The Fifth Global Conference on Health Promotion Health Promotion: Bridging the Equity Gap 5-9th June 2000, Mexico City

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1. Introduction

The Fifth Global Conference on Health Promotion (5GCHP) – *Health Promotion: Bridging the Equity Gap* – was held 5-9th June, 2000 in Mexico City. This conference built on the advances of the previous four International Health Promotion Conferences, particularly taking forward the priorities of the last International Conference on Health Promotion held in Jakarta, Indonesia in 1997.

The First International Conference on Health Promotion held in Ottawa, Canada, in 1986 created the vision by clarifying the concept of health promotion, highlighting the conditions and resources required for health and identifying key actions and basic strategies to pursue the WHO policy of Health for All. *The Ottawa Charter for Health Promotion* identified prerequisites for health including peace, a stable ecosystem, social justice and equity, and resources such as education, food and income. Key actions to promote health included building healthy public policy, creating supportive environments, strengthening community actions, developing personal skills, and reorienting health services. The Ottawa Charter thus highlighted the role of organizations, systems and communities, as well as individual behaviours and capacities, in creating choices and opportunities for the pursuit of health and development.

Building healthy public policy was explored in greater depth at the Second International Conference on Health Promotion in Adelaide in 1988. Public policies in all sectors influence the determinants of health and are a major vehicle for actions to reduce social and economic inequities, for example by ensuring equitable access to goods and services as well as health care. The *Adelaide Recommendations on Healthy Public Policy* called for a political commitment to health by all sectors. Policy-makers in diverse agencies working at various levels (international, national regional and local) were urged to increase investments in health and to consider the impact of their decisions on health. Four priority areas for action were identified: supporting the health of women; improving food security, safety and nutrition; reducing tobacco and alcohol use; and creating supportive environments for health.

This latter priority became the focus of the Third International Conference on Health Promotion in Sundsvall, Sweden, in 1991. Armed conflict, rapid population growth, inadequate food, lack of means of self determination and degradation of natural resources are among the environmental influences identified at the conference as being damaging to health. The *Sundsvall Statement on Supportive Environments for Health* stressed the importance of sustainable development and urged social action at the community level, with people as the driving force of development. This statement and the report from the meeting were presented at the Rio Earth Summit in 1992 and contributed to the development of *Agenda 21*.

The Fourth International Conference on Health Promotion held in Jakarta, Indonesia, in 1997 reviewed the impact of the *Ottawa Charter* and engaged new players to meet global challenges. It was the first of the four International Conferences on Health Promotion to be held in a developing country and the first to involve the private sector in an active way. The evidence presented at the conference and experiences of the previous decade showed that health promotion strategies contribute to the improvement of health and the prevention of diseases in developing and developed countries alike. These findings helped to shape renewed commitment to the key strategies and led to further refinement of the approaches in order to ensure their continuing relevance. Five priorities were identified in the *Jakarta Declaration on Leading Health Promotion into the 21st Century.*

These were confirmed in the following year in the *Resolution on Health Promotion* adopted by the World Health Assembly in May 1998:

1. Promoting Social Responsibility for Health
2. Increasing Community Capacity and Empowering the Individual
3. Expanding and Consolidating Partnerships for Health
4. Increasing Investment for Health Development
5. Securing an Infrastructure for Health Promotion

At the start of the new century, two challenges remain: to better demonstrate and communicate that health promotion policies and practices can make a difference to health and quality of life; and to achieve greater equity in health. Concern for equity is at the core of the health promotion concept and a thread that runs through the previous conferences and their declarations. Our understanding of the root determinants of inequities in health has improved significantly. Yet inequalities in social and economic circumstances continue to increase and erode the conditions for health. For these reasons, the Fifth Global Conference on Health Promotion focused on bridging the equity gap both within and between countries.

Conference objectives, structure and processes

The Fifth Global Conference on Health Promotion had as its **overall goal** an examination of the contribution made by health promotion strategies to improving the health and quality of life of people living in adverse circumstances. The joint organizers were the World Health Organization (WHO), the Pan American Health Organization (PAHO/AMRO) and the Ministry of Health of Mexico.

The **conference objectives** were:

- To show how health promotion makes a difference to health and quality of life, especially for people living in adverse circumstances;
- To place health high on the development agenda of international, national and local agencies;
- To stimulate partnerships for health between different sectors and at all levels of society.

The conference brought together a wide range of **participants** from about 100 countries, reflecting the various groups and sectors of society that are responsible for or influence the determinants of health. These included Ministers and other major policy- and decision-makers from both health and other sectors; representatives from international and national development agencies, non-governmental organizations, community-based organizations; the private sector; and scientists and practitioners from various fields, including experts in evaluation and communication.

The conference had two **programme components**: a five day technical programme and a two day ministerial programme. These were linked by two joint sessions. At the end of the ministerial programme, several political delegations joined the technical programme.

The preparation of the **ministerial programme** involved the development of the *Mexico Ministerial Statement for the Promotion of Health: From Ideas to Action*, signed at the conference by 86 Ministers of Health or their representatives - a clear sign of political commitment to health promotion. The Ministerial Statement is available in the Annex of this report.

The Statement:

- affirms the contribution of health promotion strategies to the sustainability of local, national and international actions in health, and
- pledges to draw up a country-wide plan of action to monitor progress made in incorporating health promotion strategies in national and local policy and planning.

The **technical programme** was structured around the priorities for health promotion set out in the Jakarta Declaration (1997) and confirmed in the World Health Assembly Resolution on Health Promotion (1998)[1]. The six technical sessions addressed areas Member States and societies as a whole are urged to act upon:

- Strengthening the Evidence Base for Health Promotion
- Increasing Investments for Health Development
- Promoting Social Responsibility for Health
- Increasing Community Capacity and Empowering Individuals and Communities
- Securing an Infrastructure for Health Promotion
- Reorienting Health Systems and Services with Health Promotion Criteria

Each of the six thematic sessions consisted of a plenary followed by breakout sessions allowing discussion of the key elements in smaller groups. In each plenary three case studies and one technical report were presented, then the floor was opened for questions and comments. The technical reports were presented in final draft form to allow for a peer review process during the conference. These are published separately from this report[2].

The conference provided several **mechanisms for active participation** of all participants.

After each plenary, up to 15 breakout sessions were held. These were supported by a facilitator and rapporteur who worked as a team throughout the week (see Annex 6).They guided the debate along pre-defined questions, as well as considering the issues that emerged out of the plenary debates. Breakout sessions provided participants with the opportunity to both:

- give input into the conference report being written during the event, and
- provide targeted feedback towards the finalisation of the technical reports.

A writing team (see Annex 6) was established to ensure a participatory writing process of this conference report on the technical programme[3]. Breakout session rapporteurs met regularly with this team to provide feedback from participants' discussions. In addition, two drafts of the conference report were circulated during the course of the week, allowing all participants to provide further comments in writing.

A similar process was set up for participants' work towards the *Framework for Country wide Plans of Action for Health Promotion*. The intention of this framework was to provide countries that signed the *Mexico Ministerial Statement for the Promotion of Health: From Ideas to Action,* with a tool that guides and supports their efforts to develop and implement country specific action plans. This framework is also available separate from this report[4].

All **products of the conference**,

[1] See Annex for WHO Document WHA 51.12, May 1998
[2] See Annex for information on how to obtain this document
[3] See Annex regarding the report of the Ministerial Programme see Annex
[4] See Annex for information on how to obtain this document

- the six technical reports
- the case studies
- the Mexico Ministerial Statement for the Promotion of Health: from ideas to action
- the framework for country wide plans of action for health promotion, and
- this conference report

are being made widely available beyond the group of 5GCHP participants via various communication channels, including print media and the WHO website[5].

2. The Opening Ceremony

The opening ceremony was held at the National Anthropological Museum, Mexico City on Monday 5th June. The conference audience was addressed by Lic. Jose Antonio Gonzalez, Minister of Health, Mexico; Dr Gro Harlem Brundtland, Director General, World Health Organization; and Dr George A.O. Alleyne, Director, Pan American Health Organization.

Participants witnessed the signing of the *Mexico Ministerial Statement for the Promotion of Health: from Ideas to Action*. The conference audience was then addressed by Dr Ernesto Zedillo Ponce de Leon, President of Mexico.

Some selected quotes are provided below.

> "Considering that the commitment for health goes beyond the boundaries of the health sector, the Conference is a platform to discuss the character of a Global Alliance for Health Promotion to harness the potential of the many sectors of society, and create new partnerships in equal footing among the different sectors and at all levels of government." *(Lic. Jose Antonio Gonzalez, Minister of Health, Mexico)*

> "WHO's overall strategy helps to set priorities. It lays out four strategic directions: reducing excess mortality and disability, reducing risks to human health, developing health systems that equitably improve health outcomes, and putting health at the centre of economic and development policy. All these four directions have elements of health promotion. Each involves us in disseminating knowledge, establishing consensus on how knowledge can be implemented, and encouraging healthy public policies that encourage people to implement the knowledge for themselves." *(Dr Gro Harlem Brundtland, Director-General, World Health Organization).*

> "It is not enough to look at the health outcomes. One must look at those social conditions that determine health outcomes – the determinants of health....... During this week we must look at the disparities in these determinants of health and determine to what extent they are distributed so unequally as to produce health disparities. It is of fundamental importance that in discussions on equity we understand the difference between disparities in health status and disparities in the determinants of health that cause these health inequalities or inequities." *(Dr George A.O. Alleyne, Director, Pan American Health Organization)*

> "Health is a collective responsibility that necessarily implicates the active participation of the population especially in preventive action and in health promotion action like those

[5] See Annex for information on how to obtain these documents

that will be analysed during this conference." *(Dr Ernesto Zedillo Ponce de Leon, President of Mexico.)*

The complete speeches of Dr Brundtland and Dr Alleyne are provided in Annex 1 and 2.

3. Joint Technical-Ministerial Sessions

The technical and ministerial programmes combined on two occasions. The **first** occasion was on Monday 5th June on the theme **setting the stage**. Presentations were given by:

- Dr Achmed Sujudi, Minister for Health, Indonesia, who spoke of the Jakarta Declaration and Indonesia's progress in implementing its national plan for health promotion;

- Professor Michael Marmot, University College London, United Kingdom, who gave the keynote speech on determinants of health with special emphasis on social and economic factors and inequities in health;

- Dr Alex Kalache who described the new organizational arrangements for health promotion in WHO, Geneva.

Professor Marmot's speech is published jointly with the six technical reports of this conference.

The **second** joint technical-ministerial session was held on Tuesday 6th June and provided an opportunity for feedback between the two programmes and **sharing conclusions** from the Ministerial meeting. This session was structured around the four key **themes addressed at the Ministerial meeting**, namely:

- Healthy Public Policies: Equity, Investment for Health and Development;
- Social Responsibility for Health Promotion: Community Participation and the Involvement of all Sectors;
- Re-Orienting Health Systems and Services;
- Mental Health and Healthy Life Conditions: Major Challenges for Health Promotion.

The main outcomes and conclusions from the Ministerial Programme are published separately from this report[6].

4. The Technical Themes and Case Studies

This section summarizes the discussions that took place in the breakout sessions following the six plenaries. The technical reports and case studies presented in the plenaries are available in separate documents and are not covered in detail in this report[7].

