Geneva Health Forum

Rethinking Determinants of Health in Today's Global Context:

From Knowledge to Action

Roundtable

Tuesday 19 May 2026

Campus Biotech, Geneva

During the 79th World Health Assembly

IBFAN defending breastfeeding

heds Haute école de santé Genève

PREMIERE URGENCE INTERNATIONALE

emp'ACT initiatives solidaires et durables

UICC

UNIVERSITÉ DE GENÈVE FACULTY OF MEDICINE Geneva Centre of Humanitarian Studies

GENEVA GRADUATE INSTITUTE

GLOBAL HEALTH CENTRE

Climate Action Accelerator

GENEVA ENVIRONMENT NETWORK

GAHP GLOBAL ALLIANCE ON HEALTH AND POLLUTION

Introduction

The determinants of health have been at the heart of global health thinking for forty years. Since the adoption of the Ottawa Charter in 1986, the field has produced frameworks, evidence, tools, and case studies demonstrating what works. And yet the gap between that knowledge and its application remains wide. The question is no longer what should be done, it is why implementation fails, and what would it take to make it succeed.

Against this backdrop, the Geneva Health Forum convened a 3.5-hour working session on 19 May 2026 at Campus Biotech, Geneva, as part of the 79th World Health Assembly. The session brought together around 100 participants from across the global health landscape: practitioners, researchers, policymakers, and civil society representatives. It was designed to move from knowledge to action, to identify the enabling factors and barriers shaping action on the determinants of health, to surface practical levers for change, and to generate action-oriented messages capable of informing policy and practice.

Objectives

- Shared understanding of the key enabling and limiting factors shaping action on the determinants of health.
- Identification of practical, context-relevant levers to strengthen policy, practice, and cross-sector collaboration.
- Initial formulation of a small set of priority, action-oriented messages, including policy directions and concrete ways to strengthen collaboration across actors.
- Strengthened momentum, connections, and engagement for continued dialogue and collaboration, including concrete entry points for participants to carry forward within their own contexts and toward the GHF biennial conference in November 2026.

What the Session Produced

Four thematic roundtables on governance and political factors, social and cultural dynamics, environmental and structural conditions, and economic and commercial determinants worked independently and arrived at convergent conclusions. A plenary synthesis identified three cross-cutting patterns that emerged consistently across all four tables, followed by closing reflections from two global health leaders.

The discussion brought together the following participants:

- Laura Catalina Izquierdo Martinez, Physical Therapist, PhD candidate, Haute école de santé de Genève (HEdS-Genève) — session moderator.
- Ilona Kickbusch, Founder of the Global Health Centre, Graduate Institute Geneva.
- Sandra Ernesto, Project and Fundraising Manager, emp'ACT.
- Patti Rundall, Policy Director, IBFAN Global Advocacy.
- Zuzanna Tittenbrun, Global Resources Manager, Union for International Cancer Control (UICC).
- Anne Mahrer, Co-President, Aînées pour le climat.
- Jana Konstantinova, Professor in International Development, Geneva School of Diplomacy & International Relations.
- Sara Botero Mesa, Scientific Collaborator, Institute of Global Health.
- Nicole Valentine, Technical Officer, Determinants, Urban Health, Promotion and Behaviours Unit (DUB), Department of Health Determinants, Promotion and Prevention (DPP), WHO.
- Chantal Autotte Bouchard, Responsible of Public Health within Technical Services and Knowledge Management (STC) at Première Urgence.
- Diana Rizzolio, Director, Geneva Environment Network
- Alexandre Robert, Health Programme Manager, Climate Action Accelerator.
- Nadya Wells, Senior Research Adviser, Global Health Centre.
- Adela Beatriz Santos Domínguez, Postdoctoral Fellow, Global Health Centre (Geneva Graduate Institute); researcher on global health governance, legislative institutions, and domestic implementation of international health agreements.
- Maria Paola Lia, Executive Director at The Global Alliance on Health and Pollution (GAHP).
- Gauden Galea, Honorary Professor, University of Malta & Former Strategic Advisor on NCDs and Innovation, WHO/Europe.
- Faten Ben Abdelaziz, Head of the Enhanced Wellbeing Unit in the Department of Health Promotion at the World Health Organization (WHO).

