

Feedback was also received from the consultations held by the Health Development Agency, England, the IUHPE Best Practice Conference in Stockholm and at the inter-country expert meeting at the African Medical Research Foundation in Nairobi.

Before presentation to the participants for finalisation at the Bangkok conference, the draft charter was placed on the WHO web site for public comment over a period of three weeks.

At the conference, the draft charter was again revised twice by the Charter Finalization Group,³ following feedback from the in-depth discussions during the 29 technical sessions at the conference, and following an extended plenary session before the final version was presented and accepted at the close of the conference.

WHO is committed to the development of a global framework for health promotion strategy for the implementation of the charter, including a set of objectives, timelines and mechanisms to monitor the progress. Colleagues of the health promotion community worldwide are urged to take part in the development and implementation processes.

Notes

1. Members of the charter drafting and finalising groups were: Hiram Arroyo, Robert Beaglehole, John Catford, Carissa Etienne, Siripon Kanshana, Moushira Khattab, Ilona Kickbusch, Zanele Mthembu, Alok Mukhopadhyay, Don Nutbeam, Desmond O'Byrne, Bosse Pettersson, Blanche Pitt, John Raeburn, Sylvie Stachenko and Tang Kwok-cho.
2. A full list of the members and track leaders is available at the conference web site: <http://www.who.int/healthpromotion/conferences/6gchp/committees/en/index.html>
3. Non-government organisations such as the HealthWrights, Health Promotion Forum of New Zealand, People's Health Movement and Red Cross; networks such as the Euro Health Net, the International HP Foundation Network and Global Forum for Health Research; aid organisations such as the Swiss Agency for Development and Cooperation and Irish Development Aid; public health and professional associations such as Public Health Agency of Canada and the International Union for Health Promotion and Education; United Nations organisations such as the World Bank and the United Nations Economic and Social Commission for Asia and the Pacific; and the private sector such as the International Federation of Pharmaceutical Manufacturers and Associations and a number of multinational companies in the food and non-alcohol beverage industry.

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The future of health promotion

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Ronald Labonte

*Give me back the Berlin Wall
Give me Stalin and St Paul
I've seen the future, brother, it is murder
— Leonard Cohen, 'The Future', 1991*

This is a rather sobering way to begin an essay on the future of health promotion. A stanza from a song penned by Canada's muse of melancholia, Leonard Cohen, is also, admittedly, poetic hyperbole. But, written shortly after the collapse of communism – that constitutive 'other' to Western individualism and market capitalism – Cohen's poesy is also remarkably prescient.

By citing this stanza I am not inciting the field of health promotion to embrace fatal criminality, or even unwarranted pessimism. I am, at heart and in politics, an optimist, which I consider less a personality trait than an act of political resistance and empowerment. But I am provoking us to move beyond our committed and often effective localism, despite its importance, to consider the bigger canvas of social determinants. For the future may not be murder. But it is likely to be murderous, unless we are able to hold our politicians and economic elites accountable to policies that will sustain health, and do so equitably.

Celebrating the ordinary

This task can quickly overwhelm us, particularly if we subscribe to the hubris that it belongs to us alone, or is one in which we offer unique leadership. Fortunately, neither is so. More importantly, and perhaps reassuringly, there is still much we can offer in 'celebrating the ordinary'. This is how I described the near-future of health promotion in an essay published several years ago in this very journal.¹ To summarise a few points from that essay:

- Health promotion remains an emancipating ideal for those working in the health sector. It describes an ideology and set of practices by which we invite ourselves into the movement of enhancing social justice and environmental sustainability.
- Health promotion has struggled, and continues, to bridge numerous seeming antinomies:
 - Unhealthy lifestyles/unhealthy living conditions.
 - Individual interventions/collective mobilisations.

- Social engineering or ‘top down’/empowerment or ‘bottom up’.
- Professional expertise/community wisdom.

Bridging these opposites is never complete or perfect. Indeed, our efforts to do so largely define what is exciting, novel and important about our work. Health promotion has shown its effectiveness in numerous areas, but particularly in high-income countries, including tobacco control, reducing the incidence and impact of HIV/AIDS, and in early childhood development interventions.

In all cases, community mobilisations and civil society advocacy were key elements of success. In all cases, multiple strategies, multiple actors, committed funding and committed time were required. In all cases, some efforts were made to deal with underlying health determinants – poverty, income inequality, gender discrimination, to name a few – but such efforts so far have been insufficient to make much of a difference. Health promotion shines in local work but still only glimmers at higher political levels.

