



*HealthBridge works with partners world-wide  
to improve health and health equity through research, policy and action*

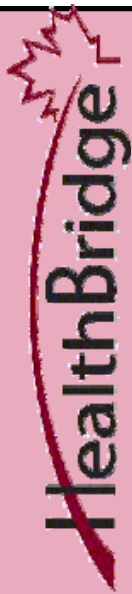
## **Annual Report 2010**



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## **Message from the Board Chair**

I am very pleased to introduce the annual report of HealthBridge. The report demonstrates the remarkable contributions of the staff and partners of HealthBridge to international health development.

In terms of development trends there is increasing attention being paid to non-communicable diseases (NCDs). NCDs are the leading cause of death globally; nearly 80% of NCD deaths occur in low- and middle-income countries. The NCD epidemic is thwarting poverty reduction efforts.

The UN General Assembly, the principal decision-making body of the UN that represents all UN member states, has just concluded its Summit on NCDs in order to bring global attention to these diseases and agree on a plan of action to address them. The Summit focused on the 'four most prominent non-communicable diseases, namely, cardiovascular diseases, cancers, chronic respiratory diseases and diabetes', and the 'common risk factors of tobacco use, alcohol abuse, unhealthy diet, physical inactivity and environmental carcinogens'.

The Summit is the biggest and best opportunity to put NCDs on the global agenda. It has the potential to secure commitment from Heads of Government for a coordinated global response to NCDs, substantially increase financial resources for NCDs, and save millions from premature death and debilitating health complications. It also has the potential to lead to measurable targets and commitments from governments to take action on NCDs, for which they can be monitored and held accountable through regular reporting. And HealthBridge is playing a role in defining this action plan.

Our very own Shoba John, Program Manager based in India, was Chair of a session at the Civil Society Hearings held in New York in June 2010, where civil society had an opportunity to highlight some of the key issues that should become part of the plan coming out of the Summit. Francis Thompson, Tobacco Control Advisor for HealthBridge, was a speaker on the floor, emphasizing the importance of taxation as a powerful tool not only for reducing consumption of less favourable substances, but also for raising much needed revenue to address NCD prevention. And Kristie Daniel, Program Manager for Livable Cities, stressed the importance of addressing the physical environment as a critical factor in enabling increased physical activity and improved nutrition for prevention of NCDs.

HealthBridge's Livable Cities program has been addressing NCDs since 2007 and has recently been increasing its efforts. The program aims to promote sound urban design to improve health, gender equity, the urban environment, and poverty reduction efforts. You can read more about HealthBridge's leading edge research in this Report.

The future continues to be bright for HealthBridge. On behalf of the Board I wish to recognise the outstanding work of the staff in Canada and the field.

**Dr. Frank Eady**  
Chair, HealthBridge Board of Directors



# Contributing Expert Advice on NCDs Prevention: *A spotlight on the ecocity*

URBAN DESIGN THAT MAKES IT EASIER FOR RESIDENTS TO BUY FRESH FRUITS AND VEGETABLES, and to do most of their daily travel by foot and bicycle, will lead to far healthier populations and lower rates of non-communicable diseases (NCDs).

But how are policymakers to learn the importance of sound urban design, how are planners to learn the methods, and how are those working for health to promote it?

HealthBridge is playing an important role in international dialogues on this issue, including preparing materials for meetings prior to the UN Summit on NCDs, providing input to guidelines for ecocities or livable cities being developed through international collaboration by Ecocity Builders, and in sharing lessons learned at the recent Ecocity World Summit in Montreal.

In Montreal, HealthBridge and its partners made presentations on the role of civil society in advocating for and saving public spaces. (Such public spaces are essential for exercise and socializing, and thus well-being.) We provided information about our successful efforts in Bangladesh, India, Nepal and Vietnam, and HealthBridge gave a talk on Ecocity Economics 101: How to Overcome the Economic Myths that Impede Progress towards



Ecocities. Finally, the HealthBridge Regional Director spoke at the Summit's final plenary on the future of ecocities.

While ecocities, or livable cities, still seems a visionary concept to many, the global obesity epidemic, high rates of NCDs, and related problems such as pollution, traffic deaths and climate change, all point to the need for a drastic rethinking of how to plan our cities. HealthBridge is at the forefront of the movement to ensure healthy urban design that will increase well-being in numerous ways.

