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Globalization and Health Promotion
The Evidence Challenge

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"We no longer inhabit, if we ever did, a world of discrete national communities. [T]he very nature of everyday living – of work and money and beliefs, as well as of trade, communications and finance . . .connects us all in multiple ways with increasing intensity" (Held, 2004).

The *Ottawa Charter for Health Promotion* (World Health Organization, 1986) identified in shorthand many of the strategies and tasks in an emerging field and literally wrote its practice into being. Each subsequent international health promotion conference probed a different area of the *Charter's* defining *raisons d'être*. Each subsequent conference also involved an increasing number of health promotion workers, policy-makers and scholars from developing countries, internationalizing what had been seen as an elite field concerned primarily with changing unhealthy rich world lifestyles. There were several plausible reasons for this:

- The end of the epidemiological transition: poorer countries were adding chronic diseases associated with Western consumption patterns without diminishing their burden of infectious ills, and richer countries were experiencing costly skirmishes with new or re-emerging pandemics as microbes became 24 hours from anywhere.
- The rising importance of Asian countries within a global economy: the West could no longer give short shrift to the Rest.
- A growing consciousness of one planet, one people: From the moonwalk to Greenpeace to climate change, new technologies and new social movements were thrusting a new awareness of the slender threads of planetary survival upon all of those within media reach.
- And beneath it all, the lurking late millennial behemoth of "globalization," a contested and already weary term that describes the accelerating global integration of trade in goods and services, and financial flows unimpeded by national borders.

Unsurprisingly, one of the foci of the 2005 Bangkok gathering was globalization itself. As the *Bangkok Charter for Health Promotion* expressed: "Health promotion must become an integral part of domestic and foreign policy and international relations" (World Health Organization, 2005).

Doing so raises two fundamental questions about the nature of evidence as it pertains to globalization: First, what is the evidence for globalization's impacts on

health status, and how do we adjudicate it? Second, how do we measure the impacts of interventions aimed at a target as large as the planet and all its peoples?

It's About the Money

Before turning to these questions, let's consider the shibboleth itself: globalization. To some, it describes a function of technology, culture and economics leading to a compression of time (everything is faster), space (geographic boundaries begin to blur) and cognition (awareness of the world as a whole) (Lee, 2002). While undoubtedly true, these have been societal qualities for as long as there have been written records of societies. The recent and important qualitative shift lies in the intensity of these changes. Others have argued (convincingly) that "economic globalization has been the driving force behind the overall process" (Woodward et al., 2001), i.e., the source of globalization's recent intensification, bringing with it new challenges to health and its promotion. The major forms of economic globalization include:

1. The scale of cross-border private financial flows (most of it speculative) resulting from capital market liberalization. Daily currency trades dwarf the total foreign exchange reserves of all governments reducing their ability to stabilize their currencies when speculators decide to cash in their winnings. Each country experiencing a currency crisis (from Mexico and Thailand to Russia and Brazil) has seen increased poverty and inequality, and decreased health and social spending (O'Brien, 2002; Cobham, 2002), with women and children disproportionately bearing the burden (Gyebi et al., 2002).

2. The establishment of binding trade rules, primarily through the World Trade Organization (WTO). These trade rules limit the policy flexibilities of national governments in ways that could imperil public health (Labonte & Sanger, 2006b; Labonte & Sanger, 2006a). As the "Doha Development Round" of negotiations intended to benefit disproportionately developing countries continues to sputter to an inconclusive end due to rich world mercantilism, bilateral and regional agreements multiply in which the economic might of the wealthier countries invariably eclipses the nominal democracy that inheres in the WTO.

3. The reorganization of production across national borders. At least one third (and as much as two-thirds) of global trade is intra-firm between affiliated companies of transnational corporations (TNCs) (Gyebi et al., 2002; World Commission on the Social Dimensions of Globalization, 2004). The emergence of these global production or commodity chains allows TNCs to locate labour intensive operations in low-wage countries (often in exclusive export processing zones or EPZs, known for poor wages and working conditions), carry out research and development in countries with high levels of publicly funded education and public investment in research, and declare most of their profits in low-tax countries.

4. The crisis of climate change. For over 20 years health promotion has recognized the centrality, if not primacy, of the physical environment as a prerequisite

to health (Labonte, 1991a; Labonte, 1991b). Virtually all environmental markers show deterioration in our life support. Climate change is undoubtedly the most urgent global health issue and its linkage to global market integration is straightforward: Moving goods around the world consumes fossil fuel and exhausts greenhouse gases. In the UK, increases in trade-related shipping are now cited as the principle reason why that country will not meet its Kyoto commitment.

In crude summary, if we want to interrogate the evidence-base for how globalization is affecting health we need to follow the flows of finance capital, and how its creation and accumulation is affecting health risks.* In particular, we need to assess how the economic drivers of globalization are affecting equity in both health opportunities (the determinants of health, or what the *Ottawa Charter* called the "prerequisites to health") and health outcomes, and at different levels – from the household, to the community, the region, the nation. The evidence task is daunting.

