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Prince Mahidol Award Conference

Mainstreaming
Health
into Public Policies

Report on

the Prince Mahidol Award Conference 2009
28 – 30 January 2009 Bangkok, Thailand

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Prince Mahidol Award

Prince Mahidol Award for the Year 2008 Award in Public Health (joint award)



Michiaki Takahashi
Emeritus Professor
Board Member
Research Foundation
for Microbial Diseases
Osaka University
Japan

Professor Michiaki Takahashi graduated from Osaka University Medical School in 1954. He completed a Graduate Course of Medical Sciences in 1959, majoring in poxvirus virology. Then he was appointed as Research Assistant, Department of Virology, Research Institute for Microbial Diseases, Osaka University. He studied development of attenuated measles and polio vaccines. He was promoted to Associate Professor in 1963. He studied the adenovirus at Baylor Medical College (Houston) as a one year research fellow (1963-1964) supported by the Rockefeller Foundation, and then studied genetics of bacteriophage in Fels Research Institute, Temple University (1964-1965). While staying in Houston, his son (3 years old) took severe chickenpox, and he had an idea of developing varicella vaccine in the near future.

In 1965, he returned to the Research Institute for Microbial Diseases, Osaka University and studied conditional lethal mutants with regard to malignant transformation of cultured cells with adenovirus and herpes simplex virus. From these experiences, he was convinced that the varicella-zoster virus is a member of the herpes virus group, even though it may never be linked to human cancer. In 1971, he isolated a strain of Oka (taken from the surname of a patient with typical chickenpox) of VZV, and started to develop a varicella vaccine. He succeeded in development of a varicella vaccine (Oka strain) in 1974. He was honored with the Kojima Saburo Memorial Award (1975), the Asahi Award (1985) and then the “Scientific Achievement Award” from the VZV Research Foundation (N.Y.) in 1997.

He was promoted to Professor of the same Department in 1979 and then jointly appointed to Director of the Institute (1984-86). He retired from Osaka University in 1991 and is now Emeritus Professor of Osaka University, and a Board Member of the Research Foundation for Microbial Diseases of Osaka University.

Prince Mahidol Award



Prince Mahidol Award for the Year 2008 Award in Public Health (joint award)

Dr. Yu Yong Xin
Director Emeritus
First Department of
Viral Vaccine National
Institute for the Control
of Pharmaceutical and
Biological Products
People's Republic of China

For his seminal role in developing the attenuated SA – 14-14-2 vaccine for Japanese encephalitis virus which is widely regarded as the most efficacious vaccine now available. The vaccine has been administered to over 200 million children throughout Asia and proven to be effective in preventing JE encephalitis.

Dr. Yu Yong Xin and co-workers at the National Institute for the Control of Pharmaceutical and Biological Products have spent nearly three decades starting from early 1950s to derive a candidate live – attenuated Japanese encephalitis (JE) vaccine through a long process of passage, cloning and sub – selection. The vaccine was tested for immunogenicity and efficacy in experimental animals and human subjects. Dr. Yu also supported efforts to increase the availability of the vaccine within and outside China. The SA 14-14-2 JE vaccine is widely regarded as the most efficacious and safest JE vaccine now available. It has been licensed for use in South Korea, Nepal, Sri Lanka and India and petitions for licensure are pending in many other countries.

A series of international trials has established this vaccine as achieving 99% efficacy within days of administration of a single dose and maintaining 95% efficacy for five years following the administration of a single dose. The vaccine has been administered to over 200 million children in China since 1988 and to over 30 million individuals in India and to millions more in Sri Lanka and Nepal, all without any proven adverse events. Studies in China and subsequently in Nepal demonstrated high efficacy in preventing encephalitis from Japanese encephalitis virus infection in children.

Dr Yu's research and support allowed this vaccine to be available to the endemic countries at an affordable price ensuring that most susceptible children would be safe from this disease.

Prince Mahidol Award



Prince Mahidol Award for the Year 2008 Award in Medicine

Professor Emeritus Sérgio Henrique Ferreira

Department of Pharmacology
Faculty of Medicine of Ribeirão
Preto University of São Paulo
Brazil

Professor Ferreira receives the award for his contribution on the discovery of the Bradykinin Potentiating Factor (BPF) and participation in the discovery of the mechanism of action of non – steroidal anti – inflammatory drugs (NSAIDS) by an inhibition of prostaglandins synthesis. Both discoveries led to the synthesis of a new class of anti-hypertensive agent, an angiotensin converting enzyme inhibitor and anti-inflammatory drug, COX 2 inhibitor, respectively.

Dr. Ferreira discovered bradykinin potentiating factor, BPF, a peptide which was found in the venom of a Brazilian snake, Bothrops jararaca which inhibits the conversion of angiotensin I and strongly potentiates the effects of bradykinin. This discovery paved the way for the development of a new class of anti-hypertensive drug, the angiotensin converting enzymes inhibitors (ACE), the first of which was captopril.

While working in London in the early seventies with John R. Vane (Nobel prize in Medicine, 1983), he participated in the discovery that the mechanism of anti-analgesic and an anti – inflammatory actions of aspirin – like drugs was the inhibition of the synthesis of prostaglandins. His studies on the basic mechanisms involved in inflammatory hyperalgesia led to the discovery of a selected class of analgesics in particular COX 2 inhibitor. He discovered the peripheral action of morphine and proposed the development of peripheral acting opiates or opiates antagonists which would not penetrate the blood brain barrier, thereby, alleviate the side effects of opiates.

Inhibitors of angiotensin converting enzymes are now widely used as antihypertensive agents. They are used as first line antihypertensive therapy. They are also recommended as drug of choice in hypertensive diabetic patients and patients with diabetic nephropathy. Many studies have confirmed the role of this drug for preservation of renal function in these patients. This drug is also recommended for the treatment of congestive heart failure. Many studies have confirmed its efficacy on reduction of mortality and morbidity in congestive heart failure.

COX 2 inhibitors are now widely used to relieve suffering of countless numbers of patients with inflammatory disease with fewer side effects.

His contributions to science have been extensively recognized. Dr. Ferreira holds since 1995 the National Order of Scientific Merit in the Great Cross level, and received many accolades. He is in the editorial board of several international journals, is foreign member to the U.S. National Academy of Sciences.

Message from Chairs of the Organizing Committee



Prof. Dr. Vicharn Panich
Chair

Organizing Committee
International Award Committee
Prince Mahidol Award Foundation
Thailand



Dr. Ariel Pablos-Mendez
Co-Chair

Organizing Committee
Managing Director
The Rockefeller Foundation, USA



Dr. Toomas Palu
Co-Chair

Organizing Committee
Lead Health Specialist
The World Bank, Cambodia

Since the Ottawa Charter for Health Promotion in 1986, and other subsequent Conferences on health promotion, healthy public policy has been acknowledged of its importance and has been subsequently reaffirmed in various global high level conferences. While healthy public policy focuses on public sectors outside the health sector mandating “health of the population” an essential factor when formulating their policies, the movement towards healthy public policy has still been mainly confined to the health sector. Slow progress has been observed on the concrete achievement of healthy public policy. However, more concrete examples were observed in the linkage between health and economic consideration when taking policy

decision. Recently, in the European Union, Health in All Policies was endorsed and several countries demonstrated their commitments, whereby developing countries have yet to learn from them.

The International Prince Mahidol Award Conference 2009, thus, focuses attention on advocating the global movement and brings awareness from various sectors to put a “health lens” in their policy formulation under the theme “Mainstreaming Health into Public Policies”. A number of experiences and lessons drawn from country case studies and cross cutting issues were discussed and deliberated at this Conference. This paves the road towards ensuring “health in all policies” by country governments, civil societies and international development partners.

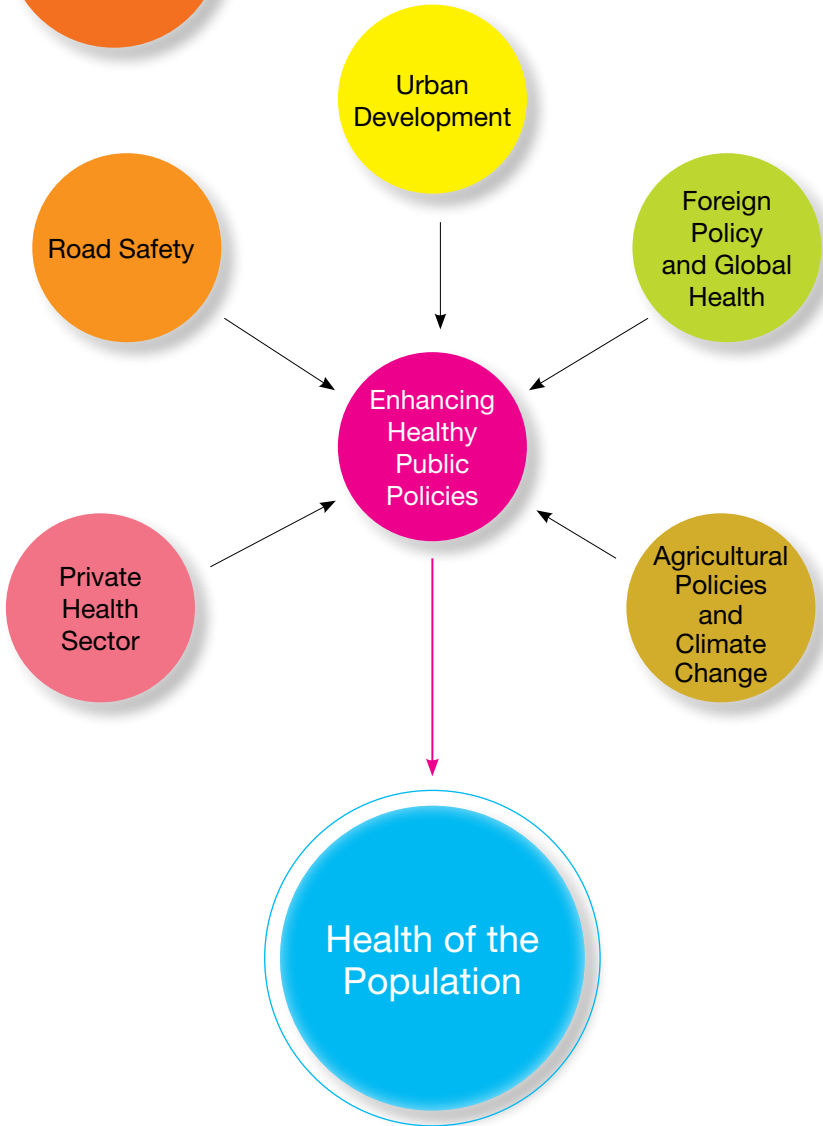
We are convinced that the processes, mechanisms, participation, and also the outcome of the Conference will contribute to stronger and more concrete movement in ‘mainstreaming health into public policies’.

