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## A STRATEGY FOR HEALTH PROMOTION<sup>a</sup>

A description of the Health Promotion programme  
at the Regional Office for Europe,  
World Health Organization, Copenhagen

<sup>a</sup> Text prepared by Ilona Kickbusch, based on a paper written by Ron Draper for the Symposium on Community Participation and Empowerment Strategies in Health Promotion, 5-9 June 1989, Bielefeld, Federal Republic of Germany.

1990

EUR/HFA target 13

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Text edited by David Breuer

### TARGET 13

#### Healthy public policy

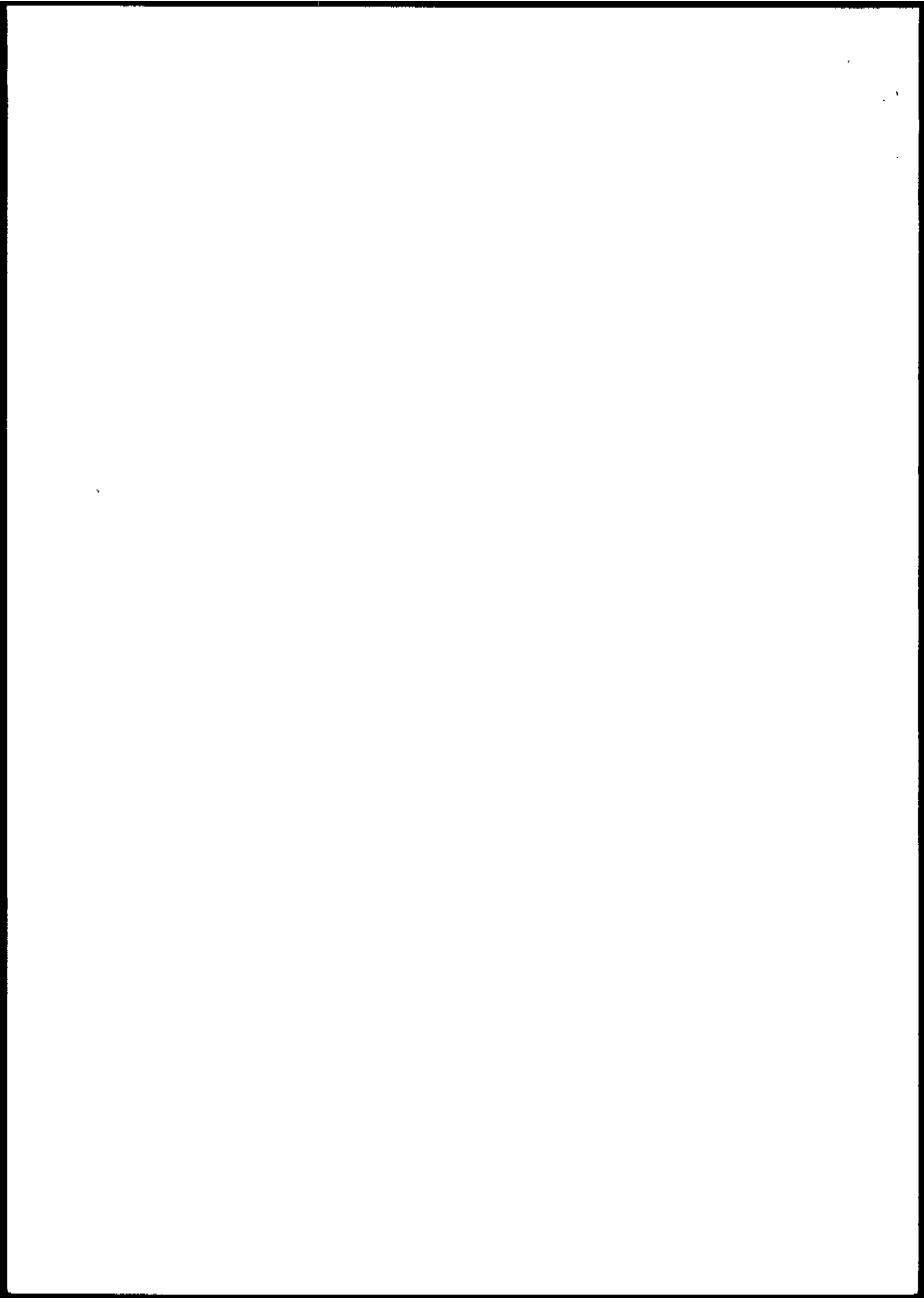
By 1990, national policies in all Member States should ensure that legislative, administrative and economic mechanisms provide broad intersectoral support and resources for the promotion of healthy lifestyles and ensure effective participation of the people at all levels of such policy-making.

