

REGIONAL COMMITTEE

Provisional Agenda item 10

Fifty-ninth Session
Dhaka, Bangladesh
22-25 August 2006

SEA/RC59/5/Inf.2

30 June 2006

**REGIONAL STRATEGY FOR HEALTH PROMOTION
FOR SOUTH-EAST ASIA**

This paper was originally prepared for review and discussion at the Regional Consultation on Regional Strategy for Health Promotion for South-East Asia, held from 26-29 June 2006, in Chiang Mai, Thailand.

CONTENTS

Introduction.....	1
Health Promotion Practice: Health Education vs. Health Promotion.....	3
Bangkok Charter for Health Promotion in a Globalized World.....	4
Regional Strategy for Health Promotion for South -East Asia.....	5
Objectives	6
Strategic Directions	7
Infrastructure for coordination and management	7
Capacity building.....	7
Regulations and legislation.....	8
Partnerships, alliances and networks.....	9
Evidence for health promotion	10
Social mobilization and advocacy	10
Health promotion financing	11
Management of change	12
Role of Member States.....	13
Role of WHO.....	14
Conclusion	14

Introduction

1. Health promotion is a core function of public health and is effective in reducing the burden of both communicable and noncommunicable diseases, including mitigating the social and economic impact of such diseases. The goal in promoting health is to mitigate the impact of risk factors associated with broad determinants of health leading to premature death and illness, and ultimately, to improve the quality of lives of individuals and communities. It is therefore a good public investment. To effectively address the identifiable determinants of health, health promotion requires that strategic directions and policies be formulated in addition to political commitment. Health promotion activities need to be planned, monitored, and evaluated. Similarly, the outcomes and the process have to be documented and disseminated widely in order to guide programming and resource allocation. Therefore, a sound strategy remains an essential pre-requisite for implementing effective health promotion interventions.

2. Countries of WHO's South -East Asia (SEA) Region recognize the need for addressing the growing burden of noncommunicable and communicable diseases as well as the new and emerging threats to health, such as earthquakes, emerging diseases like avian influenza (bird flu), SARS and HIV/AIDS, and the re-emerging diseases like dengue, TB and malaria. Furthermore, they face inequalities within and between the countries, resulting in limited resources chasing unlimited social needs. All this is due in part to a growing marginalized population that continues to place a huge burden on social services and the environmental system. Health promotion holds the key to halting or reversing the existing situation particularly in addressing primary risk factors as well as the social and economic determinants of health.

3. Member States in the SEA Region have advocated for strengthening health promotion as part of their efforts for health systems development in a series of global meetings beginning with the Alma -Ata Primary Health Care Conference (1978), Global Health Promotion Conferences, as well as at the various sessions of the World Health Assembly. The resolutions WHA42.44, WHA51.12 and WHA57.16 called for Member States and WHO to give priority to strengthening health promotion. Beginning with the first Conference on Health Promotion held at Ottawa, Canada in 1986, Member States from the Region were represented at a series of conferences on health promotion, organized by WHO in collaboration with

national, regional and global players, in Adelaide, Australia (1988), Sundsvall, Sweden (1991), Jakarta, Indonesia (1997), Mexico City, Mexico (2000), and Bangkok, Thailand (2005). The Region hosted two global conferences, in Jakarta and Bangkok, which demonstrated the Region's active involvement and commitment to health promotion.

4. Globally, there is a disproportionately high number of premature deaths and illness, which are preventable. Among the global challenges that have a direct impact on the health and social well-being of people including those in the SEA Region, include, but are not limited to:

- Increasing inequities within and between countries due to socio-political and economic changes;
- Changing patterns of consumption, particularly associated with food and information;
- Demographic changes that affect working conditions, learning environments, family patterns, and the culture and social fabric of societies;
- Socio-political and economic changes, including commercialization and trade, and
- Global environmental change.