## Helping to Build Healthy Cities in Asia

For the first time in human history there are more people living in cities than in rural areas; there are more adult deaths than child deaths; there are more overweight than underweight people in the world. In our increasingly urbanized world, non-communicable diseases (NCDs) have become the leading cause of death worldwide.

Nearly 80% of NCDs deaths occur in low- and middle-income countries. The NCDs epidemic is seriously thwarting poverty reduction efforts.

Unhealthy eating and physical inactivity, two of the four major NCD risk factors, are particularly related to community and societal factors that hinder people's access to healthy foods and the opportunity to engage in physical activity. How cities are built affects how we move and what we eat. Evidence is needed to inform national and local policies that will help prevent NCDs. HealthBridge is working with partners in Bangladesh, India, Nepal and Vietnam to build the evidence base for population-based strategies for policy interventions:

- In Bangladesh, a pedestrian analysis to understand the walking environment, including infrastructure policies and pedestrian attitudes;
- In India, the mapping and audit of a park, to inform on the availability and accessibility of parks, as well as a better understanding of this particular park's quality for children, especially girls;
- In Vietnam, a mapping of the nutrition environment focusing on supermarkets, markets and fruit and vegetable vendors;
- In Nepal, an assessment and comparison of the availability, price and quality of fruits and vegetables versus unhealthy food options; and a survey of the influence of food advertising on the urban poor.

## *NCDs at the United Nations*

The four main noncommunicable diseases — cardiovascular disease, cancer, chronic lung diseases and diabetes — kill three in five people worldwide, and cause great socio-economic harm within all countries, particularly developing nations.

The United Nations High-level Meeting on Non-communicable Disease Prevention and Control, 19-20 September 2011, presented a unique opportunity for the international community to take action against the epidemic, save millions of lives and enhance development initiatives.

Many in civil society feel that the Meeting fell short in significant ways. For example, it delayed setting targets for reducing salt intake and tobacco use until 2012. However, it did call for accelerated implementation of the global tobacco treaty, the FCTC.

See the Political Declaration here: [http://www.un.org/ga/search/view\\_doc.asp?symbol=A%2F66%2FL.1](http://www.un.org/ga/search/view_doc.asp?symbol=A%2F66%2FL.1)

# NCD RESEARCH: Examining the Nutrition Environment in Dhaka

AS PEOPLE TRANSITION FROM SUBSISTENCE TO URBAN LIVELIHOODS, those who in the past produced their own food are now almost completely reliant on purchased food. This has changed access and availability of healthy and unhealthy foods.

Unhealthy eating patterns are thus rising, particularly in low-resource settings and among marginalized women and children. This is leading to a double burden of under-nutrition and over-nutrition, resulting in several nutrition-related chronic diseases, including cardiovascular diseases, stroke and diabetes.

Recent research examines the role that the nutrition environment plays in encouraging healthy eating. This research identifies four types of nutrition environments that have been shown to have an impact on healthy eating:

- Community Food Environment - the distribution of food sources including the number, type, location, and accessibility of food.
- Consumer Food Environment - what consumers encounter within and around food outlets, including the availability and price of healthful food choices, and quality of food.

- Organizational Food Environments — the availability and price of food available in institutions such as schools and workplaces.
- Information Food Environments — the information that is available that describes a healthy diet.

Work for a Better Bangladesh (WBB) and HealthBridge will be conducting a nutrition environment study that will give us a better understanding of both the community and consumer food environments in Dhaka. We will compare two neighbourhoods of different socio-economic status to determine the accessibility and availability of fresh fruits and vegetables as well as the accessibility and availability of calorie-dense, nutrient-deficient foods.

This research is unique in that it will include mobile vendors, a group that up until now has received little attention in the nutrition environment research. By including mobile vendors we hope to get a complete picture of the food environment and the role that each distribution group plays in creating a healthy (or unhealthy) nutrition environment. This information will help us design appropriate interventions.



# Working with women to improve the family diet

**N**orth of Potosi in the Bolivian Andes is a harsh mountainous environment, with rates of poverty and malnutrition among the highest in the Americas. World Neighbors has been in Potosi for over 20 years, working with the people to improve their agricultural production and, more recently, their food security and nutrition status.

