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Disaster Management through a Health Promotion Lens

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Keeping up to date - Edition 36

Welcome!

Each issue tells you about a current research, evidence and thought on an important issue for your work in health promotion. All articles are peer reviewed.

This edition is on Disaster Management through a Health Promotion Lens. We are thankful to Dr. Tara Kessaram and Associate Professor Louise Signal, the authors of the article. We also acknowledge the reviewers.

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Introduction

Recent events across the world have illustrated the severe and astonishing effects of natural disasters. Such events are compelling, prompting many to question how they may assist and support those affected. This literature review considers natural disasters to be an important public health problem, and examines strategies which aim to reduce their impact from a health promotion perspective. In doing so, this article illustrates the valuable contribution that health promotion professionals may make to the field of disaster management. While much of the literature reviewed pertains to developing countries, this report considers how these strategies may be employed in New Zealand, and the challenges that may be encountered in their application.

Methods

The discussion presented is based on a narrative literature review. A search was first conducted using Ovid MEDLINE to identify articles which explored the intersection of health promotion and disaster management. Key terms used were health promotion, health education, disaster, emergencies, floods, cyclonic storms, and earthquakes. As a limited number of relevant studies were retrieved, a broader search of online resources was undertaken to ascertain the key components of disaster management. The literature identified served as the basis for reflecting on how a health promotion framework may be applied to disaster management, and how health promoters may contribute to this discipline.

Disasters

A disaster is defined as "a serious disruption of the functioning of a community or a society involving widespread human, material, economic or environmental losses and impacts, which exceeds the ability of the affected community or society to cope using its own resources" (1). Disasters can result from hazards of human or natural origins. Natural disasters, the focus of this report, include those of geophysical, hydrological, meteorological, and climatological origins (2).

Disasters impact all aspects of life. Considering health in its broadest sense as defined by the World Health Organization (3), disasters therefore affect multiple determinants of health, and are thus an important public health issue. Health consequences of disasters, as outlined by the Pan American Health Organization (4)include, but are not limited to, loss of life and injury; loss of shelter and displacement; psychological distress; lack of food and clean water; increases in enteric diseases; and damage to infrastructure, including health care facilities, which may consequently worsen pre- and post-disaster morbidity.

Continued on page II

Figure 1 illustrates the number of disasters and the number of victims worldwide, from 1990 to 2010. The number of natural disasters has increased over this period, with 385 occurring in 2010, affecting over 217 million people (2). Though developing countries are disproportionately affected, developed countries are not immune, as evidenced by the recent earthquakes in Japan and New Zealand, and tornado storms in the USA. Further, climate change and the natural hazards and subsequent disasters it may cause, make this an issue of high global public health importance (5).

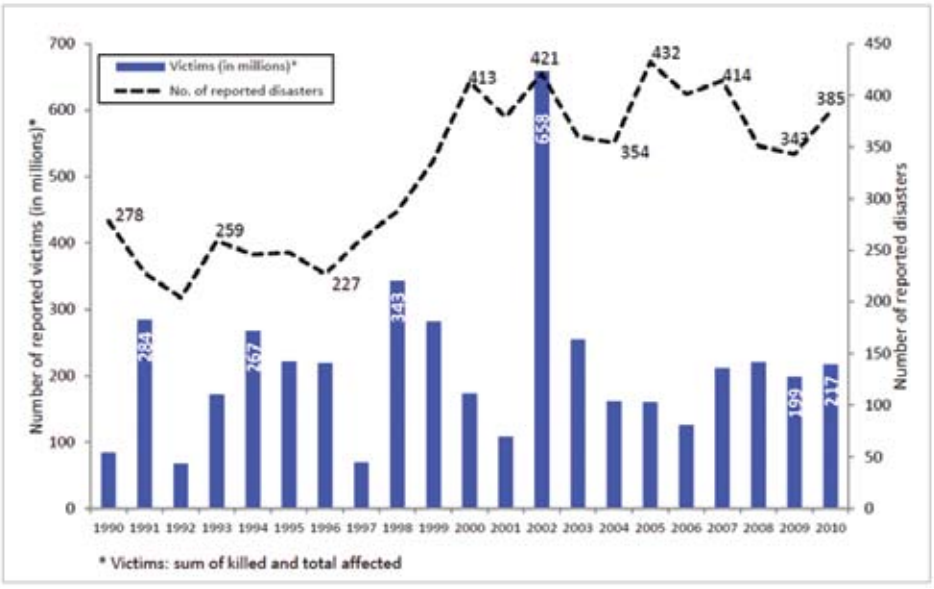

Figure 1. Number of disasters (geophysical, hydrological, meteorological, and climatological) and number of victims worldwide, 1990 - 2010. As printed in Guha-Sapir D, Vos F, Below R, with Ponserre S. Annual Disaster Statistical Review 2010: The numbers and trends. Brussels: CRED; 2011.

