

Transitioning to the New Public Health Paradigm: Shaping the Future of Health Promotion Practice in Nepal—A Qualitative Analysis

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BACKGROUND

- **Early 20th Century:** Focused on sanitation, disease control, maternal-child health via vertical programs; reduced mortality but ignored social determinants and behavior.
- **1974 Lalonde Report:** Introduced "health field" concept, emphasizing prevention, lifestyle, and environment; criticized for overemphasizing individual responsibility.
- **1978 Alma-Ata Declaration:** Promoted "Health for All" via primary health care, equity, and community participation; vision narrowed to selective PHC; needs renewed commitment.
- **Opposing Systems:** Neoliberalism (user fees) and Soviet-style systems (corruption, abuse) challenged Alma-Ata, leaving legacies of inequality.
- **Six Public Health Paradigms:** (I) health protection, (II) sanitary movement, (III) contagion control, (IV) preventive medicine, (V) primary health care, (VI) new public health/health promotion.

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- **Ottawa Charter (1986):** Health as daily life resource, shaped by determinants; promotion enables people to increase control over well-being.
- The Ottawa Charter (1986) defines health promotion as "**the process of enabling people to increase control over, and to improve, their health**".
- It emphasizes that health is a positive concept—a resource for daily life, not just the objective of living—encompassing social, personal, and physical resources.
- Consistent with the WHO Ottawa Charter (1986), health is a resource for daily life shaped by multiple determinants, and its promotion involves enabling people to increase control over their well-being.

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- **Ottawa Charter (1986):** Reframed health as a daily living resource, emphasizing empowerment, healthy policy, and equity [6].
- **New Public Health Movement:** Integrated human rights, scientific evidence, and policy to improve well-being [7].
- **Healthy Cities Movement:** Supported these initiatives by promoting community empowerment and enabling environments for behavior change [8,9].
- **New Public Health Framework:** Balanced specific protection and health promotion by integrating science, politics, and ethics [10].
- **Tech advancement since early 2000s** rapidly changed global public health
- **Health Social Movements** pushed equity and challenged biomedical authority [11]
- **Community participation** still a challenge [6,12]
- **Digital platforms** enabled virtual participation and social learning [13]

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- **Health literacy** evolved into *Public Health Literacy* for population-level change (2016 Shanghai Declaration) [14-16]
- **Liberal systems** a challenge—lifestyle focus overlooks structural determinants; needs advocacy & political sensitivity [17,18]
- **New public health** advances SDGs & planetary health via advocacy, intersectoral policy, capacity building (IUHPE-led) [19]
- **Salutogenesis** frames health as resilience & coherence, not just no disease [20]
- **IUHPE 2025 Conference** reaffirmed equity, sustainability, indigenous knowledge for planetary health [21]
- **Nepal's health system** evolved from First Health Plan (1956) through PHC, democracy, federalization [23,24]
- **Triple burden of disease**—NCDs caused 71% of deaths in 2023—demands urgent new public health actions in Nepal [25]

Problem Statement

- Nepal's health system relies on traditional, curative models despite global mandates (Ottawa Charter, etc.).
- Federalized system is constrained by limited health promotion integration.
- Triple disease burden (communicable, NCDs, injuries) is exacerbated by inequities and poverty; NCDs cause >70% of deaths.
- Urgent need for systemic, evidence-based, community-centered interventions.

Rationale

- Applies New Public Health principles (empowerment, literacy, equity, collaboration) to Nepal's context.
- Aims to advance health equity, sustainability, and SDG goals.
- Addresses the gap in evidence on how professionals operationalize these principles.

Justification

- **Epidemiological Necessity:** Rising triple burden and NCD dominance require a shift from biomedical to prevention-oriented, equity-driven approaches.
- **Systemic Context:** Federalization creates a need for leadership grounded in intersectoral collaboration and community empowerment.
- **Knowledge Gap:** Limited understanding of how health professionals interpret and apply New Public Health in policy; this study fills that gap.
- **Policy Impact:** Provides evidence to enhance policy coherence, align Nepal with global standards, and build a resilient, equitable public health system.