Technical Theme 1 : Evidence Base for Health Promotion

The nature of evidence in the context of health promotion was the focus of the first plenary. The technical report "Strengthening the Evidence Base for Health Promotion" was written and presented by Dr David McQueen. This technical session was unusual in that no case studies were presented and no breakout sessions followed the plenary. However, the issue of evidence

[6] See Annex for information on how to obtain this document
[7] See Annex: Conference products/documents.

was discussed as a cross-cutting theme during all other technical sessions and was taken up in all breakout sessions. This is referred to below in the relevant sections. In addition, a special 5GCHP Ad Hoc Working Group on Evaluation in Health Promotion met on several days during the networking time.

A number of major initiatives concerning this issue have been undertaken in North America and Europe. These were outlined in the plenary presentation. Overall, the concept of evidence was a source of considerable debate throughout the conference. Traditional scientific, and particularly medical, definitions of evidence were felt by many conference participants to be too limiting. It was felt that health promotion is a form of participatory action that requires participatory research leading the development of evidence. Traditional scientific convention does not allow for this. Participants felt that evidence needs to be derived from the full range of experiential knowledge. Moreover, the focus of health promotion on the determinants of health and on personal and social change requires relevant measures and indicators. It was the view of many that we are currently not measuring the right things.

Further discussion took place in **the 5GCHP Ad Hoc Working Group on Evaluating Health Promotion** that was initiated by WHO to help clarify and define the role of health promotion evaluation, and identify those gaps that need to be addressed further. In a series of meetings, **the working group** participants discussed and challenged the evidence debate presented in the plenary session on evidence and the related draft technical report. Major points of the lively and sometimes heated discussions were:

- the distinction between purposes for evaluation and types of evidence to be collected for each purpose;
- the evidence debate from a *global* perspective, and the yet missing voices and approaches, such as those from developing countries;
- the differences between evidence and evaluation, and the issues of measuring complex systems of change;
- the need for partnerships with stakeholders and for measuring both processes and outcomes.

The working group developed **the following** *core set of concrete recommendations* for WHO:

- to continue the discussions and work**,** across regions and schools of thought, started by this 5GCHP evaluation working group, and
- to assist in the development of an infrastructure and core set of techniques for health promotion evaluation.[8]

Several experts expressed that their institutions may be interested in becoming part of a global infrastructure to be created in support of health promotion evaluation.

Technical Theme 2 : Investment for Health

The theme of Investment for Health was explored in the second plenary session, presented by Dr Erio Ziglio and Professor Spencer Hagard. The connection between health and human development was explored with particular reference to the Investment for Health approach adopted by the European region of WHO. This is a vehicle which, through benchmarking, enables governments, regions and localities to explore the contribution of each sector to the creation and maintenance of health. The strong connection between social, economic and

[8] See Annex for a more detailed description.

human development, and health was highlighted. Case studies from Trinidad and Tobago, Gaza and Germany were presented[9].

Five broad themes emerged from the discussions amongst conference participants:

- investing in human and social development;
- achieving integrated, multi-sectoral investments for health;
- improving understanding of the relationship between investment and health;
- improving the quality of indicators used to assess development in countries.

Investing in human and social development

Through the breakout sessions, the conference participants strongly expressed the view that Investment for Health is not about economics, but about human and social development. If the prerequisites for health do not exist, social and economic development will be stalled. To the prerequisites identified by the *Ottawa Charter* should be added democracy and political stability. Specifically, it was felt that countries need to re-negotiate their external debt relations to include good health and social development conditions, alongside those concerned with economic development. Human resource and social development should be the cornerstone of any countrywide development plan.

Achieving integrated, multi-sectoral investments for health

Conference participants felt there was extensive evidence to show that integrated, multi-sectoral approaches to investment for health are effective in contributing to both health and economic development. Much of this evidence is of a historical and comparative nature, but provides a compelling case for investing in health.

Improving understanding of the relationship between investment and health

One fundamental step in this process is to make people aware of the relationship between different forms of investment and health. Through such understanding, people are far more likely to relate to and take ownership of health as a public good.

Examples from the case studies and wider discussion indicated that understanding and ownership depend on the reference points of those receiving the message. Not everyone sees the relationship between human and social development and health in a broader sense. Most fundamentally, the concept of health held by those in key political positions is crucial.

For example, the municipalities in all parts of the world that have made greatest progress in taking actions to promote health and achieved a more holistic/integrated approach, are those in which the mayor holds a more broadly based concept of health. This demonstrates both the importance of engaging people and the impact of individual decision-makers on progress. Sharing experiences, stories and case studies as “evidence”, alongside more traditional forms of evidence is important. Stories influence decision-makers as well as scientific evidence. The political and technical dimensions interact. Disseminating case studies in a consumable form (like the videos shown at the conference) can generate political change. This approach can also address the issue of public accountability.

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[9] See Annex

Improving the quality of indicators used to assess development in countries

Conference participants were also concerned that there was still a paucity of health indicators (as distinct from disease indicators) used at the global and local level. Such health indicators may include measures relating to the determinants of health. Moreover, given the close links between socio-economic development, inequities in access to resources and health, health in itself becomes an indicator of development. Similarly, participants felt the prerequisites for health and major determinants of health should be *the* focus of indicators. There is also a need to develop indicators on *equity* separate to the measures of *inequality* which now exist.

Technical Theme 3 : Social Responsibility for Health

The issue of social responsibility emerged during the Jakarta Conference with particular reference to the role of the corporate sector as potential new partners in promoting health. The technical paper *Promoting Social Responsibility for Health: Progress, Unmet Challenges and Prospects* was written and presented by Professor Maurice Mittelmark in this plenary. In his presentation, Professor Mittelmark focused more on community level issues and concerns. The concept of equity-based health impact assessment was presented. Case studies were presented from Gujarat and Calcutta in India, and Henan in China[10].

Five broad themes emerged from the discussions amongst conference participants:

- What constitutes social responsibility for health?
- How do you measure it?
- Issues of equity and gender
- The case studies and what they reflected in terms of the prerequisites of success
- Cultural diversity

What constitutes social responsibility?

It was clear from the feedback received from participants that social responsibility, like health, means different things to different people. Defining it becomes particularly important when identifying who is responsible for what. In working together people need to be clear about rights and responsibilities and need to go through a process of defining social responsibility for health in their own terms so that there is collective ownership.

Different levels, as well as different sectors, need to be clear on roles and responsibilities. Participants identified that Governments are socially responsible for the promotion of democracy, for mobilizing key players and bridging the gap between human rights and social rights at the community level. Some participants felt that Governments too often sign up to Human Rights but fail to follow through and support them at the local level.

However, if social responsibility is devolved, governments too often give up their own responsibilities. A key challenge is to link the different levels of society and develop a dialogue to overcome the inherent tensions.

Some participants pointed out that both workplaces and trade unions have a role to play. Trade unions in particular are currently under-utilised allies. However, some participants felt that in the private sector, social responsibility only signifies economic self-interest.

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[10] See Annex

To some participants social responsibility for health is also about the ability to respond - and that implies skill development and capacity building. To others it is seen as a right.

Participants also identified the development of social responsibility for health as a political process and a potentially dangerous one for its advocates. In at least two breakout groups, this led to a discussion on the barriers to its development

Finally, conference participants pointed out that at the centre of social responsibility lies the issue of respect, respect for the social fabric of a community.

How do we measure social responsibility for health, and is there an evidence base

It was felt by conference participants that little evidence is currently collected on the mechanisms through which social responsibility is related to health improvement. Indeed it is an important dimension missing from current research, particularly in relation to sectors other than health. The key challenge is to come up with appropriate benchmarks for different levels of government and society.

Gender and equity

In many parts of the world, women currently play a prominent role in social responsibility for health at community level. The issue of equity in relation to women emerged as an important issue, which some felt had been neglected, in contrast to social structure inequities. Social responsibility is always seen as the primary responsibility of women, thus men currently take only a marginal role. Moreover, there are different perceptions as to what constitutes social responsibility between men and women. Nevertheless, social responsibility needs to be the responsibility of the whole community.

The focus on the community and case studies

The case studies became an important focus of discussion within the breakout groups. They demonstrated multifaceted action, all starting a different point but with long-term and sustainable consequences. They were developed over long periods of time, had political commitment, reflected partnership approaches particularly between expert, community and local government. They used appropriate technology and were examples of the strong link between environment and health. They also showed the importance of good feedback to the community as part of the process.

Cultural diversity

Just as there are different perceptions of what constitutes social responsibility between men and women, participants argued that there is no national or international consensus on its definition. Social responsibility and how it is defined is a culturally specific concept. Discussion and operationalisation of the concept, as well as measurement of social responsibility, must take this into account.

Technical Theme 4: Building Community Capacity and Empowerment of the Individual

Dr Helena Restrepo summarised the key points in her technical paper on Increasing Community Capacity and Empowering Communities for Promoting Health. She argued that community capacity building lies at the heart of health promotion. Drawing on the work of Paulo Friere she

outlined the main characteristics of community capacity building. She also highlighted the challenges to this approach, particularly in the context of general trends towards economic insecurity, corruption, lack of solidarity, and human rights violation. Her presentation was followed by case studies from Nigeria, Colombia and the United Kingdom[11]. Both the case studies and the presentation generated a passionate response from participants.

The debate in the group breakout sessions was equally lively. Five themes emerged, all demonstrating the tensions around community capacity building and empowerment:

- Capturing the evidence of success and value of community capacity building
- The need for capacity building amongst community health promoters
- The keys to successful community capacity building
- Government and health sector perceptions
- The role of women

Capturing the evidence of success and value of community capacity building

All participants felt that there was a long and established history of community development involving varied and innovative experiences. The systematic documentation of these is crucial. This implies the development of research skills amongst practitioners as well as the development of a greater number of opportunities to communicate work in this area, including publication in journals. One scientific challenge is to find ways, using appropriate qualitative data, of describing the growth and change that takes place in people and communities through empowerment-oriented health promotion strategies. A simple measure of the outcome of community capacity building could be the actions that people take in response to adversity. The systematic relationship between community capacity building, social capital and health needs more and better documenting.

The need for capacity building amongst community health promotion workers

A consistent theme that came through in all the group discussions was the need for better training of community health promotion workers to ensure good practice. Advocacy skills were seen as particularly important. There also needed to be greater investment in network infrastructures. A suggestion from one group was a global website on community capacity building, including guidance on best practice.

The keys to successful community capacity building

Some discussion took place around defining the keys to successful community capacity building. Fundamental to this process is that control of decision-making rests with the community concerned – with little or no outside involvement. Where governments or outside agents are involved, they should take the role of facilitator, not provider. Process is at the core of community capacity building. That process is often slow, and generally needs to be slow to ensure relevance to community aspirations, cultural sensitivity, and to improve the chances of sustainability. Participants also emphasised the importance of systematic planning and good facilitation.

Government and health sector perceptions

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[11] See Annex

Participants expressed concerns that both government and the health sector still do not understand community-based health promotion. Indeed it was emphasised that many top-down, governmental interventions in the past have cut across existing community strengths and undermined existing, locally relevant activity. This danger still remains, especially in some countries where, according to some participants' perception, there is a return to centralisation of health promotion within health services. Community capacity building requires considerable skills and these should be addressed in the training of health professions and public servants in order to avoid or minimise the chances of such practices in the future.

