Health-Promoting Health Systems

Imperatives for Action

Strengthening Health Systems

Conference Working Document
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Today it is unacceptable that people become poor as a result of ill-health. Worldwide there is an urgent need to refocus on how health systems promote the health of the population.

The Tallinn Charter – Health Systems for Health and Wealth

HEALTH-PROMOTING HEALTH SYSTEMS
IMPERATIVES FOR ACTION

<table>
<thead>
<tr>
<th>THE FACTS</th>
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<tbody>
<tr>
<td>Health systems that balance prevention, cure and health promotion have better health and economic outcomes</td>
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<tr>
<td>Health systems have the authority and responsibility to promote health and tackle health inequities</td>
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<tr>
<td>Health systems have the authority and responsibility to advocate for healthy public policies across government and address the structural determinants of health</td>
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<th>REQUIRED ACTION</th>
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<tr>
<td>Increase the performance of health systems by better balancing the portfolio of policies and services so as to optimize the mix between health promotion, prevention, cure and rehabilitative care.</td>
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<td>Demonstrate leadership by making the case for the promotion of health in all policies</td>
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<td>Build high-quality health promotion capacity across the whole Health systems workforce</td>
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<td>Create opportunities for citizens to actively contribute to improving their own and their community's health</td>
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KEY MESSAGES

1

No matter how a health system is organized in a given country, it should aim to help people to stay healthy, be responsive to needs and be financially fair.

Within the political and institutional framework of each country, a health system is the ensemble of all public and private organizations, institutions and resources mandated to improve, maintain or restore health.

Health systems encompass both personal and population services, as well as activities to influence the policies and actions of other sectors to address the social, environmental and economic determinants of health.

2

Systematic efforts to strengthen services and policies which promote the health of individuals and communities significantly contribute to improve the performance of health systems

Keeping People as Healthy as Possible
There is clear evidence that systematic and ongoing health promotion, if properly designed and based on evidence, makes a significant contribution to keeping people as healthy as possible

Reducing the Risk of Illness and Improving Compliance with Treatment
Developing community based health records to better understand and monitor the context in which individuals live and work gives a better understanding of the main factors which influence health choices and behaviors. Designing programs and services which address these needs reduces the risk of illness, increases compliance with treatments and prevents relapse.

Acting on the Broader Determinants of Health
Health system partnerships with other sectors, for example in developing healthy public policies, are essential to address the broader determinants of population health.
A balanced portfolio of services which optimizes the mix between health care, prevention and health promotion is needed to reduce inefficiencies and unmet demands whilst ensuring fairer health outcomes now and in the future.

On their own, treatment and care - while important - are not sufficient to meet health requirements and potentials in a given country. The ability to refocus health systems to include the promotion of health, with an emphasis on a more balanced investment among cure, care, rehabilitation, disease prevention and health promotion, is crucial for attaining the health potential of a nation.

A mixed portfolio of service types serves to reduce levels of demand and increase access to health through providing earlier interventions and through pursuing healthy public policies with other sectors. Together these create conditions that help keep people healthy and promote healthy lifestyles.

Health systems have a responsibility to tackle health inequities through advocating for health equity in all policies across government.

International evidence points to an uneven distribution of health and disease, penalizing those in socially disadvantaged positions, whether the latter is measured by income, education, occupation or other indicator of socioeconomic status. The magnitude of the differential is substantial, not trivial. When considering the underlying reasons for the observed differential in health, evidence indicate that a prominent role is played by systematic inequities in exposure to health hazards and risk conditions in the population’s everyday living environments. This means that some groups in society have a much poorer chance to promote their health than others.

One strategy health systems can take to reduce unequal risks of illness and improve treatment outcomes is to advocate for and actively pursue healthy public policies which tackle these structural determinants of health.
Health promotion must be mainstreamed as a core business of health systems. To do so actions can be taken in all four functional areas of health systems: stewardship, service delivery, financing and human resourcing as described in the Tallinn Charter – Health Systems for Health and Wealth

STEWARDSHIP

HEALTH SYSTEMS AS A KEY ADVOCATE FOR HEALTH IN ALL POLICIES

Health promotion is crucial for this health system function as it provides oversight for developing and ensuring policies to keep people healthy. Stewardship can provide such oversight both within the health system and across other policy sectors. Its impact is crucial for effective health promotion and for it own efforts to create supportive environments for individual and population health. It comprises policies, health intelligence, laws, regulations, guidance and administrative procedures and tools we use to keep people healthy and to ensure they are well treated when ill.

It is important, therefore, to ensure that health is considered when deciding on policy in other areas of government including employment, trade, development, education, environment, justice, housing and agriculture. Efforts to operationalize and sustain cross sectoral discussions with a focus on healthy public policy, require appropriate mechanisms and clear frameworks for accountability within government administrations.

- The advocacy role of health systems is crucial in overcoming structural barriers to promoting healthier lifestyles and in creating supportive environments for keeping people healthy. For example: regulation of goods such as tobacco; legislating for environmental conditions that promote safe and affordable water supply; lobbying urban planners to create safe and accessible spaces for play and physical activity. These actions are dependent on making good use of health information (e.g. health impacts of different urban designs and using this information to advocate for change for more health-promoting urban planning).

- Health impact assessments are an important part of developing healthy public policy within the health sector and with other sectors. Regular use of health impact assessments that include analysis of health equity impacts, are important to ensure that the health equity dimensions are systematically considered in the preparation and planning of health and other sectors initiatives. This helps to ensure cross sectoral actions have positive impacts upon health equity and reduces the likelihood of unintended negative health equity consequences.
FINANCING

**Health Systems as Protector Against Poverty Related Ill-Health**

This consists of the collection, accumulation (pooling), and allocation of funds as well as purchasing and paying for goods and services used for the health system to operate effectively and efficiently. Financing arrangements should sustain the redistribution of resources to meet health needs and reduce or eliminate financial barriers to the use of needed services. It is unacceptable that people become poor as a result of ill-health.

