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Douglas Gordon Oration

An alliance for global civil society advocacy
for the public’s health:
WFPHA and the PHAA

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Good morning ladies and gentlemen, friends for public health.

I would like to take this opportunity to pay respect to the Wurundjeri people of the Kulin Nation, the traditional owners and stewards of the land on which this meeting is being held.

I would also like to express my appreciation to the Public Health Association of Australia for inviting me to address you and for arranging my visit to this beautiful city. It is truly amazing that the voyage from Ottawa to Melbourne can be accomplished in relative comfort in a bit more than a full day’s timespan. We do live in a globally connected community.

It is a pleasure and an honour to be with you today to present the Douglas Gordon Oration during the Public Health Association of Australia’s 42nd annual conference. The theme of your conference, A ‘fair go’ for health: tackling physical, social and psychological inequality, is an excellent springboard for my presentation.

I would like to share with you today my reflections about the important role played by national public health associations and to make a call to action for these same organizations to be active and fully-engaged participants in global public health advocacy. What I would like to achieve today, through this presentation, is to convince you, the members of the PHAA and Australia’s public health community, to become actively engaged within the global public health association community through the World Federation of Public Health Associations.

The WFPHA is the unique civil society world body representing the interests and voice of public health and the global community of national and regional public health associations, schools of public health and other
interested organizations. Our mission is to promote and protect global public health. It does this by supporting the establishment and organizational development of public health associations, by facilitating the sharing of knowledge, skills and resources, and through promoting and undertaking advocacy for policies and practice.

The WFPHA was conceived by representatives from 13 international health organizations and public health associations during the 94th Annual Conference of the American Public Health Association, held in 1966 in San Francisco. The following year, at the time of the World Health Assembly in Geneva, delegates representing 32 national public health associations convened to adopt a Constitution, with 16 core member associations serving as the initial executive board. One of these was the Public Health Association of New Zealand, then known as the New Zealand branch of the Royal Society of Health.

Up to that point in time, no non-governmental organization in official relations with the World Health Organization represented the field of public health or the community of national public health associations. The creation of the WFPHA changed that situation.

Over the past four-and-a-half decades the global public health association community has expanded and matured. From only a few dozen countries having national public health associations in 1967, the year the WFPHA was founded, now almost 90 countries are served by a public health association. That number continues to grow. The WFPHA currently counts over 85 member national and regional public health associations, regional associations of schools of public health, as well as several academic and
health-oriented institutions/organizations that share the Federation’s mission and values.

Cumulatively, the Federation’s member associations represent a voluntary membership community of over 250,000 public health professionals, researchers and practitioners. In fact, the WFPHA’s global reach is considerably higher, as the reach of its national public health association members extends far beyond their immediate membership. The Federation’s reach also includes partnerships with several international professional associations, including the World Medical Association, the World Dental Federation and the International Council of Nurses, as well as affiliation with global health initiative such as the Alliance for a Cavity-Free Future and the World Justice Project.

Over the past forty-six years, the WFPHA has played a leadership role in global public health advocacy. It has produced over 40 resolutions, declarations and position papers on a broad range of public health topics. They relate, among other issues, to climate change and environmental health, conflict/peace and health, globalization-trade and public health, tobacco control, health systems sustainability, universal and equitable access to primary health care services, health human resources, prison health and the prevention of non-communicable diseases.

The Federation’s flagship activity is the World Congress on Public Health. Held every three years, this unique global event brings together public health practitioners, researchers and members of the global public health community with counterparts from other sectors and disciplines to discuss and seek solutions and to create advocacy around a wide range of issues affecting the public’s health. The most recent, the 13th World Congress, was
hosted by the Ethiopian Public Health Association in April 2012. This event, the second time a World Congress was held in Africa, brought together over 3,600 individuals from 120 countries under the theme *Towards Global Health Equity: Opportunities and Threats*.

Declarations from recent World Congresses focused on health as a global public good (in Brighton, UK 2004); eliminating social inequalities as a result of globalization (in Rio de Janeiro, 2006); health as the first human right (in Istanbul, 2009), and a call to action for global health equity through the social determinants of health (in Addis Ababa, 2012).

The Federation has used these position statements and declarations to inform and advocate for stronger and effective public health policies and strategies at the global level, through the World Health Organization and other multilateral organizations. Several WFPHA member associations have used these positions as instruments to support their public health policy advocacy efforts in their own countries. They have also formed the evidence base for presentations and statements by WFPHA representatives at international and national conferences and meetings.