5. The efficacy and cost-effectiveness of health promotion in mitigating the impact of social and economic determinants of health at individual and community levels is widely recognized and acknowledged. However, major challenges still remain, especially in the countries, where both rural and urban populations are most vulnerable to the changing social and economic situations that influence health and social outcomes. Therefore, the specific health promotion challenges that require innovative approaches include:

- Resource mobilization and allocation, including the establishment and adoption of alternative sources of financing for promoting health;
- Addressing complex socioeconomic and cultural changes at family and community levels;
- Involving the whole of government (not only the Ministry of Health) to address the social determinants of health throughout the life cycle;

- Actively engaging civil society, the private sector and nongovernmental organizations in health promotion;
- Strengthening the capacity for health promotion across sectors and at multiple levels; and
- Evidence gathering regarding the efficacy of health promotion and the utilization of such evidence in policy decisions and programming.

Health Promotion Practice: Health Education vs. Health Promotion

6. The Ottawa Charter for Health Promotion, adopted at the Global Conference on Health Promotion held at Ottawa, Canada in 1986 is credited for ushering the concept and principles of health promotion. Health promotion now has an established inventory of proven effective strategies and techniques to promote health since the Ottawa Conference (1986). Health promotion takes a more comprehensive approach to promoting health by involving various players and focusing on multi-sectoral approaches compared to health education.

7. Health education focuses on communicating health information and knowledge, and providing skills in order to support the individual to adopt desired (positive) healthy behaviours voluntarily. It uses communication processes, namely individual discussions, mass and group media to reach target groups through a strategy known as information, education and communication (IEC). Health education incorporates various social marketing techniques for advocacy and social mobilization, but it uses them predominantly for issue-specific interventions, e.g. reproductive health, condom promotion, immunization or specific disease control. Health education practices are usually the sole responsibility of health professionals from the ministries of health, with support in some cases from the Ministry of Information in the form of graphic artists and technicians from newspapers, radio and television.

8. Health promotion practices, on the other hand, are critical elements of primary health care and essential media in the delivery of public health particularly tackling communicable and noncommunicable diseases, and other threats to health. It is proven to be effective in terms of both cost and efficacy in mitigating the social and economic impact of diseases. It recognizes health as a human right and seeks

to promote the highest attainable standard of health of every human being without any form of discrimination.

9. Health promotion seeks to respond to global developments that contribute to increasing inequality, changes in the patterns of consumption, the environment, cultural values and traditions, communication and changes in family and social fabric among others. These major global changes have a major impact particularly among vulnerable groups such as women, children and the elderly as well as among minority and indigenous groups.

10. Health promotion practices require support and action by all sectors and stakeholders to make concerted efforts in advocacy, investment, capacity building, regulation and legislation, and partnership and alliance building to promote health. Furthermore, health promotion encourages various players to contribute to promoting health including civil society groups, communities, the private sector and all other ministries. In addition, the leadership and authority for providing technical guidance in promoting health remain the role and responsibility of the Ministry of Health.

11. To achieve desired results, health promotion activities should use the settings-based, population-based or issues-based approaches. Healthy settings such as schools, markets, cities, townships, villages, islands or various workplaces provide an opportunity to address complex health and social needs or concerns of individuals and communities in places where daily decisions are made and where behaviours are manifested. The settings approach also allows for integrating activities into existing social activities that take into consideration cultural values, communication patterns and local leadership issues in a given socio-political environment.

Bangkok Charter for Health Promotion in a Globalized World

12. In August 2005, the Global Conference on Health Promotion held in Bangkok, Thailand, adopted the Bangkok Charter for Health Promotion. The WHO Executive Board at its 117th session held in January 2006, also reviewed the progress of work on health promotion including work related to the Bangkok Charter, and submitted a resolution to the 59th WHA (Resolution EB117.R9).

13. The Bangkok Charter confirms the need to focus on health promotion actions to address the determinants of health. It also expands the five action areas identified in the Ottawa Charter, and encourages stakeholders in all sectors and settings to: (a) advocate for health based on human rights and solidarity; (b) invest in sustainable policies, actions and infrastructure to address the determinants of health; (c) build capacity for policy development, leadership, health promotion practice, knowledge transfer and research, and health literacy; (d) regulate and legislate to ensure a high level of protection from harm and enable equal opportunity for health and well-being for all people; and (e) partner and build alliances with public, private, nongovernmental and international organizations and civil society to create sustainable actions.