Such work continues to be important – it is the ‘ordinary’ of our field that needs to be celebrated, extended and sustained into the future.

The challenge of tackling the extraordinary

Holding the course – and improving on it – is a future-necessary, but a future-insufficient. For the ordinary is becoming extraordinary with respect to trend-lines and emergent phenomena. If the *Ottawa Charter for Health Promotion* were to be updated, at least four new urgencies are already upon us:

- The communications revolution and, like all other goods, its digital divide between rich and poor. The Internet, for example, is wielded disproportionately by the already powerful.
- The rise of an imperious global corporate capitalism. Liberalisation of trade, services and financial markets is consolidating corporate economic and political power. By creating global production chains and using transfer pricing and tax haven nations, corporations rise above the regulatory and re-distributive tax capacities of the state.
- As health promotion succeeds in its anti-tobacco and healthy eating strategies in the high-income nations that birthed its practice, new trade rules and rich-country arm-twisting have opened the doors to the rest of the world, creating a double burden of chronic diseases to compete with existing infectious pandemics.
- The emergence of ‘inherently global health issues’ that transcend national boundaries. The export of unhealthy lifestyles is one such example (see Table 1).

Disease, *per se*, is absent from this list, which concerns the

underlying determinants of disease. This is not to say that disease prevention efforts are unimportant, and especially in such instances as HIV, tuberculosis or malaria prevention. But these remain primarily diseases of poverty and inequality. War and conflict, in turn, are greater in regions of poverty and disease, which in turn are greater in regions of limited economic development and unwisely premature global market integration.³ Only environmental degradations have some future equity in their grim harvest, although their present effects still follow lines of class, gender and ethno-racial discrimination.

Most of the concern for global health issues in high-income countries has been appropriated by an increasingly worrisome ‘security paradigm’ that in many high-income countries means that foreign policy is more militaristic than humanistic. This security paradigm is already a threat to basic human rights, both in how we treat the non-white majority of the world’s population, or surrender our own domestic rights to an illusion of safety from ‘terrifying Others’ that all justifications for increased militarisation require.⁴ The increased investment in the ‘security paradigm’ contradicts the empowerment ethos that has underpinned the past two decades of health promotion. Further, budgetary allocations to national and global security far exceed foreign aid from all donor nations combined.^{5,6}

These trenchant points speak to a few other inter-related and immediate challenges on our health-promoting horizon:

- **Racism or ethnic conflict.** It appears to be rising, and historically grows more as resources and opportunities become scarce. The Balkan conflicts of a decade past were as much the result of the fall of the Berlin Wall and collapse of communism’s systems of redistribution as it was of centuries’ old enmities.⁷ Confronting intolerance and challenging stereotypes must become part of the health

Table 1: Inherently global health issues.²

Environmental global degradation

- Greenhouse gas emissions (climate change)
- Biodiversity loss
- Water shortage
- Decline in fisheries
- Deforestation

Social /economic

- Increasing poverty/inequality
- Financial instability (capital markets)
- Digital divide
- Taxation (tax havens, transfer pricing)

Cross-cutting

- Food (In)security
- Trade in health-damaging products
- Governance
- War and conflict

promotion agenda. There is also an optimistic inverse to racism, which not only challenges but invites new opportunities for health promotion: the rise in popular discourse of indigenous systems of health and social knowledge. These 'wisdom systems' present alternatives to medical reductionism and market consumerism, and create new bridges for intercultural understanding and, most importantly, respect.

- **Population movements, and in two respects:**
 - The escalating 'brain drain' of skilled health professionals from grossly underserved and desperately ill areas, such as sub-Saharan Africa, to economically privileged countries such as the USA, Canada and Australia that can readily afford to train what skilled professionals they need.
 - The increasing number of economic and ecological refugees who are being forced by progress, scarcity or conflict to abandon agrarian pasts for an industrial or post-industrial future.
 - The proliferation of slum dwellers has yet to manifest in high-income countries as obviously as it has in poorer nations. But the rapid urbanisation of an increasing number of humanity occurring in concert with weakening state structures – both an effect of 'free market' policies – threatens new disease risks and health problems on an unprecedented scale.⁸
- **Demographic shifts:** High-income countries are ageing at a rate where there will be an insufficient labour force in the future to support them, mocking our efforts to promote healthy ageing. Low-income countries have a surplus of young, manually skilled workers who could rectify this. Opening our doors to larger numbers of poorer migrants – while supporting the development higher-skilled citizens in poorer countries – may be an important step in promoting future health.