Opening Remarks

Ilona Kickbusch

Founder of the Global Health Centre at the Graduate Institute of International and Development Studies

Ilona Kickbusch opened the session by situating the day's work within forty years of evolution in the determinants of health field. She began with a foundational reminder: only 30 to 40 percent of health outcomes are explained by healthcare itself, while 60 to 70 percent are shaped by social, economic, and environmental factors. The causes of ill health cannot be addressed through healthcare alone. Action on health means action on its determinants.

She traced the arc from the 1986 Ottawa Charter, which established the prerequisites for health and five action areas, through the WHO Commission on Social Determinants of Health, the 2011 Rio Declaration, and the SDGs, four decades of political and scientific development that have produced substantial knowledge without closing the implementation gap.

Her central conceptual argument was that the canonical Dahlgren-Whitehead rainbow, an ordered, nested and stable model, is no longer adequate. The foundations of health are themselves under systemic stress. Planetary boundaries have been transgressed. Determinants are dynamic, relational, and political, not fixed layers on a diagram. As she put it: *"the rainbow has served us well; now we need a new map."*

She named three emerging frontiers: commercial determinants — corporate practices as structural health risks, from ultra-processed food and tobacco to regulatory capture and lobbying, captured in the framing "from tobacco to TikTok"; digital determinants — algorithmic amplification of harmful content and data extraction as a form of extractivism of health capital; and planetary health — climate change as the greatest health threat, biodiversity loss, One Health, and environmental justice as health justice.

She closed by naming what she called the binding constraint precisely: political will, not evidence, is what is missing. Translating structural evidence into policy action, overcoming commercial and political resistance, and sustaining long-term population-level interventions remain hard, not because the knowledge does not exist, but because the political conditions for acting on it have not been created.

Experiences from the field

Four case study presentations grounded the discussion in concrete field realities, each illustrating how the determinants of health play out in practice, and what enabling conditions made action possible.

"Community-Based Management to Ensure the Human Right to Water and Address Environmental Determinants of Health"

Sandra Ernesto, *Project and Fundraising Manager, emp'ACT*

The case presented the experience of communities in rural Colombia who, after decades of armed conflict and natural resource exploitation, built and managed their own water supply systems, known as community aqueducts. This model of non-profit, community-led management emerged not from top-down design but from necessity and has endured in spite of, and in resistance to, a neoliberal framework that has long favored private interests over community needs.

The central message of the case was the power of organized civil society to navigate complex legal and institutional processes on its own terms. After decades of collective mobilization by community associations and the National Network of Community Aqueducts, a landmark law was adopted in late 2025 that formally recognizes communities and their

aqueducts as legitimate water managers and guarantees the right to community self-management. Civil society did not wait for the state to act. Instead, it built the evidence, the alliances, and the political case for a legal framework that protected what communities had already created.

The barriers remain real: economic pressures, extractive industries, privatization models, and climate change all continue to threaten equitable water access, and the effective implementation of the law requires continued support and accompaniment.

"Controlling the marketing of commercial formulas - a child's first UPF"

Patti Rundall, *Policy Director, IBFAN Global Advocacy*

The International Baby Food Action Network (IBFAN), founded in 1979, is a people's network of over 300 groups in more than 114 countries, one of the longest-surviving single-issue civil society organizations in the world. Patti Rundall presented its decades-long campaign to regulate the marketing of breastmilk substitutes, products she described as a child's first ultra-processed food.

The case began with a foundational insight: the baby food market was built not on the failure of breastfeeding but on manufactured doubt — doubt that women can breastfeed, cultivated deliberately through commercial channels including, from the earliest days, the clinics and health workers companies sponsored. This framing set up the central tension of the presentation: an industry that has consistently operated through health systems to shape behavior, and a civil society that has spent decades fighting to keep health policy free from that influence.

The 1981 International Code of Marketing of Breast-milk Substitutes, the first consumer protection tool of its kind, was the movement's landmark achievement, and it would never have happened without civil society outrage. Today, 148 countries have laws that incorporate the Code to some extent, covering 92 percent of global births. Countries substantially aligned with the Code show exclusive breastfeeding rates in the first six months more than twice as high as countries with no Code legislation.