- The overall allocation of resources should strike an appropriate balance between health care, disease prevention and health promotion so that systems can effectively and efficiently address current and future health needs.

To this end, the financing function of health systems should allow for:

- **Health Promotion Presence** - health promotion must be funded.
- **Health Promotion Integration** - while ring fencing of resources may have advantages delivery at least should be integrated.
- **Health Promotion Sufficiency** - health promotion financing must be appropriate to task.
- **Health Promotion Continuity** - funding should be recurred and not short term.

**Human Resourcing**

**Health Systems as Enablers for Keeping People Healthy**

In order to properly integrate health promotion with the overall functioning of health systems, the recruitment, deployment and investment in skilled human resources is vital.

- Countries require an adequate and appropriate number of trained Public Health Professionals with specific expertise in health promotion, a focus upon integrating health promotion within the broader health system.
- Recruited human resources should be skilled to work also with other sectors to influence their development to create better conditions for individual and population health.
- Continuous professional training, appraisal and reward systems must be put in place to ensure and support the appropriate level of capacity across the health systems workforce, covering primary, secondary and tertiary care and including the domains of management planning and policy support.
Delivering health promotion action in terms of policies and programmes requires health systems to:

- Put in place incentives, quality measures and reporting mechanisms to ensure that health promotion goals are systematically delivered across the service delivery function of health systems.
- Run health promotion and prevention programmes based on evidence and when appropriate fully integrated with their primary care strategy.

An effective integration of health promotion into the core business of health-promoting health systems requires the functions of service delivery, financing, human resourcing and stewardship to perform in a mutually-reinforcing manner.
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<tr>
<td>ECD</td>
<td>Early Childhood Development</td>
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<tr>
<td>ECOSOC</td>
<td>United Nations Economic and Social Council</td>
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<td>EU</td>
<td>European Union</td>
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<td>EUROSTAT</td>
<td>Statistical Office of the European Community</td>
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<td>FAO</td>
<td>Food and Agriculture Organization</td>
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<td>GCHP</td>
<td>Global Conference on Health Promotion</td>
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<td>GDP</td>
<td>Gross Domestic Product</td>
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<td>GHI</td>
<td>Global Health Initiative</td>
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<td>ILO</td>
<td>International Labour Organization</td>
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<td>IMF</td>
<td>International Monetary Fund</td>
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<td>JMP</td>
<td>WHO/UNICEF Joint Monitoring Programme</td>
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<td>MDG</td>
<td>Millennium Development Goal</td>
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<td>NIGZ</td>
<td>Netherlands Institute for Health Promotion (Nationaal Instituut voor Gezondheidsbevordering en Ziektepreventie)</td>
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<td>NSIPH</td>
<td>National Swedish Institute of Public Health</td>
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<tr>
<td>OECD</td>
<td>Organisation for Economic Co-operation and Development</td>
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<td>PHC</td>
<td>Primary Health Care</td>
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<td>UN</td>
<td>United Nations</td>
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<td>UNAIDS</td>
<td>The Joint United Nations Programme on HIV/AIDS</td>
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<td>UNDOC</td>
<td>United Nations Office on Drugs and Crime</td>
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<td>UNDP</td>
<td>United Nations Development Programme</td>
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<td>UNFPA</td>
<td>United Nations Population Fund</td>
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<td>UNICEF</td>
<td>United Nations Children's Fund</td>
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<td>UNIFEM</td>
<td>United Nations Development Fund for Women</td>
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<td>UNPD</td>
<td>United Nations Procurement Division</td>
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<td>UNSTAT</td>
<td>United Nations Statistics Division</td>
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<td>WHCA</td>
<td>World Health Communication Associates Ltd</td>
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<td>WHO</td>
<td>World Health Organization</td>
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<td>WHOSIS</td>
<td>World Health Organization Statistical Information System</td>
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PURPOSE

This discussion paper is presented to help stimulate discussions related to the Health Systems track of the 7th Global Conference on Health Promotion (GCHP), Nairobi 26-30 October 2009. It aims to provide a strategic framework for reframing, repositioning and renewing efforts to strengthen health systems to be more health promoting. To this end the paper analyses the health promoting aspects of the four main functions essential to any health system: service delivery; stewardship; resource generation; and financing. It then applies this analysis to three major global health challenges: the Millennium Development Goals (MDGs); socially determined health inequities; and the needs of socioeconomically disadvantaged groups. Building on this analysis and its application to key global health challenges, the paper makes a case for increasing the health promoting potential of health system to “close the implementation gap” in health promotion. In no way does the paper purport to represent a definitive or final view on this complex topic – it is intended to stimulate discussion and to advance our work in this area. After the meeting in Nairobi, the views and issues raised by participants in relation to the Health Systems track will be used to refine and revise the paper as one of the product of the 7th GCHP.

INTRODUCTION

Of the five action areas in the Ottawa Charter (WHO, 1986), there has been little systematic attention paid to the challenge of re-orienting health services and systems. Nevertheless, the need to better balance investment among cure, care, prevention and health promotion is as important today as it was in 1986 (Wise and Nutbeam, 2007). Current global health challenges – including the financial crisis, climate change, MDGs and pandemic influenza – offer new opportunities to reframe, reposition and renew efforts to strengthen health systems to increase the effectiveness and sustainability of health promotion action. As Dr Margaret Chan, Director General of WHO, pointed out while addressing the 59th Session of the Regional Committee for Europe:

“For once, the ironic twists of history may turn in the favour of public health. The potential of the Declaration of Alma-Ata to revolutionize the delivery of health care was cut short by an oil crisis, an economic recession, and the introduction of structural adjustment programmes that reduced budgets for social services, including health care. Today, a financial crisis and severe economic recession have encouraged world leaders to seek the kind of value system that primary health care has always represented. Perhaps this time around, in a world jarred awake by crises, some long-standing arguments will finally be heard.”

