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Inter-country Consultation on Regional Strategy for Health Promotion for South-East Asia

Chiang Mai, Thailand, 26-29 June 2006

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1. Background and objectives

Health promotion is a cornerstone of primary health care and a core function of public health. Its value is increasingly recognized: it is both effective and cost-effective in reducing the burden of disease and in mitigating the social and economic impact of disease.

The First International on Health Promotion (Ottawa, 1986) and the resulting Ottawa Charter for Health Promotion are recognized worldwide as the foundation of the concepts and principles of modern health promotion. The Ottawa Conference and the subsequent series of WHO global conferences held in Adelaide (1988), Sundsvall (1991), Jakarta (1997), Mexico City (2000), and Bangkok (2005) provided global commitment, guidance and direction on actions to be taken to address the determinants of health in order to achieve health for all.

Member countries of the WHO South-East Asia Region (SEAR) are facing a double burden of communicable and noncommunicable diseases. In addition, new threats to health like HIV/AIDS and avian influenza epidemics, as well as re-emerging diseases such as malaria, tuberculosis and kala-azar, are taxing the limited resources to deal with these health problems. Although calls for healthy public policies have been made at all the global conferences on health promotion, the Regional Committees, and World Health Assemblies, SEAR has never had a regional strategy to guide Member countries in the implementation of effective health promotion interventions.

As a follow-up to the last Global Conference on Health Promotion held in Bangkok, Thailand in August 2005, the Region is now finalizing its first regional strategy through a consultative process that seeks to integrate the key action areas identified in the Bangkok Charter for Health Promotion. Health promotion is a process that enables people to have control over their health and its determinants and thereby improve their health. It is known to be most effective when implemented under the direction of a clear strategy.

A multi-sectoral consultation on the Regional Strategy for Health Promotion was organized in Chiang Mai, Thailand on 26–29 June 2006, with the following objectives:

- To review and exchange health promotion experiences within the South-East Asia Region;
- To review the draft Regional Strategy for Health Promotion for SEAR within the context of implementing the Bangkok Charter for Health Promotion;
- To develop a framework for a Regional Action Plan for Health Promotion including the establishment of a Regional Network for Health Promotion.

The meeting brought together the senior representatives from the ministries of health and education, academic Institutions, United Nations agencies, international institutions and national nongovernmental organizations involved in health promotion.

In addition to the discussions, field trips were organized to several health promotion settings, namely a health promoting school, a health promoting hospital, and the WHO Collaborating Centre for Oral Health at Lamphun Province. A health promoting market and the Provincial Public Health Office were also visited in Chiang Mai Province. The participants were particularly impressed with these health promoting settings in addressing specific local health issues.

The programme and list of participants are in Annex 1 and 2 respectively.

2. Inaugural session

The inaugural address of Dr Samlee Plianbangchang, Regional Director, WHO South-East Asia Region was delivered on his behalf by the Director, Department of Noncommunicable Diseases and Mental Health, Dr U Than Sein. The Regional Director thanked the Ministry of Public Health for hosting this important meeting. In his remarks, Dr Samlee pointed to some of the changes that have occurred since the Ottawa Charter for Health Promotion in 1986. These changes include rapid globalization and urbanization; trade liberalization; demographic, social and political

transitions; and the information technology revolution. Dr Samlee noted that public health service delivery needs to keep pace with these changes. Participants were informed that the WHO Regional Committee would discuss the Regional Strategy for Health Promotion for South East Asia in August 2006 and participants were therefore encouraged to deliberate openly and build consensus on the strategic directions. Further, the Regional Director reminded participants of the need for management of change, strengthened advocacy, regulation and legislation, improved capacity and enhanced partnerships, all of which are critical for health promotion action. Dr Samlee wished the consultation every success and participants an enjoyable stay in Chiang Mai.

Dr Siripon Kanchana, Inspector General, Ministry of Public Health, Thailand, delivered the welcome message on behalf of the Minister of Public Health, Thailand. In his message, the Minister thanked WHO/SEARO for selecting Thailand to host this consultation on the Regional Strategy for Health Promotion for South-East Asia. Since Thailand hosted the 6th Global Conference on Health Promotion in August 2005, it was fitting that Chiang Mai was chosen as the venue to finalize the Regional Strategy for Health Promotion. He reaffirmed the commitment of the Government of Thailand to implementing actions and commitments contained in the Bangkok Charter, and hoped that the other SEAR countries would endeavour to do the same. Dr Siripon urged participants to focus on concerted actions for health promotion, and wished them a pleasant stay in Chiang Mai and a successful consultation.

3. Global and regional overview

Dr K. C. Tang, WHO/HQ Senior Health Promotion Officer, presented a global overview of health promotion. He contextualized the presentation using recent landmarks such as the World Health Assembly Resolution WHA57.16 (2004) on Health promotion and healthy lifestyles and the Bangkok Charter for Health Promotion in a Globalized World (2005). Resolution WHA57.16 urges Member States to strengthen their capacity to develop and implement comprehensive health promotion policies and to prioritize the promotion of healthy lifestyles among children and young people. The Bangkok Charter, resulting from the 6th Global Conference on Health Promotion, stresses the need to address health inequities within and between countries.