And yet the industry continues to create new markets, deploy deceptive labelling, buy influence, and operate in emergencies in ways that undermine the Code. The key messages Rundall drew from this experience were direct: keep health policy planning, implementation, and monitoring free from commercial influence; recognize that partnerships with industry, which by definition are arrangements for shared governance, shared goals, and shared decision-making, carry implications that must be weighed carefully; and hold governments accountable as duty-bearers to protect the right to health, food, and dignity.

"Coalition building for tobacco taxation: experiences from Kenya and Uganda"

Zuzanna Tittenbrun, *Global Resources Manager, Union for International Cancer Control (UICC)*

The third case study presented the experience of UICC and Cancer Research UK in supporting civil society coalitions in Uganda and Kenya to advance tobacco taxation as a lever for reducing tobacco use and cancer burden. The program worked with a coalition-led approach, bringing together civil society organizations, government partners, revenue authorities, ministries, and parliament, with the objective of translating evidence into concrete policy change.

The approach produced tangible results: the Kenya Tobacco and Nicotine Tax Coalition achieved unified tax rates, while the Uganda Tobacco Tax Coalition succeeded in doubling taxes on imported cigarettes. What made these wins possible was a combination of factors: strong and unified coalitions capable of speaking with one coordinated voice; an evidence-based approach using modelling, data, and policy briefs; strategic engagement with government actors including revenue authorities; public mobilization through media, youth, and communities; and sustained capacity building in both technical and advocacy skills.

The barriers were equally instructive. Industry interference and misinformation were countered with evidence, media engagement and capacity building. Political and public resistance was addressed by shifting toward public awareness and youth engagement. Technical complexity and data gaps were met with training and modelling tools. Limited funding required continuous adaptation and prioritization.

The case illustrated a point that would resonate throughout the morning's roundtable discussions: civil society was instrumental, not as a passive beneficiary of policy change, but as the active force that built the political conditions for it. The victory on tobacco taxation in both countries was not a government gift; it was the result of organized, coordinated, evidence-based advocacy over time.

"Trop Chaud"

***Anne Mahrer**, Co-President, Swiss Senior Women for Climate Protection (Aînées pour le Climat)*

The fourth case study presented the eight-year legal journey of the Swiss Senior Women for Climate Protection**,** a group of older women who, in 2015, began a process that would ultimately result in a landmark ruling by the European Court of Human Rights. The case was dismissed three times by Swiss courts between 2017 and 2020, on grounds including that the plaintiffs had no special concern**,** since climate change affects everyone**,** and that the 1.5-degree threshold had not yet been breached. The group persisted and brought the case to Strasbourg, where a public hearing was held in March 2023.

On 9 April 2024, the Grand Chamber of the European Court of Human Rights ruled in their favor, establishing that Switzerland had violated the European Convention on Human Rights by failing to take adequate measures to address climate change. The verdict established a foundational principle: climate protection is a human right, and states have an obligation to protect their citizens from its adverse effects.

The political aftermath was immediate and significant. In June 2024, a parliamentary majority in both chambers of the Swiss Federal Assembly deemed that the Court had overstepped its mandate and asked the Federal Council not to implement the ruling, putting Switzerland in direct conflict with its international obligations. The Council of Europe's Committee of Ministers has since refused twice to close supervision proceedings against Switzerland, reminding it of its obligations to elaborate a carbon budget compatible with 1.5 degrees, to improve access to courts for climate-related questions, and to submit a compliance report.

The case illustrated a point directly relevant to the morning's discussions: organized civil society, even without institutional backing, even after repeated dismissals, even when facing a government unwilling to comply, can establish new legal terrain.

Roundtables

Following the field case studies, participants moved into four thematic roundtables, each facilitated by one moderator and a note-taker. The four tables ran simultaneously for approximately 80 minutes across two parts: a first phase focused on identifying key enabling and limiting factors, and a second phase on formulating actionable levers and messages. The outputs of each table were then brought back to a collective plenary synthesis.

Governance and Political Factors — "Shaping governance systems to accelerate action on health"

Moderated by:

***Jana Konstantinova**, Professor in International Development, Geneva School of Diplomacy & International Relations*
***Sara Botero Mesa**, Scientific Collaborator, Institute of Global Health, University of Geneva*

The table identified a persistent and underappreciated problem at the heart of why global health policies fail between conception and implementation: a neglected middle layer. While global institutions establish priorities and frontline communities bear the consequences, the local officials, district health teams, and hospital managers between them receive the least support and carry the heaviest implementation burden. This structural gap, between global mandates and local realities, was named as the central governance problem the session needed to address.