(Chan, 2009)

This paper maintains that health promotion is essential to the development of Primary Health Care (PHC). Furthermore, health promotion can contribute to the kind of leadership that health systems need in order to take full advantage of today’s opportunities. Strong and effective health promoting health systems are needed to sustain population health development in an equitable and sustainable manner. For this to happen it requires that health promotion be reframed in a health systems context, and repositioned from the margins of systems to the mainstream, thus renewing and enhancing its active voice in policy debates and action.

Part 2 focuses on strategic considerations of how enhanced health-promoting health systems can contribute to address key global health priorities and commitments; including the MDGs, the determinants of health and health promotion issues related to socioeconomically disadvantaged groups. The paper also includes a "Health-Promoting Health Systems Imperatives for Action" that presents the main issues in a ministerial briefing style.

Although most of the material used for this document is drawn from the experience of the European Region of the WHO, it is presented here in a way that the authors believe has global relevance and applicability.

PART 1. HEALTH SYSTEMS AND THEIR MAIN FUNCTIONS

The aim of Part 1 is to revisit the WHO definition of health systems and the functions they need to develop in order to achieve their goals, including the promotion of population health and the reduction of health inequities.

1.1 DEFINING HEALTH SYSTEMS

In 2008, the WHO Regional Office for Europe held a Ministerial Conference on Health Systems in Tallinn Estonia. It was the year that marked the thirtieth anniversary of the Alma-Ata Declaration of Primary Health Care (PHC) (WHO, 1978). One of the major results of this Ministerial Conference was the now internationally-known Tallinn Charter – Health Systems for Health and Wealth. The Charter defines a health system as:

“the ensemble of all public and private organizations, institutions and resources mandated to improve, maintain or restore health. Health systems encompass both personal and population services, as well as activities to influence the policies and actions of other sectors to address the social, environmental and economic determinants of health.”

(WHO Regional Office for Europe, 2008a)

The Charter’s values and rationale are firmly based on the human right to enjoy the highest attainable standard of health, which is included in the WHO Constitution (WHO, 2006a), the Universal Declaration of Human Rights (United Nations, 1948), the Convention on the Rights of the Child (United Nations, 1989), and the Millennium Development Goals sponsored by the United Nations. Importantly, the Charter acknowledges the importance of WHO health promotion charters – Ottawa 1986, Jakarta 1997 and Bangkok 2005.
The Tallinn Charter has been endorsed by the 53 Member States of the WHO European Region and key European institutions and international agencies. Member States have clearly affirmed the central role of health promotion in health systems through a number of statements:

- investing in health is investing in human development, social well-being and wealth;
- today it is unacceptable that people become poor as a result of ill-health;
- health systems are more than health care and include disease prevention, health promotion and efforts to influence other sectors to address health concerns in their policies;
- well-functioning health systems are essential to improving health: strengthened health systems save lives; therefore
- health systems need to demonstrate good performance.

(WHO Regional Office for Europe, 2008a)

The Charter points out that while the structure and magnitude of health systems in Europe (and elsewhere in the world) may vary due to historical, economic and cultural factors, they share a common set of functions related to service delivery, resource generation, financing and stewardship. These are summarized in the box below.

**Box 1: The Main Functions of Health Systems**

<table>
<thead>
<tr>
<th>Functions</th>
<th>Description</th>
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<tr>
<td><strong>Service delivery</strong></td>
<td>This relates to the delivering of personal and population-based health services. The most visible function of any health system is the delivery of services to individuals, groups and entire populations. Key issues are the choice of services to be delivered, in what settings, and by what mechanisms. Strengthening PHC is a particularly important strategy to promote the aims of access, coverage and quality. PHC provides a natural platform for intersectoral and inter-professional cooperation, for the integration of vertical programmes in existing structures and services (as opposed to their development in parallel structures with its implied inefficiencies), and for health promotion.</td>
</tr>
<tr>
<td><strong>Resource generation</strong></td>
<td>This entails identifying and developing the resources necessary to support health systems – knowledge, medical devices, physical infrastructure and most importantly human resources. These resources are necessary to deliver health services within the cultural, historical, economic and political context of a specific country. Resource generation is a matter of key importance for well-performing health systems. Investment in human resources and developing adequate skills for health promotion is particularly critical.</td>
</tr>
<tr>
<td><strong>Financing</strong></td>
<td>This consists of the collection, accumulation (pooling) and allocation of funds used for the health system to operate effectively and efficiently. Countries are confronted with many difficult choices and complex tradeoffs as they use various approaches in their efforts to achieve health system goals within the constraints of available funds. Financing arrangements should sustain the redistribution of resources to meet health needs and reduce or eliminate...</td>
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financial barriers to the use of services. Financial arrangements should provide incentives and transparency for the efficient and holistic organization and delivery of health services. For health promotion it is important that the overall allocation of resources should strike an appropriate balance between health care, disease prevention and health promotion so as to effectively address current and future health needs.

**Stewardship**

While countries may have different structural approaches to governing their health system, ministries of health determine the vision for health system development and have the mandate and responsibility for legislation regulation and enforcement of health policies, as well as for gathering intelligence on health and its social, economic and environmental determinants. The term “stewardship” thus refers to the ensemble of systematic activities aimed at ensuring that: (i) the health system has direction, and other functions are well orchestrated and oriented to promote health goals; (ii) “healthy public policy” (also termed nowadays as “Health in All Policies) is promoted in order to maximize health gain by increasing policy cooperation, adjustment and in some cases even integration between health and other policy areas/sectors; and (iii) the relationships between health-related stakeholders are ruled and regulated in a context of evidence-based transparency and accountability, with monitoring and audit functions established to inform them.

Source: WHO Regional Office for Europe, 2005a; 2008a

These health system functions are interconnected. All functions are essential for health systems to successfully deliver their goals. Experience suggests that action on one single function is unlikely to lead to substantial progress in health promotion or in other desired health outcomes, unless supported by synergies with the other functions (WHO Regional Office for Europe, 2008a).