In light of the above, there is currently an international commitment to the "substantial reduction of disaster losses, in lives and in the social, economic and environmental assets of communities and countries" in the Hyogo Framework for Action 2005-2015 (HFA), to which New Zealand is a signatory (6) (p. 3). The HFA was adopted by 168 members of the United Nations at the World Disaster Reduction Conference in 2005 (7). The HFA has three strategic goals: i) "the integration of disaster risk reduction into sustainable development policies and planning"; ii) "development and strengthening of institutions, mechanisms and capacities to build resilience to hazards"; and iii) "the systematic incorporation of risk reduction approaches into the implementation of emergency preparedness, response and recovery programmes" (8). The substantial progress New Zealand has made between 2009 and 2011 towards achieving these goals has recently been described by the Ministry of Civil Defence and Emergency Management (9).

Stages of Disaster Management

Given the multiple health consequences of disasters, and also the similarities between the determinants of vulnerability and the determinants of health, interventions which seek to decrease vulnerability and increase resiliency to disasters can be considered public health and health promotion work. Such interventions may occur at all stages of a disaster. In New Zealand, these stages are described as the 'Four Rs': reduction (of risk), readiness, response, and recovery (10). There is an important relationship between the stages of recovery and reduction of risk. Though this relationship is recognised in the New Zealand Civil Defence and Emergency Management Strategy (Objective 4a) (10), it is better emphasized by conceptualising the stages of disaster management as a cycle, as illustrated in Figure 2 below from the Pan American Health Organisation (4).

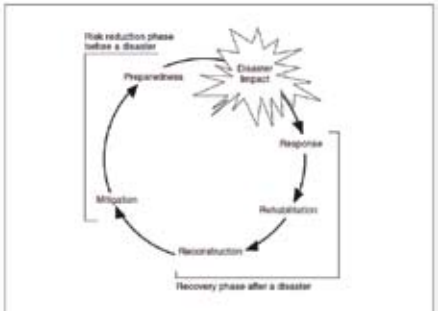

Figure 2. Disaster Management Cycle. As printed in Pan American Health Organization 2000 Natural Disasters: Protecting the Public's Health, Pan American Sanitary Bureau, Regional Office of the World Health Organization, Washington, D.C.

The stages within this cycle are mitigation and preparedness, followed by response, rehabilitation, and reconstruction (4). This review uses examples from many of these stages with emphasis placed on the common health promotion strategies under which they occur. These are most evidently strengthening community action, building healthy public policy, and developing personal skills. These three strategies contribute to creating supportive environments. Although this article does not explore the role of the health sector, this is undoubtedly of vital importance, and warrants further reflection.

Disaster Management in a Health Promotion Framework

Strengthening Community Action

Health promotion is committed to empowering communities through community action to identify their needs and priorities and to develop and implement strategies to improve their health (11). There has been a paradigm shift in disaster management discourse, away from military "command" and "control" approaches (12, 13) towards those which echo this ethos of empowerment and involve the community at all stages of the cycle. The above definition of a disaster reflects this in its emphasis on disruption to a community and the exceeding of a community's ability to cope. It follows that programmes designed to increase the capacity and resiliency of a community will lessen the impact of a disaster. To this effect, the second strategic goal of the HFA emphasises the development of "institutions, mechanisms, and capacities at all levels, in particular at the community level" (6) (p. 4).