The discussion converged on the idea that effective governance must shift from top-down mandates to participatory, community-informed, locally empowered action. Key enabling factors named were: stronger local capacity, deeper community participation, better science-to-policy translation, and legal frameworks that support local implementation. Barriers included power imbalances that concentrate decision-making in the Global North, broken institutional silos across health, academia, policy, and the private sector, poor communication between levels of governance, and economic and political constraints driven by donor interests and political instability.

The action message the table produced was direct: health governance must move from top-down mandates to participatory, community-informed action, embedding genuine local ownership, accountability, and multi-directional decision-making at every level of the system.

Social and Cultural Factors — "Activating and strengthening community dynamics for health-promoting action"

Moderated by:

***Nicole Valentine,** Technical Officer, Equity and Health, Social Determinants of Health Department, World Health Organization*
***Chantal Autotte Bouchard,** Head of Technical Services and Knowledge Management (STC) at Première Urgence.*

The table organized its discussion around the conditions for social mobilization, what makes it possible, what prevents it, and what governance mechanisms would systematically support it. A clear consensus emerged: social mobilization does not happen spontaneously. It requires structured conditions such as time, platforms, shared purpose, and institutional permission, that most people most of the time do not have.

The primary enabling factor named was strengthening activism by creating structured opportunities for people to connect, mobilize, and act collectively, supported by a sense of personal agency and the belief that change is achievable. Community leaders and religious actors were named as trusted intermediaries and norm-shapers; education as a foundation for health literacy and long-term change.

The primary barrier was lack of stability: poverty, precarious living conditions, and unstable lives that leave no mental space to engage with health or well-being. Secondary barriers included the unregulated use of data by commercial agents and the violence and misinformation conveyed through social media, which create a toxic environment for building health-promoting norms. Health promotion's own tendency to defer to medical leadership rather than assert its own agenda was also named as an internal barrier.

The action messages the table produced were: Formulate advocacy for authorities in a way that holds them accountable and provides them tools to act, particularly through digital governance; lead and respond with empathy as a precondition for trust and lasting change; empower youth as agents of change, not just beneficiaries; and invest in small-scale, structured interventions at school level, such as nutrition programs, as entry points for building broader positive attitudes toward health overall. A specific structural recommendation was also added: support associations involved in social mobilization, help single-issue organizations to connect with each other, and create norms, including workplace norms, that give people dedicated time to participate in civic engagement on health determinants.

Environmental and Structural Factors — "Acting on environments to improve health"

Moderated by:

***Diana Rizzolio**, Director of the Geneva Environment Network.*
***Alexandre Robert**, Health Program Manager at Climate Action Accelerator.*

The table opened with three guiding questions: who are the key factors influencing action on health determinants and how do they interact; what enables or limits political and international action; and what governance levers and collaboration opportunities can strengthen action across these contexts.

The enabling factors the table converged on were: organized and persistent civil society using all available leverage, legal, scientific, and political, never giving up; independent science that produces evidence capable of informing policy; rights-based legal frameworks that give standing to affected communities; and a multi-sectoral, transdisciplinary approach that does not work in silos. The experience of the Aînées pour le Climat, presented earlier in the morning, was cited directly: the judges in Strasbourg listened to the scientists, even when politicians did not.

The key barrier named was for-profit lobbying and private-interest influence: political interference that systematically prioritizes short-term economic interests over long-term environmental and health ones, combined with short-termism in governance cycles incompatible with slow-moving environmental crises.

The action message was anchored in an existing recommendation from a WHO-mandated Pan-European Commission on Climate and Health, which had proposed declaring the climate crisis a global public health emergency. The table agreed that participants should encourage their respective governments to support this proposal, lobbying politicians, using media, and mobilizing civil society. The proposal was understood as a starting point that could later be extended to pollution and biodiversity loss. The broader principle was also named: once a public health emergency is declared, member states are obligated to act, creating accountability frameworks that go beyond voluntary commitments.

