The Bangkok Conference: steering countries to build national capacity for health promotion

Millions of young people in the developing world never achieve two decades of life, let alone seven, and so it is with mixed feelings that *Health Promotion International* celebrates its 20th birthday this issue. Much has been written and said about the antecedents and milestones of the health promotion phenomenon [e.g. (Catford, 2004)], but what is clear from history is that any rapidly growing movement or organization needs to re-invigorate its purpose for existence as well as build its capacity for success. This is vital if health promotion is to be truly a response to both national and global challenges. The forthcoming Bangkok Conference and foreshadowed Bangkok Conference will seek to fill this gap.

The leadership of the World Health Organization (WHO) over this period has been paramount and has been enacted through a series of International Conferences on Health Promotion (Ottawa in 1986, Adelaide in 1988, Sundsvall in 1991, Jakarta in 1997 and Mexico City in 2000). The status and direction of health promotion globally is due in no small measure to these technical and scientific meetings. In response, the World Health Assembly (WHA) called on member states in the spirit of Alma-Ata, to develop strategies for health promotion and to strengthen the required structure and resources at all levels (WHA42.44). The WHA Resolutions on Health Promotion (WHA51.12) and on Diet, Physical Activity and Health (WHA55.23) recognised the Ottawa Charter as a worldwide source of guidance and inspiration for health promotion. But this important resource needs to be complemented with innovative and authoritative advice in light of new challenges and opportunities, particularly for low- and middle-income countries.

Encouragingly, WHO in partnership with the Royal Government of Thailand is organizing the 6th Global Conference in Bangkok on 7–11 August 2005. Entitled ‘Policy and Partnership for Action: Addressing the Determinants of Health’, the conference seeks to achieve a set of ambitious outcomes:

1. Frameworks and strategies for sustainable and integrated health promotion directed at tackling health challenges and their determinants, and managing globalization.
3. Examples of successes and lessons in addressing the social, economic and environmental determinants of health.
5. Global monitoring, reporting and capacity-building initiatives for enhancing health promotion.
6. Energized and committed participants and partnerships from diverse sectors and all WHO regions for carrying forward the recommendations of the Conference.

**THE BANGKOK CHARTER FOR HEALTH PROMOTION**

The programme is structured into four tracks: (i) emerging context of health promotion; (ii) strategies for sustainable integrated health promotion actions; (iii) current and future health challenges; and (iv) challenges and opportunities of globalization. In addition, the Thai Day will present some of the leading developments occurring in that country, not least through the pioneering work of the Thai Health Promotion Foundation. Up to nine plenary presentations and 28 technical discussions have already been planned, as well as sessions for the development and endorsement of the Bangkok Charter for Health Promotion.

The Conference title, outcomes and programme have been developed by members of
the Conference Organising and Programme Committees, the track leaders and colleagues from WHO in Geneva, and at the regional and country levels. The track leaders are: Alok Mukhopadhyay of the Voluntary Health Associations of India, Wilfred Kreisel of the WHO Centre for Health Development in Kobe, Suwit Wibulpholprasert of the Thai Ministry of Health, Bosse Petterssen of the Swedish National Public Health Institute, Blanche Pitt of the African Medical and Research Foundation, John Catford of Deakin University Australia, Robert Beaglehole of the WHO in Geneva, Ilona Kickbusch of Switzerland Health Promotion, Jacques Baudouy of the World Bank and Srivinas Tata of the Indian Ministry of Health.

Like its forebear, the Bangkok Charter seeks to reach many target audiences, including top level politicians and key decision makers in government and regional authorities, health and educational institutions, experts in health promotion, chronic and communicable disease prevention and public health, United Nations agencies, development banks, private sector, non-governmental organizations (NGOs) and the community. The purpose is to provide a tool that will help policy and decision makers build the necessary financial and technical support within their countries and spheres of influence for the implementation of effective health promotion. The Bangkok Charter will also identify new and emerging challenges to public health, help mobilize concerted action across all sectors to address them, and provide vision and goals for the future. Special attention and focus will be given to poor and marginalized groups, and to the role of civil society, NGOs and the private sector in promoting health.

