

1931 2010

# Jo Eirik Asvall's Memorial Guide



**World Health  
Organization**

REGIONAL OFFICE FOR **Europe**

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Jo Eirik Asvall's Memorial Guide  
1931-2010

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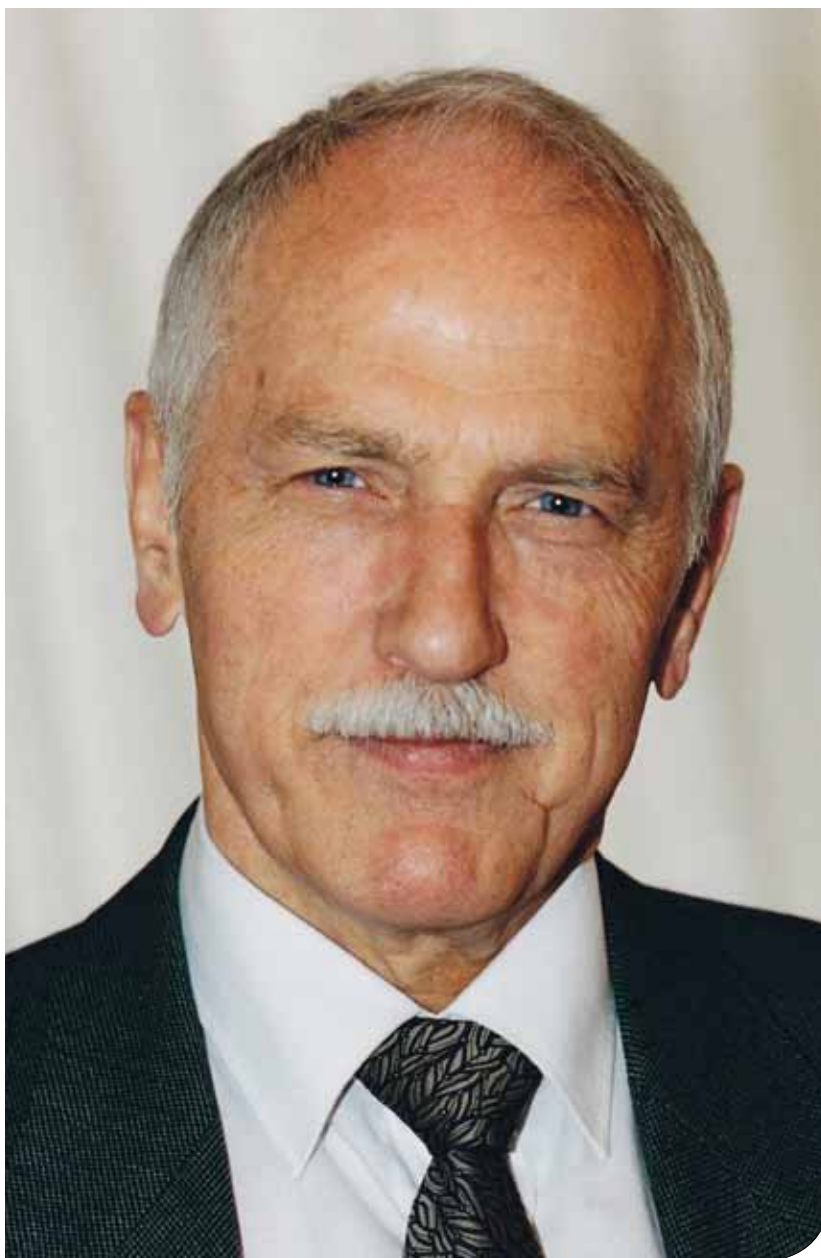
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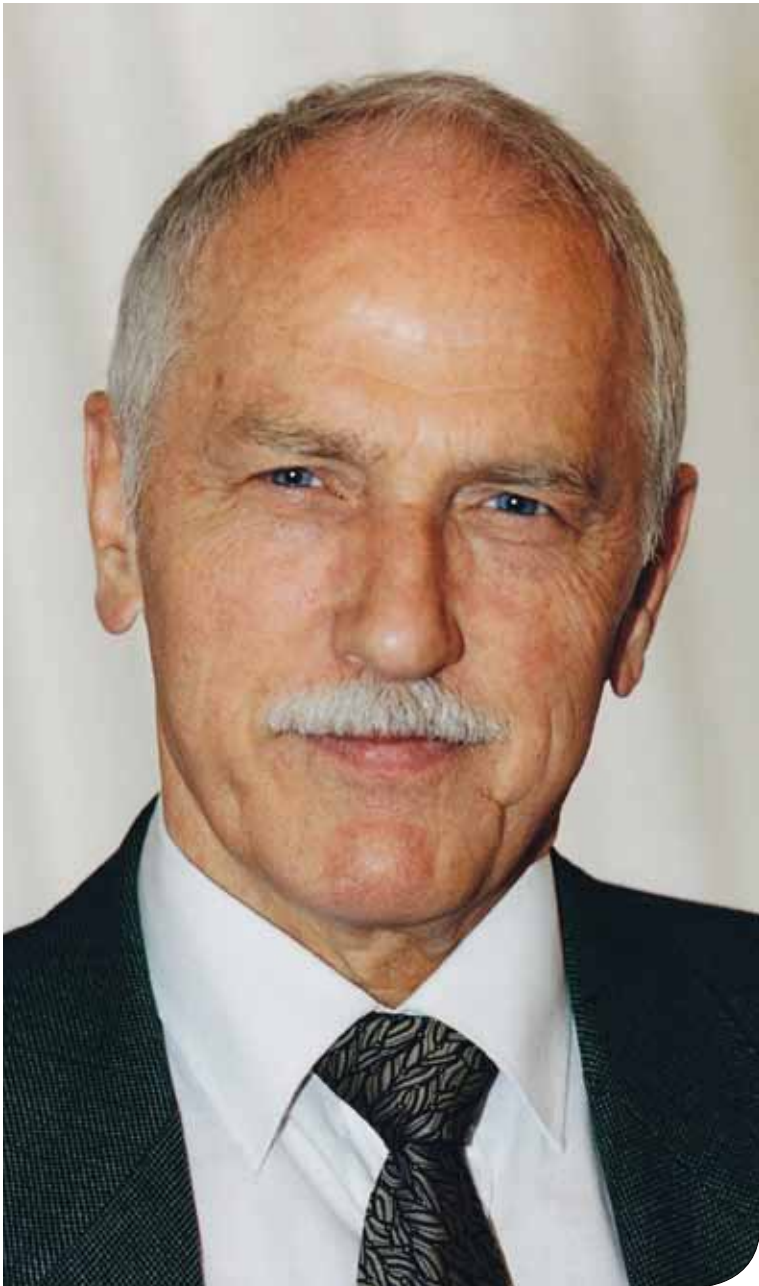
REGIONAL OFFICE FOR **Europe**

# Table of Contents

<b>Summary</b>	1
<b>Introduction: Spreading the glow</b>	21
<b>Guide to this guide</b>	26
<b>Acknowledgements</b>	29
<b>Section 1. Introducing Jo Asvall: Witness voices</b>	31
<b>Section 2. Jo Asvall's story: Some annotated autobiographical reflections</b>	63
Early life <i>Turnus</i> years	64
WHO Malaria Project	66
Oncology and the Norwegian Ministry of Health	71
Return to WHO     Director, Programme Management (DPM), WHO Regional Office for Europe: origins of Health for All	75
Health for All challenges and achievements: health promotion	93
Building interactive networks     engaging partners and settings	100
Environment and Health	112
Quality of care and health services	118
Armed conflict in the former Yugoslavia	126
Bringing east and west together     EUROHEALTH	131
Moving forward	138
After WHO	145



<b>Section 3. Ten rules of the road</b>	149
Rule 1. Be there, where and when you are needed	150
Rule 2. Put international health first	152
Rule 3. Aim to influence systems and policies	156
Rule 4. Turn vision into action	158
Rule 5. Opt for evidence over eminence	163
Rule 6. Blend ethics and science with political know-how	166
Rule 7. Build movements for change     let a thousand flowers bloom	170
Rule 8. Hire talented people and give them space to move	172
Rule 9. Be courageous	177
Rule 10. Lead by example, spread the glow	179
<b>Section 4. Thank you, Jo</b>	183
<b>Section 5. His final words</b>	195
<b>Annex</b>	203
Invitation letter	204
Questionnaire	206
List of witnesses	207



**Summary**  
**Résumé**  
**Zusammenfassung**  
**Резюме**

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1931-2010

# Jo Eirik Asvall's Memorial Guide

1931 2010

This memorial guide draws on Jo Asvall's memoirs, dictated for a WHO history project (2006–2008) and interviews with 60 witnesses to his life and achievements, in order to provide a profile, life history and rules of the road for public health leadership. The WHO Regional Office for Europe has tried to create in this guide a communication platform that will both allow a new generation of public health advocates and leaders to get to know, as well as old hands to reacquaint themselves with, Jo Asvall and learn from his values, approaches, life work, challenges and achievements.

As the WHO Regional Director for Europe for the period 1985–2000, Dr Asvall championed and shepherded the development of the WHO European Health for All (HFA) strategies and targets from concept to practical application in local communities and institutions across the now 53 countries in the WHO European Region. The Health for All approach, supported by a new HFA database that compared health system performance in all WHO European countries on a wide variety of common health indicators, inspired and catalysed health systems to look beyond health services and start addressing previously neglected social, lifestyle and environmental determinants of health.

The Health for All development process, under Asvall's leadership, led to many landmark public health agreements and initiatives, including:

- the Ottawa Charter for Health Promotion (1986);
- the European Charter on Environment and Health (1989);
- the St Vincent Declaration on Diabetes Care and Research Europe (1989);
- the Ljubljana Charter on Reforming Health Care (1996);
- national Health for All strategies in 43 European countries (1985–2000); and

- significant regional commitments on nutrition and physical activity, tobacco control and reducing harm from alcohol.

Through this process, Asvall reoriented the way WHO worked in Europe, expanded its technical roles and developed the Regional Office as a change agent, proactively advocating, with its partners, public-health-oriented policies in all sectors.

Jo Asvall led the WHO Regional Office for Europe through some of the most turbulent and challenging times in its history. Following the fall of the Berlin Wall and the dissolution of the USSR and Yugoslavia, he helped orchestrate the expansion of the European Region to include 22 new countries and systematically assisted these new Member States to address the challenges of transition. He established a new way for WHO to work with countries, by opening up liaison offices in each, staffed by national public health professionals who could provide direct assistance to health ministries in shaping and adapting WHO programmes and resources to country contexts. He raised the awareness of the international health, development and donor communities of the changing and urgent health needs of the Region, especially the newly independent states and countries of central and eastern Europe, and brought new resources and attention to address growing health gaps and inequities between and within all countries.

In 1986, he led the WHO global response to the Chernobyl disaster, which provided rapid advice on protective actions that countries and individuals could take. In 1991 he became the first WHO director to take the WHO Regional Office for Europe into a ‘hot’ war. Strongly supported by many European Member States, he established WHO offices in each of the countries involved in the armed conflict in the former Yugoslavia and fielded WHO staff to work with local public health leaders on programmes to protect or rebuild public health infrastructures and services, addressing mental health and rehabilitation needs. Furthermore, Dr Asvall personally led negotiations between health ministers of the countries involved, which helped to establish agreements to protect health care facilities.

Jo Asvall understood the importance of partnership and the need to engage people in a wide variety of settings and agencies in promoting health. During his tenure as Regional Director, he established a broad range of new public health networks linking WHO with important groups – such as medical, nursing, midwifery and pharmacy associations, chronic disease and patient organizations and health communicators across the European Region – and important settings for health promotion, such as cities, schools, regions, hospitals and prisons. This gave birth to, for example, the European Forum of Medical Associations and WHO, and the WHO Healthy Cities, health-promoting schools and Regions for Health networks. All of these were bound together by the common regional Health for All policy. Taken as a whole, they formed what Dr Asvall called “a great public health army of collaborators” and significantly enhanced the power of the European public health movement.

Jo Asvall was born on 24 June 1931 in Oslo, Norway. He received his medical training at Oslo University and a Masters degree in public health from Johns Hopkins University in 1969. He began his career with WHO in 1959 after finishing his military service at the Norwegian Air Force Research Centre. From 1959 to 1963 he initiated WHO’s first national malaria eradication projects in Africa, working in Togo and Dahomey. He returned to Norway in 1963 to work as a clinical oncologist at the Radium Hospital in Oslo, where he helped develop Norway’s cancer registry, established the hospital’s first professional development plan and introduced systems approaches to management. He moved from there to become Director of the Hospitals Department of the Norwegian Ministry of Social Affairs, where he worked under the leadership of Karl Evang from 1971 to 1976 and coordinated the development of Norway’s first national hospital development plan. He returned to WHO in 1976 to serve as regional programme manager for national health planning and evaluation. He became Director, Programme Management of the Regional Office under Regional Director Leo Kaprio in 1979 and was elected Regional Director in 1985. He held this position for the next 15 years. After retirement from WHO, Dr Asvall became Director of the Danish Rehabilitation and

Research Centre for Torture Victims and continued to work for WHO as a consultant.

**Ten ‘rules of the road’ for public health leadership can be drawn from Jo Asvall’s experience:**

- Rule 1.** Be there, where and when you are needed.
- Rule 2.** Put international health first.
- Rule 3.** Aim to influence systems and policies.
- Rule 4.** Turn vision into action.
- Rule 5.** Opt for evidence over eminence.
- Rule 6.** Blend ethics and science with political know-how.
- Rule 7.** Build movements for change – let a thousand flowers bloom.
- Rule 8.** Hire talented people and give them space to move.
- Rule 9.** Be courageous.
- Rule 10.** Lead by example, spread the glow.

In his final speech to WHO staff just days before his death, Jo Asvall’s message was:

*“Let me say this as strongly as I can. The Regional Office’s potential for action is almost limitless – both for raising resources and for going into issues that are controversial, but where we can help our Member States! Our Constitution gives us that mandate – and in my own view also a strong responsibility for action. Be courageous and willing to take risks, but be sure you have the Constitutional mandate to lean on!”*

## Un guide à la mémoire de Jo Eirik Asvall 1931 2010

Ce guide s'inspire des mémoires écrites par Jo Asvall entre 2006 et 2008 dans le cadre d'un projet relatif à l'histoire de l'OMS, et des entretiens avec soixante témoins de sa vie et de son œuvre, pour dresser un portrait de cet homme, évoquer son parcours et proposer des règles de conduite à suivre lorsque l'on occupe des fonctions de direction dans le domaine de la santé publique. Avec ce guide, le Bureau régional de l'OMS pour l'Europe a voulu créer un instrument de communication qui permette à la nouvelle génération de défenseurs de la santé publique et aux responsables dans ce domaine, ainsi qu'aux plus anciens, de découvrir (ou de redécouvrir) Jo Asvall et de tirer un enseignement de ses valeurs, de ses points de vue, de l'œuvre de sa vie, des défis qu'il a relevés et des choses qu'il a accomplies.

6

En tant que directeur régional de l'OMS pour l'Europe de 1985 à 2000, le docteur Asvall a plaidé en faveur de la mise en place des stratégies et des buts de la politique de la Santé pour tous dans la Région européenne de l'OMS et a piloté les travaux menés à cette fin, depuis le stade du concept jusqu'à celui de l'application pratique à l'échelle des populations et des institutions locales des 53 pays que compte aujourd'hui la Région. Sous l'influence et l'impulsion de cette politique, qui s'appuyait sur une nouvelle base de données comparant les performances des systèmes de santé de tous les pays de la Région européenne de l'OMS à partir d'un vaste ensemble d'indicateurs sanitaires communs, les systèmes de santé ont élargi leur perspective au-delà des services de santé et se sont attaqués aux déterminants de la santé relevant des facteurs sociaux, du mode de vie et de l'environnement, dont on faisait jusqu'alors peu de cas.

L'élaboration de la politique de la Santé pour tous, sous la houlette du docteur Asvall, a donné lieu à de nombreux accords et initiatives historiques en matière de santé publique, notamment :



- la Charte d’Ottawa pour la promotion de la santé (1986) ;
- la Charte européenne de l’environnement et de la santé (1989) ;
- la Déclaration de Saint-Vincent sur les soins aux diabétiques et la recherche sur le diabète en Europe (1989) ;
- la Charte de Ljubljana sur la réforme des systèmes de santé (1996) ;
- les stratégies nationales visant à promouvoir la Santé pour tous dans 43 pays européens (1985 2000) ; et,
- d’importants engagements au niveau de la Région en matière de nutrition et d’activité physique, de lutte antitabac et de réduction des effets nuisibles de l’alcool.

Grâce à ce processus, le docteur Asvall a donné une nouvelle orientation aux activités de l’OMS en Europe, élargi son rôle technique et transformé le Bureau régional en un acteur du changement qui a plaidé activement, avec ses partenaires, en faveur de politiques axées sur la santé publique dans tous les secteurs.

Jo Asvall a dirigé le Bureau régional de l’OMS pour l’Europe pendant des périodes qui figurent parmi les plus mouvementées et les plus difficiles de l’histoire de ce bureau. Au lendemain de la chute du Mur de Berlin et de la dissolution de l’URSS et de la Yougoslavie, il a contribué à l’élargissement de la Région européenne à 22 nouveaux pays et s’est employé sans relâche à aider ces nouveaux États membres face aux problèmes posés par la transition. Il a instauré de nouvelles méthodes de travail entre l’OMS et les pays, en créant dans chacun de ces pays des bureaux de liaison constitués de professionnels nationaux de la santé publique pouvant apporter une aide directe aux ministères de la Santé afin que ceux-ci modulent et adaptent les programmes et les ressources de l’OMS en fonction du contexte national. Il a en outre sensibilisé le monde de la santé et du développement ainsi que les bailleurs de fonds internationaux à l’évolution et à l’urgence des besoins sanitaires de la Région, notamment ceux des nouveaux États et pays indépendants d’Europe centrale et orientale, en obtenant de nouvelles ressources et en attirant l’attention sur la nécessité de

remédier aux déséquilibres et aux inégalités croissants en matière de santé entre tous les pays et au sein de ces pays.

En 1986, il dirigea l'action menée par l'OMS à l'échelle mondiale face à la catastrophe de Tchernobyl, qui permit de fournir rapidement des conseils relatifs aux mesures de protection pouvant être prises par les pays et les personnes. En 1991, il devint le premier directeur du Bureau régional de l'OMS pour l'Europe à donner à l'Organisation un rôle dans une guerre ouverte. Avec le ferme soutien de nombreux États membres européens, il créa des bureaux de l'OMS dans chacun des pays impliqués dans le conflit armé en ex-Yougoslavie et envoya des membres du personnel de l'OMS coopérer avec des responsables locaux de la santé publique dans le cadre de programmes consacrés à la protection ou à la reconstruction des infrastructures et des services de santé publique et à la prise en charge des besoins dans les domaines de la santé mentale et de la réadaptation. Par ailleurs, le docteur Asvall dirigea personnellement des négociations entre les ministres de la Santé des pays concernés, ce qui favorisa la mise en place d'accords visant à protéger les établissements de soins de santé.

8

Jo Asvall comprit l'importance de la coopération et la nécessité de faire participer des représentants d'environnements et d'organismes très variés à la promotion de la santé. Pendant son mandat de directeur régional, il mit en place une multitude de nouveaux réseaux de santé publique reliant l'OMS à des groupes importants associations de médecins, d'infirmiers, de sages-femmes et de pharmaciens, organisations de malades chroniques et de patients et spécialistes de la communication en santé dans toute la Région européenne – et à des environnements également importants pour la promotion de la santé – villes, écoles, régions, hôpitaux et prisons. C'est ainsi que virent le jour, par exemple, le Forum européen des associations de médecins et de l'OMS, et les réseaux Villes-santé de l'OMS, Écoles-santé et Régions-santé en Europe. Toutes ces initiatives étaient reliées entre elles par la politique commune de la Santé pour tous mise en œuvre à l'échelle régionale. À elles toutes, elles formaient ce que le docteur Asvall appelait « une grande armée de collaborateurs en santé publique »

et ont considérablement accru le pouvoir du mouvement européen en faveur de la santé publique.

Jo Asvall était né le 24 juin 1931 à Oslo (Norvège). Il fit ses études de médecine à l'université d'Oslo et obtint une maîtrise en santé publique à l'Université Johns Hopkins en 1969. Il commença sa carrière à l'OMS en 1959, après avoir effectué son service militaire au centre de recherche de l'armée de l'air norvégienne. De 1959 à 1963, il lança les premiers projets nationaux d'éradication du paludisme menés en Afrique par l'OMS, au Togo et au Dahomey. Il retourna en Norvège en 1963 pour occuper un poste de clinicien oncologue à l'Hôpital norvégien du radium d'Oslo, où il participa à la création du registre norvégien des cancers, mit en place le premier plan de perfectionnement professionnel dans cet hôpital et établit des stratégies de gestion fondées sur les systèmes. Il quitta ensuite ce poste pour devenir directeur du service des hôpitaux au ministère norvégien des Affaires sociales, où il travailla sous la direction de Karl Evang de 1971 à 1976, et coordonna l'élaboration du premier plan national de développement des hôpitaux en Norvège. En 1976, il réintégra l'OMS en tant que directeur des programmes régionaux chargé de la planification et de l'évaluation de la santé au niveau national. Il devint directeur de la gestion des programmes du Bureau régional sous l'autorité du directeur régional Leo Kaprio en 1979 et fut lui-même élu directeur régional en 1985, poste qu'il occupa pendant quinze ans. Après son départ de l'OMS, le docteur Asvall devint directeur du centre danois de réadaptation et de recherche pour les victimes de la torture tout en continuant à travailler pour l'OMS en tant que conseiller.

L'expérience de Jo Asvall permet de définir dix règles de conduite à suivre lorsque l'on occupe des fonctions de direction dans le domaine de la santé publique :

Règle n° 1 : Être présent au moment et à l'endroit où l'on a besoin de vous.

Règle n° 2 : Donner la priorité à la santé internationale.

Règle n° 3 : Se donner pour but d'influencer les systèmes et les politiques.

Règle n° 4 : Traduire dans les faits sa vision de l'avenir.

Règle n° 5 : Préférer les données factuelles à la renommée.

Règle n° 6 : Combiner l'éthique et la science au savoir-faire politique.

Règle n° 7 : Semer les graines du changement et laisser leurs fleurs s'épanouir.

Règle n° 8 : Embaucher des personnes talentueuses et leur donner une marge de liberté.

Règle n° 9 : Être courageux.

Règle n° 10 : Donner l'exemple, être un modèle.

Dans le dernier discours qu'il a adressé au personnel de l'OMS quelques jours avant son décès, Jo Asvall déclarait :

*Je tiens à l'affirmer haut et fort : les possibilités d'action du Bureau régional sont pratiquement illimitées, qu'il s'agisse d'obtenir des ressources ou d'examiner des questions certes sujettes à controverses, mais sur lesquelles nous pouvons aider nos États membres. Notre Constitution nous investit de cette mission, mais aussi, selon moi, d'une importante responsabilité d'action. Soyez courageux et n'hésitez pas à prendre des risques, mais en étant sûrs que vous pouvez vous appuyer sur la Constitution.*

## Gedenkschrift für Jo Eirik Asvall, 1931 2010

Diese Gedenkschrift stützt sich auf Jo Asvalls für ein Projekt zur Geschichte der WHO (2006 2008) diktierte Memoiren sowie auf Interviews mit sechzig Zeitzeugen seines Lebens und seiner Leistungen, was zusammen ein Profil, eine Lebensgeschichte und, Verfahrensregeln' für Wegbereiter der Public Health ergeben soll. Das WHO-Regionalbüro für Europa wollte mit dieser Gedenkschrift eine Kommunikationsplattform schaffen, die es einer neuen Generation von Public-Health-Fürsprechern und Wegbereitern ermöglicht, Jo Asvall kennen zu lernen, aber auch ‚alten Hasen‘ die Möglichkeit bietet, ihre Bekanntschaft mit ihm zu erneuern und von seinen Werten, seinen Einstellungen, seiner Lebensarbeit, seinen Herausforderungen und großen Leistungen zu lernen.

Als WHO-Regionaldirektor für Europa verfocht und führte Dr. Asvall 1985 2000 die Entwicklung der Strategien und Ziele der Gesundheit für alle in der Europäischen Region der WHO bis zur praktischen Verwirklichung dieses Politikkonzepts auf lokaler Ebene und in Institutionen überall in den mittlerweile 53 Ländern der Europäischen Region der WHO. Dieses Konzept der Gesundheit für alle, das durch eine neue Datenbank gestützt wurde, mit deren Hilfe man die Leistung von Gesundheitssystemen in allen Mitgliedstaaten der Europäischen Region der WHO anhand umfassender gemeinsamer Gesundheitsindikatoren vergleichen konnte, bot den Gesundheitssystemen Anregung und beschleunigte die Entwicklung, die dazu führte, dass man den Blick über das eigentliche Gesundheitswesen hinaus auf bis dahin vernachlässigte gesellschaftliche und auf durch Lebensweise und Umwelt bedingte Determinanten von Gesundheit richtete.

Unter Asvalls Führung kam es in diesem Entwicklungsprozess zu zahlreichen bahnbrechenden Public-Health-Vereinbarungen und Initiativen,

- der Ottawa-Charta zur Gesundheitsförderung (1986);

- der Europäischen Charta Umwelt und Gesundheit (1989);
- der Erklärung von Saint Vincent zur Diabetesversorgung und forschung in Europa (1989); und,
- der Charta von Ljubljana zur Reform der Gesundheitsversorgung (1996).

Zwischen 1985 und 2000 erarbeiteten 43 Mitgliedstaaten der Europäischen WHO-Region landesweite Strategien zur Gesundheit für alle, und die Region ging in den Bereichen Ernährung und körperliche Betätigung, Tabakbekämpfung und Eindämmung von alkoholbedingten Schäden weitreichende Verpflichtungen ein. Durch diesen Prozess bewirkte Asvall eine Neuausrichtung der WHO-Arbeitsweise in der Europäischen Region, weitete das Kompetenzfeld der Organisation aus und machte aus dem Regionalbüro einen „Vermittler des Wandels“, der zusammen mit seinen Partnern aktiv für public-health-orientierte Politikkonzepte in allen Sektoren eintrat.