Through our research over the past few years we have learned that the key causes of malnutrition in the North of Potosi are related to: the low diversity of produce in the diet; the limited time a mother has to cook nutritious food; the general lack of recognition in mothers of the importance of providing nutritious food to their children, and limited family support. We are now following the principles — and using the tools of — Participatory Action Research (PAR), including participatory community video, which allows us to get closer to the people in the community and work together in bettering their lives.

The culture, particularly the women's culture, is largely oral and unwritten. So the use of drawings and a community-made video about health and nutrition has helped the women better understand nutrition and the importance of eating healthy meals. We are now working with the women of North of Potosi to integrate foods into their diet that are more nutritious than the common noodles and rice (which are easy but inadequate), with a focus on indigenous plants.

We have been successful in developing local appreciation for the value of the diversity of the indigenous crops, and reintegrating these into people's daily diets. The diets of the participating families now often contain wheat, barley, quinoa, rye, corn, fava beans, *tarwi* (lupin bean) and, of course, potatoes. The families are improving the local varieties of peach trees and prickly pear bushes, and saving native vegetables like *berro andino* (Andean watercress). We always take into account the seasonal availability of foods, and plan accordingly.

We work with the communities towards the goal of having everyone, including parents, children, grandparents and other members of the extended family, contribute to bettering the diet and sharing their wisdom about food and nutrition. We work to empower mothers so that they can better decide the best diet for the growth of their children. While much has been accomplished, there is still a great deal to be done, as we need to document the lessons we have learned and then scale up the intervention to reach the thousands of other malnourished families throughout Potosi and elsewhere in Bolivia.

**- By Yesmina Cruz, Nutritionist,  
World Neighbors, Bolivia**



**Cayetano of Chacoma films a 95-year-old-woman, Inocencia of Choque, describing the foods she ate as a child.**  
*Yesmina Cruz photo.*



**Andreas of Qayastia is filming a traditional method for preparing wheat for consumption.**  
*Yesmina Cruz photo.*

# Can tax save the world? (or at least public health)

**WANT PILES OF EXTRA CASH? WANT TO BE A PUBLIC HEALTH HERO? THEN HAVE WE GOT A DEAL FOR YOU...**

That was one of the key pitches to politicians by NGO advocates at the UN High-level Meeting on Non-Communicable Diseases in September: raise tobacco taxes and save millions of lives, while helping to balance your budget.

In the end, the advocates barely needed to try, because tobacco taxation is rapidly becoming part of the conventional wisdom in global health. WHO Director-General Dr. Margaret Chan talked it up in the opening plenary; New York Mayor Michael Bloomberg did the same in the closing plenary. Even *The Economist*, in its report on the NCD Summit (as the UN meeting was also known), called it “perhaps the single best way of curbing cancer and diseases of the heart and lungs, as well as raising money for health care”.

There is still a long way to go to translate this verbal support, offered in a health-centric forum, into action by finance ministries. Nevertheless, Russia and Brazil, to name just two prominent examples, are well on their way to substantial tobacco tax boosts next year.

The pragmatic argument for tobacco taxation is simple: of all the classic tobacco control interventions, tax is the only one that works, that affects all smokers (and potential smokers), and that you can keep doing over and over again. Banning tobacco advertising and requiring workplaces to be smokefree are both good ideas also, but if you do them right the first time, you can only do them once. Tax increases, in contrast, require repeat action (if only to keep up with rising prices and incomes).

For those who care about public health and development, there are two questions to consider. First, are tobacco taxes fair? Second, can tax be as effective to deal with other health problems?

On fairness, critics (including the tobacco industry) point out that in most countries, smoking and income are inversely related. So if tobacco taxes had no impact on behaviour, they would amount to a highly regressive tax paid primarily by the poor.

Fortunately, they do affect behaviour – and disproportionately the behaviour of the poor. On average, poor households are better off when tobacco taxes are raised. Not only are they more likely to get the health advantages of quitting smoking, they often re-direct tobacco spending to food, housing or education.

Can taxation be used to deal with the other main risk factors for NCDs – alcohol, bad diet and physical inactivity? The leap to higher alcohol taxes looks straightforward, although even there, we need to ask ourselves whether we are trying to discourage all consumption or merely “excessive” consumption.



To deal with physical inactivity, a key issue is urban design and transport. A global shift to North American levels of car dependency would imply a global shift to North American levels of obesity. Taxes on cars, on fuel, on parking space or on low-density housing could be powerful tools to encourage active transport (and slow down climate change). However, the social, economic and political fallout need careful analysis.

