and nutrition).

The eight reviews consulted for this paper are described briefly in Table 1. All reviews used established criteria for ascertaining quality of the studies reviewed. Although several of these reviews aimed to be international in focus, or to focus on specific regions of the world other than North America and Europe, the majority of the reviews outlined in Table 1 relied solely or heavily on evidence of the effectiveness of health promotion interventions in North America and Europe. Many of the authors of these reviews noted that, although they attempted to find evidence from other parts of the world, little or no evidence, at least in English literature, was available.

KEY LESSONS ABOUT THE EFFECTIVENESS OF HEALTH PROMOTION INTERVENTIONS, STRATEGIES AND ACTIONS

The cited reviews of evidence for the effectiveness of health promotion interventions showed that interventions using a combination of health promotion strategies and actions are effective and cost-effective at preventing and addressing a wide variety of chronic diseases and their associated risk factors, as well as health determinants. One strategy in particular, 'strengthening community action', showed the need for more evidence of effectiveness. In Table 2, the strategies are grouped according to the level of action and linked to the key actions that are required for success based on this review.

Six key lessons can be drawn from the common findings and conclusions of these reviews.

1. *Investment in building healthy public policy is a key strategy*

Reviews of health promotion interventions addressing several issues and determinants identified the creation of healthy public policy as a key strategy. Relevant actions include investment in government and social policy, the creation of legislation and regulations and intersectoral and interorganizational partnerships and collaboration. In some cases, reviews suggested that the creation of healthy public policy was the strategy for which the most evidence of effectiveness exists (e.g. legislation for road safety and social policy for income security and poverty reduction).

Ross' review of programmes aimed at alleviating poverty and improving the health of people experiencing poverty found that little research existed on the effectiveness and cost-effectiveness of programmes addressing poverty and health inequities. A major challenge for determining the effectiveness of programmes targeting poverty and health inequities is that many interrelated

Table 1: Reviews consulted

Review	Description of review
Hoffman and Jackson, 2003 (for World Bank)	Review of effective and cost-effective interventions focusing on the prevention of major non-communicable diseases and reduction of their associated risk factors, including lifestyle factors and health determinants (e.g. poverty and food security) www.utoronto.ca/chp/reportsandpresentations.htm
Garrard *et al.*, 2004 (Australia)	Findings of reviews of the cost-effectiveness of health promotion interventions targeting cardiovascular disease and diabetes prevention
Hosman and Jane Lopis, 1999 (for IUHPE)	What mental health promotion interventions are effective at addressing mental health as well as a variety of other health issues and health determinants
Svanstrom, 1999 (for IUHPE)	Review of injury prevention and safety promotion interventions
Schuit *et al.*, 1999 (for IUHPE)	Review of food and nutrition programmes in Europe
Ross, 2003 (Canada)	Review of programmes and interventions aimed at alleviating poverty and improving the health of people experiencing poverty and improving maternal and child health http://secure.cihi.ca/cihiweb/dispPage.jsp?cw_page=GR_323_E
Warren, 1999 (for IUHPE)	Review of health promotion interventions targeting disenfranchised youth, which explores the effectiveness of addressing high-risk behaviours for contracting HIV/AIDS
Hills *et al.*, 2004 (Canada)	Review of literature of different community intervention approaches

Table 2: Key lessons: health promotion strategies, levels and cross-cutting actions

Levels	Structural		Social/group		Personal behaviour	
Health promotion strategies	Building healthy public policies	Creating structural environments to support health	Strengthening community action	Creating social environments to support health	Developing personal skills	Creating environments to support healthy personal decisions
Key cross-cutting actions	Intersectoral collaboration and interorganizational partnerships Participation and engagement in planning and decision-making Healthy settings (e.g. healthy schools, healthy workplaces and healthy municipalities) Political commitment, funding and infrastructure for social policies Multiple strategies at multiple levels across multiple sectors Awareness of socio-environmental context					

risk factors are involved, which poses difficulties for both the implementation and determining the effectiveness of interventions. Ross was, however, able to find some modest evidence regarding the effectiveness of government policies. The extent to which poverty is reduced at a country-wide level is directly related to how much is spent. In a study of 12 countries, poverty was reduced by 30% to 80%, depending on government spending levels. Because this did not take into account the inequitable distribution of benefits within certain subgroups, Ross also stated that creating broad policies requires attention to implementation strategies. Regardless, it is action at the healthy public policy level, specifically through government development and spending in social policy areas such as income security and employment, that can begin to be effective in reducing poverty (Ross, 2003).

In Svanstrom's review of injury prevention and safety promotion interventions, it was found that in preventing road injuries, educational activities alone were not very effective. Legislation has been shown to be the most efficient way to prevent some injuries such as making bicycle helmets mandatory (Svanstrom, 1999).

Hoffman and Jackson's review found legislation and enforcement around tobacco use, advertising and sales, to be key parts of successful tobacco programmes, and taxation was shown to be the most cost-effective for reducing smoking (Hoffman and Jackson, 2003).

2. *Supportive environments need to be created at all levels*

Several reviews point to creating supportive conditions and environments as a strategy that is essential in order to ensure that other strategies are effective. This includes implementing a variety of actions that represent supportive conditions at the structural (policy), social (including community) and individual levels (Table 2).

Warren's review found that successful youth health promotion strategies addressing high-risk behaviours must address the social and economic conditions that lead youth to be at high risk. Key to the success of interventions was making behaviour change accessible, including the availability of instrumental supports such as condoms, and psychosocial and emotional supports such as counselling, peer counselling, outreach and life skills training. Effective interventions not only aimed to change behaviour among at-risk youth, but also addressed societal perceptions of youth by targeting a variety of stakeholders, including parents, professionals and community leaders (Warren, 1999).

Hosman and Jane Lopis' review found that mental health promotion interventions have improved maternal and child health and reduced pre-term delivery and low birth weights, as well as reducing teen pregnancy. Central to effective mental health promotion is the creation of positive individual, social and environmental conditions (Hosman and Jane Lopis, 1999). Ross' review of poverty-related interventions found that several programmes focusing on pre-natal nutrition were effective at reducing low birth weights. Key activities created supportive environments at a variety of levels by providing instrumental supports such as food vouchers or supplements, group support, nutritional education, counselling and home visits (Ross, 2003). That supportive environments are required for success for all three other health promotion strategies is illustrated in Table 2.

3. *Effectiveness of community action is unclear and requires further evidence*

The eight literature reviews included as part of the Hills *et al.* paper on 'Effectiveness of Community Initiatives to Promote Health' agreed that community interventions have had mixed results. Although their impact in terms of behaviour change has ranged from modest to disappointing, they have achieved success in terms of community and systems change (Hills *et al.*, 2004).

In Svanstrom's review of injury prevention and safety promotion interventions, it was found that in preventing road injuries, educational activities alone were not very effective, but community programmes that involved local participation and policy and legislative change actions have been very effective (Svanstrom, 1999).

Garrard *et al.*'s review of health promotion interventions targeting cardiovascular disease and diabetes prevention identified that although specific large-scale programmes using multifaceted community-based interventions were often effective, they generally failed to produce substantial change over improvements occurring in the general population (Garrard *et al.*, 2004).

Before deciding that community action is not as effective as a health promotion strategy, it is necessary to remove other possible explanations, such as a lack of consistent definitions, appropriate indicators, evaluation protocols and qualitative systematic review criteria for assessing community interventions. This is an area that requires further investigation and is the target for intensive efforts in Latin America, Canada, Europe, and the Cochrane Collaboration, to name a few.

4. *Personal skills development must be combined with other strategies for effectiveness*

Many reviews of health promotion effectiveness showed that developing personal skills (including the actions of health education, health communications and training and skills development) was an ineffective strategy if implemented in isolation from other strategies, particularly with disadvantaged groups and communities of low socio-economic status. Central to the effectiveness of personal skills development is the need to also implement strategies that create structural-level conditions to support health and increase access to goods, products and services.