What under-girds all of these trends, and what makes the health promotion task of interceding in them, is a retreat from the progressive goals of equity. The health-promoting resolution to these existing or emerging trends will cost each of us personally. The mathematics of ecology, economy and population allow no other conclusion. This brings me to the evidently most chilling future scenario, that of ecological collapse.

Proclaiming survival

Each time history repeats itself, the price goes up.
— Popular graffiti

Climate change is on the top of the list of inherently global health issues in Table 1. That was a deliberate positioning. The litany of health effects of climate change are, or should be, well known: from the heat deaths we are already experiencing, to

the expansion of many infectious disease vectors, to the loss of food sources and potable water.

The history of most civilisations, as writers such as Jared Diamond (*Collapse*⁹) and Ronald Wright (*A Short History of Progress*¹⁰) inform us, has been one of ruining their ecologies. This despoliation underpins their collapse, fuels population movements and, where there have been contiguous land masses or the technologies to cross oceans, gives rise to the next rising empire. The folkloric canary in the mineshaft is the story of the Easter Islanders, whose ideological enslavement to a belief in the ancients led to the erection of huge stone monuments, whose movement required skids of timber which, as competition among the families for more and bigger monuments accelerated, denuded the island of every last tree. No trees, no birds, no insects, no mammals, no fresh water, no food. And by the time the Europeans bumped into the island, almost no people. The tragedy is that they likely knew what would happen even as they cut the last tree. Just as we know what will likely happen as we continue to fish our oceans to extinction, eliminate our carbon sinks and biodiversity, contaminate our sources of fresh water, grow our supposedly healthy economies with a continued addiction to toxic fossil fuels, and blind ourselves to the consequences with an ideological enslavement to growth as the only marker of progress. This time, however, the collapse, if it occurs, will not be confined to a single island. It will be global, and the toll will be in the billions.

I have been portraying an ugly and frightening picture of the future. It is based less on sensationalism than on evidence, at least if one is to accept the forecasting scenarios of the Central Intelligence Agency's public report of late 2003.¹¹ We need to confront this if we are to plan our own form of pre-emptive strike to prevent its occurrence. I make no apologies for my use of military metaphors. We are entering a new period of global warfare. But it is not a war against terrorism, but against the terrors of disease, poverty, discrimination and environmental abuse. It is a war not for victory, but for survival.

Reclaiming rights

But how do we gird ourselves for such a struggle? What does this mean for us in daily practices of our work, our 'celebratory ordinary'? Our first offence is a strong defence against two dinosaurs of our own deceptive self-interest:

1. Neoliberalism: the orthodoxy that the rational pursuit of individual interests through the market, with only the lightest of government interventions to correct market failures, will lead to collective betterment. As if the wars in the Congo waged over the self-interested control of diamonds, coltan and other minerals, and the five million lives it has cost, represents a collective betterment.
2. The 'end of history' thesis: the controversial idea that the

collapse of the Soviet Union marked capitalism and liberal democracy as the ultimate social achievement of humankind, to which there is no alternative. We may not want to re-erect the Berlin Wall, but the loss of the communist 'Other' has created a vacuum in a coherent alternative – however flawed – that provided ideological and political momentum to social movements within industrialised countries and fostered 'third way' experimentation of mixed markets and central planning for many developing countries.

What is there to challenge neoliberal dominance or to provide a moral argument for a less selfish society that still possesses political 'legs'? One of our first reminders should be that contemporary capitalism comes in many hues, with some economically vibrant countries managing to buffer the inequalities of the free market by sustaining strong taxation and redistributive programs. Rates of child poverty are related to the taxation and size of the public purse and are ameliorable, even in developing countries.¹² Countries in Northern Europe/Scandinavia show greater redistributive generosity in terms of the proportion of GDP that is spent as development assistance, with rates twice those spent in English-speaking developed countries such as Australia, the UK, Canada, and last, the USA.¹³ The challenge for our Nordic alternatives, however, will be their ability to create a fairer set of globalisation rules, which at present embody the dominating individualism of the Anglo-American nations.

A second source of future strength resides in the discourse and obligations under human rights. A key text is Article 12 of the International Covenant on Economic, Social and Cultural Rights which proclaims "the right of everyone to the enjoyment of the highest attainable standard of physical and mental health".¹⁴ It reads a little like the WHO's founding documents and the Ottawa Charter but with a trenchant difference: it specifically obligates State parties to ensure provision of a number of health care and public health services, as well as equitable and affordable access to such key underlying health determinants as "safe and potable water and adequate sanitation, an adequate supply of safe food, nutrition and housing, healthy occupational and environmental conditions, and health-related education and information, including on sexual and reproductive health".¹⁵

It also obligates States to *respect* the right to health in other countries by ensuring that any other international agreements they negotiate "do not adversely impact upon the right";¹⁶ to *protect* against infringements of this right by third parties such as corporations; and to *fulfil* this right, which for rich countries like Australia and Canada means international assistance and co-operation to poorer countries.