First: Moving from International to Global

In apprising the evidence-base (essential with respect to knowing where and how to intervene) we first need to distinguish a *global* approach to health promotion from an *international* approach. Until recently, researchers, development agencies and non-governmental organizations (NGOs) mobilized around "international health:" the greater burden of disease faced by poorer groups in poorer countries. Actions on health remained, at best, a partnership between wealthier and poorer countries on diseases or health issues within the poorer partners' borders. International health as a practice paradigm is still important. If nothing else, there is a global obligation under various human rights treaties (e.g. Article 12 on the Right to Health in the International Covenant on Economic, Social and Cultural Rights) and development commitments (such as the Millennium Development Goals and their associated targets) for those countries with more financial and human capital to spend some of it on the problems of those with less. But a number of recent world events have changed the landscapes of what we once called "international relations" – and hence international health – irrevocably.

The first event was the 1970s recession in the industrialized world, compounded by the "oil crisis" and US monetary policies that dramatically increased interest rates. These events led many developing countries to default on international loans from rich world creditors that had been thrust upon them indiscriminately (perhaps even as a deliberate form of creating economic servitude) and as requisites to pay for the quadrupled price of oil imports. The "debt crisis," in turn, re-shaped the

* One small indication of this: In 2005, the net capital flow from developing to developed countries (based on [debt payments + profit repatriation] – [development assistance + foreign direct investment] came to over US$483 billion (UN DESA, 2006). This is a striking reversal of the early 1990s when developed countries managed to trickle a very small positive capital flow in the other direction. Today, world's poor are indirectly but no less perversely subsidizing the debt-fuelled excess consumption and lifestyle venality of the rich.

International Monetary Fund (IMF) and World Bank into watchdogs for developing countries to keep them on a policy track that would allow them to repay most of their debts and to open their markets for international investors. This policy track of "structural adjustment" embodied the neo-liberal economic orthodoxy and conservative politics of the wealthier countries that dominate decisions in both institutions: reductions in public spending, privatization of productive state assets, welfare minimalism, cost-recovery for remaining services and rapid liberalization of financial markets and lowering or elimination of tariffs (Schrecker & Labonte, 2006).

Other transformative events included:

- The fall of the Berlin Wall, which established the United States as the world's only superpower and created a normative vacuum for alternative models of development that could no longer experiment with "third way" blends of state centralism and market capitalism.
- The 1992 United Nations Conference on Environment and Development, which fostered a "global environmental consciousness" with special emphasis on the developing world's need for both economic growth and environmental protection.
- The diffusion of information and communications technologies (ICTs), which transformed the nature of global capitalism, while increasing the speed and scale with which civil society could analyze and mobilize responses to capitalism's more egregious abuses.

In this new landscape, a shift is needed in how health promotion is conceptualized, from an international concern with poorer countries' greater burden of disease to a more critical recognition that both the determinants and the consequences of this burden are inextricably linked to processes of globalization.

Second: Mapping the Linkages

How do we show these inextricable linkages? The pathways between globalization and health are neither short nor direct; as a health determinant, globalization represents perhaps the most distal causal element. In assembling the evidence base for its health impacts, a heuristic is needed against which the multiple arrays of research findings might be organized into defensible causal pathways.* Many such heuristics (or models) exist; I will use one that I developed not because it is best, but because it is the one I am most comfortable explicating.

This framework (Fig. 12.1) argues that globalization – simply defined as increased interdependence through accelerating global market integration – will have different

* It is important to note here that "causal" is not used here in the narrow sense of scientific certainty or statistical probability, but more in the legal sense of "burden of proof." As will be seen in the discussion of narrative syntheses that follows, conventional scientific notions of causality cannot apply when investigating such complex social phenomena as globalization.