Hoffman and Jackson found that people of low socio-economic status are unlikely to participate in lifestyle interventions and are more likely to participate in initiatives that will lead to a noticeable improvement in their quality of life in the short term. For example, interventions aiming to improve indoor air quality in homes or to increase food access and quality are more likely to be effective with low-income groups. In addition, non-communicable disease interventions using a variety of diverse strategies and actions to address socio-environmental conditions were shown to be more cost-effective than those focusing solely on individual behaviours and lifestyles. For example, taxation was shown to be most cost-effective for reducing smoking, and increased access to better stoves or cleaner fuel was cost-effective to improve indoor air quality (Hoffman and Jackson, 2003).

Both Schuit *et al.*'s review of food and nutrition programmes in Europe and Hoffman and Jackson's review of food security interventions found evidence that food security and nutrition interventions that focus on the most disadvantaged groups are most effective, but that it is essential in these interventions that the life realities of people, including the barriers to accessing nutritious food, are considered and addressed. According to both reviews, food interventions are more likely to be effective when they produce tangible short-term benefits such as increasing access to food (through income generation or food access activities) or better-tasting food (Schuit *et al.*, 1999; Hoffman and Jackson, 2003).

Warren's review of health promotion strategies addressing high-risk behaviours that put youth at risk for contracting HIV/AIDS and other health issues found that successful interventions address not only the health issues, but also the social and economic conditions that lead youth to be at high risk. Key to the success of interventions was the provision of motivations to change behaviour (including peer education, communications strategies, support and training) and making the products and services needed to achieve the behaviour change accessible (such as providing free access to condoms, counselling and clean needles) (Warren, 1999).

5. *Interventions employing multiple strategies and actions at multiple levels and sectors are most effective*

Reviews of health promotion interventions working on a wide range of health issues and health determinants conclude that the most

effective interventions employ multiple health promotion strategies, operate at multiple levels (often including all of the structural, social group and personal levels), work in partnership across sectors and include a combination of integrated actions to support each strategy.

Reviews of interventions focused on non-communicable disease provide a strong case for employing multiple strategies and actions at multiple levels. Garrard *et al.*'s review of health promotion interventions targeting cardiovascular disease and diabetes prevention asserts that the most effective non-communicable disease prevention and health promotion approaches operate at all levels, involve the collaboration and partnership of organizations in multiple sectors and use multiple strategies (Garrard *et al.*, 2004). Similarly, a key finding of Hoffman and Jackson's review was that effective and cost-effective interventions for primary prevention of non-communicable disease used a combination of health promotion strategies at various levels in multiple settings (Hoffman and Jackson, 2003).

Specifically, Hoffman and Jackson found that interventions that were shown to be effective at reducing tobacco use, increasing physical activity, preventing cardiovascular disease and increasing food security involved a combination of health promotion strategies occurring at the personal, community and structural levels. For example, comprehensive tobacco programmes in several states in the USA have led to significant decreases in smoking in the population. These effective combinations of strategies included developing healthy public policy, creating structural and social conditions to support health and developing personal skills. Key health promotion actions that were part of these strategies included policy development, legislation, taxation, increasing access to food, increasing opportunities for physical activity, health education, health communications, lifestyle and skill-building. These comprehensive approaches used multiple strategies at multiple levels and included actions such as legislation and enforcement around tobacco use and sales, media campaigns, supporting local public health agencies, community-based prevention programmes and school-based education for youth (Hoffman and Jackson, 2003).

Hosman and Jane Lopis found that effective mental health promotion interventions operate at the personal and social/group levels, involving multiple activities and addressing multiple life factors, to create positive individual, social and environmental conditions, thereby enabling people to enjoy positive mental health and enhanced quality of life (Hosman and Jane Lopis, 1999).

6. *Certain actions are required for effectiveness for all four Ottawa Charter strategies*

Key health promotion actions were identified in several reviews as being central to the effectiveness of interventions. These critical actions are represented as cross-cutting actions in Table 2: actions that need to occur at the structural, social and personal levels and that need to be implemented in conjunction with all of the major health promotion strategies of the Ottawa Charter. These actions include the following.

- *Intersectoral collaboration and interorganizational partnerships at all levels*:

  For example, in Svanstrom's review of injury prevention interventions, it was found that the most effective programmes involved multiple sectors and organizations, including various government departments and non-governmental organizations (NGOs) and groups, as well as local stakeholders (Svanstrom, 1999). See also the case examples described later in this paper.
- *Community participation and engagement in planning and decision-making*:

  For example, Warren found that in order for youth health promotion strategies addressing high-risk behaviours to be effective and relevant, interventions need to engage at-risk youth to participate in the development and delivery of interventions and need to target a variety of stakeholders, including parents, professionals and community leaders (Warren, 1999). The engagement of youth and community leaders as part of the decision-making process was listed as a critical factor in the success of the 'Youth for Health' project in Ukraine (Canadian Society for International Health, 2004).
- *Creating healthy settings, particularly focusing on the settings of schools, workplaces and cities and communities/municipalities*:

  For example, Hoffman and Jackson found schools, workplaces and municipalities to be effective settings for many interventions addressing non-communicable diseases and their risk factors, because they provide opportunities to effectively reach large numbers of people with sustained interventions. Schools

can reach many children directly at a critical time in their lives, whereas workplaces can reach adults on a daily basis over a long period of time and have been shown to be cost-effective settings for interventions for both employers and employees. Municipalities offer great potential to effectively address a variety of health issues and determinants on the basis of the municipal governments' responsibility for key areas that affect people's lives, including urban planning, recreation, transportation and aspects of health. The healthy cities and communities movement offers examples and important lessons on how municipalities can address multiple health determinants, risk factors and health issues through a settings' approach (Hoffman and Jackson, 2003). A key component of the settings' approach is the formation of collaborations, partnerships and coalitions.

- *Political commitment, funding and infrastructure for social policies*:

  For example, Ross' review finds that government development and spending in social policy areas, such as income security, play a role in reducing poverty (Ross, 2003). Government commitment to engage citizens and change policies to promote health in Bogota was a key to its success (Caballero, 2004; Edmundo, 2004; Silva, 2004).
- *Awareness of the socio-environmental context is essential:*

  Most reviews used for this paper stressed that health promotion interventions are only effective when they are relevant to the context in which they are being used. This includes awareness of the social, cultural, economic and political context; the capacity and development of infrastructures and systems in key sectors such as health, education and government and the life realities of particular target populations or communities. Contextual differences are particularly important to consider in developing countries, as the majority of the reviews discussed earlier relied solely or heavily on evidence of the effectiveness of health promotion interventions in North America and Europe. Many reviews stressed that the goals, strategies and actions of any intervention be relevant and appropriate to the people they aimed to reach and the systems they aimed to work within. In addition, reviews pointed to the active participation and engagement of community members in planning and decision-making as a key health promotion action that could help to ensure that an intervention was appropriate to its context.

CASE EXAMPLES OF CURRENT INITIATIVES

To further illustrate the power of integrating several health promotion strategies at the structural, social and personal levels, some case studies were drawn from different parts of the world and focus on different topics or audiences. These particular cases were selected because evaluation information was available or because the process and outcomes were well documented. Key to the success in all case studies was partnership development. They are described very briefly below and each case demonstrates the effectiveness of partnerships at a different level—international, national, regional and local.

International level case example: WHO framework convention on tobacco control

The framework convention on tobacco control (FCTC) is the WHO's first convention and came into effect on 27 February, 2005. As of that date, 168 countries have signed the convention and it has been ratified by the national governments of more than 50 countries. The lengthy 12-year process to develop the FCTC required a partnership between WHO, UN bodies, governments, NGOs and academia. The country negotiating teams were examples of intersectoral collaboration by including members from a wide range of government departments, such as health, tax, finance, economics and trade, development and planning, foreign affairs, treaties and law, commerce, customs and sometimes the tobacco companies. The convention includes a range of policy measures such as legislation requiring health warnings on cigarette packets, creation of smoke-free areas, bans on tobacco advertising and promotion, provision of cessation services, increased tobacco taxes and a crackdown on smuggling. The process of developing the FCTC has had several advantages—governments were encouraged to take action ahead of the finalization of the convention, health ministries became

more politically mature and awareness was raised among other government ministries (World Health Organization, 2003).