14. The Bangkok Charter also identifies four commitments essential for implementing health promotion by Member States and other partners, to make health promotion: (a) central to the global development agenda; (b) a core responsibility for all of government; (c) a key focus of communities and civil society; and (d) a requirement for good corporate practice. The policy actions and commitments contained in the Bangkok Charter form the nucleus of the strategic directions for this Regional Strategy.

Regional Strategy for Health Promotion for South-East Asia

15. In order for the countries of SEAR to translate the gains in life expectancy seen over the past decades into improved quality of life for the general population, concerted efforts are needed in addressing the determinants of health, particularly those contributing to premature death and illness due to communicable and noncommunicable diseases, and new threats to health.

16. The Regional Strategy for Health Promotion for South-East Asia identifies the strategic directions that should address multi-sectoral and interdisciplinary needs of countries as well as being applicable throughout the health systems, namely, at the preventive, curative, promotive and rehabilitation levels. Ultimately, implementation of the strategic directions should invest available financial and technical resources in interventions that utilize the settings-based approach as these are likely to address comprehensively, the needs of individuals and communities in places where individuals live, play and work. The strategy also

requires technical and financial support of WHO and other partners, in addition to the active involvement and commitment of Member States to implement the strategic directions identified.

17. The Regional Strategy would provide a framework for countries of the Region to build a critical mass of human resources for health promotion, drawn from health and non-health disciplines, public/private sector, civil society groups and communities to implement multi-sectoral and multi-disciplinary interventions at all levels of society, support planning and implementation of healthy lifestyle activities and health-supportive environments to address the determinants of health and other threats to health across sectors and settings. It seeks to provide direction to Member States and partners for addressing determinants of health including new threats to health in order to reduce morbidity and premature mortality, and ultimately, to improve the quality of life of individuals and communities in the Region. It supports all efforts to implement commitments and actions recommended in the Bangkok Charter, adopted at the Sixth Global Conference on Health Promotion, as well as the attainment of targets set under the Millennium Development Goals (MDGs).

Objectives

18. The objectives of the Regional Strategy for Health Promotion for South-East Asia Region are to:

- Guide Member countries of the SEA Region in establishing, implementing and maintaining adequate infrastructure, policies, plans of action, legislations and regulations, and alternative financing and evidence-gathering measures to mitigate the impact of identifiable determinants of health including new threats to health across population groups;
- Provide mechanisms for supporting the fostering and sustaining of local, regional and global partnerships, alliances and networks towards harnessing new technical and financial resources in order to expand multisectoral collaboration to promote health, and
- Strengthen the capacity to gather evidence, and to design and implement policies on health promotion efficacy, and to support the utilization of such evidence in making decisions related to policy, advocacy and/or programmes of intervention.

Strategic Directions

Infrastructure for coordination and management

19. There should be an established and sustained infrastructure in each country to coordinate and manage health promotion activities across sectors and administrative levels in the country. The technical and managerial capacity for health promotion should include interdisciplinary staff. Most ministries of health have a unit, a section or a centre for health education, sometimes at the level of a Directorate. A few countries have changed such unit/section/centre to health promotion, but almost all of them are functioning as the IEC arm of the Ministry. There should be clearly delineated roles and responsibilities for the coordination and management team and also an adequate budget and other technical resources in order to effectively support health promotion in the country.

20. Selected specific roles and responsibilities should include but not be limited to:

- **Providing guidance** regarding policy and programmatic issues across sectors and settings, in order to manage the changing environment related to implementing of the regional and global strategies for health promotion;
- **Responding to emergencies in a timely manner** and also with adequately planned health promotion interventions, e.g., risk communication and community mobilization;
- **Creating and sustaining a supportive environment** conducive to planning, implementation and evaluation of health promotion activities; and,
- **Ensuring coordination and management of health promotion activities supported** by sound policies, legislation and financial resources in order to respond to the multi-sectoral health promotion demands and expectations.