Index:

HEALTH PROMOTION  
URBAN HEALTH  
EUR  
WORLD HEALTH ORGANIZATION

C O N T E N T S

Introduction	3
1. Development of the programme and strategy	3
2. Building a framework for policy and action	4
2.1 The Ottawa Charter for Health Promotion (1986)	
2.2 The Adelaide recommendations: healthy public policy (1988)	
2.3 The Third International Conference on Health Promotion - Creating Supportive Environments, Sundsvall, Sweden (1991)	
3. Implementing the strategy	7
3.1 Policy	
3.2 Supportive projects	
3.3 Research and information	
3.4 Training	
4. Applying the strategy to cities	8
5. Challenges for the future	9
References	11



## Introduction

The strategy for health promotion of the World Health Organization (WHO) has been developing since 1981. It has been an integral part of the contribution of the WHO Regional Office for Europe to achieving health for all by the year 2000 (1). It has three components that are at different stages of development:

- building and legitimating a framework for health promotion;
- exploring the dynamics of policy formulation and implementation; and
- testing such policy in practice, at the national and city levels.

WHO receives political direction from its Member States, represented through national ministries of health. The health promotion programme therefore focused on the responsibilities and policies of national governments as the starting point for strategy. This focus has since broadened to include regional and local administrations and new types of infrastructure for health promotion that are emerging, particularly at the local level. The WHO Healthy Cities project is implementing this part of the strategy by actively seeking to strengthen organizational innovation that encourages greater community involvement in health.

This paper describes the development of the WHO health promotion programme in Europe and some of the key challenges that confront WHO in developing this programme further.

### 1. Development of the programme and strategy

The health education programme laid the groundwork for developing health promotion at the Regional Office as an integral part of the regional strategy for health for all, adopted by the WHO Regional Committee for Europe in September 1980. In 1981 the Regional Committee adopted a resolution (EUR/RC 31/10) on health education and lifestyles that established a new approach to health education based on a social concept of health. This reflected the new interest in lifestyle issues related to health, one of the key components of the regional strategy for health for all. In 1981 a paper on a social concept of health education was published and disseminated widely by the European Office of the International Union for Health Education (2). The health education community quickly adopted it as a key contribution. A broad approach to lifestyles and health education was further advanced by the 1985 technical discussions of the Regional Committee on lifestyles and their impact on health (3). These discussions were crucial in establishing a lifestyles approach to health education and health promotion (4-8), which is based on an understanding of lifestyles that reflects both the context and meaning of human actions in health.

Based on the work done by the health education programme between 1980 and 1985, the Regional Committee agreed to create a new programme area at the Regional Office, and in 1984 the health promotion programme began its work as part of the Seventh General Programme of Work of WHO (9). In 1984 the Regional Committee adopted 38 regional targets for health for all (10), in which the targets for lifestyles conducive to health support the principles of health promotion. The health promotion programme began its work by developing the concept and principles of health promotion. Through the support of the International Union for Health Education, a document describing the concept and principles (11) was widely disseminated and translated and constituted the basis for further programme work. As a first step, two areas were given special attention: developing national policies for health promotion, and developing health promotion programmes in communities. Top-level experts from throughout Europe helped in formulating frameworks for both areas, which were

then published in 1986 (12). A glossary of health promotion terms was also prepared (13), which is now available in five languages (14). Particular attention was given to health promotion research, including indicators (15), and a network of institutes and experts was established (16-18). Self-help (19-21) and health promotion and family health were given special attention. Clearinghouses were established for both areas and both publish regular newsletters (22, 23).