As Chairs of the Organizing Committee, we are grateful to all contributions by many organizations to make the Conference a success. The main contributors are the Rockefeller Foundation, the World Bank, the Prince Mahidol Award Foundation, and the Royal Thai Government who co-host this conference. Each parallel session was sponsored by organizations that provide support in terms of technical assistance and / or funding support to the participants. We are most thankful to the following organizations: the Task Force on Child Survival and Development, the Rockefeller Foundation, the World Bank, the World Health Organization, the Food and Agriculture Organization, and the People’s Health Movement. We also acknowledge the active participation and deliberations by all conference participants.

In addition, we would like to express our appreciation to the Secretariat Team who worked so hard in preparing for the Conference.

Finally, we would like to extend our sincerest thanks to the conference participants for an interesting, constructive and successful exchange of ideas and experiences.

Conference
Overview



Mainstreaming Health into Public Policies

28 – 30 January 2009
Imperial Queen's Park Hotel
Bangkok, Thailand

1. Rationale

Health has become a very high priority global development agenda in the last decade judging from the tremendous increase in health related ODA, global and national political attention, global health partners, and active public involvement. These investments, however, focus mainly on tackling the three major infectious diseases, i.e. HIV/AIDS, Tuberculosis, and Malaria, and less on the health systems capacity building and other MDGs such as maternal and child mortality, nutrition, and environmental health.

The Constitution establishing the World Health Organization defines health as “A state of complete physical, mental and social well-being, and not merely the absence of diseases and infirmity”. The Executive Board of WHO in 1996 added ‘spiritual’ well-being to the definition, although not yet globally accepted. It has been accepted with ample evidences that health is a multi-sectoral and multidimensional social issue. All public policies thus have both positive and negative implications on well-being, or health. Improving health thus necessitates the involvement and the advocacy for ‘health’ lens in all public sector policies.

Healthy public policy is thus an explicit concern for health promotion and development. The main intention of healthy public policy is to create a supportive environment to enable people to lead healthy lives, as stated in the 1986 Ottawa Charter for Health Promotion:

“Health promotion goes beyond health care. It puts health on the agenda of policy makers in all sectors and at all levels,

directing them to be aware of the health consequences of their decisions and to accept their responsibilities for health...

“Joint action contributes to ensuring safer and healthier goods and services, healthier public services, and cleaner, more enjoyable environments.”

In pursuit of healthy public policies, all parties concerned, including international development partners, lending agencies, donors, national and sub-national governments, private corporate sectors involved in foreign policies, agriculture and food, trade, education, industry, energy, finance and investment, science and technology, transport and communications, and finally security, need to take into account health as an essential concern when formulating their policy.

There were global firm commitments towards healthy public policies, notably in the 1986 Ottawa Charter and confirmed now and again in subsequent international conferences on Health Promotion [Adelaide, Australia (1988), Sundsvall, Sweden (1991), Jakarta, Indonesia (1997), Mexico City, Mexico (2000) and Bangkok, Thailand (2005)]. Nevertheless, slow progress in the concrete achievement of healthy public policy were observed. Concrete examples are not often described. The movement on healthy public policy was still confined to the health sector, whereas significant concerns among non-health sector policies providing an enabling environment to health of the population have rarely been envisaged.

It is therefore an opportune time to revisit and advocate the global movement and awareness on mobilizing commitments from leaders in all sectors, to apply, as a rule of good practice, a ‘health’ lens in formulating their policies. It would be highly beneficial that the global political leaders commit to ‘mainstreaming health into all public policies at all levels’.

The Prince Mahidol Award Conference is an annual international conference hosted by the Royal Thai Government, the Prince Mahidol Award Foundation, and relevant International Organizations, Foundations and Civil Society Organizations. The Conference serves as an international forum for sharing evidence for health related policies and strengthens social

commitments for health development. This conference is closely linked to the annual Prince Mahidol Award for public health and medicine, one of the most prestigious international health awards. It has taken the lead to organize the 2009 conference together with Intergovernmental Organizations including the UN, foundations, bilateral development partners, and global civil society organizations.

2. Objectives

1. Review the evidence and examine concrete examples of the health impacts that stem from public policies in non-health sectors:

1.1. To review evidence on the positive and negative impacts of various public policies, especially in non-health sectors, on the health of the population. The topics of discussion will be both issue-based as well as sector-based by selecting the issues / sectors that have health implications.

- i. To identify and share the experiences on various mechanisms and issues related to EIA, HIA, institutional capacity to enforce, monitor and lessons learned
- ii. To identify what structures and mechanisms work best to encourage the formulation and implementation of healthy public policy
- iii. To examine critically case studies related to healthy public policy
- iv. To review various practices and experiences of donors and lenders in non-health sectors which impact health of the population
- v. To identify how to improve the international rule-making process

2. To discuss and agree on tangible policy recommendations on establishing, strengthening, and sustaining mechanisms in mainstreaming health into all public policies at all levels.

Background of The Prince Mahidol Award

The Prince Mahidol Award was established in 1992 to commemorate the 100th birthday anniversary of Prince of Mahidol of Songkla, who is recognized by the Thais as ‘The Father of Modern Medicine and Public Health of Thailand’.

His Royal Highness Prince Mahidol of Songkla was born on January 1, 1892, a royal son of Their Majesties King Rama V and Queen Savang Vadhana of Siam. He received his education in England and Germany and earned a commission as a lieutenant in the Imperial German Navy in 1912. In that same year, His Majesty King Rama VI also commissioned him as a lieutenant in the Royal Thai Navy.

Prince Mahidol of Songkla had noted, while serving in the Royal Thai Navy, the serious need for improvement in the standards of medical practitioners and public health in Thailand. In undertaking such mission, he decided to study public health at M.I.T. and medicine at Harvard University, U.S.A. Prince Mahidol set in motion a whole range of activities in accordance with his conviction that human resources development at the national level was of utmost importance and his belief that improvement of public health constituted an essential factor in national development. During the first period of his residence at Harvard, Prince Mahidol negotiated and concluded, on behalf of the Royal Thai Government, an agreement with the Rockefeller Foundation on assistance for medical and nursing education in Thailand. One of his primary tasks was to lay a solid foundation for teaching basic sciences which Prince Mahidol pursued through all necessary measures. These included the provision of a considerable sum of his own money as scholarships for talented students to study abroad.

After he returned home with his well-earned M.D. and C.P.H. in 1928, Prince Mahidol taught preventive and social medicine to final year medical students at Siriraj Medical School. He also worked as a resident doctor at McCormick Hospital in Chiang

Mai and performed operations alongside Dr. E.C. Cord, Director of the hospital. As ever, Prince Mahidol did much more than was required in attending his patients, taking care of needy patients at all hours of the day and night, and even, according to records, donating his own blood for them.

Prince Mahidol's initiatives and efforts produced a most remarkable and lasting impact on the advancement of modern medicine and public health in Thailand such that he was subsequently honoured with the title of "Father of Modern Medicine and Public Health in Thailand".

In commemoration of the Centenary of the Birthday of His Royal Highness Prince Mahidol of Songkla on January 1, 1992, the Prince Mahidol Award Foundation was established under the Royal Patronage of His Majesty King Bhumibol Adulyadej to bestow international awards upon individuals or institutions which have made outstanding and exemplary contributions the advancement of medical, and public health and human services in the world.

The Prince Mahidol Award will be conferred on an annual basis with prizes worth a total of approximately USD 100,000. A Committee, consisting of world-renowned scientists and public health experts, will recommend selection of awardees whose nominations should be submitted to the Secretary-General of the Foundation before May 31st of each year. The committee will also decide on the number of prizes to be awarded annually, which shall not exceed two in anyone year. The prizes will be given to outstanding performance and/or research in the field of medicine for the benefit of mankind and for outstanding contribution in the field of health for the sake of the well-being of the people. These two categories were established in commemoration of His Royal Highness Mahidol's graduation with Doctor of Medicine (Cum Laude) and Certificate of Public Health and in respect to his speech that:

"True success is not in the learning, but in its application to the benefit of mankind".

The Prince Mahidol Award ceremony will be held in Bangkok in January each year and presided over by His Majesty the King of Thailand.

Mainstreaming Health into Public Policies



Noeleen Heyzer
Executive Secretary
UN Economic and Social
Commission for Asia and
the Pacific On behalf of
The Secretary-General
United Nations

It gives me great pleasure to send warm greetings to all the participants in this conference. In today's globalized world, events and decisions in one country or region can have far-reaching reverberations. Public health is among the challenges that transcend borders, and affects all nations and peoples. The recent global fuel, food and financial crises, and the threat posed by climate change, all have profound implications for people's health and well-being.

Such challenges cannot be addressed by a single country or group of countries. As the only universal organization with a comprehensive mandate, the United Nations is uniquely placed to lead the world in responding to these twenty-first century threats.