### 1.2 STRENGTHENING THE HEALTH-PROMOTING POTENTIAL OF HEALTH SYSTEMS

While models for health promotion abound, there are very few that explicitly consider how health promotion action requires the backing of high-performing equitable health systems (SNIPH, 2006). For nearly three decades the Ottawa Charter has guided the development of health promotion and public health more broadly. The Ottawa Charter defines health promotion as

"The process of enabling people to increase control over and improve their health. It involves the population as a whole in the context of everyday lives, rather than focusing on people at risk with specific diseases and is directed towards action on the determinants or causes of health”

(WHO, 1986).

The Ottawa Charter calls for shared responsibility for health promotion in health services in creating health systems which contribute to the pursuit of health. The Charter states that the:

“... role of the health sector must move increasingly in a health promotion direction, beyond its responsibility for providing clinical and curative services. That health services
need to embrace an expanded mandate which is sensitive and respects cultural needs and that this mandate should support the needs of individuals and communities for a healthier life, and open channels between the health sector and broader social, political, economic and physical environmental components. Reorienting health services also requires stronger attention to health research as well as changes in professional education and training. This must lead to a change of attitude and organization of health services which refocuses on the total needs of the individual as a whole person.”

(WHO, 1986)

Of the five action areas identified by the Charter, namely building healthy public policies, creating supportive environments, strengthening community actions, developing personal skills and reorienting health services, there has been little systematic attention to the latter (Wise and Nutbeam, 2007).

What prevents health systems from strengthening their health-promoting potential? This paper proposes that part of the answer lies in the lack of integration, active advocacy and leadership from health promotion within health systems. Consistently sidelined by dominant medical authorities, the profession of health promotion has too often separated itself from mainstream health systems and neglected cooperation or has been bought-in by its own sector! Notable exceptions, of course, exist (e.g. the Health Promoting Hospital initiative, www.euro.who.int/healthpromohosp, WHO, 2004). Importantly, contextual changes, as identified in the comments of Dr Margaret Chan above, point to this as an opportune time to accelerate progress towards mainstreaming health promotion within strategies to strengthen health systems.

Functional health system frameworks, such as the one described in the Tallinn Charter, offer useful insights into potential “re-entry” points for such mainstreaming efforts. Since health systems must aim to tackle global, regional, national and local challenges, the skills and leadership potential inherent to health promotion emerge as critical resources. The strengthening of service delivery, creation of new human resources, development of balanced financial systems and the guidance of stewardship would each greatly benefit from social communication and the facilitation of cross-functional collaboration within health systems. Experienced health promotion teams could contribute by working “on the inside” to help health systems better achieve their goals of improved health, responsiveness and financial fairness (see figure below). Health promotion approaches, for example, have been shown to strengthen service delivery (Wanless, 2002; 2004). Health systems have better health outcomes when built on PHC, where health promotion is a key element (WHO, 2009b). Approaches that emphasize locally appropriate action across a range of social determinants, balance prevention and promotion with investment in curative interventions, and place an emphasis on the primary level of care with adequate referral to higher levels of care are better performing than those where such balance is distorted (Gilson et al., 2007).
Examining cases in which health promotion skills and approaches have been strategically applied to building healthy public policies and supportive environments - key areas identified in the Ottawa Charter - gives us some useful insights as to how health services can be re-oriented to “close the implementation gap.” Health promotion, for example, has been very successful in building capacity to advocate for change, engage and empower citizens and facilitate effective intersectoral action (IUHPE, 2000). These approaches have shown to be effective in a wide variety of lifestyle and environmental interventions and settings such as tobacco control, road safety, Health Promoting Schools (NIGZ, 2009) and Healthy Cities (WHO Regional Office for Europe, 2009c). Much of the success of these initiatives relates to their ability to engage with finance, transport, education, labour and environment sectors (NIGZ, 2009).

It is important now to capitalize on this strong foundation and begin to “get our own house in order” by directing some of these skills towards creating more health-promoting health systems.

Importantly, these health promotion skills and know-how can help inform stewardship activities that advocate health in all policies and a political commitment to health and equity in all sectors. Health promotion skills and approaches, as demonstrated in work done on lifestyle, environment and settings, can be used to help health systems play a more active role in countering societal pressures towards harmful products, resource depletion, unhealthy living conditions and environments and the factors influencing health-damaging behaviour (NICE, 2007). Health promotion can usefully inform resource generation functions, by training health professionals and other health system workers so they can be in a better position to influence people and policy makers to change behaviours and approaches in more health promoting ways. Health promotion skills can also strengthen action by health workers aimed at reducing health inequities and addressing health gaps within and between societies.
Health promotion can also strengthen the financing function of health systems. There is a wealth of evidence about how health promotion can improve population health (IUHPE, 2000). This body of evidence must now be put to use to make health systems more effective, efficient and sustainable. An independent review of the British National Health Service (NHS), for example, concluded that unless the health system scales up action in evidenced-based health promotion, in cost-effective interventions in disease and injury prevention and in addressing the wider determinants of health, the NHS will not be sustainable in the future (Wanless, 2002; 2004). Wise and Nutbeam (2007) point out that the findings of this and similar reviews in countries such as Sweden, Canada and the Netherlands, offer a new evidence-based platform for investment and integration of health promotion aimed at a high-performing, equitable health system. Moreover, there appears to be a lot of scope for improving the mix of care, prevention and promotion services within health system and advocating better allocation of resources and financing to enable the health promoting components to be realized.

Part 2 of this paper provides more specifics about how health promotion can contribute to achieving global priorities and commitments and how it can strengthen and help in pursuing effective and equitable health systems.

PART 2. GLOBAL PRIORITIES

At the time of the 7th GCHP in Nairobi, the world faces unprecedented global challenges including pandemic influenza, the financial crisis and economic downturn, a food crisis and climate change (World Bank, 2009a). In this context strengthening the promotion and protection of the health of individuals and communities as a core activity of health systems is not optional but a must.