Dr Tang highlighted that, building on the recommendations of the Ottawa Charter, the five policy actions stipulated in the Bangkok Charter are 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; and
- partner and build alliances with all stakeholders to create sustainable actions.

Dr Tang also explained that Member States and their global partners should commit to making 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; and (iv) a requirement for good corporate practice.

In conclusion, Dr Tang underlined the need to establish benchmarks for gathering evidence on the effectiveness of health promotion, report progress in the implementation of the Bangkok Charter, and involve all stakeholders in promoting health.

Dr Davison Munodawafa, Regional Adviser for Health Promotion, WHO/SEARO, presented an overview of health promotion in the Region. He explained the concepts and principles differing health promotion from health education, in that health promotion involves a variety of players while health education is the sole responsibility of the ministry of health, which focuses on information dissemination. Health promotion includes broader issues such as advocacy, empowerment, mediation and partnership. He highlighted the challenges faced by the Region as: the double burden of communicable and noncommunicable diseases; new threats to health such as avian influenza, a possible influenza pandemic, tsunamis and earthquakes; re-emerging diseases such as tuberculosis,

malaria, dengue, kala-azar and yaws; and the unfinished maternal and child health agenda. The roles of Member States and WHO in promoting health were presented within the context of the Regional Strategy for Health Promotion for South-East Asia. The key strategic directions for implementation of the Regional Strategy were identified as:

- (1) infrastructure for coordination and management;
- (2) capacity building;
- (3) regulations and legislation;
- (4) partnerships, alliances and networks;
- (5) evidence for health promotion;
- (6) policy advocacy and social mobilization;
- (7) health promotion financing, and
- (8) management of change

Discussion on these eight key strategic directions, along with possible impediments and solutions to implementing the regional efforts, are presented in Section 4 below.

Regional framework for noncommunicable disease control and health promotion

Dr Jerzy Leowski, Regional Adviser for Noncommunicable Diseases (NCD), SEARO presented the Regional Framework for NCD Control and Prevention. NCDs – a growing burden resulting in premature deaths – include cardiovascular disease (CVD), cancer, chronic lung diseases and diabetes, and account for 54% of deaths and 44% of disease burden in SEAR. Dr Leowski noted that 80% of CVD and diabetes and 40% of cancers are preventable.

Dr Leowski highlighted that NCDs were due to: underlying social, economic, cultural, political and environmental determinants, such as globalization, urbanization, population ageing; modifiable risk factors, such as unhealthy diet, physical inactivity, tobacco use; non-modifiable risk factors, such as age and heredity; and intermediate risk factors, including raised blood pressure, blood glucose, abnormal blood lipids and

overweight/obesity. These risk factors contribute to chronic conditions such as heart disease, stroke, cancer, chronic respiratory diseases and diabetes.

Dr Leowski then described the guiding principles contained in the Regional Framework as:

- (1) integrated action based on national health policy and strategy;
- (2) application of a public health perspective;
- (3) stepwise implementation;
- (4) focus on awareness generation, health promotion and disease prevention – reduction of risk factors;
- (5) inter-sectoral, multidisciplinary, multilevel approaches;
- (6) combining population-wide and high risk approaches; and
- (7) addressing health disparities and minimizing health inequality.

Five countries of the South-East Asia Region were implementing community-based NCD prevention projects (Bangladesh, India, Indonesia, Maldives and Sri Lanka), which seek to build the capacity of policy-makers and programme managers responsible for prevention and control of major chronic noncommunicable diseases.

Dr Lakshmi C. Somatunga, Director, Non-Communicable Diseases, Ministry of Health, Sri Lanka discussed the prevention and control of NCD in her country. A surveillance system for priority NCDs and an intensive Health Education Campaign to address avoidable risk factors through physical exercise had been established. The guiding principle of the campaign is the promotion of healthy lifestyles throughout the lifespan.

As a result of the country-wide campaign, improvement has been seen in coordination between sectors, behavioural change among children, community exposure to correct messages, the quality of management of major NCDs, systematic collection of information for action, particularly on surveillance, and demand for prevention.

Several factors that contributed to this success were shared, such as high literacy rates due to the free education policy and compulsory education scheme, and the integrated policy on free health services in the scheme, including the provision of primary health care infrastructure.

Dr Chaisri Supornsilaphachai, Ministry of Public Health, Thailand, indicated that NCDs affected the population disproportionately. In terms of DALYs, more than half of the health loss among men and two-thirds among women in 1999 were attributed to NCDs. The National Health Exam Survey (NHES) provides evidence on risk factors associated with cardiovascular disease, identified as hypertension, diabetes, hypercholesterolemia, overweight or obesity, and regular smoking. Among men, 44% were at risk of one of these factors, 20% of two risks, 7% of three risks and 2% of four or more of these risk factors. The prevalence of hypertension was 23% among men and 21% among women. Among men who were found hypertensive, only 23% had been diagnosed by health care personnel. Compared with hypertension, the treatment coverage of diabetes showed a higher percentage among women (49%) than among men (33%). This survey also showed that men had a lower BMI than women (25% overweight and 9% obese). The 3RD National Health Examination Survey provided disturbing evidence that the prevalence of regular smokers is 45.9% among men, twenty times higher than among women. The Thailand Government has set up the Thai Health Foundation to address these challenges.