Economic and Commercial Factors — "Aligning and engaging economic actors to protect and improve health"

Moderated by:

***Nadya Wells**, Senior Research Adviser, Global Health Centre.*
***Adela Beatriz Santos Domínguez**, Postdoctoral Fellow, Global Health Centre - Geneva Graduate Institute; researcher on global health governance, legislative institutions, and domestic implementation of international health agreements.*

The discussion focused on how economic and commercial actors can either support or undermine health protection, depending on the governance mechanisms, incentives, legal safeguards, and accountability structures in place. Participants emphasized that commercial actors should not be treated as homogeneous; different sectors, products, and business models require different regulatory, fiscal, and engagement strategies.

The central structural insight of the table was captured through the metaphor that emerged during the discussion: civil society, public institutions, and communities are in a rowboat, while commercial actors are in a speedboat. Industry mobilizes faster, with greater financial resources, stronger legal capacity, and more strategic influence. This asymmetry is not merely financial, it is linguistic, institutional, and temporal. This framing named the core problem: not that commercial actors are morally deficient, but that the system's structure gives them systematic advantages over public-interest actors.

Enabling factors named included legal and governance structures that create predictable engagement rules with clear firewalls preventing commercial capture; fiscal and economic levers: taxes, incentives, and return-on-investment framing, that shift commercial behavior toward prevention and reduced harm; community-based and participatory governance as a necessary corrective from below; and strategic use of shared language across sectors, since public health actors, NGOs, governments, and industries do not currently speak the same language.

Key barriers were the asymmetry of speed, resources, and technical capacity between commercial actors and public-interest institutions; lobbying and private-interest influence over parliamentary and regulatory processes; implementation gaps, even politically supported health measures can fail when they reach the local or sectoral level without adequate capacity, enforcement, or communication; and fragmented public capacity, leaving health protection dependent on sectors beyond health that are rarely coordinated around a common goal.

The table's action message was that negative externalities generated by commercial and economic systems must be made visible, named, measured, communicated, and brought into every institutional conversation, whether in global health governance, national regulation, local implementation, or civil society advocacy. The final synthesis pointed toward a broader structural shift: from voluntary corporate responsibility to structured accountability, and from damage control to economic models that internalize negative externalities and reward prevention.

Plenary Synthesis

Maria Paola Lia

Executive Director, Global Alliance on Health and Pollution (GAHP).

Maria Paola Lia facilitated the plenary synthesis by inviting each roundtable's moderator to report back with one key message, one enabling factor, and one barrier, a constraint that forced each group to distil what mattered most rather than report everything.

What emerged across all four tables was a convergent diagnosis: political will is the binding constraint, not evidence or frameworks; commercial and private interests are the primary structural barrier; and governance systems oriented toward GDP and economic indicators cannot produce the health outcomes that frameworks oriented toward well-being, planetary health, and One Health require.

The session also produced one new framing, coined during Table 3's report and embraced by Maria Paola Lia as a genuine contribution of the day: "all policies for planetary health." Evolving beyond the established "Health in All Policies" approach, this formulation reorients the goal of governance itself toward the health of people and the planet.

She closed by framing the Geneva Health Forum as an enabling platform, a space for taking these collective messages forward toward the WHA, toward communities, and toward the organizations and alliances represented in the room

Closing Reflections

Faten Ben Abdelaziz

Head of the Enhanced Wellbeing Unit, Department of Health Promotion, World Health Organization

"The elephant in the room is economic models, because decision-makers are guided by economic growth objectives, and the language of return on investment is quite dangerous for public health."

Faten Ben Abdelaziz anchored her reflection in a question the morning's discussions had circled around without fully confronting: are we going to keep addressing risk factors and exposures doing business as usual, or are we going to talk about the elephant in the room? The elephant, she argued, is economic models. Decision-makers are guided by economic growth objectives and required to demonstrate return on investment and cost-benefit ratios. That language, she said, is dangerous for public health. If we are serious about addressing the root causes of ill health, we need to go more upstream.

She illustrated this with the metaphor of Sisyphus: every time the private sector faces a regulatory constraint, it produces a new product: e-cigarettes after cigarettes, new food formulations after reformulation requirements. Colleagues on tobacco control and nutrition have been fighting the same battle again and again. The boulder keeps rolling back because the economic model driving it remains untouched.

Drawing on her own work at WHO, she described how attempts to advance a well-being agenda required connecting across UN processes — at ILO, at OECD, and beyond — on measuring progress beyond GDP and building social and solidarity economies. When she attended those processes herself, she found no one from the health promotion or social determinants community present. That absence, she argued, is itself the problem: the conversation on economic models is happening without us.