Recent years have seen growing political awareness of the fundamental relationship between health, sustainable development and economic stability. The SARS epidemic and the ongoing alert against avian influenza are among the most recent examples. Indeed, SARS revealed that pandemics have the potential to bring the global economy to a standstill.

Health is a dominant theme of the Millennium Development Goals. Reducing child mortality, improving maternal health and combating diseases such as HIV/AIDS, malaria and tuberculosis are goals unto themselves. But our efforts to achieve the other goals and targets - those related to poverty, hunger, environmental sustainability and access to safe water and adequate sanitation - will also have a direct impact on public health.

“ The recent global fuel, food and financial crises and the threat posed by climate change, all have profound implications for people’s health and well-being ”

The world has seen an unprecedented rise in public and private funding to meet health challenges. Bilateral aid has increased substantially in recent years, as have the budgets of major health-related UN organizations. A number of major global health partnerships have also come into being. Several country-led initiatives have been set in motion. Private philanthropies and the corporate sector have also scaled up action, becoming full partners with governments and non-governmental organizations in the delivery of care in poor countries.

Another encouraging step is the creation of the so-called H-8, bringing together the World Health Organization, UNICEF, the United Nations Population Fund, UNAIDS, the World Bank, the Global Fund to Fight AIDS, Tuberculosis and Malaria, the Global Alliance for Vaccines and Immunization, and the Bill and Melinda Gates Foundation. The H-8 is strengthening dialogue and improving coordination among key players inside and outside the UN system.

With these developments, the UN system has made significant progress on several fronts, including the fight against measles, poliomyelitis, malaria, HIV/AIDS and certain tropical diseases.

“ Recent years have seen growing political awareness of the fundamental relationship between health, sustainable development and economic stability ”

However, significant challenges remain. Profound inequities in health care, deficient health systems and insufficient health expenditures in many areas are obstacles to progress. And as in so many realms, it is the poor who suffer first and most.

I continue to press all partners to explore new opportunities in global health and to focus on critical priorities. These include building functioning and affordable health systems, advancing progress on women's health, especially maternal health, and pushing for action on neglected tropical diseases.

I encourage all stakeholders to continue to build on the current momentum, and I commend the organizers of the Prince Mahidol Award Conference for highlighting the importance of developing public policies that protect and affirm the right to health as clearly recognized in the Declaration of Human Rights and the World Health Organization Constitution. Please accept my best wishes for a successful conference.

“ Profound inequalities in health care, deficient health systems and insufficient health expenditures in many areas are obstacles to progress ”



Harnessing Scientific Discovery and Development to Improve Health of the Poor



Michiaki Takahashi
Emeritus Professor
Osaka University
Prince Mahidol Laureate 2008

Various prophylactic vaccines and treatment methods have been developed for many infectious diseases, markedly reducing the morbidity and mortality from these infectious diseases in developed countries.

However, on a global scale, infectious diseases are still raging. The annual report of the World Health Organization shows that the number of deaths from infectious diseases per year reached 14,700,000, accounting for about 1/4 of all deaths. In particular, in developing countries where medical environments and equipment are still poor, vaccines are the life-lines for children.

Poverty - not only from the economical point of view, relates to the quality of human lives. Various organizations try to tackle how to improve this issue. To approach this problem from health fields, promoting wellness, especially preventive medicine, would be one of the solutions to get out from the poverty situation.

From this point of view, I would like to talk about scientific discovery and development to improve the health of the people, including the poor. Especially I would like to focus on the development of the vaccines for poliomyelitis and measles, both are contributing much to improve health of children in the world.

In 1949, Enders, Weller and Robbins at the Harvard School of Public Health demonstrated that poliovirus could be grown in non-nervous human embryonic tissue, work that was later honored with the Nobel Prize. Two different approaches for vaccine development pursued at the time were successful: inactivation of poliovirus by formalin pioneered by Jonas Salk,

licensed as inactivated polio vaccine aPT) in 1955 after one of the largest controlled field trials.

Attenuation of the three serotypes of poliovirus were performed by Albert Sabin, licensed in 1961 as monovalent oral poliovirus vaccine (OPV), and later in 1963 as trivalent OPV. Poliomyelitis has affected humankind since ancient times. Development and widespread use of poliovirus vaccine has effectively controlled poliomyelitis in industrialized countries. The global poliomyelitis eradication initiative, adopted in 1988 by the WHO, has led to dramatic decreases in the incidence of poliomyelitis in developing countries. Although some issues remain, global eradication has been proposed and judged feasible.



The (WHO, PAHO, CDC) consultative group concluded that eradication (of measles is possible) using currently available vaccines and that a strategy based on periodic mass campaigns and strengthening of immunization services will be needed in most developing countries

In 1954, Enders and Peebles successfully isolated measles virus in human and monkey kidney tissue cultures. Adaptation of the virus to chick embryo and cultivation in chick embryo tissue culture led to vaccine development and was licensed in 1963. Their vaccine was later improved, further attenuated by Schwarz and by others. Widespread vaccination affected the incidence of measles and its associated complications in the world.

Around 1980, Our Foundation (The Research Foundation for Microbial Disease of Osaka University) helped Fiocruz (the national vaccine producing facilities), and Brazil, through JICA (Japan International Cooperation Agency), to construct facilities to produce a large dose of measles vaccine (CAM 70 strain), which was completed and has been operated well. The measles vaccine produced has not only met national demand but they are supplying neighboring countries. Our Foundation is helping also Bio Farma (national vaccine producing facilities), in Indonesia, for measles vaccine production, through JICA.



Now these science and technological cooperations are bearing fruit, and they can produce this measles vaccine at low cost and save children.

In 1996, the WHO, PAHO, and CDC convened a meeting to review progress in global measles control and the elimination effort in the Western hemisphere. The consultative group concluded that eradication was feasible using currently available vaccines and that a strategy based on periodic mass campaigns and

“ Poverty... it relates the quality of lives... To approach this problem from health fields, promoting wellness, especially preventative medicine would be one of the solutions to get out of poverty situation ”

strengthening of immunization services would be needed in most developing countries. As of 2006, four of the six WHO regions have adopted goals for measles elimination (Americas by 2000, Europe and the Eastern Mediterranean by 2010, and the Western Pacific by 2012). The African and South East Asian regions have measles mortality reduction goals as they are in the final stages of polio eradication.

It is necessary for us to cooperate with each other, not to produce only for our own benefit, but to help people around the world to live together.



“ ...on a global scale, infectious diseases are still raging. The annual report of the WHO shows that the number of deaths from infectious diseases per year reached 14,700,000, accounting for about 1/4 of all deaths ”

Mainstreaming Health into Public Policies



Judith Rodin
President
Rockefeller Foundation

Thank you for the privilege of joining you, and the honor of speaking at this remarkable gathering, during this critical time. It's a special treat to be with Your Royal Highness, to celebrate the long lineage and legacy of Thailand's global leadership – especially in the field of modern public health. I'm also delighted to return to Bangkok – a crucial center of Rockefeller Foundation work since 1917, when our forbearers first joined with Prince Mahidol to bring the benefits of public health to Southeast Asia.

He was a visionary. He understood and heralded the deep and abiding connections among science, health, and economic vitality. He created infrastructure – both intellectual and material – to promote inquiry and discovery, to spread the benefits of health care, and to achieve real and lasting economic and social transformation. Prince Mahidol's intrepid spirit is entwined in Thailand's DNA. It informs and inspires continuous aspiration for and accomplishment in Thai public health. His commitment to bring health scholars and professionals together across political and ideological boundaries, between disciplinary fields, and against the grain of inherited academic prejudices remains particularly relevant today.

Our theme – “mainstreaming health into public policies” – reminds us that the 21st century's health challenges cannot be addressed independently from the 21st century's other challenges. As one of the Rockefeller Foundation's early 20th century framers put it: “Science and education may be the brain and nervous system of civilization, but health is the heart. It is the organ that pushes vital fluid to every part of the social organism.” Especially today, enduring social, economic, and environmental progress is predicated on healthy families, healthy communities, healthy

cities, and healthy countries. In a moment, I'll talk about the Rockefeller Foundation's exciting new initiative to help realize the transformation of health systems around the globe.

This and all our work is framed by the age in which we now operate: a time when national borders matter less... when health challenges are increasingly shared – and inextricably interconnected with the gamut of vulnerabilities that jeopardize wellbeing:

- food and economic crises
- global climate disruption
- the deluge of populations migrating to unplanned urban areas.



Indeed, the very natures of wellness and illness are changing – as are the systems evolving to sustain or heal them – all driven by powerful global forces.

Our theme—
"mainstreaming
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There is no doubt, mankind is the beneficiary of revolutions in medicine – the result of advances in communications, technology, and knowledge that were unfathomable just a generation or two ago. Life expectancy doubled in a century. Eight out of every ten people live in countries where poverty is declining. But still, not everyone's lives are improving fast enough, nor are they improving equitably. Nor, in this environment are they guaranteed to continue improving.

According to a World Bank report released in December, worldwide economic growth will plummet by more than half in the coming year, bottoming at less than one percent. Each successive one percent drop in growth could trap another 20 million people in poverty. And we know that poverty and disease in Bangkok matters in Boston and Bangladesh – in Bali and Bahrain.



Why?

Because of the scope and impact of our collective actions and interactions. In a word, globalization. Globalization has sparked sweeping transformations in industry, finance, and politics. It has profoundly changed the ways we lead our lives, relate to one another, and engage with the world. It ties together the fates

and fortunes of people in distant corners; no country, economy, or ecosystem remains untouched.

At The Rockefeller Foundation, we believe that, with partners, we can harness this interdependence for good. We call this “smart globalization”. It means helping individuals, communities, and institutions tap into growth and opportunity while developing stronger resilience to risks and challenges. It means helping more people in more places connect with the ideas and innovations, technologies and techniques, strategies and solutions to survive, learn, adapt, create, and flourish. It means that we still face common dangers, but can also benefit collectively by developing new competencies and capacities to absorb these risks.