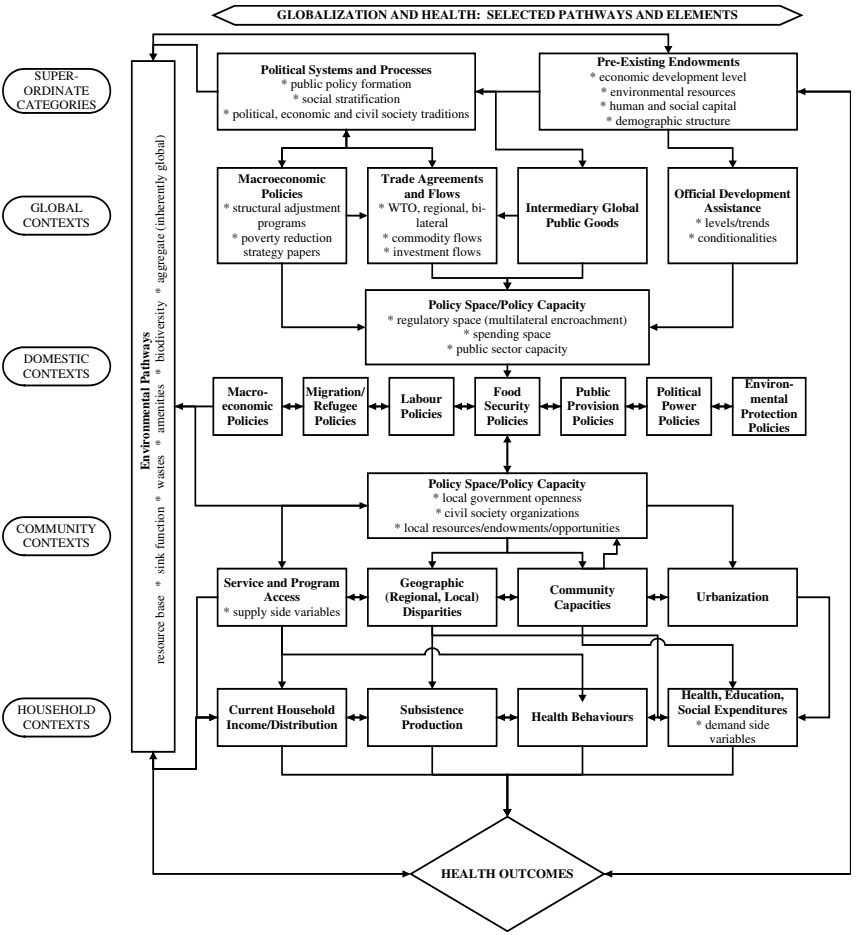

FIGURE 12.1. Globalization and health.

health effects depending on the political history and resource endowments of different countries or regions. The most obvious and important differences relate to existing stocks of capital – financial (wealth), human (educational and health levels), natural (resource base), social (an imprecise term that I will not try to shorthand). A small, landlocked African country facing critical health crises and with low population literacy rates and technologically unsophisticated industry will not adjust to the competitive pressures of open markets as well as a rich, economically advanced nation with well-developed social infrastructures. But even at similar development levels, political traditions play an important role. Post-tax/transfer child poverty is much less in the social democratic Nordic countries than in the market-liberal Anglo-American countries. HIV prevalence is much higher in Africa than other parts of the world and, within Africa, in some countries but not in others due at least partly to differing national policy choices.

But these policy choices (or "policy space" in the argot of international political economy) is increasingly constrained by what the framework describes as the "drivers" of global market integration: macroeconomic policies such as those embodied in structural adjustment programs and, more recently, poverty reduction strategy papers; free trade agreements and increased if usually inequitable flows in goods and services. These drivers have their countervailing global forces: those multilateral institutions – such as the UN agencies, but also the Global Fund and other Global Public Private Partnerships – that work to provide global public goods (disease research, surveillance, prevention programs, treatment); and development assistance as an inadequate and too often self-interested and patronizing system of global wealth redistribution.*

The causal and intervention questions of importance to health promotion work up and down the framework. One could start with a typically "international" health promotion question: What is the effectiveness of community health workers in improving maternal/child health? A typically sound approach to answering this question would be a pre-post study using a randomized, quasi-experimental or multiple case-study design where the number or skill-set of community health workers was the independent variable. (I will bracket the ethical questions of who conducts such research, and the evaluative complexity of creating testable logic models for *why* specific actions of community health workers would be health promoting. While important to health promoters, they are unimportant to the points I am raising in this chapter.)

The framework allows us to re-define this international question into a global one. Working down the globalization/health framework from the level of program intervention, one would also ask: How are resources for health controlled within the home? How do household education or income levels interact with community health workers in explaining differences in outcomes? Working up the framework, the questions would be: How equitably are community health workers distributed within and between rural and urban areas? Are policies for public provision of services adequate? Are there regional management structures in place to ensure service quality and continuity?

But working even further up – to the national and global levels – one would need to ask: What are the constraints on national government expenditures to ensure an adequate and equitable supply of community health workers? What role do international aid agencies or multilateral institutions play in worsening or lessening these constraints? How does the proliferation of "siloed" global health

* The Global Fund (to fight AIDS, Tuberculosis and Malaria) was established by the Group of 7 (G7) countries in 2001. Reliant on donations – almost all of which come from governments – the Fund has always struggled to secure enough resources to meet the competitive demand from developing countries. Regarding development assistance, only a few countries have ever reached the long-agreed target of 0.7% of their Gross National Income to aid; and much aid remains tied to the purchase of goods or services from the donor country. For a fuller discussion of these issues, see (Labonte et al., 2005; Labonte & Torgerson, 2005; Schrecker & Labonte, 2006).

programs affect the development of a more integrated and effective public provision system? What role do trade agreements play, particularly in employment conditions or income generation that might affect household resource levels? How does the "brain drain" of skilled health workers from poor to rich countries affect the supply of community health workers or, more importantly, the supply of nurses or physicians needed as more highly skilled back-ups? How does capital flight or the existence of offshore tax havens constrain expenditures, or promote corruption that, in turn, might ripple down the public and private systems of delivery? Each of these questions, in turn, begs an analysis that locates the answers within the historical and political contexts of a particular country, while incorporating findings from cross-country analyses that might determine whether elements of the key globalization "drivers" are primarily responsible, or more domestic factors afford the predominant explanation.*

Case Example: HIV in Zambia

Zambia is one of the southern African countries hard hit by the HIV/AIDS pandemic. Using the trope of a woman I will call Chileshe and key elements of the globalization/health framework, a different set of health promotion policy issues emerges than the more traditional (though still essential and often effective) interventions of prevention through education and treatment through antiretroviral treatment (ART) roll-out.

Chileshe, like tens of thousands other Zambian women, is waiting to die from AIDS. Prevention programs and expanded treatment campaigns are too little, too late. She acquired the disease from her now dead husband, who lost his job in a textile plant and moved to the capital, Lusaka, where he sold used clothing as a precarious street vendor. Alone and lonely, he traded money for sex with women desperate to support their own lives, and those of their children. And so the epidemic spread eventually reaching Chileshe.

