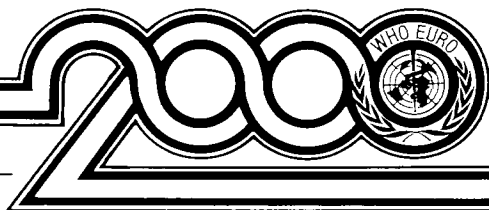


HEALTH FOR ALL



Health for all and schools of public health: implications for training

ASPHER



WHO Regional Office for Europe
ASPHER — Association of Schools of Public Health in the European Region

NOTE

Throughout this booklet the expression "school of public health" should be interpreted as encompassing any related institution responsible for postgraduate training in public health and social medicine.

ASPHER

The Association of Schools of Public Health in the European Region (ASPHER) was created in 1966. It is an association of institutions and individuals responsible for education in public health at the postgraduate level within the European Region of the World Health Organization. It comprises not only the leading schools of public health and tropical medicine but also many active university departments of social medicine, and other bodies (including a National Board of Health and a Communicable Disease Surveillance Centre) with postgraduate teaching functions. In addition to some 50 institutions, there are many distinguished individual members.

The Association provides a network for the exchange of information, ideas and initiatives. The main thrust of ASPHER's efforts has been directed towards collaborative international projects in the pursuit of its objectives.

ASPHER enjoys close working relationships with WHO and with kindred nongovernmental organizations such as the Association for Medical Education in Europe (AMEE) and the European Association of Programmes in Health Services Studies (EAPHSS).

ASPHER exists to develop postgraduate and continuing education in public health, to promote research — especially in epidemiology and in the organization and management of health care — and to apply both education

and research to enhancing the effectiveness and raising the quality of health and allied services.

The philosophy and strategy of health for all by the year 2000 provide a fresh challenge and a new focus for the Association.

The health for all strategy and targets of WHO in Europe

Since 1980, the work of the European Region of WHO has concentrated on the formulation of a pan-European health strategy, including 38 targets for health for all^{a,b} and 65 indicators to measure progress in countries towards those targets. The 32 countries of the European Region have collaborated in the process. They have all adopted the targets and have pledged to realign their national health policies accordingly. This is the contribution of the European Region to the global WHO objective of health for all. It is an unprecedented programme. The challenge now is to achieve its goals for the welfare of the 800 million people living in the European Region.

^a *Targets for health for all*. Copenhagen. WHO Regional Office for Europe, 1985.

^b See Annex 1 for a list of the 38 European regional targets.

A WHO/ASPHER initiative

At its meeting in August 1986 in Gothenburg, Sweden, the Executive Board of ASPHER wholeheartedly decided to encourage its constituent schools and departments to incorporate the spirit and content of the European health for all strategy and targets into their teaching programmes. Subsequently, ASPHER and the Regional Office established a Task Force on the Training of Health Professionals for Health for All, and decided that its first activity should be a meeting to define the scope and content of future projects and activities.

This booklet is an outcome of the first meeting of the Task Force, held at the Regional Office in Copenhagen on 19 and 20 February 1987. Representatives of ASPHER attended, as well as staff from WHO headquarters in Geneva and the Regional Office.

It is hoped that this initiative will be followed by many others, thus demonstrating how the European health for all strategy and targets can be used as a framework for reorienting educational programmes of health personnel.

Ways for change

More and more European countries are making use of the regional strategy and targets for health for all to prepare their own national health policies. These policies imply, among other things, that changes should be introduced in the education and training of health personnel.

Among the many groups of personnel necessary to take the lead and to implement changes in health care delivery, public health personnel have a special role to play. Their education and training must take into account the health for all policies and targets.

Schools of public health educate and train a wide variety of health personnel, often in multiprofessional settings. They are therefore in an excellent position to influence the thinking of these people in favour of the health for all policies and targets.

Opening the first meeting of the WHO/ASPHER Task Force, Dr Asvall, WHO Regional Director for Europe, called for ASPHER to assume a leadership role in influencing the process of change through schools of public health and departments of social medicine. He identified a number of ways in which this could be done, such as:

- motivating public health practitioners to apply the health for all strategy, and providing them with appropriate skills and knowledge so as to enhance their status and performance;

- indirectly influencing universities in their own countries, particularly in partnership with AMEE and the Association of Medical Deans in Europe (AMDE);
- clarifying the implications of health for all for the education of health personnel and of personnel in other sectors;
- stimulating actual change and contributing to the application of the health for all strategy through integrated projects such as “Healthy Cities”.