National level case example: the Canadian tobacco control strategy

The Canadian tobacco control strategy continues to involve preventing the uptake of smoking, facilitating smoking cessation among smokers and protecting the public from second-hand smoke. Key health promotion actions that continue to be part of this comprehensive programme include coalition-building; national policies to ban tobacco advertising on television and sponsorship of sports and arts events; legislation and enforcement around where tobacco can be sold, as well as its use and sales to minors; taxation and increasing the price of tobacco products; media anti-smoking and second-hand smoke campaigns; school-based education for youth; providing free access to cessation information, support and counselling as well as subsidizing nicotine replacement therapies in some areas and local municipal by-laws banning smoking in public places and workplaces. Such comprehensive tobacco programmes have shown that they are effective, as have specific aspects of these initiatives such as increasing tobacco prices through taxation (Health Canada, 2002).

Regional level case example: youth for health in Ukraine project

In 1998, the Youth for Health Ukraine–Canada project was launched, funded by the Canadian International Development Agency and managed by the Canadian Society for International Health. The initiative aimed to address the large and increasing percentage of youth in Ukraine, demonstrating at-risk behaviours by empowering youth, promoting healthier living and behaviours and emphasizing gender equity and youth involvement. The Ukrainian Institute for Social Research as the lead organization built partnerships with ministries of health, education and family and youth, another research institute, the Kyiv City Government and a youth NGO. When they adapted their project model in the regions, the institute worked mainly with different levels of government and youth NGOs. The mutual collaboration of all partners has been key to the success of the project model. The project's activities have included intersectoral partnerships; the development and implementation of an integrated health education curriculum in schools; developing a training programme for service providers who can promote youth health; involving youth and practitioners in designing educational materials, resources and programmes to promote healthy youth behaviour and evaluation of the strategies and research on youth behaviour, existing law and policy on youth health and media influence on youth. The work of the project has led to strong public and political support at the national level for a national health promotion policy and improvements in the quantity and quality of youth health promotion policies and programmes at national, regional and local levels (Canadian Society for International Health, 2004).

Municipal level case example: reforming Bogota, Colombia

To improve citizens' health and well-being and reduce rising crime rates, the Mayor of Bogota, Colombia, Dr Antonus Mockus, in 1995 initiated actions that required the involvement of all government departments and active citizen engagement. To make citizens feel safe, lighting in public places was enhanced, traffic in the centre of the city was reduced, 'safe women only' nights were organized and police officers were retrained in appropriate law enforcement practices. To reduce traffic, the cost of parking was increased, car free days were encouraged and a new public transport system was built. Other reforms included modifying hours of operation for bars and entertainment places and improvements to city water and sewerage services. In order to promote a culture of treating one another with respect, artists and street performers were involved, and positive behaviour by citizens was publicly rewarded and promoted (e.g. good taxi drivers were identified by citizens). Intersectoral collaboration under the leadership of the mayor was an important component. As a result of these actions and reforms, Bogota saw a reduction in homicide rates from 80 per 100 000 inhabitants in 1993 to 22 per 100 000 in 2003. Traffic fatalities dropped from an average of 1300 a year to 600. The cities' water consumption dropped, public transportation usage increased and driver behaviour improved (Caballero, 2004; Diaz, 2004; Silva, 2004).

Local level case example: mobilizing men as volunteers in Southern Africa AIDS trust

The Southern Africa AIDS trust began as an initiative of the Canadian Public Health Association and the Canadian International Development Agency. It is now an NGO that aims to increase the HIV competence of communities through supporting community agencies. For example, Word Alive Ministries International is a church-based community organization in Malawi which found that as their home-based care for people with HIV/AIDS and TB developed, 40% of their home care clients were men but all their HBC volunteers were women and cultural barriers limited the ability of female volunteers to meet the needs of male clients. To address this, they had to use a combination of strategies that included breaking down myths and stigma about care work and HIV/AIDS for men by showing local men in action, involving community leaders to identify potential male volunteers and providing training, support and supervision to counteract gender stereotypes. Some of the preliminary additional benefits from this mobilization of male volunteers were that it reduced unhelpful gender stereotypes, increased the acceptance of condoms among men and decreased the stigma associated with volunteer care work for men (SAT Southern African AIDS Trust, 2002–2003).

In summary, these case studies are not in-depth analyses but brief illustrations of how multiple intersectoral strategies, especially including partnership building operating at the individual, community and structural levels, are critical for success.

DISCUSSION AND CONCLUSIONS

The evidence for the effectiveness of the four health promotion strategies from the Ottawa Charter is mixed. No strategy stands on its own as a clear success—they all need to act in conjunction with each other and certain supporting actions in order to be effective. The strongest evidence for effectiveness for one strategy is linked to building healthy public policies. Structural level change results in measurable change within the time frames of the studies reviewed. At the other end of the spectrum, strengthening community action has mixed evidence of success. As stated earlier, more research and evaluation is needed in relation to this strategy.

Although 'creating supportive environments' is a major strategy in the Ottawa Charter, attention needs to be given to the fact that it is actually three strategies at three different levels (Table 2). Its importance receives more emphasis if it is explicitly discussed in conjunction with each of the three other Ottawa Charter strategies, particularly at the structural level. It is also clear from the reviews that developing personal skills could not stand on its own to be effective and requires additional strategies, particularly in creating supportive environments and policy development.

Some of the strategies that are weakly referred to in the Ottawa Charter should be given more prominence given the evidence of their effectiveness. They exist as cross-cutting actions that are required at all levels of health promotion (Table 2), specifically:

- interorganizational partnership building and intersectoral collaboration at all levels;
- participation and engagement of all people in decisions that affect their lives;
- healthy settings as places where comprehensive strategies that involve multiple actions and partnerships that occur at multiple levels;
- political commitment, funding and infrastructure for a broad range of social policy and health promotion actions;
- multiple strategies in multiple settings at all three levels (structural, social and personal) and involving several sectors are required for success;
- all strategies require attention to the socio-environmental context.

The four health promotion strategies from the Ottawa Charter addressed in this paper have been effective tools to address many of the issues we faced in the 20th century when used in combination (e.g. addressing and preventing chronic and communicable diseases and addressing lifestyle determinants). It should be noted that the reviews used in this paper focused largely on evidence published in English, although most of the case examples originated in non-Western countries. This potential cultural bias in the effectiveness of health promotion strategies hopefully will be addressed in the future as more evaluation and research emerges, for example, through the global project on health promotion effectiveness

sponsored by the International Union of Health Promotion and Education where each region of the world is gathering evidence of effectiveness with a progress report due in 2007. In addition, with respect to the lack of information about the effectiveness of community actions, the Public Health and Health Promotion field of the Cochrane Collaboration has identified community-building interventions as its first priority topic for review (Cochrane Collaboration, 2005).

The world is much more interconnected at a global level than it was in 1986 when the Ottawa Charter was created, and the emerging issues of today are different than those that we faced in the past. However, on the basis of the past success of health promotion strategies in addressing social determinants and health issues, the multi-level and multi-faceted nature of these strategies and the attention to social context, it is possible that health promotion strategies have a great potential to address the emerging health issues of the 21st century. These four health promotion strategies from the Ottawa Charter are potentially still relevant and important in addressing the emerging health challenges of the 21st century, especially when they are strengthened and integrated with other actions, such as partnerships, community engagement in decisions, attention to socio-environmental context, political commitment and use of multiple strategies in many settings, levels and sectors.

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CAPACITY BUILDING

Community capacity building and health promotion in a globalized world

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SUMMARY

In this paper, community capacity building (CCB) is seen as part of a long-standing health promotion tradition involving community action in health promotion. The conceptual context of the term CCB is presented, and compared with other community approaches. The usage of the term is variable. It is submitted that its common features are (i) the concepts of capacity and empowerment (versus disease and deficiency), (ii) bottom-up, community-determined agendas and actions and (iii) processes for developing competence.