Public health associations from across the world learn from each other about what works and how, about engaging with their members and the community, the do’s and don’ts about engaging with government and other stakeholders and developing policies. There is also a sharing of information about how to influence policy decisions through effective advocacy locally, nationally and internationally.

In my inaugural speech as President of the WFPHA in April 2012, I highlighted four priority areas for action during my two-year term:
1. Improving the WFPHA’s organizational capacity and self-sustainability
2. Strengthening the capacity of national PHAs and the WFPHA to influence public health policy and practice
3. Action on public health priorities at the global level, and
4. Preparations to mark the WFPHA’s 50th anniversary in 2017.

We started to move forward on all of these items. One of the first tasks was to obtain the WHO Executive Board’s approval for another multi-year term of the Federation’s status as an NGO in official relations with the World Health Organization. I am pleased to report this occurred in January of this year, and I would like to acknowledge the efforts of my colleague Dr. Bettina Borisch, the Director of the WFPHA’s secretariat office in Geneva, and our part-time staff for spearheading this initiative.

Our relationship with WHO is an important one. As I mentioned previously, we were at the time of our founding in 1967, and we remain today, the only non-governmental organization in official relations with the WHO representing the field of public health and the community of national public health associations.

During my meeting last year with Dr. Margaret Chan, the WHO’s Director General, we talked about how the Federation could help move forward the WHO’s agenda. She was quite forthcoming: first, contribute to the definition in practical terms of public health for the 21st century; second, help build skills and competencies for public health in low and middle-income countries; and third, advocate for the achievement of health and health equity through universal health coverage and the social determinants of health. The Federation has taken this to heart, with these three issues as elements of the new 3-year WHO/WFPHA collaborative action plan launched last month.
The Federation is also reaching out and exploring new inter-organizational collaborative partnerships with other health professional organizations, including the International Epidemiological Association.

In May of this year, the WFPHA hosted a 2-day workshop to review and update its 5-year strategic plan.

One of the first tasks accomplished was the validation of the WFPHA’s vision. “Leading the quest for a healthy global society” is our beacon. We also reaffirmed the Federation’s guiding principles that define everything we do over the next five years:

- Right to health, wherein health is a fundamental human right and public good
- Social Justice & Equity, to ensure non-discrimination and the elimination of health disparities
- Diversity and inclusion, being a global public health perspective that includes diverse social and cultural backgrounds, ethnicity, race, gender, sexual orientation and disability
- Partnerships for collaboration at all levels, from community to global, as a basis for mutual learning and capacity building, and
- Ethical conduct and mutual respect in everything we do in the name of public health.

The WFPHA’s 2013-2017 strategic plan has five goals:

1. Advocate for effective global policies to improve the health of populations
2. Advance public health practice, education, training and research
3. Expand and strengthen partnerships
4. Promote and support the advancement of strong member associations, and
5. Build an effective, responsive and sustainable WFPHA.

Each of the strategic plan’s five goals is supported by a set of strategic outcomes with an associated set of tasks. Two of these goals are pertinent to this presentation. The first is to help WFPHA member associations enhance their role as catalysts for change in their countries and their role in support of global public health advocacy. The second is to enhance the capacity of the WFPHA to influence discussions and decisions on global public health issues.

Public health associations are a unique type of organization. They are the non-governmental, politically independent and authoritative voice for public health. In some countries, they are its only voice.

National public health associations are voluntary membership organizations. They do not licence public health workers, they do not regulate them, nor do they certify them. There is no obligation for public health workers to be members. In other words, the members of national public health associations become involved in their association because they believe out of their own personal conviction that Health for All is the right thing to do. This is an important element of the credibility of national public health associations, for it demonstrates the commitment of their members to public health and well-being. It is a voice that cannot and should not be ignored by governments and other stakeholders, including the corporate sector.
The contribution to and influence of national public health associations in the development and application of policies, programs and practices that protect, promote and improve the public’s health and address health equity are impressive. The 2011 WFPHA Annual Report highlights some of them.