The role of women

As in previous discussions, participants again emphasised the role of women at the core of health development and capacity building initiatives. Some participants felt that this issue comes up repeatedly because of the inherent skills of women which still do not receive proper recognition. Women who are already organised can transfer skills and enhance their own capacity with new skills.

Technical Theme 5 : Securing an Infrastructure for Health Promotion

In presenting his paper on *Infrastructure to Promote Health: The Art of the Possible*, Dr Rob Moodie stressed the need both to build on and improve existing infrastructures to promote health and create a core of dedicated infrastructures for Health Promotion. In light of the barriers identified, he stressed that Health Promotion does not happen by chance. This presentation was followed by two case studies[12] from South Africa and Mexico and one case study illustrating the global movement for active ageing[13].

The debates in the breakout sessions highlighted four main themes:

- Appropriate infrastructures for health promotion
- Equity
- Development of human resources
- Building collaboration

Appropriate infrastructures for health promotion

There was a general discussion on the importance of having an infrastructure that reflects health promotion concepts and principles. That implies not developing new bureaucratic infrastructures or centres but building on what already exists. This means strengthening the capacity to act and developing the mechanisms to do this, and in turn, moving away from traditional vertical structures to networking type structures. It also means recognising that responsibility is not just with government, but involves a whole range of sectors. Appropriate structures are those which strengthen democracy and provide sustainable, continuing support at all levels, particularly at the community level. There should also be mechanisms that provide leverage on resources, and clear benchmarking of standards.

There was much discussion and little agreement on whether a national body dedicated to health promotion was required. Points of view depended very much on the situation in a country.

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[12] See Annex for a more detailed description.
[13] See Annex

Equity

As with discussions on the other topics, the issue of equity was a consistent theme that ran through the consideration of infrastructures for health promotion. Ensuring that any infrastructure pays attention to encouraging equity is fundamental. Such infrastructures also encompass the global dimension. At this level, new forms of mentorship need to be developed between regions and countries. It is also important to recognise that differences in access to technology such as the internet have the potential to increase inequity in access to information. This needs to be addressed in any communication infrastructure.

At all levels, attention to equity means reallocation and redeployment of resources. Any infrastructure needs to have capacity to apply leverage on government policy to ensure that equity considerations remain to the fore. Such an infrastructure also requires equality in top-down and bottom-up elements for delivery of all the elements of health promotion to be successful.

Development of human resources

Participants discussed the need for capacity building in human resources as an essential element of any infrastructure for health promotion. An infrastructure for effective training should be in place and some specific skills are essential. Skill development in democratic planning was highlighted as particularly important. Closer integration between universities and community members was also felt to be important. More fundamentally, there should be basic education for all in what constitutes a health-promoting society.

Building Collaboration

It was reiterated by participants that multi-sectoral collaboration lies at the heart of health promotion and of any infrastructure needed to support it. Communication must be encouraged and credibility established with existing organizations by building coalitions to develop an effective agenda, with emphasis on good practice. Such coalition building takes health promotion beyond the sole remit of the health sector.

Technical Theme 6 : Reorienting Health Services

Dr Daniel Lopez Acuña presented the major findings of the technical report on *Reorienting Health Systems and Services with Health Promotion Criteria*, co-written by five authors[14]. He expressed the need to integrate health promotion and prevention as an integral part of the health care delivery process and to incorporate health promotion principles into health services management. He laid out several strategies to achieve this and outlined steps towards a "second wave of health sector reform". The three key steps highlighted in the paper were to reorient health systems and services with health promotion criteria to increase the effectiveness of health interventions, to promote the quality of care, and to improve public health practice.

His presentation was followed by presentation of case studies from Ecuador, the USA and Pakistan[15].

[14] See Annex
[15] See Annex for a more detailed descritpion.

The crucial role of communities in evaluating the quality of health care services was highlighted. A core question raised was that of the role of governments or the state in the reorientation of health systems and services.

The breakout session consisted of very lively discussions which focused on four main themes:

- Making the case for reorientation
- Equity
- The public/private mix
- How to move things forward.

Making the case for reorientation

A number of participants felt that the reorientation of a health system should involve the integration of health promotion at every stage of the system. The challenge in doing this was in making the case for change. Inevitably, systems are resistant to change. There is a need for clear arguments that can persuade people of the need for change from inside and outside the system. This includes presenting the evidence in such a way as to make it meaningful to politicians. A central role was proposed for WHO in setting up a committee to explore such a reorientation and how it should be implemented. Overall government leadership and political will are most important for any reorientation.

The public/private mix

The case studies provided examples of the reorientation of health care services rather than the larger issue of the reorientation of a health system. Moreover, they reflected only the example of nongovernmental organisations (NGOs). This led to considerable debate as to who is responsible for what within any health system.

There was also a general debate on the role of the state in the provision of the public health function. This is especially important in countries where health service delivery is increasingly managed by the private sector. Issues were also raised relating to universal access to health services in a health care system predominantly managed by the private sector .

In some countries, the models that NGOs have developed have allowed better involvement of the community in decision-making. However, participants felt strongly that Governments should take responsibility for reorientation.

Equity

Coverage in terms of access lies at the heart of equitable health systems. There are some examples of successful reorientation of health systems in different countries, and all have made a contribution to equity. Participants commented that, at its best, an equitable system would include health system reorientation in any needs assessment within a community, as well as a community-controlled health committee.

How to move things forward.

Participants had a far-ranging discussion on how to move forward in terms of a “second wave” of health reform. Although reorientation of health systems had been a fundamental element of the Ottawa Charter, development has been patchy and there has been no systematic analysis of

what has happened and what is possible. The technical paper was seen as a first stage in developing a strategy for change.

5. A Framework for Countrywide Plans of Action on Health Promotion

The *Mexico Ministerial Statement for the Promotion of Health: From Ideas to Action* (MMS) was signed by 87 Ministers of Health or their designates at the official opening of the conference. The MMS was the outcome of a carefully planned process of consultation and briefings, which took place throughout the proceeding year. An initial draft statement prepared by the conference organisers was circulated globally to all Ministers of Health for their comments and suggestions. The Statement was modified accordingly and a revised version once more circulated. Two briefing sessions on the draft statement were held for the diplomatic corps accredited to the UN at WHO. The MMS took forward the spirit of the *WHA Resolution on Health Promotion* (WHA51.12). The MMS states that health promotion must be a fundamental component of public policies and programmes in all countries in the pursuit of equity and better health for all and pledges support for the preparation of countrywide plans of action for promoting health. It states that the plans will vary according to national context, but will follow a basic framework agreed upon during the Fifth Global Conference on Health Promotion. In follow-up to this commitment, on arrival at the conference, participants received a first draft of a *Framework for Countrywide Plans of Action in Health Promotion*. This first draft was used as the basis for a plenary presentation on Tuesday 6th June, followed by a breakout session to discuss the content, direction and application of such a framework. Following further discussion and feedback, a revised version was approved by the conference. This final version is available on the conference website.

6. Health Promotion in Mexico

During Mexico Day, Wednesday 7th June, Plenary session D was dedicated to showcasing a range of Mexican experiences of health promotion as a cross-cutting approach applied to disease prevention. The five themes were: an overview of the strategic programmes of the Vice Ministry for Disease Prevention and Control; health promotion strategy of the immunisations programme; health promotion approaches in health of the elderly; the basic health care packages; and the health education components of the free textbook provided by the Ministry of Public Education.

The following initiatives and points were discussed: a programme on health of the elderly with special attention to diabetes and hypertension; a programme to encourage physical activity; the important role of the community in housing improvement and achieving health development goals; communication strategies such as "The Messenger for Health" which provides information via radio to encourage adequate use of health services and self-care; and the "Heart to Heart" campaign for prevention of noncommunicable disease.

Programmes using the Settings approach were also presented. There are 1,483 "Municipalities for Health", a strategy that advocates for healthy public policy, and enables cross sector action to create healthy and supportive environments. This strategy has succeeded in placing health on the local development agenda and on the national agenda. The "Health Promoting Schools" initiative provides socially and culturally relevant life skills and school health activities centred on the development of youth and adolescents. The family health programme "Health begins at home" trains local community health workers as health promotion agents with the purpose of establishing "health-friendly houses". There are 46 indicators to evaluate the impact and process of these programmes.

The Immunisations Programme covers children, youth and pregnant women, and is extending coverage to the elderly. The Health of the Elderly programme carried out by the Mexican Social Security Institute (IMSS) focuses on primary and secondary disease and risk prevention. This programme emphasises self-care and physical activity. An important activity is the establishment of an information system that monitors results and reports on risk factors identified by the surveillance system.

PROGRESA is a programme that provides a basic health care package. Its objective is to extend coverage to health services. A communication strategy using persuasive messages is in place to prevent tobacco use. The programme encourages self-care and provides ongoing training of health workers to deliver the basic health care package. This model of primary health care provides basic services while reducing the costs of health care.

The school health programme of the Ministry of Education has introduced key health concepts which are included in the free textbook programme. Public education provides 3 million children with free textbooks (approximately 160 million books have been distributed). The content centres on the development of life skills, values, attitudes and practices for a healthy and fulfilling life, including self-esteem, self-respect and respect for others, gender equity and tolerance education. Children develop an integral concept of health and development, learn to express and manage their feelings and to establish nurturing relationships, learn about the changes in their own bodies and how to protect the environment.

During the Mexican case study presentations, a variety of experiences were shared that illustrate culturally relevant health promotion at the community level. There were nine simultaneous working groups with approximately 5 presentations in each. Each session centred on a health promotion approach. One session was dedicated to health promotion strategies with different population groups. Another showcased health promotion experiences across the life cycle and with a family focus. Yet another group presented and discussed experiences with the settings approach: schools, municipalities, communities and workplace health promotion. The richness and diversity of experiences illustrated the relevance of health promotion at the local level. This session facilitated a common understanding of health promotion and provided input for many reflections. During the discussions, however, it became apparent that a common understanding of health promotion was lacking and that the existing networks of “Health Promoting Schools”, “Healthy Municipalities and Communities” and the “Consortium of Universities”, could very well be engaged in promoting a common understanding of health promotion.

7. Key issues arising from the meeting.

Restatement of the relevance of health promotion

Health promotion is the process of enabling people to exert control over the determinants of health and thereby improve their health. As a concept and set of practical strategies it remains an essential guide in addressing the major health challenges faced by developing and developed nations, including communicable and noncommunicable diseases, and issues related to human development and health.

Health promotion is a process directed towards *enabling people* to take action. Thus, health promotion is not something that is done *on* or *to* people, it is done *by, with* and *for* people either as individuals or as groups. The purpose of this activity is to strengthen the skills and capabilities of individuals to take action and the capacity of groups or communities to act collectively *to exert control over* the determinants of health and achieve positive change.

In tackling the determinants of health, health promotion will include combinations of the strategies first described in the *Ottawa Charter*, namely developing *personal skills*, strengthening *community action*, and creating *supportive environments for health*, backed by *healthy public policy*. Special attention is also given to the need to *reorient health services* towards health promotion.

Thus, health promotion will include actions directed at both the determinants of health which are outside the immediate control of individuals, including social, economic and environmental conditions, and the determinants within the more immediate control of individuals, including individual health behaviours.

The inputs to the conference in the form of presentations, case studies and posters clearly demonstrate that health promotion remains as powerfully relevant a strategy for social development as it was when it first emerged as a concept at the First International Conference on Health Promotion fifteen years ago. In particular, it remains an important set of strategies to address the factors influencing inequities in health.