4. Presentations on key strategic directions

Infrastructure for coordination and management

In Bhutan, several lessons related to coordination and management were derived from the implementation of tobacco control by establishing a national committee. Bhutan has been a signatory to the Framework Convention on Tobacco Control since 2003. The country set up a national committee whose mandate was to coordinate and manage tobacco control, including a total ban on the sale of cigarettes, establishing smoke-free zones and imposing high taxes on those permitted to import cigarettes. The initiative enabled the government to review and improve the legislation and policy enforcement for tobacco control.

In Myanmar, the National Health Committee, the highest inter-ministerial advisory group of all concerned ministries first convened in 1998 to discuss implementation of the Guidelines for Prevention and Control of Smoking in the country. In March 2002, the National Tobacco Control Committee of Myanmar was formed, headed by the Minister of Health. The

Committee consists of heads of related departments and chairpersons of several national NGOs, and sets guidelines for tobacco control measures.

In Nepal, the National Health Education Information and Communication Centre under the Directorate of Health Services launched an integrated Information Education and Communication Programme in 2002. The Centre is placed directly under the Ministry of Health and Population as the focal point for health promotion activities of all its departments.

Capacity building

Dr Karabi Mazumadar, Institute of Behavioural and Allied Sciences, India, spoke of the need for regional, national and community-specific solutions to propagate the concept of capacity building. Dr Mazumadar further stated that the successful involvement of youth, NGOs, teachers and other sectors and stakeholders, as well as community leadership, depended on first building their capacity on related health issues, policy development and leadership.

In 2003, the Maldives Health Promotion Network Workshop offered participants from multiple sectors the opportunity to develop knowledge and skills on health promotion, including partnerships and shared learning experiences.

In Thailand, the importance of capacity building of all stakeholders for health promotion was highlighted through the philosophy “Give a man a fish, you have fed him for a day, but teach a man to fish, you have fed him for a lifetime”. A model and various strategies for capacity building in health promotion for a “Healthy Thailand” were elaborated by Dr Prapapen Suwan, Faculty of Public Health of Mahidol University. She noted that health promotion comprised: healthy public policies, socio-economic measures and regulation, financing, environmental health measures, organizational development, community-based work, preventive health services and health education programmes.

Dr Suwan linked these areas to WHO core competencies in health promotion, such as influencing policy and practice, leadership and managing health promotion programmes, partnerships and networking, marketing and publication, and education. Dr Suwan further elaborated on

what was needed for successful health promotion, namely a health promotion action plan; partnerships with organizations and communities to enhance health; marketing of positive health practices; developing health promotion competency in people; management of activities; continued professional development; evidence-based health promotion and education practices.

Dr Suwan also highlighted the need to integrate the concept of health promotion in the school curriculum up to college level, as well as the importance of developing good competencies in planning, monitoring and evaluation.

Regulation and legislation

Mr Saifuddin Ahmad, Bangladesh Anti-Tobacco Alliance (BATA), briefly outlined the work of his NGO, which was established in line with the Global Commitment on Tobacco Free Initiative. BATA had assisted the Government of Bangladesh with various activities, such as drafting the law, regulations and rules on tobacco control and taxation, and formulating the 3-Year Plan for Tobacco Control. Through partnership with other stakeholders, BATA also participated in the enforcement of related rules and regulations on tobacco control. Mr Ahmad emphasized the role of NGOs in supporting other issues such as physical activity and child safety.

In Bhutan, several steps have been taken following the signing of the Framework Convention on Tobacco Control on 9 December 2003, including a ban on the sale of tobacco products, increased taxes on imported cigarettes and the introduction of Smoke Free Places. Regulations and legal institutions dealing with various aspects of tobacco control, including cross border trade and transport via privileged vehicles have also been initiated.

The National Tobacco Control Committee of Myanmar first drafted the Tobacco Control Law in 2002. In the same year, tobacco advertising was banned in the vicinity of schools, hospitals, health facilities, sports stadiums and maternity homes. In April 2003, the ban was extended to other settings throughout the country. The Control of Smoking and Consumption of Tobacco Products Law was adopted on 4th May 2006 as the State Peace and Development Council Law.

Ms Pamodinee Wijayanayake, Executive Director, Alcohol and Drug Information Centre (ADIC), Sri Lanka, explained the role of NGOs in supporting the development and implementation of policy and legislation for public health issues in her country. Dr Pamodinee highlighted several health policies produced in Sri Lanka in which ADIC had been at the forefront through advocacy. Through the relevant line ministries, NGOs, and Parliament, ADIC has supported the establishment of the many policies and legislation. The broad aim of the National Health Policy (1996) is to increase life expectancy by reducing preventable deaths from both communicable and noncommunicable diseases through health promotion.

Other policies are the Population and Reproductive Health Policy (1998); the National Policy for Rural Water Supply and Sanitation Sector (2001); the National Policy on Early Childhood Care and Development (2004); the Mental Health Policy (2005); the National Nutritional Policy (2005) and the Alcohol Policy, adopted by Parliament in 2006.

Policies in development include the National AIDS Policy, the School Canteen Policy, the School Health Policy, the National Youth Policy, the National Framework for Injury Prevention, the Policy on Rabies Prevention, and the Policy on Dengue Prevention. Thailand has numerous other acts and strategies on tobacco, breast feeding, solid waste management domestic violence and physical activity.