Several have played leadership roles in the ongoing fight for tobacco control. Former Australian Public Health Association President Mike Daube has played a key role in this fight not only in Australia but in providing leadership to the WFPHA through the Federation’s tobacco control working group. I want to take this opportunity to recognize the leadership of Australia in tobacco control – your country is a model we should emulate. Your former health minister, Nicola Roxon, was in my home province of Québec a few weeks ago, briefing a provincial government committee about Australia’s packaging restrictions. Why my country’s federal government is dragging its feet in adopting plain packaging is beyond me. But if my province can take progressive and independent action on this issue, then more power to it. The evidence is before us, and our advocacy efforts must continue. Thank you for helping us move forward.

Other PHAs focused their efforts on public health education and training; on the prevention and control of both infectious and non-communicable diseases; and on the quality of and access to essential public health services such as immunization and maternal-newborn and child health services. Still others have worked with their governments and with professionals from other sectors to enhance water supply and sanitation and solid waste disposal. A few PHAs introduced community-based insecticide-treated mosquito bednet programs before their use became widespread. Some public health associations have brought a population health perspective to problem analysis, policy development and project design,
and are promoting a social-determinants-of-health approach to achieve better health and health equity. And many associations have championed politically unpopular causes, gaining hard-won advances over the years in the prevention and treatment of HIV and AIDS including better access to essential medicines, to clean needle and syringe programs and to treatment protocols including alternative pharmacotherapies for dependent users.

In my recent and former role as Director of Policy at the Canadian Public Health Association, I followed with interest the PHAA’s policy development and advocacy efforts. Your association and my home national public health association are similar in several respects.

Both have made social justice and health equity pillars for action. Both have a long tradition of convening practitioners, partners, and stakeholders to share their experience, knowledge, and best practices. Both tackle the conventional public health issues of disease and injury prevention, health promotion, health protection, population health assessment, epidemiological surveillance, and emergency preparedness, as well as issues related to the social and ecological determinants of health. Both have spoken out and pushed the boundaries on public health issues. In some cases our two associations have been lauded for their efforts. In other instances they have paid a price for doing so, politically as well as financially.

Our two national public health associations do what PHAs do best: they are ardent advocates for evidence-informed and effective policies and practices that put into place the conditions which protect and promote individual and community health. And when they can, CPHA and PHAA have contributed to ways and means to improve health outcomes for particularly at-risk and vulnerable populations.
Both CPHA and PHAA have been active WFPHA members over many years. CPHA joined the Federation in 1972. The PHAA did so fifteen years later in 1987. Margaret Conley, a former PHAA Executive Director, served as WFPHA’s President between 1991 and 1993. CPHA has held the WFPHA Presidency on three occasions – between 1978 and 1980, from 2000 to 2004, and my two year term which began in April 2012 and runs to May 2014.

I want to thank your association’s Executive Director, Michael Moore, for his active participation over the past few years in the Federation’s work, especially his important and welcome input during last May’s workshop to renew the Federation’s strategic plan. Michael kept us on the straight and narrow, kept our discussions on track and focused on what is practical. Thank you Michael!!

I would also like to thank the PHAA for its generous supplemental financial contribution to the WFPHA this year, over and above its assessed annual dues. These are tough financial times for all non-government organisations, national as well as international. However, following the global financial crisis, an emphasis on equity becomes even more important than in the past as governments narrow their focus to macroeconomic growth which so often results in a disproportionate distribution of wealth and increasing inequalities.

Our two national public health associations are fortunate. They are relatively well-resourced, both financially as well as in terms of the capacity of their members to provide considerable voluntary in-kind support to the associations’ activities. This is not the case for many national public health associations.
In 2011 the WFPHA canvassed its member associations about their role in
promoting action on the social determinants of health. We asked them to
identify the successes, failures, opportunities, and obstacles they
encountered. The respondents felt that the two primary roles of a public
health association are to: 1) advocate for effective policy and program
interventions (that is, “agenda setting”) and 2) provide the data and
evidence to local and national decision-makers, so they can take effective
action. They added that public health associations can and should play a
central role in raising awareness among the public, the media and politicians
about health equity and the many practical means to incorporate a social-
determinants-of-health approach into the health portfolio.

WFPHA’s members felt the Federation has a special advocacy role to play
with multilateral agencies and governments, adding that it should be more
vocal and influential. They also voiced their concern about the lack of
political commitment and national action on the social determinants of
health, and the need for more means to exchange information about
promising practices in the application of policies and strategies that
promote health equity.