A brief literature review looks at some of the main contributions from the 1990s on, which reveal an emphasis on building competencies, the measurement of community capacity and the attempt to break CCB down into operational components. Academic research on the impact of CCB on health is lacking, but multiple case studies documented in the 'grey literature' suggest CCB is highly effective, as does research in related areas, such as community empowerment.

Five contemporary case studies submitted by the contributing authors show both the range and efficacy of CCB applications. The concluding synthesis and recommendations say that what is needed for health promotion in a globalized world is a balance between global macro (policy, regulatory, etc.) actions and those of the human and local scale represented by CCB. It is concluded that action centred on empowered and capable communities, in synergistic collaboration with other key players, may be the most powerful instrument available for the future of health promotion in a globalized world.

Key words: community capacity building; community development; community health promotion; global health promotion

CONCEPTUAL FRAMEWORK OF THIS PAPER

This paper has two aims. One is specifically to consider the concept of community capacity building (CCB) in health promotion and to look at current international examples of its application. The second aim is the more general one of keeping the community dimension of health promotion on the agenda when the macro considerations of globalization are occupying centre stage. We argue that although macro determinants, policy and regulatory perspectives are obviously crucial for health promotion in a globalized world, so too are the more 'meso' and 'micro' perspectives of community and 'people'. Each level is equally important, and harmonization and balance between these levels is required. However, it is asserted that, global considerations

notwithstanding, the community dimension is the one that most embodies the quintessence of health promotion, since it directly pertains to the Ottawa Charter ideal of people having control over their own health and its determinants. The structure of this paper follows that asked for by the WHO conference organizers.

The term c*ommunity capacity building* came to attention in the 1990s, the latest in a long-standing tradition of health promotion concepts with 'community' as a prefix, where *community* refers to any medium-sized grouping of people united by social connections, a common identity and common goals. (In particular, 'community' relates to people living in a common locality). Associated concepts are community development(CD)/organization/action/empowerment.

The usage of *community capacity* seems to come from the wish to emphasize an 'assets' or 'strengths' approach to conceptualizing community health promotion, versus a deficits or pathology approach, and to emphasize empowering or bottom-up approaches, versus those where professionals or others in power impose their own agendas. However, if the academic research literature is anything to go by, top-down, pathology approaches are still dominant. Arguably, the term CCB gives more emphasis to cognitive, behavioural and political *competency* dimensions than to social relationships, although a number of leading authors do explicitly emphasize the social relationship aspect, represented by terms such as networks, support, social cohesion, social capital and sense of community. It is suggested here that the term *community development* be retained to represent those situations where the competency and social relationship dimensions are given equal attention. However, in practice, the term CCB seems to be currently a fashionable one used by many to cover almost any activity in the community health promotion domain, so it becomes somewhat academic to be too precise about terminological boundaries. In this paper, we opt to use the term CCB quite generally, the key aspects being a focus on (i) the concepts of capacity and empowerment (versus disease and deficiency), (ii) bottom-up, community-determined processes and agendas (versus top-down/externally determined) and (iii) processes for developing community competence.

Various concepts are associated strongly with CCB. The most important, already mentioned, are *empowerment* (relating to both political and psychological power), and *community control*. Others are *participation* ('real' versus token) and *self-determination* (agendas set by communities, not outsiders). To the extent that social processes are also important in CCB, a variety of terms prefixed by 'social' are used, such as *social connectedness/capital/cohesion/belonging/inclusion/support/networks*. The concept of *civil society* is also associated with CCB, usually meaning organized society other than government or the military, especially the non-governmental organization (NGO) component.

Equity and *equality* are central concepts, implying primacy for CCB processes involving the most disempowered, an emphasis on dignity, justice and respect for all, and attending to political, economic and other societal structures that result in inequity. *Marginalized, excluded* and *poor* communities are prioritized. The concept of *development* is relevant here, and indeed most case studies of successful CCB and CD come from the less 'developed' parts of the world. However, CCB principles are also applicable in highly developed settings. Some CCB examples involve an activist political dimension, others not. The organizational aspect of CCB is important. Concepts here include *planning models, capacity domains, needs/wishes assessment, asset-mapping, governance, sustainability* and *evaluation*. The American term *community organization* has overtones of CCB.

Although the core of CCB is community-determined process, there are frequently professionals and others in authority (such as local government) involved, a reality likely to increase in the current environment of across-government and intersectoral action, and perhaps more corporate involvement in health promotion. Here, concepts such as *partnership* and *collaboration* come to the fore. Where health promotion professionals are involved, their role includes *facilitation, consultancy* and *advocacy*. (A criticism of the term CCB is its implication that experts 'teach' communities what to do. It is emphasized here that 'true' CCB is where communities are in control of their own capacity-building processes, only using professionals as it suits them).

Contextually and philosophically, CCB in health promotion (CCB-HP) has *ecological* and

public health perspectives, seeing communities as *human systems nested in wider system*s, influenced by many *internal and external inputs*, and having *outputs* that are *global* and *positive* (e.g. 'overall well-being'), rather than just specific disease impacts. This 'holistic' and human-system view readily encompasses dimensions such as *spirituality, qualitative experience, traditional healing, folk wisdom* and *indigenous culture*, often neglected in more reductionist and positivist approaches. CCB-HP shares public health's *population* and *social determinants* perspectives, its valuing of *social justice* and *healthy policy*, and its emphasis on *research* and e*valuation.*

Finally, aiming for *synergy* between communities and all other relevant sectors of society, which influence health and well-being is recommended. This acknowledges that although communities are central to the health promotion enterprise, they cannot act alone. Wallerstein (2005) says: 'Multiple case studies have shown that synergy between all elements (anti-poverty strategies, NGO-government collaboration, empowerment and participatory development and active health programs) is probably most effective at improving health and development outcomes'.

LITERATURE REVIEW

Since this review has to be brief, for a more comprehensive background, the reader is referred to previous reviews and position papers: the paper on CCB written for the fifth Global Health Promotion conference in Mexico (Restrepo, 2000), a major American conference on the topic (Goodman *et al.*, 1998), a comprehensive Canadian report on CCB measurement (Smith *et al.*, 2003), a technical report written last year for WHO on CCB and community mobilization (Raeburn, 2004), a forthcoming WHO report on empowerment and health promotion (Wallerstein, 2005) and various books on theory and practice (e.g. Laverack, 2005). Here, we summarize some highlights.

Restrepo's (2000) paper has a Latin American perspective and emphasizes the political and power dimensions of CCB, placing it in a context of equity, social justice, democracy and respect for human rights. There are many good examples of effective CCB projects in Latin America. It is stressed that CCB is a collective and political activity, and that coercive or manipulative citizen participation has to be avoided. Partnerships with stakeholders are crucial. Social exclusion and poverty are priorities, and socio-economic development is intrinsic to CCB-HP. Essentially, the starting point for all CCB action is the 'prioritization of problems and needs made by the citizens'.

The Goodman *et al.* (1998) publication is based on a symposium organized by the US Centers of Disease Control and Prevention on community capacity (CC) from a measurement perspective. They define CC as: 'The characteristics of communities that affect their ability to identify, mobilize and address social and public health problems; and the cultivation and use of transferable knowledge, skills, systems and resources that affect community- and individual-level changes consistent with public health-related goals and objectives'. They see CCB as having both social and organizational aspects. Ten capacity dimensions that can be 'built' in a community are: participation, leadership, skills, resources, social and inter-organizational networks, sense of community, understanding of community history, community power, community values and critical reflection.

Likewise, Laverack (2005) provides an analytical approach to the components of CCB. He outlines nine domains of CC: stakeholder participation, problem assessment capacities, equitable relationship with outside agents, organizational structures, resource mobilization, links to other resources and people, stakeholder ability to 'ask why', control over programme management and local leadership. He also emphasizes the concept of 'parallel tracking', where top-down and bottom-up approaches can be harmonized in situations where agendas are initially set by outside authorities.

Smith *et al.* (2003), in their report on measuring CC, cover dozens of papers on the topic. They also point out how variable the definition of CC can be, outlining five major variations. This of course affects how the concept is measured.