Jo Asvall führte das WHO-Regionalbüro für Europa durch einige der turbulentesten, schwierigsten und reizvollsten Phasen in der Geschichte der Organisation. Nach dem Fall der Mauer, der Auflösung der Sowjetunion und dem Zerfall von Jugoslawien förderte er die Erweiterung der Europäischen Region, die 22 neue Länder aufnehmen musste, und unterstützte diese neuen Mitgliedstaaten systematisch in ihrem Bemühen, sich den Herausforderungen des Wandels zu stellen. Unter Asvall begann die WHO anders mit den Mitgliedsländern zu arbeiten. Man eröffnete in jedem Land „Verbindungsbüros“, in denen aus dem jeweiligen Land geholte Public-Health-Führungskräfte tätig waren, die wiederum den Gesundheitsministerien direkt helfen konnten, WHO-Programme und -Ressourcen zu gestalten und den Gegebenheiten des jeweiligen Landes anzupassen. Asvall schärfte in den internationalen Gesundheits-, Entwicklungs- und Gebergemeinschaften das Bewusstsein für die sich wandelnden und dringlichen gesundheitlichen Bedürfnisse der Region, vor allem in den Neuen Unabhängigen Staaten und in den mittel- und osteuropäischen Ländern, er lenkte die Aufmerksamkeit auf das zunehmende gesundheitliche Gefälle und die wachsenden

gesundheitlichen Chancenungleichheiten zwischen den Ländern und innerhalb der Länder und erschloss neue Ressourcen für die Beseitigung dieser Missstände.

Asvall leitete 1986 nach der Katastrophe von Tschernobyl die globale Reaktion der WHO, die rasch Ratschläge dazu veröffentlichte, mit welchen Maßnahmen sich die Länder und jeder Einzelne schützen konnten. 1991 führte er als erster Regionaldirektor für Europa die Organisation in einen Krieg. Mit der engagierten Unterstützung zahlreicher Mitgliedstaaten der Europäischen Region richtete er in jedem der in den bewaffneten Konflikt im ehemaligen Jugoslawien verwickelten Länder WHO-Büros ein und schickte WHO-Mitarbeiter in diese Büros, wo sie vor Ort mit führenden Gesundheitsfachkräften Programme zum Schutz oder Wiederaufbau der Infrastruktur und der Dienste des Gesundheitswesens erarbeiteten und sich mit der Bewältigung der psychischen Gesundheitsprobleme und des Wiederaufbaubedarfs befassten. Darüber hinaus leitete Dr. Asvall persönlich Verhandlungen zwischen den Gesundheitsministern der beteiligten Länder, was dazu beitrug, dass Vereinbarungen zum Schutz von Gesundheitseinrichtungen zustande kamen.

Asvall begriff, wie wichtig partnerschaftliches Zusammengehen ist und dass man die Menschen unter den unterschiedlichsten Rahmenbedingungen und organisatorischen Gegebenheiten für die Förderung von Gesundheit gewinnen musste. Während seiner Amtszeit als Regionaldirektor etablierte er eine ganze Bandbreite von neuen Public-Health-Netzwerken, die die WHO mit wichtigen Gruppierungen verbanden, so mit Ärzte-, Pflege-, Hebammen- und Apothekerverbänden, mit Organisationen für die Bekämpfung von chronischen Krankheiten, mit Patientenorganisationen und Gesundheitsmultiplikatoren überall in der Europäischen Region der WHO, aber auch mit für die Gesundheitsförderung wichtigen Settings wie Städten, Schulen, Regionen, Krankenhäusern und Gefängnissen. Dadurch kamen beispielsweise das Europäische Forum der Ärzteverbände und der WHO, das Gesunde-Städte-Programm der WHO, die Gesundheitsfördernden Schulen und das Netzwerk Regionen für die Gesundheit zustande. Alle verband dabei

die regionale Politik Gesundheit für alle. Insgesamt bildeten sie das, was Dr. Asvall als „große Public-Health-Armee von Mitstreitern“ bezeichnete, die die Durchschlagskraft der Public-Health-Bewegung in der Region wesentlich stärkte.

Jo Asvall wurde am 24. Juni 1931 in Oslo, Norwegen, geboren. Er studierte Medizin an der Universität Oslo und machte 1969 an der John Hopkins University seinen Master of Public Health. Seine Laufbahn in der WHO begann er 1959, nachdem er im Forschungszentrum der norwegischen Luftwaffe seinen Militärdienst abgeleistet hatte. Zwischen 1959 und 1963 war er in Togo und Dahomey tätig und rief dort die ersten nationalen WHO-Projekte zur Eradizierung der Malaria ins Leben. 1963 kehrte er nach Norwegen zurück, wo er am Osloer Radiumkrankenhaus als klinischer Onkologe tätig war und sich am Aufbau des norwegischen Krebsregisters beteiligte, den ersten professionellen Entwicklungsplan für das Krankenhaus aufstellte und in der Verwaltung Systemmanagementkonzepte einführte. Sein Weg führte ihn danach in das norwegische Sozialministerium, wo er die Abteilung Krankenhäuser leitete. Er arbeitete dort von 1971 bis 1976 unter der Leitung von Karl Evang und koordinierte den Aufbau des ersten landesweiten Krankenhausentwicklungsplans von Norwegen. 1976 kehrte er zur WHO zurück, wo er die Funktion als regionaler Programm-Manager für nationale Gesundheitsplanung und -evaluierung übernahm. Unter Regionaldirektor Leo Kaprio wurde er 1979 Direktor für Programm-Management am Regionalbüro für Europa, und 1985 wurde er selbst zum Regionaldirektor gewählt. Dieses Amt hatte er fünfzehn Jahre lang inne. Nach seiner Pensionierung wurde Dr. Asvall Leiter des dänischen Rehabilitations- und Forschungszentrums für Folteropfer und war nebenbei noch als Berater für die WHO tätig.



**Zehn, aus den Erfahrungen von Jo Asvall gewonnene, Verfahrensregeln' für Public-Health-Wegbereiter:**

- Regel 1.** Sei dort, wo und wenn du gebraucht wirst.
- Regel 2.** Gib der internationalen Gesundheit den Vorrang.
- Regel 3.** Strebe danach, Systeme und Politiken zu beeinflussen.
- Regel 4.** Setze deine Vision handelnd um.
- Regel 5.** Wähle Evidenz statt Ruhm.
- Regel 6.** Verbinde Ethik und Wissenschaft mit politischem Know-how.
- Regel 7.** Schaffe Bewegungen für den Wandel – lass' tausend Blumen blühen.
- Regel 8.** Hole dir begabte Leute und lasse ihnen Bewegungsfreiheit.
- Regel 9.** Sei mutig.
- Regel 10.** Sei ein leuchtendes Beispiel.

In seiner letzten Ansprache vor WHO-Mitarbeitern nur wenige Tage vor seinem Tod lautete Jo Asvalls Botschaft:

*„Lassen Sie mich das so stark betonen wie überhaupt möglich. Das Regionalbüro besitzt ein nahezu unbegrenztes Handlungspotenzial, sowohl im Hinblick auf die Ressourcenbeschaffung als auch wenn es um kontroverse Fragen geht, bei deren Lösung wir unseren Mitgliedstaaten helfen können! Unsere Satzung verleiht uns dieses Mandat - und meiner Meinung nach auch eine starke Verantwortung zum Handeln. Seien Sie mutig und bereit, Risiken einzugehen, doch seien Sie sicher, dass Sie sich dabei auf das Satzungsmandat stützen können!“*

## Мемориальное руководство, посвященное памяти Jo Eirik Asvall 1931–2010 гг.

В основу данного мемориального руководства положены мемуары Jo Asvall, которые были надиктованы для проекта по истории ВОЗ (2006–2008 гг.), и интервью с шестьюдесятью “свидетелями” его жизни и достижений. Оно преследует цель дать представление о характере, истории и “дорожных правилах” лидерства в общественном здравоохранении. В этом руководстве мы Европейское региональное бюро ВОЗ постаралось создать своеобразную коммуникационную платформу, которая позволила бы как новому поколению защитников интересов и лидеров общественного здравоохранения, так и “старой гвардии” узнать Jo Asvall (или заново познакомиться с ним) и почерпнуть для себя что-то новое из его системы ценностей, методов работы, трудов всей его жизни, трудностей, с которыми ему приходилось сталкиваться, и его достижений.

Занимая должность директора Европейского регионального бюро ВОЗ в 1985–2000 годах, д-р Asvall выступал вдохновителем и организатором процесса развития стратегий и целей политики ВОЗ “Здоровье для всех” в Европейском регионе, начиная от выработки концепции и кончая практическим применением в местных сообществах и учреждениях во всех теперь уже 53 странах Европейского региона ВОЗ. Политика “Здоровье для всех”, реализация которой обеспечивается новой базой данных “Здоровье для всех”, где приводится сравнение эффективности работы систем здравоохранения во всех странах Европейского региона ВОЗ на основании большого количества общих показателей здоровья, стала стимулом и катализатором, побуждающим системы здравоохранения выходить за рамки медицинских услуг и начинать работать с социальными, поведенческими и экологическими детерминантами здоровья, которые ранее игнорировались.

Результатами процесса развития политики “Здоровье для всех” под руководством Asvall стали многие знаковые соглашения и инициативы в области общественного здравоохранения, в том числе:

- Оттавская хартия по укреплению здоровья (1986 г.);
- Европейская хартия по окружающей среде и охране здоровья (1989 г.);
- Сент-Винсентская декларация по лечению и исследованиям в области диабета в Европе (1989 г.);
- Люблянская хартия по реформированию систем здравоохранения (1996 г.);
- национальные стратегии “Здоровье для всех” в 43 странах Европейского региона (1985–2000 гг.), а также
- важные обязательства, принятые Регионом в области питания и физической активности, борьбы против табака и снижения вреда, связанного с алкоголем.

Посредством этого процесса Asvall изменил принципы деятельности ВОЗ в Европе, расширил ее технические функции и сделал из Регионального бюро “агента перемен”, который вместе со своими партнерами активно выступает в поддержку политики, ориентированной на общественное здравоохранение, во всех секторах.

Jo Asvall возглавлял Региональное бюро ВОЗ на протяжении одного из наиболее беспокойных и трудных периодов во всей его истории. После падения Берлинской стены и распада СССР и Югославии он принял участие в организации расширения Европейского региона – в него вошли 22 новых государства – и постоянно помогал этим новым государствам-членам преодолевать трудности переходного периода. При нем ВОЗ выработала новый способ взаимодействия со странами, открыв представительства в каждой стране, в которых работали люди, играющие ведущую роль в общественном здравоохранении своих стран. Эти люди могли напрямую помогать министерствам здравоохранения формировать и адаптировать программы и ресурсы ВОЗ в соответствии с условиями этих стран. Он смог повысить осведомленность международных сообществ в области здравоохранения, развития и донорства о проблеме меняющихся и неотложных потребностей Региона в деле охраны здоровья населения, особенно в новых независимых государствах и странах Центральной и Восточной Европы, и обеспечил новые ресурсы и повышенное внимание для преодоления растущих разрывов и неравенства в отношении здоровья между странами и внутри стран во всем Регионе.

В 1986 году он возглавил процесс осуществления ответных мер ВОЗ в связи с аварией на Чернобыльской АЭС на глобальном уровне, включавших в себя экстренные консультации по мерам защиты, которые должны были принимать страны и граждане. В 1991 году он стал первым директором Европейского регионального бюро ВОЗ, при котором ВОЗ осуществляла свою деятельность в условиях боевых операций. Пользуясь решительной поддержкой многих государств-членов Европейского региона, он учредил представительства ВОЗ в каждой из стран-участниц вооруженного конфликта в бывшей Югославии и развернул деятельность сотрудников ВОЗ на местах для проведения работы с местными лидерами общественного здравоохранения в рамках программ по защите или восстановлению инфраструктуры и служб общественного здравоохранения, а также программ по психическому здоровью и реабилитации. Более того, д-р Asvall лично возглавил тайные переговоры между министрами здравоохранения стран-участниц конфликта, что помогло заключить соглашения о защите медицинских учреждений.

Jo Asvall осознавал важность партнерства и необходимость вовлекать в работу людей в самых различных учреждениях и ведомствах на благо укрепления здоровья. Находясь в должности Регионального директора, он создал множество различных новых сетей в сфере общественного здравоохранения, которые позволили связать ВОЗ с ключевыми объединениями в этой области, такими как ассоциации врачей, медсестер, акушерок и фармацевтов, организации по хроническим заболеваниям и объединения пациентов и специалистов по коммуникации в области здравоохранения в Европейском регионе, а также с такими важными для укрепления здоровья институтами и организациями, как города, школы, регионы, больницы и места лишения свободы. В результате были созданы, например, Европейский форум медицинских ассоциаций и ВОЗ, сети ВОЗ “Здоровые города”, “Школы, способствующие укреплению здоровья” и “Здоровые регионы”. Всех их объединила общая региональная политика “Здоровье для всех”. Вместе они составили то, что д-р Asvall называл “великой армией партнеров общественного здравоохранения”, и значительно укрепили силу и мощь европейского движения за общественное здравоохранение.

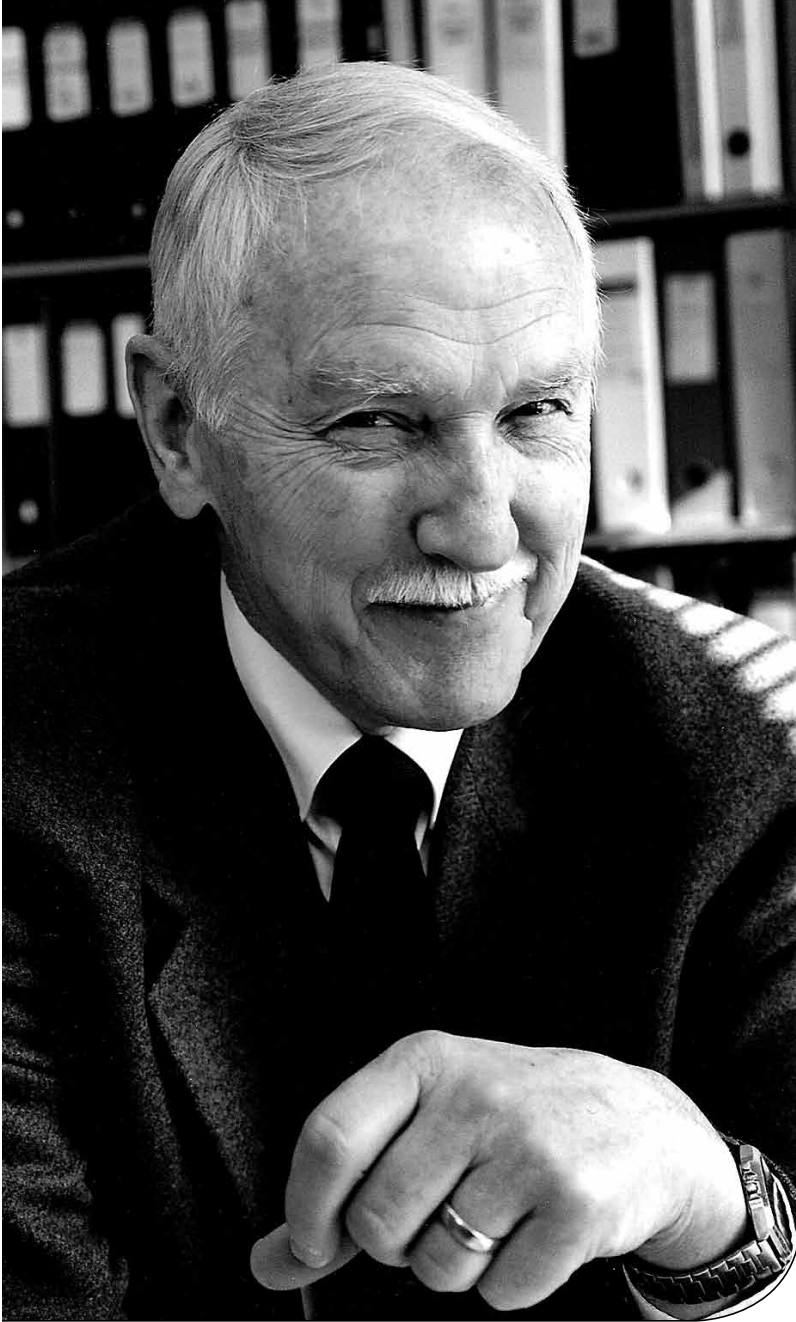
Jo Asvall родился 24 июня 1931 года в Осло, Норвегия. Он получил медицинское образование в Университете Осло, а степень магистра общественного здравоохранения – в университете имени Джонса Хопкинса в 1969 году. Он начал свою карьеру в ВОЗ в 1959 году после прохождения военной службы в Исследовательском центре Военно-воздушных сил Норвегии. В 1959–1963 годах он инициировал первые национальные проекты ВОЗ по искоренению малярии в Африке и работал в Того и Дагомее. В 1963 году он вернулся в Норвегию и стал клиническим онкологом в больнице лучевой терапии в Осло. Там он способствовал созданию онкологического регистра страны, учредил первый план профессионального развития больницы и внедрил системный подход к управлению. После этого он занял должность директора Управления больницами в Министерстве социального обеспечения Норвегии, где в 1971–76 гг. работал под руководством Karl Evang, координируя разработку первого национального плана по развитию больниц Норвегии. В 1976 году он вернулся в ВОЗ и стал региональным руководителем Программы по планированию и оценке эффективности национального здравоохранения. Он стал директором по управлению региональными программами Европейского регионального бюро ВОЗ под руководством Регионального директора Leo Kargio в 1979 году, а в 1985 году был избран Региональным директором. Он занимал эту должность в течение последующих 15 лет. После выхода на пенсию д-р Asvall стал директором Датского реабилитационно-исследовательского центра для жертв пыток (RCT), продолжая сотрудничать с ВОЗ в качестве консультанта.

**Из опыта работы Jo Asvall можно вывести десять “дорожных правил” для лидеров общественного здравоохранения:**

- Правило 1.** Быть там и тогда, где и когда вы нужны.
- Правило 2.** Ставить на первое место интересы международного здравоохранения.
- Правило 3.** Стремиться влиять на системы и стратегии.
- Правило 4.** Превращать мечты в действие.
- Правило 5.** Считать фактические данные важнее высоких чинов.
- Правило 6.** Сочетать этику и науку с политическими приемами.
- Правило 7.** Выстраивать движения сторонников перемен – и пусть расцветают тысячи цветов.
- Правило 8.** Привлекать талантливых людей и давать им свободу маневра.
- Правило 9.** Быть смелым.
- Правило 10.** Вести за собой, показывая пример, разжигать пламя.

В своем последнем выступлении перед сотрудниками ВОЗ, всего за несколько дней до смерти, Jo Asvall высказал такую мысль:

*“Я хотел бы от всего сердца сказать вам следующие слова. Потенциал для действий Регионального бюро практически безграничен, как в деле мобилизации ресурсов, так и при решении вопросов, которые имеют противоречивый характер, но в которых мы можем помочь государствам-членам! Этот мандат заложен в нашем Уставе – и, по моему убеждению, он обязывает нас действовать решительно. Будьте смелыми, будьте готовы идти на риск, но будьте уверены в том, что у вас есть данные Уставом полномочия, на которые вы можете опираться!”*



Spreading the glow

## Introduction

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It gives me great pleasure to welcome you to this Jo Eirik Asvall memorial guide. I am told that this is the first time WHO has published a tribute book to one of our colleagues. I have decided to take this step both to acknowledge Dr Asvall's great contribution to public health in Europe and to take this opportunity to catalyse some reflection and dialogue on the public health values, approaches, policies, targets, actions and leadership principles which informed and guided this great man's life.



I first met Jo Asvall when I was a young professional working for the international department in the Hungarian Ministry of Health and Social Welfare. He came for a country visit in 1981, when he was Director, Programme Management under Dr Leo Kaprio. The WHO Regional Office for Europe had just launched the first common European Health for All strategy in Fez, Morocco and he came to convince us about the importance of this new strategy and explore with us ways we could work towards its objectives.

Let me say that everybody, including myself, was very impressed by his knowledge and ability to analyse complex issues (not to mention his beautiful blue eyes!). In a very short time, he was able to expand our vision of public health – even introducing us to the ‘wild’ idea that health was created in sectors other than health! The importance of lifestyle, environment and social determinants of health were new things for my country, like so many others. And I cannot emphasize this point too strongly: under Jo Asvall's, Leo Kaprio's and Halfdan Mahler's leadership, public health in Europe as we know it today was born.

Jo Asvall was a great visionary, manager and action guide. He measurably helped all countries in the WHO European Region and beyond to open up a new page in our public health histories; to look more broadly at the determinants of health and truly understand and embrace WHO's definition of health as more than the absence of disease. And his ideas and approaches helped steer



the development of European and global public health policy and action through some of the most turbulent and challenging times in history. His bold and persistent championing of Health for All policies and targets, the needs of newly emerging countries in the Region and his ability to catalyse action for health by his ever growing ‘army of public health collaborators’ has significantly enhanced the health and well-being of Europe and the world.

In developing this book, we at the Regional Office have invited 60 witnesses to Jo Asvall’s life and achievements to share with us some of their thoughts, stories and memories of him. We could easily have had 600 or 6000. Our aim is to introduce Jo Asvall to people who did not know this public health legend and to rekindle thoughts, feelings and dialogue amongst those who did. Importantly, most of this book is filled with Jo Asvall’s story as told by himself. We are so immensely grateful to him for having had the foresight and taken the time to dictate his memoirs as part of a WHO oral history project. This is such a treasure house of information. Jo Asvall was always a good story-teller and teacher. He was an excellent speaker, very convincing and charismatic, especially when he was talking about a subject close to his heart. One could see his enthusiasm on his face and in his eyes. Most important, he was able to convince people that what he was advocating was the right way to go. And that was a huge ability. I believe readers will be able to see that ability in his words. Here he tells his story, but at the same time tells us the story of public health in Europe and beyond. Jo Asvall could tell this story better than anyone because he was, in fact, one of our public health giants, who, throughout his life, honestly, humbly, powerfully, reliably and consistently carried the public health/Health for All torch and spread its glow.

I had the honour and privilege of working with Jo Asvall in many capacities and in many locations over many years. I was really looking forward to working with him here in my new capacity as Regional Director. On my first days in the job, I set up an office for regional directors emeritus and I was hoping he could be here a little to work with me: to teach me and to preach to me. We had a lot of communication recently and I still have the e-mails that he sent

to me in the last few months of his life. They are in my inbox and remain very precious to me. Here is an extract that I would like to share with you.

*Dear Zsuzsanna,*

*No one — you perhaps excluded! — has a stronger wish for you to succeed. As for helping out with the policy work, there is nothing I would like more — that is truly the heart and soul of WHO in general and for the Regional Office's new image and drive even more! The new policy must:*

- *... rest on — and must be seen to rest on — solid scientific ground; it cannot be a policy of general lofty principles only, as you see from many other organizations. Without it, it will be shot down.*
- *... be embraced by the Member States. This does not just mean saying yes in the Standing Committee of the Regional Committee and in the Regional Committee, but that the Member States truly embrace it with enthusiasm as their own joint effort, so they feel inspired by it, support its use in their countries and want to actively promote it.*

*... No one knows better than I the multitude of demands that will fall on you right now ... I have only one serious worry ... considering what I have said above about my own health status, I do believe it is urgent to start our talks ... this may be a question of now or never.*

*... I would be grateful if you kept the information regarding my medical condition strictly to yourself — once people know they look at you and treat you as a totally different person, and that's absolutely the last thing I would like to happen!*

*Warm Regards, Jo*

He gave me so much good advice after I was nominated for this job: what I should do, what I should not do, what are the important principles for the Regional Director, how to be sure not to submit to any pressure from anyone, neither Member States nor any institutions. And to have integrity — he was a person of integrity.

We met for the last time on 29 January 2010, when Jo was invited

by then Regional Director Marc Danzon to the handover ceremony on my taking office, and it was there that he gave his last speech to WHO staff. The written version of the speech is in section 5 of this guide. Jo made extraordinary efforts to get to WHO that day. He was terminally ill. Few were aware of his physical condition: all were awed by the power of his words.

As the Regional Office looks to the future and as we start to shape our new directions, there are many lessons to learn from revisiting Jo Asvall's journey as described in this guide, the course that he navigated and charted for us during his over 20 years in the WHO Regional Office for Europe. As we build our new European health strategy, enhance our capacity to address the root causes of health, find ways to curb the noncommunicable and communicable disease epidemics that confront us, flatten our organizational structures, strengthen our technical capacities, empower our staff, develop and rekindle partnerships and networks, and enhance the importance of health for people, systems and policy-makers in all sectors, Jo Asvall's legacy will be a continuing source of inspiration, nourishment and benchmarking.