[1] *According to the Centre for Research on the Epidemiology of Disasters, a disaster is recorded in the database when at least one of the following criteria is fulfilled: 10 or more people reported killed; 100 or more people reported affected; declaration of a state of emergency; call for international assistance (Guha-Sapir D, Vos F, Below R, with Ponserre S. Annual Disaster Statistical Review 2010: The numbers and trends. Brussels: CRED; 2011).*

This strategy is both a fundamental and logical component of disaster management. Communities are the first responders in a disaster and the primary stakeholders (14). Community involvement can contribute to the sustainability of a disaster management project (14, 15). In addition, a lack of community participation in disaster response may lead to a failure to meet needs, an unnecessary increase in external resources, and dissatisfaction with the response (14) (p. 3).

Community-Based Disaster Management (CBDM) is a model of intervention supported by the United Nations Centre for Regional Development and employed in many countries, particularly developing countries. In such projects, local communities evaluate their situations, are involved in creating and implementing plans to mitigate the impact of disasters, and are provided with more access to and control over resources to assist with disaster response (16). The effectiveness of projects embodying this model was evaluated in 2002 through a series of case studies in which information was collected from workshops conducted at selected sites (16). This research concluded favourably on the effectiveness of CBDM. For example, in Orissa, India, after the 1999 super-cyclone, the Orissa Disaster Management Project was created and included many community-based activities, such as village and block management plans, village disaster management committees and task forces, and training of volunteers to assist in the disaster response. As a result of the project's activities, in the floods of 2001 communities were able to act and organise more quickly (16).

This review also highlighted the effectiveness of another CBDM project, the Flood Proofing Project in Bangladesh. A separate participatory action research report of this project's pilot concluded similarly (17). An impact assessment was conducted in two of the participating villages following a typical season of monsoon flooding. Although no baseline data are provided, this report suggests that the villages experienced subsequent benefits of low diarrhoeal disease, access to clean water in households that had been raised from the ground, and no deaths. In addition, the participatory nature of the project gave people a voice and sustained the relevance of the project to the people's needs (17).

The principles of community-based disaster management can be applied in developed countries. Project Impact, created by the Federal Emergency Management Agency in the USA, focused on mitigation and was designed to involve individuals, communities, and businesses in determining the community's risk, setting priorities and allocating resources to achieve the overall goal of reducing the effects of a future disaster (18). In New Zealand, best practice guidelines for building community resilience, and examples of local initiatives, have been published and acknowledge the effectiveness of the highest level of community engagement - empowerment (19). The importance of Māori as a community stakeholder, particularly with regard to the relationship with the environment -kaitiakitanga - has also been recognised (10). Also, for the post-disaster recovery stage, Australia produces guidelines for ensuring community participation and community development (20).

Indeed, the HFA states that the stages of relief, rehabilitation, and reconstruction provide opportunities for the "rebuilding of livelihoods...and reconstruction of physical and socio-economic structures, in a way that will build community resilience and reduce vulnerability to future disaster risks" (6) (p. 5). This approach was demonstrated in Japan when it became evident that, three years after the 1995 earthquake in Kobe, urban infrastructure had been restored but people's livelihoods had not (21). The Kobe Action Plan, based on the People's Rehabilitation Plan, was subsequently formulated by the people of Kobe, based on their experiences and viewpoints. The plan outlined initiatives to achieve three goals identified by the community: unifying communities; supporting people's organisations to ensure they can continue to meet the needs of the community; and obtaining a sustainable civil society (22).

Challenges

There are many challenges to implementing a community based approach to disaster management. Using semi-structured interviews with community members and project participants, Allen (23) evaluated a community-based disaster preparedness initiative in the Philippines. Though participants expressed feelings of individual empowerment, the author notes the potential for such initiatives to be disempowering, particularly if they neglect local knowledge and context. Furthermore, community-based projects may become burdensome for the communities, particularly when their capacity is not enhanced with increases in resources or power (23). Another qualitative study of community involvement in post-disaster damage assessment in Fiji found that limited capacity of the government hindered its ability to facilitate community involvement (15). Finally, a report on a CBDM programme in Taiwan (24) noted low attendance. This may have been because those who had experienced major disasters were in adverse financial situations and could thus not afford the time to participate (24). In a similar vein, an evaluation of Project Impact initiatives, which used interviews, focus groups, and document analysis, revealed participants' concerns regarding the lack of representativeness of minority and vulnerable populations in the programme (25).

International experience in health promotion has shown that empowered communities are effective in determining their own health (26). Furthermore, empowerment has been shown to have important impacts on health and to be a "viable public health strategy" (27) (p. 14). Bearing in mind the limitations highlighted above, there is a strong rationale and body of evidence supporting community action as a core component of disaster management.