Dr Asvall indicated that the Regional Office was anxious to help ASPHER in these activities in any way possible.

Are the strategy and targets relevant to the schools of public health?

Equity in health is a central theme in the health for all strategy and targets. It is the unique role of the public health sector to reduce inequalities in health and to ensure a preferential allocation of resources. Because of their training, service and research activities, schools of public health are in the best position to seek information on the extent of inequalities and to stimulate political awareness of the problem.

On the basis of the health for all strategy and targets, health problems can be reconsidered, goals set up at national and local levels, and appropriate indicators selected. A more concrete community diagnosis at the grassroots level will follow. This, in turn, will lead to the consideration of alternative solutions calling for *intersectoral* approaches, and to the reorientation of health care and related systems to ensure the optimal deployment of resources. This is how the principles of health for all will be put into practice.

The relationship between input, processes and output must be constantly evaluated. Education and research are central to this process at every stage. Therefore, schools of public health are at the centre of the process and must have links with all the component parts of the system. The overall system must also be seen within an environment that has physical, cultural, economic and political dimensions.

Two examples

The use of the regional targets — and their particular significance for schools of public health — can be illustrated through two examples.

THE FIRST EXAMPLE refers to that group of targets (13–17) related to *health promotion* and lifestyles conducive to health. A number of emerging trends and new directions have led to the concept of a new public health. This concept was embodied in a charter presented at the First International Conference on Health Promotion, held in Ottawa in November 1986.^a

THE SECOND EXAMPLE is in the fields of *appropriate technology* and *quality assurance* (targets 31 and 38). Many of the new approaches and concepts tested in these areas could very appropriately be introduced in the educational and research activities of schools of public health, such as scenario approaches to technology, comparisons of regional variations of practice, quality assurance methods and the use of computers in health care. Schools ought to carry out an advisory role in these areas as well — organizing consultations with decision-makers, industry, politicians and the media to influence the direction of their actions and to steer them towards health for all.

^a "Ottawa Charter for Health Promotion", available in the WHO Regional Office for Europe, Copenhagen.

These new dimensions in public health are highly relevant to schools of public health and give them an added opportunity to improve their image and their visibility. Furthermore, schools are in a unique position to promote intersectoral approaches in health.

Integrating health for all at various educational levels

How could the regional health for all strategy and targets be adapted to specific educational requirements and the needs of individual schools of public health?
Alternative approaches.

The concepts and strategies of health for all must be integrated into the three major tasks of the schools — research, education and training, and service — as well as in their advisory and advocacy roles. The education and training responsibilities of schools/departments of public health vary from one country to another, depending on their structures and overall functions and on the extent of their role in relation to training nationals from other countries, particularly developing ones. Schools may participate in the training of health professionals at several complementary and interconnected levels:

- within the basic medical curriculum;
- as inservice training for health workers involved in part-time public health activities;
- at the master's level in public health;

- at the doctorate level for training teachers/researchers in public health;
- as part of continuing education programmes.

In addition to training public health professionals (a captive audience), schools ought to attract and educate other professionals whose decisions will influence progress towards health for all. Taking up this new role implies that the schools are interested in extending health for all knowledge to the other professions, creating appropriate learning materials and methods, and pursuing major efforts to market the concept of health for all to these people.

The integration of health for all at each of these educational levels will call for specific approaches.

How can the strategy and targets be used in the educational process?

The regional health for all targets were specifically designed as a framework for policy-makers and not primarily with an educational purpose in mind. On the other hand, the targets propose desirable health outcomes and possible ways of achieving these, thus making them very suitable for developing problem-centred educational activities.

One could conceive a course that would start by covering the elements common to all targets, such as those related to the health service structure, epidemiology and statistics, and then proceed to cover the specific knowledge and skills required from health personnel involved in the achievement of each individual target.