Focus on the determinants of health

Health is a resource for life which enables people to lead individually, socially and economically productive lives. It is a positive concept emphasising social and personal resources (physical, mental and spiritual).

It has long been acknowledged that there are certain prerequisites for health which include peace, adequate economic resources (and their distribution), food and shelter, clean water, a stable ecosystem, sustainable resource use, and access to basic human rights. It was clear from the conference that the challenge to meet these fundamental needs must remain a core goal for all action directed towards health, social and economic development.

Recognition of these prerequisites highlights the inextricable links between social and economic conditions, structural changes, the physical environment, individual lifestyles and health. These links provide the key to an holistic understanding of health, and are meaningful to people's lives as they experience them.

Bridging the Equity Gap

A major underlying theme of the conference was to consider ways in which health promotion strategies can be employed to bridge inequitable differences in health status in populations, both between and within countries. The issue of equity in health was considered consistently in the breakout sessions, and addressed directly or indirectly through each of the technical reports. Considerable attention was given to underlying causes of inequity in health, especially regarding access to resources for health, and both social and structural inequities, especially gender inequity. By maintaining a focus on the determinants of health, and by emphasising the importance of empowerment, health promotion strategies also address the fundamental determinants of inequity in health. Thus, health promotion represents a viable, strategic response to inequity in health.

Because of the focus on addressing the determinants of health, health promotion requires political, social and individual actions. These actions need to be scientifically sound, socially relevant and politically sensitive.

Health promotion is scientifically sound

There is no single scientific "discipline" of health promotion. Given the range of strategies that are employed to promote health, the scientific basis for health promotion is drawn from a wide range of disciplines, including the health and medical sciences, social and behavioural sciences, and the political sciences. Health promotion may be considered an integrative discipline, using a systematic process to bring together different disciplinary perspectives to achieve intended outcomes.

For this reason it is difficult to determine a simple and universally agreed set of rules of evidence for health promotion. "Evidence" is inevitably bound to social, political and cultural context, and will be related to the method of action, process of change and measure of outcome which are valued by the population affected by actions to promote health.

Health promotion is scientifically sound. The different inputs to the conference (presentations, case studies, posters) demonstrated that there is a rich experience of practice as well as the traditional scientific literature which continues to guide decision-making in health promotion. This evidence can be used as the foundation for transparent accountability for actions taken. Health promotion actions should be based on a sound analysis of the issue being addressed, and should be informed by established theories and models of change drawn from its broad scientific base. A systematic approach to programme planning will, in many cases, greatly improve the chances of detecting a successful outcome and of being able to link observed outcomes to the actions taken. It is important to emphasise that health promotion strategies translate into more than defined programmes and products. For example, assessment of the value and impact of public policy requires quite different measures and methods to those used in programme evaluation.

It is clear from the deliberations at the conference that much work remains to be done to locate and assemble health promotion experiences from around the world to improve the scope and quality of the scientific basis for action, and contribute to knowledge development. This must include further debate on the methods and measures which can be appropriately used to evaluate health promotion strategies.

Health promotion is socially relevant

All actions to promote health occur within a social context. The strategies adopted to address the determinants of health need to be continually adapted to ensure their social and cultural relevance and to ensure that their effect increases rather than reduces equity in health. This is especially true for actions addressing health determinants in indigenous populations. Health promotion must be socially and culturally relevant.

Many of the case studies presented at the conference demonstrated that strategies to promote health should be grounded in a meaningful assessment of people's needs and aspirations, and should engage people in the process of addressing these. This ensures that social responsibility for health is genuinely shared between people and their government, and public and private interests at all levels.

The report of the Ministerial meeting and the Ministerial Statement make it clear that governments have special responsibilities to guarantee basic and universally accepted human rights, support democratic and participatory processes, and create infrastructures and conditions which support action to address the determinants of health.

The different inputs to the conference also strongly demonstrated the importance of collective action at the local level. Effective action at this level is built on an informed population, equitable participation in decision-making and a sense of belonging. It was also clear from the case studies that health promotion at this level is inextricably bound with economic and social development. In this regard, building the capacity of communities to take action to address locally determined problems is central to health promotion. Part of this process of building community capacity is to create the conditions within which community leadership and social entrepreneurialism can emerge and act as catalysts for change.

Many find the concept of social capital useful in describing both the process and outcome of locally based action for health.

Health promotion is politically sensitive

Health promotion is an inherently political process as it is essentially concerned with individual and community empowerment. Health promotion often necessitates actions which require political processes in the form of resource allocation, legislation and regulation.

The determinants of health are not restricted to the influence of health ministries and health professionals. Addressing these determinants and achieving greater equity in health requires political processes and actions which extend well beyond these boundaries. For these reasons, the role of health ministers and of health ministries is substantially greater than a restricted concern with the provision of essential health services.

Achieving greater investment for health in other sectors, by both governments and the private sector, remains an important goal, and one for which health ministers and ministries have an important advocacy role. As new models of governance emerge it is essential that health ministries retain this important health leadership role.

This responsibility was recognized by the Ministers of Health and their delegates in their report to the technical conference. Emphasis was given to the role of health ministers and ministries as advocates for health within government, and as the organizational mechanism through which health impact assessment of government policies could be managed.

What also emerged from that meeting was a clear request for health promotion actions to be informed by and responsive to prevailing political realities. This included the need for accountability, built on the use of scientifically sound health promotion actions.

Tension exists between emphasising the direct role of government in health promotion and the need to transfer powers and responsibilities to communities to determine their own health.
The continued effects of globalisation reduce the powers of national and local governments, yet also place greater responsibility on them to monitor and manage the health, social and environmental impact of global trade and transnational businesses. Private enterprises have a major influence on health. This influence can be direct in terms of the employment and economic rewards they offer, as well as their impact on working conditions and job security. Other impacts are less direct, for example environmental pollution. At present, the political processes required to manage the health impact of globalisation are not well developed.

The role of women in health development

A continuing theme throughout the conference was the role of women as a cornerstone of health development. The poor living conditions and social status of women lie at the heart of

inequity in health, since women take social responsibility for themselves and for their children in such disadvantaged circumstances. The empowerment of women through economic actions, through education and, importantly, through women's collective action is a crucial element in the resolution of the major inequities in life circumstances. Ensuring women have a voice in decision-making processes, and supporting their participation could have a substantial impact in effective health promotion.

8. Conclusions and Recommendations

The conference process was directed towards addressing some of the fundamental challenges which need to be met to ensure continued progress in addressing inequities in health by drawing upon the concept and strategies of health promotion. The products of these processes include the development of the *Mexico Ministerial Statement for the Promotion of Health: From Ideas to Action* and a *Framework for Countrywide Plans for Action* to support its implementation. These documents provide useful guidance for countries and for their Ministers concerning action to address the determinants of health and to ensure greater equity in health.

The conference also considered the resources and structures needed to develop and sustain capacity for health promotion at local, national and international levels. These are considered below.

Strengthening the "science and art" of health promotion

It was clear from the technical discussions and ministerial meeting that continued efforts need to be made to strengthen the "evidence base" on which health promotion policies and practices are founded. This can be done if all forms of evidence, derived from the full range of experiential knowledge, are included. In addition, this evidence needs to be better disseminated through improved exchanges of information within and between countries. Finally, it was clear that this evidence has to be communicated in ways that are politically, socially and culturally relevant to countries and communities.

This will require:

- continued **investment in appropriate research and evaluation** to improve understanding of the determinants of health, and the effectiveness of health promotion strategies to address these determinants. This will require a broad range of research methods which reflect the values, process and intended outcomes of health promotion policies and practices;

- the **development of indicators** which are more sensitive and relevant to health (as opposed to disease), health determinants, equity in health, and the short-term impact of particular health promotion strategies, and processes of change;

- improved **interaction, co-operation, and participation** among researchers, policy-makers, practitioners, and the communities with whom they work. Through improved interaction there is a greater chance that researchers will answer questions that are valued and valuable for decision-making, and that policy-makers and practitioners will make greater use of research findings;

- identification of practical strategies that can be employed to better **locate, assemble, synthesise and communicate** findings from ongoing research and evaluation, and experiences from case studies. This can be achieved in a variety of ways using established

methods such as through conferences and grass-roots networks, and publication in journals, as well as making use of newer technologies, including the internet;

- greater attention to opportunities to **communicate evidence in ways that are socially and politically relevant**. This has to do, in part, with the timing and orientation of the presentation of evidence.

The case studies presented at the conference were testimony to the extraordinary spirit, creativity and resourcefulness of practitioners and activists, mostly operating at community level. Processes which develop practical skills and capacities for health promotion, which encourage leadership for health, and which support the emergence of social entrepreneurs in communities are vital for the continued development and implementation of health promotion ideas and actions. This will require:

- **solidarity** among practitioners and activists who are often working in adverse circumstances with meagre resources. The development of **networks, alliances and partnerships** for health by concerned individuals and organisations is an important practical strategy for building solidarity;

- **mobilisation of resources** (financial, material and human) to ensure the implementation and sustainability of health promotion policies and practices at all levels. Such resources may come from a variety of government, non-government and private sector sources. Governments at all levels have a responsibility to ensure that the necessary resources are mobilised to implement existing and new policies and programmes, laws and regulations for health;

- the **development of community capacity** which is built on good access to information on the determinants of health and supportive infrastructures, including training;

- the **development of human resources** through education, training and exchange of experience. Universities and other educational institutions have a vitally important role in ensuring exposure of a wide range of professions to health promotion concepts and strategies (including but not limited to the health professions);

- creation of **networks and associations of practitioners** for mutual support and personal development. These associations should avoid exclusivity. Given the multi-disciplinary nature of health promotion there is considerable advantage in opening up such associations to a broad range of people and professions.

Strengthening political skills and actions for health promotion

A strong and consistent theme of the technical meeting concerned the need to work with and through existing political systems and structures to ensure healthy public policy, adequate investment in health, and facilitation of an adequate infrastructure for health promotion. This will require:

- **democratic processes** which emphasise decentralisation of power, resources and responsibilities for health;

- continued **social and political activism** where this is needed to influence government policies and to strengthen powers and responsibilities of communities to determine their

own health;

- use of a system of equity-oriented **health impact assessment** particularly of public policies at all levels of government, and of private sector policies and practices. This is a concrete mechanism to underpin inter-sectoral action for health, and to support social responsibility for health among governments, the private sector, NGOs and communities;

- **reorientation of health services** towards health promotion and primary prevention, and to achieve greater equity in health. A “second wave” of health sector reform may offer an important window of opportunity to achieve this change;

- **improved interactions** between politicians, policy-makers, researchers and practitioners. This will help ensure that, on the one hand, health promotion actions are informed by and responsive to prevailing political realities and scientific advances, and on the other, the importance of investing *for* health, and *in* health promotion is well communicated and widely understood;

- plans and structures which strengthen existing **capacity for implementing health promotion strategies**, and support **synergies between different levels** (local, national, international). These structures may be supported by governments, non-governmental organisations or the private sector. The *Framework for Countrywide Plans of Action for Health Promotion* may be helpful in guiding these actions.