Part 2 shows how health promoting activities need to be better applied to a wide range of policies and programmes linked to agreed global commitments and priorities. In doing so, Part 2 aims to highlight the urgency for “closing the implementation gap”, the main topic of the 7th GCHP. Examples have been taken from the MDGs, the determinants of health and, the protection and promotion of the health of socioeconomically disadvantaged populations. While the specifics of implementation will always be context specific and vary between low, middle and higher income countries, the general principles of health promotion activities described can be applied in all contexts. Some of the topics explored have been addressed in other documents prepared for the 7th GCHP but not from a health system perspective. Looking at ways health promotion can help improve population health outcomes through strengthening health system capacities is what this Part 2 is designed to do.

2.1 MILLENNIUM DEVELOPMENT GOALS

The United Nations Millennium Declaration, adopted in 2000 by 189 nations, embraces a vision of a world in which countries work in partnership for the betterment of all, particularly the most disadvantaged. This vision was transformed into eight Millennium Development Goals (MDGs) with 20 targets and over 60 indicators. At high-level meetings in 2008 to mark the MDG half-way point, world leaders expressed concern about shortfalls in progress to many of the Goals (United Nations, 2008a; 2008b).
This section outlines some strategic considerations on how health promotion principles and action can contribute to progress towards the MDGs globally. Ways in which health promotion approaches can strengthen health systems and make them more sustainable and effective is identified by focusing on the health system functions described in Part 1.

Millennium Development Goals 4 and 5 are explored as examples and similar considerations could also be extended to MDG 6. There are other MDGs that address key determinants of health such as poverty, education, gender equality, environmental sustainability and global partnership for development. MDG 1, which focuses on poverty, will be explored in the next section on social determinants of health. This selection of MDGs is used only to highlight examples and in no way means that health promotion (and the need to strengthen health systems) is not relevant to other MDGs.

<table>
<thead>
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<th>MDG 4 - Child mortality</th>
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<tr>
<td>The target is to reduce by two-thirds the under-five mortality rate by 2015. The indicators for monitoring progress include the under-five mortality rate, infant mortality rate, and the proportion of 1 year-old children immunized against measles</td>
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Poorly funded health systems, and inadequate human resources and infrastructure are some of the main obstacles to implementing health programmes and initiatives that can reduce infant mortality rates (The Global Fund, 2009). Fifty-seven countries, most of them in Africa and Asia, face severe health workforce shortages. WHO estimates that at least 2,360,000 health service providers and 1,890,000 management and support workers, or a total of 4,250,000 health workers, are needed to fill the gap (WHO, 2006a).

Achieving the reduction in the under-five mortality rate requires investment in programmes that ensure both survival (less mortality) and promote healthy development (less morbidity). Such an approach requires linkages between health and other sectors, such as education, social protection, etc. Importantly, it is recognised that in countries where health systems are weak, systems in other sectors are also likely to be weak. It has been found that multi-sectoral (combined) interventions are more likely to be taken up because they may also have relatively low delivery costs, less duplication of services, and a more appropriate identification of those who are most likely to benefit. Families have been found to be more motivated to seek services where “multiple” outcomes such as child growth and health are perceived as possible (Irwin et al., 2007).

In developing such intersectoral actions, the experiences and lessons from within health promotion can significantly contribute to progress in MDG 4 (as well as other MDGs). These experiences can inform the stewardship of health systems in their work with other sectors (such as education, community services, social protection) and in building coalitions to achieve a common goal of ensuring survival and healthy development (emotional, social, cognitive and physical) for children from the moment of birth. (See also the Discussion Paper of Intersectoral Action prepared for this 7th GCHP.)
If we turn to MDG 5 (Improve Maternal Health), similar considerations can be made. Globally, of all of the Goals MDG 5 is the furthest behind with meeting targets. During the 2009 World Health Assembly, Dr Ban Ki-moon, Secretary-General of the United Nations, stated that:

“Today, maternal mortality is the slowest moving target of all the Millennium Development Goals. Together, let us make maternal health the priority it must be. In the 21st century, no woman should have to give her life to give life.”

(Ki-moon, 2009)

In 2005, more than 500,000 women worldwide died during pregnancy, childbirth or in the six weeks after delivery (United Nations, 2008a). Maternal mortality decreased globally by less than 0.4% per year between 1990 and 2005. This is far below the 5.5 per cent annual decrease needed to reach the target. Accelerated improvements in reproductive health care, including but not limited to better obstetric care, are required in all regions (UNIFEM, 2009; United Nations, 2008a). Globally, it is estimated that the prevention of unplanned pregnancies could reduce maternal deaths by around one quarter, including those that result from unsafe abortion (UNIFEM, 2009).

Health promotion action is much needed here to ensure better implementation and monitoring of the continuum of care, which begins with family planning and goes through antenatal care, appropriate diagnosis of complications and referral to the right level of care. Interventions that could save the lives of mothers and babies and reduce suffering are required to strengthen the service delivery function by health systems. Such interventions are well known but are not fully implemented in many countries. In some areas, outdated and dangerous practices are still widespread. This is an area where health promotion action and advocacy can be most helpful. Health promotion approaches can be used to enhance personal skills and develop supporting environments. In the areas covered by MDG 5, to be fully effective, health promotion action must go hand in hand with strengthening the PHC elements of health systems.

2.2 ADDRESSING THE SOCIAL DETERMINANTS OF ILL-HEALTH

The efficacy and importance of health promotion skills and capacities to health system functioning is also apparent when we look at addressing the social determinants of health.

