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Development of a Regional Strategy on Comprehensive Health Promotion

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1. INTRODUCTION AND BACKGROUND

The World Health Assembly resolution WHA 42.44 (1989), on Health Promotion, Public Information and Education for Health and the Resolution WHA 51.12 (1998), on Health Promotion recognized the spirit of Alma-Ata that was carried forward in the Ottawa Charter for Health Promotion and in the Adelaide strategies for Healthy Public Policies. The Ottawa Charter identified five essential elements for the development of health promotion: (a) building healthy public policy, (b) creating supportive environments, (c) strengthening community action, (d) developing personal skills and (e) reorientation of health services. In the resolutions, Member States were called to develop strategies for health promotion and health education principles as an essential element of primary health care, and to strengthen the required infrastructure and resources at all levels.

While most Member States widely accepted and applied these concepts of health promotion, implementation has been slow, especially, in most countries of the South-East Asia Region.

In May 2004, the World Health Assembly through its resolution WHA Resolution 57.16 on Health Promotion and Healthy Lifestyles Member States to strengthen national capacity in developing and implementing comprehensive health promotion plans as well as promoting healthy lifestyles among children and young people. WHO was also requested to provide support to countries in the above areas focusing on the management of risk factors outlined in the World Health Report 2002.

Four intercountry meetings have been held on health promotion within SEAR (a) Health Promotion and Health Education (1996), (b) Health Promoting Schools (1997) (c) WHO Mega Country Initiative on Health Promotion (1998) and (d) Health Promoting Hospitals (1999). In addition, an inter-regional meeting on capacity building for health promotion and an inter-regional meeting on integration of health promotion within health systems were organized by WHO HQ, in 2003. While some of the recommendations of the above meetings have been implemented, some have yet to be followed-up.

The weakest area identified in national health promotion programmes is an ineffective multi-sectoral mechanism due to either the non-existence of a clear national policy or comprehensive national health promotion plan. Although many small health promotion projects have been implemented in the countries, no systematic evaluation to demonstrate health promotion effectiveness has taken place. This has resulted in low priority being accorded to health promotion among several health and other development programmes.

WHO has been supporting countries to strengthen health promotion, applying the above five elements, through the healthy settings approach. Although some progress has been made in some countries, especially in the area of multi-sectoral collaboration to build supportive environments, few have been able to expand this concept into a national health promotion policy, particularly within the health systems.

To follow-up on the declarations and statements of previous global conferences and to provide new direction in health promotion, the Sixth Global Conference on Health Promotion is being organized in Bangkok, Thailand in 2005.

This workshop of national focal persons has been organized to review and adopt the regional strategic framework for comprehensive health promotion. It will also agree on the draft regional work plan for the next biennium in order to develop harmonized regional and country work plans. It would also provide an opportunity to discuss the preparations for the Sixth global conference on health promotion at regional as well as national levels.

2. OBJECTIVES

- (1) To undertake a situation analysis of health promotion in SEAR countries;
- (2) To review and adopt the Regional Strategy on Comprehensive Health Promotion;
- (3) To draft the Regional Work Plan for 2006-2007;

- (4) To identify actions for implementation of WHA Resolution on Healthy Lifestyles and the Global Strategy on Diet, Physical Activity and Health;
- (5) To establish a regional network for health promotion;
- (6) To plan for the 6th Global Conference on Health Promotion.

3. PARTICIPANTS AND PROGRAMME

A total of 31 participants attended the workshop. They were national focal persons for health promotion and for primary health care or health systems. WHO staff responsible for health promotion from HQ, the Regional Office and four WR Offices also attended. Please see Annex 1 for the List of participants.

The four-day workshop was a combination of presentations, plenary discussions as well as group discussions. Important outcomes from this workshop were: a draft Regional Strategy on Comprehensive Health Promotion, a Draft Regional Work Plan for 2006-2007 and the proposed mechanism for establishing a regional network for health promotion. Please see Annex 2 for detailed Programme of the workshop.

4. INAUGURAL SESSION

The Message from Dr Samlee Plianbangchang, Regional Director, WHO South-East Asia Region, was read by Dr William Aldis, WHO Representative, Thailand.

In his message, the Regional Director highlighted how the concept of health promotion evolved since the WHO working group in 1984 set out the principles of "health promotion", and the subsequent global conferences that strengthened the Ottawa Charter adopted at the first conference. As a result, health promotion had become an agenda item for a much wider group of sectors than before. The emphasis now was not so much on public health policy as on "healthy public policy", ensuring that all policies, such as fiscal, environmental, agricultural and industrial, promoted health rather than weakened it.

He also highlighted that the main theme of the World Health Report 2002 “Reducing risks, promoting healthy life”, was the outcome of one of the largest research projects ever undertaken by the World Health Organization and showed that a relatively small number of risks caused a huge number of premature deaths and accounted for a very large share of the global burden of disease. Reducing these risks would result in significant gains in the form of healthy life expectancy for people in all countries. These gains could be achieved through the greater use of existing cost-effective interventions and population-wide, risk-reduction strategies.

It was also pointed out that the ultimate goal should be to increase “healthy life expectancy”, and not merely to increase life expectancy. To achieve this required a healthy life-course approach, which, in other words, meant promoting health from conception to death.

He reiterated that that the World Health Organization would strengthen efforts to support Member States in the following areas: production and dissemination of evidence for effective health promotion; formulation of healthy public policies, and sustainable health promotion efforts; and increasing the institutional capacity to promote health.

5. HEALTH PROMOTION – A GLOBAL PERSPECTIVE

In his presentation, Dr. Tang Kwok-Cho, Senior Professional Officer on Health Promotion, Department of Chronic Diseases and Health Promotion, WHO/HQ, covered the contexts of health promotion, the state-of-art in health promotion, what health promoters are doing now, why it is done and how.

He said that demography, epidemiology, environment, urbanization, technology, globalization of trade, information technology and international travel and the role of the private industries determined the current contexts of health promotion.

It was now accepted that integrated health promotion (HP) worked. The use of combinations of the five Ottawa action areas and the evidence based approach were the cornerstones of integrated HP. This had contributed to the achievement of health and reduction of health inequities and led to economic

gains. For example, an extra year of life expectancy increased per capita GDP by 4%; a government could save \$2 for every \$1 spent on tobacco control and save \$155 for every \$1 spent on immunization.

Still, there was a need to identify sustaining actions for integrated HP. While national capacity had been strengthened, progress had been uneven. Many countries still did not have the policies, human or financial resources or institutional capacity for sustainable integration of HP.

New frameworks, models and methods were required to tackle structural determinants of health and to make the health system more HP-oriented, appropriately deal with the private sector, and enhance capacity to promote health at both the institutional and community levels.

Presently, health promoters are involved in setting strategic priorities, strengthening capacity to promote health and build partnership with prime movers on health promotion. Advocacy for the adoption of sustainable integrated HP to prevent disease and promote health, reduction of health inequities within and between countries by addressing social determinants and meeting the opportunities and challenges of globalization were the strategic priorities, he added.