Building Healthy Public Policy

Healthy public policy exists when health is on the agenda of all sectors, and all sectors account for the impact of their activities on health (11). Just as health extends beyond health care, reducing the impact of disasters requires public policies in multiple arenas. The HFA outlines multiple social and economic development practices to augment resiliency. In the preparedness and mitigation stages, these include policies which foster the sustainable use and management of ecosystems and the environment. Policies which support the protection and strengthening of public facilities and physical infrastructure, such as schools, health care facilities, waterworks and power plants, communication and transportation networks, and culturally important lands and structures, are also important (6) (p.11). In recovery from a disaster, the HFA recommends the provision of social safety net mechanisms to assist those that are most vulnerable (low-income, elderly or disabled populations) and the establishment of financial risk sharing mechanisms (6). These recommendations are reflected in some aspects of New Zealand policy. Relevant legislation includes

[2] *Flood proofing is defined as "long-term non-structural or minor structural measures that can be taken by individuals, families or communities to mitigate the effects of floods" (17 p. 1) This project also included activities centred on community mobilisation and training, and small scale agricultural, forestation, and erosion control measures (16, 17).*

Continued on page IV

the Resource Management Act (1991), the Building Act (2004), the Civil Defence Emergency Act (2002), and the Earthquake Commission Act (1993) (9).

Healthy public policy also includes the formation of partnerships between agencies and inter-sectoral action, across levels in society. In the afore mentioned CBDM project in Taiwan, the first step involved forming partnerships between community leaders, experts in disasters, local government, academia, and emergency planners, including public health specialists (24). A further illustration of the need and effectiveness of inter-sectoral action, in the post-disaster stage, is the Jaffna District Health Promotion Network (JHPN) (28). This network was formed in Sri Lanka after the tsunami in 2004. The network eventually involved 33 agencies from multiple sectors including health, education, arts and culture, and development. Some, such as microfinance and income generation, had not previously worked under the auspices of health (28). Of note, the network used the Ottawa Charter to guide their actions in the recovery and rehabilitation stages. The JHPN therefore represents a multi-sector, multi-agency, post-disaster response, based on a health promotion framework, which addressed the underlying determinants of health and vulnerability (29). As the JHPN worked through participatory community development, this example also demonstrates how inter-sectoral action and public policy can support and strengthen community action. This relationship was noted at the 7th Global Conference on Health Promotion in Nairobi in which it was acknowledged that "community empowerment necessarily addresses the social, cultural, political and economic determinants that underpin health, and seeks to build partnerships with other sectors in finding solutions" (30).

Developing Personal Skills

Developing personal skills is a third strategy of disaster management represented by the provision of information and education. This may take the form of risk communication and crisis communication which are becoming integral parts of public health activities (31). The crisis and risk communication model (32) combines principles from both disciplines and demonstrates how this strategy may be used in all phases of a crisis. It is similarly applicable to the stages of disaster management.

Information provision in disaster management is necessary and anchored by the belief that the public has a right to know about risks and hazards (32) in order to make informed decisions regarding their wellbeing. Evidence for the effectiveness of such information provision, however, is mixed. New Zealand researchers Paton and Johnston warn against assuming that the provision of such information leads to preventative action (33). They illustrate this point by citing a study of a volcanic risk communication programme by Ballantyne et al 2000 (34). In this study, the provision of information resulted in 28% of respondents feeling less concerned about hazards, inferring that the local government (the information source) would be responsible for managing the hazard and their safety. Paton and Johnston state that this would "[reduce] the likelihood of their both attending to risk messages and adopting recommendations" (33)(p. 270). Similarly, a review of the literature on warning systems determined that there was "no conclusive evidence regarding whether or not a public education or information program actually makes a significant difference of increasing human response to warnings" (35) (p.121).