The Rockefeller Foundation’s support for the Mekong Basin Disease Surveillance Network – MBDS – is a touchstone example. As some of you know firsthand, MBDS helps monitor and control potential pandemics by bridging the cultural, technological, and logistical divides that prevented the countries of the greater Mekong Basin from banding together to confront common health threats. People with different skill sets, speaking different languages, reporting to different hierarchies now enjoy new ways of working together. And, as a result, policymakers track health risks across national boundaries, identify outbreaks and potential transmission routes, and organize and mobilize responses for treatment and prevention. MBDS has stitched together a patchwork of providers into a tapestry of service.

One small case tells a big story about this work’s importance. A few years ago, a 15-year-old girl in Laos fell ill, suffering from respiratory symptoms and various aches and pains. Her family sought care, but soon found that the local hospitals had exhausted their repertoire of tests and treatments – with no conclusive diagnosis. Could it be H5N1? It seemed unlikely. The girl’s family insisted she was not in close contact with infected birds. Still, in a coordinated effort, Lao and Thai officials collaborated to send the child to Thailand, where medical centers are better funded and equipped – and where the girl was, in fact, diagnosed with Avian Flu. Shortly thereafter, multinational health teams, organized by MBDS, fanned across 20 villages in two adjoining regions. They interviewed almost 8,000 families, found 150 individuals with flu symptoms, several

of which were potential hosts for Avian Flu. They distributed treatments. And they improved the surveillance capacity of hospitals in Laos to prevent the kind of missed opportunities that kept this girl from getting a proper diagnosis in her home country.

Only a few years earlier, there was little or no collaboration for this kind of incident. But, through MBDS, a broad, integrated, region-wide public – private partnership initiated and institutionalized structures that will help save lives and prevent potential pandemics. This was – and is – “smart globalization” at work. It’s also just one chapter – and one we’re still writing – in the Rockefeller Foundation’s long history in the global health field.

Our predecessors led control efforts against the 20th century’s scourges of the poor, including hookworm and yellow fever. They organized an ongoing, worldwide push for public – private partnerships that accelerate the development of drugs and vaccines to end HIV/AIDS, malaria, tuberculosis, and other diseases. And in this era, we have chosen the transformation of health systems as the next frontier on which we’ll help promote innovation, broker partnerships, and strengthen resilience.

You may ask, why health systems? Why now? For the last decade, the global health community has focused its attention on disease – and population – specific programs. The success is measured in the enormous number of lives saved. But too often during this same period, larger systems have remained neglected –leading to human resource and other crises, as highlighted by the Joint Learning Initiative. Millions of people still can’t reach the care they need. Or, if they can, they find themselves trapped in poverty from the cost burden of a catastrophic health event. And in too many places, high quality health care is still a luxury for the few.

Affordable, effective, quality health care cannot be achieved unless systems are addressed as a whole. For example, if we only focus on service without also developing complementary financing mechanisms, outcomes will not improve. If countries lack professional stewardship, then the benefits of improved informatics and eHealth technology – shaped at Mahidol University’s BIOPHICS and elsewhere – will not be maximized.

As globalization accelerates, health systems are dramatically altered – the result of momentous demographic, epidemiological, economic, and technological shifts. We believe the forces propelling globalization can be harnessed to steer the transformation of health systems on a better path.

The Rockefeller Foundation’s initiative will work with partners and grantees in a handful of sub-Saharan and Southeast Asian nations to implement catalytic pilots. This will help inform the construction of sustainable, efficient, and, most importantly, effective health systems elsewhere.

At the country level, this new initiative will pursue three major goals:

First, enhancing the professional capabilities of health systems’ stewardship in developing countries. Second, engaging the private sector in the search for innovations to provide and finance health services for the poor. And third, expanding the use of interoperable information technology in services and systems – or eHealth. No one institution can accomplish these objectives alone.



Especially today, enduring social, economic, and environmental progress is predicted on healthy families, healthy communities, healthy cities, and healthy countries

We look forward to continued dialogue with you about all these opportunities – to forging new partnerships at the national and global levels. And, surely, the next few days’ activities and discussions will:

- demonstrate the significance of health systems as a central component of global health policy arrangements
- enrich understanding of the broader determinants of health
- and elevate the most promising solutions to improve health outcomes.

Of course, human health is a dependent variable. It depends on the health of the economy. It depends on the health of the cities in which the majority of mankind lives. It depends on the health of the climate and natural resources on which we all rely. Economic inequality and unremitting, dire poverty, environmental degradation and accelerating, unplanned urbanization: these issues are interconnected with poor health. The most effective way to address one is to address the others. And The Rockefeller Foundation takes precisely this outlook in our work. When we



bolster food security and agricultural productivity in sub-Saharan Africa, we don't just feed starving people; we nourish the public health of entire communities.

When we strengthen urban planning, infrastructure, financing, and governance in developing countries, we also establish the preconditions for better hygiene, nutrition, housing, and living conditions – the building blocks of wellness. And there's an immediate link between global health and the climate crisis—with especially critical implications for this part of the world. Every year since the 1970s, climate change has contributed to another 150,000 deaths – half of which occur in Asia. One of every two people in Africa, Asia, Latin America, and the Caribbean suffers from one or more diseases associated with inadequate water and sanitation – impacts of climate change. During the past two decades, the number of people affected by hydro-meteorological disasters has more than doubled in developing countries, and now exceeds 250 million people every year.

And as the world warms, the consequences will worsen. We know that, during the next three decades, 60 percent of the world's population increase will occur in Asia's urban areas—and 80 percent of Asian countries are threatened by rising sea-levels. The Asian Development Bank predicts that crop yields in the Asia-Pacific region will decrease by up to 10 percent in the next decade, leaving 132 million people vulnerable to hunger. We cannot afford to stand pat. Health systems, in particular, must adapt for the continued climate disruptions that are on the way, regardless when or whether the world reins in carbon emissions.

The Rockefeller Foundation is building on our success wiring the Mekong Basin Disease Surveillance Network to set up the Asian Cities Climate Change Resilience Network, which we launched

“ ... Our work is framed by the age in which we now operate: a time when national borders matter less... when health challenges are increasingly shared—and inextricably interconnected with the gamut of vulnerabilities that jeopardize wellbeing... ”

earlier this week here in Bangkok. This alliance of governments and donors... scientists, academics, and planners...health care and emergency service providers... will chart new strategies for cities to prepare for and recover from the very local impacts of the global climate crisis. In addition, we and others will support the expansion of geographic information systems and seasonal health forecasts to predict when and where outbreaks are possible. We must push the edge of discovery, learning more fully how climate change interacts with other determinants of public health.

Let me close with this. Today, our world faces unprecedented economic challenges, social strains, and environmental threats. Our task is to find and follow new approaches to meet the great challenges of our time; to help more people live healthier, better, more productive lives. My Rockefeller Foundation colleagues and I believe we can. And this important assembly is another crucial mile-marker in the journey. I look forward to our continued work together. Thank you all.

“ Eight out of the people live in countries where poverty is declining... But still, not everyone’s lives are improving fast, nor are they improving equitably. Nor in this environment are they guaranteed to continue improving ”



The Social Determinants of Health



Timothy Evans

Assistant Director – General
Information Evidence
and Research
World Health Organization

In 2003, the 25th Anniversary of the Declaration of Alma Ata, the newly elected Director General JW Lee in reviewing progress with respect to primary health care identified the area of social determinants of health and intersectoral action as the area where progress was least evident. In response, he decided the WHO would launch a Commission on the Social Determinants of Health to provide evidence – based advice on how countries, WHO and other partners could more effectively take action on the social determinants of health.

Five years later, the Commission, chaired by Sir Michael Marmot, drawing on inputs from commissioners, knowledge networks, civil society, countries and meetings around the world, launched its report with the headline that “social injustice is killing on a grand scale”. The report entitled “Closing the Gap in a Generation” made 3 broad recommendations:

1. Improve Daily Living Conditions;
2. Tackle the Inequitable Distribution of Power, Money, and Resources; and
3. Measure and Understand the Problem and Assess the Impact of Action.

The report’s recommendations and simple summative statement – a world where social justice is taken seriously – could not have been more timely in light of the global financial meltdown and the recent change of government in the United States.

Based on the strong demand from member states for WHO leadership on Primary Health Care, Dr. Margaret Chan, upon her election as Director General WHO in November 2006, made Primary Health Care one of the priorities for her administration. In October 2008, WHO issued its World Health Report entitled, Primary Health Care, Now More than Ever. Following in the footsteps of the world's foremost advocate of Primary Health Care – Halfdan Mahler – the Report attempts to bring together Mahler's "two-part symphony" whereby the first part introduces the moral or ethical dimension – "health for all" – and the second part a more technical dimension – the eight point agenda of "primary health care". As such, the 2008 World Health Report talks about PHC as The mobilization of forces in society – health professionals and lay people, institutions and civil society – around an agenda of transformation of health systems that is driven by the social values of equity, solidarity and participation.

This re-formulation of PHC while similar to that emerging from Alma Ata 30 years earlier, is different in a number of significant ways as shown below.

How experience has shifted the focus of PHC

Early attempts at PHC	Current concerns of PHC Reforms
<ul style="list-style-type: none"> • A basic package for the rural poor • Mother and child focus • Acute, infectious, diseases • Healthy local environment • Scarcity and downsizing • Government, topdown services • Bilateral aid, technical assistance • First level care, not hospitals • PHC is cheap 	<ul style="list-style-type: none"> • Universal access, comprehensive services • All disadvantaged groups • Health risks, illness across life course • Healthy global and local environments • Managing growth to universal coverage • Public/private mixed health systems • Global solidarity, joint learning • Coordinated referral to appropriate care • PHC is not cheap, but good value for money

The Report puts forward four “reforms” that are deemed relevant to the concerns of all health systems:

1. Universal Coverage reforms to address equity, solidarity and social inclusion;
2. Service Delivery Reforms towards People Centered Care;
3. Public Policy Reforms to promote and protect the health of communities;
4. Leadership Reforms to encourage more reliable health authorities.