What has Chileshe's plight to do with globalization? The answer lies principally with the macroeconomic policies imposed by the World Bank and the International Monetary Fund as conditions for new loans to help Zambia cope with its debt crisis. In 1992, Zambia was required to open its borders to textile imports, including cheap, second-hand clothing. Its domestic state-run clothing

* Much of the debate on globalization and health has been framed by cross-country regression analyses using various measures of economic globalization (e.g. inward and outward trade and financial flows, depth of liberalization), domestic performance (e.g. economic growth, "good governance") and health (e.g. average life expectancy). The problems with such studies are that the choice of variables and time frames can produce contradictory findings, the reliability of required data points for many countries is questionable and there is little attention paid to distributional equity within countries. The "stylized" findings of such studies may be useful as stimuli to discussion but are no substitute for detailed, country- or region-specific historical analyses.

manufacturers, inefficient in both technology and management by wealthier nation standards, could not compete, especially when the importers of second-hand clothing had the advantage of no production costs and no import duties. (Ironically, many of the second-hand clothes that flooded Zambia and other SSA countries began as donations to charities in Europe, the USA and Canada.) Within eight years, 132 of 140 clothing and textile mills closed operations and 30,000 jobs disappeared, which the World Bank later acknowledged as "unintended and regrettable consequences" of the adjustment process (Labonte et al., 2005).

For conventional economists, this is a textbook example of how and why trade liberalization works: Consumers get better and cheaper goods (at least for a while) and inefficient producers are driven out of business. However Chileshe's husband, and then Chileshe herself, paid a heavy price that cascaded throughout other sectors of Zambia's limited manufacturing base, with some 40 per cent of manufacturing jobs disappearing during the 1990s. Other facets of structural adjustment also played a role in Chileshe's HIV infection. Part of the standard adjustment package is privatization of state industries to raise short-term revenue to continue servicing overseas debts. This privatization robs a country of the ability for profitable state-run sectors to cross-subsidize social spending in such crucial areas as education and health. Liberalization of financial markets makes it easier, in turn, for foreign-owned firms to move their profit offshore and avoid having it taxed for public spending or re-invested for domestic growth within the country. This is precisely what happened in Zambia. As well, the assumption that growth would inevitably follow such shock treatment, leading to new forms of employment and taxation to replace the sources lost by unemployment and tariff revenues, proved theoretically sound but empirically false. The net result was a dramatic drop in the monies available to the state to invest in health or education. This was buttressed by other adjustment requirements – a decrease in public spending, a cut in public sector wages and the introduction of cost-recovery (user-fee) programs in health and other social services. All of this was imposed just at a time when the AIDS pandemic was starting to surge.

In varying degrees this story recurred throughout many southern Africa countries. While the economic outcomes of adjustment remain equivocal (some countries weathered the changes better than others), and the World Bank and IMF argue that things would likely have been worse without these changes, in Africa the economic outcomes were largely negative and, in the case of health impacts, singularly destructive (Breman & Shelton, 2001). In effect, African people not responsible for the debts that precipitated the adjustment process were required to sacrifice their health to ensure the debts would be repaid.

As evidence and global campaigning on the "death by debt" mounted, the Bank, IMF and their major shareholders – the wealthier industrialized countries – initiated the "Heavily Indebted Poor Countries" (HIPC) program of debt relief. This program did free up monies for investing in health and education, and requirements for cost-recovery were slowly dropped, but the discredited economic policies of structural adjustment still resided in the background of the newer and mandatory "poverty reduction strategy papers." One key element is the imposition

of public spending ceilings, based on two neo-liberal economic principles: public debt is bad, so public spending must be constrained; and inflation is bad, so increases in public spending must be slow and small. To qualify for debt-relief, Zambia agreed to keep its public salary spending below 8% of its GDP. A few years ago, Zambia increased its salaries for health workers and teachers to help stem their exodus to wealthier countries, and provided incentives to those working in grossly underserved rural areas. Combined with a drop in the price of its primary export commodity (copper) and increases in other sector spending, Zambia crossed the 8% threshold and was summarily dropped from the debt relief program. It then had to pay over US$300 million in debt servicing costs, money that did *not* go into HIV prevention programs or to rebuild and sustain its fragile public health system. A subsequent rebound in global copper prices and an agreement by a major donor country to pay directly the salaries of some of its teachers (thereby taking the costs off the government's books) allowed Zambia to re-qualify for debt relief a year later.

HIV/AIDS prevention programs, using the "best practice" lessons of health promotion past, have worked in slowing or decreasing the pandemic in countries like Zambia, but their expansion has not kept pace with the disease (UNAIDS, 2006). One key reason – despite such new Global Public Private Partnerships as the Global Fund – is a lack of funds, a problem partly embedded in the fiscal, lending, debt-recovery, trade and intellectual property policies of wealthier nations, and the economic prescriptions the international financial institutions that they dominate continue to impose of poor countries. Another key reason is that such prevention programs continue to be disease-specific and fail to rise to the health promotion future challenge posed by the recent (2005–2008) World Health Organization's Commission on the Social Determinants of Health: What good does it do to treat a disease and then send people back to the conditions that made them sick?