Integrated health promotion had received much prominence due to common behavioural risk factors: for example, 4 of the most prominent noncommunicable diseases - cardiovascular disease, cancer, chronic obstructive pulmonary disease and diabetes - were linked by common behavioural risk factors – tobacco use, unhealthy diet and low physical activity.

Synergistic effects had been demonstrated in combining HP strategies. Use of combinations of the five Ottawa action areas in different settings across different age groups, continuing, coordinated and shared care, integrated efforts by different sectors (curative and prevention etc) within the MoH and within different ministries (road and transport and trade etc) contributed to this synergy.

The integrated approach included partnerships with key partners outside the government such as Member States, international and inter-governmental agencies, aid organizations, civil societies, professional associations, the private sector, and individuals and groups in the wider community.

The importance of sustaining actions for integrated HP could not be over emphasized. Reducing health inequities and addressing social determinants were the cornerstones in improving health as poor and marginalized people get sicker and die sooner than people in more privileged social positions. People's health seeking behaviour differed in accordance with their social positions. Additionally, Dr. Tang discussed issues related to globalization and with private industry.

He also analysed what was meant by the capacity to promote health. It included expertise, structures, policy, funding, information, partnership with other ministries and NGOs etc and collaboration with academic institutions/professional colleges.

Prime movers for health promotion at the international level included UN agencies, inter-governmental organizations, international NGOs/civil societies, aid organizations, professional associations, trans-national corporations and the media. Ministries of Health and WHO were no longer the only guardians of health. Health was everyone's business and needed to be promoted at the community, national and international levels. Therefore, the role of these sectors was indispensable for effective and sustained health promotion.

The strategic priorities for health promotion could be set through the WHO Executive Board, the World Health Assembly and Global Conferences such as the 6th Global Conference on Health Promotion to be held on 7-11 August 2004 at Bangkok.

Ways to strengthen capacity and to promote health and build partnerships with prime movers was also discussed.

6. HEALTH PROMOTION IN THE SOUTH-EAST ASIA REGION

Dr. Sawat Ramaboot, Director, Department of Noncommunicable Diseases and Mental Health, WHO South-East Asia Regional Office made a presentation on the situation of health promotion in the Region.

Currently, though all countries had national health education/health promotion units most did not have a national health promotion policy and plan. The “healthy settings” approach had been initiated in all countries but there was a lack of proper evaluation. The lack of national capacity in health promotion planning and implementation, poor multi-sectoral collaboration/partnerships for health promotion and lack of evidence-base for advocacy and policy were some of the major challenges. Initially, to address these issues, advocacy and leadership for health promotion was very important. National capacity for health promotion needed to be strengthened, and due to the low priority given to health promotion as compared to clinical care, sustainable financial mechanisms needed to be established.

The regional goal was to create and maintain an environment and conditions that could support the health and well-being of the people of Member States throughout their lifespan. Dr Sawat identified the following strategies to help reach this goal:

- Development and implementation of national comprehensive health promotion policy and plan;
- Inter-agency and inter-sectoral collaboration and partnerships;
- Building and strengthening national capacity;
- Supporting knowledge management initiative, evidence-based health interventions;
- Development of health promotion information and indicators for evaluation;
- Establishment of regional network for health promotion;
- Establishment of a sustainable financial mechanism.

The priority action areas identified for 2005 are: (i) Inter-country meeting of National and WRO focal points for health promotion to develop regional health promotion strategies, and develop a joint health promotion work plan for 2006 – 2007; (ii) evaluation of the national health promotion programme in selected countries, and (iii) supporting the 6th Global Conference on Health Promotion.

In the period 2006 – 7, the following areas should receive priority: Supporting the development and implementation of national comprehensive health promotion policy and strategies, promoting evidence-based health promotion, and establishment of a sustainable financial mechanism.

7. COUNTRY REPORT SUMMARIES

Participants from each country made presentations on one or two successful examples in delivering health activities through health promotion.

7.1 Bangladesh

Health Promotion in Bangladesh is characterized by strong Government commitment and inputs, plus commendable support from development partners, NGOs and the private sector. Given the cross-cutting nature of health promotion, it provides much needed promotion to components of the essential health services in the public, private and NGO sectors. The dichotomy between health and family planning directorates makes for separate health promotion. However, a task force has been established in the Ministry of Health and Family Welfare headed by a Joint Secretary to coordinate health promotion activities and enforce regulations on the development, production and dissemination of health messages to ensure that standards and quality criteria are adhered to.

The two most successful health programmes using health promotion initiatives in Bangladesh were EPI and Control of Diarrhoeal Diseases (CDD).

The objectives of the EPI programme were to reduced childhood mortality and morbidity and to reduce the attack rate of VPD with the target of eradication of poliomyelitis, elimination of neonatal tetanus and control of measles.

The lessons learned from EPI are: effective community participation in NID made Bangladesh polio-free in 2000; the country received the GAVI reward. Safe injection practice has been introduced in the EPI programme, Hep-B has also been introduced and planning for measles catch-up campaign and Hib Vaccine introduction is in the pipeline. The objectives of CDD were to reduce diarrhoeal morbidity and diarrhoea-related malnutrition and to

reduce diarrhoeal mortality by 50% with strategies to promote establishment of ORT corners in health facilities. The targets was to set up appropriate infrastructure at the district and thana levels to implement the ORT communication campaign.

Lessons learned under CDD were: objective-based training helped to enhance more than the targeted rates, communication campaigns helped increase notification and response to new initiatives, contradicts and commitment and dedication resulted in greater achievements.

7.2 Bhutan

The health sector has established a wide network of health facilities equitably distributed throughout the country.

The history of health promotion in Bhutan is relatively new. However, components of health promotion were incorporated while addressing public health issues since the start of modern health services.

Bhutan has achieved successes in the area of public health. Leprosy and iodine deficiency disorders have been eliminated while polio is on the verge of eradication. The Primary Health Care approach adopted by Bhutan has been recognized through SasaKawa Award. Work in the area of tobacco control has led to the banning of the sale of all tobacco products in the kingdom through community and public action.

Iodine Deficiency Disorders (IDD) were identified as a major public health problem in 1964, based on the report that goitre was almost universally prevalent. Because of the seriousness of the situation, the 63rd National Assembly passed a resolution in 1964 that only iodized salt must be imported and, in 1983, the first nationwide IDD study was conducted after which the IDD Control Programme was established in 1984. In 1985, the first and only Salt Iodization Plant was established in the country. All the salt entering Bhutan was iodized at this plant and over a period of 15 years, Bhutan has achieved universal salt iodization and eliminated IDD as a public health problem based on the evaluation carried out by representatives from WHO/UNICEF/ the Micronutrient Initiative (MI), the International Council for Control of IDD (ICCIDD), and the Network for Sustainable Elimination of IDD.

The successful elimination of IDD can be largely attributed to strong political commitment including high level advocacy and a strong monitoring system.