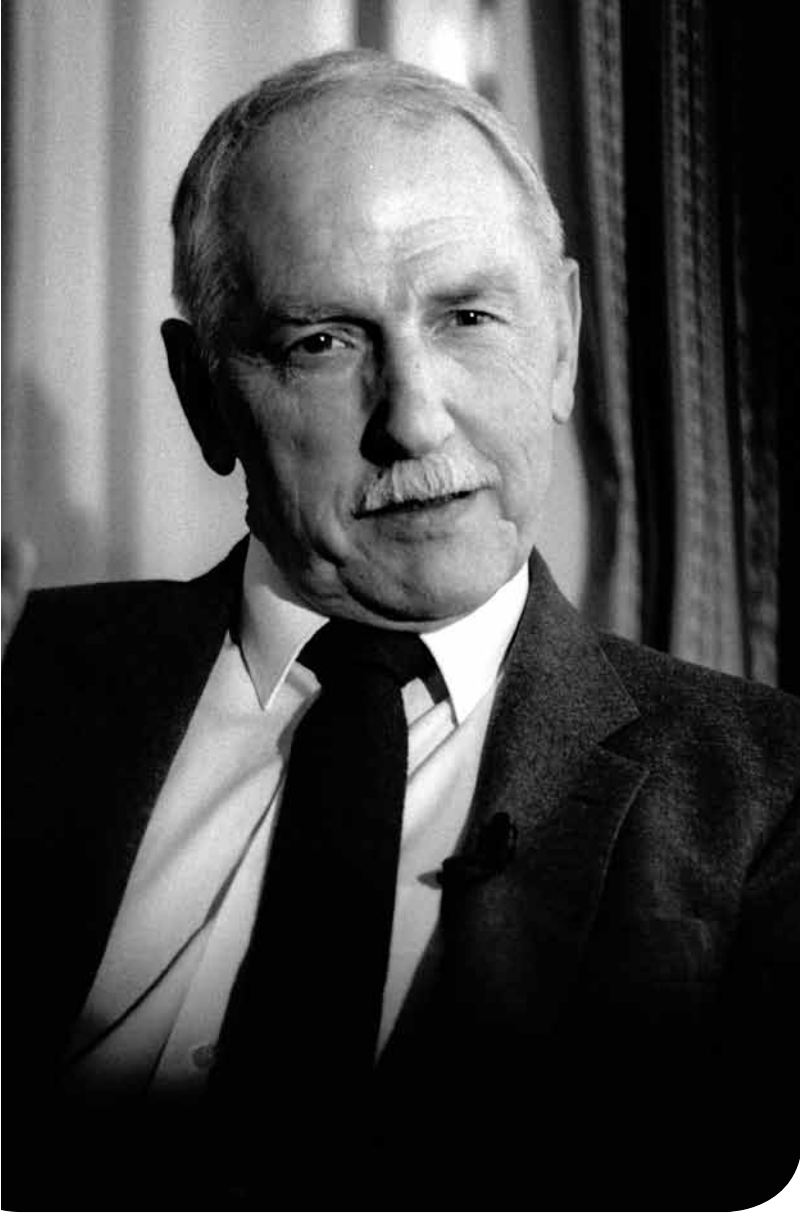
When asked if he thought of anything else he could have done with his life that would have been more satisfying than working for WHO, Jo replied:

*My heart has always been with WHO and I was so proud to be a part of this Organization. It was beyond my wildest dreams to have had this chance to work with WHO. I haven't had a dreary day in my life and I feel extremely privileged because how many people can say that? I have been really lucky.*

And we, Jo, have been lucky and privileged to have known you and had you in our lives. Many thanks to you, Jo. We love you and will cherish and draw on your memory and energy as we keep spreading the glow.

**Zsuzsanna Jakab**

*WHO Regional Director for Europe*



**Guide to this guide**

The idea for this oral history tribute book to Jo Eirik Asvall came from Zsuzsanna Jakab (the Regional Director of the WHO Regional Office for Europe) in the weeks following Jo’s funeral. It stemmed from a desire to acknowledge the extraordinary work of WHO’s relentless former Regional Director Emeritus and to **find an effective way to “hold his memory dear and learn from him”**.

To this end, this Jo Asvall memorial guide tries to create a communication platform that will allow a new generation of public health advocates and leaders to get to know, as well as old hands to reacquaint themselves with, Jo Asvall and learn from his values, approaches, life work, challenges and achievements.

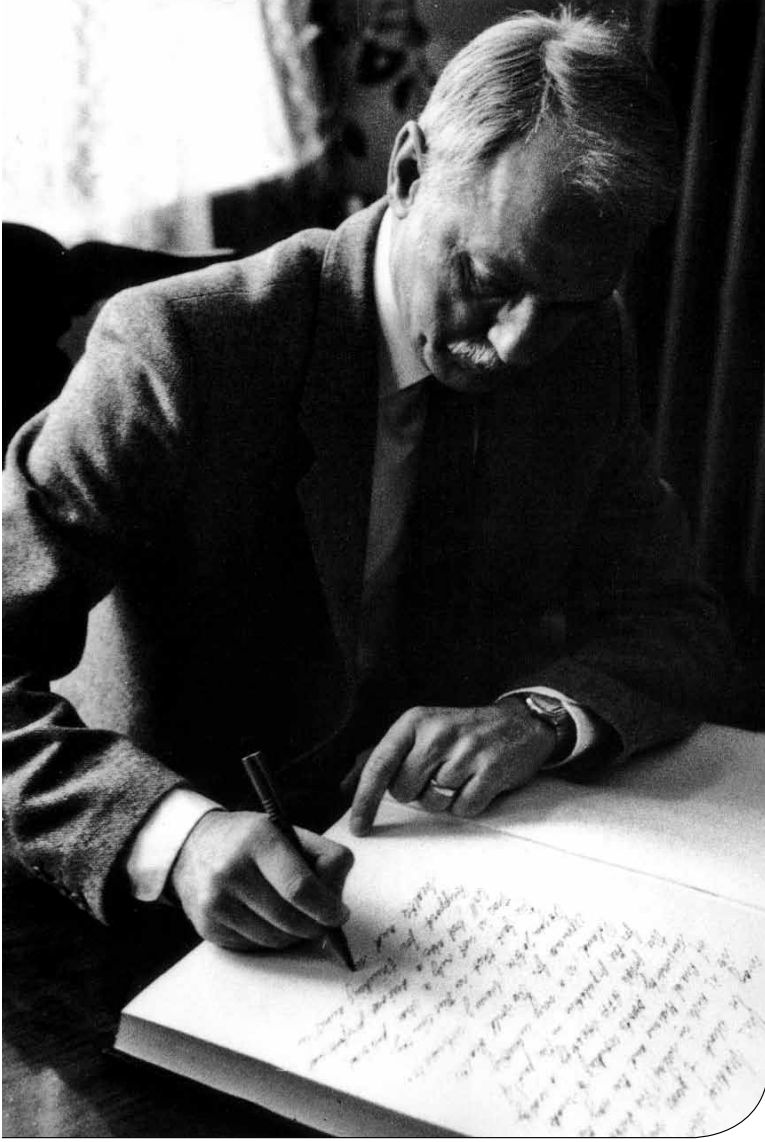
The guide begins by introducing Jo Asvall through the voices of a wide variety of witnesses: people who knew, worked and walked with him at different times of his life. Zsuzsanna Jakab invited these witnesses to participate in this WHO project (the letter of invitation and alphabetic list of names can be found in Annex) and extracts from their contributions are included in section 1.

Then comes Jo Asvall’s story **as told by himself**. Almost all of the text in section 2 is drawn from transcripts of interviews that Jo gave to a WHO history project between 2006 and 2008. Through over 60 hours of interviews, Jo told the story of how he journeyed from being a young doctor working in isolated northern Norwegian villages to becoming head of the WHO Regional Office for Europe. Our thanks go first to Jo Asvall for leaving behind such a rich record of his thoughts and unique experiences, and second to the WHO project team for creating and maintaining such an important public health knowledge resource. Additional interview material used in section 2 was gathered directly from Jo Asvall in December 2009 and January 2010 as part of a WHO writing project that produced a twenty-year history of the environment and health process in Europe for the Fifth European Ministerial Conference on Environment and Health, held in Parma, Italy in March 2010. These interviews were the last ones Jo ever gave. In addition, section 2 includes witness commentary at appropriate points.

Section 3 reflects the belief that Jo Asvall would see this guide as a teaching opportunity: a chance to inform, instruct, inspire and ignite action. So ten rules of the road for public health leadership are presented, which draw inspiration from Jo's words and witness interviews. These rules were originally introduced and delivered by Franklin Apfel as part of a eulogy given at Jo's funeral.

Section 4 gives the witnesses a chance to say thank you to Jo and the guide ends by giving Jo the last word through publishing extracts from his final speech, given at the Regional Director handover ceremony on 29 January 2010.

This book is accompanied by a DVD that contains the complete text of this book, additional pictures and key documents produced during the Asvall era.



## Acknowledgements

Many people have contributed to the making of this book. First, Zsuzsanna Jakab has been the driving force behind this project. Special thanks are due to the Asvall family, particularly Kirsten Staehr Johansen Asvall, who has reviewed all material and provided pictures and stories.

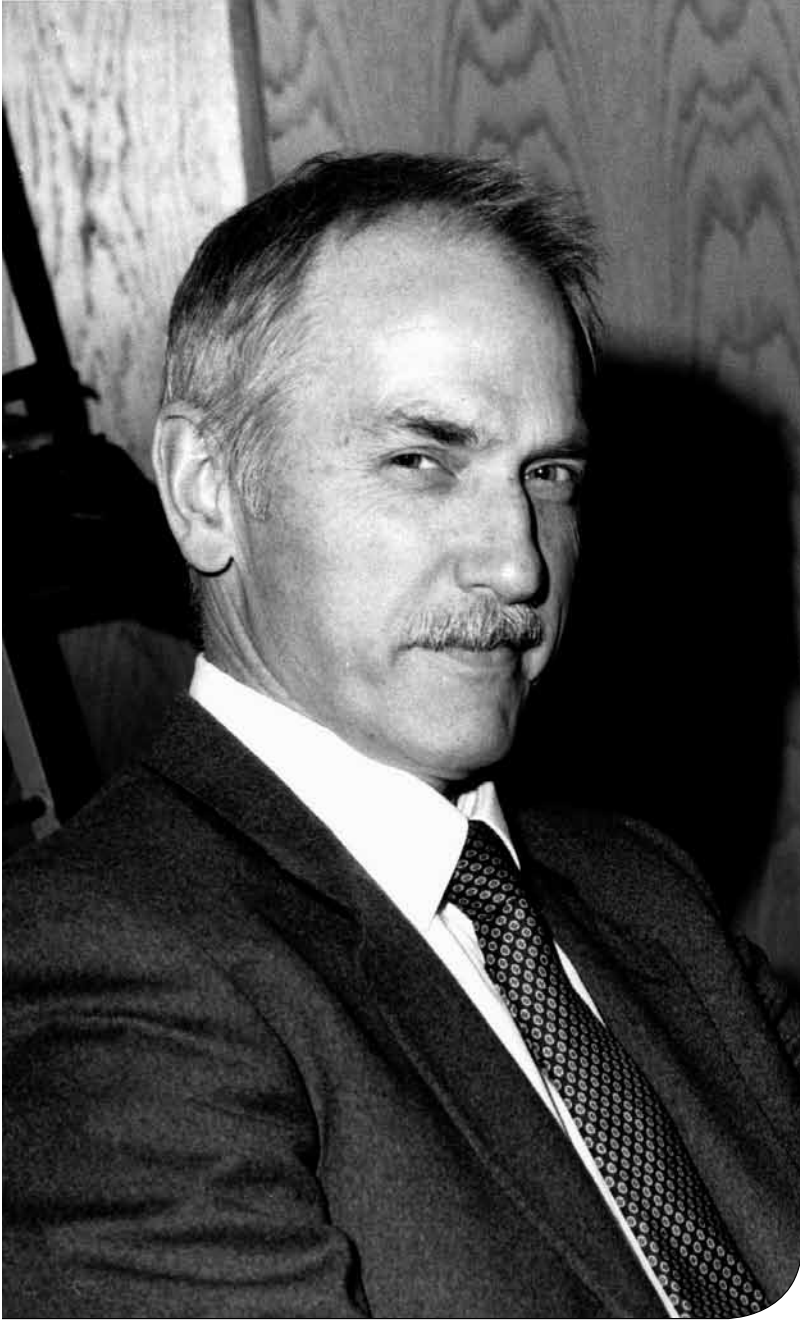
Very special thanks are due to all the witnesses for their time and stories, without which this memorial guide would not have been able to capture so many diverse, rich and loving insights into Jo Asvall's personality, life and times. All of the witnesses' contributions helped shape the development of this guide. Space considerations, however, have allowed us only to include small extracts from most witnesses.

We are grateful to the staff of the Regional Director's Office – Elena Nivaro and Tanya Michaelsen as well as Anne Jakobsen and Johanna Kehler – who ensured that all the witnesses were traced (with their correct e-mail addresses) so that they could be invited to join in telling Jo's story. Carole Modis, who as a member of the Association of Former Staff of WHO initiated an 'oral history of WHO' project (see: <http://www.who.int/formerstaff/en/index.html> under the heading "History Matters"), deserves special thanks for making Jo Asvall's taped interviews (2006–2008) available. We are also grateful to Carole Modis and Lisa Copple, a staff member of the Regional Office, for transcribing the recorded interviews.

Franklin Apfel (World Health Communication Associates (WHCA) Managing Director and Project Director) developed the concept for this project and worked as writer and editor-in-chief. The project team included: Phil Chamberlain (freelance journalist, writer and editor), Mike Jempson (Director, MediaWise Trust, writer and editor), Carinne Allinson (freelance editor), Wayne Powell (Administrator, MediaWise Trust and Project Manager) and Sabrina Cecconi (WHCA Programme Manager). This team was supported by colleagues at the University of the West of England (Bristol, United Kingdom) who helped with transcription, including Adam Clarke, Lucia Dobson-Smith, Arvind Howarth, Myra Lee, Poushali Mitra and Emma Stinchcombe. Final thanks go to WHCA Associates Tuuli Sauren, who provided exquisite and sensitive design work; Steve Turner, who developed the memorial film and DVD; and Erik Luntang for his sharp editing of photos submitted.

We are grateful for all the photographs received for use in this book, generously contributed by: the Asvall family, the WHO Regional Office for Europe archive and the witnesses. All photo credits go to these sources unless otherwise indicated.





## Introducing Jo Asvall Witness voices

### Section 1.

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## You had to notice Jo Asvall

I would recall three things. First, his physical presence. He bore himself erect, he bore himself proudly. You had to notice Jo Asvall. He was not a person who would come into a room quietly — you had to notice Jo Asvall. And the second thing I would recall is that he spoke precisely, he spoke specifically, and he was always clear about what he espoused. And third, when he spoke, he displayed a passion for public health and for improvements in health — that was very welcome for a person of his standing.



### George Alleyne

*Director Emeritus, Pan American Health Organization (PAHO)*

## A true gentleman

Jo Asvall was a great leader, a good communicator, a person extremely committed to his work and his vision of health for all, a very well prepared public health scientist. But most of all, Jo was a true gentleman, an honest, sincere and reliable friend. He was a great leader (always steering but very rarely pushing), with a strategic vision and a strong sense of accountability and a deeply-rooted commitment to evaluation practices.



The first impression when I met him was not that special. Actually he looked a bit cold and stiff. Very reserved and introspective, almost rigorous and even austere. But with time, when I started getting to know him better, I realized that, on the contrary, Jo was very friendly, affable, generous, and extremely sociable and hospitable. His house was always open to friends and his relaxed and witty attitude made us all always feel at home. It is difficult to forget his charming smile and contagious laughter, as well as his pleasant, enjoyable and often funny remarks and interesting stories. Jo Asvall was European in the true sense of the word.

He always contributed to the health improvement of all citizens of the WHO European Region with absolutely no difference among its Member States.

### **Marta di Gennaro**

*Head of the Department of Innovation, Ministry of Health of Italy*

### **Committed to the noble cause of health for all**

I first met Jo Asvall in the 1980s when I was a professor of cardiology at the University of Tirana. Jo Asvall was a great man and good friend who was totally committed to the noble cause of health for all people. When I became the first President of my country, he provided great help to me and my country in our efforts to reorganize our health system and improve the quality of our health care. He helped us, for example, set up cancer registries, building on his personal experience as an oncologist in Norway. He was a brilliant, righteous, moral, persistent health leader with an inspiring personality. It is an honour to pay tribute to him.



### **Sali Berisha**

*Prime Minister of Albania*

### **Renaissance man who kept learning**

Jo Asvall had a complex personality. First, he was a visionary, missionary, leader, manager and politician, to name a few of his many attributes. He was a true Renaissance man with a mission: to fight for much better health in Europe. Jo also wasn't afraid to get his hands dirty: he mended his socks, he constructed a home, etc.



Second, he had different public and private personas. In public he tended to be serious, committed and cordial and didn't show much

emotion or weakness. Privately he was supportive, warm-hearted and showed lots of humour.

Third, he took the protestant work ethic very seriously. His meetings tended to be focused less on how well we did than on what we could do better. He drove himself and those around him hard. He would get up early and work long hours. When we flew back from meetings, when everyone else was relaxing he was often there dictating his travel reports. He had a perfectionist attitude – utopian in vision and expected achievement. He was not afraid to talk about mistakes, always wanting to do better.

Fourth, he was always eager to learn and explore. He started out goal-oriented, but I saw him learn, for example, to focus also on process and embrace qualitative measurements related to health promotion.

### **Herbert Zöllner**

*Former Regional Adviser Futures Fora, WHO Regional Office for Europe*

### **Very many details**

The way he thought, handled people and managed was open. He had his own way, but you could talk to the guy. He didn't cut you short. He may not change his mind, but he would listen. He would not get angry with you as such. He would try it another way if he didn't get his way with you. He'd try to circumvent you in some way. He was nice. He never got excited or loud.



I can tell you straight out Dr Asvall went into the details. Very many details. We were out in Paris on a pre-visit one time and he asked so many questions (how many plugs there were in the walls and where they were and this sort of thing) of my counterpart – a local ASO [administrative service officer] from UNESCO [United Nations Educational, Scientific and Cultural Organization] – that the man got a little bit confused there: who was the Regional Director and who was the administrative officer? That was the kind of person he was. He didn't do it to make trouble. I said to him sometimes,

“Jo, give me a break for Christ’s sake. If I do something wrong, tell me afterwards, but let me do my job please.” I could talk to him (in Danish) that way, when it was just the two of us, because we were on good terms. He wouldn’t lose his cool. He never did. He would just give me one of his big smiles.

### **Knud Thoby**

*Former Administrative Support Officer; WHO Regional Office for Europe*

### **A man of the world, always open to new ideas**

Frankly speaking, Jo was a man of the world, a great human being. I think just focusing on him as a Scandinavian or European doesn’t capture and acknowledge the totality of his importance for WHO and global health.



Yes, he was Regional Director for Europe, but he played a most significant role within WHO for the issues which were beyond, or outside of, Europe. He played a global role. He provided, for example, fantastic support for the programme on AIDS and polio eradication in headquarters.

Jo was always open to new initiatives, to new technology, to new approaches. It was no problem to come to him and say, “Jo, we have an idea. What about that activity there, and there, and there?” and he was always very supportive to that. Of course, he did not always approve the idea, because you could be wrong and sometimes we didn’t know about something behind the issue, like there being political complications. So we didn’t always receive the green light, but he was never closed and saying “Oh, no, no, no, no! We have a lot already, not necessary to do that.” He was very, very supportive to any sort of new initiative.

### **Sergei Litvinov**

*Former Director, Programme Management and Regional Adviser for the EUROHEALTH Programme, WHO Regional Office for Europe*

## Sensitive to gender issues

I first met Jo Asvall in my capacity as a new officer for preventive medicine in the Ministry of Health, dealing with the WHO Regional Committee with my Director of Public Health. I was really impressed. I saw this tall, slim, good-looking man and my first impression was a very serious man. Much dignity; maybe even a little severe. He had a natural authority. He had great charisma and gave a very inspiring speech at this Committee and afterwards, when my director introduced me, I could see that he was in fact full of humour and kindness. He was simple and easy to approach.



He was very motivating and inspiring. He was convinced of the role of public health and also the WHO European office. I think he was 100% devoted to WHO and its goals and objectives. I considered him my mentor at WHO because he called me to chair the permanent committee of the Regional Committee and to participate in several important strategic meetings. He was very encouraging and he gave you self confidence. You could do more than you thought you could. He encouraged female candidates and was sensitive to gender issues.

### Danielle Hansen-König

*Director-General of Health, Directorate of Health, Ministry of Health, Luxembourg*

## A capacity to listen

I was eight years in the WHO Regional Office for Europe working with Jo, firstly as Country Programmes Coordinator and then as Director for Health Policy and Services. During those years there were agreements and disagreements. What was most admirable in Jo was his capacity for listening to other people's views,



even when they were completely out of line with his thinking and strongly (sometimes even aggressively) conveyed. I didn't find any

other person, in my personal or professional life, with this kind of tolerance towards other ways of thinking.

I remember once I strongly disagreed with him on an issue and I wrote him a short memo. He immediately invited me home for a beer and told me, “You know, we don’t write to each other, we discuss with each other.” So it was, he always conveyed the impression to you that he’s going to listen to you. It was an important life lesson. You can try to be intellectually competent, do your work, be determined, but at the same time be open to other people’s views.

### **Constantino Sakellarides**

*Former Director for Health Policy and Services, WHO Regional Office for Europe*

### **Like an old friend**

For Jo Asvall everyone was a potential partner. If you were a liaison officer, director of an institute, workshop leader or a minister, it did not make any difference. For him the thing that really mattered was if somebody was ready to actively promote the health of Europe or not.



When Jo Asvall called me to accept the task of Liaison Officer for Hungary, I told him: “Jo, me, the antidiplomat?” He said, “Yes, I need you.” However, whenever we went to a meeting or other event together, he always whispered in my ear: “Please behave!” He had a great sense of humour.

For me Jo Asvall was a like an old friend. Someone who knew me and my troubles but did not speak about them but just went ahead and did very thoughtful and kind things to make me feel more at ease. It’s not easy to explain. He had empathy not only sympathy. If I had a problem, I could always phone him. You could always talk. He was a boss and at the same time he was not a boss. He would never behave like he was above you. I liked him very much.

### **Marianne Szatmari**

*Former Liaison Officer for Hungary*

## He was no slob

I never saw anything like it. I have never seen anybody work like that. But it was not work as most of us know it. It was like work as art; he was like an artist who can't sleep at night, he has to get up and paint something or finish a piece of sculpture or whatever it is.

Work was art for Jo. When he slept

I don't know. But he never showed any weariness and some of our meetings were quite long and tiring. We'd all travel together and have to go to a meeting early in the morning and late at night and he was always fresh. I was shocked. He was always crisp, like he had just stepped out of a shower. I am sure it didn't make any difference what time of day or night, whenever you saw Jo Asvall you knew he had just stepped out of a shower and he was always clean shaven and he dressed immaculately. His tie was never skewed to the right or to the left, it was always dead centre and the tips of one branch of the tie met the other one. I mean there was never one too long and one too short. He was no slob, believe me. He was a neat dresser in his head as well as his body. He had neat, intellectual handwriting. The way he thought was very neat, everything about him was neat.



## Lowell Levin

*Consultant, WHO Regional Office for Europe; Emeritus Professor of Public Health, Yale University, USA*

## He moved us forward

Jo Asvall was really a very, very intelligent man. He could make an excellent analysis of things and he had real foresight and was willing to take risks, like with the Health for All targets, the Healthy Cities movement or the changes in 1989. He didn't just let the Office roll on,





he knew that public health meant taking action, showing foresight, moving forward not standing still.

### **Hona Kickbusch**

*Former Director, Department of Lifestyles and Health, WHO Regional Office for Europe (1990–1994); Director, Division of Health Promotion, Education and Communication, WHO headquarters in Geneva (1994–1998)*

### **Equal partners**

Jo Asvall and I first met in the early 1980s when, as Director, Programme Management, he visited Hungary and I escorted him on a visit around my country. He showed frank interest in our health system and society. We had long discussions during this visit, which included programmes in rehabilitation facilities and even climbing some castle ruins on the weekend. I was impressed by his relaxed style and straightforwardness. He treated me, a junior civil servant of the health ministry with poor English skills, as an equal partner.



Jo Asvall was not just a public health leader but an experienced advocate and teacher. He often behaved like a Greek philosopher: explaining and arguing while walking, or chatting during lunch.

Almost a decade later, in the mid 1990s, I returned to international health policy work as health minister of my country. During those four years we met many times and he gave me a lot of wise advice regarding our health reforms, especially in reducing excess hospital capacities. He did it gently, positively and emphatically, very often quoting the experience of Norway.

### **Mihály Kökény**

*Former Minister for Health of Hungary and current Chairman of the Executive Board of WHO (2010–2011)*

## A health legend

I met with Jo Asvall almost every year at the World Health Assembly, from 1979 onwards. In spite of many obligations and duties he had during the Assembly, he always found time to hear about health problems in my country. He was a patient listener, sincerely interested and full of understanding and concern. He was a highly motivated and devoted professional, dedicated to health objectives and goals, not only of the Region, but of each and every particular country; a professional who was capable of recognizing countries' health needs and ready to provide them with advice, support and assistance in developing and implementing their own health policies. Because of these attributes, Jo Asvall has become a hero in health systems of many countries and in the future he will always be remembered as a health legend.



## Dusan Bobarevic

*Former Director of the Department for International Cooperation of the Federal Ministry for Labour, Health and Social Policy of the former Republic of Yugoslavia*

## Pleasant collocuter

I'd recommend to new public health students to behave, act and live like Dr Asvall. Dr J. Asvall was a brilliant diplomat and pleasant collocuter with a permanent accompanying, exquisite sense of humour. I met Dr Asvall for the first time in 1990, when he attended the First World Congress on Prevention of Abortion, 'From Abortion to Contraception', held in Tbilisi, Georgia. More than 400 representatives from 134 countries attended the conference, including high-level officials. I was warned that among them, the most ambitious was considered to be the Director of WHO Regional Office for Europe, Dr Asvall. Accordingly,



I was awaiting his arrival with respect and even fear, more so as our institute was a WHO collaborating centre. When I finally met him I saw a most pleasant man – a handsome, even beautiful, smiling person who was approachable and highly professional. This was the beginning of a lifelong friendship.

### **Archil Khomassuridze**

*General Director of the Zhordania Institute of Human Reproduction, Georgia*

### **A visionary with a task**

“A vision without a task is but a dream,  
A task without a vision is mere drudgery,  
A vision with a task – there is the hope  
of the world.”

Jo Asvall’s vision was evidence-based and well researched; he was clear about the tasks needed to achieve the vision; and he was inspirational and able to make people from many backgrounds see how they could contribute to this achievement.



### **June Crown**

*Past-President of the United Kingdom Faculty of Public Health; former District Medical Officer, Bloomsbury Health Authority, London, United Kingdom*

### **Life-saving planning**

In a general staff meeting I accused Dr Asvall of over-planning. So he put up a slide showing a sinking ship, with all passengers drowning except one who had a lifeboat ready!

### **Marsden Wagner**

*Former Regional Adviser for Maternal and Child Health, WHO Regional Office for Europe*



## Such was he always

Dr Jo Asvall was a talented, well educated, erudite, responsive and kind person, who perfectly knew history, literature, was fond of music. He was very good company. He always said to me that one should work hard regardless of all hardships, work for people, help people, do a lot of good for people every day. Such was he always.