In August 2008 the WHO-established Commission on Social Determinants of Health (CSDH) completed its work and presented its findings and recommendations. For the first time, evidence relating to the social determinants of health and to socially-caused health inequities was put together, in a systematic manner for the entire world. A number of recommendations based on the three overarching principles of action were put forward. They all draw on health
promotion principles embodied in the Ottawa (1986), Jakarta (1997) and Bangkok (2005) Charters. These principles include:

1. Improve the conditions of daily life – the circumstances in which people are born, grow, live, work and age.
2. Tackle the inequitable distribution of power, money and resources – the structural drivers of those conditions of daily life – globally, nationally and locally.
3. Measure the problem, evaluate action, expand the knowledge base, develop a workforce that is trained in the social determinants of health, and raise public awareness about the social determinants of health.

(WHO, 2008a)

Furthermore, the Health Systems Knowledge Network of the CSDH identified the following 4 overarching features of health systems that, when present, can help to promote the health of socially disadvantaged and marginalized groups as well as produce general population gains:

1. Intersectoral action across government departments to promote population health
2. Organizational arrangements and practices that involve population groups and civil society organizations
3. Progressive universalism - health care financing & provision arrangements that aim at universal coverage with particular benefits for socially disadvantaged and marginalized groups.
4. A vital and comprehensive primary health care approach

(Gilson et al., 2007)

Three of the above (1, 2 & 4) are fundamental to health promotion practice. Furthermore, the advocacy capacity of health promotion can help influence the adoption of universal coverage approaches. Health-promoting health systems are thus in a strong position to tackle the social determinants of health.

POVERTY

The highest risk to the health of both individuals and communities is poverty. Action to promote health, therefore, should be an integral part of fighting poverty and social exclusion. Poverty severely limits the chance of living a healthy life. Poor health can also be a major cause of impoverishment, particularly in low income communities, as it puts a heavy burden on the family budget, and can push individuals into further poverty. Importantly, the protection and promotion of health for individuals and communities enables them to take advantage of opportunities for education and employment (which then helps improve their chances to move out of poverty and social exclusion).

<table>
<thead>
<tr>
<th>MDG 1 – Poverty</th>
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<td>The eradication of poverty is addressed in MDG 1, whose targets are: (1a) halving, between 1990 and 2015, the proportion of people whose income is less than one dollar (PPP) a day; (1b) achieving full and productive employment and decent work for all, including women and young people; and (1c) halving, between 1990 and 2015, the proportion of people who suffer from hunger</td>
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<td>(UNSTAT, 2009).</td>
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Whitehead and Dahlgren (2007, p.46), state:

"High levels of economic stress, poor housing, unemployment, limited access to essential health services and structurally determined unhealthy lifestyles cluster together and heighten the impact of the health of exposed groups."

Health promotion activities can help health systems focus on, and address, poverty reduction as a determinant of health. Health interventions that overlook this fundamental issue may result in actually increasing health inequities. Health promotion can draw on ethical values and principles and bring attention to the fact that in spite of poverty being “the world’s biggest killer and greatest cause of ill-health and suffering across the globe” (WHO, 1995), it is rarely stated as a cause of major diseases. This is in spite of the fact that it is identified as a cause of death and ill-health in the International Classification of Diseases, where it is given the code Z.59.5 (WHO, 1995). Even in the health professional community, the tendency is to disguise the links between poverty and poor health, often by using misleading terminology (Whitehead and Dahlgren, 2007). Poverty-related diseases in poor countries are usually referred to as tropical diseases, even though many of these diseases were common in the cold climate of northern European countries before their economic development. Equally misleading, in high-income country contexts, is the tendency to refer to, for instance, cardiovascular pathologies and diabetes as diseases of affluence, even though those with the highest levels of affluence within a country are those with the least risk of these diseases (Whitehead and Dahlgren, 2007). Health promotion can help make it clear that when particular diseases are directly or indirectly caused by exposure to absolute or relative poverty, they should correctly be referred to as poverty-related diseases.

Poverty impacts health and health system usage in many ways and at different levels. The final report of the Commission on Social Determinants of Health (WHO, 2008a) provides evidence of how the socioeconomic context within which a person lives, as well as her or his position within that context, can result in differential exposure to health threats; differential vulnerability to those threats; differential access to quality health services (e.g., through differential healthcare-seeking behaviour influenced by financial and other constraints); and differential outcomes and consequences as a result of service usage (e.g., related to treatment compliance and success) (WHO, 2008a). Likewise, ill-health and health system usage beyond the financial means of an individual and/or household can increase multidimensional poverty.

A health promotion lens helps to approach poverty as a multidimensional phenomenon, often consisting of interlinked and reinforcing facets such as:

- reduced income, consumption and employment;
- insufficient or poor quality nutrition;
- poor health and limited access to health services;
- limited access to education;
- low levels of participation in decision making; and
- lack of personal empowerment, reflected in the limited possibility to influence one’s life situation (Ziglio et al., 2003; IMF, 2004).

In considering progress towards the target of reducing poverty in general, it is important to remember that all of the MDGs tackle the inter-related facets of poverty. Lack of progress on any of the Goals will threaten the attainment of MDG 1. Likewise, lack of progress on MDG 1 will be detrimental to all of the other MDGs.
In the *Tallinn Charter: Health Systems for Health and Wealth*, Member States commit themselves to promote the shared values of solidarity, equity and participation through health policies, resource allocation and other actions, ensuring due attention is paid to the needs of the poor and other socioeconomically disadvantaged groups. Furthermore, policy-makers were called to take action by World Health Assembly Resolution WHA 62.14 to raise awareness among public and private health providers on how to take account of poverty and exclusion when delivering services; to achieve better distribution of funding according to people’s ability to pay, thus avoiding impoverishment as a consequence of ill-health or service usage. The Resolution urges policy-makers to take into account health equity in all national policies that address social determinants of health, and to consider developing and strengthening universal comprehensive social protection policies, including health promotion, disease prevention and health care, and promoting availability of and access to goods and services essential to health and well-being (WHO, 2009c).

**EDUCATION**

The final report of the Commission on Social Determinants of Health calls for the need to address education as a determinant of health (WHO, 2008a), particularly given the importance of education in securing other determinants such as occupation, income and social inclusion. There is significant evidence of health inequities between people with higher and lower educational levels across the world (Mackenbach, 2006).