Australians Arole *et al.* (2004) give a social relationship emphasis to CCB, though this is done by regarding social process as a means rather than as a goal. They say: 'Improving capacity is about strengthening the ability of a community through increasing social cohesion and building social capital'.

Jackson *et al.* (2003) did a 4-year participatory qualitative project on measurable indicators of CC in four 'problem' Toronto neighbourhoods. They found these 'poor' communities were 'rich' in community resources and activities, especially fairs and celebrations, with residents having a positive view of their communities. They conclude 'Community capacity builds over time …', as successes accumulate and barriers are surmounted.

Finally, in this brief review, a Hong Kong study by Tang *et al.* (2001) of 3381 professionals identified three main factors to do with CC: participation and commitment, community resources, and health literacy. For professionals to assist CCB processes in their communities, the key was seen as building workforce capacity.

In spite of the emphasis on measurement, there is as yet little formal academic research on the effectiveness of CCB in terms of randomized control trials or systematic evaluative or qualitative studies. However, related academic literature reviews show health improvement with empowerment programs (Wallerstein, 2005) and CD (Raeburn and Corbett, 2001). Outside the academic literature, strong support for the effectiveness of CCB comes from hundreds if not thousands of documented 'grey literature' case studies from around the world. A recent example is an overview publication by the Voluntary Health Association of India (Mukhopadhyay, 2004), which shows dramatic gains from CCB in the health and capacity of hundreds of the poorest and most 'backward' Indian rural communities from 1993–2003.

Such examples could be multiplied many times, with a sample being given in the next section. Collectively they provide an impressive picture of a very powerful approach to health promotion.

CASE STUDIES

The followings case studies were contributed by the participating authors and are listed alphabetically by country of origin. They illustrate not only the principles discussed earlier, but also the wide diversity of interpretations of the concept of CCB.

Africa: Effective participation by the very poor

A core component of CCB is meaningful participation by community people. Although this first case (Box 1) is perhaps more treatment than health promotion, it uses a health promotion approach, showing the power of such participation, and its ability to benefit large numbers of people in a highly effective way.

Box 1

Onchocerciasis (River Blindness) is a highly prevalent disease in Africa affecting millions of people. It leads to misery, loss of productivity and social ostracism in affected people in their most productive years of life.

A major challenge for controlling the disease is how to deliver annual ivermectin treatment to all target communities and sustain high treatment coverage over a very long period. Past efforts using health workers to treat most of those affected by the disease in rural communities have led to low therapeutic coverage.

This study uses a participatory approach to develop a community-directed treatment with ivermectin (mectizan), including tools for recording and reporting. The African Programme for Onchocerciasis Control has adopted and used this approach since 1995 in 19 African countries.

Evidence from field evaluation confirmed that the strategy is appropriate and cost-effective and has led to significant reduction in symptoms, thereby contributing to improvement in the welfare of the poorest people.

Brazil: Partnership and power-sharing

Partnership was a theme of the Bangkok Conference and is a critical factor for the future of CCB. Here the issue is policy development. Although the Brazilian experiment (Box 2) is not strictly speaking a health promotion project, its implications for health both directly in terms of funding priorities relating to determinants of health and indirectly in terms of citizen empowerment should be obvious.

Box 2

An innovative experiment in urban governance has been taking place for the past 16 years in the city of Porto Alegre, Southern Brazil. This involves a 'participatory budget' (PB) process. Instituted by the City government in 1989, PB is defined as a process designed to promote sound, transparent management of municipal affairs by involving city residents in decision-making on budget allocations. The PB allows populations of different neighborhoods of the city, within a well-defined process of citizen participation, to debate and set municipal investment priorities. The process is gradually gaining credence as an urban governance model based on cooperation and partnership between local governments and civil

society. It provides a model for direct popular participation and is now being tried in 70 other Brazilian cities and in many other countries. 'It is truly the citizens who set the investment priorities for the municipal budget' (Cabannes, 2004).

Honduras: El Guante and 11 communities: community participation for health promotion in Honduras, Central America

This case illustrates well the power of community-initiated action and the building of capacity to enhance health in poor and isolated rural communities. The constructive partnership with health authorities is also a feature here (Box 3).

Box 3

El Guante and 11 other villages surrounding it are poor rural communities typified by their strict agricultural activities. They are located in Cedros, district of Francisco Morazán, 72 km north of Tegucigalpa, the capital of Honduras.

With a total population of 3559 living in harsh social and economic conditions, these inhabitants cope with geographical dispersion and a high incidence of sanitation and hygiene problems that impact directly on their health.

Two years ago, they gathered under the shade of a tree and discussed their problems. Everyone, including children, took part in this discussion, and the entire community initiated the task of establishing their own health clinic.

This impressive community participation was supported by the Ministry of Health, which was willing to help these communities improve the quality of and access to health services. On 30 March 2004, the Ministry and the communities signed an agreement in which a new model of primary health services was to be implemented. The purpose of this model is to offer complete medical attention to the inhabitants of the 12 communities, and also develop a model based on an integrated family–community approach, using health promotion strategies and actions to help achieve changes towards healthy lifestyles.

The project is centred on community participation, which is articulated through community organizations in each of the 12 communities. These community organizations develop educational programmes based on improving health and nutritional lifestyles, personal and domestic hygiene and awareness of the environment. The organizations also develop training courses and make health promotional visits to high risk inhabitants. They have organized an adolescent club that provides information on topics such as reproductive and sexual health, activities promoting a clean environment and various others.

With the aid of visionary and proactive guidance by local leaders, effective social development programme management is being achieved in these communities. Important strategic alliances have also been established with other communities and organizations that help define plans for community improvement.

With this union between government and civil society, the inhabitants of these communities are improving their health and lifestyles. Simultaneously, they have managed to establish a frontline healthcare clinic that provides high quality, efficient and highly humane medical treatment to all the population.

New Zealand: Community houses and empowering resource centres

New Zealand (NZ) is the most highly developed of the countries cited here, but is also the world's 'newest' country in terms of significant human settlement, including Maori, European, Pacific and Asian. There is a strong valuing of community and 'fairness' in NZ, and many examples of CCB projects and partnerships. This case is based on one such project (Box 4).

Box 4

In 1973, NZ's first Community House (CH) opened, a collaboration between the University of Auckland and the new, low-income suburban community of Birkdale in Auckland, NZ's biggest city. The overall aim of this project was 'community well-being', and it was modelled generally on self-determined CD projects in developing countries. There are now some 300 CHs in NZ, with over 40 in Auckland. In one region of 300 000 people, an associated organization is the Empowering Resource Centre, which runs on Ottawa Charter principles. It is a community/health authority partnership and provides a wide range of human and practical resources to assist with CCB and self-help groups. Although the various CH projects vary in style and aims, the ideal is a project completely under community control and governance, with maximal participation by all residents. The original Birkdale project achieved a participation rate of 10 000 of its 14 000 residents (all ages), with significant increments in health and well-being on multiple measures. This project still survives 30 years later. At the heart of this is a simple community-controlled organizational approach called the PEOPLE System (Planning and Evaluation of People-Led Endeavors). Capacity-building is intrinsic to this, with many leadership and other skills being acquired by literally hundreds of people in each community. Over the years, this approach has been tried successfully in many settings, and various formal evaluations have shown its positive impact on health, well-being and sense of community. A current application is in Glen Innes (GI), one of the poorest and most ethnically mixed communities in Auckland. At the time of writing, 40 highly motivated residents are out in the streets of GI doing a random needs/wishes household survey as part of establishing their own

community-controlled project dealing with many dimensions of community well-being.

Thailand: 'The new paradigm of health and community capacity'

The host country for the Bangkok conference, Thailand is a leader in innovative health promotion practice in Asia. The recently instituted nationwide exercise programme, which was able to involve 30 million voluntary participants within two years, is one striking example. Equally, the rural community development programme in Khon Kaen province outlined here is a dramatic example of CCB in action (Box 5).