Partnerships

In Bangladesh, several initiatives have been implemented among partner organizations such as the Dhaka Ahsania Mission, Save the Children, UNICEF, Bangladesh Scouts and the Consumers Association of Bangladesh.

In India, the Ministry of Health and Family Welfare works with civil society partners and NGOs to address health issues in the country affecting young people, women and the elderly. Multisectoral measures are also undertaken that require the involvement of other central ministries and State Governments. Dr Alok Mukhopadhyay, Chief Executive, Voluntary Health Association of India, seconded this approach to build partnerships with NGOs and the private and corporate sectors in order to ensure a wider reach and involvement of various stakeholders.

Dr Yudhiastuty Februhartaty from the Regional Center of SEAMEO-TROPMED, Indonesia, presented the role of the Center in promoting and enhancing human resource development in health promotion, particularly through the prevention and control of tropical diseases. Dr Februhartaty mentioned the human resources development courses offered at the Regional Centers for Health Promotion including the Diploma and Doctorate Degree Programmes on various specialities. The organization regularly reviews its curricula to respond to the challenges of the changing public health scenario.

Several other NGOs, along with the Ministry of Health of Indonesia, have documented cases of goitre and cretinism, and found that government control over the production and distribution of iodized salt in several regions was weak. NGOs and community leaders held discussions with the local provincial government on this problem. Among the results and follow-up activities were government commitment and a plan of action developed by local government along with local regulation to better control the production and distribution of iodized salt.

Another NGO initiative is in Depok Municipality where a Forum on Healthy Villages has initiated an advocacy campaign aimed at raising awareness of health promotion issues among all stakeholders. A network of concerned NGOs is supported by the media in promoting the healthy village concept.

Dr Wasim Zaman, Director UNFPA, CST, Nepal, explained the role of UNFPA and stressed the need for partnerships at the global and local levels. The public health issues related to gender disparities, namely violence, adolescent reproductive health, HIV/AIDS and STI, were discussed. Dr Zaman further noted the need for time-bound, measurable indicators, along with flexible planning and consideration of the diverse cultural beliefs and values. UNFPA is committed to working with WHO in strengthening country initiatives in health promotion.

Mr Adulyanon presented a partnership model for alcohol control and injury prevention related to road accidents in Thailand. The model is being implemented through the National Committees on Alcohol Control and on Road Safety. Alcohol consumption in Thailand jumped threefold over a 14 year period (1989 to 2003), before dropping from 36% to 6% in 2006. Mr Adulyanon also introduced the regional network SEATCA (Southeast Asia Tobacco Control Alliance). This collaboration between the Thai Health

Promotion Foundation and the Rockefeller Foundation targets Cambodia, Indonesia, Lao PDR, Malaysia, Myanmar, the Philippines, Thailand and Vietnam. The activities of SEATCA include: regional networking and policy advocacy; a regional collaborative research programme; the ASEAN Fellowship Programme; and the establishment of national forums. In 2004, SEATCA received the WHO Award for its contribution to tobacco control, and in 2006, the SEATCA Coordinator received the Luther Terry Award for outstanding leadership in tobacco control.

Ms Rosanne Wong, UNESCO, Thailand, spoke about the World Education Forum in Dakar (2000), to achieve Education for All by 2015. Recognizing the poor health and nutrition of children as underlying factors for low enrolment, low attendance, poor performance and early drop out, UNESCO saw the need for interagency partnership with WHO, UNICEF, WFP and several NGOs. The FRESH (Focusing Resources on Effective School Health) approach is basically the promotion of health and nutrition through schools, covering areas for action on health policy, safe water and sanitation, skill-based health, hygiene and nutrition education. Ms Wong shared UNESCO Bangkok's HIV/AIDS preventive education experiences with the FRESH approach in building capacity of the education sector to better respond to the HIV/AIDS epidemic. The Teacher Training Manual: Reducing HIV/AIDS Vulnerability Among Students in the School Setting was published in 2005.

In Myanmar, it was noted that health promotion was to be integrated into multisectoral activities in order to enhance healthy lifestyles and well-being throughout life. Partnerships have been encouraged with WHO, UNICEF, the ministries of Education, Sports, Information and Mines, and numerous international and national NGOs. Resource mobilization is one of the priorities of these partnerships.

In Sri Lanka, there are numerous ministerial partnerships that address health-related matters, including the physical activity programmes implemented by the ministries of Youth Affairs and Sports, and Education and Higher Education, which has led to the inclusion of health and physical education in the curriculum.

In Thailand, partnership was critical for the success of Action Smoke Free for Health, comprising the Centre of Research for Tobacco Control

(Mahidol University), media/campaigning networks, NGOs, the National Committee on Tobacco Control, the Health Professional Partners Medical Association, the Dental Council, the Nurse Association, the Pharmacist Council, the Public Health Association and the Department of Disease Control of the Ministry of Public Health.

Ms Susan Loo, Programme Officer, WHO Kobe Centre for Health Development, shared the mission and vision of the Organization. She focused specifically on the Healthy Urbanization Project whose objectives are to: (a) develop strategies to reduce health inequity in urban settings; (b) demonstrate the applicability of these strategies; (c) build capacity; and (d) promote advocacy. The four project sites are in Chile (Santiago), China (Suzhou), India (Bangalore) and Japan (Kobe).