The era of “command and control” leadership in health is increasingly a relic of the last century – a new era of “steer and negotiate” leadership is upon us



Last week, the WHO Executive Board considered the recommendations of these two reports and agreed resolutions on Social Determinants of Health; and Primary Health Care based Health Systems. While discourses in the global temple of health can often be fractured and competitive, what emerged from the perspectives of member states was remarkably convergent and mutually reinforcing. Synthesizing across these two Reports and these policy discussions, six general themes emerged that I believe are of relevance to the focus of this meeting.

1. Values

PHC and SDH both place social justice, health equity, solidarity and inclusion front and centre. As one Member State at the Executive Board remarked “health equity is a powerful reflection of social justice”. The CSDH report makes an appeal to our intolerance of these inequities by noting that social injustice is killing on a grand scale? There is no good biological reason why the life expectancy of a girl born in Sierra Leone should be 50 years less than a girl born in Japan. Likewise, it’s alarming to observe that with good urban governance the life expectancy at birth of a population exceeds 75 years of age and with poor urban governance the life expectancy falls below 40 years of age! These dramatic differences in life chances are not immutable! Moreover, as “values” surveys of populations indicate, the value of equity in health, and social inclusion are widely shared across all countries. Healthy public policies therefore cannot lose sight of these core values.

2. Measurement and Monitoring

Giving life and meaning to values requires indicators and measures. In too many countries, the most basic public health function — counting births and deaths, and determining causes of death — is largely absent, systematically missing vulnerable population groups, and unacceptably inaccurate. Health equity begins and depends on making each person's health needs clearly visible. Bringing the needs of the most vulnerable into proper focus, however, may encounter both “technical” and “political” hurdles that cannot be ignored: for example – how do we accurately measure the mortality rates of slum dwelling populations characterized by very high mobility? Or what political and legal challenges must be overcome in understanding the health needs of migrant populations that have no right of residence or working papers? Understanding differential needs often requires effective efforts to link data sets between the health and other sectors. For example, understanding who dies from road traffic accidents and why, may involve linking police records with department of transportation records and hospital emergency department files. These “intersectoral” challenges have both technical and political dimensions that are significant but surmountable.

3. Walking the Talk in the Health Care Sector

The report of the Commission on Social Determinants notes that the health sector is socially designed and operated... in short “determined”. Member states at the Executive Board last week described, one after another, how progress on communicable diseases, non-communicable diseases, and disease outbreaks is contingent on both a better understanding of, and an ability to act on, the social determinants. One of the CSDH knowledge networks entitled Priority Public Health Conditions examined how actions in disease prevention and treatment differ by integrating a social determinants approach. The clear recommendation emerging from this work is that social determinants should inform all priority health condition programs.

This recommendation rings true when considering the widespread tendency within the health care sector towards exclusion, inequity and impoverishment. The harsh evidence that around

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In the spirit of the Prince Mahidol Awards Conference, a considerable, research investment is required to advance the “science of the art”

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the world over 100 million persons annually are impoverished due to payments on health care, is a stark reminder that there are no guarantees in the health care sector related to the adage “first do no harm”. The magnitude of the health workforce shortages across countries and the clustering of professionals towards tertiary care hospitals within countries, explain in large part slower than expected progress in attaining health goals like the MDGs. The proliferation of discrete, disjointed and often duplicative programs that label people as diseases often fail to meet the population’s reasonable expectations of health services that are comprehensive, coordinated, and compassionate. These worrisome and widespread trends lead Sania Nishtar, a health policy expert, to conclude in the case of Pakistan “that unless deep – rooted systemic reform of the service delivery system and its governance arrangements is undertaken holistically, not much will change”. Addressing these financing, health workforce and organization of services challenges, however, cannot be done without effective intersectoral engagement: how can fairer approaches to financing health systems link more effectively with broader social protection policies?; how can the education sector be more responsive to the demands of the health workforce? How can we strike a public-private mix that is best for health equity? What are the management strategies for more effective “integration” of essential services?

4. Beyond the Health Care Sector

While the pitfalls of the health care sector are enormous, even if it were able to fully deliver on its promise, there is growing and widespread recognition that it is insufficient on its own to address yesterday’s, today’s and tomorrow’s health challenges. The absence of a pill for poverty or deprivation gives rise to The Commission’s two primary areas of recommendation. 1) improve daily living conditions; and 2) Tackle the Inequitable Distribution of Power, Money, and Resources. It also underlies the third PHC reform in the WHR 2008 related to public policy to promote and protect the health of communities. While it is clear there is a need for more, and more effective action beyond the health – care sector, less clear is what action and how. As one member of the Executive Board remarked – rather poetically – on the challenge of taking action on the social determinants of health: “it is clearly a mosaic composed of many, many small stones”.

In the spirit of the Prince Mahidol Awards Conference, a considerable, research investment is required to advance the “science of the art”. A good place to start would be to look at some examples of “success”. How for example has Bangladesh managed to lower cyclone related mortality over the last 30 years by over 100 fold? Similarly, what can be learned about the significant health benefits to women and children arising from the micro-credit programs to poor women in Bangladesh?

Despite the need to learn much more, experience and expertise in Thailand are already relatively high in this regard. Hopefully these assets can be made highly contagious, or even a pandemic threat in the next 2 days!



In too many countries the basic public health function – counties births and deaths and cases of death – is largely absent... Health equity begins and depends on making each person's health needs clearly visible



5 The Global Frontier

However, if such a “Healthy Public Policy” Pandemic resulted in widespread national competencies, the playing field for health and health equity is increasingly shifting from the nation state to the global frontier. Microbial unification, global warming, an international code of conduct for ethical recruitment of health workers, framework conventions on tobacco control, multinational health services companies, global agreements on trade and intellectual property etc. etc.–together these issues are rapidly ushering in a new era of global health policy. Many countries are developing their own global health policies drawing from across the wide range of relevant sectors – foreign affairs, development, labor, immigration, trade, and health among others. Gordon Brown, at the launch of the CSDH report in London in November 2008, remarked that “health is indisputably global”.

This growing awareness of global health systems is increasing demand for more responsive global governance mechanisms and raising fundamental questions about the adequacy of existing global institutions to respond. The Financial Times correspondent Gideon Rachman observed recently in relation to the global economic system “that the institutions of global governance are very, very weak”. While the situation for institutions of global governance for health may not be so dire, there is certainly cause for concern as reflected in the

widespread discourse on “global health architecture”. The WHO, conceived 60 years ago as a technical agency to provide advice to member states, is being asked increasingly to promote consensus, broker agreements, and negotiate rules or standards related to global health challenges most of which are highly intersectoral. Just as the WHO secretariat is finding it challenging to respond to this growing demand, so too are its member states who often struggle to find people who are adequately informed and available to represent their national interests effectively in such global negotiations.



100 million persons annually are impoverished due to payments on health care, is a stark reminder that there are no guarantees in the health care sector related to the adage “first do no harm”



6. Leadership and Leadership Capacity

Pursuing the ambitious reforms inherent in revitalized PHC, the recommendations of the CSDH, and the national and global agendas of healthy public policies, places an enormous premium on leadership — especially public sector leadership. As such, leadership is the focus of the fourth reform of the WHR on PHC. Several important dimensions of this leadership are worth mentioning. The first is the need for long-term commitment in order to realize the potential of PHC reforms necessitating an ability to stay the course beyond electoral cycles. Achieving universal coverage requires two to three decades not two to three years! The second is to foster an ability to learn through implementation and to make course corrections to grand plans. The Mexican social protection reforms known as “Seguro Popular” are exemplary in this regard having built in evaluation mechanisms from the outset that informed subsequent changes in the implementation of the reforms to enhance their effectiveness. A third issue relates to the importance in undertaking any reform of ensuring an inclusive process that engages the views of diverse stakeholders. The era of “command and control” leadership in health is increasingly a relic of the last century — a new era of “steer and negotiate” leadership is upon us. This is perhaps most vividly seen here in Thailand where the first national health assembly took place in December 2008. This new institutional structure seeks to formalize a social learning and action process that draws on stakeholders – citizens, civil society, private sector, providers, researchers, policy-makers and politicians amongst others – to debate and agree directions for health in Thailand. I’m sure we’ll hear and learn more about the National Health Assembly

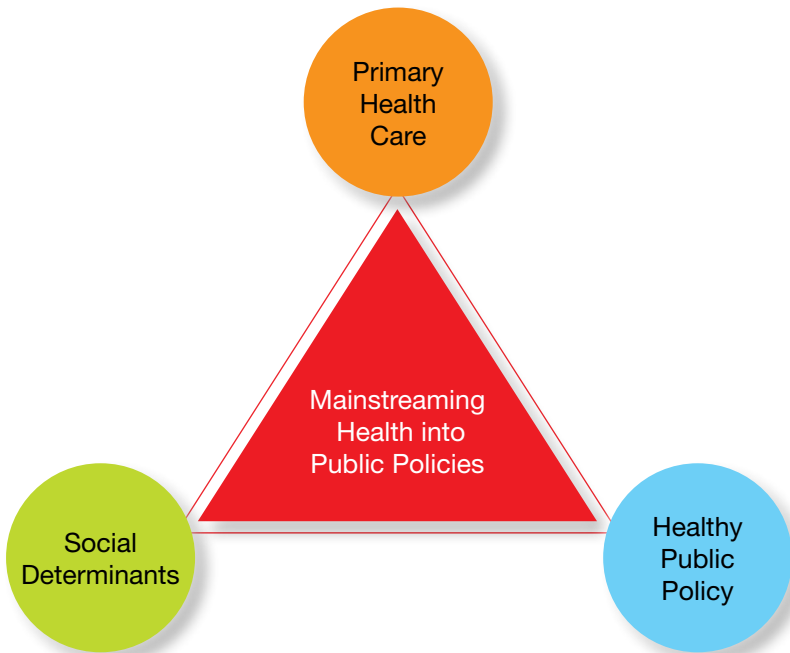
in the next few days, however, from my less than fully informed perspective it represents the sort of “innovation” in health leadership that is required to keep up with the demands of increasingly complex health systems. It also represents the kind of “innovation” in health that the world has come to expect of Thailand.

