WHO is making a difference through health promotion

‘Never underestimate the power of individuals to change the world—indeed that is the only way it happens’
Margaret Mead

The World Health Organization’s 50th anniversary in 1998 was a watershed year for policies, programmes and people. Across its extensive portfolio, pioneering work was celebrated, new challenges were recognized, inspiring dreams launched, old friends thanked and new faces welcomed. This was also the experience of WHO’s health promotion programme.

‘We are slowly learning one of life’s most important lessons: not just how to live longer, but also how to stay longer in good health with less dependence on others.’ So commented the retiring Director General, Dr Hiroshi Nakajima, in the 1998 World Health Report (World Health Organization (WHO), 1998a). This document, the fourth in an excellent series, outlines the major developments and achievements in health in the past 50 years and describes the economic, population and social trends which will influence health into the 21st century. The report presents encouraging evidence about the impact of health promotion approaches. It is clear that when there is dynamic leadership, public participation and support, a clear sense of purpose and adequate resources, health status can be substantially improved.

Under the new leadership of Dr Gro Harlem Brundtland as WHO’s Director General, another exciting chapter in WHO’s history is about to unfold (Brundtland, 1998a, b). This novel era is one that needs to see health promotion both maturing and broadening as an essential approach for health gain. Drawing on her Norwegian experience as a physician for 30 years, a politician for 20 and a Prime Minister for 10, she confirmed in her opening addresses that societies can be changed and that poverty can be fought ‘My motivation will be this; making a difference—being able to make an effort—being one of many dedicated people working together for what we believe in. I envisage a world where solidarity binds the fortunate with those less favoured. Where our collective efforts will help roll back all the diseases of the poor. Where our collective efforts assure universal access to compassionate and competent health care. Bringing the world one step closer to that goal is our call for action.’

This new impetus comes at an opportune time as there have been widespread and justifiable calls for reform of WHO. For example the 1997 Conference on Intersectoral Action for Health (IAH) concluded that there was a need for a full scale change in the vision, policies, structure, approaches and activities of WHO to enable it to move from rhetoric to action on an IAH strategy (WHO, 1997a). In the same year formal consultation with non-governmental organizations on a new global health policy for the 21st century called for a number of new developments (WHO, 1997b). These included proposals for a Health For All value system, and the establishment of a global ‘health watch’ surveillance system modelled on Amnesty International’s work in human rights.

Despite the concerns, we can affirm with confidence that WHO is already ‘making a difference’ in health promotion development. Over a 15-year period a new health and social movement has been conceived, birthed and nurtured with far reaching effects (e.g. Catford, 1996; Gillies, 1998). The contributions of WHO’s health promotion programme delivered through its Geneva headquarters and regional offices are legion. For example, highlights over the last year include (O’Byrne, 1998):

- consensus on global health promotion established through the Fourth International Conference on Health Promotion, 21–25 July 1997, which resulted in the Jakarta Declaration (WHO, 1997c);
• global school health initiative strengthened through the establishment of three networks, as well as preparation of nine technical documents in an ‘Information series’ and support for several conferences;
• methodology and tools produced including a range of technical and research documents, glossary, bibliography and website (http://www.who.ch/hpr);
• global initiative for the most populous countries developed—the Mega Country Health Promotion Network involving 11 countries;
• development of partnerships for health promotion with the non-governmental and private sectors, together with the beginnings of a Global Health Promotion Alliance;
• Fifth Global Conference on Health Promotion planned for June 2000 in Mexico City, with a main goal of progressing the Global Alliance for Health Promotion.

Much credit for this truly pioneering work goes to Dr Ilona Kickbusch, one of the founders of Health Promotion International and Chair of the Editorial Board. She has been the key instigator of WHO’s approach to health promotion and has been extremely successful in placing it high on international, national and local health agendas. For example at an international level, the 51st World Health Assembly adopted the first global health promotion resolution and urged all member states to implement the five priorities set out in the Jakarta Declaration (WHO, 1998a). At a national level in the UK, the Royal College of Physicians used the Ottawa Charter as the platform for policy development concerning alcohol and smoking control (Royal College of Physicians, 1992, 1995). At operational levels the Ottawa Charter, and latterly the Jakarta Declaration, have also been used as the basis for planning by literally thousands of health projects across the world (e.g. Department of Human Services, 1998).

Until September 1998 Ilona Kickbusch was Director of the Division of Health Promotion, Education and Communication in Geneva and was previously in a similar position at WHO’s Regional Office for Europe in Copenhagen. She has since taken up an appointment as Professor of Public Health at Yale University, New Haven, USA, where she will be leading a major new initiative on international health. We should expect her to continue moving the agenda forwards in innovative and challenging ways (e.g. Kickbusch, 1997).