These activities provided essential input and testing for the strategy for health promotion. By 1986 the health promotion programme could build its work on both a clear conceptual approach and several major intervention programmes in the European Region. A strong network of professionals from a wide range of disciplines could provide expertise. What began as a small programme on health education is now a major unit within the Regional Office with a staff of 10-15 people.

## 2. Building a framework for policy and action

The first element of the WHO strategy for health promotion includes developing the concept of health promotion and making health promotion visible and accepted. In 1986 the health promotion programme began to set an agenda for the new public health and to build a consensus around this agenda, which has helped to develop a new approach to public health.

Two international conferences on health promotion, undertaken by WHO with various co-sponsors, provided the vehicle for this process. The first was held in Ottawa, Canada, in 1986, and the second in Adelaide, Australia, in 1988. A third is planned for Sundsvall, Sweden, in June 1991. The first conference arrived at a framework for health promotion, the second explored the implications of government decision-making for health, and the third will deal with the relationships between environments and health.

Although the Regional Office planned and organized these conferences, they were part of an interregional project on health promotion set up by the WHO Director-General at the end of 1984 and supported by his Development Fund until 1988. This interregional project has now become part of the terms of reference of the new Division of Health Education and Promotion at WHO headquarters, which underscores the relevance of health promotion to both developing and developed countries. This Division began its health promotion activities by establishing a Working Group on Health Promotion in Developing Countries in October 1989. A World Health Assembly Resolution (WHA42.44) on health promotion, public information and education for health fully supports this development.

### 2.1 The Ottawa Charter for Health Promotion (1986)

The first International Conference on Health Promotion in Ottawa was sponsored by the Canadian Department of National Health and Welfare, the Canadian Public Health Association and WHO. The goals were to review the state of health promotion and to develop a vision for the future. About 200 delegates from 38 countries (mostly highly industrialized) attended the conference. The selection of conference participants reflected the prevailing view at that time that health promotion was only relevant to developed countries. The conference extensively relied on work done previously in the European Region, including a survey of organized health promotion activities in several countries (24), and the concept and principles of health promotion developed in 1984 (11). Discussions at three European summer seminars on health promotion from 1984 to 1986 (25, 26) helped in preparing the Ottawa Charter for Health Promotion. A study group on health promotion that convened in Copenhagen in 1985 and included representatives from most of the WHO

regions (27) also articulated some of the fundamental issues to be discussed at the Conference, including the relationship between health promotion and primary health care, which is particularly relevant to the developing countries.

The most important achievement of this Conference was the Ottawa Charter for Health Promotion (28), which was adopted as a consensus statement. The Ottawa Charter has widely dispersed intellectual roots in many disciplines, social movements and practical experiences. It set a new direction for health promotion action.

The Ottawa Charter affirms the importance of fundamental living conditions and resources as prerequisites for health. Peace, shelter, education, food and income are identified as being essential for health. This brings health promotion back to its roots in public health and broad social policy. The Ottawa Charter was also the first WHO document to identify a stable ecosystem as a prerequisite for human health.

The Ottawa Charter defines health promotion as the process of enabling people to take control over and to improve their health. Recognizing that power and control are the central issues in health promotion is a distinct shift away from the manipulative overtones of social marketing and behavioural change of many government programmes, and points towards community empowerment.

The Ottawa Charter describes health promotion action in terms of advocacy, enabling and mediating, which implies: a new type of institutional mandate beyond traditional health services, broader terms of reference beyond illness and disease, a different relationship with the community, and new skills and different training.