Despite Thailand’s example, the capacities for such leadership are not a given in most countries or global institutions and as such deserve explicit strategic attention moving forward. These leadership capacities relate to individuals — the spectrum of skills, the curricula for teaching such skills, the faculty, course and schools where such skills are taught or learned. These capacities also relate to institutions where leadership must be exercised — not only in the public sector – from local to global levels of governance – but also among the diverse range of institutional players that populate the health landscape.

I’m sure this meeting will help catalyze long over – due attention to these leadership capacity challenges – both individual and institutional – that are required to enhance healthy public policies.

Let me conclude by making reference to a mentor to many of you here who’s book *The Triangle that Moves Mountains* has been an inspiration to so many. With great humility and respect to Professor Prawase Wase, I would like to draw on his metaphor of the triangle to suggest that Primary Health Care, Social Determinants of Health and Healthy Public Policies represent three critical agents that when triangulated can move mountains to accelerate equity in health.

“ The proliferation of discrete, disjointed and often duplicate programs that label people as diseases often fail to meet the population’s reasonable expectations of health services that are comprehensive, coordinated, and compassionate ”



“

... Primary Health Care, Social Determinants of Health and Healthy Public Policies represent three critical agents that when triangulated can move mountains to accelerate equity in health... Tim Evans

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Panel Session

Chair: Julian Schweitzer

(Director of Health, Nutrition and Population, Human Development Network, the World Bank)

Moderator: Lincoln Chen (President, China Medical Board)

Speakers:

Roy Kwiatkowski (Director, Environmental Health Research Division, Health Canada): Health Impact Assessment (HIA) and Healthy Public Policy

Karen Lock (Professor, LSHTM): Enhancing Public Health Through Policies in Other Sectors: Examples from EU Food and Agriculture Policy

Van Hubbard (Rear Admiral, US Public Health Service and Director, NIH Division of Nutrition Research Coordination, National Institutes of Health): The Goal of Healthy Weight in Americans

Amphon Jindawatthana (Secretary General, National Health Commission, Thailand): Health Impact Assessment as a Social Tool for Healthy Public Policy: Thailand's Experience

Armin Fidler (Lead Health Policy Adviser, the World Bank): Public Policies for NCDs and Aging

Kimmo Leppo (Adjunct Professor, University of Helsinki): Health in All Policies: Perspectives from EU and Finland

Lori Leonard (Associate Professor, John Hopkins School of Public Health): A Case Study of the Chad Pipeline Project



Summary

The presentations discussed a series of health problems that have multi-dimensional social determinants, and offered a series of interventions and policy tools for healthy public policies. These included environmental impact assessments, campaigns with specific targets, institutionalizing public consultation processes and engagement of communities, and roles of transnational organizations in establishing standards as transnational public policy.

The main question that was put for further discussion was about identifying the biggest barriers to the effective implementation of Healthy Public Policies. Ignorance – knowledge gaps, weak implementation, or unused opportunities to exploit “win-win synergies” between non-health sector interventions and health outcomes were raised as barriers.

Knowledge is important. We need to fill the knowledge gap to understand what are the key population level risk factors for individual risk behaviors, for example on diet, physical activities, and what are the inter-relationships between individual and population risk factors. Mortality rates of cardio-vascular disease vary between countries and over time that can not only be explained by individual physiological determinants. We need to have “science based” visions for the future. Research and effective translation of research into policy and practice are keys of success to prevent disease and disabilities attributable to overweight and obesity. But as one of the panelists (Roy Kwiatkowski) noted, communication between experts in different sectors need to be improved to solve the problem of ignorance.

Non-communicable diseases (NCDs) in particular have multiple determinants. NCDs are current major problems in developed and developing world — there is no time to wait and we need to act quickly. “The Future is Now!” There is a public policy case to address with NCDs as they may have externalities such as drunk driving; there is an information asymmetry issue about determinants and effective mitigation measures, and they may cause catastrophic costs to households and become economic burden to societies. Multi-sectoral approaches including public-private partnership are required to reduce mortality, focus on

social protection for aging population in need, and address risk factors through taxation, communication, and incentives.

The example of obesity was discussed in several sessions. It is a chronic problem requiring life long management. Multiple sectors need to be involved and a supportive environment at community level, and change of social norms is needed. Only demand side policies in food supply chain to influence consumer behavior are not enough to solve food's complex systems. Policies fail to consider the role of 'supply side' policies on food price and availability of affordable health food, fruits and vegetable. The upstream determinants of both production and consumption are often neglected.

Health Impact Assessment (HIA) has been evolving from its roots in Environmental Impact Assessment and health promotion and health public policy advocacy into a more integrated policy instrument that could be applied to public and private development projects, sectoral, and even broader economic policies. It is mainly a preventive measure to avoid adverse health impacts of policies and programs. The key challenges are lack of strong institutionalization of the tool and greater integration of science and evidence into policy making and community engagement in HIA.

Thailand provided, however, an important example how to institutionalize HIA through inclusion of the 'principle of community participation' in the 1997 Constitution and institutionalizing HIA in the 2007 National Health Act.

As the Chad Oil Pipeline experience demonstrates, HIA should not only look at investments and policies directly impacting health. Policies not directly about health can also shape health through remaking social institutions. For example, in Chad's case, resettlement and compensation policies disproportionately favored men thus enforcing gender inequalities that may also impact health of women and children. The presentation also noted that in big international development projects transnational safe-guard policies may supersede national public policies that may have positive impact on raising national policy standards.



As one of the panelists and speakers, Dr. Kimmo Leppo noted, “the proof of the pudding is not in the recipe but in the eating,” i.e. proof of healthy public policy is not the design on paper but the implementation. Major issues of implementation gaps are lack of political will, lack of push from the health sector, and diplomacy and persuasion skills. Small successes with initiatives where interest between sectors is mutual, opens up doors for future more significant inter-sectoral action to achieve “health in all policies.” Application of the EU Food and Agriculture policies to improve nutrition in schools is one such example.

To solve the implementation problems, the role of partnering in the implementation of individual, community, and national strategies, and providing added value are needed.

The key conclusions from the panel session were as follows:

- We need more health sector leadership in promoting health in all public policies – need to fight, need to form alliances and civic movement.
- This requires political will as well as skills and experience in advocacy, negotiations, etc.
- The Thai experience with the National Health Assembly is an important global milestone and policy lesson. This social innovation could prove to be a sustainable democratic movement that could help with healthy public policy.

Key message from the presentations:

- Health has multidimensional causality and interventions, but it should not be an “either-or” dichotomy between health and other sectors, but rather two complementary approaches to be discussed together.
- The health sector should step up the leadership, advocacy, and diplomacy role to push for a healthy public policy agenda.



“the proof of the pudding is not in the recipe but in the eating,” i.e. proof of healthy public policy is not the design on paper but the implementation.

Kimmo Leppo





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NCDs are current problems — there is no time to wait and we need to act quickly. “The Future is Now!”

Armin Fidler



People are not passive recipients of public policy...

Lori Leonard on the Chad Pipeline Project



We are actually moving further away from our 2010 targets for obesity

Van Hubbard

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Road Safety

**Parallel
Session:**

Speakers and Panelists:

Kavi Bhalla
Tony Bliss
Hiroshi Ishizuki
Ahmad Farhan Mohd Sadullah
Chin Hoong Chor
Roger Johansson
Julio Urzua
Saul Billingsley

Moderators:

Armin Fidler
Mark Rosenberg

Road safety is a global epidemic problem, accounting for a substantial proportion of health, economic and social burden worldwide. The severity of the road safety problem is at a magnitude of concern, particularly in the developing world. How to make accurate and comprehensive data on the road safety magnitude and related determinants is still a great challenge, especially for low and middle income countries (LMIC). Understanding of local conditions can boost the benefit of inter – country knowledge sharing in order to promote road safety, which by nature contains context specific issues. Technical knowledge can support policy decision making for effective and cost – effective policy interventions. However, knowledge alone cannot solve the problems.

Evidence and experience worldwide confirms that road traffic injury (RTI) and mortality are preventable, and therefore road safety is achievable. Firstly, the global community has to look broadly and holistically. The road safety is an issue that must be included in many public policy areas, including transportation, city planning and design, and social development. Road safety is not an exclusive issue for any one sector, therefore multi-sectoral collaboration is essential. Leadership and ownership among relevant sectors are of paramount importance, while coordination and communication could solve the problem of fragmentation. Experience in many countries illustrates the benefits of innovative

paradigms for road safety, including shifting from a 'victim blaming' mentality towards road users (especially vulnerable road users) into the concept of 'shared responsibility', and the view of road safety as a 'right for everyone', and as a matter for 'social equity'.

Strategic leadership and management is needed to bring all relevant stakeholders on board to develop a common direction and clear shared goal, comprehensive plans, including strategic, operative and tactic plans, toward long term benefit. Collective and continuous progress and collective action at national, regional and global levels, together with local tailored action, can promote policy momentum and commitment at all levels. In addition, support for road safety can be enhanced by finding ties to other important issues including global climate change and mass transit. International agencies must recognize their role in strengthening national and local capacity for road safety and sustainable development.