Alternatively, courses could be envisaged as focusing wholly upon certain targets. For example, target 9 could be used to construct a new course on cardiovascular diseases in public health. This would include epidemiology, the analysis of risk factors, environmental components, legislation, health care delivery and appropriate technology.

Some schools have already considered how to develop training materials to support courses in relation to the regional targets. In a preliminary study, the Nordic School of Public Health has suggested the following packages:

- workbooks on health for all policy formulation and implementation;

- learning materials based on the adaptation of WHO project documents — such as the countrywide integrated noncommunicable disease intervention (CINDI) programme, the Healthy Cities Project and the target book itself;
- “essential information” briefing materials geared towards politicians, top-level health managers, health workers, etc.

What should be done? Guiding principles for action

Educational leaders and teachers in schools of public health must be informed and motivated so that they become aware of the health for all movement, understand it and accept its values. Clear and specific information on the regional strategy and targets should be provided to avoid resistance through misunderstanding. Teachers, therefore, need to be briefed on health for all, and guidelines should be provided for teacher training.

The needs and profiles of students at schools of public health should be better known, and this is particularly important when schools address the educational needs of personnel outside the health sector.

Training methods and educational material could be made available to those schools that decide to reconstruct their courses around health for all.

Educational modules prepared on individual targets or groups of targets must include learning objectives as well as other course materials.

A large amount of target-related material already exists (particularly in WHO) and its potential for education and training needs to be exploited. Such material should be retrieved and annotated, and relevant bibliographies compiled.

Where necessary, new materials must also be created. They should be simple to use and include CASE HISTORIES and CASE STUDIES. Eventually, a

clearing-house will have to be established, either at the Regional Office or at a school of public health.

It is essential, however, that teachers remain fully responsible for their own courses. Whatever educational material is produced and offered should be used to support their work and should be enlivened with their own personalities.

When the various components described above are well developed, it will be possible to build them into a framework for learning and teaching new approaches to public health based on health for all.

Other pathways for establishing curricula for health for all must be explored. For instance, the reorientation of training programmes in individual schools of public health will be induced by — and a natural consequence of — the schools' involvement as technical advisers to their local authorities.

Decisions and recommendations of the first meeting of the WHO/ASPHER Task Force

1. The members volunteered to work immediately on the preparation of behavioural objectives and educational material relating to a number of individual targets: target 9 (circulatory diseases), including reference to target 38 (appropriate health technology); target 16 (positive health behaviour); and target 23 (control of hazardous wastes). Relevant published and unpublished material produced by WHO will be identified and abstracted.
2. Booklets will be prepared to support schools of public health in their efforts to market health for all to decision-makers, leaders of opinion and professional groups in their countries and communities.
3. The establishment of a clearing-house located in WHO or in a school for teaching and learning materials, including case studies and tested ideas, will facilitate the above-mentioned developments. Implementing this proposal will, however, require additional resources.
4. Major resources beyond those available to WHO, ASPHER and individual institutions are indeed needed to develop fully an educational policy for a new public health based on the regional targets. Funding organizations will be approached for support.
5. All schools of public health, departments of social medicine and other interested training institutions or parties should be informed immediately of

the Task Force's views and plans as a first step towards enlisting potential contributors. A short report of the meeting will be prepared and distributed for this purpose.

6. A second meeting of the Task Force will be convened as soon as warranted by progress in the above recommendations. The development of working drafts of guidelines and educational materials will then be reviewed.

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Annex 1

List of targets in support of the European regional strategy for health for all

1. By the year 2000, the actual differences in health status between countries and between groups within countries should be reduced by at least 25%, by improving the level of health of disadvantaged nations and groups.
2. By the year 2000, people should have the basic opportunity to develop and use their health potential to live socially and economically fulfilling lives.
3. By the year 2000, disabled persons should have the physical, social and economic opportunities that allow at least for a socially and economically fulfilling and mentally creative life.
4. By the year 2000, the average number of years that people live free from major disease and disability should be increased by at least 10%.
5. By the year 2000, there should be no indigenous measles, poliomyelitis, neonatal tetanus, congenital rubella, diphtheria, congenital syphilis or indigenous malaria in the Region.
6. By the year 2000, life expectancy at birth in the Region should be at least 75 years.
7. By the year 2000, infant mortality in the Region should be less than 20 per 1000 live births.