**MDG 2 - Education**

The MDG 2 target is to ensure that, by 2015, children everywhere, boys and girls alike, will be able to complete a full course of primary schooling. In the developing world as a whole, enrolment coverage in primary education reached 88 percent in 2007 (United Nations, 2009). Improving early childhood development contributes to reaching MDG 2.

(UNSTAT, 2009).

Health promotion has a good and long-standing tradition here. For example, schools are key settings for health promotion. School-based health promotion programmes include actions to build health literacy but also entail a whole school approach addressing aspects such as: the social and physical environment of the school, staff development, provision of school lunch, provision of exercise and health programmes, and the school's social atmosphere (NIGZ, 2009).

Globally, at least 200 million children aged under 5 years fail to reach their potential in cognitive and social-emotional development, due to: malnutrition (caused by poverty, that leads to stunting) iodine and iron deficiency, and inadequate stimulation in their first 5 years of life (Irwin et al., 2007). Early cognitive and social-emotional development are determinants of school progress. Both stunting and poverty are associated with fewer years of schooling. Early childhood development (ECD) programmes are designed to improve the survival, growth and development of young children, prevent the occurrence of risks and ameliorate the negative effects of risks (Grantham-McGregor et al, 2007). Health promotion is central to ECD programmes. Health promotion actions comprise, but are not limited to:

- breastfeeding and nutrition support;
- comprehensive support to and care of mothers before, during and after pregnancy; parenting and caregiver support; and
- services for children with special needs

(WHO, 2008a; Irwin et al., 2007).
Child development health promotion programmes involve a range of family support, health, nutrition and education systems and services. Here, too, the health system has a particularly pivotal role to play. It is often the point of early contact with a child and can serve as a gateway to other early childhood services. Health promotion professionals are usually trusted sources of information for families and can give critical guidance both to system users and other providers about: how to communicate with infants and children; ways to stimulate children for better growth; how to handle such common developmental problems as sleep, feeding and discipline; and ways to reduce common childhood injuries (Irwin et al., 2007). In this way health promotion can support the resource generating function of health systems.

2.3 SOCIOECONOMICALLY DISADVANTAGED POPULATIONS

This section looks at how health promotion approaches are needed to strengthen health systems in supporting, protecting and improving the health of socioeconomically disadvantaged populations. In many countries there is an accumulation of health hazards, risk factors, and risk conditions such as unemployment or job insecurity, bad housing and unhealthy physical environment in less advantaged socioeconomic groups. It is often the case that the people who live in the poorest housing and have the most unsafe working conditions are also those who have the greatest risk of unemployment, have poor diets, are more likely to be smokers and have restricted access to prevention and health care when ill (WHO Regional Office for Europe, 1999).

A health promotion lens should help to view the overall pattern of risk exposure, not just each factor separately. For example, taking a life-course perspective - looking at the trajectories of different social groups from birth to old age – this cumulative disadvantage becomes even clearer. In an assessment of the British evidence a 1995 Report by the Department of Health concluded:

“It is likely that cumulative differential exposure to health damaging or health promoting physical and social environments is the main explanation for the observed variations in health and life expectancy”.

(Department of Health, 1995)

The implications of this growing body of evidence that has culminated in the final report of the CSDH in 2008 are profound. Addressing the uneven distribution of health-related factors across the population requires the search for more health-promoting health systems. In such a search, health promotion can contribute to a better understanding of the uneven distribution of:

- health and disease
- exposure to health hazards
- behavioural risk factors
- risk conditions
- opportunities and barriers to adopting a healthier lifestyle
- access to essential goods and services, including prevention and health care
- health assets.

Health systems performance can then be more tailored to overcome the root causes of these uneven distributions. Here all the functions of health systems described in Part 1 have a role
to play. Furthermore, it cannot be assumed that all health promotion interventions will be equally effective for all social groups. Here, better measurement and monitoring is needed to examine for instance, the impact of interventions on gender specific, socioeconomic and ethnic groups. The establishment of appropriate accountability mechanisms on health equity is an important step forward for health-promoting health systems and their efforts to reduce health inequities (WHO Regional Office for Europe, 1999). To give an example, let’s take the part of migrants that that are at risk of social exclusion.

AN EXAMPLE CASE: SOCIOALLY EXCLUDED MIGRANT POPULATIONS

According to the European Commission’s Joint Report on Social Inclusion 2004, social exclusion is:

“...a process whereby certain individuals are pushed to the edge of society and prevented from participating fully by virtue of their poverty, or lack of basic competencies and lifelong learning opportunities, or as a result of discrimination. This distances them from job, income and education and training opportunities, as well as social and community networks and activities. They have little access to power and decision-making bodies and thus often feel powerless and unable to take control over the decisions that affect their day to day lives.”

(European Commission, 2004)

In recent years there has been an increasing concern in several European countries, and supra-national institutions such as the EU and the Council of Europe, on how to protect and promote the health of socioeconomically disadvantaged migrant populations. This is also an issue that is discussed in the Nairobi Conference in the sub-plenary.

Enabling the highest attainable standard of health of all people without distinction of race, religion, political belief, economic or social condition is called for by the WHO Constitution (WHO, 2006a). Attention to the protection and promotion of the health of socially excluded migrants, and other disadvantaged groups, is required if health systems are to ensure equity and responsiveness to the needs of an increasingly heterogeneous population.

If we take the European context as an example, it is estimated that 72 million of the world’s 200 million international migrants live in the WHO European Region (IOM, 2008). In Europe, the migration process helps contribute to economic development and counterbalances aging populations in destination countries. Through remittances (i.e., money earned abroad and sent back to home countries), the migration process also contributes to poverty reduction and social protection in countries of origin. Socioeconomically disadvantaged migrant populations can face determinants of ill-health including limited access to health services and adverse living and working conditions. In some countries higher prevalence of health problems including communicable diseases, poor nutrition, reproductive and sexual ill-health, occupational health problems, and mental disorders are reported to be serious challenges for the promotion of health among migrants (Council of Europe, 2000). Recent research provides further evidence that some migrant populations may be disproportionately affected by noncommunicable diseases such as obesity and diabetes (Papademetriou et al., 2009).