One of the difficulties for the Bangkok Charter in tackling the issue of national capacity building concerns the lack of available information upon which to base its recommendations (Nutbeam, 1998). Whilst considerable effort has been made internationally to strengthen capacity, there is no clear picture of the extent of the progress made or the shortfall that may still exist. Anecdotal reports suggest that the capacity to promote health in high-income countries in Australasia, Europe and North America is improving, but in low- and middle-income countries it is limited. There are three reasons for this uncertainty: (i) no agreement on the scope and definitions of what to measure; (ii) no valid system globally to collect the data consistently over time; and (iii) no mechanism to present the information in a way that compels a policy response. Without progress in these areas comparisons over time or between areas cannot be made. As the old adage goes ‘if you can’t measure it, you can’t manage it’.

Whilst the concept of ‘capacity’ varies for different types of organizations or levels (Tang et al., 2001; Joffres et al., 2004), at a national level it commonly concerns infrastructure components. These include policies, surveillance systems, research and evaluation capability, a skilled workforce and programme delivery mechanisms (IUHPE, 2004; Tang et al., 2005). One of the complexities of health promotion is that there is no single ‘one size fits all’ in terms of intervention design. Responses have to be tailored to the issue, context and resources available. Whilst this may be true of programme content, it is arguable that each country needs a basic health promotion infrastructure, just as it does for government, health, education, justice, etc.

In preparation for the Bangkok Conference, WHO has initiated a mapping exercise of national capacity through its network of Regional Health Promotion Advisers or Focal Points (David Nyamwaya of AFR, Maria Teresa Cerqueira and Marilyn Rice of AMR-PAHO, Erio Ziglio and Chris Brown of EUR, Jaffer Hussain and Abdul Halim Joukhadar of EMR, Sawat Ramaboot of SEAR and Susan Mercado of WPR). This is being led by Drs K. C. Tang, Desmond O’Byrne and Robert Beaglehole of the Department of Chronic Diseases and Health Promotion at WHO in collaboration with John Catford (Australia) and with the support of a Reference Group comprising Marcia Hills and Simon Carroll (Canada), Katrin Engelhardt (Germany), Regina Ching (Hong Kong SAR China), Srinivas Tata (India), Maurice Mittelmark (Norway), Risintha Premaratne (Sri Lanka) and Maggie Davies (UK). Questionnaires have been developed and data is being collected so that some preliminary analysis and recommendations for the future may be presented at the Conference. Importantly, the mapping exercise needs to be ‘health issue free’ so as not to impose a developed country perspective on the findings. Health promotion is a tried and tested approach for chronic disease prevention, but it also has value for the control of infectious diseases and for new emerging diseases; indeed all three areas will be considered at the Conference. While the capacity to address the risks of chronic diseases and injuries in many low- and middle-income
countries is limited, their capacity to deal with infectious diseases may well be satisfactory.

Eight broad domains, which are not health issue dependent, are proposed at this stage of development to track national capacity in health promotion. They could comprise the presence or availability of the following:

1. National policies and plans: national government policies and plans for health promotion priorities, which embrace the underlying concepts of the five Ottawa Charter strategies. These could cover a number of health promotion priorities for the country or be presented as separate policies for these priorities. Support for the range of strategies described in the Ottawa Charter should be clear, comprising: healthy public policy; personal skills/education; supportive environments; community strengthening; and reorienting health services. The health promotion dimensions should be transparent and not subsumed within treatment services or clinically oriented secondary prevention programmes.

2. National leadership: core of expertise and leadership within the national Ministry of Health for health promotion development, coordination and partnerships. This could include an identifiable ‘health promotion’ unit/section/centre/department within the Ministry, or a group described differently but with similar functions that are explicitly stated. Access to external advisers both within and outside government would also be important.

3. Joined up government: coordinating mechanisms within the Ministry of Health and across national government for policy development and plan implementation for health promotion priorities. This would provide the opportunity for different units within the Ministry to cooperate around common health promotion issues (e.g. nutrition and primary care services, substance use and mental health services, active living and aged care services). In addition, different departments and national agencies within government should be assisted to cooperate around the economic, social and environmental determinants of health. Partnering mechanisms could be varied but should be effective in supporting collaboration for health promotion (e.g. health with education/agriculture/transport, etc.).

4. Programme delivery: delivery structures and mechanisms for health promotion priorities at national and/or subnational levels, including support for inter-sectoral partnerships. This concerns a defined organizational unit(s) with responsibilities and accountabilities for the delivery of health promotion programmes and capacity building initiatives. Such delivery arms could be located at national and/or subnational levels according to country needs. The development and maintenance of partnerships would be a key role, including generating links with the private sector.

5. National partnerships: national partnerships among NGOs, civil society, private sector and government for health promotion priorities. This would provide an important resource for the progression of health promotion in addition to direct government programmes. With support from government, NGOs and others can work most effectively through formal and informal partnerships and alliances.