Back to the Evidence

Chileshe's story is what is now referred to as *evidence-informed* rather than the more narrowly construed concept of *evidence-based*. In areas of health promotion intervention where the causes and policy implications are complex and contested, evidence alone will never be sufficient or persuasive in itself. As most health promoters have long known, "healthy public policy" usually arises from the entwined efforts of those who provide as much evidence as possible and those who then lobby its importance. While evidence matters, policy battles are won as much through influence networks and individual testimonies as by the reasoned arguments of narrative syntheses or systematic reviews.

Chileshe's story, and the claims I have just made about structural adjustment and HIV/AIDS in Zambia, derive from a form of research synthesis that is important in evidence-gathering in global health research: narrative syntheses – referred to in comparative historical sociology as process tracing – in which

"hundreds of observations are marshaled to support deductive claims regarding linkages in a causal chain" (Goldstone, 2003, p. 49). Narrative syntheses incorporate several elements which, in Chileshe's case, include: (a) description of the national and international policy context; (b) country- or region-specific studies that describe changes in determinants of health, such as the level and composition of household income, labour market changes, access to education and health services; (c) evidence from clinical and epidemiological studies that relates to demonstrated or probable changes in health outcomes arising from those impacts; (d) ethnographic research, field observations, and other first-hand accounts of experience "on the ground." In assembling such evidence – aided by whatever globalization framework appears best suited to the need (health promotion research or evaluation) – it is necessary to recognize that rarely can conclusions be stated with the degree of confidence in findings that is possible in a laboratory situation or even in many epidemiological study designs, where almost all variables can be controlled. As Sir Michael Marmot, chair of the WHO's Commission on the Social Determinants of Health, expresses: "The further upstream we go in our search for causes," and globalization is the quintessential upstream variable, "the less applicable is the randomized controlled trial," and the greater the need to rely on "observational evidence and judgment in formulating policies to reduce inequalities in health" (Marmot, 2000).

An example that more formally applied the techniques of process tracing than my account of Chileshe is a recent study that identified the multi-step pathways that lead from globalization to increased vulnerability to HIV infection among women and children in sub-Saharan Africa (De Vogli & Birbeck, 2005). The researchers identified five manifestations of, or responses to, globalization at the national level: currency devaluations, privatization, financial and trade liberalization, implementation of user charges for health services and implementation of user charges for education. An array of existing research studies was assembled to interrogate each of these pathways. The first two pathways were found to operate by way of reducing women's access to basic needs, either because of rising prices or reduced opportunities for waged employment. The third operated by way of increasing migration to urban areas, which simultaneously may reduce women's access to basic needs and increase their exposure to risky consensual sex. The fourth pathway (health user fees) reduced both women's and youth's access to HIV-related services, and the fifth (education user fees) increased risk of exposure to risky consensual sex, commercial sex and sexual abuse by reducing access to education. The explanatory approach the researchers adopted complements recent systematic reviews of research on determinants of vulnerability not only to HIV/AIDS but also to tuberculosis and malaria. These reviews concluded that vulnerability to all three diseases is closely linked; that poverty, gender inequality, development policy and health sector reforms that involve user fees and reduced access to care are important determinants of vulnerability; and that "[c]omplicated interactions between these factors, many of which lie outside the health sector, make unravelling of their individual roles . . . difficult" (Bates et al., 2004, p. 268).

Health Promoting Globalization Interventions in Fact

To date, health promotion interventions into globalization as a health determinant have been limited. Any effort to establish the globalization/health promotion evidence and effectiveness link is premature and perhaps even misplaced. As with all complex phenomena, the ability to single out a particular intervention (or even sets of interventions) as probabilistically formative in changes to the economic practices of globalization is methodologically impossible. Within a normative frame of strategic assumptions, however, akin to economists' reasoned but no less idealized models for which they are annually awarded Nobel science prizes, it is possible to assess certain actions against certain links in the chain by which globalization affects health outcomes. Essentially this entails working one's way through the framework, piece by piece rather than as a whole. Here we can encounter some evidence of health promotion effectiveness, two examples of which follow.

The International Framework Convention on Tobacco Control

The International Framework Convention on Tobacco Control (FCTC) was adopted by the World Health Assembly in May 2003 and is considered the first international health treaty – or, in health promotion jargon, the first global healthy public policy. As of September 2006, 168 countries had signed the agreement and 139 had become states parties to it following ratification. The FCTC requires these countries to enact bans on tobacco advertising, marketing and promotion, implement warnings on packages and implement measures to protect exposure to second-hand smoke, and "encourages" them (in multilateral parlance, a term that conveys intent without obligation) to raise tobacco taxes and consider litigation to hold the tobacco industry liable for its wrongdoings. The FCTC is not as strong a treaty as health and civil society organizations (CSOs) wanted. Several of these CSOs participated in the negotiating forum that led to the FCTC, and continue to lobby for amendments and compliance as a "Framework Conventional Alliance." They are credited with maintaining pressure against the continuous efforts of countries such as Germany, Japan, and the US – each with large tobacco industries – to weaken substantially the health provisions. Japan, whose government is a key stakeholder in its tobacco industry, played a particularly obstructionist role and successfully watered down the FCTC wording in several key sections (Assunta & Chapman, 2006).*

* The study by Asunta and Chapman is a good model for evidence-informed analyses of how "soft power" plays out in multilateral health negotiations. The study identified the pro-tobacco position of Japanese governments and officials during the FCTC negotiating rounds, the increasing number of negotiators sent by Japan to the different sessions (they had the largest number at the final round), texts of Japanese positions taken over the course of the negotiations and the extent to which these were embodied in the final treaty.