In a second member survey, WFPHA members called on the Federation to
help build their capacity to advocate for effective and evidence-informed
public health policies and practice. They asked the Federation to help them
gain greater local and regional visibility and external support for their
advocacy initiatives. They also called upon the WFPHA to build stronger
links with international organizations as a means of getting public health
integrated within global initiatives, such as the place of public health within
the post-2015 human development goals.
Although some PHAs have chalked up successes in terms of what their advocacy action has achieved, we must also appreciate the challenges they face in terms of their capacity to influence thinking and action along the ‘policy to practice’ continuum. While they have demonstrated some success in this regard, many have done so in the face of considerable organizational and contextual challenges.

These are many and varied, depending upon the local situation. They include fragile organizational capacity, heavy reliance on limited volunteer input and resources, difficult political environments where speaking out on issues is minimally if at all tolerated, national contexts wherein governments have not made a political commitment to the concept of health equity, or where investments in public health are decreasing. These PHAs also voiced their frustration about the lack of or difficulty in securing externally-sourced organizational funding support, especially when they have to compete with the larger and better-funded international NGOs working in their countries.

In 1982, with funding support from the Canadian International Development Agency (CIDA), the Canadian Public Health Association launched an innovative international health program. Its goal was to enhance the global civil society public health voice, by supporting the creation of national public health associations and their organizational development. Over the next 26 years, through what became known as the Strengthening of Public Health Associations – SOPHA – Program, this Canadian initiative contributed to the establishment and organizational strengthening of public health associations in 31 different jurisdictions around the world.
I was involved in this exciting and innovative endeavour for almost 13 of the 21 years I worked at CPHA. It was a remarkable initiative – working side-by-side with passionate people in other countries, to help establish and nurture the organizational capacity of new public health associations, sometimes in very difficult political, social and economic circumstances. The majority of the SOPHA Program’s public health association partners were located in Africa and Latin America. Some of them were created in fragile transitional democracies, for example in Russia and Romania; and others, in post-war situations, such as in Kosovo and Bosnia & Herzegovina. Each had their own history, their own reason for being – but all shared a common desire: to contribute to the achievement of the Alma-Alta Declaration’s call of Health for All.

Some former SOPHA Program partners have become successful in their own right, for example the public health associations in Indonesia, Uganda, Burkina Faso, Cameroun, Cuba, Mozambique, Ethiopia and Nicaragua. Others, for reasons sometimes beyond their control, fared less well – the PHA in the Palestinian Territories comes to mind.

This unique international initiative helped PHAs become strong advocates for public policy, to implement and manage public health interventions and research initiatives, to independently pursue funding opportunities, to mentor other PHAs, and to effectively increase their impact and role in public health in their communities, in their countries and around the world. The SOPHA Program was also instrumental in building strong civil society voices for public health in several countries, in many cases a voice welcomed and even encouraged by national ministries of health and international agencies.
The SOPHA Program contributed to a strengthening of the global PHA movement by sponsoring and supporting membership of PHAs from low- and middle-income countries in the WFPHA. It also supported their participation at international conferences and meetings, and helped generate the flow of evidence to the Federation from member associations for global advocacy. The value-add of this initiative has been recognized by several organizations, including the World Bank and as well by WHO which conferred the Sasakawa Health Award on CPHA.

CPHA was not the only public health association to lend technical assistance to sister public health associations. About 15 years ago, the PHAA with funding from AusAid, implemented for a few years a SOPHA-type program in the South Pacific region. The American Public Health Association has also provided support through workshops on public health leadership and organizational development. I’d like to acknowledge the substantial financial and organizational support provided by the APHA to the WFPHA for many years – without which the Federation would not exist today.

The SOPHA Program ended in December 2012 when funding from CIDA was not renewed. Despite CPHA’s best efforts, we were unable to secure funding for its continuation. ‘Civil society organizational capacity building’ and ‘civil society advocacy’ do not appear to be ‘in vogue’ at funding agencies at the moment.

So, where do we go from here?

As I mentioned, building the capacity of public health associations and as well that of the World Federation to influence policy discussions and decisions is one of the building blocks of the Federation’s new 5-year
strategic plan. We are exploring how the Federation might develop and launch a SOPHA-type program. Our capacity to do so, however, is constrained.

We need the help and support of experienced national public health associations to conceptualize and prepare a proposal. We also need the help of experienced national public health associations to market the proposal to potential funders.