Her call to the room was direct: this conversation cannot take place in isolation from the decisions being made at the WHA and at the UN. Health promotion professionals must get acquainted with these broader agendas, on well-being, on measuring progress beyond GDP, on eradicating poverty beyond growth, because those processes provide the mandate to hold governments accountable. New competencies are needed: the capacity to analyze the political economy of well-being, and a different style of lobbying and advocacy. As we mark the 40th anniversary of the Ottawa Charter, she asked, what kind of skills and competencies will be required to address these challenges?

Gauden Galea

Honorary Professor, University of Malta; Former Strategic Adviser on NCDs and Innovation, WHO/Europe

"Health promotion came in as a river, and it is now in its delta, with a large number of streams of action that have emerged, have some kinship, share values with the ideas of Ottawa, but have now developed their own identity. Unfortunately, some of them hate each other. We have both a richness in our spread of ideas and approaches to health promotion, but also a political risk that we are taking."

Gauden Galea framed his closing reflection around the central question the session was designed to answer: we have defined the determinants, described their impact, and expressed our aspirations, but what do we do next, concretely?

Reflecting on the arc from Ottawa to today, he traced forty years of evolution in the field using the food system as a case study: from early epidemiology and dietary risk factors, to the commercial and political critique of the food industry, to the current era where food is a matter of systems, climate, geopolitics, and planetary constraints. The same arc applies to every determinant. Yesterday's gap was evidence. Today's is power, governance, and delivery.

He named the information environment — platforms, algorithms, and business models — as a foundational new determinant of health, one that requires not just better messaging but active engagement with the governance of digital platforms and AI systems. On commercial determinants, his slides referenced WHO/Europe data showing the scale of

harm driven by tobacco, alcohol, ultra-processed food, and fossil fuels, and documented how industry uses a repeating playbook across sectors, lobbying, misleading evidence, policy delay, and legal pressure, to slow regulation and protect markets.

Drawing on all four case studies from the morning, he identified one common pattern: action meant that rules changed. That is the practical translation of "build healthy public policy." The question each participant should carry forward is: what rule do you want to change?

He traced how the streams that emerged from Ottawa — disease prevention, health literacy, planetary health, social determinants, health equity — have each grown into their own territory, sometimes with mutual contempt. That fragmentation is a political vulnerability at precisely the moment when a unified voice is most needed.

Four themes were named as the field's priorities going forward: making peace — trust, safety, participation, and freedom from fear — an operational part of the health promotion agenda; advancing the well-being agenda beyond narrow economic metrics; changing the rules around commercial determinants; and governing information environments — platforms, algorithms, AI — in the public interest. As he put it, the well-being agenda, commercial determinants, and information as a determinant had been "rammed down the room's throat the whole morning", the task now is to act on them.

The closing argument was distilled into six verbs: **Regulate** harmful products and exposures; **Protect** policy from interference; **Finance** prevention and community capacity; **Organize** coalitions that survive political cycles; **Govern** information systems as determinants of health; **Measure** implementation and well-being over time.

He closed with a personal mandate for everyone in the room: before November, identify one reform to advance, one alliance to strengthen, one harmful influence to expose, one community process to support, and one indicator to track.

A Shared Diagnosis

Three patterns emerged independently across all four roundtables, cutting across the different themes each table explored and pointing toward the same underlying diagnosis.

Political will is the binding constraint — not evidence. Every table confirmed this independently, without coordination. The frameworks exist. The evidence exists. The case studies proving action is possible already exist. What is missing is the political will and structural conditions to act on them. This is a harder problem than a technical one: it requires engaging with power and interests, not developing better evidence or cleaner frameworks.

Commercial interests are the primary structural barrier. Lobbying, for-profit influence, and structural resource asymmetry appeared in every table. The speedboat versus rowboat metaphor — coined at Table 4 — captured a structural truth: commercial actors mobilize faster, with more resources and greater strategic capacity than public-interest actors. This asymmetry is not a failure of public health advocacy; it is the structure of the system. Addressing it requires more than better communication — it requires changing the incentive structures that make harm profitable.