Capacity building

21. Health promotion is an emerging discipline that requires leadership for policy development, health promotion practice, content and skill base, research and documentation, knowledge transfer and health literacy. Building national capacity for health promotion is critical if countries are to realize the expected outputs. Till date, not many countries in the Region have undergraduate and graduate training

in health education, less on health promotion. Even where they exist, many cater only to a handful of people. Except for a few institutions in India, Sri Lanka and Thailand, the training in health education has not been revised to incorporate skill-based health promotion modules.

22. In this context, the Regional Strategy should encourage Member States to (a) ensure that a critical mass of trained and qualified health promotion professionals exist in the country to address the multiple socio-cultural and behavioural issues across sectors and population groups; (b) ensure that both health and non-health practitioners receive under-graduate, graduate, and pre-and in-service training in health promotion from competent trainers/teaching institutions in the country or outside the country; (c) allocate adequate financial and technical support to institutions of learning that are offering health promotion, in order to be able to allow these institutions to meet national demands for health promotion workforce; and (d) avail fellowships and/or scholarships for qualified nationals to undertake training in health promotion including those seeking advanced training outside the country.

Regulations and legislation

23. In order to ensure reduction of tobacco use and to have a high level of protection from harm through consumable products, and to guarantee equal access to health and social services for all people, there must be legislation, regulations and mechanisms for enforcement in the country. Nine of the 11 countries of the Region are the contracting Parties to the WHO Framework Convention for Tobacco control (FCTC). Many countries have also adopted legislative measures to reduce harm from use of alcohol. A few countries have drawn up a framework to implement the WHO Global Strategy on Diet, Physical Activity and Health.

24. The role of government in promoting health through legislation and regulations should be to (a) introduce public legislation, policies and regulations that promote, support and protect health of all citizens as well as establish mechanisms for enforcement with special attention on protecting vulnerable groups such as women, children and the elderly; and (b) ensure that existing strategies, legislation and policies regarding economic and social development are revised and re-aligned in order to promote, protect and support health, as well as remove ambiguity in interpretation and enforcement.

Partnerships, alliances and networks

25. Partnership for health promotion plays an essential part in resource mobilization and advocacy. The Ministry of Health stands to benefit significantly in terms of other partners joining to support its work in the form of financial support or human resource support or other forms of support. Parliamentarians of India were sensitized through a health promotion workshop and health checkup. Employees of the ministry of health were screened for diabetes and a healthy lifestyle centre was established in the premises of the health ministry. These advocacy efforts helped to raise the level of awareness and commitment for health promotion in India. In Sri Lanka, the Sri Lanka Medical Association is working with the Ministry of Health through the Diabetes Taskforce to develop capacity building for health professionals in prevention and control of diabetes at the community level.

26. In that regard, the regional strategy should seek to: (a) encourage Member States to create and sustain a political and economic environment conducive to initiating and maintaining partnership, alliances or networks with nongovernmental organizations, private and public stakeholders, local and international development partners for purposes of mobilizing financial and technical resources for promoting health; (b) designate the coordinating role for establishing partnership, alliances and networks to the Ministry of Health in order to avoid duplication and conflict which could result in wasting limited resources; (c) encourage the participation of various players in forming partnerships and networks for promoting health at different levels including institutions of public health, private organizations, nongovernmental organizations, civil society groups and community-based groups.

27. The private sector and civil society groups should work closely together in promoting health in order to reward good business practices and keep in check bad business practices. The private sector should return to the community some of its profits in the form of support to grassroots initiatives to promote health. Community projects that target young people or women are popular with communities and politicians and are likely to yield positive community relations.

Evidence for health promotion

28. While the utility of health promotion is widely acknowledged, there is still a need to continue to demonstrate and document the evidence in order to close the gap between practice and evidence and to justify the allocation of resources. It is essential that a mechanism for gathering evidence as well as analysis, documentation and dissemination is established and sustained to assess the performance of various aspects of the Regional Strategy e.g., health promotion policies, programmes, infrastructure, investments or capacity building.