Tobacco, in contrast, was never considered a major public health problem. The prevalence of smoking is 1% and the use of other tobacco products is 7%, based on the 2001 IECH study. Tobacco control activities were initiated by the communities fuelled more by religious beliefs rather than public health concerns. The form of Buddhism practiced in Bhutan considers use of tobacco in any form a sin. By 2000 Bhutan was able to declare 18 out of 20 districts tobacco-free through local initiatives. Bhutan has received international recognition for initiatives taken in the area of tobacco control. The sale of all tobacco products has been banned from 17th December 2004.

Bhutan has signed and ratified the WHO Framework Convention on Tobacco Control.

7.3 India

India has an institutionalized infrastructure for health promotion. At the apex level, it is the Central Health Education Bureau and the Central Bureau of Health Intelligence.

At the state level, there are family welfare units and health education officers, in addition to school health services. Currently, the age pyramid is fast changing with the age groups 15-19 and those above 60 years increasing rapidly while the number of those below 15 has shown a slight decline.

There is a heavy burden of major noncommunicable diseases. This includes 25 million cases of cardiovascular diseases, 25 million cases of diabetes, 2.4 million cases of cancer, and 1 million cases of Cerebrovascular disease/stroke.

Major noncommunicable diseases have common risk factors. Today's risk factors are tomorrow's diseases. Risk factors, however, can be kept under surveillance.

NCD risk factor surveillance is currently being carried out by piloting the WHO STEPS framework in Delhi, Nagpur, Dibrugarh, Chennai, Trivandrum

through the Integrated Disease Surveillance Programme. Integration is built up on the existing surveillance systems and decentralized to the States. Integration in terms of communicable diseases and noncommunicable diseases, data compilation from both the public and private sectors, and involvement of the health services and the medical colleges is being pursued.

When addressing common risk factors it should be recognized that these are deeply engraved in the social and cultural framework and cannot be seen in isolation.

Tobacco control through the tobacco cessation clinic network, school-based programmes, life skills, rapid assessment and action planning process were highlighted as initiatives in health promotion.

7.4 Indonesia

Health reforms launched in 1999, are intended to achieve a new vision of health development, i.e. "Healthy Indonesia 2010". Three pillars are essential to achieve the vision, i.e.: healthy behaviour, healthy environment, and good quality, affordable health services. Among the three pillars, healthy behavior is considered to be the main pillar, as this would lead to healthy environment and also good quality affordable health services.

To develop healthy behaviour, a health promotion programme has been implemented throughout the country. At the central level, there is a Centre for Health Promotion within the Ministry of Health. In each province and district, there is a unit responsible for health promotion.

The strengths of the health promotion programme in Indonesia are: (1) the new paradigm of health development recognizes health promotion as a priority, (2) the new national health system includes community empowerment as one of its six subsystems, (3) promotion of healthy behaviour is included in the minimal standards of district health services, (4) health promotion has been identified as one of the six obligatory services of health centres, (5) some important policies have been established, i.e. on iodized salt, restriction of tobacco consumption, etc, and (6) increased awareness among health programme officials on the importance of health promotion.

The weaknesses of the programme include: (1) weak linkages among health promotion units, especially between one administrative level and the

other, (2) variability in organization of health promotion units, (3) lack of health promotion manpower, quantitatively and qualitatively, (4) unreliable information system for health promotion, and (5) health promotion is not firmly integrated into health programmes.

Opportunities to strengthen the programme come from: (1) globalization and the advancement of technology, especially multimedia, (2) the implementation of the decentralization policy which enables health promotion to be fitted into the local needs and situation, (3) the amendment of decentralization acts which will help strengthen linkages between administrative levels, and (4) the development of good governance.

The threats are: (1) the larger variety and complexity of health problems, (2) increase of unhealthy behaviour in the community, and (3) the probability of dehumanization of health services due to the application of advanced technology in health services.

Referring to the above SWOT, the national policy for health promotion covers, among others, the following areas: (1) health promotion should be integrated into health programmes, (2) basic approach of health promotion are empowerment, development of social support, and advocacy, (3) evidence-based health promotion should be developed, and (4) capacity building for health promotion, especially manpower development, should become a priority at every administrative level.

National strategies to implement the policy are: (1) development of local health promotion policy in every province and district, (2) development of resources for health promotion, (3) organizational development for health promotion, (4) integration and synchronization of health promotion at every administrative level and among administrative levels, (5) development of information system and evidence-based health promotion, (6) acceleration of partnership and collaboration, (7) development of health promotion methods and media, and (8) facilitation of health promotion development, especially at the district level.

7.5 Maldives

Maldives has successfully controlled many communicable diseases. The HIV rate is low. However, nutritional disorders are common and noncommunicable

diseases (NCDs) are emerging as major health concerns. There is a high incidence of thalassaemia.

Health promotion in Maldives is carried out both by the government health sectors and others. Private hospitals and clinics, other government agencies, e.g. school health programme, Ministry of Environment; Narcotics Control Board, NGOs – SHE, FASHAN, DCSM, Care Society, international organizations – WHO, UNICEF, UNFPA and community organizations are involved.

The Maldives Health Promotion Network has been set up to provide a forum for members of government sectors, international organizations, NGOs and the private sector to work towards a more comprehensive and effective approach to health promotion. Among its aims are improving communication between sectors, increasing quality of HP activities, encouraging partnerships, saving resources and identifying best practice. Currently, they hold quarterly meetings with a theme and have a quarterly newsletter, an e-mail network and an updated database of HP best practices.

The 6th National Development Plan contains a Health Master Plan for 1996-2005. The first National Health Promotion Plan covered the period 2000-2003. The plan for 2005-2008 is being developed.

The Review of Health Promotion in the Maldives, 2004, covers progress towards achieving the goals of the first National Health Promotion Plan. It contains findings of key informant interviews and community workshops in Male' and atolls and gives details of HP by health sector and many other government and nongovernmental sectors. The review is being used as a basis for consultation to develop the new HP Plan.

The Tobacco-Free Island Initiative was initiated as a community-based programme, driven initially by activities of Island Women's Committees, following the example of Madifushi Island, which became tobacco-free in 1993.

The interventions include local awareness-raising and health education campaigns, official recognition of tobacco-free status by the President through an award and prize money, and official recognition of women's tobacco-free status by the Ministry of Health, through plaques and certificates.

The impact is measured by inspections, home visits and reporting by health workers and community leaders. Four islands - Madifushi (Meemu Atoll), Berinmadhoo (Haa Alif Atoll), Hathifushi (Haa Alif Atoll) and Nolvivaramfaru (Haa Dhaal Atoll) have been declared as Tobacco-Free Islands. nine islands have been declared as Women's Tobacco-Free Islands.

Among the lessons learnt were that tobacco control programmes are more effective if the initiative comes from the community and women's groups. Women's development committees, for example, can play an important role in promoting health within the community.

7.6 Nepal

The country faces many health challenges. These include a high level of Total Fertility Rate (4.1), neonatal mortality (39 per 1000), infant mortality (64.4 per 1000), Maternal mortality (539 per 100,000), a low literacy level (66%), rapid, unplanned urbanization and population growth.