Participants at the conference recognized the need to make progress in advancing the science, the art, and the politics of health promotion. The challenges identified above represent a substantial agenda which is far beyond the responsibilities of any single international organization, government, non-governmental agency, institution, or community. Participants at the conference committed themselves to actions to address these challenges in ways that are feasible and relevant to their circumstances. Participants also recognised that addressing many of these challenges will require continued concerted action and solidarity between the different health promotion actors represented at the meeting.

To ensure progress, participants recommended that WHO, in accordance with the 1998 *World Health Assembly Resolution on Health Promotion* (WHA51.12) take the next steps to establish an alliance for global health promotion to address these challenges, and work to implement the *Mexico Ministerial Statement for the Promotion of Health: From Ideas to Action* and other recommendations from previous international conferences as well as local/regional declarations on health promotion.

9. Annexes

Annex 1. Keynote speech given by Dr Gro Harlem Brundtland at Opening Ceremony

Annex 2. Keynote speech given by Dr George A.O. Alleyne at Opening Ceremony

Annex 3. Conference Programme

Annex 4. 5GCHP Ad Hoc Working Group on Evaluation in Health Promotion

Annex 5. WHA 51.12 Resolution on Health Promotion

Annex 6. Acknowledgements

- Speakers at the plenary sessions
- Facilitators of the plenary sessions
- Rapporteurs and facilitators of the breakout sessions
- Report writing team for the technical programme of the 5GCHP
- Conference organizers

Annex 7. Conference Products and Documents

- Mexico Ministerial Statement (with list of countries that have signed)
- List of 5GCHP case studies presented
- List of 5GCHP technical reports presented

Please check the following web sites
http://www.who.int/hpr/conference

to obtain the documents referred to in this report.

Dr Gro Harlem Brundtland
Director-General
World Health Organization

Fifth Global Conference on Health Promotion
Mexico, 5 June 2000

Your Excellency, President Ernesto Zedillo,
Secretary of Health, José Antonio González Fernández,
Dr Alleyne,
Distinguished Participants,
Colleagues, members of the press,

Last Wednesday, I was at a mass meeting in Bangkok. Standing on a platform I looked out over a sea of blue caps and white T-shirts. Wave upon wave of slogans against tobacco. Ten thousand health volunteers from villages all over Thailand had marched or bicycled to the city to mark the World No Tobacco Day. Health was being promoted on a giant scale. From local level to regional, from regional level to national, people were mobilised.

The speeches, though, weren't just about telling people not to smoke. They were not about local, or even national issues. They were about levels of taxation, about world-wide bans on advertising and the Framework Convention on Tobacco Control. These global responses support a growing national movement in Thailand: a movement against a public health disaster now killing someone in our world every 8 seconds.

What happened that Wednesday morning brought out the essence of health promotion. Promoting health is about enabling people to keep their minds and bodies in optimal condition for as long as possible. That means that people know how to keep healthy. It means that they live under conditions where healthy lifestyles are feasible. It means that they have the power to make healthy choices. Yes, health promotion is about making decisions - within the household, within society, and within the nation state. Its about making decisions within international institutions - whether they are concerned with development, trade, health or finance.

So much has happened since the last global Conference on Health Promotion in Jakarta in 1997. The landscape for international health is changing in fundamental ways. More and more people understand the benefits of good health. We know what needs to be done - in our lives and in our environments. We now understand the links between health, politics and the economy more clearly than ever before. For those of use meeting here in Mexico City, dedicated to promoting health, this really is a powerful moment.

It is a powerful moment because **we know how to benefit from the increasing inter-dependence in our world**. Yes, globalisation frightens some people and causes uncertainty to many more. But it also presents us all with genuine opportunities. New opportunities for global solidarity continue to emerge. There is great convergence - of values, of ideas and of action.

At the same time the search for equity and justice in health now involves more people in effective local-level action than ever before, reflecting our cultural and linguistic diversity.

Bringing the two trends together, we recognise the power of linking global values with local action. This is our responsibility as workers for health, as health promoters. No group is better placed to ensure that greater economic integration brings benefits to those who need them the most. Through encouraging

global solidarity while nurturing diversity, we help to shape events in line with the values of equity and fairness.

Now to a second reason why this is a powerful moment. **Health is very big news** - everywhere. It involves more and more people. Health is no longer a concern only of health professionals. A much wider constituency is engaged.

Let us reflect on what is happening:

- Both national and international health issues are prominent on the agenda when Heads of State, including the G8 leaders, debate the major political issues of our time. Just last week, global health featured prominently within the discussions at the U.S. European summit. (CHECK)

- A month ago, Africa's Heads of State assessed the economic impact of malaria for their continent and their peoples. They took responsibility for a continent wide effort to help people to halve the impact of malaria on their lives. They undertook to promote a series of proven interventions, making them available to people in their homes, when they need them.

- More and more governments see good health as a critical element of Human Security. In some nations this combination of human development and national security has become the basis of foreign policy. It is therefore no surprise that a health issue – HIV/AIDS in Africa – has been taken up by the Security Council of the United Nations.

- The mobilisation of resources to improve national efforts for promoting health is on the agendas of finance ministers as they discuss debt relief with the World Bank and IMF.

- Sustained improvement in International Health is a key theme in the Millennium Report by the United Nation's Secretary-General.

Health has now moved to the heart of domestic and international development agendas. Good health is *increasingly recognised as a pre-requisite if communities are to be enabled to fight against poverty.*

How can those of us who promote health take advantage of this powerful moment? We have an unparalleled opportunity to make a real difference. Our Mission is clear. We must empower people to make healthy choices for themselves and their families.

When the World Health Organization set out to improve health 50 years ago, there were hopes that antibiotics, vaccines and biomedical technology would provide the tools to achieve health for all.

However, decades of health development have clearly shown that technologies are not enough to guarantee people's health. A range of civil, cultural, economic, political and social conditions have to be addressed as well.

Many of the major determinants of better health lie outside the health system. Knowledge. Made available to people. Clean environments. Access to basic services. Fair societies. Fulfilled human rights. Good government. Enabling people to make decisions relevant to their lives, and to act on them.

Let us agree on the key points: **for people to have the power to be healthy, they first need knowledge**. Accurate, reliable knowledge about how to achieve good health, and about the risks to health that they face in their daily lives. They need knowledge that helps them to make the best choices and to implement them. They need to know how she or he can achieve good health: how the family can stay healthy. As we see from the recent trends of reduction in heart diseases and cancers in several industrialized countries, up to date, applicable knowledge is a pre-requisite for better health.

Knowledge is necessary, but it is not sufficient. **For people to have the power to be healthy, they must be in a position to choose better health**. This means making the right choices, and putting them into practice. If people are not able to do so, the new knowledge leads to frustration. That is why health promotion has focussed extensively on the issues of healthy cities, healthy schools, healthy workplaces and healthy homes. Environments within which people can choose to be healthy, and implement their choices in their daily lives. A good example is this city, which has made great strides to improve its environment over the past decade.

Yet, the combination of knowledge and a healthy environment may not be enough. Many people will still not feel that the power to be healthy is in their hands. **The third element is their being empowered to make the healthy choices for themselves** - and stick to them. This means local, national – and even international – policies that give them the freedom to do what they want, and need, to do.

- Promoting sexual health, among teenagers, often requires those responsible for local or national government to adopt policies that fly in the face of deeply-held beliefs

- Enabling people at risk to protect themselves and their families from the risks of malaria may call for liberalised access to mosquito nets, insecticides with which to coat them, treatment for those affected by malaria.

- Empowering young people to avoid tobacco use involves global action to limit the tobacco industry's attempts to lure children and youth into smoking: knowledge and encouragement are, on their own, insufficient to protect those under 20 from nicotine addiction.

Promoting health means transcending the narrow slot traditionally labelled "health promotion". That is why, when I am asked who is in charge of health promotion at WHO, I answer: "I am." All departmental staff, be they in Geneva, the regional or the country offices, have explicit health promotion responsibilities.

Promoting health means reducing risks to health and modifying behaviour that affects it. Our contribution is clear. We help to provide knowledge about determinants of health, and ensure that it is made widely available. We help to build consensus around ways in which this knowledge can be put into practice - in different settings, among different communities. We encourage public policies that help people themselves to take the action necessary to put this knowledge into practice.

We recognise that this work poses important challenges:

- *How to balance the role of governments in pursuing healthy public policies while, at the same time, enabling individuals to choose what they want to do for themselves as long as it does not harm others?*

- *How can we be sure that the complex debates about interactions between different risks to people's health are comprehensible to the majority who lack specialised knowledge, wherever they live, whatever their circumstances?*

- *How can we help health systems evolve into organisations that work on behalf of all people, reflecting the complex interplay of risks to people's health, and offering advice to individuals, to communities and to local authorities that promote health-seeking and care-seeking behaviour?*

- *Which mechanisms are appropriate - and effective - to take forward trans-national interventions against global health threats, such as tobacco?*

- *What approaches can we use to promote access to public goods - such as essential drugs - when people are unable to access them because of systematic market failures?*

- *How do we ensure that minimum environmental, labour and health standards are followed in a world where investors move assets in a matter of months and capital in a matter of seconds to ensure maximum short-time gains?*

You will be discussing such questions over the coming days. The member states and secretariat of the World Health Organization have a key role to play in helping to find answers.

WHO's overall strategy helps to set priorities. It lays out four strategic directions: reducing excess mortality and disability, reducing risks to human health, developing health systems that equitably improve health outcomes, and putting health at the centre of economic and development policy.

All these four directions have elements of health promotion. Each involves us in disseminating knowledge, establishing consensus about how the knowledge can be implemented, and encouraging healthy public policies that encourage people to implement the knowledge for themselves.

In serving as the international technical agency for health, WHO has several core functions through which the directions are pursued.

WHO will set standards and bring forward the evidence. Take the issue of food safety. Our core function is to act as an independent provider of knowledge and evidence.

Yet, providing knowledge is not enough. Evidence must translate into action. We must speak out about the information we possess. Broaden the constituency of organizations that have the power to act. Build coalitions of different partners – nationally and internationally. Working with others will translate ideas and commitments into better and more effective health systems.

Then we must help policy-makers, regulatory authorities and trade bodies make the best decisions possible. The tougher the issue for society, the greater the need for WHO to help decision-makers reach informed judgements.

We in WHO have learnt that programmes and policies are most likely to be sustained and successful if the people they are meant to serve are engaged in their design and implementation. Initiatives that rely on one sector alone are less likely to be effective than multi-sectoral efforts. Local initiatives are more likely to be effective when supported through global efforts.

The issue of tobacco illustrates this. The current annual toll of 4 million tobacco deaths world-wide will rise to 10 million by 2030. Seventy per cent of the increase will damage developing countries. The WHO Framework Convention on Tobacco Control will become one of the most powerful tools to promote health.

Full negotiation on this item will begin in October, and already we see emerging unprecedented global support for strong action. Adoption of the Convention, and its implementation, will be a crucial move by nations of the world to adopt healthy public policies.

Mr President,

Promoting health is a noble pursuit, but is it a goal in itself? Many of you would say yes, and I share that view. But I would like us to widen our ambitions. **Health is important not only for how it lengthens life and improves its quality – it is also an important contributor to economic and social development.**

Poverty perpetuates ill health.

In all our efforts we have to give special attention to the challenge of reducing poverty. The Nobel economics prize laureate Amartya Sen defines poverty as “deprivation of capability”. He argues that people are poor not only because their income is low, but because they do not have access to basic services, such as health and education, which would have increased their freedom. Poverty, he says, seriously deprives people of a number of choices they must have available in order to live a satisfying life.