Research Objectives

- **General objective:** to explore the current understanding, explaining and applying new public health practices by Nepalese health professionals in Nepal




































Specific Objectives

- To understand the current state of old and new public health concept among Nepalese health professionals
- To explore how health professionals interpret and explain the key principles of New Public Health among policy makers
- To examine the extent to which New Public Health practices are being applied by health professionals in current health policies and decision making process
- To identify facilitators and barriers influencing the adoption of New Public Health approaches within Nepal's health governance system
- To develop actionable recommendations for strengthening the integration of New public health principles in future health related policies.

Research Design & Methodology

- Qualitative research approach.
- Descriptive qualitative design.
- Phenomenological inquiry for lived experiences.
- Thematic and narrative analysis used.

Conceptual Framework

 Period / Framework	 Core Concept	 Key Focus Areas	 Contribution to Public Health
1974 – Lalonde Report (“Health Field Concept”)	Shift from biomedical model to determinants of health	 Lifestyle  Environment  Biology  Health care system	Expanded health beyond medical care; emphasized prevention & behavior change
1978 – Alma-Ata Declaration (PHC)	“Health for All” through Primary Health Care	 Equity  Community participation  Accessible services	Established equity & universal access as global priorities
1986 – Ottawa Charter (Health Promotion)	Health as a resource for daily life	 Social determinants  Empowerment  Social justice	Introduced health promotion actions and intersectoral approach
Health Promotion Action Areas	Strategic health promotion interventions	 Healthy public policy  Supportive environments  Community action  Personal skills  Reoriented health services	Provided practical framework for interventions
Health in All Policies (HiAP)	Integration of health across sectors	 Agriculture  Education  Transport  Urban planning	Promotes intersectoral governance for better population health
One Health Approach	Human–animal–environment linkage	 Animal health  Ecosystems  Human health	Strengthens disease prevention & global health security
Planetary Health	Health linked with ecological sustainability	 Climate change  Environmental degradation  Sustainability	Aligns public health with climate resilience & sustainability
Salutogenic Theory (Antonovsky)	Focus on health creation (not disease)	 Well-being  Sense of coherence  Resilience	Shifts focus to positive health & coping capacity
Empowerment Theory	People-centered decision making	 Participation  Community control  Voice	Encourages bottom-up governance & ownership

Operational Definition of New Public Health

- “The New Public Health (NPH) is a holistic, rights-based, and equity-focused public health paradigm that promotes individual and societal well-being by addressing biomedical, social, economic, environmental, and political determinants of health. Aligned with Primary Health Care and the Health for All vision, it emphasizes community participation, empowerment, and multisector governance through Health in All Policies and strong health systems. Grounded in the Ottawa Charter, NPH expands beyond individual behavior change to focus on supportive environments, health literacy—including digital literacy—and structural action on inequities. Integrating planetary health, One Health, and sustainability, it advances resilience, social justice, and collective action to improve public health outcomes across the life course.”

Key of Operational Definition

- **Broadened Scope:** Expanded focus from infectious diseases to include non-communicable diseases, lifestyle factors, and environmental risks.
- **Root Causes:** Addresses social determinants of health (e.g., socio-economic status, education, living conditions).
- **Empowerment:** Uses policy, education, and environmental changes (per the Ottawa Charter) to enable individual and community control over health.
- **Collaboration:** Emphasizes cross-sector partnerships (government, community, private sector) over sole reliance on medical interventions.
- **Evidence-Based:** Leverages data and epidemiology to tackle health inequalities.
- NPH is a holistic, equity-based approach.
- Addresses social, economic, and environmental determinants.
- Promotes participation, empowerment, and governance.
- Focuses on sustainability and resilience.

Data Collection Strategy

- Key Informant Interviews (KIIs) used.
- Face-to-face and online modes.
- Sample increased from 27 to 57.
- Expansion based on thematic saturation.

Study Population & Sites

- 57 participants from multiple levels (Federal, provincial and Local).
- Includes policymakers, academicians, practitioners.
- Five health professional groups included.
- Sites: MoHP, provinces, academic institutions and via Online - KII as well.

Sampling Method

- Purposive sampling technique.
- Participants selected based on expertise.
- Ensures relevant and rich data.

Data Collection Tools

- Semi-structured interview guides (English/Nepali).
- Audio recording and field notes.
- Reflexive journal maintained.
- Tools pre-tested before use.

Validity & Reliability

- Credibility: Member checking.
- Dependability: Audit trail.
- Transferability: Context description.
- Confirmability: Reflexivity and peer review.