Evidence from Hurricane Katrina, however, demonstrates that the provision of information, and its quality, in an acute situation has important implications for those threatened by hazards. In a survey of New Orleans evacuees in Houston, Texas shelters, Brodie et al write that those who stated they had heard clear evacuation instructions were more likely to report that they had evacuated before the storm, than those who stated the instructions were not clear (36). Communication and information is therefore vital in disaster management. Differential effects of the provision of risk information, however, indicate a need for messages to be disseminated widely, and understandable and clear to all, accounting for different cultures, languages, and literacy levels in society. Ultimately, however, the effectiveness of the provision of information on vulnerability reduction is limited. Interviews with Katrina evacuees indicated that, in the context of being able to evacuate, many constraints existed on translating knowledge of risk into protective action. These included a lack of transport, lack of disposable income, and fear of losing jobs (37). Fundamental changes in economic and social policy which address these underlying determinants are therefore necessary to reduce the impact of disasters.

Challenges for New Zealand

Many challenges exist to the implementation of these strategies in New Zealand. As demonstrated above, addressing underlying vulnerability to disasters is crucial and requires action on its multiple social and economic determinants. With regards to health, prioritisation of these same determinants has failed to occur in New Zealand (38). Furthermore, the current economic and political climate represents a significant barrier to achieving this, due to underinvestment and lack of support for public health and health promotion.

A second challenge is to incorporate health promotion professionals and practice into disaster management. The process of this literature review highlighted that, despite disasters representing a major public health problem, and the parallels between disaster management and health promotion, there is limited literature on the intersection of these two disciplines. Their separation may be a barrier to research and effective action. Health promotion professionals have strong connections with multiple communities and can therefore contribute significantly to community-based disaster management programmes. With their skills, knowledge of communities, and commitment to equity, health promoters are well equipped to assist with community needs assessments and policy needs assessments, in all phases of disaster management. In addition, health promotion and communication literature, such as that concerning the use of the health belief model and social marketing theory, has contributed to crisis and risk communication practice (31). More collaboration between the two fields would therefore be greatly beneficial for research and practice.

A final and extremely important challenge in disaster management is that of ensuring equity. Hurricane Katrina demonstrated the inequity of the impact of disasters, having particularly affected African Americans and those with low-incomes (39). The causes of such disparities are multifactorial. A study of interviews with African Americans who did not evacuate before the storm (40) revealed not only limited financial resources as a factor, but also themes of perceived racism in transportation and evacuation. Participants also described historical examples of a lack of concern for poor and minority populations in New Orleans (40). A review of the disaster literature from the USA (41) demonstrated the inequity in vulnerability to disasters and also reported many findings of higher rates of mortality, morbidity, and injury in ethnic minorities

following a disaster. Recovery was also more difficult due to less insurance and savings, lower incomes, lower access to information, and higher unemployment (p. 164). Furthermore, this review found evidence of "cultural ignorance, ethnic insensitivity, racial isolation and racial bias in housing, information dissemination and relief assistance" (41) (p. 169).Jones's articulation of institutionalised racism as "differential access to the goods, services, and opportunities of society by race" (42) (p.1212)enables understanding of how inequity in vulnerability arises and is sustained.

Not only are there clearly inequitable differences in vulnerability to disasters, but disasters, like Hurricane Katrina, have the potential to increase existing disparities in health (43).This has important implications in New Zealand, particularly for Māori, Pacific Island peoples, and low-income populations. For example, a higher percentage of Māori, compared to non-Māori, live in areas of greater deprivation (44).In addition, Māori have markedly worse health outcomes than non-Māori (45). In disaster management programmes, New Zealand must therefore address the economic and social aspects of vulnerability while ensuring that current inequities are not augmented by a disaster. To do so, the Health Equity Assessment Tool (46) can be used to assess the impact of proposed programmes on current inequalities, particularly their impact on Māori. In addition, the TUHA-NZ framework (47) used in health promotion can be applied to assist programmes in reflecting and enacting the principles of the Treaty of Waitangi. These principles are compatible with those found in disaster management, particularly in regards to community involvement, the most common elements of which are "partnership, participation, empowerment and ownership by the local people" (14) (p. 2).

Conclusion

This literature review has demonstrated how a health promotion framework may be applied to the work of disaster management. In doing so, it has illustrated the contribution that health promotion strategies can make to increasing resiliency and reducing vulnerability, in order to minimise the impact of disasters on people and their health. Community action is fundamental to reducing this impact, but must be supported by healthy public policy, including inter-agency cooperation and multi-sector involvement, in order to comprehensively address all determinants of vulnerability. These strategies may be supplemented by those which develop personal skills, through education and the exchange of information about risk, to enable individuals to make decisions which safeguard their health and livelihood. Throughout disaster management, interventions must focus on equity in order to reduce current disparities and ensure that existing inequalities are not widened by disasters.