There remains considerable doubt whether our political processes will honour their human rights obligations, or instead sacrifice them to the altar of economic growth and 'free' markets.

The enforcement of human rights obligations requires monitoring, analysis and mobilisation – skills which many health promoters have in abundance. At least some of us need to apply those skills to the right to health.

Conclusion

Imagining the future can take two approaches. One is that of trends projection. It is the one I have taken, and invariably paints a dystopian picture. Another is that of back-casting from a preferred future, a path followed by many of the Healthy Cities/Healthy Communities initiatives of years past. Utopian in outlook, back-casting can create collective visions that form the basis of better intercultural understanding, or what is sometimes now called 'bridging' and 'linking' forms of social capital. We need to re-invigorate such visioning in our work. It is one task that can bind our celebratory ordinary to the urgency of our emerging extra-ordinaries.

But we also must confront the fallacy of our field: promoting the physical and mental health of individuals whose well-being rests, in part, on economic practices that are today's equivalent of logging the last Easter Island tree is morally unacceptable and, from an intergenerational health vantage, indefensible. What are we to do about that?

I will not give an answer, but offer a means. A decade ago I argued that the health promotion that inspired the Ottawa Charter arose from the progressive social movements of the time. Increasingly, these movements are coalescing around the nascent just-globalisation movement. This is also where our health promotion of the future must seek its new and renewing mandate. There is, as yet, no consensus on the strategic actions emanating from this just-globalisation movement. Perhaps there never will be and, like progressive social movements before it, the just-globalisation movement represents more a fundamental shift in thinking, which we then apply to the contexts in which we work.

Health promotion has been burdened too long by its attempts to regulate the self. It is time for us to embrace and promote an ethic of socially responsible hedonism, the just pursuit of pleasure that harms no one else and does not detract from others' abilities to seek pleasure. A few years ago in Brazil I learned the samba. Every year during *Carnival* the social in-cohesion of that country's skewed wealth distribution – rivalling South Africa's as the worst on the planet – is momentarily obliterated in the world's biggest dance festival. As Emma Goldman, the early 20th century anarchist, feminist, and trade unionist, inspirationally aphorised: "If I can't dance then it's not my revolution."

Be rigorous. Be righteous. Act with revolutionary passion. And always dance the night away.

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Prolead: health promotion leadership development in the Western Pacific region

Vivian Lin and Sally Fawkes

A review of health promotion programs in the Western Pacific region,¹ undertaken for the World Health Organization (WHO) in 2001, pointed to the importance of infrastructure and capacity development for achieving health promotion effectiveness. The general framework for achieving health promotion effectiveness was captured in a checklist that distilled the key requirements for ensuring program effectiveness (see Table 1).

In pointing to elements required for program development and implementation,¹ the review identified leadership as a key attribute of a health promotion system. To promote health, leadership is concerned with mobilising decision-making and resource management to support pro-health governance – that is, to ensure that the analysis, advocacy and action necessary for influencing health determinants can be brought into system-level decision-making and lead to better population health. Improving leadership skills was recommended as a priority for enhancing implementation effectiveness. Specifically, it was recommended that a leadership development program be piloted that recognised the particular challenges of mobilising resources across diverse sectors and across the health system to promote health. This brief report provides an overview of achievements of such a program, Prolead, which was implemented during 2004/05. Prolead was designed and conducted by the WHO Regional Office of the Western Pacific (WHO WPRO) in partnership with the Government of Japan, SEAMEO TROPMED, and La Trobe University School of Public Health, Victoria.

Program objectives and design

In the context of building national capacity for health promotion in developing countries of the Western Pacific, Prolead emphasised challenges for leadership in health promotion within Ministries of Health. These included integration of health promotion within health care delivery, re-focusing health services so they are preventive and health promoting in orientation, and changing people's health-seeking behaviour, as well as forming strategic alliances with other sectors that shape the broader determinants of health. The role of the program was to engage individuals with leadership potential in a transformative process: "changing mindsets in order to take risks" would be one of the key challenges. The 'leadership agenda'² would revolve around the need for individuals to ultimately lead – and assist others to lead – health-promoting changes within local,