The Ottawa Charter outlines the five overlapping and interactive means of action that constitute a comprehensive strategy for health promotion: building healthy public policy, creating supportive environments, strengthening community action, developing personal skills and reorienting health services.

This health promotion strategy is comprehensive and acknowledges that action must be undertaken simultaneously on a number of fronts that interact. The Ottawa Charter underlines the intention of developing a new public health that responds to the health problems of the end of the twentieth century (29-31).

The Ottawa Charter has received enthusiastic response: at least 19 translations have been widely published. It is used as a basis for health promotion policy, programmes, research and training. Selected materials from the Conference are available in special issues of Health promotion (32) and the Canadian journal of public health (33) and in selected conference proceedings (34).

## 2.2 The Adelaide recommendations: healthy public policy (1988)

The Second International Conference on Health Promotion - Healthy Public Policy was convened in Adelaide 18 months after the Ottawa Conference to explore the effects of government decision-making on health, particularly in sectors not usually within the mandate of health planners. The theme of the Conference embodies the political process that will lead to stronger foundations for health (35).

The Adelaide Conference adopted a consensus statement called the Adelaide recommendations (36), which describes healthy public policy as being "characterized by an explicit concern for health and equity in all areas of policy and by an accountability for health impact". This definition is valuable because it uniquely captures a consensus that has been emerging during the first decade of the strategy for health for all. Achieving health for all requires equitable access to the prerequisites for health; many of these can only be secured through public policy. Using public policy to achieve equity in health involves diverse government portfolios, including agriculture, education, social welfare, housing and economics. Creating political support for this wide involvement in health requires an innovative and effective system of political accountability that makes visible the positive and negative effects on health of sectors other than health.

The Adelaide recommendations identify four areas as priorities for immediate action for healthy public policy (36): supporting the health of women, improving food and nutrition, controlling the use of tobacco and alcohol and creating supportive environments for health.

These priorities have far-reaching implications. The Conference proposed, for example, that countries develop women's health policies in which women's own health agendas are central, including equal sharing of caring work and supportive mechanisms for such work. The Conference advocated that the public health and ecological movements join together in pursuit of socioeconomic development that conserves our planet's resources. One year later the World Health Assembly adopted a resolution (WHA42.26) on WHO's contribution towards the international efforts towards sustainable development.

Healthy public policy is as old as the history of public health and almost everywhere in the world there are examples of its practice. What is new is drawing together health, equity, comprehensiveness and accountability and seeking to systematize formulation and implementation.

The Adelaide recommendations (36) have been translated into at least eight languages and are being distributed and used widely. Selected papers and case studies from the conference have been published (37) and the national case studies presented at Adelaide will be reassessed at a meeting in Europe in June 1990.

### 2.3 The Third International Conference on Health Promotion - Creating Supportive Environments, Sundsvall, Sweden (1991)

The Adelaide recommendations laid the groundwork for the Third International Conference on Health Promotion - Creating Supportive Environments, to be held in Sundsvall, Sweden, in June 1991. The view of environments will be broad, including physical, social and institutional dimensions and assuming that the environment can contribute positively to people's health as well as being safe. The Conference will explore how policies and patterns interact and connect to affect people's lives.

One of the aims is to define the shared agenda advocated by the Adelaide recommendations between people who focus on public health and people who concentrate on environmental and ecological issues: the health of future generations is intimately linked to conserving the global environment, as outlined by the report of the World Commission on Environment and Development (38). Health beyond the year 2000 depends on sustainable development: development that meets the needs of the present generation without compromising the ability of future generations to meet their needs. The Conference will link the WHO strategy for health for all with the initiatives arising from the World Commission on Environment and Development,

particularly focusing on health in developing countries. The Division of Health Education and Promotion at WHO headquarters is responsible for organizing the Conference. A Conference office has been set up in Sundsvall. The WHO European health promotion programme is represented on the organizing committee and the programme and planning committee.