The synergy between disaster management and health promotion may be captured by recognising the contribution that health promoters can make to this field. In the context of the earthquakes in Christchurch, New Zealand is experiencing a window of opportunity to reflect on how it proceeds in future disaster management. This paper suggests that health promotion teams should incorporate disaster management into their future action plans. Furthermore, it suggests that public health services should ensure that health promoters become integral participants in both disaster management planning and response. In conclusion, a health promotion approach to disaster management would be instrumental and invaluable; the strategies outlined above can undoubtedly inform and assist New Zealand, in the current recovery and rehabilitation stage, in reducing the impact of future hazards and potential disasters.

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From the Editor

In 1985 the Ottawa Charter was adopted for health promotion. The charter has been instrumental in shaping and informing health promotion around the world, including New Zealand. To mark its 25th anniversary, here is a full text for your reflection.

Ottawa Charter for Health Promotion

First International Conference on Health Promotion

Ottawa, 21 November 1986 - WHO/HPR/HEP/95.1

The first International Conference on Health Promotion, meeting in Ottawa this 21st day of November 1986, hereby presents this CHARTER for action to achieve Health for All by the year 2000 and beyond. This conference was primarily a response to growing expectations for a new public health movement around the world. Discussions focused on the needs in industrialized countries, but took into account similar concerns in all other regions. It built on the progress made through the Declaration on Primary Health Care at Alma-Ata, the World Health Organization's Targets for Health for All document, and the recent debate at the World Health Assembly on intersectoral action for health.

Health Promotion

Health promotion is the process of enabling people to increase control over, and to improve, their health. To reach a state of complete physical, mental and social well-being, an individual or group must be able to identify and to realize aspirations, to satisfy needs, and to change or cope with the environment. Health is, therefore, seen as a resource for everyday life, not the objective of living. Health is a positive concept emphasizing social and personal resources, as well as physical capacities. Therefore, health promotion is not just the responsibility of the health sector, but goes beyond healthy life-styles to well-being.

Prerequisites for Health

The fundamental conditions and resources for health are:

peace,
shelter,
education,
food,
income,
a stable eco-system,
sustainable resources,
social justice, and equity.

Improvement in health requires a secure foundation in these basic prerequisites.

Advocate

Good health is a major resource for social, economic and personal development and an important dimension of quality of life. Political, economic, social, cultural, environmental, behavioural and biological factors can all favour health or be harmful to it. Health promotion action aims at making these conditions favourable through advocacy for health.

Enable

Health promotion focuses on achieving equity in health. Health promotion action aims at reducing differences in current health status and ensuring equal opportunities and resources to enable all people to achieve their fullest health potential. This includes a secure foundation in a supportive environment, access to information, life skills and opportunities for making healthy choices. People cannot achieve their fullest health potential unless they are able to take control of those things which determine their health. This must apply equally to women and men.

Mediate

The prerequisites and prospects for health cannot be ensured by the health sector alone. More importantly, health promotion demands coordinated action by all concerned: by governments, by health and other social and economic sectors, by nongovernmental and voluntary organization, by local authorities, by industry and by the media. People in all walks of life are involved as individuals, families and communities. Professional and social groups and health personnel have a major responsibility to mediate between differing interests in society for the pursuit of health

Health promotion strategies and programmes should be adapted to the local needs and possibilities of individual countries and regions to take into account differing social, cultural and economic systems.

Health Promotion Action Means:

Build Healthy Public Policy

Health promotion goes beyond health care. It puts health on the agenda of policy makers in all sectors and at all levels, directing them to be aware of the health consequences of their decisions and to accept their responsibilities for health.

Health promotion policy combines diverse but complementary approaches including legislation, fiscal measures, taxation and organizational change. It is coordinated action that leads to health, income and social policies that foster greater equity. Joint action contributes to ensuring safer and healthier goods and services, healthier public services, and cleaner, more enjoyable environments.

Health promotion policy requires the identification of obstacles to the adoption of healthy public policies in non-health sectors, and ways of removing them. The aim must be to make the healthier choice the easier choice for policy makers as well.