**Parallel
Session:**

Agricultural Policies and Climate Change: Challenge and Opportunity for Future Diets and Public Health

Speakers and Panelists:

Josef Schmidhuber
Ricardo Uauy
Cristina Grandi
Simon J. Funge – Smith
Mary R. L'Abbe

Moderators:

Kraisid Tontisirin
Myint Htwe

PART 1: Theoretical / Global Issue Presentations

A. The Key Messages from the Presentations

The world's food and agricultural systems face important challenges i.e. rising food demand, stagnation of production capacity in particular in the African continent, the need to produce bio-energy, and climate change.

Malnutrition in all its forms should be recognized i.e. under-nutrition, life course approach to nutrition for health, burden of nutrition related chronic disease and prevent age related functional decline.

The Italian experience, the introduction of organic food into school meals, demonstrates a sustainable food system in the countryside, supporting local economies, healthy eating habits in particular young children, thereby contributing to good health and attitudes towards healthy diet. It also increases consumer awareness of environmental issues.

Fish are a major source of protein, vital lipids and micronutrients for a large part of the world's population, particularly the poor. However, the role and value of fish and aquatic resources are often hidden amongst other dietary and health factors.

Canada has pursued a multidisciplinary approach to decrease Trans Fatty Acid (TFA) levels in Canadian foods. Several initiatives undertaken (e.g. mandatory nutrition labeling) improve consumer awareness and industry capacity which results in continuing the progress of decreasing TFA levels in the Canadian food supply.

B. Major Problems and Issues

- The greatest challenge is ‘agricultural and food security’ due to increasing demand and threats on the supply side.
- The inadequate diets of vulnerable people is still the major problem
- In combination with lifestyle changes, largely associated with rapid urbanization, diet-related chronic non – communicable diseases (NCDs) are increasing in particular those attributable to obesity and being overweight.

C. Suggested Solutions

In order to maintain long term productivity, there are some recommendations as follows:-

- To apply technical adaptation measures in production systems to confer better protection against climate change
- To help lower Green House Gas (GHG) emissions using two approaches:- to reward efforts made in agriculture to reduce emission and to tax GHG emission through agriculture and its products
- To support environmentally friendly products e.g. locally procured organic foods
- To encourage healthy life style and increase availability and accessibility to affordable healthy food
- To consider and maximize benefit of local products such as inland fishery through management of rural resources and self – governance
- To strongly promote and seriously implement an effective policy in supporting the right to food, adequate in both quantity and quality, and addressing the prevention of diet related chronic diseases with a life course perspective.

D. Involvement of Stakeholders

Addressing challenges of agricultural and food system and the double burden of malnutrition and obesity need active and coordinated participation beyond health and agriculture,



for example education, transport, commerce and environment. In addition, increased cooperation between international agencies, governments, private and civil society is required.

It is recognized that mainstreaming health considerations into national development policies and programs be given due importance.

PART 2: Issue – based / Sector – based Case Studies

This session dealt with five papers namely, Global trends in food and nutrition issues: climate change, biofuel and soaring food prices; Addressing the double burden of malnutrition and obesity; Sustainable, Organic School Meals in Italy and two case studies: Fisheries Self-Governance and Taking TFA out of the Food Supply.

A. The Key Messages from the Presentations

Major trends and challenges are focusing on increasing demands for food, the need to produce bioenergy feedstocks and the additional pressures on agriculture through adaptation to and mitigation of climate change and its impact on agriculture and health.

There is a critical need to concentrate on solving the existing problems through appropriate research and policy agendas in which under – nutrition and nutrition – related chronic disease (NRCDs) are intertwined. As more people reach older ages greater emphasis needs to be placed on NRCDs.

Since 1986 the number of organic school canteens has progressively increased in Italy. At present 793 organic school canteens delivering around 1 million partly or entirely organic meals each day, representing about 50 percent of the total school meals delivered in the country. The Italian experience has shown that the introduction of organic food in school meals generates a wide range of benefits for the community. It promotes a sustainable food system in the countryside, supporting local economies and rural development, and at the same time it promotes healthy eating habits in particular young children in schools, thereby contributing to good health. It also sustains a traditional food culture and increases consumer awareness of environmental issues.

A rural study of a province in Cambodia demonstrates the contribution of fish in the diet as a source of protein, vital lipids and micronutrients to mothers and their children. Small – scale producers, processors and markets face various constraints in realizing benefits from globalization including expanding trade in fish and fishery products. These include inadequate access to markets, financial services, know – how and capacity to meet increasingly demanding sanitary requirements. This situation is aggravated by fishery resource decline, coastal habitat loss, and by conflicts both within and outside the fishery sector.

Canada has been pursuing a multidisciplinary approach to decrease Trans Fatty Acid (TFA) levels in Canadian foods. Initiatives undertaken include mandatory nutrition labeling, which included the identification of TFA content of foods, and several initiatives to improve consumer awareness and industry capacity.

By the mid – 1990s, using both dietary intake data and analysis of human tissue samples, researchers estimated that Canadians had one of the highest average intakes of TFAs in the world (estimated to be approximately 8.4 g/day). This resulted in the formation of the Canadian Trans Fat Task Force. Based on the dietary intake modeling using the recommended TFA limits above, it was estimated that the average daily intake of TFA for all age groups would represent less than 1% of energy intake, consistent with the WHO recommendations. There was a ministerial announcement that results from the Trans Fat Monitoring Program would be posted on Health Canada's website.

B. Major Problems and Issues

One of the key drivers of future demand on the world's resource base is its fast growing population in the developing world. In combination with lifestyle changes, largely associated with rapid urbanization, such transitions, while of benefit in many countries, still result in inadequate diets, and are often accompanied by a corresponding increase in diet – related chronic Non – Communicable Diseases (NCDs).

These two problems co – exist, and these countries are confronted with a “double burden of malnutrition” resulting in novel challenges and strains in their health systems. Malnutrition in all its forms; should be recognized. Effective treatment and control of acute wasting are essential in order to reduce hunger,



malnutrition, poverty and mortality in children in accordance with the internationally agreed Millennium Development Goals. Systematic reviews of available evidence on effectiveness of interventions have been published in the Lancet Series on Maternal and Child Undernutrition for Life course approach. Prevention of diet related chronic disease needs to be addressed the with a life course perspective.

A common denominator for an integrated view of health and nutrition is the systematic “life – course” approach. This is based on the compelling and highly relevant relationship that exists between the processes of under nutrition and poor growth in fetal life or early infancy and metabolic and malignant diseases of adult life. The postulate of the “Developmental Origins of Health and Disease (DOHaD) hypothesis is that the early environment programs metabolism, organ growth and functional development in an irreversible manner even after the original deprivation has been resolved in later stage of life.

There is increasing threat to fisheries and related policy drivers, and intensification of marine capture fisheries. Fish is increasingly being used for animal feed. Environmental degradation is changing the water regime in inland fisheries, and the effect of mining development is contributing to the contamination of aquatic ecosystems. There is a move to self governance, but the solution lies somewhere in between where equitable access is assured.

C. Suggested Solutions

The need to adapt to and help mitigate the impacts of climate change, poses a double challenge for global agriculture; as the single largest emitter of GHG, agriculture could increasingly be burdened with the need to help abate GHG emission. At the same time, many farmers, often already producing in marginal agro – ecological conditions, will have to adapt to and cope with a deterioration of their production environments caused by climate change.

We need effective policies in support of the right to food (adequate in quantity and quality). The economic constraints that limit food supply at the household level need to be addressed.

Urbanization which is the abandonment of traditional diets and their replacement with an urban dietary culture should be

discouraged. Governments may need to consider launching universal subsidized quality school lunches.

Cost considerations should be such that the cost is affordable to the needy families. Considerable opportunities exist for improving rural livelihoods, family nutrition and health through the management of aquatic resource biodiversity, wetlands, and water resources. While increasing agricultural production is important and necessary, care should be taken to ensure that this does not have negative impact on wild aquatic resources.

The Trans Fat Monitoring Program is moving forward. It is expected that the next set of monitoring data will be released early this year (January 2009). As with the first and second data releases, Health Canada will work with stakeholders prior to the publication and continue to encourage the replacement of TFA with healthier alternatives such as monounsaturated and polyunsaturated fats rather than replacement of TFA with SFA.

D. Involvement of Stakeholders

The key stakeholders are the agriculture sector, environment sector, health and population sector. Agriculture and food security policies and programs targeted appropriately to meet the needs of poor people can serve to address not only income generation, but also contribute towards food and dietary diversification. There is now a great need and opportunity to focus on food production and its associated supply chains to achieve diets that will support lifelong health, and are both calorie-adequate and of sufficient quality to meet micro-nutrient requirements.

- Inclusion of academia and education sectors in the activities of the agriculture sector in organic school canteens is critical.
- To encourage national health departments to engage more with fisheries departments to look into where the wild aquatic resources are contributing to nutrition and diet, as well as the possible policy threats to this contribution.
- The Canadian experience with the reduction of the TFA content of foods, indicates that success can be achieved when all sectors work collaboratively searching for solutions to address this important risk factor to human health.
- Finally, it is important to recognize that mainstreaming health considerations into development policies and programs will have much better impact towards achieving MDGs and the goal of health for all.



**Parallel
Session:**

Global Strategy for Health Diplomacy: A Way Forward for Foreign Policy and Global Health

Speakers and Panelists:

Bjørn Skogmo
Devi Sridhar
Laragh Golligly
Pirawat Asawapranee
Gustavo Gonzalez – Canali
Inga Nyhamar
Bounpheng Philavong
Gaudenz Silerschmidt
Keizo Takemi

Moderators:

Nick Drager
Lucy Chen
Bates Gill
Ilona Kickbusch

Key Messages from the Presentations

1. The Meeting recognizes the unprecedented attention that has been paid to health issues over the past decade as a result of globalization, the common objective of all Member States in their pursuit of the Millennium Development Goals (MDGs), the changing international landscape which has become more people centered, social determinants outside the health sector which increasingly impact on health and the growing linkages between foreign policy and global health.
2. The Meeting recognizes the need to broaden the scope of foreign policy and shares the belief that health is an important foreign policy issue of our times that requires a stronger strategic focus on the international agenda.
3. The Foreign Policy and Global Health Initiative can help heighten awareness of our common vulnerability in the face of health threats. It brings health issues more strongly into the arena of foreign policy discussions and contributes to the global health agenda by strengthening the case for joint collaboration between health and foreign affairs experts.
4. The Meeting stresses the need for Member States to ensure adequate financial resources to continue moving towards the realization of the health – related MDGs, as well as the



need for creative and innovative financing in addition to the Overseas Development Assistance, notwithstanding the global economic downturn.