The National Health Education, Information and Communication Centre was established in 1993. In 2002, it was placed directly under the Ministry of Health and became the focal point for planning, programming, implementation, monitoring and evaluation of health promotion activities. Its role covers the five areas of health promotion identified in the Ottawa Charter. Its goal is to contribute to the attainment of the highest level of health of the people. It strives to raise the health awareness of the people as a means to promote improved health status and to prevent disease through the efforts of the people themselves and through full utilization of available resources.

Its targets include developing a comprehensive HP policy and strategy, implementing HP activities at all levels of the health system through a "one-door" system, involving all local NGOs/INGOs in HP activities, develop a set of country indicators for HP and determine factors that hinder HP.

The lessons learnt to date indicate that marginalized populations receive inadequate health promotion messages, expansion of community level HP and Education activities help people to change desired behaviour, active volunteers and community people make health promotion programmes effective and interpersonal communication is more effective.

7.7 Sri Lanka

Sri Lanka is undergoing a demographic, epidemiological, technological and social transition. The lifestyles of people are changing resulting in changes in health needs.

While the health needs of youth, adolescents and the elderly are emerging as important concerns, the care of mothers and children should also be maintained. Services for non-communicable diseases also need to be considered as a priority. Services in relation to gender equality and reproductive health is another important area. Thus, health promotion should not only cover noncommunicable diseases prevention but also cater to prevention of communicable diseases leading to a complete state of well-being of the people.

Two main initiatives in health promotion in Sri Lanka are seen as success stories. One is “Healthy Community through Health Promoting Hospitals” and the other is “Promotion of Healthy Lifestyles among children and adolescents through Health Promoting Schools”.

Healthy Community through Health Promoting Hospitals

This initiative was piloted in selected hospitals with inputs from the Health Education Bureau, the centre of excellence for health promotion in the Ministry of Health.

The overall objective was to improve the health and well-being of patients, relatives and staff by developing hospitals into health promoting settings.

The five strategies of health promotion identified in the Ottawa Charter had been adopted with a number of interventions and activities. Among these interventions, establishment/strengthening of a health education/promotion unit in hospitals, formation of policy and guidelines for health promoting hospitals, advocacy and capacity building for hospital health promotion could be considered as very crucial.

The results were very encouraging and exciting. Health promotion in hospitals has been taken up as a priority by members of the hospital

community including relatives, patients and staff, almost all health administrators and even by donors. Donor support increased significantly.

This pilot initiative should be sustained and expanded to more hospitals to promote the well-being of the community at large.

Promotion of healthy lifestyles among children and adolescents

This is another very exciting initiative taken by the Health Education Bureau. Later, several other agencies also initiated some activities.

The establishment of a School Health Promotion unit named as “School Health Club” was an activity/initiative with the overall objective of establishing a new health culture. This was to be achieved through the educational process and communication network by inculcating healthy habits and developing lifeskills to effectively deal with the demands and challenges of everyday life.

Several other activities were also conducted in keeping with the main strategies of health promotion. The development of policy and guidelines, capacity building and advocacy were given priority attention.

As this is an initiative dependent on the enthusiasm and interest of both the health and education ministries, the lessons learnt elaborate how a multisectoral approach to achieve the wellbeing of children and adolescents can also help to achieve the wellbeing of the community at large.

This pilot project needs to be continued as today’s empowered children and adolescents who can cope efficiently and effectively with the demands and challenges of everyday life with improved lifeskills will be the empowered and productive adults of tomorrow.

7.8 Thailand

Health is well-being, the holistically interrelated state of physical, mental, social and spiritual wellbeing. In order to foster this core concept of the Health Development Plan, the Ministry of Public Health has initiated and implemented the health promotion programme using various approaches –

population groups, health issues and settings, working with all related parties and the people at all levels.

Two examples of comprehensive health promotion initiatives were presented. The first one was the development of healthy public policy. The Ministry of Public Health worked with other public sector agencies, the private sector, NGOs, leaders etc. to develop the "Healthy Thailand" policy and strategic plan, which was approved by the Cabinet in November 2004 and declared by the government to be the national agenda.

Another example was an effort to create a supportive environment for health through the promotion of food safety. The National Food Safety Project was initiated with the aim that all food produced, imported and consumed in Thailand should be safe and of international standards. Three main categories of food are targeted – fresh or raw agricultural products, processed food products and ready-to-eat or cooked food. The interventions try to cover the overall food chain from farm to table. The active participation of all partners within and outside the Ministry of Public Health has helped in achieving impressive progress.

7.9 Timor-Leste

This is a new Member State of the WHO South-East Asia Region. The estimated population is 924,000 with an average life expectancy of 50-58 years. Demographically, it has a very young population: 52% are under 15 years of age; 21% are under 5 years of age. The total fertility rate is 7.7 and rising. Households are large with around 6.5 members although 20% have 9 or more members.

Overall literacy is estimated at 54.5% for men and 45.5% for women. Water supply for families is inadequate (29% with provision at dwelling; 70% of households have no private toilet; 73.9% of households have no electricity).

Communicable diseases account for 60% of deaths, particularly among children. Malaria, acute respiratory infections and diarrhoeal diseases are the main killers. Tuberculosis is prevalent and yaws and filariasis are endemic.

Maternal mortality remains high (estimated to be 800 per 100,000 live births). Infant mortality rates (78-150 per 1,000 live births) and under-five mortality rates (125 per 1,000 live births) are among the highest in the world.

The guiding principles of health promotion in Timor-Leste are those highlighted in the Ottawa Charter.

The overall goals in health development are promotion of social responsibility for health; increased investments for health development, expansion of partnership for health promotion, increased community capacity and empowerment of individuals and improved infrastructure for health promotion.

The following strategies are envisaged: Strengthening community action to develop a shared responsibility for health and to take action to improve health; targeted health promotion programmes that address priority needs of the general population, increasing knowledge and skills of individuals, communities, civil society, and all bodies to promote health as a shared responsibility. Effective, targeted communication to ensure provision of quality health information and improved access to quality health information are also included in the strategies to promote health.

After five years of implementating the health promotion strategy, an impact evaluation would be undertaken. It will measure changes in behaviour, the environment, health knowledge, social participation and lifestyle or risk factors.

Regional Strategy on Comprehensive Health Promotion in the South-East Asia Region

Dr. Chai Kritiyapichatkul, Temporary Adviser to the Regional Director presented the draft Regional Strategy on CHP for comments and adoption by participants.

The World Health Assembly resolution WHA 57/11 which requested WHO to address major risk factors to health and to continue to advocate an evidence-based approach to health promotion and to provide technical support to Member States as well as the declaration by the Ministers of Health at the Fifth International Conference on Health Promotion, were very important global declarations relating to health promotion.