We need your engagement as volunteer technical advisors, to work with counterpart associations in other countries to help improve their organizational, programmatic and policy advocacy capacity. We are seeking as well the engagement of national public health associations to help the WFPHA enhance its global public health advocacy capacity, so that we gain visibility and enhance our advocacy efforts.

So, here I am, making a pitch to you, the members of the Public Health Association of Australia and members of other national public health associations who are with us today, to engage with the WFPHA as we move forward to expand and reinforce the global civil society voice for public health.

I would like to conclude my presentation by advocating for the engagement and action within the global public health community by you and your public health association on four levels:

1. Within your own PHA. Several eminent global public health leaders have argued for the adoption of a strong dialogue on global health at the national level, to engage both politicians and citizens alike in defining a
strategy to address the risks to the health and wellbeing of nations, regions and the world. Such a strategy would define the principles, values, intent and direction of global health actions on health problems that directly, or indirectly, threaten national populations as well as defining how a nation can contribute to resolving global health issues. I encourage the PHAA to take a global perspective within its domestic public health policy development and advocacy;

2. At a bilateral level, through conjoint action on public health issues with other national public health associations. For example, PHAA could work with CPHA on public health approaches to address tobacco control, alcohol and illegal psychoactive substances, injury prevention and safety promotion, and as well on the ways and means to make a fair go for health and health equity a normal way of doing business by all levels of government, by the private for-profit sector and by civil society;

3. At the regional level. The WFPHA is promoting and supporting the creation of regional networks of public health associations. The African Federation of Public Health Associations, through the combined efforts of over two dozen national PHAs on the African continent, was launched in September 2011. The WFPHA collaborates closely with the European Public Health Association and the emerging networks of national PHAs in the Asia Pacific region, in the Middle East, and in Latin America.

The PHAA is part of an emerging organization – the Asia-Pacific Public Health Association Network - with headquarters in Beijing. The 4th Asia-Pacific Regional Public Health Conference takes place in Nha Trang, Vietnam in November 2013; the next one in 2015 in the Republic of Korea. I encourage the PHAA to actively engage within this regional network to advocate for public policies that affect regional health and
health equity. For example a brief about the public health implications of the proposed Trans Pacific Partnership Treaty (TPPA) would be a useful advocacy instrument; and,

4. Finally, at the global level. The PHAA can be an active and leading WFPHA member by seeking a seat on the Federation’s Governing Council in 2015 as a representative from the Asia-Pacific region, by nominating members to sit on the Federation’s Committees and Working Groups, by providing input to the WFPHA’s policy-related activities such as the WFPHA/WHO collaborative study on ‘What is public health for the 21st century’ and in the public health competencies initiative. I’d also welcome PHAA’s involvement in the conceptualization and marketing of a SOPHA Program-type initiative.

The next World Congress, to be hosted by the Indian Public Health Association, will take place in Kolkata in February 2015. I would like to encourage PHAA members to submit abstracts for concurrent sessions, poster presentations and workshops. It is an opportunity to bring to the world’s attention the progress made by Australia in achieving health for all, and as well to share experiences about how things were done and how they might be adapted in other locations. It is also an opportunity to engage in and provide input into global public health advocacy issues.

We count on the active participation of national public health association members to make the World Congress a success. One of the Federation’s challenges is securing funds to support the participation of public health students, practitioners and researchers from low- and middle-income countries at the Congress. Your PHAs’ assistance to seek and secure funding support for this purpose would be most welcome.
The 15th World Congress, which normally would take place in 2018, has been moved forward by a year, to coincide with the celebration of the WFPHA’s 50th anniversary in 2017. The Call for Bids to host this special World Congress was released last week. All WFPHA Full Member associations, of which the PHAA is one, are eligible to submit a bid. I understand that the Board of the PHAA has committed to doing so. The WFPHA would welcome your bid, as, to the best of my knowledge it would mark the first time a bid is submitted from the continent of Oceania.

Ladies and gentlemen, I appreciate greatly this opportunity to share with you my thoughts and ideas as to how we can, together, strengthen the global civil society advocacy voice for public health and health equity. The ultimate goal is good health and well-being for all, not just for some. The WFPHA intends to become more pro-active in this regard and also support its members in their efforts, nationally, regionally and globally, to do the same. I believe together we can achieve what Sir Michael Marmot has challenged us to do, that is to close the gap in a generation.

Thank you/Merci beaucoup.