29. The Strategy should recommend to: (a) monitor systematically health promotion policies, programmes, infrastructure and investments related to health promotion; (b) establish indicators and expected products based on health promotion objectives for planned activities including technical and financial support; (c) document all evidence and disseminate it among local, regional and global stakeholders; and promote the utilization of the evidence by practitioners and policy makers in making informed programmatic and policy decisions including allocation of resources or future programme direction.

Social mobilization and advocacy

30. In order for health promotion to remain high on the global and national agenda, there is a need to involve various stakeholders to demand health. Social mobilization and advocacy uses multiple approaches to increase public awareness and interest in health. In order to ensure effective communication, the actions being advocated for are often conveyed through the use of mass media and group media channels of communication in the language preferred by the target audience.

31. The Strategy encourages: (a) the participation of intended beneficiaries and other stakeholders in advocating for health; (b) advocating for the integration of health promotion across sectors and settings; (c) the involvement of high profile citizens and international celebrities to become health promotion ambassadors for purposes of lobbying government officials and private corporations.

32. The consumers and beneficiaries of public health services, that is, individuals, families and communities and civil society groups, should be involved throughout all phases of health promotion activities, in order for them to gain greater control

over decisions and actions affecting their health. In that regard, it is essential that individuals, communities and civil society groups participate in the setting of standards and norms of production and distribution of consumable products as well as policies, strategies, legislation and regulations and information aimed at promoting health. It is essential to ensure the participation of all people in all aspects of promoting health irrespective of age, gender, ethnicity, religious or cultural beliefs and values, among others.

33. Civil society groups and other community-based groups should empower individuals, families and communities to demand for and have access to information and services that promote health in various sectors and settings. The formation of a functional partnership and alliance between Member States and the private sector, health promotion professional associations, and civil society and consumer groups, should be facilitated for the purpose of building capacity for additional financial and technical resources to promote, support and protect health.

34. The strategy should promote grassroots community initiatives by civil society groups and local and international nongovernmental organizations in health settings e.g. schools, "wet" and food markets, hospitals, clinics, villages, workplaces or youth centres, and to use these as "Best Practice Models" to demonstrate evidence for health promotion.

Health promotion financing

35. Health promotion activities are not spared from competing for the limited budget of national or regional health administrations. Despite the fact that health promotion is an essential public health function, and any expenditure on health promotion is considered a justifiable investment, these activities often receive inadequate financial support compared to the demand placed upon it.

36. Thailand adopted the "Health Promotion Act" in 2000 in order to have sustainable financing for health promotion, through the use of dedicated taxation from sales of tobacco and alcohol, managed by an autonomous body called, the Thailand Health Promotion Foundation or ThaiHealth. Nepal adopted a similar legislation a few years ago but the dedicated taxation on cigarettes has to be used for the national Cancer Hospital. In Sri Lanka, new legislation for the establishment

of a National Tobacco and Alcohol Authority has been discussed in Parliament since 1994.

37. The Regional Strategy, therefore, encourages Member States to: (a) request each sector or ministry to allocate adequate financial resources for supporting health promotion activities; (b) create and maintain a functional partnership with the private sector and donors including UN agencies in order to mobilize extra-budgetary resources; (c) consider exploring the possibility of establishing a Health Promotion Foundation along the lines of ThaiHealth or a similar arrangement. Member States need to allocate adequate financial and technical resources to support and sustain the various health promotion strategy activities across sectors and settings. Where the national budget is not adequate to support health promotion activities, there is a need for Member States to consider alternative funding sources e.g., the setting up of a Health Promotion Fund using special taxes.

Management of change

38. Health promotion requires that various players other than health professionals be involved in addressing the determinants of health. Due to the numerous health demands that compete for limited resources, it is also critical that alternative sources of funding be identified at country and regional levels. This demand for resources places a huge burden on both practitioners and policy makers at national and local levels and often creates resentment towards health promotion. In the SEA Region, new threats to health such as earthquakes or avian influenza, and neglected diseases such as dengue also compete for limited resources.