But improvements in health reduce poverty and enable growth.

As in Europe at the end of the 19th and beginning of the 20th century, we have seen that developing countries which invest relatively more, and well, on health are likely to achieve higher economic growth.

In East Asia, for example, life expectancy increased by over 18 years in the two decades that preceded the most dramatic economic take-off in history.

A recent analysis for the Asian Development Bank concluded that fully a third of the phenomenal Asian economic growth between 1965 and 1997 resulted from investment in people's health.

There is solid evidence to prove that investing wisely in health will help the world take a giant leap out of poverty. We can drastically reduce the global burden of disease. If we manage, hundreds of millions of people will be better able to fulfil their potential, enjoy their legitimate human rights and be driving forces in development. People would benefit. The economy would benefit. The environment would benefit.

Our task is no less than this. It is a difficult one. But - at this powerful moment, here in Mexico - we can commit ourselves to its achievement.

Thank you.

Dr George A.O. Alleyne
Director PAHO*

HEALTH PROMOTION—BRIDGING THE EQUITY GAP**
México, D.F., Mexico, 5 June 2000

Mr. President
Mr. Secretary of Health
Madam Director-General of WHO
Ministers of Health
Ladies and Gentlemen.

It is my very pleasant task to join with the Secretary and the Director-General in welcoming you to this Fifth Global Conference on Health Promotion. This is a joyous occasion for me and my colleagues in the Pan American Health Organization as we welcome you to the Americas for this Conference.

First, I must thank the Government of Mexico for its generosity and having shown us the hospitality for which Mexico and Mexicans are famous. There could not have been a better country to host this Conference, which returns to the Americas for the first time since the historic Ottawa conference in 1986 that set health promotion firmly as a priority in the minds of all those who are concerned with the public's health.

It is also very appropriate that this opening ceremony should be held in this museum which has the world's greatest ethnographical collection. Mr. President, every time I come here I am transported back in time and the realism of the exhibits stirs a chord in me. When I was here two months ago this Conference was very much on my mind and for a while I had the strange sensation that the very stones were rising up and the statues were speaking to me. And indeed they spoke of a past that is very relevant to the issues before us this week.

They spoke of the great civilization of Teotihuacan and the glory of Tenochtitlán of the Aztecs, and had me see the latter as a city that was the largest and most beautiful of its time. They spoke of a public policy that was healthy to the extent that the elected rulers were themselves enjoined to set an example in their lives and avoid health-damaging behavior. This public policy in the city that was the umbilicus of the world had public latrines, proper disposal of waste water and public servants who kept the streets clean. The five lakes were mirrors of the sun and moon. Personal hygiene was at a level only dreamed about in most other places.

Community action and responsibility for the local waterways were in part responsible for them being so clean. The orientation of the health services was seen in the delivery of medical treatment based on a welfare system. The network of veterans' hospitals and the quarantine system were fore runners of current public health practice. Moctezuma I had founded the famous botanical and zoological gardens and his herbarium had collections of medicinal plants from all parts of middle America.

These stones and statues would tell me of equality of opportunity, of education for all, which undoubtedly contributed to good health.

And I could not but think that your Tenochtitlán was indeed a healthy city and exemplified many of the basic concepts of health promotion that were so well codified in the First Conference in Ottawa and solidified in other subsequent ones.

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* Pan American Health Organization, Pan American Sanitary Bureau, Regional Office for the Americas for the Americas of the World Health Organization.

** Presented at the Fifth Global Conference on Health Promotion. México, D. F., Mexico, 5-9 June 2000.

I came back to reality with the hope and conviction that this Fifth Conference would indeed light a new fire for health promotion. It would seek to show that equity in health was indeed important and that the strategies for health promotion are essential to bridge the gaps and decrease the disparities that are unjust and unfair and therefore represent inequity.

But why should we be so fixed on the concept of equity in health? Does this idea that is behind the noble goal of Health For All still have currency today? I say it does. There are two concepts that must guide us in our discussions. First there are disparities of health outcomes or disparities in health status, but they are not manifestations of inequity unless we can say that they are unjust or unfair. It is almost intuitively apparent that a good such as health that is universally prized as among the most important attributes in life should not permit of disparities that are unfair. In our lexicon, the concept of equity is translated to mean that the difference that exists should be avoidable, should be beyond the will or volition of the individual or group and ideally there should be an agent to which responsibility can be assigned.

It is not enough to look at the health outcomes. One must look at those social conditions that determine health outcome—the determinants of health. Many of the constitutions of our countries speak to the right to health or as better put by the American Declaration on the Rights and Duties of Man. It is of fundamental importance that in discussions on equity we understand the difference between disparities in health status and disparities in the determinants of health that cause these health inequalities or inequities.

This Conference will address the possibility that the strategies of health promotion will reduce the health disparities that we deem inequities. I have no doubt that you will have examples to share of how public policy has been or can be shaped such that the disparities in health determinants be reduced. One important aspect of such policy relates to the proper balance between maintaining a strong central state authority and yet decentralizing many operations to a more peripheral level. I am pleased to note the progress Mexico has made in this regard and we in the Pan American Health Organization have been witnesses to the universality of coverage in many of your states to which much of the execution has been decentralized.

I hope that this Conference will not ignore the possibility— nay imperious necessity that attention be paid to gender equity. Gender discrimination as a cause of ill health is all too often ignored because its manifestations are so subtle.

The call for re-orienting the health services has been heard clearly in this Region and almost every country is engaged in some reform of the health sector. Every one of them has equity as a desideratum in addition to efficiency and effectiveness. There will be opportunities during this Conference to reflect on how the main constituents of the reform process are being played out in national contexts.

Equity is one of the basic value principles I have espoused loudly and vigorously in the Pan American Health Organization and it represents a basic focus of our technical cooperation. We ask if there are gaps in health outcomes or determinants and can our technical cooperation address them. We have concrete examples to demonstrate that this is possible.

Mr. President, these Conferences are global rather than international and this implies that the business of promoting the public's health is a matter that involves nations yes, but involves a wider constituency. The call for partnership is as clear today as when it was issued in Jakarta at the Fourth Conference and I am pleased to note the many examples of such partnerships that have flourished globally and regionally in favor of health.

Mr. President, Mr. Secretary, let me thank you again for your hospitality and as we go out from this place, I hope that we will indeed hear the voices of some of your gods of years past. And I trust they will give us some of their wisdom such this Fifth Conference will fulfill the high aspirations of those who

have come here from every part of the world to examine how the application of the strategies and principles of health promotion can enhance equity in health.

Again I bid you welcome.

MINISTERIAL PROGRAMME

Sunday 6th June

When	What
14:00 onwards	Participant registration
Late afternoon	Welcome reception
18:00	Briefing of the Ministerial delegations

Monday 5th June

When	What	
9:00 – 10:30	**Opening Ceremony**	
	Speakers:	Lic. José Antonio González Fernández, Minister of Health, Mexico
		Dr Gro Harlem Brundtland, Director General, WHO
		Dr George A.O. Alleyne, Director, PAHO
	Signature of the Mexico Ministerial Statement for the Promotion of Health	
	Welcoming Message:	Dr Ernesto Zedillo Ponce de León, President of Mexico
10:30 – 11:00	Return to Sheraton Hotel and Healthy Break	
11:00 – 12:30	**Joint Technical-Ministerial session - Setting the Stage**	
	Overview of Past Accomplishments and Present Challenges	
	Chairpersons:	Lic. José Antonio González Fernández, Minister of Health, Mexico
		Dr Gro Harlem Brundtland, Director General, WHO
		Dr George A.O. Alleyne, Director, PAHO
	Introduction:	Dr. Achmad Sujudi, Minister of Health, Indonesia
	Speakers:	Dr Michael Marmot, Department of Epidemiology, University College, London
		Dr Alexandre Kalache, Acting Director, Department of Health Promotion, WHO
	Facilitator:	Dr. Roberto Tapia C.
12:30 – 14:00	**Lunch**	
14:00 – 16:00	**1st Ministerial Session: Healthy Public Policies Equity, Investment on Health and Development**	
	Chairperson:	Dr Gro Harlem Brundtland, Director General WHO
	Secretary:	Lic. Mario Luis Fuentes Alcalá, General Director of the Mexican Institute of Social Security, Mexico
16:00 – 16:30	Healthy Break	

16:30 – 18:30	**2nd Ministerial Session: Social Responsibility for Health Promotion: Community Participation and the Involvement of all Sectors** Chairperson: Dr George A. O. Alleyne, Director PAHO Secretary: Lic. Socorro Díaz Palacios, General Director, Institute of Social Security and Services for State Workers, Mexico
20:00	**Special Performance of the Mexican Ballet**

Tuesday, 6th June

When	What
9:00 – 11:00	**3rd Ministerial Session: Reorienting Health Systems and Services** Chairperson: Dr David Satcher, Surgeon General of the United States of America Secretary: Lic. Enrique Burgos García, General Director of the Programme for the Integral Development of the Family, Mexico
11:00 – 11:30	Healthy Break
11:30 – 13:30	**4th Ministerial Session: Mental Health and Healthy Life Conditions: Major Challenges for Health Promotion** Chairperson: Dr Manuel Urbina Fuentes, Undersecretary, Ministry of Health, Mexico Secretary: Dr Enrique Wolpert Barraza, President of the National Academy of Medicine, Mexico
13:30 – 15:00	Lunch - Buffet
15:00 – 16:30	**Joint Technical-Ministerial Session: Sharing the Conclusions of Two Days' Work** Minister Tim Menakaya, Nigeria Minister Hamza Rafeeq, Trinidad and Tobago Minister Aaron D. Chiduo, Tanzania Minister Fr. Savvides, Cyprus Prof Don Nutbeam – Technical report Synthesis & Facilitator: Dr Julio Frenk, WHO
20:00	**Ministers' Closing Dinner**