Fragmentation weakens collective power. Institutional silos, sectoral fragmentation within the health promotion field, and the absence of connections between single-issue campaigns all reduce the collective power available to those working toward compatible goals. As Gauden Galea observed in his closing, health promotion came in as a river and is now in its delta — a large number of streams that share values with the Ottawa Charter but have developed their own separate identities, and sometimes mutual contempt. The session itself — bringing together actors who rarely share a room — was an attempt to counter that fragmentation, if only for a morning.

Key Messages

The session did not produce new knowledge. It produced convergence: participants from across governments, international organizations, civil society, and academia arriving at the same conclusions from different starting points. That convergence is itself the message.

The evidence is not the problem. The knowledge to act on determinants of health has existed for decades. Frameworks, tools, and case studies are not missing. What is missing is the political will to apply them, and that is a harder problem, because it requires engaging with power rather than developing better evidence.

Commercial interests must be treated as a structural problem, not a communication challenge. The asymmetry between commercial actors and public-interest actors is structural. It will not be resolved by better messaging or more

persuasive advocacy alone. It requires fiscal tools, governance firewalls, and legal frameworks that change the incentive structures making harm profitable.

Fragmentation is a political vulnerability that must be addressed deliberately. The health promotion movement's fragmentation into single-issue campaigns with separate identities weakens its collective political capacity. Building connections between organizations working toward compatible goals — on climate, food, tobacco, digital health, social determinants — is not optional. It is a strategic necessity.

Going upstream means challenging economic models, not only their effects. Fiscal tools, regulations, and awareness campaigns address symptoms. As Faten Ben Abdelaziz argued in her closing, the engine generating those symptoms — economic models oriented toward GDP rather than well-being — remains largely unchallenged. Health promotion professionals need political economy literacy and active presence in the processes — at ILO, at OECD, and across the UN system — where economic models are being shaped.

Each of us has a verb. Gauden Galea distilled the morning into a six-verb personal agenda: to advocate for new regulations, to protect against conflicts of interest and interference, to finance sustainably, to organize communities and movements, to govern information systems as determinants of health, and to expose harms and generate public accountability. His closing invitation was direct: as you think about your next meeting, ask yourself: do you have one reform to advance, one alliance to strengthen, one harmful influence to expose, one community process to support, one indicator to track?

What's Next: Continuing the Process

Throughout 2026, the Geneva Health Forum is developing its guiding theme, Rethinking Cooperation in Global Health, through a series of strategic events designed to build intellectual and political continuity rather than produce isolated discussions. The May session is one step in that sequence. The outputs generated here are not endpoints; they are starting points for continued collective reflection and action.

The November 2026 GHF biennial conference will build directly on what the May session produced. Rather than starting the conversation again from scratch, November is designed to go further: bringing people with concrete field experience to test the May session's findings against practice, deepen the action-oriented messages produced by each roundtable, and generate specific commitments that participants can carry forward within their own organizations and contexts.

As part of the November conference, GHF has launched a call for field experiences on the determinants of health. Practitioners, researchers, cities, and civil society organizations are invited to submit a short abstract describing a concrete experience: what was done, in which context, and what it produced. Contributions addressing the health implications of environmental crises: climate change, pollution, and biodiversity loss, and experiences from cities and local authorities are particularly welcome. Further information is available at Geneva Health Forum : Together, let's build the health of tomorrow!

Annex

The following tables present the enabling factors, key barriers, and action messages produced by each roundtable during the session. They reflect the moderators' synthesis of each table's discussion.

Table 1 — Governance and Political Factors.

Enabling factors	Key barriers	Action messages
• Community engagement • Local ownership • Capacity building • Multisectoral collaboration • Effective leadership • Inclusive governance • Legal frameworks • Representation of diverse voices • Trust-building • Strong communication mechanisms	• Lack of trust in institutions • Weak communication channels • Institutional silos • Political volatility • Unequal power dynamics • Insufficient representation • Funding constraints and donor influence • Weak translation of evidence into policy • Limited connections between global and local actors	• Strengthen capacity-building initiatives for local health workforces • Increase community participation throughout policymaking processes • Improve communication between global institutions, national leaders, and frontline implementers • Develop mechanisms to better translate scientific evidence into policy and practice • Foster multisectoral and interdisciplinary collaboration • Increase representation of local communities and Global South perspectives in global governance structures • Strengthen legal frameworks that facilitate local implementation of global commitments • Promote governance models that emphasize ownership, accountability, and trust.