## Farman Abdullayev

*Former WHO Liaison Officer for Azerbaijan*

## A symbol of ethics, tact and diplomacy

Dr Asvall had arrived in our country as a senior adviser of WHO to examine the possibilities for helping our country in the framework of WHO assistance to the countries. His stature, his smile and elegance of behaviour struck all of us at the first sight. I and my colleagues have learned a lot from him over the years



and have the highest regard for him as a unique international public health professional, a man of honour, a symbol of ethics, tact and diplomacy. He helped draw attention to both the assets and needs of our country. He was always careful to deal with every detail of a problem and could remember important details that others would not even notice. For us he came to symbolize WHO, its values and mission, and we considered him to be a man to be honoured, adored and imitated.

## Vladimir Gusmari

*Former WHO Liaison Officer for Albania*

## Obvious candidate

A sincere and ardent practitioner of public health in its broadest sense as outlined by WHO, a firm advocate of equity in health and health as a human right, dedicated to people and to support of countries in their health development, promoter of healthy environments and lifestyles, involved in health technology and innovation. When Dr Mahler retired, Jo was an obvious candidate to replace him, but he refused to pose his candidature just in case Dr Mahler might change his mind and stand again for Director-General. Although I was retiring simultaneously with Dr Mahler, I told Jo that if he were to be appointed I would be ready to stay on with him for one year in order to ensure a smooth transition.



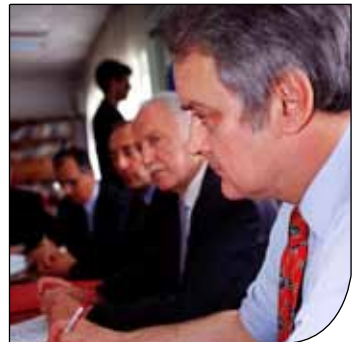
### Joshua Cohen<sup>1</sup>

*Former Chief Adviser, Director-General's Office, WHO headquarters*

## An ability to inspire and generate loyalty

I think Jo Asvall's greatest accomplishment was his ability to inspire and generate loyalty and warmth of feeling amongst the people who worked for him and public health advocates outside the Regional Office.

The Regional Office in his years was intellectually alive. It was a powerhouse of innovation and ideas which captured the imagination and interests of people who worked inside the Office and made them want to work there. There were always discussions going on about public health in Europe. People worked weekends and nights. The parking lot was always full.



<sup>1</sup> Joshua Cohen died on 9 July 2010, just one month after making this contribution to this guide.

And this had an effect outside the Office as well. When I worked for the Department of Health in the United Kingdom, I can tell you that many of our ideas about health improvement, prevention and promotion were coming from the European Office.

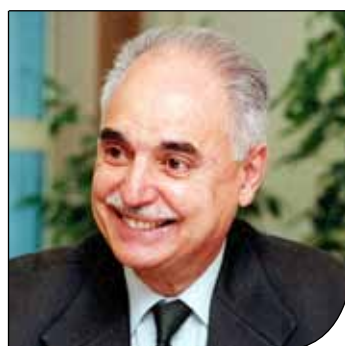
It was really a wonderful time. A time when Asvall was able to build on people's internal commitments and capture the imagination of people outside.

### **Richard Alderslade**

*Former Regional Adviser, Humanitarian Assistance and Partnerships, WHO Regional Office for Europe*

## **True spirit of cooperation and collaboration**

For me, Dr Asvall will always be remembered as a symbol of what can be achieved in public health by transparency, cooperation, dedication and persistence to achieve the target.



Dr Asvall is an excellent example of the true spirit of cooperation and collaboration. When polio was 'travelling' between many countries of the Eastern Mediterranean and European Regions, we decided together to establish a coordinated approach involving 18 countries and areas with diverse political systems. Representatives of these countries met regularly to exchange information openly and together to plan sound strategies to fight poliomyelitis. These countries organized synchronized National Immunization Days so that all the children under 5 (resident or mobile) were vaccinated simultaneously.

As a consequence, 15 of the participating countries and areas became polio free by the year 2000 and the number of cases in the remaining countries decreased significantly.

The successful lessons learned from this MECACAR initiative and the forum of partnership which it created have now been used as a model in other parts of the world. Similarly, they are being used for

other infectious disease control and elimination challenges, such as measles.

I also very much appreciated Jo's more recent visit to Gaza and his endeavours in meeting the urgent health and humanitarian needs of the people there.

### **Hussein A. Gezairy**

*WHO Regional Director for the Eastern Mediterranean*

## **An iron fist in a velvet glove**

Jo Asvall had a unique sense of synthesis, integrating the complexity of health problems, and never became attached to one single aspect only. These qualities helped him to highlight the heterogeneity of the various aspects of care. He also offered very pragmatic solutions which could help us to improve healthcare delivery: for example, in the St Vincent



Declaration where needs of patients and their families, as well as the importance of new approaches for continuing education of healthcare providers, were seriously acknowledged and integrated for the first time on a Regional basis into diabetic care programmes. It was at that time that the official need for patient education was recognized. Dr Asvall expressed a unique inner balance which helped him to face the most heterogeneous situations despite very complex political situations. He had an iron fist in a velvet glove. He was gifted with an exceptional sense of observation, fundamental respect for national and cultural differences, and although he had outstanding skills in analysing what he saw, he never judged the healthcare providers in their attempt to improve health and quality of life of patients.

### **Jean-Philippe Assal**

*Former Director, WHO collaborating centre for reference and research in diabetes education (1983–2008), Geneva, Switzerland*

## Always trying to do the right thing

Jo Asvall was a visionary, with a clear sense of purpose, determined, uncompromising. He saw the big picture but also had a capacity for seeing the significance of and coping with the detail. You could at times disagree profoundly with him but you would go along with him because you knew he was trying to do the right thing. I think that as Regional Director he always tried to show and to act on his commitment to the whole Region. This was true, even if in different ways, both before and after the upheaval that came with the end of the Cold War. He was sustained in that by the good fit that he saw between Nordic and United Nations values, especially solidarity and equity. He ensured that these values were prominent and explicit in all Regional policy documents.



### Keith Barnard

*Former Principal Investigator, WHO collaborating centre and Head, Nuffield Centre for Health Services Studies, University of Leeds, United Kingdom*

## Three leadership assets

David Gergen, who was adviser to five US presidents, said in his book *Eyewitness to Power: the essence of leadership* that a good leader needs three assets: one is a really strong vision and that, I think, Jo Asvall certainly had. He was clearly committed to the Health for All objective and how to bring really great ideas down to goals and implement them in the countries. Secondly, he needs a lot of technical knowledge. Someone who doesn't know what he is dealing with is lost. Jo Asvall drew on the best of traditional medicine and knowledge





of medicine and brought it into the public health arena. And thirdly, he needs a strong character. Jo Asvall was an extremely determined public health leader who was committed to that part of public health he considered to be important. He was a person who could enthusiastically talk about things and he wanted you to share that enthusiasm and align to his ideas. It was clear from the first minute I met him that he felt that the Regional Director should actually be the one who leads the Organization and that the Regional Committee as a strategic board above it should give him the support he needs.

He learned to be an effective politician and how to use the instruments of international organizations to bring health to countries. He saw the European Region as a public health laboratory and developed approaches, like Healthy Cities, that when found to be effective could be exported to the rest of the world.

### **Thomas Zeltner**

*Former Head of the Swiss Federal Office of Public Health and Secretary of Health and Head of the Swiss delegations to the Regional Committees and World Health Assemblies of WHO (1991–2009)*

### **Masterfully brought Europe together**

Europe is a very complicated beast. There are so many countries, each with its own needs, own language, own ideas about how public health should be done. In his time the situation was further complicated by the opposition between the west and the east. To bring all these countries together in pursuit of a common goal was a masterpiece.



Making WHO and the Regional Office for Europe a significant voice in all these countries is a big challenge. WHO doesn't have much money. It is an organization that strives to introduce and maintain moral norms of public health. The great success of a leader of WHO is to get people listening to the notions which

might be useful to all and bring about consensus on the ideas that could be useful to public health. Jo Asvall was able to do this!

### **Norman Sartorius**

*Former Director of the Division of Mental Health, WHO headquarters*

### **A good judge of the useful**

Jo Asvall was a straight man, full of life, devoted to his job, a good friend who served his Organization loyally. He was a man of many interests – music, theatre and arts. He was a cultured man. For the WHO Regional Office for Europe he helped the Organization shift from being focused just on technical scientific work



to much more practical intercountry and country-based activities. He was able to sift through so many theories and reports and was uniquely able to judge what could be useful. He helped see how Health for All was important to Europe. For Greece, he was a great supporter of our programmes and helped us overcome many performance challenges.

### **Meropi Violaki**

*Honorary General-Director of the Hellenic Ministry of Health and Solidarity; Greece*

### **A true egalitarian**

Jo Asvall was truly an egalitarian. This was good for women and others. He very quickly took Mahler's global Health for All targets and said we need a European version. We were the first region to do it and it was because of his leadership and advocacy.



### **Carolyn Murphy**

*Former Director of Administration and Finance, WHO Regional Office for Europe*

## Not sentimental socialism

Jo Asvall came to the fifth General Assembly of the Association of Schools of Public Health in the European Region in 1977 to give us encouragement and try to work out how we could relate to the WHO programmes. He made an immediate impact because he was charismatic, so committed, so



forthcoming. He was not what one thought of as the typical international civil servant. He was a breath of fresh air. He was very clear about what he thought we should be doing and one encouraging outcome was the European Collaborative Health Services Study, which demonstrated international comparisons between primary and secondary care.

Jo Asvall had a presence, he was focused, he was articulate. He never waffled or rambled. He always had a point to make and would always make it with clarity. And he would expect people to respond. In fact, I can never remember when people did not respond or did not want to respond – not because he was deliberately provocative but because he was striking chords that resonated, particularly with young public health people who had concerns about social justice and about the value of education and environmental background and dealing with inequalities to ensure people had equality of opportunity and to realize their potential. Not sentimental socialism but a practical, public health-oriented programme, scientifically based, evidence-based, irrefutable in terms of public policy, never at all party political.

### **Alexander (Sandy) Macara**

*President, National Heart Forum, United Kingdom; former Chair, British Medical Association*

## Never any disrespect for his fellow man

Jo Asvall was an enormously innovative and systematic person in health learning and administration. He understood how effective reorganization of health services required a needs and existing resource (asset) assessment. Jo was a true Scandinavian representative because of his honesty, rationality, decency and respect of fellow men irrespective of age, sex and ethnic background. He had an attitude of public health leader. I never saw any attitude of disrespect to his fellow men.



### Otto Steinfeldt-Foss

*Former Director of Mental Health Services, Norway*

## Helped with health reform

I met Jo Asvall in 2000 in Istanbul during a WHO European Regional Committee Meeting. I was Minister of Health of the Kyrgyz Republic at that time. Under his leadership, WHO helped us develop the ‘Manas’ Health Care Reform Project (1996-2006). This project was instrumental in facilitating the development of a rational comprehensive approach to health care reform.

### Tilek Meimanaliev

*Former Minister of Health of Kyrgyzstan*

## Would have been a very good Director-General

While he was first and foremost a great public health thinker, Jo Asvall was also an extremely good diplomat. When he disagreed, he always did so politely. For instance he would say (smiling), “I beg to disagree, for this and this reason”. He usually pointed out very



well why he disagreed and thus often managed to convince. Later on, when he became Regional Director, I worked with him on WHO's top-level Global Programme Committee. Of course, there were different priorities and opinions in this group comprising all regional directors, but even here I never saw Jo get really upset. He was an extremely good diplomat.

Jo was much more global than just European. He would have been a very good Director-General. He was positive and looked towards the future. He had a global vision of health in the world, supported by his experience in many continents. Many of his ideas have now found their way into practical policies and action for health throughout the world.

### **Claire Chollat-Traquet**

*Former WHO Director, Division of Development of Policy, Programmes and Evaluation, WHO headquarters*

## **Evidence over eminence**

Jo Asvall can be described as one of the first professional and technical pillars of public health in Europe. The WHO European office before Jo was mostly technical and diplomatic in nature when Jo came in the atmosphere changed. Evidence-based public health and health care were introduced.

He was the man who said that the top technical and professional people should speak out even if they were sometimes politically incorrect. When views expressed by national or international public health representatives were not technically or professionally well underpinned, Jo was not afraid to highlight that. Jo pursued the technical agenda with a certain level of personal integrity and a moral standard that made it acceptable to people.

If Jo himself were in a classroom of new public health students, contrary to some of his predecessors and successors or any directors of WHO in any part of the world, Jo would be informal. He would joke and would like to interact with people as a normal human being. Jo never had an aggrandizing attitude. He always wanted to be a regular citizen of Europe.

Jo dealt with people with integrity and honesty; he also had a tendency to tell other people how to behave. But it was acceptable in the way he did it. He had a disarming style. The powerful instrument that Jo had was his facial expression. He had bright blue eyes and even if he was furious at certain things he would smile at you. He was one of these unusual people whose eyes could smile. His whole face could smile at you and with his optimistic eyes, it would be unusually disarming. And this would make it very difficult for a person not to be influenced by that.

**Ok Pannenberg**

*Former official of the Netherlands Ministry of Health (1980–1985); official of the World Bank (1986–2010)*

**Proud of ‘our boss’**

Dr Asvall had ‘old world charm’. It didn’t matter that he was the boss, he never behaved arrogantly. He would do all the things that some people now think are old-fashioned, like holding your chair or opening the door, helping you put on your coat, or making sure you were looked after at the table.



He was a gifted speaker and you could see him take the audience with him, whoever they were – ministers, presidents, parliamentarians. By the time he was finished, they were already getting a policy process started. At times like that I would feel quite proud that he was our boss.

**Anna Ritsatakis**

*Former Head, WHO European Centre for Health Policy; WHO Regional Office for Europe*

## Almost too good to be true

Jo Asvall never paid much attention to formalities. He just walked in like any other colleague and started talking and discussing. There was no protocol involved in his manner. It was just like talking to your neighbour or colleague. He was very relaxed in a positive way. I'd describe him to a classroom of new public health students as knowledgeable, goal-oriented, approachable, honest, reliable, visionary and supportive. Sometimes it felt like he was almost too good to be true. He would encourage people to speak openly. He also allowed himself to be challenged, which I believe showed his strength as a leader. He did not gossip at any time. He was always open to listening but had his arguments for the final solution. He was a very hard-working man who believed in democratic principles and was not different in front of you than behind your back. He did not play games that would bargain on people's situation and never tried to buy you onto his side.



### **Mikko Vienonen**

*Former WHO Special Representative of WHO Director-General in the Russian Federation (1999–2006); Regional Adviser for Health Services Management, WHO Regional Office for Europe (1993–1999)*

## Six hours of sleep

I was always envious of Jo's ability to be satisfied with only six hours of sleep a night. He would wake early, take a shower and be ready for a long day. His working day was always longer than others' and this was definitely an advantage.

### **Sverre Harvei**

*Former Head of the Hospital Division in the Ministry of Health, Norway*

## Maintained an interest in tropical medicine

Jo Asvall was handsome, dignified, diplomatic, single-minded when he wanted something, had amazing determination, was not prepared to give up, optimistic and quite caring about the people around him.



I remember being impressed that he maintained a big interest in tropical health issues, or issues that weren't really relevant to the European Region, and often he'd ask me to get papers on things going on in tropical health.

## Linda Topping

*Former Personal Assistant to Jo Asvall, WHO Regional Office for Europe (1991–1999)*

## A networker who catalysed action

I may say, in my view, that Jo was the main architect in making WHO Europe very prestigious. Due to his vision and talent, the WHO Regional Office for Europe achieved great success. He made WHO an instrument that could really help countries to resolve health problems in a practical way. He not only created a network of WHO offices in countries but also a network of collaborating centres. He knew that the Regional Office needed to reach out beyond its own staff. It had to engage other collaborators and scientific organizations. Jo was able to help interconnect and catalyse action by some of the vast scientific resources of European Member States.



## Isuf Kalo

*Former Regional Adviser for Quality of Care and Appropriate Technology; WHO Regional Office for Europe*



## He gave us confidence

Jo Asvall was a real champion for nurses and midwives. He helped open up a broader canvas for the profession, firstly through the European Conference for Nursing in 1988 (Vienna) and more recently through the WHO Regional Office for Europe policy framework HEALTH21 (2000). He believed that a nurse



is not just someone who operates in a hospital or who visits the patient in their own home to do, for example, a dressing. He legitimized our wider role ... he had a real belief in our contribution throughout the life-cycle. He gave us confidence in ourselves. He was a great advocate of our role in public health.

Nurses and midwives should, he believed, focus on health (and not just sickness) because even sick people have the potential for health gain. This view about nursing was quite visionary at the time. The nurse working with families in a community context was something that people were familiar with but he saw a similar role for the nurse in the hospital. He wanted the hospital nurse to understand the importance of the family and the community context to the sick person's recovery. He was a visionary, from my point of view.

### **Ainna Fawcett-Hennessy**

*Former Regional Advisor, Nursing and Midwifery, WHO Regional Office for Europe (1995–2006)*

## CINDI is born

I met Jo Asvall for the first time in the WHO Executive Board when he was presenting his progress report on the European Regional Health for All implementation. I was head of the Noncommunicable Disease (NCD) Department in Geneva at that time.

I must admit that his report, compared to that of other regions, was really very impressive, very well



structured, backed up by both conceptual elements and practical experience. He was really very friendly and very open. Then I said, why don't we have lunch together. And we went to a small restaurant. And we had a very nice and long talk about NCDs and how alcohol strategy and health promotion could guide actions in NCDs and be used in developing policies at the national and other levels. We talked about how we could bring our work to countries. And it was from that conversation that I believe the Countrywide Integrated Noncommunicable Diseases Intervention (CINDI) Programme was born!

Soon after that I was contacted by a director in the European Office who asked me about going out to the countries. So that was how things were started.

### **Vilius Grabauskas**

*Former Director, Noncommunicable Diseases, WHO headquarters; Chancellor, Kaunas University of Medicine, Lithuania*

### **A humble and egalitarian elitist**

Jo Asvall was a strange combination of a medical rationalist. He had this cold mind but at the same time he had a warm heart. As a cold person, he could think in terms of statistics and mathematics, and as a warm person he had a way with people – old and young, men and women. It was also why he became so successful as an adviser. He consulted after he had resigned from Copenhagen. Then he could capitalize on his social and managerial skills.

At bottom he was and remained not just a Scandinavian, but a Norwegian. He was, almost by necessity, an elitist (intellectually) but he was a humble and egalitarian elitist. When we talked about his past, he talked with the greatest passion about his time as a young physician in the little district of Vikna (1957), about 800 kilometers north of Oslo. But what was special about Jo was that



he transformed his Norwegian egalitarianism into a transnational egalitarianism.

### **Ole Berg**

*Professor of Health Management at the University of Oslo, Faculty of Medicine, Department of Health Management and Health Economics, Norway*

### **An orchestra leader**

During 1961–1964, I was Regional Malariologist at WHO Regional Office for Africa (Brazzaville, Congo) while, until 1963, Asvall was the Togo/Dahomey WHO Malaria Project Leader. I was therefore frequently visiting Asvall in Togo to follow up his project activities. In 1978 I was reassigned to WHO Regional Office for Europe (Copenhagen) as Chief of Coordination. Until 1982 my activities were regularly programmed with and agreed by Asvall, who meanwhile had become Director of Programme Management. One of the most remarkable and successful programmes of that time was the WHO Regional Office for Europe Disaster Preparedness Programme that included both natural and man-made disasters. This plan helped change the way WHO dealt with disasters. Previously, natural disaster support from WHO was mainly centred around providing cash or commodities as a token of sympathy. This plan outlined a wide variety of other actions, including on-the-ground support, and provided a framework for action in many regional disasters. My impression was that Jo Asvall was like an orchestra conductor. He was capable of obtaining the best from his staff, thus implementing a multi-faceted regional health programme.



### **Concetto Guttuso**

*Former Chief of Coordination, WHO Regional Office for Europe (1978–1985)*

## Kept Health for All alive

Dr Jo Asvall was a true comrade-in-arms to Dr H. Mahler in developing and promoting the Health for All strategy, with values of equity and solidarity in health and primary health care and health promotion as cornerstones of the European thrust to improve the health of citizens in all 53 Member States up to the end of his service in WHO, even when WHO headquarters downplayed it in the late 1990s.



## Mark Tsechkovski

*Former Director of Health Systems and subsequently Disease Prevention and Quality Care, WHO Regional Office for Europe (1987–1995)*

## Cohesive force

While I was working in WHO headquarters in Geneva, my relationship with Jo Asvall was particularly intense during the phase when he was the Director, Programme Management in Copenhagen. In that function he was a member of the Programme Development Working Group, which had been established in the late 1970s. Its members were the programme managers of the six regions of WHO, who met periodically. I was the Secretary to that committee. Jo Asvall was a very constructive and cooperative colleague who helped in bringing about a better cohesion between and among the WHO regions and headquarters in the implementation of the Health for All policy.



In the early 1990s, in the context of the dramatic changes after the fall of the USSR, I admired the way in which Jo Asvall, by now WHO Regional Director for Europe, integrated the 20-plus new Member States and their particular challenges into the work of the

Region. He supported these countries in establishing their own health systems in response to their needs.

I last saw him when he accepted an invitation to give a talk in Berlin in 2008 and I enjoyed a lively discussion as usual.

### **Ingar Brueggemann**

*Former Personal Representative of the WHO Director-General to the United Nations, New York*

### **He knew every single subject**

In my view, Jo Asvall was a great Regional Director because he knew every single subject. When you are going to a country as a Regional Director they expect everything from you. They expect you to know the politics, the strategic issues, the technical issues and if you can't take on any of the challenges – be it genetics or



economics – then they don't take you seriously. So that's why Jo was extremely popular within the Member States, because whatever issue came up with the president, the ministers, he could talk about that.

When he went to the institutions to talk about technical issues he could also talk the talk. Jo liked the technical issues and knew them deeply enough to discuss them with experts. But having said that, he also had a good political mind – both in policy-making and in the diplomatic sense. If there were any political issues coming up in the Region, Jo was well aware of how to deal with them. So Jo combined the political knowledge and skills as well as a deep technical knowledge.

### **Zsuzsanna Jakab**

*WHO Regional Director for Europe*

## Tackled issues personally

Jo Asvall was the type of leader who was prepared to tackle issues personally

he would not just delegate all the time. He was prepared, when needed, to pick up the phone and was extremely efficient. He was the spirit of the office and always open to innovation. My own experience is that whenever he had an opportunity to exchange views he would do it with an open mind and friendly approach. He had a very strong and far-reaching vision of what WHO Regional Office for Europe should do.



That period between 1980 and 2000 was an extremely positive one. He had a vision about how best to work with new and old Member States but also how they could establish their own objectives. My own experience was that in spite of problems, difficulties and obstacles, we were never at any time going to stop our collaboration on the undertaking to establish specific country-based centres and offices of the Regional Office (also known as geographically-dispersed offices). He was very strong.

### Vittorio Silano

*Former Consultant, WHO Regional Office for Europe; Chairman, Scientific Committee, European Food Safety Authority*

## So happy to be close to him

Two years ago I invited Jo Asvall to come and spend some time with our students at the Kazakhstan School of Public Health in Almaty. Dr Asvall came and gave lectures and held discussion seminars with our masters students. Everyone was so impressed and excited to hear his stories and vision for health in Europe. Everyone was so happy to be close to him.



The Kazakhstan School of Public Health was actually his idea. In 1997 he signed the agreement with the then Minister of Health to establish the school. The aim was then as it is now, to bring new knowledge and skills to the people of our country and beyond.

### **Maksut Kulzhanov**

*Rector, Kazakhstan School of Public Health*

### **His last letter**

Dr Asvall was very different from other managers and leaders I worked with because he always had a very human aspect in his relationship with his staff, friends and colleagues. I never saw him being blunt or making another person feel ashamed. He always told the truth, in a way that made one accept that this was the truth. If he had to say something negative, he did so in a sensitive way, trying never to hurt anyone. He was a hero for me, a true role model.



And how he was able to find time for everything, I really do not know. For example, when I wrote travel reports Dr Asvall would read them line by line with a red pen in hand. He would make meticulous notes on the margins for future ideas, ways of expansion, all the while pointing things out: “Be cautious with this, expand on that”, etc. He always got back to me immediately, my travel reports never waited long on his table and he looked at everyone’s travel reports! In more than ten years of our professional relationship, I never had to say, “Dr Asvall I sent you a letter, you haven’t given me a reply yet.” He was always prompt doing whatever he had to do and in the meantime he was able to find time for our private problems.

I did not know he was ill and just before he died I had asked him for a reference letter. He wrote a five-page letter. And then I heard that he had passed away and, at the funeral in Copenhagen, I learnt from Kirsten and from his granddaughter, Emma, that he wrote this letter when he was in hospital while he was very sick. He told them that he wanted to finish it. It was the last thing he wrote in his life and that is something that shows his character. In his last moments, in lots of

pain, in the hospital, he did not even mention his illness, did not tell me that he was not feeling well, or that he was not able to do it. He helped me and he did it on time and he did it in a perfect way and that is something that is very touching for me.

**Serdar Savas**

*Former Regional Adviser on Health Policies and Systems and Director, Programme Management, WHO Regional Office for Europe (1993–2000)*





## Section 2. Jo Asvall's story

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Some annotated autobiographical reflections

*Editors' note: Between March 2006 and November 2008 Jo Asvall was interviewed by Carole Modis in Geneva for a WHO history project. During these over 60 hours of interviews he reflected on his life, public health challenges and accomplishments. Here we draw on edited extracts from these memoirs to allow Jo to speak for himself and share some of his own thoughts on key events and lessons learned. Witness observations and comments are incorporated at appropriate points in the historical narrative.*

## **Early life**      **Turnus years** (from interview 3/3/06)

Jo Asvall was born on 24 June 1931, the youngest of four children. His father ran the first telegraph office in Norway; his mother was a telegraph operator.