Technical Conference Programme at a glance

Timeline	SUNDAY 4	MONDAY 5	TUESDAY 6	WEDNESDAY 7	THURSDAY 8	FRIDAY 9	SATURDAY 10	Timeline
8.00-8.45		Participant registration						8.00-8.45
8.45 - 9.00			Rapporteur summary of Monday session	Rapporteur summary of Tuesday session	Rapporteur summary of Wednesday session	Rapporteur summary of Thursday session		8.45 - 9.00
9.00 - 9.30		Opening ceremony - Signature of the Mexico Ministerial Statement	**Plenary Session 2:** Social responsibility for health	**Plenary session D: Health Promotion in Mexico**	**Plenary session 4:** Securing an infrastructure for health promotion	**Plenary Session E:** Scientific Information for Health Promotion		9.00 - 9.30
9.30 - 10.00								9.30 - 10.00
10.00 - 10.30								10.00 - 10.30
10.30 - 11.00		Return to Sheraton	Healthy Break	**Mexican Case Study Presentations**	Healthy Break			10.30 - 11.00
11.00 - 11.30		**Joint Technical-Ministerial session A** - Setting the stage: Overview of past accomplishments and present challenges	**Breakout session 2:** Social responsibility for health		**Breakout session 4:** Securing an infrastructure for health promotion	Healthy Break		11.00 - 11.30
11.30 - 12.00						**Plenary Session F:** Joint feedback on technical reports and operationalisation of country-wide plans of action		11.30 - 12.00
12.00 - 12.30								12.00 - 12.30
12.30 - 13.00		LUNCH	LUNCH	LUNCH	LUNCH			12.30 - 13.00
13.00 - 13.30						**Adoption of the guidelines for the country-wide plans of action**		13.00 - 13.30
13.30 - 14.00						**Closing ceremony**		13.30 - 14.00
14.00 - 14.30	**Participant Registration**	**Plenary Session B:** Evidence Base for Health Promotion	Working groups on country-wide plans of action	**Plenary Session 3:** Increasing community capacity and empowering the individual	**Plenary session 5:** Reorienting Health Systems & Services	LUNCH	Optional visits to Mexican projects on Health Promotion	14.00 - 14.30
14.30 - 15.00	↓		Break					14.30 - 15.00
15.00 - 15.30		**Plenary Session 1:** Increasing investments for health development	**Joint Technical- Ministerial Session C** Sharing the Conclusions of Two Days' Work					15.00 - 15.30
15.30 - 16.00				Healthy Break	Healthy Break			15.30 - 16.00
16.00 - 16.30				**Breakout session 3:** Increasing community capacity and empowering the individual	**Breakout session 5:** Reorienting Health Systems & Services			16.00 - 16.30
16.30 - 17.00		Healthy Break	Breakout session on country-wide plans of action					16.30 - 17.00
17.00 - 17.30		**Breakout session 1:** Increasing investments for health development						17.00 - 17.30
17.30 - 18.00								17.30 - 18.00
18.00 - 18.30			Networking sessions	Networking sessions	Networking sessions	Networking sessions		18.00 - 18.30
18.30 - 19.00	Welcome Reception	Networking sessions						18.30 - 19.00
19.00 - 19.30								19.00 - 19.30
19.30 - 20.00				Mexican Evening				19.30 - 20.00
20.00 - 22.00	↓	Ballet Folklorico						20.00 - 22.00

Closed rapporteur feedback sessions are scheduled at the end of each breakout session.

5GCHP Ad Hoc Working Group on Evaluation in Health Promotion[16]

The following text is taken from a summary report by Mary Hall, the working group rapporteur, the major *points and recommendations of which were presented to the 5GCHP conference by David McQueen.*

1. There was general agreement on the distinction between purposes for evaluation, and the types of evidence one collects for each. One purpose is for the benefit of the program and its stakeholders. The evidence gathered in this type of evaluation is used to guide the program and to make improvements. Process measures are used as evidence for this purpose. A second purpose for evaluation is to provide proof to funders and policy makers that the program has an impact, an effect, a value. The types of evidence collected for this purpose are outcome measures that demonstrate the impact of the program or policy.

2. Many voices are still missing from the discussion/debate on evidence. These may be representatives from developing nations, or people who are not typically included in such discussions as they do not tend to hold the type of government offices that allow them at the table. The workgroup must find a way to uncover these voices, and the approaches used by developing nations that are meaningful. These voices and methods must be incorporated into the existing body of evidence.

3. Participants requested further definition of the core techniques for conducting health promotion evaluation. However, before this core can be agreed upon, it is essential to more closely define the term "health promotion." If it is agreed that the heart of health promotion is community and policy change, then health promotion evaluation should include techniques on how to measure that complex system of change.

4. Whatever the context for health promotion evaluation, such evaluations must be conducted in partnership with stakeholders and/or the communities in which programs are taking place. This requires that stakeholders are also involved in program planning, and that evaluation measures chosen will be meaningful to stakeholders/communities. Evaluations should be conducted equitably, both in the process and in applying the outcomes. Resources for evaluation should also be applied equitably.

Recommendations:

WHO should establish an Evaluation Development Workgroup that will be responsible for creating a plan for the development of evaluation globally.

- This Workgroup, which should build on work previously done by the European Workgroup, should consider existing work in this area, and should integrate unpublished work into current evaluation knowledge.

[16] Co-chairs: Ligia de Salazar (Colombia); David Mc Queen (United States) - Core group set up by the 5gchp organisers: the co-chairs of the WG; representatives of major leading initiatives on HP evaluation; the members of the 5GCHP technical review and support group; - WG Participants: invited and welcomed experts from developed and developing nations

- Evaluation approaches should recognize the importance of equity in conducting locally-determined evaluation, and should emphasize the use of participatory approaches and multisectorial involvement in evaluation.

- This Workgroup should have equal representation from developed and developing countries, and diverse cultural representation. Members, to be selected in collaboration with global partners, should have expertise and experience in evaluation and health promotion. The Workgroup should complete its work within one year of being convened.

World Health Assembly Resolution on Health Promotion

FIFTY-FIRST WORLD HEALTH ASSEMBLY **WHA 51.12**

Agenda item 20 16 May 1998

Health Promotion

The Fifty-first World Health Assembly,

Recalling resolution WHA42.44 on health promotion, public information and education for health and the outcome of the four international conferences on health promotion (Ottawa, 1986; Adelaide, Australia, 1988; Sundsvall, Sweden, 1991; Jakarta, 1997);

Recognizing that the Ottawa Charter for Health Promotion has been a worldwide source of guidance and inspiration for health promotion development through its five essential strategies to build healthy public policy, create supportive environments, strengthen community action, develop personal skills, and reorient health services;

Mindful of the clear evidence that: (a) comprehensive approaches that use combinations of the five strategies are the most effective; (b) certain settings offer practical opportunities for the implementation of comprehensive strategies, such as cities, islands, local communities, markets, schools, workplaces, and health services; (c) people have to be at the centre of health promotion action and decision-making processes if they are to be effective; (d) access to education and information is vital in achieving effective participation and the "empowerment" of people and communities; (e) health promotion is a "key investment" and an essential element of health development;

Mindful of the new challenges and determinants of health and that new forms of action are needed to free the potential for health promotion in many sectors of society, among local communities, and within families, using an approach based on sound evidence;

Appreciating the potential of health promotion activities to act as a resource for societal development and that there is a clear need to break through traditional boundaries within government sectors, between governmental and nongovernmental organizations, and between the public and private sectors;

Noting the efforts made by the 10 countries with a population of over 100 million to promote the establishment of a network of most-populous countries for health promotion;

Confirming the priorities set out in the Jakarta Declaration for Health Promotion in the Twenty-first Century,

1. URGES all Member States:

   (1) to promote social responsibility for health;

   (2) to increase investments for health development;

   (3) to consolidate and expand "partnerships for health";

   (4) to increase community capacity and "empower" the individual in matters of health;

   (5) to strengthen consideration of health requirements and promotion in all policies;

   (6) to adopt an evidence-based approach to health promotion policy and practice, using the full range of quantitative and qualitative methodologies;

2. CALLS ON organizations of the United Nations system, intergovernmental and nongovernmental organizations and foundations, donors and the international community as a whole:

   (1) to mobilize Member States and assist them to implement these strategies;

   (2) to form global, regional and local health promotion networks;

3. CALLS ON the Director-General:

   (1) to enhance the Organization's capacity with that of the Member States to foster the development of health-promoting cities, islands, local communities, markets, schools, workplaces, and health services;

   (2) to implement strategies for health promotion throughout the life span with particular attention to the vulnerable groups in order to decrease inequities in health;

4. REQUESTS the Director-General:

   (1) to take the lead in establishing an alliance for global health promotion and in enabling Member States to implement the Jakarta Declaration and other local/regional declarations on health promotion;

   (2) to support the development of evidence-based health promotion policy and practice within the Organization;

   (3) to raise health promotion to the top priority list of WHO in order to support the development of health promotion within the Organization;

   (4) to report back to the 105th session of the Executive Board and to the Fifty-third World Health Assembly on the progress achieved.

Tenth plenary meeting, 16 May 1998
A51/VR/10

Acknowledgements

The conference organizers, World Health Organization, Pan American Health Organization and the Mexico Ministry of Health, wish to express their warm appreciation of all those who actively contributed to the Fifth Global Conference on Health Promotion.

In this annex to the report of the *technical* programme special thanks are extended to the following groups of persons whose contributions were essential to the success of the conference.

Speakers at the plenary sessions

Rina Alcalay
Keziah Awosika
Parveen Azam Khan
Elizabeth Casey
Indira Chakravarty
Mirai Chatterjee
Gerard d'Abreau
Michael Drupp
Jonathan Fielding
Mariana Galarza
Alonso García Acosta
Mariano García Viveros
Rodolfo Garzón Mendizábal
Pat Graham-Casey
Rebecca Holmes
Alexandre Kalache
Rolf Altmann
Daniel López-Acuña
Michael Marmot
Enrique Martinez
David McQueen
Maurice Mittelmark
Rob Moodie
Antoinette Ntuli
Martín Pacheco
Scott Ratzan
Helena Restrepo
Jonathan Rosenberg
Aown Shawa
Wang Shugeng
Achmad Sujudi
Zhang Zeshu
Erio Ziglio
Elizabeth Zonneveld

Facilitators of the plenary sessions

John Batten
Bryna Brennan
Somsak Chunaras
Gillian Durham
Julio Frenk
Uton Muchtar Rafei
Roberto Tapia

Rapporteurs and facilitators of the breakout sessions

Robert Anderson
Tariq Bhatti
Malinee Chulavachana
Halina Cyr
Richard Horst Noack
Martin Pacheco
Fran Perkins
Bosse Pettersson

Gerard D'Abreau
Ligia de Salazar
Doris Gillis
Martha Lucia Gutiérrez
Nancy Hailey
Piedad Huerta
Josefa Ippolito-Shepherd
Sergio Maresman
Guillermo Mendoza
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Roberto Tapia, MoH, Mexico
Javier Urbina Soria, MoH, Mexico
Lisa Véron, WHO

FIFTH GLOBAL CONFERENCE ON HEALTH PROMOTION

Health Promotion: Bridging the Equity Gap
Mexico City, June 5th, 2000

Mexico Ministerial Statement for the Promotion of Health : ***From Ideas to Action***

Gathered in Mexico City on the occasion of the Fifth Global Conference on Health Promotion, the Ministers of Health who sign this Statement:

1. Recognize that the attainment of the highest possible standard of health is a positive asset for the enjoyment of life and necessary for social and economic development and equity.

2. Acknowledge that the promotion of health and social development is a central duty and responsibility of governments, that all sectors of society share.

3. Are mindful that, in recent years, through the sustained efforts of governments and societies working together, there have been significant health improvements and progress in the provision of health services in many countries of the world.

4. Realize that, despite this progress, many health problems still persist which hinder social and economic development and must therefore be urgently addressed to further equity in the attainment of health and well being.

5. Are mindful that, at the same time, new and re-emerging diseases threaten the progress made in health.

6. Realize that it is urgent to address the social, economic and environmental determinants of health and that this requires strengthened mechanisms of collaboration for the promotion of health across al sectors and at all levels of society.

7. Conclude that health promotion must be a fundamental component of public policies and programmes in all countries in the pursuit of equity and better health for all.

8. Realize that there is ample evidence that good health promotion strategies of promoting health are effective.

Considering the above, we subscribe to the following:

ACTIONS

A. To position the promotion of health as a fundamental priority in local, regional, national and international policies and programmes.

B. To take the leading role in ensuring the active participation of all sectors and civil society, in the implementation of health promoting actions which strengthen and expand partnerships for health.