He said that the absence of partnerships and collaboration with other sectors to create healthy public policy, the low priority accorded to health promotion even within the health sector, limiting the responsibility for delivering health promotion to the Ministry of Health and the lack of proper documentation were some of the common problems identified in the Region. It was, therefore, time for WHO and Member Countries to seriously review and define how health services shall be reoriented and how health promotion could be effectively delivered through the existing health systems.

WHO/SEARO had supported countries to develop small-scale health promotion projects through the healthy settings approach. Although some progress had been demonstrated, a few countries had been able to expand this concept into a national health promotion policy. For health promotion to be effective and for communities to benefit from the preventive aspects of good health, HP will have to become an integral part of the health system. Those delivering health services would have to be strengthened with new skills to enable them to undertake this additional role, he added.

Although all Member Countries had generally accepted the health promotion concepts in the Ottawa Charter, 1986, and the World Health Assembly resolution 1988, they had rarely been well translated into national policy and implemented at the local levels.

The regional goal for health promotion was to create and maintain an environment and conditions which would support the health and well-being of the people throughout in the life span, reduce health risks, promote healthy life styles and settings, and respond to the underlying determinants of health.

During this biennium and the next biennium, SEARO will focus on supporting Member Countries in five main areas to strengthen health promotion: advocacy and capacity building; development of national comprehensive health promotion; demonstrating evidence-based initiatives and dissemination of health promotion effectiveness; reviewing and evaluating health promotion programmes in selected countries and the establishment of a sustainable financial mechanism for health promotion.

This draft strategy was later reviewed and discussed during the group work sessions.

The Regional strategic approaches, regional expected results and activities were listed. These are included in the text of the presentations in Annex 1.

Global Strategy on Diet, Physical Activity and Health

Dr. K. C. Tang highlighted the important components of the strategy.

It is estimated that noncommunicable diseases (NCDs) cause 60% of global deaths and account for 47% of the burden of disease. These estimates are expected to rise to 73% and 60%, respectively by 2020. Nearly 66% of NCD deaths occur in developing countries.

Physical inactivity, low fruit and vegetable intake, high salt intake, saturated fat and trans-fatty-acid intake, high blood pressure, high cholesterol and obesity are major risk factors for NCD.

Prevention of chronic, noncommunicable diseases by addressing risk factors, impacting multiple NCDs rather than single diseases and multisectoral action are the foundations of the WHO Global Strategy on Diet, Physical Activity and Health.

Dr Tang said extensive stakeholder consultations have been held with Member Countries, UN agencies, international NGOs, the private sector and expert reference groups in this regard.

The key principles have been identified. These are strategies should be multisectoral, address all major chronic NCD risk factors and have a long-term perspective. The implementation needs to address all age, sex and socioeconomic groups. Advocacy must be sustainable and the entry point at country level should be political. Tools for countries should be based on needs and the macro and micro levels should be addressed simultaneously.

Policies concerning the environment e.g. national guidelines on diet and physical activity, fiscal, agricultural and transport policies to facilitate achievement of the objectives of the diet and physical activity guidelines were discussed. School policies that improve health literacy, promote healthy diet, provide physical education and facilities and policies on marketing, especially to children, were also described.

Policies that can be adopted by the government and the private sector, aimed at changing individual behaviour, were enumerated. Recommendations to governments, the private sector and civil society were also discussed.

Provision of leadership and advocacy at international level, supporting Member States on regional and national policy and standards, national dietary and physical activity guidelines and standardized surveillance were identified as some of the responsibilities of WHO headquarters and Regional Offices in this regard.

In addition, it was suggested that who should lead collaboration with UN agencies and international partners and promote, support research in priority areas and work with WHO collaborating centres. It should also establish and support networks to build research and training capacity, mobilize inputs and interaction with civil society and promote integration of chronic NCD prevention policies with development policy.

Following Dr Tang's presentation, Dr. Sawat Ramaboot, Director, Noncommunicable Diseases and Mental Health, WHO/SEARO, made a presentation on the plan for implementing the strategy in the Region.

Dr Sawat identified the main focus of the Noncommunicable Diseases programme of WHO SEARO. This included reducing tobacco use; promoting healthy diet and physical activity and enhancing health promoting activities.

The main activities of this programmes covered surveillance (Risk Factor Surveys, InfoBase, RF profile); community-based interventions; development of national policies and strategies; capacity building; development of guidelines; national networks and the South-East Asia Network of Noncommunicable diseases (SEANET NCD).

The overall supervision and coordination of implementation was provided by the Director, Noncommunicable Diseases and Mental Health. The Regional Adviser on Noncommunicable diseases was the focal point. Health education and healthy settings were the major components of health promotion. The components under nutrition included research to address healthy diet and lifestyle in schoolgoing children and development of IEC

materials for children and adolescents in school health programmes. Integration of RF surveillance with Health Information Systems was the major component of evidence for policy.

The objectives and the areas to be covered in the SEANET-NCD meeting in 2005 were also described.

The 6th Global Conference on Health Promotion Policy and Partnership for Action.

Dr Tang briefed the participants on the arrangements for the 6th Global Conference on Health Promotion. The background to this meeting was explained. The major issues that would be addressed included: the changing context of health promotion; the need to address health inequities by tackling the social, economic and environmental determinants; the effectiveness of and need for using integrated health promotion; the need to tackle chronic diseases; MDGs and emerging health issues and the need to manage globalization.

The tentative conference programme, the topics for technical discussions and the expected outcomes were highlighted.

8. CONCLUSIONS, OUTCOMES AND RECOMMENDATIONS

8.1 Conclusions

The meeting considered the global, regional and country level situation related to health promotion. The experiences of different countries were shared and the progress and constraints discussed. The following important issues were identified during the group work and discussions:

- (1) Enhancement of national capacity on health promotion
- (2) Importance of the development of a national policy and strategy for health promotion
- (3) Advocacy for health promotion
- (4) Reorientation of current services to incorporate health promotion

- (5) Importance of the settings and other approaches to health promotion
- (6) Strengthening evidence base
- (7) Sustainable financial mechanisms for health promotion
- (8) Dissemination of information on successes and failures of HP initiatives
- (9) Multisectoral mechanisms and partnerships
- (10) Role of IT and media
- (11) Need for networking
- (12) Need for HP to address all possible determinants of health, both for communicable and noncommunicable diseases

Outcomes

- (1) The status of health promotion in nine countries reviewed
- (2) Regional Strategy on Comprehensive Health Promotion reviewed and adopted with suggestions from countries
- (3) Draft of the regional and country work plans for 2006-07 discussed
- (4) Suggestions for implementing relevant World Health Assembly resolutions considered
- (5) Framework for establishing regional network for health promotion proposed
- (6) Preparations for the 6th Global Conference on Health Promotion in Bangkok reviewed and suggestions considered.