Norway at that time was quite international. It was a country with many sailors, including all my uncles. They travelled the world on merchant ships. It was also a society with many missionaries. One of my aunts was a missionary in Madagascar and she told me about Africa when I was little – that certainly made a strong impression on me.

We lived through the German occupation and my sister was part of the Norwegian Resistance. I learned then about the importance of community solidarity, courage and action. I saw how when people stand together they could really do things which are way beyond what they normally do in their lives. I learned that you have to use your life for something else than just yourself.

When in 1945 the whole of Europe came out of the war there was the feeling that one couldn't go back to where we were in 1939. All that suffering, fifty million people killed – for that to have a meaning, it had to lead to a better society. That was what characterized Norway very much in the first seven years after the war. There was political agreement, very little in-fighting between the different parties, who were really trying to build a new and better society.

I started studying medicine at Oslo University in 1950, just a few years after WHO was formed. I remember that there was a lot

written about WHO in the newspapers at that time. I had a feeling that being able to work with health and in a developing country would really be something worth doing!

After graduation Jo did what in Norway is called *turnus* – one and a half years of obligatory community work after finishing medical university.

I worked in the small, isolated northern cities of Tromsø and Vikna and saw how problems were and were not worked out in small communities and learned a lot about the need for and benefits of primary health care.

## Thinking public health differently

Those parts of Norway are very sparsely populated, with tough conditions. Many people were fishermen and many were quite poor. When injuries or illnesses happened, a long journey was necessary to get to a hospital. I remember one time when I was on duty I was called out to a child who had drowned in a local community; it took us 45 minutes to fly out. We came down in our seaplane in this little harbour and that child was dead, had been dead for an hour. I felt so helpless and I thought about how families living there were so vulnerable, being so far away from any medical attention for emergencies. This was just how it was and people accepted it. It made a big impression on me because I thought that we had a plane, we had necessary technology, but we could not really help them much given the location and conditions in which they lived. It made me think that if you are going to serve that type of area, you have to think about public health differently. Instead of building dependence – for example, phone the hospital and get a doctor to come, etc. – we needed to find ways of giving them some measure of knowledge and resources for emergencies. If there had been someone in the local community who knew first aid, they could have done a lot for that child. That reasoning, of course, came back many years later very strongly when we were building WHO's primary health care movement.

## WHO Malaria Project (from interview 14/12/06)

Jo's *turnus* years were followed by military service at the Norwegian Air Force Research Centre, during which he conducted and published research in aviation medicine. After military service he had to choose a career path.

Most of my colleagues were going into clinical specialties but I thought, "No! I don't want to do that. Now I have a chance to do what I would like to do with my life." I took the initiative to contact WHO and enquire about their new global malaria eradication programme.

In 1958 he received what he describes as 'the most fantastic letter' of his life, which said, "WHO has the pleasure to inform you that you have been accepted. We are willing to give you a contract for a half year of training. You will be trained in malaria eradication techniques and after the training course you will come to Geneva for exams and psychological interviews and then we will see if we will give you a contract after that. You will start on 11 January 1959."

There were about twenty people in the training programme, which was at a centre for malaria eradication in Kingston, Jamaica run by WHO and the United States. We learned epidemiology, microscopy of parasites, entomology of insects and administration of programmes and public information campaigns. All those things you need to know. It was a very good training course and very practical we even went out at night to capture mosquitoes in the beautiful jungle. We also went swimming in blue lagoons and danced at the Glass Bucket restaurant, which had fantastic calypso music, on Saturday nights!

The training course also brought Jo to look at ongoing malaria eradication projects in Mexico and Ecuador.

### Policies and development

In Africa, people were poor but you didn't have that huge difference between the rich and the poor. It was a poverty due to natural causes the dry poor soil, things like that. In Latin America the poverty

was man-made, social inequity and injustice stemming from the old colonial times, racial differences: the Indians were treated like second-class citizens. So that made a deep impression on me – I was astonished. I hadn't expected to find that in Latin America. It brought home to me that it was the policies of countries that were the main obstacles to development.

Following the course and success with the psychological interviews, Jo was assigned to start the first WHO malaria eradication projects in Africa in Togo and Dahomey.

## Hurry up and wait

Dr Alvarado (the then Director of the Malaria Programme in WHO headquarters) told me, "You will go out as team leader for a WHO advisory team for Togo and Dahomey." I was thinking, "Oh how nice, I always wanted to go to the Pacific." Because to tell the truth, 'Togo' didn't ring a bell – 'Tonga' did because a few years before, when Queen Elizabeth was crowned in England, the big news in that procession was the Queen of Tonga who charmed everybody!

I said, "Could you tell me, please, where I can find some information so I can read up on these countries?"

Dr Alvarado said, "Go to the library downstairs. Tomorrow you can go home for a two-week vacation in Norway because you won't come back to Europe for two years. After Norway, you come back here for three weeks before you leave for Africa."

I went down to the library and they gave me the file on Togo and I got the shock of my life because it was in French! While I did French in school, I hadn't touched it in eight years. So I phoned my friend Luc Thelin, a WHO entomologist: "Oh no!" I said, "I have a big problem. I have to learn French in three weeks!"

He said, "I'll talk with my wife, who is a teacher." She phoned and said, "There is a language training school in Geneva which trains interpreters for the United Nations system. You phone them."

I did phone and I talked to a very nice lady and told her my predicament. She said, "Oh Dr Asvall, don't worry. When you come



Jo Asvall at a social event in Togo, early 1960s



Jo Asvall talks with colleagues in Togo, early 1960s



Jo Asvall circa 1950

back for three weeks we will give you a special individual intensive training and you will speak French perfectly! Go home and take your vacation!”

So I did and came back two weeks later to find a letter from Dr Alvarado saying, “There has been a change in plans. Dr Asvall, you leave for Africa on Sunday!” This was Wednesday. So I had to learn French in three days!

When I got to the WHO Regional Office for Africa in Brazzaville, I knocked on the door of the regional malaria adviser and said, “Good morning, I’m Dr Asvall.”

He looked astonished and said, “What are you doing here?”

I replied, “Well, headquarters said I had to come urgently; I was required in the project.”

“Oh my God, headquarters again!” he said. “You can’t go to Togo the government hasn’t signed the contract yet for the project. Since you are here, you had better stay here in the Regional Office and wait until the government signs the contract.” So I did that. Of course, I read French from morning to night. After a month, there was still no contract.

## *Excellent leadership*

### **José Oltio Espinoza**

*I first met Dr Asvall in West Africa in the 1960s. I was then assigned to Mozambique as a sanitary engineer and was requested to go and help Dr Asvall’s malaria team in Togo regarding control operations. From 1959 to 1963 Jo coordinated WHO’s first national malaria eradication projects in Africa, working in Togo and Dahomey. The considerable success of the project was due to excellent training of personnel and good operational planning, execution and evaluation done under Jo Asvall’s leadership.*

In the Malaria Project there was a lot of decentralization of operational power. I knew what I had to do and doing it was up to me. During the three and a half years I was there, I could write to Brazzaville but I only went there once a year. It was difficult even

to telephone at that time – it could take days to get a phone call through. So you had to operate on your own.

We first had to make plans about what to do. Then we trained people, organized courses, got equipment and chose pilot areas where we could test things out. When we were choosing areas in which to work we had to go out and talk with the local population, get all the village chiefs and local populations to agree. These were usually big community meetings that happened in the evening. We would sit around talking with the chiefs and leaders with everybody listening, saying what we should do and explaining why.

## **Never underestimate the power of communities**

People in those African communities didn't have money or resources but they had fantastic cooperation with the population; they did things with the population so the population actually helped themselves more. That surely was for me an experience that was useful when we later came to develop the health promotion concept in Europe, because many of the ideas which came up in this discussion I felt had to be right because that was what I had seen in Africa. The local community has a great resource in people – they are very clever and they often know quite well what the problems are. They don't know much about technical solutions. You must bring those.

There is a huge potential in local populations, particularly in the women. I remember once we went out and we had a meeting in a village which was quite isolated – we couldn't even drive there, we had to walk. We spent the night there and had a meeting in the evening when we talked about the project – what we needed to do and why we needed to do it. I said at one stage, "We will also have to see if we can make some kind of a road because the spraying teams will need to come. We will come back to that – we may start in half a year."

We left and some six weeks later the mosquito capturing team went up there in their Land Rovers to establish a monitoring station. When they came back they said that the people had already built



three roads, nine kilometers of new roads. When asked why they had done that, the villagers answered, “Well, we had a discussion after you left; we are now independent, we can’t just sit and wait for the government to do things. We decided to build the road we talked about. Now our women can go safely home from market when it is dark because it is easy to see the snakes on the road.”

Things like that showed that in the local communities, the people weren’t stupid; they were absolutely capable of taking sensible action, with energy – they didn’t need to be pushed to do that.

## Global programme called off

In May 1962, the World Health Assembly reviewed the status of malaria eradication worldwide, which at that time was already going on in all other regions. Africa was the only region where it hadn’t really started yet, only preparatory activities had begun. The conclusions were not good. There were two issues: one was that mosquito and social resistance against DDT was developing. Alternative insecticides which could be used were even more toxic, expensive and difficult to apply.

The second and more disturbing concern was the finding that even where malaria was eradicated, if there was not a good infrastructure of primary health centres the ongoing surveillance needed would not work and malaria flared up again. So the basic strategy of malaria eradication had to be modified. The World Health Assembly decided to call off the global malaria eradication campaign and instead to turn all the programmes into pre-eradication campaigns, which was actually just a way of saying ‘build primary health care systems’.

## Oncology and the Norwegian Ministry of Health (from interviews 14/12/06 and 16/12/06)

After four years in Africa, Jo Asvall resigned his WHO post and went back to do clinical work in Norway.

I could have stayed on in Togo with the new programme, but I had come right out of medical school to do that work. I felt I was

in danger of losing my clinical knowledge and that if I was going to continue to work in public health I would also need a masters degree.

I had always had an interest in cancer, so I began work as a clinical oncologist at the Radium Hospital in Oslo in 1963.

## *Medical mathematics*

### **Ole Berg**

*Very early on, Jo Asvall discovered that he was systematically inclined. When he came to the cancer hospital he had the opportunity to watch his colleagues and see how they were working and he discovered they weren't working in a very systematic way. For example, the junior doctor would see the patient first and order tests, then the more experienced doctor would see the patient and order more tests, and then a third one, and that struck him as irrational.*

*So he started to think about it. He asked some of the senior doctors: "How do you work? What are your routines?" It struck him that they had trouble explaining how and why they were working the way they did. There were a lot of traditions that guided behaviour. And this was the premier cancer hospital in Norway. It had a high international status. This surprised him.*

*So he took it up with his boss and said they should be going about it in a more systematic way. His boss sent him to the director of the hospital, who listened to him and afterwards said: "You should write a systematic report about how we are working and recommend changes!" Jo said that before he did that he would like to see how things were before, over the last 10, 15, 20 years. He did that and was surprised to see how unsystematically they had been working over the years. He also noted that many of the patients who came to the hospital turned out to be old patients coming back. All kinds of things he discovered.*

*He used that as a basis to try and modernize the way the cancer hospital was working. The director was impressed and thought he had found his successor. He wanted him and he made it clear to him. Jo was flattered. He said: "Before I do that I have to find out more about how things work and get a greater perspective. I need some training." So he went to the United States to take his Masters of Public Health at John Hopkins in 1969.*

*Then he came back and said: "I also need a year at least at the National Directorate of Health to see how Norway is functioning. Our hospital has to be an integrated part of a systematic health care system at a national level." So he worked for a year in the Directorate. He got support for that. Jo quickly discovered that things weren't systematically organized at the national level either, so he wanted to do something about this.*

**Otto Steinfeldt-Foss** met Jo when they worked together at the Norwegian Ministry of Health and Social Affairs in the 1970s. They continued their collaboration for over 40 years as Dr Steinfeldt-Foss served as a mental health consultant to WHO and assisted Jo in some major challenges over the years (see p 155). He writes:

*Jo and I worked together in the reorganization of the health services in Norway. This had the title of Planning and Organization of the Regionalized Health Services of Norway and included the reorganization of the general and mental health services. We had an enormously fruitful and absolutely congruent way of need assessment planning, organization and reorganization of the health services. We worked closely side by side. He brought us public health training from Baltimore and myself from Harvard School of Public Health as a WHO fellow.*

**Ole Berg** continues:

*So he went to the Director-General. Norway had just had the first Hospital Bill passed in 1970 and that Bill was a step in the direction of systematically organizing the hospital system. It placed responsibility for hospitals at county level. Before then, many public hospitals had been owned by cities, large towns and so on and some by private charities. They had organically grown from the turn of century. Now they needed this Bill as a basis for managing and organizing hospitals in a more systematic way:*

*The law did not comprise a plan for the organization, it just put responsibility for hospitals at county level. So Jo went to the Director-General and said we need a national plan, a plan for what kind of hospital we should have, where they should be located and so on. The Director-General said go ahead. So he got his go-ahead and started to write his plan.*

*Normally, when our government writes such a White Paper, a commission is appointed with representatives from the counties, from the directorates,*

*from medical associations — all kinds of stakeholders. This wasn't done in this case. Jo started to work on it with a few close colleagues. I asked why they didn't appoint a commission and Jo said, they didn't think about it. So he started to work on that and that was one reason why the report became so clear and systematic and so characterized by his ideas. A report produced by a commission would have included a lot of compromises. Jo's report is probably the most systematic White Paper that has ever been produced in Norway!*

*His proposed systematic approach consisted of primary care in the districts, secondary services at hospitals, then tertiary and to some extent quaternary services at selected centres. He tried to define these levels and tried also to define how many people needed to support a particular specialty. He created county hospitals and central hospitals which had more specialized services and then regional hospitals. He divided the country into five regions, and then very rare diseases that demanded a very large catchment area and then he talked about national services. He created a multi-tiered system that could more or less say where you could have hospitals. To some extent it took into account political and geographical factors because the distances could not be too great. His idea was to reduce politics to mathematics. In the old days it was a question of the political force of the various stakeholders. Now it should be a question of medical mathematics!*

## *A systematic thinker*

### **Sverre Harvei**

*I remember the first time Jo Asvall presented an argument to the Ministry of Health review committee, which included the Minister of Health and Director-General Karl Evang. This committee was in charge of central planning and granting hospital building permissions. Jo astonished all of us with his meticulous, detailed and systematic approach to analysis. He had looked at every aspect, from population density to transport to capacities in neighbouring communities. His advice against granting permission in this case was accepted!*

During his last years at the Ministry, Jo Asvall once again began to get involved with WHO through some committee work and training courses. He was appointed the Norwegian representative to an

expert meeting in Bulgaria on health programme evaluation. He recalls:

I became rapporteur of that meeting and started to do some work for the first time with the WHO European Regional staff. Leo Kaprio, the then Regional Director for Europe, was at that meeting. Soon thereafter Kaprio decided to organize a meeting on cancer in Norway and I was invited to work on that. In 1975 I also participated in a WHO travelling seminar which looked at Soviet and Finnish health systems. It was a fascinating trip, with twelve of us travelling to Kiev, Almaty, Moscow and Helsinki, meeting with experts and visiting facilities in all locations. The contrasts were staggering and illuminating. I had a chance to learn a lot about the Soviet system of planning and delivery of care.

Jo's skills and capacities did not go unnoticed by WHO.

## Return to WHO – Director, Programme Management (DPM), WHO Regional Office for Europe: origins of Health for All (from interview 16/12/06)

In 1976, I got a letter from the WHO Regional Office for Europe asking me if I would be interested in applying for the job of Programme Manager for National Health Planning and Evaluation. I was to be head of a unit with a health economist in the unit as well.

I decided to leave Norway and go back to WHO for two reasons. First, my heart has always been with WHO. One of the reasons I began studying medicine was to try to work in developing countries and to be part of the United Nations system, which was something with which I could really agree. I found the idea of WHO fantastic. In the meantime, after leaving WHO I had gone back to Norway to become a doctor again, to relearn medicine; I had dealt with and learned a lot about public health and health systems and had got my Masters Degree from Johns Hopkins. So my second reason was that I felt this was a chance to take some of the ideas that had come to me

in Norway and through my studies to a larger field in WHO – and the idea of that was very exciting and a challenge that attracted me. I liked the work in the Ministry. I could have continued and we had things there which were ready to be further developed but I thought they were on a launching pad and could carry on without me.

It was really the pull of WHO, the chance to work on an international level for the global community, which appealed to me. Therefore I decided to take the position at WHO. I thought that I would do it for two years and see how it worked out!

I turned up in the Regional Office on Scherfigsvej at ten minutes to nine and met a very anxious Herbert Zöllner, the economist, at the front door. He was standing waiting for me and he said, “Oh, I hoped you would come earlier!”

I said, “Why?”

He said, “The meeting starts at nine o’clock.”

I said, “What meeting?”

He said, “The meeting you are going to chair.”

I said, “A meeting about what?”

The meeting turned out to be on a huge project on health planning called *USA 5300*. I believe it was the only time that the United States Government asked WHO for help (this was in the 1970s under President Jimmy Carter (1977–1981)). They were thinking of revising the management of the US health care system and before doing that they asked WHO to make a global study of different models of management of national health services around the world. Some 25 studies had been done in all the regions, so all those concerned had come together at the Regional Office of Europe and were going to sit down and discuss the outcomes and make conclusions.

This was the meeting I was supposed to chair. I had never heard about the project. I must confess that I felt truly at a loss. I was led up, sat down and the room was full of people looking me. The meeting started and I hadn’t any idea what the meeting was about. That was my introduction to WHO – rather a tough start!

## *Broadening the focus*

### **Herbert Zöllner**

*I first met Jo the day he joined the WHO Regional Office for Europe in 1976. He became bureau chief of the Health Planning and Evaluation unit and I was number two. I was privileged to work with him in different capacities until he left WHO in 2000. He had just come from Norway, where he had initiated major hospital reforms. He had faced obstacles there from a budget department which always told him there was no money (and shaped his opinion of economists!) and from unions that didn't want small hospitals closed, no matter how irrational they were! I think he left Norway because he had previously worked with WHO in malaria control and saw that health reforms needed a broader focus than hospitals. Adapting WHO's Health for All approach to the European context became his life's work and made him an outstanding European leader for change.*

## *Able to criticize and not offend*

### **Carolyn Murphy**

*I recall an early mission to Portugal in 1977 when Jo had first joined the Office. It was about three years after the fall of the dictatorship in that country and Kaprio, our then Regional Director, organized a high-level mission to analyse which of the many promised health changes had really been made since democracy was declared. Jo, as the head of the Health Planning and Evaluation unit, although new to the job performed brilliantly as part of the team. He was able to represent WHO's values, concerns and interests clearly and articulately and not offend anyone in the process. I could see his leadership capacity right from that beginning.*

### **From PM to DPM**

#### *Not boat rocking then ...*

*I was not at all involved in the International Conference on Primary Health Care held in 1978. I don't even remember whether someone told me about the 1977 World Health Assembly Health for All resolution [WHA30.43, May 1977]. I didn't go to the Assembly; I had nothing to do there, as I was a programme manager (PM). Kaprio went to the Assembly with his deputy Bauhofer, an Austrian.*

We probably heard about it, but at the time that resolution was nothing that rocked the boat.

### *Do me a favour*

Kaprio went to Alma-Ata as he was very interested in primary health care. He came back and told us about it, saying it was a very interesting meeting. In 1979, Dr Bauhofer was DPM. He was very dynamic but a bit of a choleric type and people trembled when they were called to his office – really, people were shaking. I was never so affected; he would bluster but if you asked him a question then he would relax and sit down and we could



Leo Kaprio, WHO Regional Director for Europe, 1966-1985

have a normal discussion. He was a good organizer. Anyhow, he had a heart infarction and was to be out of the office for some three months. So I was suddenly called up to Kaprio who said, “Look here, Bauhofer is gone for some months. Could you do me a favour? I have so many things to do, could you go through the DPM mail every day, the incoming mail, and just write on some sheets of paper what you think I should do with these things?”

Kaprio was a very good public health professional. He was a very nice character. He had very good personal skills. He was very understanding but could be tough and firm when he wanted something. Being a Finn, he was superbly placed in the Cold War in Europe, as was Bauhofer (an Austrian). They were both from neutral countries. When I met Kaprio he had been Regional Director for more than ten years. He was a kind of benevolent king supervising – and a rather tough manager. Kaprio was the one who took the big decisions – interacting politically with the countries. He was very popular; people had great respect for him. I worked with him for a long time and I don’t think we ever disagreed on anything and if we did, it was a fair argument.



So for three months, and no one knew about it apart from Kaprio's secretary, I came and got the file; I looked through it and wrote my reflections and gave the file to Kaprio and Kaprio dealt with it. Bauhofer came back, but after some months he had a fatal stroke and died. Then I was made Director, Programme Management (in the summer of 1979). It created a little bit of a stir, as there were 65 directors who were bypassed.

## Now thou shalt ...

One of the first things that happened after I became DPM was a letter from Dr Mahler, saying that the Executive Board had discussed the outcome of the Alma-Ata Conference and had decided now they wanted to make Health for All policies at global level, and then for each of the Regions and then for each Member State.

This message from Mahler was clear: "Now regions, thou shalt make a regional health policy for Europe." Of course, I hadn't been in Alma-Ata. Kaprio had been at the Conference, so I went in to discuss this with Kaprio.

We agreed to start it all off by writing a letter to all the Member States asking them what they thought about Alma-Ata and primary health care and the idea of making a regional policy.

My own thoughts on primary care were very much formed in Norway during my *turnus* years. In Vikna we were doing normal clinical care for the populations and public health, school health, vaccinations, local hygiene, whatever preventive actions were needed at that time. I felt we had a perfect set-up there, particularly as we had a little cottage hospital where we could observe people and decide if they needed transport to a real hospital (several hours away). I felt that the public health nurses knew the population inside out and had a good rapport with the population. I felt that functioned well and provided a good standard for my thinking about primary health care.

So Kaprio sent the letter out and all the Member States replied there were 33 at that time. Algeria, Morocco and Turkey were 'developing' countries. All the rest were 'developed', including



WHO/UNICEF International Conference on Primary Health Care, Alma-Ata, USSR, 1978, Palace of Lenin

Under the leadership of Halfdan Mahler, WHO passed the first Health for All resolution at the 1977 World Health Assembly, calling for health for all by the year 2000. Built on the twin principles of social justice and equity, Health for All aimed to create healthy environments for all, with access to basic health services, education, safe water and sanitation, adequate and safe food, as well as appropriate housing. This vision was further articulated and developed at Alma-Ata in 1978, in conjunction with the United Nations Children's Fund (UNICEF), and focused on primary health care. According to the Declaration of Alma-Ata, "Primary health care is essential health care based on practical, scientifically sound and socially acceptable methods and technology made universally accessible to individuals and families in the community through their full participation and at a cost that the community and the country can afford ... It forms an integral part of the country's health system, of which it is the central function and the main focus, and of the overall social and economic development of the community" (WHO, 1978). In 1980, the Executive Board of WHO called for global adoption of primary health care and outlined six major areas of activity: health prevention and promotion, equity, appropriate technology, community participation, intersectoral coordination and decentralization. Regions were asked to make region-specific versions.

the USSR. Israel was not a member at that time – they came in 1984 from the Eastern Mediterranean Region and then Algeria and Morocco left. They replied and virtually all of them said the same thing: primary care is excellent for everybody else but no thank you. We have our beautiful hospital systems, good quality of care, and we don't need Alma-Ata – that is what they said.

## To listen or not to listen

Kaprio and I had another meeting, of course, looking at these replies. We discussed whether we should drop it and say there would be no Health for All in Europe because the Member States don't want it. That is normally what you do. You give the Member States what they want. But we thought the Member States were wrong! “Should you listen to Member States when they are wrong?” we asked each other. We thought not. Firstly, we thought they needed Health for All as well, and secondly, we were concerned that if we didn't do it in Europe, what would be the impact on developing countries if they felt that Health for All was a secondary health policy – something for developing countries while the other, real ones, had a better policy? That would have been the end of Health for All, frankly.

Therefore, Kaprio phoned Mahler and said, “We need to have some discussions.”

We went to Geneva and had a meeting with Mahler and told him about this reaction. He was not surprised. Mahler felt that the European countries were not easy to deal with and did not follow WHO advice.

Then we said that we felt we could perhaps manage to do it, but we would need some freedom to move. We said we would have to take a different approach to the policy than the one taken by the global policy – one that the European countries could sympathize with and recognize and say, “Yes, yes, that is important for us. Yes, that is something we can do.” We assured Mahler that we would maintain the basic principles of primary health care, that is that community participation, empowerment of people and appropriate technology for health would be a core part of the European policy.



WHO Director General Halfdan Mahler gives oath of office to Jo Asvall as WHO Regional Director for Europe, World Health Assembly, 1985



Mahler and Asvall at WHO Regional Committee for Europe, Copenhagen, 1985



Key handover: Jo Asvall receives the Regional Director's office key from Leo Kaprio

So Mahler said, “No problem, you go ahead.”

I have thought of that many times. I was very impressed with him because nine out of ten managers would not have liked that. They would want one policy which is the same all over. But Mahler wasn't like that; he was more interested in ideas and in movements and that the important things got through. If you needed to adapt your structure to make it politically acceptable, you should do that, instead of saying, “No, I insist and we stop there.”

## Mahler and Cohen

I have great respect for Mahler. I have seen him in many situations and the way he reacted I always found impressive. He was a real pleasure to work with but he was also always challenging. If you came to Mahler, you had to be prepared. He could be quite aggressive and try to throw you off balance to see whether you really had something of substance. Often during that time, and later when I was Regional Director, I would get a phone call and here was Mahler – not his secretary, Mahler phoning himself and he would say, “Look here, I have been sitting here reading this report from the Regional Office on care (or whatever it was). I think it is all rubbish but before we throw it in the dustbin, I will give you a chance to defend it. I will come with Cohen to Copenhagen and sit down with you for two days and discuss to see if there is something there or not.”