The benefits of a network were identified as facilitating the sharing of information; best practices and resources (e.g. health promotion materials).

Evidence for health promotion

The need to manage and reduce risk was supported in India through operational research and health systems strengthening. Health systems that address population needs as well as a health-supporting socio-economic environment were considered critical. These should be supported by health technologies and research capacity on evidence-based social-economic aspects of health. Public health related policies and programmes must be based on scientific credibility, financial feasibility and socio-political viability.

In Maldives, several activities demonstrating evidence for health promotion were carried out, such as a study on the effectiveness of IEC materials, a database of success stories and best practice, and formative research on health promotion campaigns and evaluations.

Myanmar has conducted research on CVD risk factors in selected townships of Upper, Lower, and Eastern Myanmar. In line with the STEP-WISE Survey, a prevalence study was carried out on diabetes mellitus and risk factors for major noncommunicable diseases in ten urban and five rural areas of Yangon division, among people of 25-74 years of age, as well as cancer population surveys in ten townships of Yangon division.

Policy and Advocacy

In Bangladesh, it was acknowledged that health education and promotion needed to be guided by policies towards health, poverty alleviation, gender equity, violence against women, accident prevention, environmental protection and the control of drug abuse.

Dr Tiwari (India) pointed out that health promotion had been a major focus for control of NCDs, particularly in addressing lifestyle-related behaviours in India. He identified the components of health promotion associated with NCDs as: policy interventions to promote healthy living habits, the creation of enabling environments, health education activities and early detection of risk factors. He also underlined the need for strengthening health systems.

Dr K. Srinath Reddy of HRIDAY-SHAN, India, highlighted the need for an effective public health response to reduce the huge burden of disease, disability and death in low- and middle-income countries. In order to respond to the above public health concerns, Dr Reddy presented the population strategy and high-risk strategy of HRIDAY-SHAN. The former deals with health policy, health education and healthy environments, whereas the latter strategy focuses on individual case identification and management. The high-risk strategy also enhances positive changes in the physical, social and economic environment and has great potential to modify unhealthy behaviours of individuals and communities in a cost-effective way. Dr Reddy stressed the need to put health higher on the public agenda and for research to support the evidence base. He stated that advocacy was the pathway for transforming policy goals into accomplished actions. Target groups for this advocacy included policy-makers, community leaders, the media, potential allies as well as potential adversaries. In conclusion Dr. Reddy highlighted the essential role of young people in advocacy and policy for health promotion, such as the work of HRIDAY-SHAN towards tobacco control with the involvement of youths in India.

In Indonesia, advocacy for health was the shared responsibility of various stakeholders including government, communities, NGOs, the media and universities. Dr Bangnang Hartono gave several examples of advocacy activities in Indonesia, notably the initiative of the Ministry of Health to introduce the concept of integrated community-based health services post (Posyandu) in 1984. The Minister of Health had invited the President and the First Lady to visit a Posyandu model and, after observation and

discussion with community leaders and health volunteers, the President put his signature on a Testimony Paper, declaring Posyandu as the frontline health service for children and mothers at grass roots level, to be carried out by community health volunteers. To date, Posyandu remains the main community health services approach/strategy in Indonesia to empower communities to solve their own health problems.

Another example was the adoption of Healthy Public Policy in 1999, following the Jakarta Declaration in 1998. The President declared and signed the document which stated that all development sectors should take health as their terms of reference in their development plans. In the year 2000, "Healthy Indonesia by the Year 2010" was launched by the Ministry of Health and all provinces and districts established projects, e.g. "Healthy Jakarta", "Healthy Jogjakarta", "Healthy Bali".

In the Maldives, health promotion is considered a top health sector activity and an integral part of health policy action. Health promotion has also been identified as the first objective of the Maldives Health Master Plan 2006-2015.

The concept of health promoting schools was initiated to provide vision and direction in implementing activities for school-age populations. The Ministries of Education and Health in Maldives had been working hand-in-hand to create a "health literate" community, particularly among learners and teachers.

In Myanmar, the National Health Policy provides guidance in the implementation of primary health care activities across populations and sectors. Health promotion is regarded as the cornerstone to reach individuals and communities, particularly in the promotion of their physical and mental well-being.

Dr Siripon Kanchana, Inspector General, Ministry of Public Health, Thailand, reiterated the importance of advocacy and policy development for health promotion at country level. She presented the experience of Thailand in institutionalizing the health promotion movement, launched on 17 February 2002 with the Prime Minister's announcement of the national "Empowerment for Health" programme. This was followed by the Government's decision to make 27th November the annual "National Day of Health Promotion", chosen as it commemorates the founding of the Ministry of Public Health of Thailand. Dr Siripon described briefly the

national programme on diet and physical activity which is now incorporated into all health promoting schools, representing over 60% of schools in Thailand. The focus of the programme is on nutritional intake, unsafe food and drugs, decreasing the use of tobacco and alcohol, and promoting hygienic restaurants and food stalls. The Ministry of Public Health is also working with local administrations to foster healthy markets.