8.2 Recommendations

Recommendations to countries

- (1) In order to enhance multi-sectoral collaboration for health promotion, countries should establish a high level National Steering Committee with representation of key stakeholders for health promotion

- (2) Intensify advocacy for health promotion, wherever possible, with stakeholders at all levels
- (3) Strengthen national capacity for HP
- (4) Identify and facilitate designation of WHO Collaborating Centres and Centres of Excellence for health promotion
- (5) Document and disseminate the successes and failures of health promotion initiatives
- (6) Establish a clearing house/information centre for HP
- (7) Networking for Health Promotion among the Member Countries
 - Thailand to take the lead in initiating its establishment
 - Thailand will prepare the concept paper and circulate for comments
 - SEARO, Country and WR focal points to be the core members

Recommendations to WHO

- (1) Provide technical support to develop/strengthen national policies on health promotion
- (2) Document and disseminate HP practices from within and outside the Region
- (3) Designate more Centres of Expertise and WHO CCs in HP in the Region
- (4) Provide support for development of sustainable financial mechanisms for HP
- (5) Develop and disseminate training manuals, modules and guidelines for HP and provide periodic training on HP for country staff
- (6) Support countries for documentation and strengthening of evidence-based initiatives on HP
- (7) Advocate with donor/development partners and other potential stakeholders to support HP.

Annex 1

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Annex 2

PROGRAMME

Tuesday, 7 December 2004

- 09.00 – 09.30 Inauguration
Plenary Session
- 09.30 – 10.00 Health Promotion – Global Overview – ***Dr K.C. Tang***
- 10.00 – 10.30 Health Promotion in SEAR – ***Dr Sawat Ramaboot***
- 11.00 – 12.30 Country Presentations (Bangladesh, Bhutan, India, Indonesia)
National Policy, plan
Constraints
Lessons Learnt
Discussion
- 14.00 – 15.30 Country Presentations (Maldives, Myanmar, Nepal, Sri Lanka)
- 16.00 – 17.00 Country Presentations (Thailand, Timor-Leste)

Wednesday, 8 December 2004

- 09.00 – 10.00 Comprehensive Health Promotion Strategy –
Dr Chai Kritiyapichatkul
- 10.30 – 12.30 Working Groups
Review of the Draft on Comprehensive Health Promotion Strategy
- 14.00 – 15.30 Finalization of the Strategy
- 15.30 – 16.00 Health Promotion and promotion of healthy lifestyle – ***Dr K.C. Tang***
- 16.00 – 16.30 Global Strategy on Diet, Physical Activity and Health –
Dr Sawat Ramaboot

- 16.00 – 17.00 Draft Regional Health Promotion Work Plan 2006-07 –
Dr Sawat Ramaboot
Discussions on Guidelines for working

Thursday, 9 December 2004

- 09.00 – 10.30 Working Groups
Review HP 2006 – 2007 Work plan
- 10.30 – 11.30 Plenary
Adopt the draft work plan
- 11.30 – 12.30 Preparation for 6th Global Conference on Health Promotion,
7 – 11 August 2005, Bangkok – **Dr K.C. Tang**
- 14.00 – 16.30 Working Groups (country group)
Action plan for implementation of Global Strategy on Diet,
Physical Health.
Action plan for building capacity for Health Promotion and
Promotion of healthy lifestyles.

Friday, 10 December 2004

- 09.00 – 10.30 Group presentation
Discussion
- 11.00 – 12.00 Group presentation (*continue*)
- 1.30 – 3.00 Adoption of meeting report (conclusion and recommendation)
- 3.00 – 3.30 Closing

Annex 3

GROUP WORK

Comprehensive Health Promotion Strategy

Guidelines for group discussions

The working document No.8.1, Draft Regional Strategy for Comprehensive Health Promotion in the South-East Region, will be used as background for discussions.

Members of each group are requested to discuss, in detail, the following areas:

- (1) Promotion of comprehensive health promotion strategy and establishment of healthy public policy.
 - Consider how to make health promotion a priority within the national health development plan and how can healthy public policy be established.
 - Suggest the feasibility of implementation according to examples cited in the draft strategy document.
 - Provide additional suggestions for the establishment of effective healthy public policy.
- (2) Development of multi-sectoral approach and partnership for health promotion.
 - Give suggestions on how multi-sectoral collaboration among partners for health promotion can be encouraged.
 - Give suggestions on the feasibility of implementing multi-sectoral collaboration amongst partners.
 - Provide any additional suggestions for improving multi-sectoral collaboration for health promotion.

(3) Supporting and strengthening national capacity building in health promotion

- How can capacity building the country be improved and how can WHO help the countries in this area.
- Suggest the feasibility of implementing capacity building for health promotion according to the examples cited in the document.
- Provide any additional suggestions for improving capacity building in health promotion.

Group A	Group B	Group C
1. Dr Md Humayun Kabir Talukdar	1. Prof B.P. Sanjay	1. Mr Sonam Phuntsho
2. Ms Deki	2. Dr Faizati Karim	2. Dr A.N. Sinha
3. Mr Ahmed Shakir	3. Dr Keshab Bhakta Shrestha	3. Ms Khadeeja Abdul Samad
4. Dr (Mrs) Kanthi Ariyaratne	4. Dr A.M.J.B. Walallawala	4. Mr Babu Ram Koirala
5. Dr Chanvit Tharathep	5. Dr Borworn Ngamsiriudom	5. Dr Prasert Louichareon
6. Dr Nanta Auamkul	6. Mr Pedro Canisio Amaral	6. Dr Chai Kritiyapichatkul
7. Ms Dunanty Sianipar	7. Dr Sawat Ramaboot	7. Dr T. Walia
8. Dr K.C. Tang	8. Dr Cherian Varghese	8. Dr Shailesh Kumar Upadhyay
9. Dr George John Kombo-Kono	9. Mr Narintr Tima	9. Dr Sajeeva Ranaweera

Group A Recommendations

Promotion of Comprehensive Health Promotion Strategy and Establishment of Healthy Public Policy:

Health promotion can become a priority within the national health development plan and Healthy Public Policy can be developed through the following activities:

- Establishment of a National Steering Committee for Health Promotion which comprises professional groups, health organizations, representatives from education, agriculture, religious people, industrialists, community (rural representative), mass media etc. Informal meetings for advocacy with the public sector.
- Mainstream health promotion to get political commitment.
- Evidence-based data is needed to convince policy makers for financial support.
- Social marketing is needed for health promotion.
- Dissemination of information about public health.
- Develop and introduce equity framework to policy makers.

The feasibility of implementation:

B1, B3, A1 and A3 of Draft Regional Strategy.

Additional Suggestions: Sharing experiences about the successes and failures of health promotion initiatives in different countries.

- Documentation and effective dissemination of best practices within countries and the Region.
- Accessibility of documents through workshops, conferences, websites, internet, media etc.
- Resource allocation for workshops to develop national policy.
- Expertise, if required for certain workshops.

Development of Multi-sectoral approach and partnership for Health Promotion:

Multi-sectoral collaboration among partners for HP can be achieved through:

- Setting the TOR for multi-sectoral HP setting;
- Developing the mechanism between the committee in and outside the ministry;
- Rotating the Chair of the Committee;
- Setting a common agenda for the multi-sectoral Committee.