Create Supportive Environments

Our societies are complex and interrelated. Health cannot be separated from other goals. The inextricable links between people and their environment constitutes the basis for a socioecological approach to health. The overall guiding principle for the world, nations, regions and communities alike, is the need to encourage reciprocal maintenance - to take care of each other, our communities and our natural environment. The conservation of natural resources throughout the world should be emphasized as a global responsibility.

Changing patterns of life, work and leisure have a significant impact on health. Work and leisure should be a source of health for people. The way society organizes

work should help create a healthy society. Health promotion generates living and working conditions that are safe, stimulating, satisfying and enjoyable.

Systematic assessment of the health impact of a rapidly changing environment - particularly in areas of technology, work, energy production and urbanization - is essential and must be followed by action to ensure positive benefit to the health of the public. The protection of the natural and built environments and the conservation of natural resources must be addressed in any health promotion strategy.

Strengthen Community Actions

Health promotion works through concrete and effective community action in setting priorities, making decisions, planning strategies and implementing them to achieve better health. At the heart of this process is the empowerment of communities - their ownership and control of their own endeavours and destinies.

Community development draws on existing human and material resources in the community to enhance self-help and social support, and to develop flexible systems for strengthening public participation in and direction of health matters. This requires full and continuous access to information, learning opportunities for health, as well as funding support.

Develop Personal Skills

Health promotion supports personal and social development through providing information, education for health, and enhancing life skills. By so doing, it increases the options available to people to exercise more control over their own health and over their environments, and to make choices conducive to health.

Enabling people to learn, throughout life, to prepare themselves for all of its stages and to cope with chronic illness and injuries is essential. This has to be facilitated in school, home, work and community settings. Action is required through educational, professional, commercial and voluntary bodies, and within the institutions themselves.

Reorient Health Services

The responsibility for health promotion in health services is shared among individuals, community groups, health professionals, health service institutions and governments. They must work together towards a health care system which contributes to the pursuit of health.

The role of the health sector must move increasingly in a health promotion direction, beyond its responsibility for providing clinical and curative services. Health services need to embrace an expanded mandate which is sensitive and respects cultural needs. 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.

Moving into the Future

Health is created and lived by people within the settings of their everyday life; where they learn, work, play and love. Health is created by caring for oneself and others, by being able to take decisions and have control over one's life circumstances, and by ensuring that the society one lives in creates conditions that allow the attainment of health by all its members.

Caring, holism and ecology are essential issues in developing strategies for health promotion.

Therefore, those involved should take as a guiding principle that, in each phase of planning, implementation and evaluation of health promotion activities, women and men should become equal partners.

Commitment to Health Promotion

The participants in this Conference pledge: to move into the arena of healthy public policy, and to advocate a clear political commitment to health and equity in all sectors; to counteract the pressures towards harmful products, resource depletion, unhealthy living conditions and environments, and bad nutrition; and to focus attention on public health issues such as pollution, occupational hazards, housing and settlements; to respond to the health gap within and between societies, and to tackle the inequities in health produced by the rules and practices of these societies; to acknowledge people as the main health resource; to support and enable them to keep themselves, their families and friends healthy through financial and other means, and to accept the community as the essential voice in matters of its health, living conditions and well-being; to reorient health services and their resources towards the promotion of health; and to share power with other sectors, other disciplines and, most importantly, with people themselves; to recognize health and its maintenance as a major social investment and challenge; and to address the overall ecological issue of our ways of living.

The Conference urges all concerned to join them in their commitment to a strong public health alliance.

Call for International Action

The Conference calls on the World Health Organization and other international organizations to advocate the promotion of health in all appropriate forums and to support countries in setting up strategies and programmes for health promotion.

The Conference is firmly convinced that if people in all walks of life, nongovernmental and voluntary organizations, governments, the World Health Organization and all other bodies concerned join forces in introducing strategies for health promotion, in line with the moral and social values that form the basis of this CHARTER, Health For All by the year 2000 will become a reality.

*CHARTER ADOPTED AT AN INTERNATIONAL CONFERENCE ON HEALTH PROMOTION**

The move towards a new public health, November 17-21, 1986 Ottawa, Ontario, Canada

* Co-sponsored by the Canadian Public Health Association, Health and Welfare Canada, and the World Health Organization