Joshua Cohen had a very interesting role. Mahler would use Cohen as a kind of sounding board for ideas, to be sure that someone had looked at the issue critically and identified not only the strong points but also the weak points in a proposal. They agreed on many but not on all things. They would also disagree publicly and argue with each other publicly. These discussions gave Mahler the assurance that when he took a decision, all the points had been considered and had been turned over so that he knew what kind of implications there might be, both positive and negative. He could, therefore, take a decision on better grounds than if he just read it himself or gave it to someone else who would tell him what he wanted to hear. Cohen wouldn't do that; Cohen would tell him what

Cohen thought a very open and challenging environment. It was not, “Oh, you go to the Director-General. Be careful what you say. If he is displeased, it might have implications for your job.” It wasn’t that kind of environment. It was very challenging, very stimulating. They were both intelligent and had a lot of experience, so the arguments they came with would be based on a lot of background. It was always fascinating,

When they came to Copenhagen which again I think is quite fantastic. Instead of saying, “You come here,” they came to Copenhagen and spent two days and didn’t do anything else they sat down and really went through the issues. We would include the programme manager directly responsible. I would be there as DPM when I wasn’t Regional Director. We would sit there and really go through the thing. They would say, “What do you mean by this? This looks like a really provocative statement. Do you have any background for that?” Or they would say, “Why do you say this it has been tried in Vietnam, why do think it will work here?”

Then if they liked the idea, Mahler would say, “Okay, alright, I think that is interesting. I will give you money from the Director-General’s Development Fund. Come back in two years and show what you have done.”

That kind of interaction led also to the rather unusual decision that Mahler took to delegate to the Regional Offices for Europe and Pan American Health Organization global responsibility for certain programmes. We got four such global programmes in areas where we had been spearheading developments: health promotion, quality of care (those were started as part of Health for All development), traffic accidents and the elderly, which already had been started in Kaprio’s time. In those four areas we got extra money from Mahler every year or every biennium and we had both global and Regional Office staff working together in the same unit, with one of them concentrating on development in the Region, the other operating as the global person with the other regions; they travelled to the other regions and worked with them. That was fascinating because then we got experience of the other regions and they got experience with us.

It meant, of course, when we had the programme evaluations, which at the time we had jointly with headquarters and regions, our local staff then participated in the headquarters programme committee together with the colleagues who were living here in Geneva. They were truly integrated, which led to some very interesting interactions.

This was just one more example of Mahler being a very enlightened leader. We all know his capacity for speaking and how people would look forward to his opening speech at the Assembly for the whole year. What is Mahler going to say now? Everybody who heard it still remembers his talk on what to do with crocodiles. Do you jump out in the swamp and try to kill them one by one or do you drain the swamp? That was a picture he developed in one of his famous speeches.

## *Ping Pong in the Copenhagen Room*

**Lowell Levin**

*I remember when Halfdan Mahler came to visit. Every so often he would visit the Regional Office and Kaprio and Asvall would pull various managers into their meetings. I remember one time in the Copenhagen Room in the cafeteria, Jo was there with Halfdan Mahler and about six or eight of us programme people. Jo was trying to demonstrate to Mahler that the European office knew what it was doing, even though it differed from what the Health for All planners in Geneva thought. I recall that there were some clear differences and some sharp things said. And they were very open.*

*It was a refreshing meeting. I mean, those of us who sat there looking at it like a ping pong match or a tennis match, our heads going from left to right to left to right, we were really learning about the issues. At that meeting it was sharp and clear. The Regional responsibility on a day-to-day basis and the Geneva perspective — the geo-political differences were there, you could see them — different levels of responsibility and it showed, it definitely showed.*

## Overcoming hesitations

### Meropi Violaki

*When Health for All 2000 and primary health care programmes were first introduced, European countries were a little afraid – they thought the programmes were for developing countries and not for them. They were hesitant and didn't see how it could or should be applied. Jo Asvall was one of the key persons who demonstrated to us that Health for All was relevant to Europe and guided us through an adaptation process.*

So when we got Mahler's permission to 'Europeanize' the goals, we set up internal working groups to identify core components of a new public health strategy. Importantly, we did a major epidemiological review of life expectancy. Dramatically, it showed that middle-aged men in 40% of European Region countries had static or declining life expectancy – in spite of massive increases in investment in hospital beds, physician-patient ratios, intensive care units, premature baby high technology, etc. Basically, we showed that for a large group of Europe's citizens, ill health and pathology was growing faster than care capacity.

86

In 1980, the WHO Regional Committee meeting was held in Fez, Morocco (it was a Member State in the European Region at that time), the new data were presented and a new European Health for All policy approach was introduced with four strands of action:

- lifestyle and health;
- health services and primary health care;
- environment and health; and
- support activities (training, information systems, multisectoral action, community involvement, etc.).

I remember the moment well. When I finished presenting there was absolute silence in the room. This went on for what seemed like an age. Kaprio leans over to me and says, "Jo, the first to speak will decide the fate of this policy."

Then Halter – this rigorous, scientifically conservative Director-General for Health from Belgium – gets up. He was known and



respected for his sharp-tongued, critical analyses. He said, as best I remember, “Lifestyles and health? What is that? A very vague concept, I think. We know nothing about it. But we have to acknowledge there is a problem here. We cannot close our eyes to what is now a forgotten but clearly important intervention area. We must take action here.”

Many other countries, as predicted by Kaprio, followed with positive comments and the resolution passed unanimously.

This resolution was important not only from a technical but also from a political point of view. It was the first time that the 33 countries that made up the European Region of WHO at that time had ever agreed upon a common policy in anything! This formal political endorsement gave the green light for starting to work seriously with these problems in every country as well as within WHO, triggering a large amount of activity, partly to reorient the programmes, staffing and work of the Regional Office, and partly to support and stimulate the adoption of this policy in all countries. We used this occasion to totally reorganize the Office around the four areas. Seven new programmes were started and experts were recruited in tobacco, alcohol, equity, health services and quality technology. All country programmes were reorganized to match the four main strategy areas. In many countries, the concepts, principles and strategies began to be discussed and debated in national, regional and local arenas.

## The ‘war board’

### Lowell Levin reflects on his first meetings with Asvall:

*If you walked into Jo Asvall’s office in the early 1980s, you’d think you were in the headquarters of the army far east command, the headquarters of any military organization. He had a ‘war board’ on his wall. Every detail of the operation for every aspect of every programme was on his wall. And he knew, because he checked it every morning. Every day reports came in as to the status of all these programmes — and there were many! I would say maybe 40 or 50 important different programmes. They were on the wall there. He tracked each one of them meticulously. I don’t mean vaguely;*

*I mean in detail! So efficiency and effectiveness and appropriateness and the use of all the talent that the house had was his responsibility; really, on an operational basis. And he took it seriously:*

*He was seen as the person who knew where things were and how they should work and with whom they should work and how they should complete their tasks at a level of good quality. He was a micro-manager in one sense but not really in the ordinary sense. He had distance from the detail ... he saw the detail but he didn't get involved directly in actually doing something with the detail. But he knew what was going on so he would consult with one of his programme managers, he talked from an informed status. He did not ask them, what are you doing? He knew what was going on but he wanted to find out two things: what was going on, of course, and what the barriers were to achieving the goals. What were the barriers? And then he would ask the second question of himself, how can I help as the manager of this place to facilitate the work of this programme manager?*

*What kind of an educator was he? He was an educator who looked at what was going on, what the problems were; he advised. I guess his main modality as an educator was as an adviser, someone who could tease out the possibilities with the programme manager. Now that doesn't mean that he was sent from heaven with everything he said and everything he believed and everything he valued and that all aspects of the programme were what the programme manager would have necessarily agreed to, but that was okay with Jo. He listened to your critique of his advice. And he'd have a good argument with you. Jo never took anything lying down. If he didn't agree with what you were saying or you didn't agree with him, he had this little challenge, not with any anger or anything of that sort, just a good solid, scholarly, thoughtful process of analysis.*

*His managerial style was listening, arguing carefully; thoughtfully; because he did his homework. He knew what he was talking about. He was an excellent instructor of options and he was on the ball, always on the ball and a very good manager. His style was direct, clear and not tough but firm.*

## Health for All policy and targets

Difficulties arose, however, as little experience existed across the Region about how to turn the Health for All concepts and principles into policy action.

A 1982 evaluation of countries found that not one Member State had yet developed a national Health for All strategy. To address this, the Regional Office initiated three parallel strategies: piloting Health for All in selected countries, developing targets and launching a series of Ministerial Conferences.

## Pilot countries

To show it could be done at a national level, the WHO Regional Office for Europe asked for volunteers from Member States, offering the full support of WHO technical staff to assist volunteer countries in any areas where help was needed. Finland and Holland stepped forward and initiated national policy development processes.

*Yes we can*

### Kimmo Leppo

*I worked closely with Jo Asvall in the early 1980s when Finland was pioneering the Health for All approach at a national level. We were quite sympathetic to the approach and the philosophy was a good fit for us. Jo, Halfdan Mahler and Leo Kaprio came several times together to work with us. It was important, for both Geneva and Copenhagen, to demonstrate that the Health for All approach could be relevant, that developing policies based on its philosophy was feasible and that it could actually be adopted and implemented in a developed country.*

The Finnish and Dutch national policies were reviewed and presented to the Regional Committee in 1985. Over the next 15 years, over 40 national Health for All policies were developed!

## Levers and strategic targeting

Working groups were set up in 15 technical areas, with experts from outside WHO. All had the same mandate – to look at the four areas of action adopted in 1980 and, from what they knew of the effectiveness of interventions, to draw up proposals for indicators. The Regional Office went about making an assessment of ‘how far can we go?’ based on global evidence of effective interventions, in different lifestyle, environment and health service areas. This process led to the adoption in 1984 of 38 common regional targets with indicators.

### *A stubborn perfectionist*

#### **Kimmo Leppo**

*Developing regional targets was a great undertaking. I remember how Jo worked closely and meticulously with many high-level advisers in the process. At one high-level meeting in the Netherlands, I remember him staying up till after midnight with us looking over every word and comma in our proposals related to health planning and management. He was a real perfectionist! He was stubborn but without a doubt he was the one who kept Health for All on Europe’s agenda throughout the 1980s and 1990s.*

These targets and indicators made the European Health for All policy sharper and provided a model for the Region as a whole, which countries would adapt to their own contexts.

### *Health for All database – a stimulus for health improvement*

#### **David Macfadyen**

*What Jo did, with the endorsement of the Regional Committee, was to create a database that tracked progress on 38 health targets through 65 agreed indicators. Countries agreed to provide the data for these indicators. It was a simple idea – you had targets and data to assess improvements in health and measure*



*health attainment — and that is a legacy because it continues today: The European Health for All database is there for each Member State to see their historical trends, to see where they stand geographically and with regard to other countries. It has proven to be a very, very powerful stimulus for health improvements in the individual countries.*

## Targets? It's all about impact

When we started to discuss setting targets in 1982, there were quite a number of people who said — and meant it seriously — “You are crazy! How can you do that?” We were dealing with a Europe which was totally divided into two big political blocks — east and west. The Cold War was at its coldest. There was no cooperation in any area outside of the health sector where we had cross-border links. We had a lot of discussion at that time about how we could do that. We ended up with a conclusion, which I think has been an important lesson. That was, we started with the final end: what we wanted to achieve in terms of improvement in environment and health, health care, lifestyle and health. We found out that there was virtually no difference between countries and individuals, professionals or others in what they would like to see as improved health. The difference comes if you start at the other end, which are the detailed inputs to the system that you build in order to make change come. But since the strategy was built up first by defining the outcome targets and the indicators which each country would use to measure them, we created a framework which was politically neutral and which the health professionals all over Europe recognized as professionally sound. The fight came when countries started to say, “Well if we want to strengthen primary health care, do we have to make a health centre and have all the staff working there, and should we pay them all by salary? Or can we still have the independent physicians and physical therapists sitting around and being paid by what is called fee for service? How do you do those things?”

We said that those things were up to countries. We would help them share experience from country to country, which we did a lot. As long as they could get out of the system the health impact which was essential, then we felt that each country would have to deal with those details according to its political system, etc.

## Outcome-oriented targets

There were three reasons for setting up outcome-oriented targets. First, past experience showed that health development in Europe mainly focused on the development of resources and inputs: for example, number of hospital beds, doctors, nurses, etc. The output focus aimed to shift attention and health development thinking towards analysing whether the underlying health problems were really solved or not by actions of the health care system.

Second, outcome-oriented targets make it possible to set up indicators to measure progress and on that basis to set up systematic evaluation processes.

Third, setting outcome targets has to do with the basic philosophy of Health for All – creating a mass movement for health. Setting a number of clearly defined targets that can be understood by everybody, that can motivate for change, and that can help each and every group working for health within their own frame of reference, their own resources and their own planning is an effective answer that fits countries with highly different systems.

The targets and indicators provided public health advocates, professionals, academics and government decision-makers at grassroots with a lever to push for Health for All within countries.

In 1982, the Regional Office decided to stimulate political interest and support for Health-for-All-type action by holding (over a period of several years) a series of major ministerial conferences in each of the key Health for All areas: lifestyles, environment, health services and health policy. The plan was to convene ministers, from health and other sectors, and present them with a review of relevant health evidence and agree on action priorities and implementation strategies. During Jo Asvall's tenure as Regional Director, ministerial conferences were held on lifestyles and health (Ottawa, Adelaide and Sundsvall), environment and health (Frankfurt, Helsinki and London), health systems and services (Ljubljana and St Vincent).

# Health for All challenges and achievements: health promotion

(from interview 26/5/08)

## *Guiding Star*

**Richard Alderslade**

*Jo Asvall saw public health as a pre-eminent area of political and social policy action. That is what Health for All was all about. Public health was seen as a key guiding star for society as a whole. Therefore, public health functions needed to be imbued in society at all levels – political, economic, social and environmental.*

## **We had to think differently**

I think it is difficult to overestimate the influence that the Health for All movement had on the work that WHO did in Europe. Until then the Regional Office had been involved in a series of very good programmes, but they were individual, more haphazard. With Health for All we had a unifying concept which applied to the Region as a whole and which we then tried to get all the countries to embrace and to turn into realities in their own settings. In order to do that, we had to work at two different levels. One was to develop the tools or methods or strategies, whatever you like to call them, that countries could use in order to promote and deliver Health for All. And the other thing was that we had to develop a mechanism whereby we could make the countries enthusiastic about using those tools, not only just formally embracing Health for All but turning it into a reality. That meant we had to think differently than before about how we tried to work with countries and how to stimulate work in countries.

## **Taking on health promotion**

Since our epidemiological study of health in Europe from 1960 to 1980 pointed to lifestyles and health as the main ‘culprit’, we decided to start with developing a health promotion programme.

At that time people did not really know much about health promotion. Neither did we, to be frank! We had a discussion and decided we would create a programme for two years. If it worked, we would continue and if it did not succeed, we would say, “Well, that was that, we tried.”

## Different types of people

To develop this programme we needed new staff. We felt that going into this area we needed to work with different types of people and different concepts because WHO was not accustomed to dealing with concepts like lifestyles and health. Among those new staff was Ilona Kickbusch. Ilona had the kind of unusual leadership qualities we were looking for! She was a sociologist and had worked with grassroots organizations. She was a creator and a networker and had the ability to make people enthusiastic about the work we were doing.

### *Taking a risk*

#### **Ilona Kickbusch**

*I first came to work at the Regional Office as consultant to do a three-month study on women’s health movements in Europe — but the minute I arrived, because of a staff illness, the Office needed somebody who could write about and develop the whole area of health education and promotion. You know how this stuff works: first it was three months, then it was six months and then I resigned from my job at the university in Germany and stayed on, on a longer-term contract, and then actually they decided to fill this position again and I was asked to apply. That was one of my historical meetings with Jo, when actually he told me that I had been selected and asked me if I wanted to accept. I remember that because I guess he was trying to make a joke, and he said, “You know, Ilona, the Organization has decided to take the risk with you,” and I remember that I answered, “Well, Jo, what tells you that I will take the risk with the Organization?” Basically, of course, what he meant was that I wasn’t the typical kind of person they would normally have hired. After that I was a bit insistent on continuing to be not typical!*



*My first big job was to present the new lifestyles and health programme at the Regional Committee in Berlin in 1981. I was very young at the time, 31, and quite cheeky but at the same time very, very nervous about this presenting of a new programme to all these grey-suited men. Jo was incredibly supportive and briefed me and helped me and that's something I also remember very well. He kept saying, and I was this raving feminist at the time, and he kept saying to me, "Smile, Ilona, smile! Remember to smile!" And he was so right you know — but at the time I thought, who's he to tell me to smile? — but he was totally correct and very supportive.*

*The decision was taken in Berlin that there should be technical discussions on lifestyles and health in 1983 and that then slotted into the whole lifestyle and health targets development. That's when Halfdan Mahler came to the Regional Committee and decided to create a global programme for health promotion at the Regional Office. In order to prepare for that I had many strategic meetings with Jo, Halfdan Mahler, Joshua Cohen and others. I was very privileged because even though I was rather junior, I was involved in some of these innovations and I was able to meet with the top public health leaders of the time.*

## *Toe to toe*

### **Lowell Levin**

*I had the opportunity to see Ilona and Jo go toe to toe on occasion. You didn't bend either of these people easily; and for good reason. Not because they were stubborn in the ordinary sense of the word but because they both had deep beliefs and could support their views with data or perspectives that were genuine. It wasn't a matter of personality; it was a matter of disagreeing on a principle or on a strategy; but they showed a lot of respect for each other and for the observer. This was a very educational experience.*

## *Bad behaviour vs structural change*

### **Ilona Kickbusch**

*When we were developing the Health for All health promotion targets, Jo at first thought we should follow the US approach, which developed their targets around quantifiable lifestyle and health outcomes, like we will reduce alcohol by  $x$  and smoking behaviour by  $y$  and all of that. The groups that worked with me wanted a more structural approach to*

*the lifestyle and health targets. We wanted to look at the development of healthy public policies and settings, for example.*

*It was clear that Jo was uneasy about that. I said, “Jo, you know, listing the bad behaviour with percentages is nothing very exciting and everyone’s doing it this way;” etc., etc. So to his credit, I must say, without my knowledge, he presented his target review group with the two models. The review group actually said they wanted the structural approach, which our lifestyle and health group had developed, that they saw this as much more future oriented, etc., etc. Jo accepted that and then he was very supportive of the programme and approach.*

Mahler became very interested in our health promotion work and gave us money to organize a global conference to look at health promotion. The First International Conference on Health Promotion took place on 21 November 1986 in Ottawa. It had a huge impact on our programme, on WHO and I think actually on the world. It was one of those big events where people came together around a new concept with many interesting ideas. It brought together people from many different backgrounds. With the Ottawa Conference, and subsequent conferences in Adelaide, South Australia (1988) and Sundsvall, Sweden (1991) and all the new principles of health promotion that grew from it, we further developed the global programme for WHO and the European regional programme. These conferences created and cemented very broad alliances. Out of this movement, with Ilona’s leadership, came some new ideas on how to mobilize local communities – the healthy cities, the healthy schools – these became new tools for WHO. WHO never had those kinds of tools before to try to mobilize societies for health.

## **Making the healthy choice the easy choice**

The movement also helped WHO reframe the way we talked about public health. We had some catch phrases. We knew that lifestyle and health was controversial and many people felt that it was an infringement of individual choice. So we said that it was all about making the healthy lifestyle choices the easy ones to choose. We felt that formulation was good in many ways – it was politically acceptable but it also meant that the emphasis was not just on

the individual, although that was part of it, but it was also on the conditions around the individual: economic and social conditions as well as the physical environment to make it easier to have a healthy lifestyle. So that became an important basic philosophy underlying the whole movement and the practical methods we were carrying out.

Health promotion was kind of the unifying basic concept. But then there were a lot of individual problem areas. The biggest problem in lifestyle and health was, of course, smoking and its huge detrimental effects. We then thought about how we could make smoking and tobacco a big and visible issue, so we decided to hold a European conference, the First European Conference on Tobacco Policy, Madrid, 1988. To prepare for the Conference we had a series of very good technical documents. It was a huge conference that was very successful. It led to WHO's first charter against tobacco and identified ten strategies for a smoke-free Europe<sup>2</sup> (*Editorial note: These later became part of the Framework Convention on Tobacco Control*).

We did the same with alcohol with the European Conference on Health, Society and Alcohol, held in Paris, 12-14 December 1995. For nutrition, we had the First European Conference on Food and Nutrition Policy in Budapest, October 1990. On sexual health there was the conference From Abortion to Contraception in Tbilisi, Georgia, USSR in October 1990. In all these areas we also developed programmes and action plans. We used the conference preparation

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<sup>2</sup> **Ten strategies for a smoke-free Europe**

1. Recognize and maintain people's right to choose a smoke-free life.
2. Establish in law the right to smoke-free common environments.
3. Outlaw the advertising and promotion of tobacco products and sponsorship by the tobacco industry.
4. Inform every member of the community of the danger of tobacco use and the magnitude of the pandemic.
5. Assure the wide availability of help for tobacco users who want to stop.
6. Impose a levy of at least one per cent of tobacco tax revenue to fund specific tobacco control and health promotion activities.
7. Institute progressive financial disincentives.
8. Prohibit new methods of nicotine delivery and block future tobacco industry marketing strategies.
9. Monitor the effects of the pandemic.
10. Assess the effectiveness of countermeasures.

process to get input from and engage with different European countries and institutions. And because we did that, we got very strong interest from the national structures. The chief medical officers and directors-general of health became strong allies; they pushed the programmes in their own countries that were developed in these intercountry programmes.

## Keeping all Member States interested

These lifestyle intercountry programmes are particularly important in Europe as they are of relevance to all our Member States. We did not want our Member States to just come to the Regional Committee or World Health Assembly to say, “Yes, we support WHO.” All the countries have big problems with lifestyle-related issues and we had to help them. If you want to do that, you have to work on problems that are their problems. You have to involve them in your work. That’s why in a region like Europe, it is imperative to have a strong regional programme. The country programme is important, but a country programme in Europe cannot work if you don’t have a strong regional programme. Because then you are becoming some kind of a poor developing country programme where you have staff out in the countries, but they don’t really have strong material to come with, and you don’t have any change in the western European countries because they are not interested if they are not part of developing new ideas in areas that are key to their own health problems.

## Intercountry programmes a key asset

That is why I have always felt, and I still feel very strongly, that the European Region’s intercountry programmes are our key asset. It is these intercountry programmes that determine the life and death of the Regional Office.

These programmes carried out research and development and took action; they organized working groups and conferences; they were linked up with (and learned from and shared with) key partners and our different networks. They worked with all these partners and networks all over Europe and developed intervention methods

that could be used in the different target areas of Health for All, monitored outcomes and found out what worked best. They were also responsible for following the scientific literature in their field. So at the Regional Office we had real regional and global experts in many technical areas and became a good resource for all countries, including the more developed ones.

## WHO centres

When we were faced with continuing budget cutbacks, we also started to develop an alternative kind of regional support from a new form of WHO centre. These we developed in and with Member States: for example, the WHO Centre for Environment and Health in Rome, Italy and in Bonn, Germany; the European Observatory on Health Systems and Policies in Brussels, Belgium; the WHO European Office for Investment for Health and Development in Venice, Italy; or the WHO European Office for Integrated Health Care Services in Barcelona, Spain.

We made five-year contracts and later ten-year contracts with those countries who were willing and interested in hosting these kind of centres. All of the staff in these centres were Regional Office staff and we had total control of these programmes, which were part of the programme approved by the Regional Committee. The only thing the country where the centre was located did was to pay for the staff. They were not collaborating centres; they were an extension of the Regional Office. Our environmental health staff, for example, grew from 7 to 32 when the centre was created and more money was available to the programme. These centres provided long-term intercountry staff. With these centres we were able to maintain and enhance our staffing levels even in the face of a steadily dwindling regular budget.

# Building interactive networks engaging partners and settings

(from interviews 3.11.08 and 12.11.08)

Jo Asvall understood the importance of partnership and the need to engage people in a variety of settings and agencies in promoting health. During his tenure as Regional Director he established public health networks with medical, nursing, midwifery and pharmacy associations; cities; schools; regions; prisons; chronic disease and patient organizations; and health communicators throughout the European region. These were all bound together by the Europe-wide Health for All policy, forming what Asvall called “a great public health army of collaborators”, and substantially increased the power of the European public health movement.

We knew, of course, that as an intergovernmental organization, WHO has to work with governments. The Regional Committee is composed of governments – that is clear. So helping governments make national policies according to the regional policy was always our core activity. We had quite a lot of success doing that. We also knew that we were dealing with a Europe where many countries had a structure that did not make the national ministries all that powerful in reality. We were also out to effect changes in lifestyle, environment, etc. That required action from many other partners that were not ministries, such as research organizations, professional associations, NGOs [nongovernmental organizations] and other health advocates. So we had a lot of discussion in the Regional Office and we started to build up what we called the interactive networks.

## Interactive networks

These meant that WHO, in this case the Regional Office, would branch out to one type of institution or organization or group of professionals that could have an important impact on health. We would work with them directly, supporting them to create networks where they would work together to see how the Health for All policy of the European Region should be applied in their particular sphere

of interest and responsibility. We would have this as a permanent thing so we could be sure that these networks would continuously feed us new information and be fed by us with the new knowledge and experience coming out of the work of the Regional Office. They also served as an effective channel through which we could spread in a systematic way the good experience that was now increasingly coming from different parts of Europe.

I must say that there were concerns about this reaching out activity. Some staff thought it could backfire. One could say WHO had not done that before – we did not have the mandate. We decided to do two things – first, to mention this every year in the Regional Committee when we presented the work done in the year past. And second, we informed the ministries if we were branching out in their countries. We did that with the people we knew at director-general level. In the beginning there were a few instances where they said, “Well, is this really your job? Okay, but let’s be sure that we are informed.” But after some time they relaxed and in many instances began to feel that this was actually an advantage for them and was engaging people in their own countries and beyond that could be helpful to them.

## Going beyond the ‘usual suspects’

As I said, in order to do this we had to go beyond only working with the governments and try to work with the major structures in society. And in that, of course, we knew that the health professions are extremely important in making and sometimes breaking health policies and programmes. If you want the physicians, nurses, pharmacists, others to really feel involved in a particular action, they have to really be part of it. You can’t come to them and say, “You should now do this and that.” They will just look at you and say, “All right, yes”, and they will simply continue doing what they want to. That is the nature of the independence of the professions, in a way.