The transformation of WHO under Dr Brundtland has seen the creation of nine new clusters, each headed by an Executive Director. Leadership of the health promotion programme across the organization has been placed within the Social Change and Mental Health cluster, headed by Dr Yasuhiro Suzuki. A number of partnerships will be developed with other clusters, e.g. Non-Communicable Disease, Evidence and Information for Policy, and Sustainable Development and Healthy Environments. Together with the Director General, the Executive Directors form a ‘Cabinet’. In addition to providing top level policy development and management, the Cabinet also sponsors a number of new strategic endeavours. One of these is the Tobacco-Free Initiative which is led by an impressive team comprising Professor Judith Mackay as Chair of the Policy Committee, Professor Richard Peto as Chair of the Scientific Advisory Committee, and Dr Derek Yach as Project Manager.

One of the great attractions of health promotion to the re-energized WHO is that it is strong on process but silent on specifics. This is not a deficiency but a strength because as a proven ‘technology’ it can be applied to new or existing issues in novel and creative ways. The themes that a health promotion perspective brings includes:

• person focused—with a strong consumer/citizen orientation;
• holistic health—incorporating mental and spiritual aspects;
• values dominant—particularly regarding health disparities;
• determinants based—with a socio-ecological perspective;
• social capital—with emphasis on partnerships, alliances;
• reaching out—by engaging, connecting, and horizontal networking;
• cutting edge—through, innovation, risk taking, boundary riding;
• capacity building—with communities, organizations, workers.

WHO’s Tobacco Free Initiative provides an excellent opportunity for health promotion’s values, principles and strategies to be put into practice. Already the progress is encouraging. For example regarding healthy public policy, an International Framework Convention (IFC) for Tobacco is being prepared. This is a form of treaty which is an international instrument between
States and international organizations, governed by international law. Recent examples include the Ottawa Treaty for the banning of anti-personnel mines, and the Vienna Convention for the protection of the Ozone Layer.

Dr Brundtland’s personal commitment to this task is highly commendable ‘Tobacco control cannot succeed solely through the efforts of individual governments, national NGOs and media advocates. We need an international response to an international problem’ (Brundtland, 1998c).

The IFC should have an important function in complementing country level action for tobacco control as it will cover key aspects that cross national boundaries. These include harmonization of taxes on tobacco products, smuggling, tax-free tobacco products, advertising and sponsorship, international trade, package design and labelling, and agricultural diversification. The IFC could have considerable impact in motivating national leaders to rethink priorities, and hopefully also to direct more resources to tobacco control.

Work to progress the IFC includes technical consultation with public health experts, country by country political mapping of support, and a 2-year cycle of international legal development. The timetable allows for the establishment of national IFC commissions to support an intergovernmental negotiation process. The target date for adoption of the Convention is the World Health Assembly in May 2003. During this work-up period WHO’s Tobacco Free Initiative will pursue several aspects of the Convention, and will provide technical support to strengthen capacity at country level.

As the year 2000 approaches we will be thinking of our rites of passage as we pass from one millennium to another. This will be symbolized in Australia when the Olympic torch will be passed from one hand to another across the country en route to Sydney. For WHO one of the gifts from the old to the new administration is the renewal of Health For All (WHO, 1998c). This ‘torch’ has been painstakingly developed over a 2-year period through extensive consultation and numerous rewrites.

Ten global health targets for the 21st century have been crafted, which reflect earlier HFA targets and are in line with those agreed at world conferences. The goals are to achieve an increase in life expectancy and in the quality of life for all; to improve equity in health between and within countries; and to ensure access for all to sustainable health systems and services. Targets are defined to spur action and to set priorities for resource allocation. Health promotion is writ large throughout the document and Target 6 specifically addresses lifestyle issues: ‘By 2020, all countries will have introduced, and be actively managing and monitoring, strategies that strengthen health-enhancing lifestyles and weaken health-damaging ones, through a combination of regulatory, economic, educational, organizational and community-based programmes’.

This torch needs to be carried forwards confidently by the new WHO team—to light the paths ahead and to start fires which will warm the hearts and minds of the new millennium. As a previous WHO Director General, Dr Halfdan Mahler, remarked, when commenting on the Jakarta Declaration: ‘Health is politics and politics is health on a large scale. If you want to move healthy public policies forward in a big manner, then you have to have the political dynamite that is necessary’ (WHO, 1998d). The achievements of the past in health promotion are owed an even greater commitment in the future. As WHO moves into its second half-century, with optimism we can say that such commitment does exist within our international health organization. This journal—with a new image developed from the Jakarta logo—is also eager to make a difference. Health Promotion International will continue to work in partnership with WHO to keep the flame vigorous and true.

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REFERENCES

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