The FCTC, while nonetheless a positive start in the global control of the pandemics of tobacco-related diseases, is further weakened by its potential clash with multilateral trade treaties. In 1994 the Canadian government proposed the adoption of generic ("plain") packaging for cigarettes. Tobacco companies responded that such a measure would violate their intellectual property rights, i.e., their trademarks, which are protected by the World Trade Organization and NAFTA (North American Free Trade Agreement) agreements on intellectual property. The Canadian government abandoned this proposal. In March 2002, Phillip Morris International indicated that it believes proposed Canadian regulations to prohibit use of the terms "mild" and "light" on tobacco packages would again violate several provisions of NAFTA and WTO agreements (BRIDGES, 2002). Because the FCTC failed to get the use of these descriptors explicitly banned as part of the Convention (i.e., the wording of Article 11 of the Convention states that misleading terms "may include" such words as "light" and "mild"), it is unclear if this would preclude a future trade challenge by bans on their use. This has particular bearing on the names of certain brands, likely to be considered intellectual property rights under various trade treaties, such as the Japanese brand, "Mild Seven" and the Chinese brand "Long Life." A number of countries and regions have entered voluntary agreements with tobacco firms to eliminate the use of such terms, including Canada, Australia, Brazil and the European Union, but it is unlikely these voluntary pacts would hold out against a trade dispute, should one eventually be launched. It also leaves moot what a potential dispute settlement on such a trade/health conflict might be, since efforts to state that the FCTC would prevail should conflicts with trade agreements arise also failed leaving unresolved any explicit claim to which agreement should be superordinate. Would the dispute be heard by a trade treaty panel? Or by a special panel of the FCTC? Finally, Fidler (2002) points out that "whether the framework-protocol [such as the FCTC] provides an adequate foundation for such international legal evolution is still open to question" (p.56). Apart from the decline in nations participating in or ratifying the more demanding protocols that follow adoption of the generally worded framework treaty (and on which there is little reported development under the FCTC), there are presently no enforcement measures for countries that fail to abide by the protocols or their dispute resolution decisions. Trade agreements, however, have enforcement mechanisms in the form of sanctions or direct financial penalties.*

Treatment Action Campaign

The example of the FCTC is not meant to dissuade health promotion from tackling globalization-related health problems. While encumbered with future uncertainties, the FCTC still provides a normative framework supported by almost 170 ratifying

* On a more positive note, the International Union for Health Promotion and Education continues to play a role in lobbying for global tobacco control, and its materials on draft tobacco legislation for consideration by states parties to the FCTC is linked on the Framework Alliance website (International Union for Health Promotion and Education, 2003).

nations, and offers a different venue for negotiation than trade fora alone. The FCTC also owes much to the health advocacy of professionals and civil society organizations. Evidence of the (partial) effectiveness of this advocacy resides in the simple existence of the Convention; and in most areas of public policy, especially that entailing multilateral negotiations, partial success is all that can reasonably be expected. The example also underscores the pre-eminence of mobilization and advocacy as the principal health promotion tools in tackling globalization-related health issues. A clear example of this within a national context is the South African Treatment Action Campaign (TAC). TAC first mobilized around HIV treatment access in 1998 and grew to have branches in all South African provinces and most major cities. While TAC is only one of several popular social movements that arose in post-apartheid South Africa, it is credited with being the first "to enjoy huge popular support" (Endresen & von Kotze, 2005). It is also credited with galvanizing opposition to the court challenge brought by multinational drug firms against the South African government's attempts to import cheaper versions of antiretroviral treatments (ARTs) (a challenge later dropped due to mobilized global outrage); and with prodding its own government to move away from HIV-denialism to a belated (though still inadequate) ART roll-out. TAC consistently framed its advocacy as:

- A matter of human rights (the right to health is part of the South African Constitution, and was used by TAC in a successful court case that forced the government to dispense mother-to-child HIV transmission treatment).
- Part of a larger struggle for redistribution of wealth and resources (many of TAC's member organizations are involved in labour unions, anti-poverty movements and groups seeking to prevent poor people being cut off from access to water or electricity).
- A member of the "anti-globalization" global movement.*

In 2005 TAC commissioned an extensive independent evaluation of its work (Boulle & Avafia, 2005). It recommended a number of strategies that, if acted upon, would see TAC shift from being a social movement with fluid organization and a campaign-driven focus to a bureaucratic civil society organization with specified projects and outputs. This type of transition in "grassroots" community health organizing is well known and documented in the health promotion literature (cf. (Labonte, 1998) for examples), along with the potential loss of advocacy edge it might bring. However, unlike many social movement groups in Africa, TAC has attracted significant external funding and operates with a multi-million dollar budget and over 40 full time staff (Friedman & Mottiar, 2005). Its attributed successes include the treatment court challenges in which it participated, the de-stigmatization of HIV in South Africa (and beyond), and becoming a model

* There is a rich irony in a global movement that naively adopted the media's dismissive moniker of "anti-globalization." In more recent years, this term has been eschewed in favour of the more accurate "anti-neoliberalism" or "just globalization" movement, focusing attention on what is ethically wrong and population unhealthy about much of the present form of globalization, rather than with globalization *per se*.

for other movements defending socio-economic rights and monitoring government accountability. On this last account, however, there is conflicting evidence from a non-commissioned scholarly study (Friedman & Mottiar, 2005). While both evaluation studies relied upon detailed document analysis and qualitative interviews, the latter added a theoretical analysis of new social movement theory. TAC's reluctance to engage actively in a critique of the neoliberal economic contexts accepted by South Africa's government, and its willingness to use legal challenges to win single issue campaigns, *de facto* legitimized what other activist groups perceived as an illegitimate political order.