Financing

Dr Supon Limwattananon (Thailand) presented innovative financing mechanisms for health promotion, highlighting the findings of comparative studies on various investment options. Dr Supon stated that, facing resource constraints, poor countries in Africa and South-East Asia were spending merely US\$ 47.1 and US\$ 63.2 per capita respectively on health in 2002. Spending on health promotion per capita was merely US\$ 1.6 in Africa and US\$ 2.1 in South-East Asia respectively, compared to the global average of US\$ 17.0.

Dr Supon noted that since the Ottawa Charter, some countries around the world had introduced different financing mechanisms for health promotion. One of these was raising funds for health promotion from the dedicated portion of tax revenue from tobacco and alcohol. Dr Supon gave examples from Australia, South Korea, Thailand and the USA. In 1987, the State Government of Victoria in Australia passed a Tobacco Act that led to earmarked tobacco taxes being directed to health promotion, including tobacco control programmes. The funds were managed through an organization called the "Victorian Health Promotion Foundation" or "VicHealth" which is an independent statutory public body. The work of the Foundation is funded from a dedicated 5% tax that is levied on the sale of tobacco products, amounting annually to around US\$ 25 million. About 40% of the funds collected are used for the promotion of community and school health, 30% for sponsoring sports, 20% for health research and the balance for administration. The Western Australian Health Foundation (Healthway) was formally established in 1991 through the Tobacco Control Act of 1990. The 15% increase in tobacco tax resulted in a 10% additional fund for health promotion. Of the annual revenue of A\$ 17 million from tobacco tax, 30% is spent on health promotion, the balance going to the promotion of arts and sponsorships. Earmarked tax from tobacco requires a legislative procedure and the active engagement of civil society groups and NGOs in the campaign. Thailand adopted the Australian model to establish

the Thai Health Promotion Foundation (ThaiHealth) by enactment of the Thai Health Promotion Act of 2001. The Foundation is an autonomous State Agency, functioning directly under the control of the Prime Minister. The source of funding for ThaiHealth is a 2% tax imposed on tobacco products and alcohol.

Management of change

In strengthening health systems, the Government of India has equipped the health system with the structural tools needed to incorporate appropriate health promotion and education activities into health care facilities, and to set up preventive and promotive care into the routine practice of physicians and other health care personnel. Therefore, primary health care has been reoriented to provide culturally and contextually appropriate, and evidence-based chronic-care, including the strengthening and updating of referral mechanisms.

5. Regional framework for plan of action

Participants were divided into groups to review the document on the Regional Strategy in detail. The substantive chapters of the document review: health promotion practice: health education vs health promotion; the Bangkok Charter for Health Promotion in a Globalized World; the objectives and strategic directions of the Regional Strategy; infrastructure for coordination and management; and the roles of Member States and WHO.

The participants appreciated that the development of health promotion was now receiving high priority in policy and would be debated at the forthcoming Regional Committee. They endorsed the list of issues and problems to be addressed and the eight strategic directions being proposed in the Strategy. They particularly emphasized the need for political commitment to put more resources towards health promotion, awareness and multi-disciplinary health promotion programmes on both communicable and noncommunicable diseases, and development of a political and social environment that can scale up the many successful community-based programmes using the healthy-setting approach. Participants also provided specific inputs to the strategic document. They also requested SEARO to distribute widely the final document soon after the Regional Committee in order to encourage health promotion

throughout the Region. A regional framework was also developed to implement the Strategy (Annex 3).

8. Conclusions and recommendations

Conclusions

The Region has an abundance of experiences on health promotion policies and practices carried out by Member countries, UN partners and NGOs. Several Member countries have changed the name and functional role of the nodal entity from Health Education to Health Promotion, and some have even given it a higher position within the Ministry of Health. Other countries reported that even if the name had not changed, the orientation of the programme is now on health promotion.

In order to effectively manage change, health promotion needs to be a core responsibility for the entire government, a key focus of communities and civil society, and a requirement for good corporate practice within the private sector. Most Member countries have established an issue-based “Coordinating Body” for health promotion programmes. After hearing of some success stories, all countries were encouraged to establish a high-level, multisectoral National Committee on Health Promotion and investigate innovative funding mechanisms such as tax revenues from alcohol and tobacco to support community-based activities.

The transition from “health education” to “health promotion” needs consistent advocacy, and must involve all stakeholders in policy development. The establishment of a health promotion focal infrastructure must be followed by supporting regulations and legislation, proper allocation of financial and technical resources, capacity building, and collection of evidence on the effectiveness of health promotion at all levels. WHO should play a central role in assisting Member countries in these matters.

All Member countries had experience in the development of policy, regulation and legislation on health issues. However, some countries had not yet addressed critical health promotion challenges, especially evidence on risk factors and the socioeconomic determinants of health. Enforcement of existing legislation on tobacco, alcohol and driving was still weak. Most

countries have mobilized partners and even established networks for advocating policy actions. Evidence is keys for advocacy, building partnerships and social mobilization for health promotion. Countries are utilizing their health and development research institutes to monitor health promotion policies, strategies and programme implementation, including their impact at various levels. This requires concerted efforts by the networks to document and disseminate the findings and to generate understanding among all stakeholders regarding the need for indicators to assess the cost-effectiveness of various Health promotion interventions.