6. Professional development: national-level advanced education and training programmes, and a professional association for health promotion practitioners, policy makers and researchers. This would include postgraduate training programmes to develop leadership, planning, management and evaluation in health promotion, such as Diplomas/Masters of Health Promotion, Masters of Public Health (with strong health promotion components), and advanced professional development courses. Such programmes are different to focused skills training courses for specific workers (e.g. nurses, community leaders) at the local level. To support and safeguard high standards of practice, an independent professional association is required, which can also act as an advocate for change. It is expected that a large number of health promotion managers, practitioners and researchers from the country would be members.

7. Performance monitoring: national-level research and evaluation, and information systems to track and report on health indicators relevant to health promotion policy, priorities and programmes. This would include a research and evaluation resource at national level to inform evidence-based practice and to assess the impact of health promotion programmes. In addition, a responsive information system is
required to monitor progress at a national level of health promotion programmes focusing on health issues (e.g. nutrition) and/or settings (e.g. in schools). Data could be collected at subnational level and then assimilated nationally to provide information for policy, planning and evaluation.

8. Sustainable financing: transparent and sustainable source of public financing for health promotion priorities at national or subnational levels.

This could comprise a number of public funding sources, including direct government allocations, hypothecated taxes, or through social/health insurance. The financing should be quantifiable to monitor changes in expenditure over time.

Although a number of other more discrete domains could be included or each one of them subdivided further, it is important as a policy tool for national capacity stocktaking to be straightforward in presentation and communication. Often extremely important data analyses get lost or ignored through overcomplication and poor communication. An eight-domain measurement tool has the advantage of being able to be presented diagrammatically using the eight points of a compass or eight spokes of a ‘steering’ wheel or ‘spinning’ wheel. Such analogies could also be useful in communication and presentation.

For example, the ‘National Health Promotion Capacity Wheel’ could be described as the basic tool that will help steer countries in building capacity to promote health into the future, or that each spoke is absolutely essential for the strength, stability and functionality of the spinning wheel.

Different countries will be at different stages of development, but a simple plot will indicate

![Fig. 1: The National Health Promotion Capacity ‘Wheel’.](image-url)
whether the wheel is small or distorted. A prototype ‘wheel’ for national health promotion capacity monitoring is presented in Figure 1, with a hypothetical country given as an example. In line with the Conference’s theme of Policy and Partnership, the wheel can broadly be categorized into four quadrants according to the two continuums of Inside/Outside Government and Policy/Partnership Focus. Some domains will sit between these. The Bangkok Conference should critically examine its value and consider whether such approaches would assist global progress, particularly for those countries most in need of health promotion approaches.

A final challenge will be the need to develop a set of consistent measurement criteria, at least at country level, to monitor change over time. Ideally though there could be merit in establishing global criteria so that inter-regional or inter-country comparisons could be made, in the same way that life expectancy, disease rates and literacy levels are examined. This is not an easy matter, as previous papers in this journal have described (Crisp et al., 2000; Ebbesen et al., 2004); nevertheless it is a task worth pursuing. We wish the WHO well in exploring this methodology in preparation for the Bangkok Conference, but with the Hippocratic saying very much in mind ‘to help, or at least to do no harm’. Let us therefore be prepared for some exciting new horizons post-Bangkok and be ready to seize the opportunities that will arise.

John Catford
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REFERENCES


NOTES

Inside Government
This relates to activities that are mostly under direct line management control of government.

Outside Government
This relates to activities that are mostly outside of direct line management of government but can be assisted and supported by government.

Policy Focus
This relates to activities that are more oriented towards policy development to support health promotion interventions and capacity building.

Partnership Focus
This relates to activities that are more oriented towards partnership development to support health promotion interventions and capacity building.

Scale

A: Fully and effectively implemented
This means that the activity is totally in place and working well for all the health promotion priorities at a national level. There should be evidence to demonstrate this.

B: Partially implemented
This means that the activity is partially in place and now in operation for some or all of the health promotion priorities at a national level. There should be evidence to demonstrate this.

C: Actioned
This means that work has started but that it is too early to assess impact or outputs.

D: Under development
This means that there has been a national commitment to implement the activity, and that work is under way to develop it.
E: Being considered
This means that the activity is being considered for implementation but no firm commitment has yet been given at a national level.

F: Not currently actioned
This means that the activity has either not been considered or has been rejected for implementation at this time.