39. The approaches to health promotion supported by the Regional Strategy cut across all levels of the health system. Therefore, in order to address the social, cultural and economic determinants of health, associated with a wide range of risk factors, the health promotion interventions should incorporate three distinct approaches:

- The ***settings approach***, which is associated with promoting healthy settings, e.g. healthy cities, villages, islands, districts, workplaces, markets, schools and hospitals, among others,

- The ***population-based approach***, which seeks to promote healthy populations, e.g. children, adolescents, women, the elderly and workers, etc., and
- The ***issues-based approach***, which promotes healthy practices on specific issues to address major, common risk factors in the areas of diet and nutrition, tobacco, physical activity, injury prevention, safe sex, patient safety and food safety, among others.

40. It is therefore essential that both Member States and other partners including WHO should: (a) formulate plans to respond and manage new challenges in health promotion including financial and technical resources, controversial issues and organized resistance or opposition to health promotion; (b) establish a Professional Code of Practice or Ethical Standards of Practice to set the professional conduct or behaviour expected of health promotion professionals including those affiliated with civil society groups, NGOs, the private sector or international organizations. Health promotion could be threatened by organized criticism or resistance from within or outside the health profession. In such an event, health promotion professionals should be prepared to defend the profession but also adhere to professional ethical standards.

Role of Member States

41. Promoting health should not be left to the Ministry of Health alone. Instead, governments should participate in promoting the health of its people in various sectors and settings. Member States are encouraged to embrace a “whole-of-government approach” in order to promote health through multi-sectoral and multi-disciplinary collaboration. Existing national planning and economic development policies and strategies should be reviewed to ensure that health promotion is integrated into national development plans in order to tackle the determinants of health associated with premature deaths and morbidity. Ultimately, it is critical that Member States make adjustments to current health and economic policies, strategies, approaches and resource mobilization in order to align them to health promotion.

42. Governments need to ensure that policies reflect the aspirations of civil society groups and national priorities and societal values and expectations with regard to promoting and protecting health of the general population.

Role of WHO

43. In order for Member States of the South-East Asia Region to successfully implement the Regional Strategy, WHO should continue to advocate for renewed and sustained political commitment at the highest level to health promotion. It should support and sustain the establishment of partnerships, networks and alliances for harnessing additional technical and financial resources for health promotion among international development partners, including other UN agencies.

44. It would also facilitate and support the establishment and functioning of health promotion knowledge networks in the Region such as WHO Collaborating Centres or a Regional Network for Health Promotion or Noncommunicable Diseases, such as SEANET-NCD, in order to create a forum for dialogue on regional and global health promotion and NCD prevention and control issues. Necessary technical and material support should be provided to countries of the Region to establish programmes, policies, guidelines, action plans, regulations and legislation, and evidence for health promotion, especially in facilitating the building of a critical mass of health and non-health professionals through various forms of training to promote health across sectors and settings.

Conclusion

45. The Regional Strategy takes into consideration historical developments from Alma-Ata (1978) through to Ottawa (1986) and Bangkok (2005). The impact of globalization and how it has influenced the determinants of health including social and health outcomes is reflected in the strategic directions selected for this Regional Strategy. The strategic directions are derived from required actions and recommended commitments identified in Bangkok Charter for Health Promotion. The Strategy seeks to address determinants of health and the associated risk factors. To achieve this, the Strategy advocates for the involvement of other players outside the health profession including the private sector, civil society groups and community-based groups.

46. Ultimately, the success or failure in implementing the identified strategic directions depends on the political will and commitment of the Member States to integrate health promotion across sectors and settings, and to provide an

environment conducive for various players to contribute to the promotion of health. The progress in implementing the Regional Strategy for Health Promotion for SEAR will be reviewed in early 2008 and reported to the sixty-first session of the Regional Committee in mid-2008, in preparation for the 7th Global Conference for Health Promotion to be held in Africa in mid-2009.