On diet, some countries have recently decided to impose special taxes on sugared drinks (e.g.

France), and there has been discussion of broader ‘junk food’ taxes. Again, the principle is appealing, but there are lots of potential devils lurking in the details, such as: what healthier alternatives do the urban poor have?

Be that as it may, there is an urgent need for those working on international health issues to pay closer attention to tax policy. Tax is a powerful tool to influence behaviour. It is too important to be left to finance ministries and economists.



**Tobacco activists handed out billion dollar bills at the NCD Summit to symbolise the money that governments are neglecting by not using tobacco taxes.**

## Q & A with Board Member Emeritus: Mr. David Sweanor



**How did you get interested in the issue of tobacco control?**

I was interested in many policy issues and naively thought that the harms caused by smoking were not only eminently solvable but that success could be achieved relatively quickly, giving an opportunity to move on to more complicated issues.

**Is there one success in your work to advance tobacco control that stands out from all the others?**

Focusing attention on the interaction between law, economics and public health was critically important. This included the use of tax policy in Canada and many other countries, a measure that has to date dwarfed all others in its ability to reduce the onset, continuation and frequency of cigarette smoking.

**How did you first get involved with HealthBridge? What has motivated you to continue to be involved?**

Effective international development efforts greatly interested me, and I had travelled in many developing countries. Former executive director Tim Stone shared my interest in doing global public health work on tobacco and I started working with the organization in Africa and Asia.

**What have you learned that you would like to share with organizations trying to make a difference in the world?**

I think organizations should 'aim high'; believe – because it really is true - that they actually can change the world. They need to be very pragmatic in pursuit of their goals and constantly re-evaluate their strategy and tactics in order to improve their effectiveness. It is far better to spend time thinking of ways to do better in light of changing political, scientific and economic realities than to spend time trying to defend past actions.

**You are now retired and busy as ever; please tell us about your current interests.**

I still do a lot of work on public health issues, albeit primarily on a pro bono basis, and I do my best to facilitate others working on a very broad range of topics. No longer having to focus on making a living, I focus on issues where I feel I can make a difference; to be the fool who can go into areas where sensible people fear to tread. It is, after all, through such actions that future policy breakthroughs will come. I also continue to enjoy family time, read extensively, travel widely, exercise madly and challenge myself constantly.

### An Intern's Story: Lisa MacDonald

*It is early morning in Hanoi, Vietnam, and already the streets are bustling with motorbikes, make-shift cafés and people selling vegetables, fruit, tofu, and just about anything you could imagine. Life happens on the streets in Hanoi. Before heading to the HealthBridge Vietnam office, I stop at the bakery to pick up some fresh bread and yogurt. I then ride to work "Vietnam-style" – via Xe Ôm (the motorbike taxi which literally translates as "Bike Hug"). Although riding with a Xe Ôm can be a hair-raising experience, it is much safer than attempting to cross the streets of Hanoi on foot!*

*After a busy morning working at HealthBridge, it is time for the best part of the day – lunch. The entire office closes for almost two hours as all staff gather around the table for lively discussions (in Vietnamese) and great food. After lunch, most of my colleagues take a short siesta. I wish I could bring this practice back to Canada!*

I interned with HealthBridge through CIDA's International Youth Internship Program. After working in a Public Health Unit for three years, I was ready to move my career in a different direction, and the internship position with HealthBridge seemed like the perfect opportunity. My six month internship was based in Hanoi at HealthBridge's Vietnam office. I was given a leadership role in seeking funding opportunities and writing proposals for HealthBridge's Gender, Reproductive Health and HIV, and Nutrition programs. The high level of involvement in the work I was doing, along with my friendly co-workers, made me feel like I was truly part of the HealthBridge team.

My internship experience was overwhelmingly positive, from both a personal and professional perspective. I formed meaningful friendships, experienced living and working in another culture first-hand, and gained knowledge and skills that will help me to pursue a career in international development. I was also fortunate to be offered a position as a Project Manger based at HealthBridge's Headquarters in Ottawa upon returning to Canada. I look forward to continuing to work with the HealthBridge team both in Ottawa and abroad!



# PAKUR MOTHER AND CHILD SURVIVAL PROJECT

India continues to bear the highest burden of maternal and infant mortality in the world, with a maternal mortality ratio (MMR) of 254 deaths per 100,000 live births.