8. By the year 2000, maternal mortality in the Region should be less than 15 per 100 000 live births.
9. By the year 2000, mortality in the Region from diseases of the circulatory system in people under 65 should be reduced by at least 15%.
10. By the year 2000, mortality in the Region from cancer in people under 65 should be reduced by at least 15%.
11. By the year 2000, deaths from accidents in the Region should be reduced by at least 25% through an intensified effort to reduce traffic, home and occupational accidents.
12. By the year 2000, the current rising trends in suicides and attempted suicides in the Region should be reversed.
13. 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.
14. By 1990, all Member States should have specific programmes which enhance the major roles of the family and other social groups in developing and supporting healthy lifestyles.
15. By 1990, educational programmes in all Member States should enhance the knowledge, motivation and skills of people to acquire and maintain health.
16. By 1995, in all Member States, there should be significant increases in positive health behaviour, such as balanced nutrition, nonsmoking, appropriate physical activity and good stress management.
17. By 1995, in all Member States there should be significant decreases in health-damaging behaviour, such as overuse of alcohol and pharmaceutical products; use of illicit drugs and dangerous chemical substances; and dangerous driving and violent social behaviour.
18. By 1990, Member States should have multisectoral policies that effectively protect the environment from health hazards, ensure community awareness and involvement, and support international efforts to curb such hazards affecting more than one country.

19. By 1990, all Member States should have adequate machinery for the monitoring, assessment and control of environmental hazards which pose a threat to human health, including potentially toxic chemicals, radiation, harmful consumer goods and biological agents.
20. By 1990, all people of the Region should have adequate supplies of safe drinking-water, and by the year 1995 pollution of rivers, lakes and seas should no longer pose a threat to human health.
21. By 1995, all people of the Region should be effectively protected against recognized health risks from air pollution.
22. By 1990, all Member States should have significantly reduced health risks from food contamination and implemented measures to protect consumers from harmful additives.
23. By 1995, all Member States should have eliminated major known health risks associated with the disposal of hazardous wastes.
24. By the year 2000, all people of the Region should have a better opportunity of living in houses and settlements which provide a healthy and safe environment.
25. By 1995, people of the Region should be effectively protected against work-related health risks.
26. By 1990, all Member States, through effective community representation, should have developed health care systems that are based on primary health care and supported by secondary and tertiary care as outlined at the Alma-Ata Conference.
27. By 1990, in all Member States, the infrastructures of the delivery systems should be organized so that resources are distributed according to need, and that services ensure physical and economic accessibility and cultural acceptability to the population.
28. By 1990, the primary health care system of all Member States should provide a wide range of health-promotive, curative, rehabilitative and supportive services to meet the basic health needs of the population and give special attention to high-risk, vulnerable and underserved individuals and groups.

29. By 1990, in all Member States, primary health care systems should be based on cooperation and teamwork between health care personnel, individuals, families and community groups.
30. By 1990, all Member States should have mechanisms by which the services provided by all sectors relating to health are coordinated at the community level in a primary health care system.
31. By 1990, all Member States should have built effective mechanisms for ensuring quality of patient care within their health care systems.
32. Before 1990, all Member States should have formulated research strategies to stimulate investigations which improve the application and expansion of knowledge needed to support their health for all developments.
33. Before 1990, all Member States should ensure that their health policies and strategies are in line with health for all principles and that their legislation and regulations make their implementation effective in all sectors of society.
34. Before 1990, Member States should have managerial processes for health development geared to the attainment of health for all, actively involving communities and all sectors relevant to health and, accordingly, ensuring preferential allocation of resources to health development priorities.
35. Before 1990, Member States should have health information systems capable of supporting their national strategies for health for all.
36. Before 1990, in all Member States, the planning, training and use of health personnel should be in accordance with health for all policies, with emphasis on the primary health care approach.
37. Before 1990, in all Member States, education should provide personnel in sectors related to health with adequate information on the country's health for all policies and programmes and their practical application to their own sectors.
38. Before 1990, all Member States should have established a formal mechanism for the systematic assessment of the appropriate use of health technologies and of their effectiveness, efficiency, safety and acceptability, as well as reflecting national health policies and economic restraints.