Data Analysis

- Verbatim transcription and translation.
- Braun & Clarke thematic analysis.
- Coding and theme development.
- Findings supported by participant quotes.

RESULTS

Guided by “Rapid but Uneven Public Health Transition in Nepal”

Grounded on:

- Public Health Transition and Problem Framing
- Meaning and Operationalization of New Public Health (NPH)
- Policy Processes, Governance, and Federalization
- Implementation Realities: Enablers, Barriers, and Equity
- Emerging Issues and System Adaptation

Cross-Cutting Theme: Structural Weakness of Health Promotion

Rapid but Uneven Public Health Transition in Nepal



Shaped by a triple burden of disease (communicable, non-communicable, and emerging conditions) alongside climate change, urbanization, and socio-economic disparities.



While policy discourse reflects global shifts toward New Public Health (NPH), implementation remains fragmented, selective, and often reduced to traditional approaches.

Public Health Transition and Problem Framing

1. Shifting Disease Patterns

- Persistent communicable diseases and undernutrition in rural/remote areas
- Rapid rise of NCDs, mental health issues, and behavioral risks in urban areas.

2. Triple Burden and System Mismatch

- mismatch between policy recognition and implementation

Qualitative Insight: *“When we studied, public health meant communicable diseases, maternal health, family planning... now globally NCDs and lifestyle diseases dominate... but in Nepal both are happening together.”*

Meaning and Operationalization of New Public Health



Understanding of New Public Health (NPH)



varied widely, with many participants expressing limited or unclear conceptualization



Difference from Traditional Public Health



Participants emphasized that NPH requires system transformation, not incremental additions



Health Promotion vs Health Education

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- Understanding varied widely, with many participants expressing **limited or unclear conceptualization:**
- Qualitative Insight: *“Honestly, we don’t clearly know what New Public Health exactly means... we hear the term, but there is no proper orientation.” “For us, New Public Health means awareness programs, health education, maybe some multisectoral work... but not very clear.”*
- More informed participants described broader dimensions:
- Qualitative Insight “It should include social determinants, equity, environment, and intersectoral coordination... but practically, we are far from that.”

Difference from Traditional Public Health

- Participants emphasized that NPH requires **system transformation**, not incremental additions:
- Qualitative Insight: *“It is not about adding one more awareness program... it is about restructuring the system toward prevention and equity.”*
- **However, symbolic adoption was common:**
- Qualitative Insight: *“Terminology has changed... but practice is still traditional—vertical programs, curative focus.”*

Health Promotion vs Health Education

- **A strong distinction emerged:**
- Qualitative Insight: “ *Health promotion is more than education—it includes policy, environment, and empowerment... but in Nepal, it is mostly limited to IEC activities.*”“*Health education officers are doing awareness, but health promotion is not institutionalized anywhere.*”
- **Participants highlighted the absence of frameworks:**
- Qualitative Insight : “ *There is no clear national strategy for health promotion... without that, implementation is fragmented.*”

Policy Processes, Governance, and Federalization

Policy–Implementation Gap: disconnect between policy and practice

Federalisation: Opportunity and Fragmentation

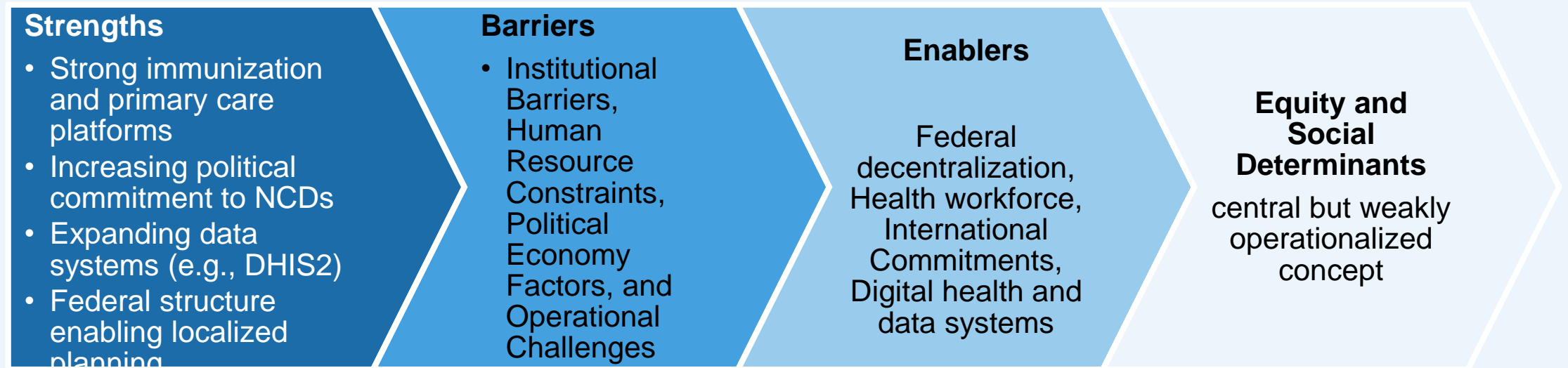
Opportunities: Local governments now have authority to design programs based on local need