All Member countries acknowledged the need for intensive capacity building at all levels to address the transition from health education to health promotion, to build leadership and management capability for policy and programme development, including health promotion. In order to build this critical mass of skilled health and non-health professionals, institutions of learning, civil society groups and development partners should be involved in capacity building. Ministries of health need to seek alliances with various local and international partners to mobilize financial and technical resources.

The participants supported the commitments and policy actions contained in the Bangkok Charter. Following much deliberation, they also endorsed the eight strategic directions elaborated in the draft Strategy for Health Promotion for South-East Asia. The Regional Framework for Action on Health Promotion was developed to guide Member countries and SEARO in carrying out priority actions for health promotion in the following areas:

- Establishing or strengthening a management and coordination infrastructure that has significant political power.
- Resource mobilization.
- Enhancement of capacity on policy development, leadership, health promotion practice, knowledge transfer and research, and health literacy.
- Promoting as well as reinforcing regulation and legislation that support implementation of policy in the field.
- Creating and maintaining partnerships, alliances and networks with potential stakeholders.

- Development of evidence.
- Management of change, advocacy, social mobilization and empowerment of people.

Recommendations

- (1) Member countries should review the existing organizational structure responsible for coordinating and promoting health promotion within the Ministry of Health, and take steps to ensure that the entity responsible for health promotion is at a high level in the administration. If not already the case, countries should consider transforming the Department of Health Education to that of Health Promotion.
- (2) Member countries should review the existing – and potential, innovative – financing mechanism(s) with a view to increasing the budget allocation for health promotion.
- (3) In partnership with the WHO Collaborating Centres for Health Promotion and Human Resources, the South-East Asia Public Health Education Network, the curricula for various training and education courses (short- and long-term, degree and diploma) on health education/health promotion should be reviewed and any necessary changes in the concept and content incorporated in order to address new challenges in health promotion.
- (4) Existing regulation and legislation should be reviewed and revised if necessary so that they may be effective health promotion tools to address public health problems such as tobacco, alcohol and other substance abuse, physical inactivity, and food and environment safety.
- (5) Ministries of health should take a proactive role in facilitating the establishment of a high-level Coordinating Body for comprehensive and integrated health promotion, with representation from key stakeholders (NGOs, private or corporate sectors, institutions, community-based groups, civil society groups, political leaders, and government/public sectors).
- (6) Member countries should maximize the utilization of existing health and development research institutes and other research centres to monitor and update health promotion policies,

strategies and programme implementation, in addressing major risk factors and determinants of health.

- (7) SEARO should share experiences by facilitating the national policy process, the dissemination of guidelines and modules in health promotion, and the development and establishment of regional centres of excellence, WHO Collaborating Centres, and national and regional networking for promoting health in the Region.
- (8) WHO should support Member countries in policy development, planning, resource mobilization, evidence on health promotion and capacity building.

Recommendations for the Plan of Action (Annex 3).

A clearly defined health promotion (HP) unit should be set up at national level to underline the importance of health promotion in the region. The first step in this direction is human resource development with technical expertise to understand the concepts and implement HP programmes in an effective manner. Partnerships between government (ministries), NGOs and other organizations are essential for the effective functioning of this unit. National HP strategies should be evidence-based following best practices. Advocacy with decision-makers to be taken up in an organized and coordinated manner. Appropriate financing should be dedicated to setting up the HP unit and to allow it to coordinate all sectors involved. Research projects to develop HP programmes and evaluate their impact are essential to sustain credibility of the HP unit in each country, as is community involvement to familiarize people with HP policies before their introduction within each country.

Annex 1

Programme

26 June 2006

- 0900 – 0915 Agenda 1. Inaugural session
 Opening address by Regional Director
 Opening message from Minister of Public Health, Thailand
 Introduction of participants
- 0945 – 1045 Agenda 2. Overview of health promotion
 Global overview
 Regional overview
- 1045 – 1730 Agenda 3. Exchange of experiences on policy actions
- (a) Policy and advocacy: Dr Srinath Reddy, India
 - (b) Discussion: Dr Siripon Kanchana, Thailand
 - (c) Investment/financing: Dr Supon Limwattananon, Thailand
 - (d) Discussion: Dr Vinayak Prasad, India
 - (e) Capacity building: Dr Prapapen Suwan, Thailand
 - (f) Discussion: Dr Karabi Majundar, India
 - (g) Regulation and legislation:
 Dr Pamodinee Wijayanayake, Sri Lanka
 - (h) Discussion: Bangladesh Anti-Tobacco Alliance
 - (i) Partnerships: Thai Health Promotion Foundation, Thailand
 - (j) Discussion: Dr Alok U., India

27 June 2006

- 0830 – 1730 Agenda 3. Presentations on key strategic directions
- Policy and advocacy: Indonesia
 - Investment/financing: Thailand
 - Capacity building: India and Thailand
 - Partnerships: Bangladesh and India
 - Regulation and legislation: Bhutan and Sri Lanka

28 June 2006

- 0830 – 1230 Agenda 4. Review of the Regional Strategy for Health Promotion:

- Group work
- Plenary discussions

- 1400 – 1730

- Agenda 5. Field trip

- WHO Collaborating Centre for Oral Health
- Provincial Public Health Office, Muang District, Chiang Mai Province
- Mae Tha Community Hospital, Lamphun Province
- Siriwatthana Market, Mai Province
- Chammathewi School, Muang District, Lamphun Province