Box 5

Ubonrat District is a rural community in Khon Kaen province, 445 km north-east of Bangkok. Most farmers there have been in a crisis involving high expenditure, low income, debt, no savings and environmental degradation. However, one group of farmers has reassessed the concept of farming for money and riches, and now pursues physical and mental health, warm families, strong community, security and a good environment, plus pride, freedom and living in harmony with nature.

The Sustainable Community Development Foundation (SCDF) has worked for 10 years to bring these successful farmers together into a large network that covers five provinces and 2650 families. As a result of pooling such local wisdom and resources, the Foundation has been able to create a learning curriculum that enables north-east farmers to learn how to be self-sufficient. They also learn how to form strong groups to solve difficult social problems and lead to community well-being. The network has recently created a project based on small-scale, well-planned intensive farming. This aims to enable farmers to focus their own resources onto a small piece of farmland (1 *rai*) to produce self-sufficiency, income for debt relief, a life pension in the form of large timber trees and, most importantly, 'all four dimensions of health and well-being'.

Within this district, Kam-pla-lai Village was the poorest. It is now a self-sufficient and resource-rich community. Forty years ago, Kam-pla-lai was in the middle of a very fertile forest, which was cut down. The villagers then turn to mono-cropping by growing sugarcane, cassava and jute. Within a few years, they were faced with high debts, low income, poor soil and labour migration. They also found themselves in very bad health. For instance, there was 25% child malnutrition, 95% liverfluke parasite infestation, depression, insomnia and other anxiety disorders. Socially, the community was in complete disorder with widespread gambling, crime (cattle rustling, robbery) and alcoholism.

Ten years ago, the SCDF and Ubonrat hospital staff chose Kam-pla-lai as one of the pilot villages in an attempt to improve the health and lifestyle of the villagers. By relying on good community leaders, positive participation from villagers and a highly effective learning process, the situation in Kam-pla-lai has dramatically improved. By facilitating regular meetings, the villagers have gradually learned how to rely on their own resources in order to rebuild their way of life. The Foundation does not directly support specific agricultural activities. Rather it provides the opportunity for villagers to learn on an ongoing basis how to solve the problems of their community. Now Kam-pla-lai is much different. Debts are lower and incomes are higher. Villagers have savings and some welfare benefits. Soil and water resources are much better. Pollution has been reduced through organic farming. Now there is no child malnutrition, no liverfluke infestation, less labour migration, no crime, no gambling and no drugs. The villagers are much happier and less stressed, and there are many strong groups and community leaders who can operate effectively both inside and outside the government system.

SYNTHESIS

These cases represent the diversity of understandings of the concept of CCB. Each shows the power of participation and partnership, and the impressive role of grassroots action, especially when this is supported by high quality agencies and governments. The sense of growing capacity, of visionary goals, of community ownership of agendas and action and of self-respect and dignity, in addition to the attainment of positive health and well-being outcomes, is testimony to this kind of approach. Ideally, any health promotion of the future will need to look for a balance between the macro policy and regulatory requirements of a globalized world and this more human level of action. The synergy of community action with all other significant players, large and small, who influence determinants of health, is also of great importance. Empowered, self-determined community action in a balanced, collaborative environment of supportive governments, agencies, corporations and policies may be the greatest weapon at health promotion's disposal. The potential of human capacity at the community level cannot be underestimated, when people work together on common goals. The Worldwatch Institute once concluded, 'Grass-roots groups are our best hope for global prosperity and ecology' (Durning, 1989). The

same could also be said for the future of global health and well-being. CCB and its associated community development processes, together with wise global policy and regulation, may well provide the most important forces at our disposal for promoting the world's health in the future.

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CAPACITY BUILDING

Mapping national capacity to engage in health promotion: Overview of issues and approaches

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SUMMARY

This paper reviews approaches to the mapping of resources needed to engage in health promotion at the country level. There is not a single way, or a best way to make a capacity map, since it should speak to the needs of its users as they define their needs. Health promotion capacity mapping is therefore approached in various ways. At the national level, the objective is usually to learn the extent to which essential policies, institutions, programmes and practices are in place to guide recommendations about what remedial measures are desirable. In Europe, capacity mapping has been undertaken at the national level by the WHO for a decade. A complimentary capacity mapping approach, HP-Source.net, has been undertaken since 2000 by a consortium of European organizations including the EC, WHO, International Union for Health Promotion and Education, Health Development Agency (of England) and various European university research centres. The European approach emphasizes the need for multi-methods and the principle of triangulation. In North America, Canadian approaches have included large- and small-scale international collaborations to map capacity for sustainable development. US efforts include state-level mapping of capacity to prevent chronic diseases and reduce risk factor levels. In Australia, two decades of mapping national health promotion capacity began with systems needed by the health sector to design and deliver effective, efficient health promotion, and has now expanded to include community-level capacity and policy review. In Korea and Japan, capacity mapping is newly developing in collaboration with European efforts, illustrating the usefulness of international health promotion networks. Mapping capacity for health promotion is a practical and vital aspect of developing capacity for health promotion. The new context for health promotion contains both old and new challenges, but also new opportunities. A large scale, highly collaborative approach to capacity mapping is possible today due to developments in communication technology and the spread of international networks of health promoters. However, in capacity mapping, local variation will always be important, to fit variation in local contexts.

Key words: capacity mapping; strategic development; workforce planning; health promotion infrastructure

INTRODUCTION

This paper reviews approaches to the mapping of resources needed to engage in health promotion at the country level. Capacity mapping approaches are illustrated with examples from across the globe. Also discussed are various uses of capacity maps. The terms 'capacity mapping' and 'health promotion' do not have self-evident meanings. Capacity mapping is perhaps easier to grasp because of the cartography metaphor. Cartography is in its narrowest sense the drawing of images meant to represent the world around us. More broadly, cartography refers to all the activities that lead to finished maps: understanding the customer's requirements, planning the work, collecting information and agreeing on unsure or disputed borders, terms, topography, features and forms. The finished map itself is out of date even before it goes to print, and many map features are disputed by people living in the places that are mapped. A map is a social construction modelling aspects of environment that are important. Maps are not produced for the cartographers, but for others whose interests influence greatly what is mapped, and how. Two useful maps of the same coastline may differ greatly, the one intended for navigation having the detail below the waterline and the other intended for landsmen having the detail above the waterline.

So there is no single way or a best way to make a capacity map, since it should speak to the needs of its users as they define their needs. Therefore, the definition of health promotion is of more than academic interest, since the definition will drive much of the decision-making about what a health promotion capacity map should include.

There remains the question of what is meant by national capacity. All ideas are disputable, even the meaning of a nation. Here, the term national refers to sovereign states, but also includes regions other than sovereign states that have been delegated the main responsibility for health promotion. Capacity refers to the ability to carry out stated objectives (Goodman *et al.*, 1998). Having the capacity to perform a task is an essential but not sufficient condition for good performance:

> The matching of capacity to a desired level of action is the art upon which many enterprises succeed or fail. It is a serious mismatch if one wishes to produce Fords and has the capacity to produce Porsches, and vice-versa. The wide spread interest in measuring capacity arises from the wish to "tune" capacity to achieve the level of action aspired to. In the development arena, including health promotion, one hardly ever hears about over-capacity. In public services delivery—education for example—there is constant tension between demands for more capacity to achieve better action, and 'good enough' capacity for affordable action. (Mittelmark *et al.*, 2005)

Health promotion capacity mapping is approached in various ways, for reasons made obvious above (see also Ebbesen *et al.*, 2004). At the national level, the objective is usually to learn the extent to which essential policies, institutions, programmes and practices are in place, to guide recommendations about what remedial measures are desirable (National Health and Medical Research Council, 1997; Wise and Signal, 2000; WHO, 2001).

For at least the past decade, national capacity for health promotion has been the subject of conferences, scholarly dialogue and political debate (French Committee for Health Education, 1995; Wise, 1998; Wise and Signal, 2000). At the Fifth Global Conference on Health Promotion in Mexico City (June 2000), national investment for health and the need to build infrastructure for health promotion were dominant themes (Moodie *et al.*, 2000; Ziglio *et al.*, 2000a).