Qualitative Insight: *"Local governments now have authority to design programs based on local needs... this is a big opportunity."*

Challenges: Unclear Roles, Weak Coordination, fragmented programs

- Qualitative Insight: *"Roles are still unclear... coordination between federal, provincial, and local levels is weak." ... "Programs are fragmented... staff from central level are redistributed without proper system restructuring."*

Implementation Realities: Enablers, Barriers, and Equity



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Strengths

Qualitative Insight:

- “Our immunization program shows that when there is clear structure and commitment, Nepal can achieve high coverage.”
- “We have a lot of data now... if properly used, it can guide planning.”
- “Local governments are closer to people... they understand community needs better.”

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Barriers

Qualitative Insight:

- **Institutional Barriers:** *“There is no dedicated structure for health promotion at any level.”* *“Health promotion is not clearly defined in policy frameworks.”* *“Till date, the National Health Promotion Strategy has not been passed; it has been roaming for the past three years. As a result, we still do not have a clear health promotion framework at the federal, provincial, and local levels.”*
- **Human Resource Constraints:** *“We don’t have trained personnel for health promotion... training is very short and not practical.”*
- **Political Economy Factors:** *“Political leaders focus on visible outputs... like buildings or ambulances... not long-term health promotion.”*
- **Operational Challenges:** *“Programs are fragmented... coordination is weak... duplication also happens.”*

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Enablers

- Participants highlighted key enabling factors:
- Federal decentralization
- Existing community health workforce (e.g., *peripheral health work forces nursing, paramedics*)
- International commitments (SDGs, NCD targets)
- Digital health and data systems

Qualitative Insight: *“If we properly mobilize peripheral health work forces nursing, paramedics, FCHVs and community structures, health promotion can be strengthened.” “Global commitments are pushing Nepal to think beyond curative care.”*

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- **Equity and Social Determinants (Expanded)**
- Qualitative Insight: Equity emerged as a **central but weakly operationalized concept**: ...*“Health services are not equally accessible, geography still determines health outcomes.”**“Poor people delay seeking care because of cost... even when services are available.”**“Health literacy is very low in rural areas... people don’t understand prevention.”**“Marginalized groups—Dalits, remote communities—are still left behind in practice.”*
- **Participants emphasized structural determinants:**
- Qualitative Insight: *“Without addressing poverty, education, and environment, health outcomes will not improve.”*

Emerging Issues and System Adaptation



1. Climate Change
2. Urbanization and Lifestyle
3. Digital and Behavioral Risks
4. Weak Intersectoral Action

Recommendations, Suggestions, and Way Forward

- Governance and System Strengthening
 - Evidence-Based Planning
 - Human Resource Development
 - Equity-Focused Approaches
 - System Reorientation
 - Anti-Corruption and Efficiency
 - Intersectoral Collaboration
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CONCLUSION

The findings suggest that Nepal's transition toward New Public Health is **Conceptually Recognized but Practically Limited**

Key Take Away:

Nepal stands at a **critical crossroads in its public health transition**. While the foundations for New Public Health exist, **system-wide reorientation is urgently needed** moving beyond awareness-based approaches toward **equity-driven, preventive, and intersectoral systems**

Photo and Bio



- Binod Kumar Aryal is an Assistant Professor of Public Health (Purbanchal University verified), with extensive experience in epidemiology, health promotion, and nutrition programs. He has contributed to national and international research and public health initiatives, with multiple peer-reviewed publications. His current work focuses on advancing New Public Health practices and evidence-based health systems in Nepal.

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