Table 2 — Social and Cultural Factors

Enabling factors	Key barriers	Action messages
• Strengthening activism — creating structured opportunities for people to connect, mobilize, and act collectively, supported by a sense of personal agency and the belief that change is achievable • Engaging community leaders and religious actors as trusted intermediaries and norm-shapers within their communities • Education — as a foundation for health literacy, critical thinking, and long-term behavioral change	• Poverty and life instability — no time to think about health or well-being • Commercial determinants not adequately regulated — little accountability for their impact on populations • Toxic communication environments — misinformation and health-related violence • Unhealthy social norms remain deeply embedded and largely unchallenged • Health promotion not at the center of interest	• Structure advocacy toward authorities, make them accountable — provide them with the tools to address it, particularly through digital governance mechanisms • Lead with empathy — a precondition for trust, engagement, and lasting behavioral change • Empower youth as agents of change, not just beneficiaries — as drivers of the transformation we seek • Invest in small-scale, structured interventions at school level — as entry points for building broader positive attitudes toward health • Support structurally the work of associations involved in social mobilization and help single-issue organizations to connect • Create norms in society for dedicating time to civil advocacy on health determinants, including workplace norms that give people dedicated time to participate.

Table 3 — Environmental and Structural Factors

Enabling factors	Key barriers	Action messages
• A holistic approach that addresses societal, health-related, and environmental dimensions together, with justice and equity treated as integral rather than secondary considerations • Efforts firmly grounded in scientific evidence • An organized civil society using transdisciplinary perspectives that bring together expertise from across sectors and fields • "All Policies for Planetary Health" as a guiding framework, ensuring health is factored into decisions made well beyond the health sector • Rights-based approaches supported by documented case studies, enabling the exchange of best practices and the analysis of co-benefits across policy areas	• A frequent gap in political commitment and will • Short-term and non-sustained perspectives — poor anticipation and a reactive rather than preventive response • Strong for-profit lobbying — primacy of economic interests over health and environmental ones • A gap in awareness about the knowledge available and in how it is conveyed and managed • Difficulty communicating complex, technical messages to the public, which can leave people with a false sense of security and a sense that they are not personally vulnerable	• Urge the WHA to declare the triple planetary crisis — climate change, pollution, and biodiversity loss — a Public Health Emergency of International Concern (PHEIC) • Establish accountability frameworks ensuring that all actors are transparent and held accountable for their actions and their inaction

Table 4 — Economic and Commercial Factors

Enabling factors	Key barriers	Action messages
• Legal and governance structures that create predictable engagement rules — legal certainty and transparent governance • Fiscal and economic levers that change commercial incentives — taxes, disincentives, incentives, and return-on-investment framing • Community-based and participatory governance — civic mobilization, health literacy, and local priorities • Strategic use of language and framing — co-creating clearer language understood by all actors involved	• Asymmetry of speed, resources, and technical capacity between commercial actors and public institutions, NGOs, or communities • Commercial lobbying hijacking regulatory processes • Implementation gaps at municipal, community, or sectoral level • Fragmented public capacity and weak accountability when health protection depends solely on health ministries • Digital environments harmful to youth	• Use differentiated legal, fiscal, and governance tools according to the type of commercial actor and harm involved • Actor: Governments and public institutions — through transparent engagement frameworks with clear rules on participation, conflict of interest, and decision-making authority • Build civic and community capacity to understand how commercial actors operate and to respond strategically • Actor: Civil society, communities, and public-interest coalitions — through community-based partnerships connected to national and global frameworks • Reframe economic and commercial determinants of health through the lens of prevention, well-being, and accountability • Actor: Governments, WHO, academia, and civil society — through shared language across sectors, supported by fiscal tools, health literacy, and participatory governance

The Geneva Health Forum is a non-profit initiative launched in 2006 by Geneva University Hospitals and the University of Geneva. It provides a neutral platform for dialogue and collaboration between public stakeholders, academia, civil society, and the private sector.

It collaborates with its partners to create synergies to address public health challenges.

Contact Geneva Health Forum:

contact@genevahealthforum.com

Layout: Geneva Health Forum

Copyright photos: Isaac Griberg - www.griberg.com