ILLUSTRATIONS OF CAPACITY MAPPING AROUND THE GLOBE

Europe

A capacity mapping model developed by the WHO Regional Office for Europe, and used as part of its Investment for Health initiative (Ziglio *et al.*, 2000a; 2000b), has at its heart National Health Promotion Infrastructure Appraisals. The first such appraisal—in the Republic of Slovenia—originated from a request for assistance from the President of the Parliament of Slovenia. Six experts prepared for a site visit by studying a wide range of documents about Slovenian geography, political system and laws, economic situation, demographic, social, health and sickness profiles, and structures and institutions. During a site visit in 1996, they conducted interviews, participated in semi-structured discussions and a workshop.

Based on the information garnered from documents and meetings, the team composed a report with two elements: (i) an assessment of Slovenia's strengths, weaknesses and opportunities for investment in health and (ii) an Investment for Health Strategy for Slovenia, based on the conclusions of the assessment. In the course of the work, the team developed a simple capacity mapping instrument to assess 10 elements of health promotion infrastructure, and subsequently applied the instrument during similar processes that were mounted in other European countries.

In Europe, a triangulation approach to capacity mapping has been adopted, using four orchestrated activities, that was reported at the WHO's Sixth Global Conference on Health Promotion in Bangkok, Thailand:

(i) Summarization of existing data on capacity for health promotion, for example, from WHO-EURO's Venice Office's 'National Appraisals of Health Promotion Policy, Infrastructures and Capacity' carried out in collaboration with a number of European member states between 1996 and 2004;
(ii) Analysis of social and economic trends affecting population health at various levels from country level to Europe as a whole (WHO, 2002);
(iii) A WHO Capacity Mapping Initiative, begun in 2005: to synthesize key social and economic trends in 20 countries across four subregions of Europe; map the current capacity of health promotion systems, with particular emphasis on responsiveness to the broader determinants of health; highlight the implications for health promotion policy and infrastructure development (WHO, 2005);
(iv) Summarization of present country-level health promotion policy, infrastructure and programmes, a project undertaken by HP-Source.net that developed a uniform system for collecting information on health promotion policies, infrastructures and practices; created databases and an access strategy so that information can be accessed at inter-country, country and intra-country levels, by policy makers, international public health organizations and researchers; analysed the databases to support the generation of models for optimum effectiveness and efficiency of health promotion policy, infrastructure and practice; actively imparted this information and knowledge, and actively advocated the adoption of models of proven effectiveness and efficiency, by means of publications, seminars, conferences and briefings, among other means (Mittelmark, *et al.*, 2005).

North America

In the USA, mapping community capacity to inform community development has for the past 25 years been stimulated by the pioneering work of McKnight and Kretzmann (1990). At a time when American public health was developing advanced methods to assess health needs and develop policy and programmes to meet public health deficits, McKnight and Kretzmann (1990) called for a new perspective—one in which policy and programmes would flow also from an assessment of communities' capacities, skills and assets. This perspective has had great influence in American public health, where the focus of health promotion has been at the individual, small group and community levels.

However, there have also been capacity mapping exercises at the state level, including all 50 states plus 8 special districts and territories such as the District of Columbia (ASTDHPPHE, 2001). Using a standard assessment form, each state/territory reported on state-level disease prevention in five arenas: (i) policy and environmental content areas addressed in the prior 3 years; (ii) examples of successful intervention in each content area; (iii) critical success factors and barriers regarding policy and environmental change interventions; (iv) roles played by local health departments; (v) key contacts. Based on data generated in the period 1996–1999, the mapping results showed clear differences between the content areas addressed by policies compared to those addressed by environmental interventions. Tobacco control was by far the most popular content area for policy development, whereas nutrition and physical activity were the most popular content areas for environmental change interventions.

In Canada, capacity mapping technology has developed, among other ways, through Canada's strong emphasis on international cooperation for development. Exemplifying this is Canadian collaboration with Nepal and Fiji to

examine various approaches to mapping community capacity for health promotion (Gibbon *et al.*, 2002). In this work, community capacity is viewed as both a means and an end, emphasizing the importance of stakeholder participation and the ability to 'ask why' and increase control over programme management, among other capacity domains such as leadership development and improvement in resource mobilization (Gibbon *et al.*, 2002). Another example of international cooperation for development is Canada's participation in a 19-country analysis of national strategies for sustainable development (Swanson *et al.*, 2004). Using a country case study methodology, the project mapped three aspects of national capacity: strategy, participation and implementation. For example, each national case strove to answer these and similar questions: Is there a national sustainable development strategy? If so, what are its goals and thematic areas? Is it linked to the national budgeting and planning processes? What roles are played by NGOs? Is there financing for implementation? Is there accountability for performance? Based on analysis of the case studies, the project extracted key learning related to leadership, planning, implementation, monitoring, coordination and participation.

Australia and Asia

Australia's experience in mapping national capacity to engage in health promotion has spanned more than two decades (Better Health Commission, 1986; National Health Strategy, 1993; National Health and Medical Research Council, 1997a; National Health and Medical Research Council, 1997b; New South Wales Health Department, 1999). Beginning with an assessment of the capacity (systems for information[1], policy and prioritization, financial, human and physical resources, management and design/delivery systems, partnerships) needed by the health sector to design and deliver effective, efficient health promotion, capacity mapping has more recently evolved in three directions (New South Wales Department of Health, 1999):

(i) First has been the continuation of mapping capacity needed to conduct project-based work, but also mapping capacity of the health sector to deliver comprehensive, integrated interventions that influence society as a whole.
(ii) Second has been mapping the capacity of the health sector and/or agencies in other sectors to sustain either interventions or positive outcomes, or both.
(iii) Third has been mapping the generic capacity of communities to identify problems and to design solutions based on the existing strengths of the community (Bush *et al.*, 2002).

There have also been reviews of Australian legislative frameworks for health promotion (Bidmeade, 1991) and of public health law (Bidmeade and Reynolds, 1997).

The capacity mapping carried out to date has resulted in clearer definitions of the health promotion capacity required by governments and, to a lesser extent, other organizations. The New South Wales Health project (1999) developed valid, reliable indicators to help with capacity building: the reviews of legislation included recommendations for the future, and the National Health and Medical Research Council (1997) review was associated with the establishment of a new national, coordinating structure for public health and health promotion, the National Public Health Partnership.

Capacity mapping in Australia has been an effective means of identifying the capacity needed by governments, other agencies and communities to promote health. It has resulted in more effective national planning and priority setting, and in commitment to the implementation of large-scale, intensive, comprehensive, integrated health promotion interventions.

Australia's experience has demonstrated the importance of mapping capacity to engage in health promotion, and has contributed to the conceptualization of 'capacity' and to the development of tools to assist in mapping. Australian experience has also highlighted the need to continue to expand the work, but more, to establish minimum benchmarks for governments and civil society to use to assess the extent to which the health of populations and people is protected, promoted and sustained.

Korea

Korean national capacity mapping for health promotion is an emerging activity, stimulated by

[1] Including monitoring and surveillance, research and evaluation.

the growth of the Korea Health Promotion Fund, a key source of funding for national health promotion programmes (Oh, 2001; Nam, 2003). The Ministry of Health and Welfare is responsible for implementation and evaluation of Health Plan 2010, the adoption of which is the foundation for building national capacity in the coming period. The Korea Institute for Health and Social Affairs is in charge of and actively developing programmes on health promotion. However, a critical lack until quite recently has been the absence of capacity to train qualified health educators. In a positive development, the Korean Association of Public Health Administration and the Korean Association of Health Education introduced standards for health education professional training in 1998 (Nam, 2003). In 1999, professional training of health educators emerged at the non-governmental level (Nam, 2002), and capacity is fast accelerating; at the time of this writing, it is estimated that around 1000 health educators work in health centres, health promotion centres and other facilities related to public health.