Maternal and child health are particularly poor in rural areas, such as the district of Pakur in Jharkhand State. A 2007-8 survey found that only 17% of mothers in the district had at least three ante-natal checkups and just 10.8% of births occurred in institutions. A major factor contributing to poor access to maternal, newborn and child health (MNCH) services in Pakur is a gap between local people and the health system due to the remote and difficult geographical terrain, and poor knowledge of the need to access health services.



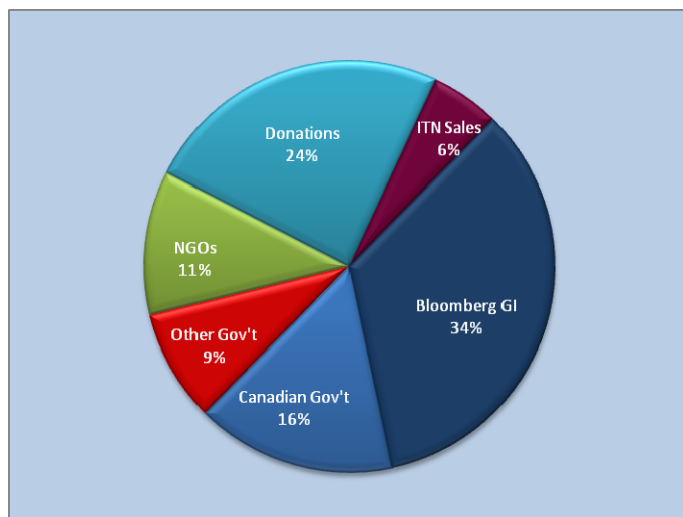
The Pakur Mother and Child Survival Project will work in collaboration with the local government to address both the supply and demand sides of the health system to improve access to MNCH services. It will be implemented with HealthBridge's local Indian partner, Evangelical Fellowship of India Commission on Relief (EFICOR), addressing the needs of about 700,000 people.

We invite you to support our efforts to reduce maternal, newborn and child morbidity and mortality in the district of Pakur, Jharkhand State. To make a donation please go to our website: [www.healthbridge.ca](http://www.healthbridge.ca). Every \$1 you give has the potential to be matched by a contribution of \$3 by the *Canadian International Development Agency (CIDA)*.

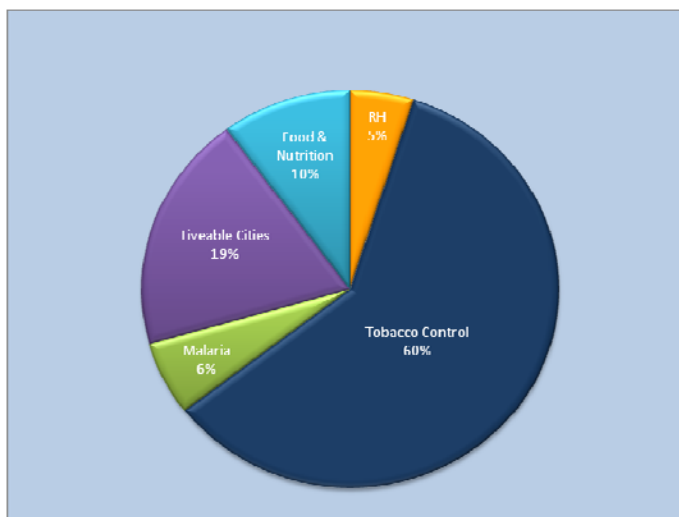
## 2010 Financial Summary

The financial summary below is an excerpt from HealthBridge's audited financial statements. For more information or for a copy of the audited financial statements please contact [admin@healthbridge.ca](mailto:admin@healthbridge.ca)

**Sources of Revenue**



**Use of Funds by Program Categories**



## Acknowledgements

- ◆ Thank you to the generous and committed **HealthBridge Board of Directors**, whose support behind the scenes is critical to our position in the world.
- ◆ The successes of the past year are the result of contributions from **HealthBridge staff** around the world. They are truly dedicated and tireless in their work.
- ◆ Thank you to our **partners**, without whom we would be unable to reach the people we aim to help.
- ◆ We are grateful for the financial contributions made by **individual donors** and the following **institutions**: Adam and Rachel Fund, Atlantic Philanthropies, Canadian International Development Agency (CIDA), Esperanza Trust, Health Canada, and International Development Research Centre (IDRC).