The feasibility of implementing multi-sectoral collaboration among partners:

B2 and B7 of Draft Regional Strategy.

Additional Suggestions:

- Set the criteria for collaborating centres;
- Support and strengthen national capacity building in HP.

National capacity building can be improved by:

- Introducing learning organization and exchange programmes between different countries in the Region;
- Establishing HP clearing house/information centre to update knowledge;
- Developing evidence-based studies.

The feasibility of implementing capacity building for health promotion:

B4 and B5 of Draft Regional Strategy.

Group B Recommendations

How to make health promotion an important priority within the national health development plan and establishment of healthy public policies.

Current priorities in the country:

- Make this available if present
- Discuss the current provisions, merits and limitations
- Identify health promotion nodal agency (establish if needed):
 - To be placed at a higher level budget, HR;
 - To work with other programmes in the health ministry /others.

Advocacy

- At what level parliament, planning commission, politicians, civil services industry, trade unions, etc.

- National commissions (eg: NCMH, Federation of Industries).
- Use success stories from other countries.
- Interagency workshops (donors and development partners eg: UNICEF).

Provide benefits of health promotion

- Curative services in comparison to preventive services.
- Health as a key to development.
- Use economic argument - Evidence-based approaches.

Development of multi-sectoral approach and partnership for health promotion

- Map the important stakeholders and their activities
 - State/market/civil society
 - Identify the sectors from the presentations-extrapolations
- Identify the focus of attention of each sector, identify overlaps and build on the common areas
- Provide other sectors the benefits of health promotion Eg: agriculture, food processing, transport, etc.
- Start interaction at the highest level (Ministry)
- Advocacy groups to influence the planning commission.
- National multisectoral commission for health promotion
- WHO to work with UN to include Health in its reports
 - Healthy life expectancy rather than overall life expectancy
 - Poverty and other social determinants - globalization

Supporting and strengthening national capacity building in health promotion.

- Curriculum, skills and competencies for health promotion personnel at different levels developed
 - In-service training
 - Post-graduate and undergraduate levels

- Career path of trained personnel
- Champions of health promotion in countries
- Promote training project - WHO Kobe centre
- HP effectiveness programme - WHO HQ
 - Documentation
 - Technical review of projects
- Use success stories
- Use of WHO collaborating centres

Group C Recommendations

Promotion of regional policy and strategies on health promotion and healthy public policy to policy makers of Member Countries.

- Building up the case
 - Situational Analysis
 - Best practices (evidence based)
 - Dissemination – W/shop/media
 - Acceptance
- Policy Formulation
 - Multi-sectoral involvement
 - Briefing at all levels
- Feasible
- Advocacy for and by various groups such as media/civil societies/NGOs/religious (WHO/Health Ministry)

Development of multi-sectoral approach and partnership for health promotion

- Mechanism put in place
 - Clarity of roles & responsibilities
 - Benefits and privileges

- Confederations/organizations with high potential for HP could be encouraged to organize multi-sectoral meetings on health-related issues
- High-Level steering Committee with involvement of all key stakeholders
- Feasible but largely dependent on support

Support Member Countries to build and strengthen capacity for health promotion

- Identify/establish WHO collaborating centres for health promotion and networking
- Strengthen existing organizations/institutions identified by the Member Countries for HP
- Develop training courses and training materials on HP for different levels (medical, health workers, other sectors, schools, etc.).
- Training at various levels
- Adequate resource mobilization/allocation for capacity building of health promoters.

Annex 4

ADOPTED REGIONAL STRATEGY

Regional Strategy for Comprehensive Health Promotion in South-East Asia Region*

1. Regional issues and challenges

In 1986, the first International Conference on Health Promotion held in Ottawa, Canada, defined health promotion as a “process of enabling people to increase control over and to improve their health.” This concept went beyond the traditional boundaries of health education. Health promotion also sought to improve health by securing the foundation for all the basic prerequisites of health, an important one being equity. At the Fifth International Conference on Health Promotion, organized in Mexico in 2000, Ministers of Health declared that health promotion must be a fundamental component of public policies and programmes in all countries in pursuit of equity and better health for all. The conference also called for the establishment of countrywide plans of action for health promotion. One major objective in the Framework for Countrywide Plans of Action for Health Promotion is to systematically integrate health promotion into the health care reform agenda.

There are no well established partnerships and collaboration with other sectors to create healthy public policy. More importantly, even within the health sector, services for preventive measures are accorded a very low priority as compared to medical care. It is time now for WHO and Member Countries to seriously review and consider how health services shall be reoriented and how health promotion can be effectively delivered through the existing health systems.

*Text Prepared by Dr. Chai Kritiyapichatkul

The following common problems have been identified; a) in most countries, the responsibility for delivering health promotion is within the Ministry of Health and, therefore, healthy public policy and the concept of healthy environments have not been well developed; b) in most countries, health promotion is always accorded low priority in national health policy, in terms of budget allocation and human resources; c) there is no proper documentation and dissemination of health promotion effectiveness to high-level decision makers.

The section on Health Promotion in the Programme Budget 2004-2005 refers to the public health impact of several major risk factors that can be reduced through health promotion, as documented in the *World Health Report 2002*. Around the world, health system reforms with a renewed focus on primary health care provide an opportunity to integrate health promotion into health systems.

WHO/SEARO has supported countries to develop small-scale health promotion projects, through the healthy settings approach. Although some progress has been demonstrated only a few countries have expanded this concept into a national health promotion policy. For health promotion to be effective and for communities to benefit from the preventive aspects of good health, this will have to become an integral part of the health system. Those that deliver health services will have to be strengthened with new skills to enable them to undertake this additional role.

The World Health Assembly resolution WHA 57/11 requested WHO to address major risk factors to health, to continue to advocate an evidence-based approach to health promotion, including providing technical support to countries to enable them to implement, monitor, evaluate and disseminate effective health promotion interventions at all levels.

WHO will continue efforts towards the development of an intensified, innovative, well-coordinated and effective health promotion movement in the Region through building national capacities of Member Countries.

2. Regional goal

To create and maintain an environment and conditions which support the health and well-being of the people of South-East Asia Region throughout the

lifespan, reduce health risks, promote healthy lifestyles and settings, and respond to the underlying determinants of health.

3. WHO Objectives

To develop and implement multi-sectoral public policies for health and integrated gender and age-sensitive approach that facilitate community empowerment and action for health promotion, self-care and health protection throughout the life course in cooperation with relevant national and international partners.

4. SEA Regional Strategic Approaches

Although all Member Countries have generally accepted the health promotion concepts promoted in the Ottawa Charter declaration in 1986 and the World Health Assembly resolution of 1988, these have rarely been well translated into national policy and implementation at the local levels.

During this biennium and the next biennium, SEARO will support Member Countries in five main areas to strengthen health promotion: (a) advocacy and capacity building. (b) development of national comprehensive health promotion; (c) demonstrating evidence-based interventions and disseminating health promotion effectiveness and (d) review and evaluate health promotion programmes in selected countries and (e) establish a sustainable financial mechanism for health promotion.