Capacity mapping in Korea with an emphasis on health promotion policies is now coming to have a higher priority, undoubtedly a product of political commitment. The example of national tobacco control policies illustrates success in government stimulation of health promotion. Today, many public health leaders are interested in strategies for implementing health promotion, and realization is growing that capacity mapping could certainly help to improve Korean health status and quality of life. Thus, Korea is an example of recently but quickly emerging interest in capacity mapping, providing the opportunity for fast developments based on lessons learned in places where capacity mapping has a longer history.

Japan

Japanese experience in mapping national capacity to engage in public health and health promotion paralleled a remarkable rise of life expectancy after the end of World War II, the increasing prevalence of lifestyle-related disease and the emerging need for nursing care. Responding to these trends, the national government advocated the development of infrastructure for health promotion through two initiatives in 1978 and 1988 and soon thereafter by Healthy Japan 21 (Kawahara, 2001). The central government continued to stimulate national capacity for health promotion by passing the Health Promotion Act in 2002. The Ministry of Health, Labour and Welfare is responsible for implementation and evaluation of Healthy Japan 21 (Hasegawa, 2004). Three organizations were established for effective implementation of the initiative at the national level, i.e. Headquarters for Promotion of Healthy Japan 21, the National Council for Promotion of Healthy Japan 21 and the National Liaison Council for Promotion of Healthy Japan 21. Surveys and research on health promotion and the development of relevant databases are conducted by the Japan Health Promotion and Fitness Foundation, the National Institute of Health and Nutrition and the National Institute of Public Health. National data on public health such as the National Nutrition Survey are regularly collected for the monitoring of public health.

There is no academic institution in Japan that offers a degree in health promotion; however, many degree programs in relevant fields such as health sciences and nutrition have lectures on health promotion as a part of their courses. Training courses for instructors of health fitness are also available at universities, colleges and at the Japan Health Promotion and Fitness Foundation. Also, the Japanese Society of Health Education and Promotion introduced professional health education in 1994.

Thus, the cases of Korea and Japan illustrate recent and rapid expansion of interest and activity in the health promotion arena. The kind of international collaboration in health promotion that has arisen in Europe during the past two decades is not yet evident in Asia, but seems on the cusp of emerging. As or more interesting, perhaps, is the very recent development of inter-continental collaboration for health promotion capacity mapping, involving European countries and Korea and Japan. In collaboration with HP-Source.net, described in an earlier section, capacity mapping has been undertaken in Korea and Japan, using the same general approach that HP-Source.net uses in Europe (Nam *et al.*, 2004). The experience in Europe, confirmed in Korea and Japan, is that control over and responsibility for health promotion is in many countries situated at a level other than the national. Accordingly, HP-Source.net was adjusted so that mapping

may take place at any administrative level, for example, at the local prefecture level in Japan. The experience in Korea and Japan also indicates a need to map developments in health promotion policy, infrastructure and key programmes, not merely whether these resources exist or not (Nam *et al.*, 2004).

IN SUM: FURTHER OPPORTUNITIES FOR CAPACITY MAPPING

A key outcome of the Fifth Global Conference on Health Promotion, held in Mexico City in June 2000, was the call for the development of countrywide plans of action for health promotion. To develop such plans and monitor progress, countries require information on what already exists, is being developed or does not yet exist in the way of policy, infrastructure and programmes. Having such information for one's own country, and from other countries, helps in priority setting and can speed the development of national plans and action. For example, existing national health promotion policies in other countries can be useful sources of ideas for a country intent on developing such policy.

Thus, mapping capacity for health promotion is a practical and vital aspect of developing capacity for health promotion. The Mexico City conference summarized the context for health promotion capacity building: because joint and individual responsibility and action are required to improve the public's health, public policies that establish the conditions for health improvement are essential. The links between social and economic determinants of health, socioeconomic structural changes, physical environment and individual and collective lifestyles, call for an integrated view of health development. Best practices in health promotion need wide dissemination, both with regard to policymaking and programme implementation. Ministries of Health cannot manage the task of health promotion alone; they need to engage other public and private sectors to generate the required policies, infrastructure and key programmes.

These contextual issues have been more or less steady factors for many years, yet in important ways, the global, national and local contexts for health promotion have changed remarkably in the last two decades. Globalization, a process set in motion many centuries ago, has been accelerated dramatically in the past decade by communication technology that is fast spreading to every corner of the globe. Among the benefits of globalization has been the linking up of health promoters everywhere, sharing ideas and experience about practical and effective ways to build capacity for health promotion. This has happened, too, in the capacity mapping arena, but there is room for improvement.

The new context for health promotion, which was a major theme of the Sixth Global Conference on Health Promotion, Bangkok, Thailand, August 2005, contains both old and new challenges, but also new opportunities. A large scale, highly collaborative approach to capacity mapping is possible today due to developments in communication technology and the spread of international networks of health promoters. In capacity mapping, local variation will always be important, to fit variation in local contexts. However, many elements of health promotion capacity can be implemented in many contexts, with suitable adjustments. An excellent approach to professional education, for example, can be implemented wherever trained people and data collection resources can be mustered. Capacity mapping provides information about what exists, and where, in the way of health promotion policy, infrastructure and key programmes. The sharing of this information can and should stimulate the dissemination of practices that are suited to the continually evolving context of health promotion.

Some key lessons have emerged from the past decade of experience with national-level capacity mapping. It is impossible to use one single mapping protocol for all health promotion capacity mapping exercises, as capacity has different meanings in different contexts, and is often politically defined. Moreover, the capacity that is required for effective health promotion in a given country may be different from that in other countries because of differing cultural, social, economic and political conditions. For example, regarding information dissemination, a developed media network may be an important aspect of capacity in high income countries but for low income countries, a developed social network is essential and more appropriate. Although there must be a reasonable degree of commonality in what constitutes capacity among countries, there will also be differences arising from addressing different health issues. For

example, the facilities, equipment and expertise required for tackling motor vehicle injury vary from those required to eradicate polio. Thus, the mapping of capacity must also take into consideration the priority health concerns of the countries.

Although it is not appropriate to pursue one single mapping protocol for the reasons given here, effort should be made to develop models of best practice and construct typologies of capacity that are suited to various purposes. This can best be done by examining the concept of capacity across different countries through a combination of qualitative and quantitative methods. The triangulation approach being used in Europe seems promising in that regard.

The mapping of capacity as a tool for policy management is an innovative area that is growing rapidly, but with a number of problems that need addressing:

- First—what to map? Systems? Money? Manpower? Activities? Plans? Intentions? Hopes and aspirations? This calls to attention the need to define the construct 'health promotion infrastructure' with care, a task for the immediate future, and not addressed at all in this paper.
- Second—what to include ... and exclude? The formal public or private investments in health promotion are often not separated from other health budgets. Much of health promotion policy, infrastructure and programmes may be hard to identify as such. This problem is of precisely the same calibre as that facing health promotion in general: broad as well as narrow definitions raise objections and generate controversy.
- Third—who to count? A health promotion workforce is obviously critical, but who is a health promoter? If a country has an established specialist force, its work will surely be counted, but if many other health professionals are doing health promoting work, their contributions will be hard to document.
- Fourth—how to map the extent of health promoting work of the hidden workforce: Of individuals themselves, of parents, of teachers, of politicians.
- Fifth—how to compare apples and oranges? Data on capacity cannot be understood without reference to the national context. Users of capacity maps that include the possibility of country comparisons need to be aware that the 'look, feel, smell and taste' of health promotion may be very different even in two geographically adjacent countries. League tables will be difficult or impossible to construct.
- Six—what data to use? Not all data are accessible or dependable. Private institutes consider data as business information and are often reluctant to share it. Public data may be tainted by political considerations.

These and many other problems stand in the way of further development of capacity mapping as a tool for policy-making. Nevertheless, dialogue and consensus building are feasible, as is collaborative work to create a base of experience with various approaches to capacity mapping. Capacity mappers and map users will not go far wrong if they respect the value, but also the limits of capacity mapping. Map making took a large step forward when Mercator invented his type of projection, yet today many geographic mapping systems are in use, each suited to different purposes. In the arena of health promotion capacity mapping, there seems little point in attempting to develop the 'right' map, but developing the right type of map for the right purpose is a worthy pursuit. A journey without a map—that is wandering.

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