Admittedly from a weak evidence base of two studies, there are three other globalization/health promotion lessons that the TAC case presents. First, it is easier to mobilize around single, simple issues than multiple, complex problems. Second, it is easier to win policy change on medically defined problems than on those residing in the social determinants of health. Third, despite the powerful vested interests represented by pharmaceutical multinationals (and their governments), moral and political challenges to one sector of neoliberal globalization does not question the basic structure or rules by which it works. The same lesson can be drawn from the quarter-century experience of, first national and now global, campaigns against tobacco. It also explains why the "just globalization" movement has tended in its health advocacy to attend more to issues of treatment access, privatization of health care services and insufficient health workers than, for example, the global financial architecture that allows an estimated US$8 to $11.5 trillion in corporate profits and wealthy individual assets to sit untaxed in offshore accounts (Tax Justice Network, 2005; Utting et al., 2000). A nominal tax on the interest-growth of the smaller sum alone would raise over $US250 billion annually for redistribution, roughly twice the value of total development assistance and debt cancellation.

Polyphony of Current and Future Possibilities

These are two of many possible examples of where and how health promotion can intervene in globalization as a health determinant. Others include:

- An increasing number of academic and CSO groupings that engage in detailed analyses of globalization and health, ranging from fairer forms of aid, trade and debt cancellation to "fair trade" alternatives, north/south program and development partnerships and the renewal of the WHO's "Health for All" primary health care ideal. The combination of critical policy analysis and social movement advocacy emanating from Canada in the late 1990s, as one example, is credited with stalling OECD talks on a controversial "Multilateral Agreement on Investments." Health arguments were central in this campaign.
- The emergence of global networks of health activists concerned specifically and explicitly with globalization. The Peoples' Health Movement, a global umbrella of these networks, is one example. Founded in 2000, the PHM has held two global assemblies (Bangladesh, 2000; Ecuador, 2004); participated in producing the world's first "alternative health report," *Global Health Watch 2004–2005*;

launched right to health campaigns in various parts of the world (notably India); and contributed extensively to the formation of the WHO's Commission on the Social Determinants of Health. Health promoters throughout the world are contributing to the PHM's work and participating in its many national campaigns aimed at changing both national and global health policies.

- The WHO itself is becoming more engaged with the globalization – health dynamic, with a unit wholly dedicated to offering national governments advice on trade, human rights and intellectual property agreements such that global health equity is not compromised. In many countries, academics, civil society and professional health organizations enjoin with health ministry officials in debating more openly the implications of global economic and trade policies on health in an endeavour to create what is euphemistically called "greater policy coherence," and what in fact means holding finance and treasury departments to task for more than simply keeping the GDP on an up and up.

Few of these initiatives, however, have been evaluated. The evidence of their impact remains moot and, in the case of the "another world is possible" globalization "movement of movements"(Mertes, 2004), it is difficult to provide narrowly causal evidence. But, as Immanuel Wallerstein has argued, there is convincing inferential evidence of impact "in getting some states – perhaps all – to inflect their policies in the direction of human rights" (Wallerstein, 2004); p.269).

Health Promoting Globalization Interventions in Theory

The absence of a firm evidence base is no reason to avoid new effort. Health promotion has never been simply about knowing what causes health inequities (health inequalities that are unfair and changeable), but what policies and programs might reduce them. If we accept that evidence of impact will always be pluralistic and argumentative, rather than definitively causal, the intervention challenge posed by globalization is less about proving what works than deciding, in the first instance, where to intervene. Here we might consider a few of the strategy areas from the *Charter*.

Under *develop personal skills* globalization substantially alters the nature of what skills health promoters might seek to develop – in themselves, in others. While "skills" under this strategy are often taken as behaviour change or coping, analytical skills related to globalization quickly surface as important and was cited as another of TAC's major successes (i.e. creating a cohort of globally critical health analysts/activists in South Africa). Health promoters themselves need to learn more from the work of development economists and economic historians. It is also well within a health promotion rubric that at least some in the field become adept at trade policy analysis. There are public workers, academics and civil society organisations in most countries with (increasingly developed) trade analysis skills, but few of these take a broader social determinants approach to the trade/health relationship, focusing instead on agreements extending intellectual property rights and their impacts on access to essential medicines. Yet on-going

trade negotiations on the lowering of industrial tariffs, or rules of government procurement (contracting out), or trade in services (and not just in health services) will have enormous health externalities that need to be understood, if not given precedence, by trade negotiators.