C. To support the preparation of country-wide plans of action for promoting health, if necessary drawing on the expertise in this area of WHO and its partners. These plans will vary according to the national context, but will follow a basic framework agreed upon during the Fifth Global Conference on Health Promotion, and may include among others:

- The identification of health priorities and the establishment of healthy public policies and programmes to address these.
- The support of research which advances knowledge on selected priorities.
- The mobilization of financial and operational resources to build human and institutional capacity for the development, implementation, monitoring and evaluation of country-wide plans of action.

D. To establish or strengthen national and international networks which promote health.

E. To advocate that UN agencies be accountable for the health impact of their development agenda.

F. To inform the Director General of the World Health Organization, for the purpose of her report to the 107th session of the Executive Board, of the progress made in the performance of the above actions.

Signed in Mexico City, on June 5th 2000, in Arabic, Chinese, English, French, Portuguese, Russian, and Spanish, all texts being equally authentic.

Mexico Ministerial Statement for the Promotion of Health : *From Ideas to Action*

This Ministerial Statement was signed by the following countries:

Algeria
Angola
Argentina
Aruba
Australia
Austria
Bangladesh
Belize
Bhutan
Bolivia
Brazil
Bulgaria
Cameroon
Canada
China
Colombia
Costa Rica
Cuba
Czech Republic
Denmark
Dominica
Dominican Republic
Ecuador
El Salvador
Egypt
Finland
France
Gabon
Germany
Guatemala
Haiti
Hungary
India
Indonesia
Iran
Israel
Jamaica
Korea
Kuwait
Lao PDR
Lebanon
Madagascar
Malaysia
Maldives
Malta
Marshall Islands
Mexico
Morocco
Mozambique
Myanmar
Namibia
Nepal
Netherlands
New Zealand
Nicaragua
Niger
Norway
Oman
Pakistan
Panama
Paraguay
Poland
Portugal
Puerto Rico
Russian Federation
Rwanda
Saint Kitts and Nevis
Saint Lucia
Samoa
Slovakia
Slovenia
South Africa
Spain
Sudan
Swaziland
Sweden
Switzerland
Thailand
Turkey
United Kingdom
United States
Uruguay
Vanuatu
Venezuela
Yugoslavia
Zambia
Zimbabwe

Case Studies presented during the Conference

INCREASING INVESTMENT FOR HEALTH DEVELOPMENT

The case study "Igniting the Fires of Hope", presented by Martín Pacheco and Gerard d'Abreau, told the story of SERVOL, an NGO from Trinidad & Tobago which offers child and youth programmes in community centres.

"Three months after Father Gerard Pantin, walked into Laventille in 1970 he confessed to one of the residents called Chaca that he was getting nowhere and was thinking of giving up. Chaca vehemently protested, 'You cannot do that! It is true that you have done nothing more than get jobs for a few dozen kids; but what you have really done is to bring HOPE to the area. Every morning you walk up the hill, those watching you think: maybe tomorrow it will be my turn to get a job. And once people have hope they will continue the struggle.' "

The case study "Environmental Health Promotion and Solid Waste Management in Gaza City", presented by Mr Aown Shawa, Mayor of Gaza City, and Ms Liesbeth Zonneveld, described how the Gaza City municipality, with EU funding and enthusiastic community participation, cleaned up its garbage- and sewage-filled streets.

" ... the aim was not just regular and affordable waste collection and disposal - project sought to involve citizens and municipal staff in a wider dialogue on 'how to improve living conditions in our city - how to make our city a healthy one', and to engage the entire Palestinian community in the battle to improve their environmental health conditions...."

The case study "Enterprise for Health", presented by Dr Herren Landig and Dr Michael Drupp, described a WHO/EURO-funded initiative on worker health promotion in Lower Saxony, Germany.

"WHO partnered with the regional association of Local Sickness Funds of Lower Saxony to create an incentive for private enterprises to invest in health. Granted 'bonuses' in the amount of one month's payment to the government's social security health insurance (for both employee and employer payments), for those companies willing to commit to comprehensive workplace health promotion."

SOCIAL RESPONSIBILITY FOR HEALTH

The case study "SEWA: Self-Employed Women's Association, Gujarat, India", presented by Mirai Chatterjee described the work of a trade union for poor, self-employed women workers who earn a living through their own labour or small businesses.

"... a Union of 220,000 women workers of the unorganised sector. Self-employed workers constitute 93 percent of the Indian workforce. They do not have regular salaried employment with welfare benefits: no weekly
day off, sick leave, pension, nor any maternity benefits. They are the poorest of workers, and yet, they ... account for 63 percent of gross domestic product in India."

The case study "Street Food Project, Calcutta", presented by Professor Indira Chakravarty, described how Calcutta authorities brought together the mayor, city and police authorities, community workers and street food vendors to improve the safety and nutritional value of street food.

"Street food vendors could be called the nutritionists of the poor. An individual's daily nutritional needs can be met with just a few rupees. However, street food can pose a significant health risk for consumers. Often ignored or tolerated by food control and public health officials, street food in many cities has become a critical concern..."

The case study "Latrine Revolution in the Henan Province", presented by Zhang Zeshu and Wang Shugeng described the project that introduced double-urn latrines to turn human excrement into non-hazardous, high quality fertiliser for use in agriculture.

"... the use of human nightsoil as fertilizer for farming is a fundamental aspect of Chinese culture. The exposed excreta emit offensive smells and serve as a favourable habitat for flies... Unhygienic conditions caused diarrhea and intestinal parasitic infections to run rampant in rural towns and villages. ... Professional health and agricultural workers invented the double-urn, funnel-shaped latrine...The new design allows human excreta to become non-hazardous fertilizer."

INCREASING COMMUNITY CAPACITY AND EMPOWERING THE INDIVIDUAL

The case study "Building Linkages with Democracy and Health" was presented by Ms Rebecca Holmes and Dr Keziah Awosika and described a partnership between 19 Nigerian NGOs and Johns Hopkins University to promote women's empowerment and participation in politics.

"Promoting the active involvement of women in public decision-making processes helps to ensure that practical gender interests are adequately addressed through appropriate policies and programs [including] reproductive and child health, literacy, access to clean water and sanitation, food supplies and prices, increased opportunities for income generation, early marriage, rights to inheritance and property, access to quality health services..."

The case study "Versalles: Healthy Municipality for Peace", presented by Dr Gilda Stella Millán and Mr Alonso García Acosta, Mayor of Versalles, described programmes implemented by this Colombian municipality to address health, education, conservation and development.

"... local development occurs within a health promotion framework and involves the active participation of community members in determining priorities for action as well as the appropriate strategies for addressing the identified needs. Using a methodology that combines analysis, action, and reflection, diverse sectors work jointly for education, community participation, equity, and sustainability."

The case study “Against the odds – Walterton and Elgin, From Campaign to Control” (United Kingdom), presented by Jonathan Rosenberg, described a North London community campaign in the 1980s which fought to prevent the local authority from

redeveloping the area as private housing for sale at prices beyond the reach of local people.

"WECH, a resident-controlled housing association, campaigned to prevent the local authority from redeveloping the area as private housing for sale at prices beyond the reach of local people. The two tower blocks were built out of steel, concrete and fibre glass. The lifts regularly broke down, the rubbish chutes blocked, and residents suffered flooding and water penetration. The worst problem was the wide range of asbestos products used as fire protection."

SECURING AN INFRASTRUCTURE FOR HEALTH PROMOTION

The case study "The Global Embrace: A World-Wide Walk Event for Active Ageing", presented by Dr Alex Kalache, described the highly visible one-day event consisting of a chain of locally organised celebrations and walks in 96 countries, occurring consecutively around the globe over a period of 24 hours.

"The vast majority of people, as they age, continue to live within their local communities. Grass-roots and community-based activities are a natural focus to promote healthy and active ageing. ... walking is not only an excellent form of physical exercise but also enhances social integration as it is a good way to meet people or enjoy the companionship of friends and family."

The case study "Equity Gauge – a tool for monitoring equity in health and health care in South Africa", presented by Antoinette Ntuli, described a project which supports improvement and reorientation of health services with the help of national and provincial lawmakers by setting up benchmarks to measure progress toward equity in health and health care.

"... a national project to help South Africans know if their health is improving and measure progress toward equity in health care provision. A partnership between South African Legislators and the Health Systems Trust to support the transformation of the health system."

The case study "Integration Of The Consensus-Action Group: A Network Of Academic And Social Institutions For Community Health Promotion And Education (Mexico)", presented by Dr. Mariano García Viveros, described the work of an action group formed to strengthen health promotion activities by mobilizing academic institutions to provide scientific support for health priority areas.

"... a network of investigators and educators to provide support to those working in health promotion, closing the gap between theory and practice. Network includes a variety of institutions with established infrastructure and significant potential for mobilizing to strengthen community capacity ..."

REORIENTING HEALTH SERVICES AND SYSTEMS

The case study “Association Vivir: Promoting Daily Health With Community Participation”, presented by Dr Mariana Galarza, described how, in response to inadequacies of the existing health system, a private NGO, provides primary and preventive services and training.

"... a non-governmental organization that opened the door to alternative forms of health care in Ecuador. According to Dr. Galarza, the predominant curative approach to health care fails to see the human being in a comprehensive light; ignoring the social, emotional, and environmental causes of illness."

The case study “Community Care Network (CCN) Evaluation Program: A Case Study of An Expanding Private/Public Partnership in Rural United States”, presented by Elizabeth Casey and Pat Graham-Casey, described how CCN addresses community health improvements via public/private partnerships to determine community needs, ensure continuum of care, and effectively manage resources.

" ... initially focused on improving cancer screening services for the underserved. It has now effectively expanded its service to include more comprehensive efforts to prevent chronic disease and improve all aspects of health care for the residents of west Texas."

The case study “Drug Abuse Prevention with Young People in Peshawar, Pakistan”, presented by Dr Parveen Azam Khan, described the work of the DOST Welfare Foundation in the treatment and rehabilitation of drug addicts and their families and prevention of drug abuse in the community.

"DOST Welfare Foundation responds to the need for effective rehabilitation based on whole person recovery, i.e. physical, psychological, social and spiritual. Treats and rehabilitates drug addicts and, in parallel, works for drug abuse prevention in the community, by strengthening young people to resist the lure of drugs and develop healthy alternatives...."

Technical Reports written for the Fifth Global Conference on Health Promotion

"Strengthening the Evidence Base for Health Promotion"

By Dr David McQueen, USA.

"Investment for Health"

By Dr Erio Ziglio, WHO Regional Office for Europe; Prof. Spencer Hagard, UK; Prof. Laurie McMahon, UK; Dr Sarah Harvey, UK; Prof. Lowell Levin, USA.

"Promoting Social Responsibility for Health: Progress, Unmet Challenges and Prospects"

By Dr Maurice Mittelmark, Norway.

"Increasing Community Capacity and Empowering Communities for Promoting Health"

By Dr Helena Restrepo, Colombia.

"Infrastructure to promote health: the art of the possible"

By Dr Rob Moodie, Australia; Dr Elizabeth Pisani, Australia; Monica de Castellarnan, Australia.

"Reorienting Health Systems and Services with Health Promotion Criteria"

By Drs Daniel López-Acuña, PAHO, WHO/AMRO; Patricia Pittman, USA; Paulina Gomez, Chile; Heloiza Machado de Souza, Brazil; Luis Andrés López Fernández, Spain.