29 June 2006

- 0900 – 1230 Agenda 6. Development of Framework for Regional Plans of Action

- Group work
- Plenary discussions

- 1330 – 1530 Agenda 7. Conclusions and recommendations
- Regional Strategy
 - Framework for Regional Plan of Action
 - Summary and Recommendations
- 1600 – 1730 Agenda 8. Closing session

Annex 2

List of participants

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Annex 3

Regional framework for plan of action based on country priorities for implementation of Bangkok charter

Strategic Direction	Priority Actions	Approaches/Models	Benchmarks
1. Infra-structure for coordination and management	<p>(a) Uniform definition agreed for setting up or renaming a health promotion unit in ministry of health in every country. In line with this long-term goal, the objectives of health promotion units should also be harmonized.</p> <p>(b) This unit should be autonomous yet affiliated to the government (see Thailand model). Countries needing to set up such a unit should ensure it is integrated in the ministry of health.</p> <p>(c) Ministries of health manage, while coordination and implementation are undertaken by inter-ministerial coordination.</p>	<p>(a) Dedicated health promotion tax to be allocated to run HP unit</p> <p>(b) HP unit should have sections and representation at national, State and district level to ensure smooth implementation</p>	<p>(a) HP unit set up and running in each country by 2009</p> <p>(b) For countries with an HP unit, fully functioning with integrated efforts by 2009</p>
2. Capacity building	<p>(a) Human Resource Development</p> <ul style="list-style-type: none"> ➤ Training of officials and implementers ➤ Inter-country exchange programmes <p>(b) Resources (physical)</p> <p>(c) Quality of programmes</p> <p>(d) Policy where the capacity of promoters and promotees are strengthened</p>	<p>(a) WHO regional training workshops</p> <ul style="list-style-type: none"> ➤ Study tours between countries ➤ Country level training ➤ Short term training <p>(b) Research capacity for designing effective interventions and evaluating impact of HP programmes</p> <p>(c) Appropriate tools (standardized curriculum) for HP programmes in</p>	<p>(a) To be ready by 2009</p> <p>(b) Preparing background: populations should have an understanding of health promotion as a prerequisite to accepting such a programme once introduced.</p>

Strategic Direction	Priority Actions	Approaches/Models	Benchmarks
		various settings, e.g. school health programme to have a template for life skills education curriculum.	
3. Regulation and legislation	<p>(a) Introduction of a HP Bill at country level with its provisions and mandates based on WHO's regional framework document of HP and taking into account the Bangkok Charter.</p> <p>(b) Development and/or implementation of regulations and legislation to reduce the burden of diseases, e.g.:</p> <ul style="list-style-type: none"> ➤ NCDs through: FCTC, alcohol legislation, regulation of food industry and promoting priority actions through appropriate govt. action and policies ➤ CDs eg. malaria, dengue, tuberculosis ➤ MCH and MCI related policies 	(a) Advocacy with appropriate agencies at country level to introduce such a Bill, e.g. with parliamentarians and Supreme Court.	<p>(a) To be introduced by 2009</p> <p>(b) Simultaneous attitude and behaviour change programmes using health promotion among people to accept such legislations and regulations once introduced and to support the Govt. policies on these issues</p>
4. Partnerships, alliances and networks	<p>(a) Public-private partnerships including civil society groups, NGOs, govt ministries, corporates without conflict of interest, business communities and philanthropic organizations</p> <p>(b) Inter-ministerial partnerships and coordination</p>	<p>(a) Donor coordination</p> <p>(b) Core group with constant membership, e.g. NGO or other stable representation)</p> <p>(c) Collective leadership (theme/sector oriented leadership, e.g. HIV, MCH</p>	<p>(a) To have such partnerships ready by 2007</p> <p>(b) Give specific roles and responsibilities to Govt. ministries and NGOs for various sections to ensure sustainability</p>
5. Evidence for health promotion	<p>(a) Evaluation and monitoring HP programmes</p> <p>(b) Collating published best practices and other programme materials to form the basis of HP strategies for the region</p> <p>(c) Plan research studies</p>	<p>(a) SEARO to hold annual review meeting of countries in the region and disseminate its progress report</p> <p>(b) A standardized template to be developed by SEARO through inter-country consultation for evaluation and monitoring HP prog. in each country</p>	<p>Review of literature and programmes by 2007 end</p> <p>Standardized templates to be ready by 2008 end</p>

Strategic Direction	Priority Actions	Approaches/Models	Benchmarks
6. Social mobilization and advocacy for policy	(a) Advocacy with decision-makers from all sectors involved in HP (b) Empowering communities to demand HP programmes through health education	(a) Community based health action (b) Community development	Social support to built to accept and practice health literacy
7. Health promotion financing	(a) Dedicated HP taxes (b) Demand side financing for HP (c) Allocating funds for HP in relevant ministries	Inter-sectoral meetings to develop an integrated plan for financing	Every sector involved in HP will have allocation of budget or HP
8. Management of change	(a) Establish status of HP (b) Flexible structure	Team work, inter-sectoral, inter-organisation, communication forum	Change = Change from MOH to inter-ministerial support for HP From HE concept to HP Establish multi-sectoral coordinating units