The Conference will be an important milestone. Three international conferences on health promotion convened over five years are providing a comprehensive framework for organized action, articulating a new role for government decision-making in promoting health, and linking health and environmental concerns. These conferences offer a vision for the future: the new public health (29-31, 39).

### 3. Implementing the strategy

The principles of health promotion challenge many prevailing trends and practices and threaten to disturb many existing power arrangements. The problems and dilemmas that arise in formulating and implementing programmes that respect these aims and principles must therefore be systematically examined. The WHO strategy for health promotion emphasizes working on this with a wide variety of partners.

Experiences from the past and present are being analysed to gain insight for the future. The Adelaide Conference extensively relied on analysis of 60 case studies that examined experiences in formulating and implementing healthy public policy. These case studies explored the political climates in which such policies were adopted, approaches used to gain political support, and processes of policy planning and implementation. Special attention was given to factors that facilitate policy development and to the most frequently occurring barriers. Case studies were discussed in small working groups that encouraged intensive sharing of experiences. A selection of case studies on local action has been published (37); national case studies were published in Health promotion (40).

#### 3.1 Policy

The WHO European health promotion programme takes ongoing responsibility for work on practical issues of planning and implementing health promotion. For example, the health promotion programme has sponsored four Vienna Dialogues on health promotion. The first Vienna Dialogue on Health Policy and Health Promotion - Towards a New Conception of Public Health was held in 1980 (41). Vienna Dialogue II discussed social and health services for elderly people (42). Vienna Dialogue III (1988) focused on localizing support structures for community health projects and gathered examples of mediating structures for health promotion (43). Vienna Dialogue IV, held in November 1989, examined structures for the new public health based on exchanges of experience between about ten countries and regions that have approached this systematically. The topics discussed included organizational arrangements, links to political systems, methods of financing, mechanisms for intersectoral action and processes to encourage community participation (44).

The health promotion programme has sponsored in-depth consultations with Hungary, Ireland, Austria, Finland, Canada and Australia on developing and implementing policies for health promotion, and conferences, consultations and joint projects with such partners as sickness funds and health insurance schemes, trade unions and businesses.

### 3.2 Supportive projects

Supportive projects are underway with such partners as:

- the European Communities (the health-promoting school) (45);
- the International Union for Health Education (infrastructures for health education) (46); and
- centres for health education (applying the health promotion framework to special issues such as smoking, nutrition and AIDS) (47-49).

### 3.3 Research and information

The investigation of practical issues is further supported by a network of collaborating centres on health promotion research, which have especially contributed to developing health promotion indicators (15) and three information networks: health promotion training (Utrecht), family health (Brussels) and health promotion projects (Cardiff).

### 3.4 Training

WHO supported a summer school on health promotion in 1989 operated by the Health Promotion Authority of Wales in Cardiff. Several training courses, master degrees and postgraduate degrees in health promotion and the new public health are emerging in the European Region and stabilizing the development of health promotion. A newsletter produced by the Dutch Centre for Health Education in Utrecht (50) regularly reports on these developments.

## 4. Applying the strategy to cities

The health promotion concept has been applied and developed in cities by the WHO Healthy Cities project, which began in 1986 and has achieved unprecedented popularity. This project is valuable because it creatively tests innovation in practice.

The Healthy Cities project in Europe comprises 30 project cities in 19 countries linked by the project office in Copenhagen (51-60). Project cities are committed to achieving greater support for health among political decision-makers and in the community, and to taking action to support the European regional strategy and targets for health for all (10). The project also encourages innovative policies and organizational forms that encourage cooperation between sectors, political commitment and community participation. Several ways have been adopted to pursue these aims. Semiannual business meetings formulate strategy and determine activities and priorities. Delegations of 5-10 people from each project city attend annual symposia to discuss major themes. The 1988 theme in Zagreb, Yugoslavia was equity (61) and the 1989 symposium in Pécs, Hungary examined community action. Creating supportive environments will be the theme in 1990 in Stockholm, and, in 1991, reorienting health services and public health, in Barcelona. Case studies prepared by project cities stimulate most of the analysis and discussion during these symposia.