Promoting the health of vulnerable migrants cannot be sustainable without a comprehensive health systems approach that builds upon strong health promotion competencies. Listed below are actions that health-promoting health systems can undertake to address migration and health issues:
STEWARDSHIP

This entails overseeing the capacity of the health system to engage other sectors, including through a health-in-all-policies approach (e.g., that migrant integration policy includes a health dimension) and advocating for a cross-government approach to meet the needs of socioeconomically disadvantaged migrants and other poor and excluded groups. The stewardship function also comprises building coalitions for migrant health, in conjunction with civil society groups and social protection service providers. Of great importance for migrant populations (including migrants who lack documentation), stewardship entails legislation and regulations providing for the Right to Health of all people and moving towards universality in coverage, as specified in the World Health Report 2008 (WHO, 2008b). Furthermore, it includes engaging in international cooperation on migration and health issues between countries of destination, transit and origin. All of these skills and competencies identified here can build on basic health promotion know-how and approaches.

SERVICE DELIVERY

Cultural and linguistic competencies and non-discrimination are the skills underlying migrant-friendly services, but ensuring these alone will not reduce health gaps between disadvantaged migrant populations and groups experiencing higher levels of social inclusion and affluence. Services must account for the living and working conditions that excluded migrants face. Services should be accessible in terms of administrative procedures (including for undocumented workers) and location (by having service points situated in disadvantaged communities). Outreach to increase health system literacy among migrant populations, including about available promotion and prevention services, can help redirect emergency service usage and avoid preventable/advanced morbidity and mortality. Migrant populations facing exacerbated exclusion and poverty may also require services with increased capacity for: early screening to decrease detection times, treating multi-morbid patients and facilitating patient compliance. In addition, disease- and life-cycle-specific activities such as HIV/AIDS prevention, mental disorder prevention and child and maternal health programmes can include targeted measures to ensure health inequities do not widen because migrant populations fall through the cracks of universal programmes. At the backbone of effective service delivery for migrant populations are (a) information systems that allow for disaggregation of data by migrant status, gender, ethnicity, occupation, income and employment, so that health inequities can be detected and the impact of policies on health equity measured; and (b) strengthened Primary Health Care that provides a platform for the interface of health promotion and health services with communities and for intersectoral and interprofessional cooperation. Improving intelligence through the identification, verification and dissemination of best practices on migration and health issues must also be integrated into quality improvement plans for service delivery.

FINANCING

Acknowledging that today it is unacceptable that people become poor as a result of ill-health (Tallinn Charter), health system financing can protect vulnerable groups including migrants by mitigating the burden of out-of-pocket health spending through moving towards prepaid systems that involve pooling of financial risks across population groups. Efforts should be made to ensure that participation in insurance schemes is not denied because of foreign-born status or lack of specific documentation such as birth certificates. Prolonged/complicated procedures for reimbursing the costs of care or medicines should be eliminated, as this will deter disadvantaged migrants from using medical services. Efforts to raise awareness among migrant populations of their entitlements and obligations are
required, and this should be linked to increasing health system literacy, mentioned above. This is an area where health promotion can make a key contribution.

RESOURCES GENERATION

The international recruitment of health workers should be guided by ethical considerations and cross-country solidarity and ensured through a code of practice (currently under discussion). This is called for by the Tallinn Charter and specified in the CSDH final report, the latter of which encourages reciprocal arrangements with regard to health workers between countries losing and countries gaining capacity. Furthermore, strengthening the human resource base for addressing migration and health issues entails increasing health professionals’ know-how on migrant health and socially determined health inequities through pre-service training and, as necessary, continuing medical education programmes. It also entails formalizing the role of cultural mediators, community outreach workers and other staff from the migrant community involved in service delivery. Cultural mediators are increasingly being used to help overcome communication and cultural barriers in health promotion programmes targeting migrant populations. Their role can be formalized by establishing minimum standard selection requirements, providing training before and during service, and standardizing compensation and performance management schemes within overall health systems development. It also may be appropriate to incorporate awareness-raising activities for other health professionals about the services provided by cultural mediators, so as to prevent any misconceptions and ensure that mediators are valued as health and social workers in their own right.

CONCLUSION

This discussion paper has described the importance for health promotion to be mainstreamed in health systems. It has proved its case by considering and analyzing the need for health promotion action and the need for strengthening health systems in order to increase performance and sustainability in achieving global health targets and priorities, reducing health inequities and protecting and promoting the health vulnerable groups.

Slow progress in this area calls for some re-thinking. This paper argues for the need to reframe, reposition and renew efforts from health promotion leaders and advocates. The reframing is about the way health promotion professionals define themselves. They need to work for the strengthening of all health system functions. They must take on a facilitative leadership role with other health professionals, communities and partner agencies in addressing the kind of issues described in this paper. The repositioning is about moving health promotion from the margins of health systems into the mainstream.

These changes will only be possible, however, if policy makers understand the potential health and economic benefits of re-orienting health services around the concepts and principles of health promotion. To accomplish this, those working in the field of health promotion will need a renewed sense of activism and advocacy. The good news is that there appears to be a newly receptive climate and fresh demand for such action at local, national, regional and global levels. It is precisely with this in mind that the accompanying brief, Health-Promoting Health Systems, Imperatives for Action, has been drafted. The Nairobi Conference will be a milestone in this challenging process.
REFERENCES


This definition mirrors the definition of health systems in the WHO Health Report 2000 and is by and large also in line with the 2007 WHO document “Everybody’s Business. Strengthening Health Systems to improve Health Outcome. WHO’s Framework for Action”.


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