In *strengthening community action*, the first and most obvious challenge is defining what is meant by "community" under increasing globalization. Would we be seeking evidence, for example, of how health promotion work has strengthened global civil society networks and cross-national partnerships/alliances, in much the same way we now look to how our more locally-based programs have strengthened different facets of community capacity? This question does not imply that such alliances or networks *need* our support, at least in terms of analytical skill-strengthening; to presume so would in many instances be supreme acts of hubris. But they can often benefit by the financial or human resources and the health-specific legitimating networks that health promoters can bring to the globalization issue under scrutiny. A key health promotion research question here is the extent to which existing global health partnerships, such as the Global Fund and other global/international disease-based funding programs, integrate health promotion thinking within their disbursements and assessments. Evaluation studies of this question are only now commencing.

In related fashion, the call to *re-orient health systems* in the context of globalization raises a particularly critical question: To what extent have the past several decades of market-oriented and economic cost-effective approaches to health system reforms aided or hindered their ability to incorporate health promotion within their functions? We know one thing quite well about market-oriented health reforms: they tend to service those who can pay at the expense of those who cannot, and rely upon insufficient charity rather than cross-subsidized and risk-pooled entitlement to fill the equity gaps (Lister, 2005). (By one recent WHO estimate, as many people worldwide may be falling into medical poverty each year due to lack of insured coverage as are lifted from poverty by globalization's engines of economic growth.) We also know that the proliferation of disease-based aid or global funding programs often fracture what existing public health systems remain in many developing countries, with their differing requirements for reporting and program organization and staffing, and especially so in sub-Saharan Africa, which has suffered an enormous loss of its health workers to wealthier countries. We know less well the degree to which broader social determinants of health are considered within these programs, or empowerment/capacity-building goals that are now generally accepted as a "parallel track" in most health promotion programs (Labonte & Laverack, 2001a; Labonte & Laverack, 2001b). There is also a newfound global rush to increase the supply of health workers; the 2006 World Health Report estimates a present global deficit of over 1 million health workers in Africa alone (World Health Organization, 2006). But will efforts to close the gap privilege clinical workers (doctors, nurses) over community workers, health promoters, educators and the larger constellation of skills inherent in health promotion practice? For that matter, will the renewed call for comprehensive primary health care emanating from within and outside of the WHO default again

to disease-based primary health care, and then to the even narrower project of simply improving access to primary *medical* care?

Finally, to *build healthy public policy* in a globalizing world is both a large and almost totalizing task. There is little in the realm of contemporary globalization's economic drivers that does not have some impact on health outcomes. One challenge – now being taken up by the Globalization Knowledge Network of the World Health Organization's Commission on the Social Determinants of Health – is to assemble a rich evidence base that indicates priority areas for intervention, as well as evidence (where such exists) of policies that have limited globalization's negative health impacts while allowing its positive health gains to be equitably shared. The somewhat belaboured issue of what constitutes evidence permeates this particular health promotion strategy. Attribution of intervention to outcome in any area of public policy change is difficult, and the more so when the policy domain is multilateral. A specific and more easily adduced evidence issue is whether efforts to use public policy levers within a country to reduce unhealthy practices (e.g. in food consumption or tobacco use) need to show that they do not simply displace these practices to another part of the planet. (As Canadian governments continue to outdo each other in restrictive tobacco legislation, its domestic tobacco industry is allowed to join its trade missions to developing countries, notably China.)*

An Apocryphal Summation

Interestingly, globalization (at least its dominant economic form) and health promotion both came into public discourse and policy practice around the same time (the late 70s and early 80s). The former, of course, is a bit of a Goliath to the latter's David, and I am not at all sanguine on the prospect of health promotion finding a magic sling shot with which to slay the toxic elements of much of globalization's present trajectory. Nor do I think it should. Health promotion (and those who mobilize under its conceptual umbrella) is one small player amongst many others concerned with steering globalization towards a future-fairer. We can learn to play our role more effectively, but gauging that effectiveness (since this is a chapter on evidence) will never be easy or complete.

I close by returning to one of my opening qualifications of contemporary globalization: the crisis of climate change (to which might be appended the related crises of resource depletion). The apocryphal environmental tale is that of the Easter Islanders, whose ideological enslavement to a belief in the ancients led to the erection of huge stone monuments, whose movement required skids of timber which, as competition amongst the families for more and bigger monuments

* I will leave the health promotion strategy to *create supportive environments* for another time, partly for brevity and partly because I never understood its distinction from the others since such environments are created through community action, public policy or both.

accelerated, denuded the island of every last tree (Wright, 2004). No trees, no birds, no insects, no mammals, no fresh water, no food. And by the time the Europeans bumped into the island, almost no people. The tragedy is that they likely knew what would happen even as they cut the last tree. Just as we know what will likely happen as we continue to fish our oceans to extinction, eliminate our carbon sinks and biodiversity, contaminate our sources of fresh water, grow our supposedly healthy economies with a continued addiction to toxic fossil fuels, and blind ourselves to the consequences with an ideological enslavement to growth as the only marker of progress.

The challenges our global environmental crisis poses for health promoters are many, to say nothing of the social crises (mass migrations, resource conflicts) that are its unsettling wake. But the most disturbing implication may be that it forces us to confront the fundamental fallacy of our field: Promoting the physical and mental health of individuals whose well-being rests, in part, on economic and consumption practices that are today's equivalent of logging the last Easter Island tree is morally unacceptable and, from an intergenerational health vantage, indefensible. This is not simply a matter of evidence – effectiveness. It is fundamentally one of equity, ethics and survival.

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