The project office is developing a system to assess progress. Project cities complete a progress report each year and are extensively interviewed about the major achievements and significant problems and questions that need particular analysis. The results of the review process will be given to cities individually and a comparative overview will identify success stories, common problems and possible solutions, providing the basis for future collective initiatives.

From 1986 to 1988, project cities mainly established infrastructures, including: building political support among municipal councillors, establishing offices with staff and budgets, setting up committees to encourage cooperation between administrative departments and building links with community groups, academic institutions and the public. Cities entered the project at different times and face different circumstances, and the progress achieved therefore varies widely. The project is now entering a stage of multi-city action, in which the structures and support that have been built are being used to remedy specific environmental problems and the concerns of particular groups in the city population (for example, children and youth, elderly people and disabled people).

An outstanding achievement of the project has been the spread of the Healthy Cities idea. As many as 300 cities actively participate in 15 national or linguistic Healthy Cities networks in Europe. Networks have also emerged in Canada, the United States and Australia. Interest has also been shown in Latin America, northern Africa and South-east Asia. This success creates organizational problems, as demand consistently exceeds the capacity of the WHO project office.

The project is flexible and creative. The numerous success stories of individual cities are becoming a valuable storehouse of information on such practical questions as gaining visibility, building political support, establishing political accountability, undertaking new ways to analyse data and creating new organizational forms for public health.

#### 5. Challenges for the future

The WHO strategy for health promotion is now five years old. This is a very short time in the history of ideas, and in terms of applying ideas in practice it is no time at all. Discussion of results is therefore tentative and speculative. Nevertheless, there are many positive things to report and good indications of directions for the future.

National, regional and local administrators can now build their work on a comprehensive strategy for health promotion that addresses the issues of the future and places health promotion in the context of broad social policy. Moreover, the strategy is flexible enough to accommodate widely varying circumstances and priorities.

Current events suggest that new ideas are being translated into action. The implications of coordinating healthy public policy have been examined. Professional training courses have been redesigned using the Ottawa Charter as the framework. Workshops and conferences on the relationships between health, the environment and sustainable development are being convened. Health promotion programmes are being re-examined with new comprehensive strategies in mind. Committees and organizations are being established to re-examine and coordinate policy to promote health instead of merely treating disease. The WHO Healthy Cities project clearly builds on the appeal of environmental issues in local areas in the 1990s.

Nevertheless, the WHO strategy for health promotion recognizes that the strategy for health for all confronts many entrenched interests and ways of doing things in daily public health practice.

Empirical and practical questions must be taken up:

- Which approaches can build systems of political accountability that maintain advocacy for healthy public policy? Does the history of environmental impact statements help here? Should the impact on health and the environment be analysed together?

- How can terms of reference and mandates for public health authorities be changed to make them effective in advocating and mediating? Health education and health promotion authorities funded by public funds have not often been successful in confronting controversial issues that disturb vested interests.
- How can participative management and collective decision-making be implemented in the health sector? The fundamental developments in theory and research and development of practice in the 1960s and 1970s hardly seem to have touched public health.
- What are the best ways to build structures and processes that encourage and reward lateral training and cooperative action across organizational boundaries? What are the implications for information systems, defining problems, planning mechanisms and organizational control?
- What kind of indicators or analytical instruments can monitor processes of policy innovation and organizational change? Better insight into processes of change is needed. The WHO strategy for health promotion enables continuing exchange and development to lead to a more effective organized effort to promote health.

The activities planned by the WHO health promotion programme at the Regional Office will aim to help to answer these questions and to supply Member States, project cities and other partners with a series of handbooks that approach these issues practically.

It is hoped that by 1991 the programme can present a new overview of health promotion that can realistically assess the first ten years of health promotion development.

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