## *Health professional Health for All champions*

### **Keith Barnard**

*Jo realized from the start that Health for All needed champions among all the various interest groups in the health field and that there would be opposition from groups who felt threatened or ignored. He took various steps to engage with these groups, stressing always that Health for All depended on working partnerships. One of the groups he was most keen to bring on board were the national medical associations. The active interest and support of the formal representatives of the medical profession would be a priceless asset.*

*I believe one of his most significant achievements was, indeed, the establishment of the European Forum of National Medical Associations and WHO as a vehicle for continuing discussion and consensus-building in a wide range of health policy issues which had an impact on the profession. My first involvement was in Rome, about 1990. I was making presentations on patients' rights and the humanization of care. It was a very tense atmosphere, a lot of suspicion and the future of the Forum was by no means certain. I went back again in about 2002 and the atmosphere was quite different. There was a packed and varied agenda, open discussion and everybody clearly wanted to be there. Jo had succeeded and then would repeat that success with forums for the nursing and midwifery associations and pharmacist associations.*

### **A hot air balloon**

So we decided we had to branch out to the health professions. The first we wanted to link to was the medical profession in Europe. There were two reasons for this. One was that the medical profession, both professionally and politically, is a very strong force and therefore it was very important to get them on board. The second thing was that we knew from the reaction of some medical associations that some of them were very hostile to the whole Health for All ideas — so hostile that a main German medical newspaper wrote, when the target documents came in 1984, “This is all a hot air balloon. When will someone get WHO back to its senses?”



We decided to get in direct contact with them and we invited them to a three-day meeting in Copenhagen.

Since there was such a big division between east and west at that time, ... we decided to first start only with the western European countries. We invited all the medical associations in western Europe. And they came — with their presidents and their general secretaries or whatever. There were two people from each.

It was in Copenhagen and we chose a fairly small room so that, you know, it would be a rather intimate thing. And we were some 40 people, I think, around the table. Dr Kaprio opened it. I was kind of Regional Director Elect — this was before Kaprio left, so this must have been around October or November 1984. So Kaprio was still there, he was still Regional Director, but he was on his way out. We both sat down and I was happy to have Kaprio there, he was the big bear and a very comforting one and very experienced. He opened the meeting as we had agreed and then to my surprise his last sentence was, “Well, ladies and gentlemen, now I leave the meeting to Dr Asvall because you know he will take over as Regional Director in February, so bye-bye everybody!” And out he went.

So, suddenly and unexpectedly here I was with all these very powerful presidents and directors of medical associations, many of whom were hostile to the ideas of primary health care and Health for All.

We presented the Health for All target documents and things like that. I said a little bit about who I was, because I had a background in clinical medicine. Having been an oncologist for many years, I thought perhaps I could ingratiate myself. Anyhow, we had a two-day meeting, discussed a number of issues back and forth.

We had some friends already before and we discussed with them — the Danes, the English and one or two other associations that we knew were friendly with us and were interested in this becoming a good meeting. So the meeting wasn't just an attack on us but it also became a discussion among the different medical associations, which was really what we had hoped for. The meeting ended in a reasonable atmosphere.

We had had some severe attacks, in particular, from Belgium on primary health care. They said, “Primary health care is something for Africa; in Europe it is totally different. You haven’t understood anything of the health problems of Europe. What we need is more specialized medicine.”

We countered and said, “Yes, we agree on that but we are thinking in those areas a major problem is quality of care and finding systems for doing that.”

The meeting went reasonably well. We had expected a lot of problems. The conclusion was that we decided to have another meeting in a year. I suggested, and they accepted, that we create a small committee to prepare for that meeting. They agreed to that; we agreed how we would select the committee with some representatives from them. To my surprise, some suggested that we should also invite the east European medical associations to the next year’s meeting.

The next conference went even better and was very interesting for everybody because it was the first time we met colleagues from the east and of course they found out they had much more in common than they thought, because here we were discussing at a professional level.

We were not discussing politics, we were discussing the Health for All strategy — what you want to achieve in terms of improvement, prevention and care — and that is something they all had in common. They disagreed on questions of salaries and what governments really should do. But they did not disagree on the quality of what they wanted to achieve and what kind of professional approaches would lead to that quality. So we got into a very interesting type of cooperation with them after that second successful meeting.

The European Forum of Medical Associations and WHO was formalized at a meeting in Helsinki in 1991. Its aims were to:

- a. improve the quality of health and health care in Europe;
- b. promote the exchange of information and ideas between national medical associations, and between the associations and WHO;

- c. integrate appropriate aspects of policies of Health for All into basic, postgraduate and continuing medical education; and
- d. formulate consensus policy statements on health issues.

### *Medical network moves on tobacco issue*

#### **Sandy Macara**

*European Forum of Medical Associations and WHO (EFMA) involvement in antismoking really got underway after a meeting in Budapest in 1994. Jo was there and we were discussing tobacco control. He said we should set up a working party on tobacco. And he suggested that as I was Chair of the British Medical Association (BMA), with the massive resources of the BMA, I should chair it but could have members from any country that wanted to contribute. I remember Poland was a particular contributor. We set up the working party with a very active programme. Jo put a lot of resources into it to enable people to attend. That working group was instrumental in changing the climate of opinion — certainly in western governments — to control of tobacco.*

*I believe that that perhaps was Jo's biggest single contribution. This idea, so obvious in retrospect but no one had thought of it up to then, that a coalition of those of us concerned about public policy on tobacco should work under the Regional Office's auspices so we had the clout of WHO — not acting just as nationals or individual health professionals, but as an international movement. It was a very happy relationship. The BMA appointed permanent staff to pursue the programme — I was in a position to see that it did — and we got sponsorship from non-industrial organizations.*

#### **The family health nurse**

We simultaneously also then looked at some of the other professions. The nursing associations were very enthusiastic about Health for All and we had a big discussion with them, which became very positive. The outcome was that the European Forum of Nursing Associations and WHO developed a new concept for nursing at primary care level, namely the so-called family health nurse.

The family health nurse would be a multi-purpose one who would work with a limited number of families; would do a lot of home visiting; would do the home nursing of granddad in bed if that was necessary; might do vaccinations if that was not organized in other ways; would be the link between the local general practitioner or practitioners and the family when that was necessary for referral or follow-up; would be the one that visited and gave advice to the mother with the newborn baby after she came home; but would also be the one that would observe the family and be trained, educated to recognize early symptoms of lifestyle and health problems. Was there a teenager, a girl without sex education? Was there a father starting to drink too much? A young boy started smoking? Whatever it was, these kinds of problems she, because she would know the family, could observe. And the final and perhaps most important task that nurse would have would be to try to sit down with the whole family and discuss their health problems and have the family discuss them and find solutions together on how to overcome these types of problems.

It was a tall order, I know, but nurses are capable of doing that. A good nurse is exactly the type of person who can do that. She can give advice to a family and if she knows them she would be respected, because she would be doing all these other things. So she would be the first-line health worker. So instead of having, as you have in countries, a home nursing nurse and you have a vaccination nurse and you know, all these different kinds of nurses, you would have one who was responsible for a fairly limited number of families — the multi-purpose Health for All specialist, if you like. That's how we saw it and that's how the nursing associations saw it with enthusiasm. They developed that concept and they developed a training programme to go with it, and they started testing it out in some countries.

### *He galvanized the forces*

**Ainna Fawcett-Hennessy**

*To me, one of Jo Asvall's greatest accomplishments related to his ability to build effective network systems across the Region in his pursuit of*

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*delivering the Health for All and HEALTH21 agendas for the people of the region — for example, the establishment of the network of medical, pharmaceutical and nursing associations, galvanizing their efforts for the greater public health good, is an important part of his legacy. His focus on country work and his leadership in helping the less well developed countries to improve the health status of their populations was remarkable. For nursing, he supported a strong nursing programme (and nursing voice) in the Regional Office throughout his tenure. He was a strong personal advocate of the profession and believed that nursing does make a difference to people's lives. Far from being minions or irrelevant, nurses, according to Jo Asvall, were equally important. That was a huge boost for the profession across Europe. Asvall said it and Asvall did it! He walked the talk.*

## Pharmacy health centres

The third professional group that we had very good cooperation with, where we also made a forum with WHO and them, was the pharmaceutical associations. The Danes helped us host the first meeting of national pharmaceutical associations and WHO. And what we explored with them was how we could apply the Health for All ideas in the work of pharmacies. And we found that they were quite puzzled in the beginning. That was not the role they saw themselves as doing. But out of that cooperation developed quite an interesting new view, I think, on pharmacists. We said, “Well, what are you? You are a place where the whole population goes. The pharmacy is in the local neighbourhood; everybody goes there probably once a year at least. But the high-risk people go there more, because they buy their drugs and whatever. You are respected, you are professional, you have a good status. Why not see if you can take on some of the lifestyle and health or quality issues?”

And with that idea we developed with them a module on smoking withdrawal, so they started offering to the population smoking withdrawal clinics or courses. Another module was a needle exchange programme for drug abusers. Some pharmacies established safe boxes, so that drug abusers could have a needle exchange there. We also started work on diabetes, how they could

use their contacts with patients to advocate for and provide more patient education and referrals as needed. So we found that this was also a profession where we could do new things, and important things, with a partner. We were just a catalyst. And they took this on as their own things. They developed these different programmes, working groups and models. We provided the experts, for example on tobacco, on drug abuse and so on, who would work with them. So actually, we ended up saying that the pharmacy should become a kind of local health centre.

## The settings approach

We then shifted our activities to reach out to other potential public health advocates and contributors in what we later came to call the settings approach. A setting to us meant a region, city, school, a home, workplace, elderly home, prison, etc., where people come together and work, live and play – where you can reach them as a group and one-on-one. We tried to look at all major settings and start networks reaching out to them.

As we began to look for important ‘settings-based’ partners, we looked first at the governmental level below the national ministries. In many countries in Europe we noted that there are quite strong regions or *länder* or provinces – with comparable structures. These often had their own politicians and tax possibilities. Many of them had extensive possibilities for influencing health developments. So we created a Regions for Health network.

The Regions for Health network attracted initial interest from a wide range of regions. This recognition by WHO of the reality and the importance of regional structures was timely. Some 40–50 regions have been associated with the Network, which offers an opportunity to share problems and experiences, look for partners and keep up to date with the latest developments.

The next level was an even more interesting one. We were looking at Europe and its structure and realized that it was changing a lot. It had become a very urbanized region. In one of our discussions, which we had every autumn when we evaluated together all our

work, the idea came up that perhaps we could reach out to cities. Perhaps cities could also start making Health for All plans. There were good arguments for that. Cities are quite independent in most parts of Europe. They have budgets and they have environment and health and social services. We thought they could do a lot with environment, lifestyle and health issues.

Actually, the first time I became aware of local action potential was interesting. I was in London for a meeting in the ministry and someone made me aware of an article that had been in *The Times*, about a little borough in London called Bloomsbury. In Bloomsbury there was a public officer who had taken the Health for All policy all by herself with her staff and said, “What can we do in Bloomsbury with this?” I asked if I could have a meeting and see them. I had a very fascinating meeting with the staff there. They were very enthusiastic. They demonstrated that a lot of things could be done at local level with the Health for All policy.

## *Local interest*

### **June Crown**

*Perhaps, for me, the most memorable was the first meeting with Jo Asvall. I was in my very small office in the Bloomsbury Health Authority (BHA) headquarters and received a telephone call from the Department of Health informing me that Dr Asvall, Director of WHO Regional Office for Europe, wanted to visit. As our offices were in central London and we were an authority with several very distinguished teaching hospitals, undergraduate and post-graduate medical schools, we were often asked to receive visitors at short notice and I prepared myself for a tour of the hospital ‘showplaces’. This, however, was different. He had heard that BHA had adopted Health for All as the basis for its planning and instructed every department (clinical, support and administrative) to include in their proposals at least one project to contribute to the achievement of Health for All targets and he wanted to know about progress. I was totally astonished, as any interest in public health was rare indeed, let alone from such a distinguished source.*

Ilona Kickbusch introduced us to some exciting programmes in Canada. We made it known that we would be interested in doing

with cities what we had done with countries, namely to have one or two as a pilot for Health for All development. We were soon astounded because we were stampeded! It was one of the most surprising and fascinating things I have seen. Suddenly there were a lot of cities coming running, saying, “We want to be with you! We want to be chosen!”

We quickly realized that the words ‘healthy city’ constituted politically a very good slogan. For mayors this was a good thing: “We will be a healthy city!” That was a good political phrase. We were not convinced that they all knew what this was all about, but they were willing to come and be part of our network.

The network grew quickly and to sizeable proportions – thousands of cities in Europe. We soon realized that we could not deal with all these cities so we created an inner core of what we called WHO Healthy Cities. Every year we met with these core cities and we planned the technical developments and the whole network management. Five-year developmental plans were elaborated and agreed. Many other cities joined through the national coordinating Healthy Cities office. The Healthy Cities network made important links with Agenda21 and the sustainable development movement.

## Healthy hospitals network

Another network was the healthy hospitals network. This one was more difficult to run with. Cities are clear, big managerial structures with good funding, etc. Hospitals are very different. Some of them are private, some are public. There are a number of Health for All issues in hospitals, but the number is more limited. Quality of care is, of course, an issue, although that issue we addressed mainly through the three networks with professional groups. Then you have correct treatment, you have waste management and you have certain lifestyle and health issues for staff and patients. In that area we had a collaborating centre in Austria, which was kind of operating as a major organizer of that network<sup>3</sup>.

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<sup>3</sup> In 1989 the first pilot health-promoting hospital project was set up at the Rudolfstiftung Hospital in Vienna, Austria. Two years later, the International Network of Health-Promoting Hospitals was initiated by WHO with the Ludwig Boltzmann Institute for the Sociology of Health and Medicine (LBISHM) designated as its first coordinating centre.



## Health-promoting schools

We also got involved with schools. We were very interested in getting to the schools with the Health for All issues. Basically in a school, like a work site or a prison or an old age home or any institution of that kind where people live, work and play, you can meet people one-on-one. Of course, schools in addition have people in their formative years.

So we created a health-promoting school concept and a network to go with it. That network was developed in partnership with the European Commission in Brussels. Here we did like we did with the Healthy Cities network – we created a unit at the Regional Office. This unit's staff then went with the Health for All message to the schools and to school networks.

The school, of course, was a primary setting and it was a big network. When I left I think there were some 5000 schools in that network, which operated a bit like the Healthy Cities network but with less money. Of course, schools are smaller entities than cities. A fundamental change we wanted was that instead of the previous health programmes in schools, with basically a nurse vaccinating and a doctor looking at the backs and the feet, we wanted to involve the people in the setting – who were they? They were the students, the teachers and the parents. We wanted these three groups to get together and to sit down and analyse their health problems whether this was smoking, teenage pregnancy, bullying, whatever were the main health problems in the schools – then for them to use the Health for All policy approach and develop their own plans for improving health.

## Health in prisons

We also created the Health in Prisons Project (after some internal debate, we decided that 'Healthy Prisons' would not work as a title! So we called it Health in Prisons). There the initiative came from the United Kingdom. There was a very strong group with a good national institute and in cooperation with the United Kingdom we created a European network that grew. I think some 15 or 20

countries were members of that network when I left. They, of course, dealt in the same principles that there should be cooperation between staff and inmates and they should deal with the health problems, i.e. drug abuse, AIDS, etc., that were most important in those prisons. They should then make their joint plans on how to deal with them.

## Environment and Health

(from interviews 12.11.08 and 12.12.09)

### From the technical to policy

The European Region, when I joined WHO, had already for many years had a very strong Environment and Health programme and we had some very competent and enthusiastic people there. They had for a number of years been operating a number of United Nations Development Programme (UNDP) programmes in Romania, Bulgaria and so on, for water and sanitation and these kind of things. We had, since the end of the 1970s, also developed a lot of good technical guidance documents, including advice on what you do if you want to plan for healthy housing or an urban environment, or how you plan for health safety concerns in nuclear power plants, what you do with dioxin, etc. And the department had good contacts with WHO collaborating centres in the Region. It was functioning very well. But it was all technical work.

Then in this evaluation session we are sitting around the table and someone raises their hand and says, “What is the impact of what you are doing in the countries?”, because now of course with the Health for All targets we were starting to think about impact in countries. Is it leading to change, and how much and what?

Ian Waddington, the then director of the department, looked a little bit puzzled and then he said, “Well look here, we produced x number of thousands of reports last year and we distributed to x number of countries and x number of institutions and you know we had so many people on courses and whatever.”

“Yeah, but are things changing in the countries?”

Well, that no one really could say.

“Are people reading your documents?”

“Well, we are of course giving them free of charge, we are not selling them.”

So it became an interesting discussion. Are we really ambitious enough? And the conclusion of that was no! We felt that now we have to try to help countries change environment and health policies to be in line with the Health for All policies, and that meant trying to reach out to different partners. That was, of course, a new agenda and the department threw itself into that with a lot of enthusiasm. Ian Waddington went back to his office and within a few weeks he came back with a plan to hold a meeting in Vienna where he would invite all the directors-general of health and all the directors-general of the environment for the European Member States.

We were in a situation around 1985 where almost all countries in Europe had new ministries of the environment. Those came in the mid-1970s, stimulated by the United Nations conference in Stockholm in the early 1970s. So suddenly you had a whole new emphasis on the environment. Of course, if it was environment and health, you needed both ministries involved.

So Waddington travelled to Vienna and came back very downhearted.

I said, “Didn’t they come?”

“Oh yes, they came, all of them.”

“Didn’t you manage to get a clear opinion out of them?”

“Yes,” he said, “that’s the problem.”

I said, “What do you mean?”

He said to me a very straightforward thing. That was: “Forget about it. They are like cats and dogs. They are fighting; they are not cooperating.”

So here we were with quite an obstacle. What do we do now? We had so many other things on our plate just then. We were preparing for the big conferences on lifestyle and health and so on. So we said, okay. We will put it on the shelf for the moment and we will come back to it in a couple of years. And in the meantime, we would try to work with these new directors-general of the environment on more technical issues and get them kind of starting working with us. So that is basically what we did.

## **Chernobyl, 1986      the turning point**

It took an external force to break through the deadlock on environment and health action in Europe. That came in 1986 with the Chernobyl disaster. Chernobyl created huge problems for health, environment and politics. In a flash, it stimulated a rethinking about how environmental factors can be key determinants of health.

I remember Ian Waddington coming into my office and saying, “Jo, we have a problem. Sweden has noted that workers at one of their nuclear plants are registering high radiation levels. They think there has been some sort of accident there.” Soon afterwards he updated me, saying that all plants in Sweden were now reporting high radiation levels and that the thought was that the accident was outside of Sweden but somewhere in Europe.

## **We had a script to follow**

So we decided okay, this is an emergency. Concetto Guttuso had developed, a year before that, a new internal manual for the Regional Office on how to act in an emergency so that whenever something happened there was a decision tree which would automatically release certain actions. To support this process there was always US\$ 25 000 (which at that time was a lot of money) set aside from the Regional Director’s Development Fund, which the current Regional Director could use at his or her discretion. It was a very good system which had been developed on the basis of a review of previous experience that we had had with earthquakes in Europe. It had analysed how we acted and found out where we needed to shape up. So we had a script to follow.

The Environment and Health department had also recently done studies on health and civil and nuclear power plants, as well as guidelines on radiation and health. So we had a good evidence base with which we could get to work.

We quickly set up an expert task force and began giving information to Member States about steps they could take to protect health: for example, use of iodine tablets, foods to avoid, etc. We got our nursing unit involved to identify issues that the public was concerned about and used this intelligence to provide public and professional information and advice.

Building on meteorological data and findings from available radioactive measuring stations (many countries had stopped measuring radiation levels after the disarmament treaty signed by United States President John Kennedy and USSR President Nikita Krushchev), we quickly pinned down the origin of the accident to one of three nuclear plants in the USSR. But there was no word from there. We tried to contact the Minister of Health in Moscow, but still no word. Eventually all was revealed.

I remember we had masses of foreign journalists. We had three American television stations camping outside the Regional Office building for several days, which at that time was quite unheard of. Today, of course, it happens all the time. It was unheard of in those days.

Some people in Geneva went to Dr Mahler saying, “Dr Mahler, isn’t this something that we should take over here now, here in headquarters?”

And Mahler said, “No, I think the Regional Office is doing this fine, you know. Let them handle it.”

So we handled it on behalf of WHO as a global issue.

The Chernobyl accident changed the way people looked at environment and health issues and created a demand for action. Five years after its rejection in Vienna, the idea of a joint environment and health ministerial conference in Europe was rekindled.

So we decided then to have a second go. We said, “Let us exploit this crisis for getting back to the environment and health agenda.” And we went to Dr Klaus Töpfer in Germany and said, “Would you like to be host?” We knew he was widely respected among ministers of the environment, which were the ones we had less contact with. So Germany hosted the first conference of ministers of health and the environment in 1989 in Frankfurt. It was a little bit like the first meeting of the medical associations and WHO. There was a lot of tension in that meeting. But it was more between the ministers of health and environment than towards WHO. We were kind of the neutral partners going in between. But Töpfer was very clever and out of that conference came the first European Charter on Environment and Health.

The Charter was very progressive. It stipulated that the preferred approach in public policy should be to promote the ‘precautionary principle’ and called for giving health and the environment precedence over considerations of economy and trade. Moreover, the Charter emphasized that one of the principles of public policy should be to pay particular attention to the protection of health and the environment of biologically vulnerable and socially disadvantaged groups. The Charter set out a broad framework for action by all levels of government, by all sectors of society and at the international level.

### *Coming together*

#### **Zsuzsanna Jakab**

*I attended the Frankfurt conference as part of the Hungarian delegation. For us, cooperation between environment and health hadn't been in the spirit of how things were done. Before Frankfurt there was virtually no cooperation between environment and health. After Frankfurt, things changed significantly:*

One of the main outcomes of the Frankfurt conference was the establishment of the WHO European Centre for Environment and Health.

This centre really changed things. It gave us resources to really start working with the issues that came out of the Frankfurt conference.

We suddenly were sitting with an environment and health staff which grew to be four times as big as we had before Frankfurt. We had much more operational money. We could do research and run programmes. So we could do a lot of work in preparation for the second Environment and Health Conference in Helsinki in 1994. In Frankfurt, we had the tiger by the tail and one thing we did with the tiger was to say, we will meet you again every five years! When we came to Helsinki we had already developed a model for a national environment and health policy, what we called NEHAPS – National Environment and Health Action Plans – that were based on the Health for All approach.

So environment and health became one of the strongest elements where really we were into national policy-making; we got both environment and health interested in the same agenda, a lot of cooperation, a lot of action was started across Europe. This was a very successful thing.

And when we came to the third conference in London in 1999, we actually had them signing for the first time a water protocol and a large majority of Member States signed that and they were very enthusiastic. They even went into transport policies, which of course were hotly debated political issues because of the auto industry in Europe, but now there were many people really gung ho and wanting to take action for health. This Environment and Health conference in London, which was the third one, was as far as I know the biggest health conference ever in Europe. We had close to 90 full ministers. Ministers of health, the environment, economy, transport, things like that. It was a big, big thing. And it even had a second kind of conference of NGOs parallel to it. It was huge and a big success. So by the end of this last century we really had got a big environment and health movement going.

It was a fascinating process to watch. And again I think it got that way because of two things. We had Health for All, which was inspirational, and we had an Environment and Health department which had very good people, smart people who were doing good technical work but had both the interest and the eye for reaching out beyond the traditional work they were doing into new and

quite fascinating fields and doing so very successfully. I was very impressed by what happened during those years.

## Quality of care and health services

(from interview 19.11.08)

### Quality of care

In 1979, when we asked Member States how they felt about the ‘Alma-Alta primary health care’, they were not all that enthusiastic.

We realized that in dealing with health services in Europe we had to go a bit broader than primary health care. In doing so, there were a number of major strands that we took up. First, we took up the issue of hospitals but linking them in a larger framework to ‘patient journeys’ – what happens to patients as they go from the first contact with primary health care and through the whole system to the end of their treatment of a particular condition.

As we worked with the issue we realized that the quality of the health care provided was very uneven indeed. And it was not just between countries but between regions within countries, between hospitals or health centres in the same region and, of course, hugely so among the practitioners of health care, whether they were doctors or nurses or midwives. So already in 1980, we started to focus on cost-effectiveness, as part of our Appropriate Technology for Health (ATH) programme. In the late 1980s this programme in the European Region changed its name to Quality of Care and Technology to reflect the new emphasis we were placing on quality of care development and technology assessment.

So we asked ourselves, “How do you improve quality of care?” At that time, the focus in medical circles was on the inputs, meaning what kind of operations were you doing and how many resources did you provide in terms of diagnostic facilities, money, personnel and all that. And quality of care was basically seen as, are you following certain standards? Is your laboratory giving consistent results? Things like that.



But we looked at quality of care differently. We asked, “What is the final outcome for the individual patients as they go through the system?” And that led us to focus on measuring those final outcomes.

As we started to implement the programme, we were criticized by professionals from almost all the Member States, saying that our advice was too general and not useful. Some suggested focusing on evaluating outcomes of common new technologies. That is how we got involved in the insulin pump studies.

## *Evaluating technology*

### **Kirsten Staehr Johansen**

*Professionals across the Region asked about this new gadget that was capable of giving patients their insulin doses more or less automatically, 24 hours a day. They wanted an independent evaluation of its value.*

*“Should we buy it”, they asked. “It is quite expensive, so we want to know if it will be good for our patients, both in the short run as well as the long run. We want to know how cost and acceptability compare to other treatment modalities.”*

*From what I had seen in the literature, the pumps were probably good but no good evaluation studies had yet been done. So we decided to look at the value of insulin pumps for diabetic patients in Europe. That led to a lot of reaching out to institutions and groups in Europe and a large multi-institutional, multicountry study led by WHO.*

*This study revealed more than we expected. First, we were surprised to learn that the quality of diabetic care in different countries in Europe varied and was often very poor and that this had little to do with technology and economic constraints. This finding was based on outcome data related to amputations because of diabetes, loss of eyesight, kidney function and other severe complications of poorly controlled diabetes. Using a new blood test called haemoglobin A1C which could indicate if the patient’s diabetes had been well regulated over a certain time, we could see that a total of two thirds of the patients included in the study did not receive the quality of care that they ought to receive with the current available technology. This was true in nearly all centres, including*

*many rich ones. The very best results were actually found in one of the poorer countries.*

*We saw that not enough emphasis was being placed on teaching the patients how to live with their diabetes by giving them the possibility of monitoring their own blood sugar, and by giving them good training on how to regulate their insulin dose and their life to keep blood sugar within the normal levels, even though experts said that probably some 90–95% of all patients could learn to do that.*

So we were facing a situation where, even in the most advanced countries like Sweden and France — where there certainly was enough money, available technology, well-trained physicians, health insurance schemes that could cover the necessary care, and all the information you could wish with regard to accessibility to new research worldwide — in spite of all these factors, we found these huge shortcomings in actual delivery of health care in Europe.