Major Problems and Issues Discussed

1. The Meeting discussed the interface between foreign affairs and global health, how health is often a complex and cross-cutting issue involving security, trade and development, human rights and humanitarian agenda and how foreign policy and global health interests do not always converge.

The Meeting recognizes the importance of mainstreaming health into public policies in a coherent manner, taking into account the participation of governmental and non – governmental actors, the leading authority of the WHO as the international organization with the mandate on health issues, the contributions of academics and think-tanks in the formulation of global health policies, while recognizing that these stakeholders can enrich as well as complicate the process of high-level negotiations on health issues.

2. The Meeting is mindful of the need to come up with acceptable definitions on key concepts relating to health (e.g. global health diplomacy, global health security, international health, global health, global public goods) and the need to have a clear overarching conceptual framework that will be beneficial for Member States in formulating and implementing their foreign health policy.

Suggested Solutions

1. Capacity building and awareness of health experts in the work of diplomacy and of diplomats in the work of public health can help bridge the gap of knowledge and promote greater synergy and collaboration between these two entities, and academic institutions and think-tanks will have an important role to play in this regard.

The establishment of a formal inter-ministerial (mainly between health and foreign affairs) consultative mechanism at the national level, with participation from relevant stakeholders where appropriate, can help countries unify and strengthen their national position when attending high – level negotiations.

Stakeholders Involved in Implementations to Solve the Problems Where Feasible

Mainstreaming health into public policies ought not stop at the governmental level. The dissemination of knowledge about issues linking public health and foreign policy can help foster a better understanding among the general public about issues that have direct bearing upon their life and well-being.



**Parallel
Session:**

Urban Development

Speakers and Panelists:

Sharon Friel
Mohamed Khalil
David Legge
Francois Barten
Timothy Evans
Toomas Palu
Laetitia Rispel
David Sanders
Buranaj Smutharaks

Moderator: Fran Baum

The 21st Century is The Century of Urban Development. More than half the world's population is now living in cities, and future urban population growth will be concentrated in mid – sized cities. Urbanization can lead to economic growth and improvements in health and human development; however, with growing inequities in slums and urban settlements, there is an imperative for inclusion and participation on urban development policies, and equity to harness the potential of cities.

There are multiple and interacting drivers of healthy or unhealthy urbanization. National growth plans and global development policies influence access to and distribution of land, food, transportation, health care, water and sanitation. The dual burden of communicable and non – communicable diseases challenges the already strained health systems. Cities are recording rising rates of injuries, accidents and violence, with conflict clearly a social determinant of ill health. However, there is great potential for better health in cities. We need to understand factors that promote health in cities, and those that pose hazards. We also need to identify and address the conditions (global, national and local) that drive exclusion. It is in cities that the far – reaching impacts of other sectors on health are evident, including housing, food and nutrition, planning, transport, working conditions, environmental pollution, and access to education and health care.



A Social Determinants Approach is needed to harness human development and promote health equity. This approach addresses Structural Determinants defined as unequal distribution in power, money, goods and services; aspires to improve conditions of daily life; and to measure and understand the problem and assess the impact of action; as recommended by the Commission on Social Determinants of Health.

Policy principles can guide urban planning processes for more inclusive cities. These include:

- Vision of a “Healthy City”
- Paradigm shifts towards security, justice and equity
- Conditions for social solidarity (inclusive practices, equity, honest governance)
- Governing capacity – regulatory frameworks, participation
- Mobilizing resources – tax, development assistance
- Health sector responses – analyses, cross–portfolio platforms (healthy cities, Primary Health Care, health promotion/social marketing)

Case Studies highlighted inequities, impact of urban, industrial and workplace policies. In Nicaragua, Egypt and South Africa, examples of the risks and hazards associated with privatization and lead pollution were described, as were efforts to address communicable disease surveillance and control. The Thailand case study offered examples of enabling legal, institutional mechanisms coupled with public campaigns and grass – roots-action. All case studies pointed to the need for, and importance of data that allows us to have stratified measures, differentiate and make the case for action. In all cases, complex, multi – disciplinary interventions that foster partnerships with communities and across sectors are required.

Several recommendations to move forward with an urban health agenda:

- Mobilize a global social movement linking networks of communities, health platforms and mid-sized cities to promote know–how and public discourse
- Build strong Primary Health Care capacity so that the health sector can work with communities and deliver appropriate technologies and ensure equitable access in particular by the poor
- Understand what is going on: data systems, assessment and response tools
- Set up the right health promoting institutional combinations: structural legislation, for example the case of the 2007 National Health Act in Thailand and
- clear mechanisms to empower civil society, for example, the Health Promotion Fund in Thailand and community–based funds and savings schemes.





**Parallel
Session:**

The Private Health Sector: Appropriate Policies to Ensure its Contribution to Achieve Health Systems Goals of Efficiency, Equity, Quality, and Affordability

Speakers and Panelists:

Gerald Bloom
Dai Hozumi
Richard Smith
Viroj Tangcharoensathien
Sara Bennett
David de Ferranti
Eytayo Lambo
Sangita Reddy

Moderator:

Ariel Pablos – Mendez

The private health sector (PHS) in developing countries is large and growing, diverse, and probably ignored by national and global agenda. Variation in attitudes and trust – mistrust towards PHS depended largely on PHS types, personal ideologies among key stakeholders, experiences, and country context. The PHS as a means to an end should be better regulated, monitored, and marshaled towards achieving national health goals by governments. The future actions should focus on an improvement in the government's ability of stewardship and a communication about the success stories and failure to the global stakeholders.

PHS via international trade has an increasing role and impact through financing and service provision. Globally, the pharmaceutical trade concentrated in the developed countries was a result of industry pressure on intellectual property protection, which results in affordability issues for the poor countries and needs the south-south collaboration and the actions through TRIPS Flexibilities. Trade in health services is markedly initiated by developing countries, and covers a variety of services. Trade policy remains a country – level activity and there needs to be collaboration between public and private by treating PHS as an ally not an enemy; and between countries, regionally which requires a paradigm shift for policy makers beyond the national boundaries.



Health markets known for information asymmetry, trust-based and path dependent have changed with pluralistic organized and unorganized providers, blurring boundaries between public and private, spread faster than the development of appropriate government institutional capacity to steer in a right direction towards national health systems goals. Policy interventions need to take into account power and the existence of segmented markets and must adapt to different local contexts by fostering the pro-poor innovation and bottom up approaches.

Health regulators in most low-income and lower middle – income countries faced intense political, administrative, and information constraints. There is a policy concern and a great need for strengthening institutional capacity to regulate and steer public and private health providers to achieve national health systems goals. In addition to rule settings, there needs to be enforcing and monitoring of compliance with the application of various regulatory instruments.

There is a resonance on a need for stewardship (from rule setting to enforcement and monitoring) capacity and constructive ways of PHS engagement via multilateral sectors. There is a need to understand in-depth the issues of trust and mistrust by governments officials on the PHS and vice versa, then move away from public-private polarization to the issues of health system goals in accessibility, affordability and quality of the services and put the people as the focus, especially on what can be done and capacity building on regulation and stewardship functions in developing countries.

The expansion of perspectives on other sectors affecting health such as trade, education, tax policy, finance, and legal environments were also raised by the panelists. Apart from strengthening stewardship capacity, there is a need for strengthening information systems, analytical and research capacity of the government on PHS. There is also a request from the PHS to ask the government to avoid double standard of rule and regulation enforcements. Finally, it is noteworthy that both public and private sectors have strengths and weaknesses, and the question is how we can enhance effective collaboration and work between the two sectors to achieve common national goals.



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PANEL			
Armin Fidler Amphon Jindawattana Roy Kwiatkowski Van Hubbard Lori Leonard Kimmo Leppo Karen Lock		Lincoln Chen Julian Schweitzer	Nusaraporn Kessomboon Toomas Palu Myat Htoo Razak Yot Teerawattananon
ROAD SAFETY			
Kavi Bhalla Saul Billingsley Tony Bliss Hiroshi Ishizuki Roger Johansson Julio Urzua	Chin Hoong Chor Armin Fidler Ahmad Farhan Mohd Sadullah Mark Rosenberg	Armin Fidler Mark Rosenberg	Rohit Baluja Lisa Hayes Paibul Suriyawongpaisal Thaksaphon Thamarangsi
AGRICULTURAL POLICIES AND CLIMATE CHANGE			
Simon J. Funge-Smith Cristina Grandi Mary L'Abbe Josef Schmidhuber Ricardo Uauy		Myint Htwe Kraisid Tontisirin	Biplab Nandi Walaiporn Patcharanarumol Sirinya Phulkerd
GLOBAL STRATEGY FOR HEALTH DIPLOMACY			
Laragh Gollgoly Bjorn Skogmo Devi Sridhar	Pirawat Asawapranee Gustavo Gonzalez-Canali Inga Nyhamar Bounpheng Philavong Gaudenz Silerschmidt Keizo Takemi	Lucy Chen Nick Drager Bates Gill Ilona Kickbusch	Pirawat Atsavapranee Sopida Chavanichkul Benedikte Dal Bates Gill Laragh Gollgoly Suriwan Thaiprayoon
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Lincoln Chen Lead Rapporteur Team			
Lead Rapporteur Team	Katherine Bond	Jeff Johns	Toomas Palu
			Viroj Tangcharoensathien