Regional strategic approaches

- (1) *Promotion of regional policy and strategies on health promotion and healthy public policy to policy makers of Member Countries and development partners*

Health promotion represents a comprehensive social and political process. It not only embraces actions directed at strengthening the skills and capacity of individuals, but also actions directed at changing social, environmental and economic conditions to activate their impact on public and individual health. Health promoters should engage in not only the technical aspect, but also the political

aspect of the policy-formulation process. Political commitment and a well-established policy are essential for the mobilization of all partners to participate in the whole process. Policy- and decision-makers are subjected to many influences, including time pressure, lobbying by interested groups, as well as professional and political agenda. Health promotion is only one consideration, if at all, among the many factors competing for attention in the complex policy-making process. With hard evidence and well developed strategies, the political battle-field can be won, consensus built and interest of the public protected. It is important for health promotion practitioners to engage effectively in the political process. It is also imperative for them to strengthen professional standards for achieving effective health promotion.

WHO/SEARO is committed to support Member Countries for advocacy and development of national healthy public policy and health promotion policy and strategy.

(2) *Inter-agency advocacy and partnership for health promotion*

Health has many pre-requisites and determinants. Good health promotion is relies on systems and services from many sectors in addition to health. Health promotion requires partnerships for health and social development between the different sectors at all levels of governance and society. In 1978, the Alma-Ata Declaration called for health for all and identified partnerships between a wide range of players as a key to achieve this goal. Similarly, the Ottawa Charter and the Jakarta Declaration on health promotion identified wide ranging partnerships as vital to achieving real gains in health.

Partnerships offer mutual benefit for health through the sharing of expertise, skills and resources and the participation in the whole health promotion process.

Existing partnerships need to be strengthened and the potential for new partnerships explored. Advocacy for partners is necessary for good understanding and collaboration.

WHO/SEARO will support Member Countries through advocacy and partnerships between relevant international development

agencies at the regional level to support comprehensive health promotion at the regional, national and local levels.

- (3) *Support development and implementation of national comprehensive multi-sectoral health promotion policy and plan of action, based on regional policy and strategies on health promotion, focus on healthy settings and promotion of health throughout the life course.*

Health promotion is a comprehensive health and social development process which requires the active and continuous participation of individuals and groups of population and support from multiple sectors. Harmonious action by all relevant development partners is essential. Only a systematic approach with a good strategy and comprehensive plan can lead to effective implementation to achieve real health gains.

Health, diseases, the environment and many health determinants are inter-related. Effective health promotion needs an holistic approach, integration of the many existing relevant programmes to develop a comprehensive health promotion plan with multi-sectoral participation.

Health promotion through settings where people live, learn, work and spend their life; promotion of health throughout the life course and promotion of healthy lifestyles are the three key effective approaches for health promotion.

The settings approach is the most effective approach. Through this approach, all stakeholders will be mobilized to actively and continuously participate in health promotion activities using the strength and opportunity as well as the system and resources of their organization.

Through the settings approach, applying the Ottawa Charter strategies, health promotion in cities, islands, schools, workplace, hospitals and communities have been demonstrated to be an effective entry point for disease control, the promotion of healthy lifestyle and healthy environments and the improvement of all related health determinants.

WHO/SEARO will support Member Countries in the development and implementation of national comprehensive multi-sectoral health promotion policy and plan of action, based on the regional policy and strategies on health promotion, focus on healthy settings and promotion of health throughout the life course.

- (4) *Support Member Countries to build and strengthen capacity for health promotion, particularly in health system development and services that support health promotion, and develop and a strengthen sustainable financial mechanism for health promotion and support human resources development.*

As mentioned above, all countries in the SEA Region have responded positively to health promotion but most countries have made very slow progress in appropriately applying the principles of health promotion into practice. One reason for the slow progress is that many countries have very limited resources and capacity. It is time now to strengthen the capacity at local and country levels for more efficient and effective health promotion.

Capacity building is the process that builds sustainable skills, resources and commitment to health promotion in various settings and sectors, in order to increase the efficiency and effectiveness of health promotion, and to prolong and multiply health gains many times over. It is an approach that seeks to enhance the potential of programmes to be sustainable and which enables people and organizations to use the experience of working on a programme a greater ability to address new challenges.

WHO/SEARO will support Member Countries to build and strengthen capacity for health promotion, develop health systems and services that support health promotion, develop and strengthen a sustainable financial mechanism for health promotion and support human resources development.

- (5) *Support knowledge management initiative and develop evidence-based health promotion and knowledge-based health promotion interventions.*

For any intervention to be effective, first and foremost, the activities to be developed must be evidence-based.

Expanding the evidence-base is high on the agenda of the international health promotion community, and it is becoming increasingly apparent that evidence is needed by practitioners for effective health promotion interventions and by policy-makers for policy decisions.

Apart from influencing policy, evidence is also an essential ingredient in building up the body of knowledge, expertise and the capacity of health promoters to plan, implement and evaluate interventions. The complexity of a health promotion intervention may make it impossible to be addressed by traditional quantitative methods in public health alone, and require the use of research methods in the behavioural and social sciences. More knowledge on comprehensive health promotion, which needs integration between the health and social sciences or multi-sciences, multi-determinants, multi-professional and multi-sectoral approaches are needed. Lessons learned from success stories are as helpful as more formal methods and are increasingly important. Knowledge management is the process to collect the vast majority of knowledge which is tacit or un-codifiable, create a flow of knowledge to develop evidence-based and knowledge-based health promotion.

- (6) *Develop a regional compendium of indicators, a health promotion information system and system for regular monitoring and evaluation of health promotion strategies and approaches.*

Health promotion is not a new area. Many health promotion activities and activities related to various health determinants have been implemented in the context of public health, primary health care, disease prevention and many social development programmes. Knowing the real situation of health promotion is necessary for the development of a comprehensive health promotion strategy and plan and its implementation. Indicators and an information system for health promotion are important tools to assess, measure and monitor situation, performance, progress and achievement of health promotion.

WHO/SEARO will develop the core set of indicators for health promotion for the Region and provide technical support to Member Countries to develop a national health promotion information

system and system for regular monitoring and evaluation of country health promotion strategies and approaches.

- (7) *Establish a regional network on health promotion, regional collaborating centre and centre of expertise on health promotion to support and strengthen health promotion in Member Countries in the Region.*

Health promotion can not be carried out effectively by the ministry of health or any single organization as it involves comprehensive health and social development. Only multi-professional, multi-sectoral harmonious participation and action can lead to real success and sustainable health gains. Networking between relevant development partners will facilitate health promotion at all levels. WHO/SEARO will establish a SEA Regional Health Promotion Network and facilitate Member Countries to develop networks for health promotion at national and local levels. Existing high-potential health promotion centres or centres of expertise in each particular area related to health promotion will be identified and established as a regional collaborating centre or centre of expertise to support regional and country health promotion capacity building and strengthen health promotion among Member Countries.