This, of course, was a big, big problem. And that was true of other conditions and was not just specific for diabetes. We concluded that a major reason for this was the fact that there was no measuring of outcomes for individual patients, no feedback of that information to the individual provider, the physician or the diabetic nurse (which they had in a number of countries), or the institutions, and therefore no management by the outcome. This became a major league theme for the Regional Office's work in this area; the fight to change the system in all countries so that they would start measuring and systematically looking at outcomes of patients.

These results were presented at a big conference in 1989 in St Vincent, Italy, and an agreement was made by the professional, patient, government and industry representatives there to set specific, realistic and achievable outcome targets for Europe to reduce some of the major health affects of diabetes. The St Vincent Declaration was endorsed by the Regional Committee in 1991 and became a programme introduced in every Member State in Europe as a way of showing in practice how quality of care could be improved in a systematic way.

## *WHO/International Diabetes Federation partnership*

### **Harry Keen**

*I first met Jo in the 1980s, when Kirsten Staehr Johansen was conducting her technology assessment of continuous subcutaneous insulin infusion (CSII) in type 1 diabetes. I had invented the technique and developed it with John Pickup at Guy's Hospital in London. The WHO Second Expert Committee (1980) which I chaired had recommended that each Regional Division of the International Diabetes Federation (IDF) should seek to join forces with its corresponding regional office of WHO to develop an action plan for the major diabetes burden in its Region. Professor Jak Jervel's initiative, as then Chair of Euro IDF, led to a meeting in Copenhagen and to the joint WHO/IDF meeting in St Vincent in November 1989. Jo gave enormous support to the St Vincent Declaration on Diabetes Care and Research in Europe, an initiative which created a surge of organized anti-diabetic activity in every WHO Member State in Europe. The momentum of St Vincent continues to this day. Throughout his tenure at WHO and beyond, Jo offered the initiative untiring and enthusiastic support. As I have said elsewhere, the gratitude, the health and indeed many of the lives of people with diabetes are owed to him and his determination.*



## **Feedback on outcomes and patient education**

The primary foci of our quality programme were on building information systems to provide feedback on outcomes and providing advice on how to improve education of patients. In this pursuit we had many collaborating partners. We then developed guidelines for national level on how to plan European diabetes programmes of this type and we very actively started to advocate this approach, including in the new countries of central and eastern Europe that emerged after the dissolution of the USSR.

## *A different way of working*

### **Isuf Kalo**

*The St Vincent Declaration diabetes programme is one excellent example of how WHO played a leading role in improving quality of care in the area of noncommunicable diseases. For the first time, different bodies working on the issue came together. Representatives of ministries of health, professional representatives (including general practitioners and nurses), representatives of patient associations, the pharmaceutical industry and the media were brought together by the WHO Regional Office for Europe and IDF Europe in one common initiative. With all these partners together, each one offering their point of view and inputs, the St Vincent diabetes programme developed a new approach, with objectives and targets, aimed at maximizing patients' health gain.*

*Jo introduced a new work culture through this initiative. He always said you have to measure and suggested that we agree five measurable targets for the programme and specify a precise deadline for accomplishment. He would talk about 'what we have to achieve in five years'. This was all new talk and concepts for us! We had no such measurable targets before this. This entirely new culture of measurement and targets for quality improvement was focused on outcomes of care, cost-effectiveness and patient satisfaction. These factors really distinguished the St Vincent diabetes programme. Moreover, this provided a model for other WHO quality movements and initiatives.*

## *Educating providers and patients*

### **Jean-Philippe Assal**

*As a clinician, I was impressed by how seriously WHO integrated the needs of patients and their families, as well as the importance of new approaches for continuing education of healthcare providers, in this St Vincent programme. It was at that time that the need for patient education was first officially recognized. The document published by WHO in the field of patient education was quite new for that period. There was very strong resistance to this document, but Dr Asvall had already foreseen all the help that the Regional Office could obtain with such a report of a WHO working group. So far it has been distributed to all the European*

*governments and has allowed the opening of several centres specializing in patient education for people suffering from chronic diseases.*

These St Vincent initiatives were quite successful. We had more than 40 countries which made national St Vincent-type policies and programmes. They established a new approach to promoting systematic quality of care. The programme branched out from diabetes to some other areas: care of pregnant women, mental health and other areas. These programmes became the main focus of our efforts to improve quality of care in Europe.

## Health system reform

In the 1980s, health systems were a highly political topic with four competing approaches. You had the ... Semashko model<sup>4</sup>, which was very medical. Secondly there was the British model – their comprehensive National Health Service. The third model was the Scandinavian one, which was a bit less regulated perhaps than the British system but also very strong in its primary health care beliefs. Finally you had the central European countries: Germany, Switzerland and Austria that basically were fairly anti-government. They believed that the physicians should have the liberty to do what they wanted and so should the population. Four main philosophies, each of which had strong beliefs so people were often fighting over their models.

However, this all changed when the communist system collapsed. And it changed in surprising ways. Because when that happened, not only did the theory of infallibility of the ... Semashko system suffer a setback, but since that had been the sparring partner that the other three systems were boxing against, they were suddenly boxing in a void.

Everybody, particularly the newly emerging countries of the former USSR and Yugoslavia, was left in a kind of floating situation. This political situation plus the rising interest in health services research in many countries made us decide that it was now time to look at health care systems in a major way.

<sup>4</sup> This was named after Dr Nikolai Alexandroich Semashko, a famous professor in public health in Moscow in the 1920s. .

So we organized, in 1996 in Slovenia, the first major conference on health systems in Europe. There we looked at issues like financing of health care, privatization, regionalization, patients' rights and all these things. One of the major outcomes of the conference was the Ljubljana Charter.

## Ljubljana Charter

All countries in the former USSR and Yugoslavia were reforming their health systems in those difficult transition years. The Ljubljana Charter committed the ministers to not forget equity, access and affordability, continuous improvement of quality of health care delivered, including its cost effectiveness, and human rights issues when planning and implementing those reforms. In those times, there were many actors and advisers offering help and giving advice. The transition countries' markets were poorly regulated and open to a lot of companies who tried to influence development. Different bilateral partners were also competing and giving advice based on their own health system organizational formats: for instance, Germany advising for health insurance, United Kingdom advising for an NHS-type approach. Everyone wanted to change something in health and in the health system and many were looking to WHO to give advice. The Charter provided the needed advice.

### *A most important charter*

#### **Maksut K. Kulzhanov**

*The Ljubljana Charter was a most important development for my country. It helped provide clear guidance related to our reform process. It provided a framework for policy development. I remember being part of a planning group that met in Hellerup, Denmark in preparation for the conference. There were many hot debates at that meeting about what should be part of the Charter. Many countries had objections to the first draft presented. Jo Asvall was at that meeting. I remember he and his team must have stayed up all night because the second day we were given a new draft which creatively incorporated all concerns. I was amazed, as were so many of my other colleagues, at how this man could find a common and clear way forward for us all.*

## The Observatory

In preparing for the Ljubljana conference, we knew that we were going into a big new field which would be very resource intensive. Therefore, before the conference we discussed what we would like to come out of it, also how we could then move more forcefully afterwards on the issues. We therefore proposed, which was accepted, to establish what we called an observatory on health systems in Europe. After the conference we started working on that. We got support from different organizations and countries. We developed partnerships with the World Bank and a number of governments, as well as other organizations and institutions in Europe, to create this permanent facility for analysing health service developments in Europe so that we could gather the experiences and feed the results back to the countries. This was first established in Copenhagen and later we moved it to Brussels.

The Observatory looks at health policies in countries and health service developments in countries: what functions, what doesn't function. If a country changes approaches, what is the result? Also it tried to pull together different types of research, for instance with regard to different methods of payment for health care, different ways of organizing privatization. What is, for example, Tajikistan doing with regard to its new health policy, what does it contain, what is the value of the experience? So it really treats a fairly broad range of issues, trying to analyse health services developments in the whole European region and to draw conclusions, analyse and feed that back to the countries. All information has been made publicly available on the internet. Observatory profiles and publications have become a major source of health system information in Europe and beyond.

Before it was, of course, the Regional Office carrying out these activities in its programme, but we felt the challenge was far too big, we didn't have the resources. We had to create a new resource to do that. This was done successfully by creating the Observatory. WHO organized it all in that we were the prime initiator and kept the secretariat functions. This, I believe, was another interesting way WHO could pull together new resources but keep them within

the framework of WHO programmes, being supervised, of course, ultimately by the Regional Committee.

## *Health for All framing reforms*

### **Carolyn Murphy**

*When the [USSR dissolved] and the European Union got involved with health policy and went into some of the eastern European countries and had money to spend on public health, they were surprised to learn that what many ministries of health in those eastern European countries wanted to do was to spend this money on implementing the Health for All policy. When asked “Why do you want to do what WHO is telling you to do, why not do your own thing?” they said, “Well, Health for All is our own thing, because we decided on it by consensus in the European Regional Committee and that’s what we want to do!”*

## **Armed conflict in the former Yugoslavia**

**(from interview 24.11.08)**

126

In 1991 Jo Asvall was the first director to take the WHO Regional Office for Europe into a ‘hot’ war.

### *He took us into war*

### **Carolyn Murphy**

*There were huge debates and arguments in the Regional Director’s executive committee about whether or not we should go into Yugoslavia. Many were very much against it. Jo’s big and deciding argument was, “What will we do after the war if we haven’t been there with them during the war? How can we move in after the war and tell them how to do this, this and this? You know, we have to help them now!” And we did.*

*There were no precedents or guidelines to go by. There was no script at all. And many of those going in were making mistakes. Some aid agencies went in with all their pre-prescribed remedies for Africa and sent many wrong things in, wrong food, clothes and so on. So Jo said, “Right! We need to have a proper public health analysis,” and that was when he got Sir Donald Acheson, who had just retired as the Chief Medical Officer in*



*the United Kingdom. He hired him and he went out and he brought public health people in and they analysed the whole thing from scratch and came up with a strategic plan.*

*There were many difficulties. I remember David Macfadyen, who was second in command at that time, telling me that they had been shipping food like mad. You see, everything in Sarajevo had to be taken in by airlift as land access routes were blocked. Space was very important and they had been shipping food in like mad and they had to make a very difficult decision just before the winter, probably the first winter, when they decided to stop all the food shipments because they simply had to get clothes in and bedding and things for the winter. They did that for two or three weeks and that was all shocking and a bit of a risk but we did it and it worked.*

*Many things had to be rethought. The prosthetics people wanted to use that Indian foot called the 'Jaipur' foot. And people thought that would be fine in Yugoslavia and Jo said, "there's no way it will be fine in Yugoslavia! The need here is for prostheses for young men who need to be active." So we started a huge prosthetics project.*

*We were always short of money but Jo never 'cut his coat according to his available budget' — he thought that we had to aim for the best and then we had to get the money for it. I do think that our activities in war were absolutely revolutionary in terms of organization and aid.*

*Jo really championed that cause. He was behind the decision to go in and he guided our policies and approaches and every time people were going down the wrong track he pulled them up and said, "Right, let's consult, let's consider."*

*There were many challenges. For example, a lot of the NGOs were doing their own thing in Yugoslavia. There was a need for coordination. There were, for example, I can't remember now how many different tuberculosis (TB) treatment regimes which were provided in different parts of the countries by different organizations. Finally, we were able to get the NGOs all working with common WHO-recommended TB treatment regimens. In the end, when people moved from one part of Yugoslavia to another they weren't changing their regimens.*

*We took a leadership role in public health there and it was all under Jo's guidance.*



Jo Asvall touring Stenkovac 1 camp. Skopje, Macedonia, 30/4/99  
Picture by: Andy Johnstone



Jo Asvall and WHO Director-General Hiroshi Nakajima in Sarajevo during armed conflict in the former Yugoslavia



Healthy Cities convoy brings supplies to Zagreb when WHO could not 'officially' help (see page 129)

## Political challenges

Jo recalls that WHO was at first in a very difficult situation politically when it was first asked to help in the war. Politically, WHO's official counterpart was the Federal Ministry of Health in Belgrade. While Croatia and Slovenia had declared themselves independent, they were not yet so by international law, as the split had not yet been endorsed by any other countries. To overcome this obstacle, Jo Asvall turned to the WHO Healthy Cities network.

### ‘A sister city to sister city thing’

We decided to use the Healthy Cities network as a vehicle (literally and figuratively) for providing first-line help. We contacted Horsens, which was a Danish, fairly small but very enthusiastic member of the Healthy Cities network, and asked if they would be willing to work with us, which they gladly accepted. We then undertook fundraising for quite a large shipment of medical supplies – some 40 tons if I remember correctly – which then were sent from Denmark in the name of the Healthy Cities movement – not as WHO but as the Healthy Cities movement, because Zagreb, the capital of Croatia, was also a member of the Healthy Cities movement. So this was a ‘sister city to sister city’ thing. It arrived in Zagreb and it was much appreciated. It came at a time when no one else was daring to start getting involved in the conflict.

I, of course, felt that it would not be politically correct to do this and not inform the Ministry of Health in Belgrade, because they will wonder what is happening here. Of course, I knew they would hear about it and felt it would be much better that I tell them than they get it from someone else.

So I phoned the head of the international unit in the Federal Ministry of Health, whom I knew very well, and I said, “Look here, I am phoning you today just to give you some information. And I don’t want your comments on it, and I am not going to comment on it, but I just want to tell you so that you know what it is all about and you can be prepared if you get questions.” I told him that the Healthy Cities network was going to send this aid and he said thank

you for this information, and that was that. So this went without a problem and we felt we had been acting reasonably within the politically difficult situation.

When the war broadened and the international community recognized the different republics, WHO established 11 offices in the war zones, at least one in each of the republics, and fielded 85 staff to work exclusively on this programme. The programme was supported by many European countries.

They partly gave us money, partly gave us donations in kind, trucks, communication equipment, medical supplies and whatever else we needed. We were, of course, very concerned that we should lose staff. We were very lucky. We never lost any staff to war actions throughout the four years that we had a programme. We had only one death from a traffic accident, which could have happened anywhere, so it was not directly war-related.

The roles we played evolved over time and with changing needs. First, we played an important coordination role. We tried to get all the various agencies working in health to meet and communicate. We tried to see what kind of supplies were needed, where and when, and in those meetings we also discussed who could do that. And if there were holes that were not filled by other organizations, we filled them. We established our own warehouses with medical supplies and trucks, the main one in Zagreb, and we would send out when it was needed, where it was needed. So we felt that was a 'soft' coordination which didn't tread on too many people's toes and turned out to be practical to do in that kind of situation.

The second thing was, of course, to try to follow the epidemiological situation. We were afraid that epidemic diseases might occur. They almost always do in war situations. None occurred during these wars. Whether we should take any credit for that, I'm not saying. What we did is, we tried to establish links with the epidemiological institutes of all the republics and we had good relations with them all. We collected information from each entity and shared it with the others and tried to see if it was necessary to have vaccinations or address any other common health threats which could arise.

Third, we quickly realized that certain things that function in peacetime do not function in that kind of conflict. The war was vicious and there were many wounded people and quite a number of disabled. There were not well developed services for so many, especially young, disabled men who had lost their legs and arms. Even in the best of circumstances such services are complex and take a lot of staff and time. We were facing a war which didn't look like it was going to end any time soon and there were casualties coming all the time. So we developed a plan for providing prostheses that were easy to transport, to use and to instruct people in using.

### *Bringing people together*

**Anna Ritsataki**

*A memorable travel experience was going with him to Sarajevo just after the war finished. Public health officers were walking into that room, not having seen each other since before the fighting started. The tension was incredible. But despite the killing and the obvious destruction outside, his personal presence brought them together in that room to talk public health.*

131

## **Bringing east and west together**

**EUROHEALTH** (from interview 25/5/08)

### *Health Diplomacy*

**Ok Pannenberg**

*I think over time, Jo Asvall played a big role in bringing together the east Europeans and the west Europeans. Between 1975 and the early 1990s, the east and west Europeans were hardly talking to each other. Jo was able to bring people together not only at technical levels but, using his personal relationships, arrange for meetings in locations where people would feel safe and open up. I remember one such meeting in a small remote Dutch island in the North Sea in 1983–1984. He brought a couple of people to this meeting: some Dutch people and the First Deputy Minister of Health in the USSR. That was an unprecedented event in those days. Soviet*

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*ministers of health did not travel to western Europe. When the guy arrived in Amsterdam, there was a lot of diplomatic stuff to make sure that he was received properly. Then the whole entourage travelled on a ferry to the remote island. There was only one hotel on the island. The whole hotel was rented. They became very open to discussion. They said what was good about their system and discussed the bad part as well. There were two or three days of these things. Every evening the Russians played piano and there was a lot of vodka. The whole atmosphere of the island meeting contributed significantly afterwards to improved relationships with the Soviets. Based on this, there were subsequently a couple of meetings in Hungary, eastern Europe and also in Berlin, so that the whole technical atmosphere between the Germans, the Dutch and the French, together with the Soviets and other east European nations, became much easier. That was clearly managed and instigated by Jo.*

The European Region found that many countries were coming out of the former USSR and Yugoslavia while they had health service infrastructures and competent professionals, the sudden political and economic changes created new health challenges and disrupted their normal functioning. Health threats due to infectious diseases (diphtheria, polio, HIV/AIDS), lifestyles (for example, smoking, alcohol, fatty food) and environmental threats (water safety, chemicals, sanitation) grew as capacity to address them fell. Mortality rates in many of these countries, particularly amongst males, soared.

Suddenly we had to give a lot of help to the so-called eastern European countries and the newly independent states (NIS). In such a situation we had to think carefully about what to do. We created a special programme we called EUROHEALTH for those countries.

## *Keeping Europe together*

### **Mihály Kökény**

*I think that one of Jo Asvall's greatest merits is that after the fall of the Berlin Wall, he recognized that new, invisible walls between east and west might rise if the former socialist countries did not receive help. By establishing the EUROHEALTH programme aimed at meeting these countries' immediate and medium-term needs, he helped keep Europe together.*



Jo Asvall with Zsuzsanna Jakab and WHO liaison officers and other WHO Regional Office for Europe staff, Paris, 1995

Jo Asvall established the EUROHEALTH project as a way of bringing resources and attention to the new Member States.

### *Keen to see for himself*

#### **Sergei Litvinov**

*In 1992, I was given the post of Regional Manager for the EUROHEALTH programme. Jo was very keen on this new programme, which politically was one of the most important programmes at that time.*

*Jo immediately wanted to go and visit these countries and talk to the ministers there, and talk to the people there, trying to bring up the idea about what WHO is, how WHO could be useful for the countries, trying to provide information about what countries could gain from cooperation with WHO. We travelled together a couple of times a year to each country. I was responsible for the NIS and Zsuzsanna Jakab was responsible for the countries of central and eastern Europe (CCEE).*

*Jo played many roles with these countries. He played the role of the good senior teacher when he carefully tried to explain to people at the country level everything about WHO. Sometimes he played the role of good friend who was interested and open to learn a lot about the countries so that we better knew how WHO could help. The programme opened up many new opportunities, challenges and activities for both WHO and the countries.*

*When EUROHEALTH started to function fully, for example, there were challenges at the country level as to how to keep WHO diplomatically not in the situation of accusing one of the sides. A lot of the [NIS were making accusations] about different things, which was quite understandable.*

*Many ..., for example, would start the discussion, "Ooh, you know, [in the past] we were miserable, we were that and that, and that, and we didn't have that, and that," and you know, in such a situation it's very easy to say "Yes, yes, yes, I'm very sorry for you," just to give sympathy.*

*But Jo never let himself do so. He always was above that. Jo never let himself take one of the sides. He always tried to be objective and find some way to negotiate with the country or official and find a way to achieve the target which he kept in mind in regard to cooperation with WHO on specific issues. Believe me, it was not a simple task. Jo was always diplomatic, despite the difficulties, despite the difficult questions, despite the difficult situation, despite the difficult financial situation. I never saw him really furious, nervous, without control. He always could manage to control himself and be diplomatic, polite and very patient. Sometimes I was surprised that, you know, under certain circumstances, you know someone else would get very easily furious but he never let himself do so.*

The Regional Office opened 23 liaison offices, one in each country, staffed by nationals, which established a new way of working for WHO.

## **Liaison offices**

There was a lot of pressure on us to establish WHO representative (WR) offices in countries, but these offices are expensive. In addition, I never felt there was need for them since although the countries we were dealing with were poor, they did have people, particularly at leadership levels, who were quite well trained and competent. It was more a question of transferring the knowledge on



how to do things that we had accumulated in the Regional Office to those countries, helping them to implement – in contrast to what one has to do in Africa, for example, where you often have to do many things for the countries, build infrastructures and pay for local expenditures, etc.

In response to the collapse of Romania, for example, when ... suddenly there was more openness in the country, we could go in and work in a different way. We then decided to make what we called a liaison office, where we hired a local public health person and established a WHO office around that person.

The liaison officers had many responsibilities and there were some things they were not allowed to do. They had to know the country and what was happening in the country with regard to health matters. They had to know which partners were valuable in that country for different programmes. They had to know about the political developments so they could tell us which people had the power to influence health development, so we knew which ones we could go to, to try to convince them to change national policies. They had to follow the health development and they had to monitor the implementation of our programmes in that country. For example, our country programme in Romania had six or seven different programme areas that the liaison office staff had to follow. They were not allowed to dispense WHO money apart from a very small amount of funds to facilitate buying some office equipment, etc. They were not allowed to negotiate the country programme that was done by the Regional Office – because in the first place, they did not have the expertise of WHO staff. Secondly, we did not want to put them in a situation where they would be tempted to divert distribution of programmes or resources to their friends.

They were under the Country Health Department, which we created in 1991 to take care of all these new problems emerging from the [new] states. That became a huge new programme for the load we had to take on. Those liaison offices did good work and they were, of course, vastly less expensive than WHO representative offices that WHO used in other parts of the world. The liaison officers were all local people, except we did at one stage establish an

international WHO staff member as head of our Moscow office, because the Russian Federation is so huge and because we wanted to start working with different regions in the country, not just the Government. That was the only one country in my time where we did that.

## *Liaison officers*

### **Vladimir Gusmari**

*I met Dr Asvall for the second time in 1992, on the occasion of his interview of a couple of candidates for the selection of the first WHO Liaison Officer in Albania. He took this interview very seriously and came himself as Regional Director, together with Zsuzsanna Jakab, who at that time was Regional Adviser for Countries of Central and Eastern Europe. WHO liaison officers proved to be one of his most successful and visionary programmes. These liaison officers keep WHO alive in countries and have informed and inspired hundreds of national professionals all over CCEE and NIS countries and have spread the WHO experience between east and west.*

There was a lot of debate in the Regional Office and in the European Regional Committee as to how best to address the needs of these new Member States.

## *Standing up for new Member States*

### **David Macfadyen**

*In 1991 there was total change in the political arithmetic of Europe. We started with 30-odd Member States and ended up with 53. Jo responded with great political sensitivity. He passionately believed that the Health for All movement was the way to sustain health in an equitable way within the emerging countries.*

*What was happening in those countries at the time was the collapse of the economy and a marked deterioration in the health situation. There was pressure from some to focus narrowly on immediate health crises. Jo did respond, promptly, to the outbreak of diphtheria, for example, but he did not want to focus only on narrow disease-specific things. He adopted a broader approach and tried to get countries, even in the midst of the crisis, to look at the determinants of health and tried to get them to consider how*

*best to reorganize health and health care services. The Health for All movement in European countries, prior to 1991, was largely identified with issues of lifestyles and environment. All changed in 1991 as needs changed. Health care reform became a top priority and Jo believed it was time to redevelop health systems within a Health for All policy framework.*

*He very courageously said to European Member States that WHO needed more money to respond to the very serious health deprivation we were seeing in central and eastern Europe. They were quite reluctant at first to see him going down this broader, more costly route but he went ahead and continued to ask and was initially turned back. Jo quite bravely ended up having a reduction in force and cutting some 40-odd staff positions so he could safeguard programmes he felt were essential.*

*Fortunately, he was able to attract a large influx of donations to the Office (voluntary funds) and we actually ended up with many more people working for WHO in different European countries. He showed considerable political courage at that time. There was a real electoral risk to him of pursuing a broad Health for All approach in the countries and not going down a narrower programme route that many Member States were asking for.*

After 1994, there was much discussion about how the WHO budgets should be allocated to the various regions and Jo negotiated with the WHO Executive Board for a reorganization of the budget to provide greater assistance to new European Member States.

## *Global budget advocacy*

### **George Alleyne**

*I do remember, in the distribution of the WHO global budget, Jo Asvall making an impassioned plea for greater allocation to the European countries, citing the increasing number of countries in Europe, etc. When you speak about budgets and budget discussions, everyone has a story to tell of why their part of the budget should be better but I remember seeing Jo negotiate and I think he did it very successfully. In my view he lobbied adequately the members of the Executive Board who were from Europe to present a very, very good case for a greater allocation of the budget to the European Region.*

Jo reorganized the budget of the Office and redirected resources to where they were most needed. Seventy-five per cent of the activities of the Office were directed to the eastern part of the Region to address needs and express solidarity. He worked hard to bring and keep the new Region together.

### *Keeping the Region together*

#### **Sergei Litvinov**

*In 1994 there was a meeting in [the Islamic Republic of Iran], which was called to discuss the setting up of a WHO region which would cover all the Islamic countries of the Middle East and the southern part of Europe. All the central Asian republics of the former USSR, Azerbaijan and Turkey were invited to join Pakistan, Afghanistan, Syria, [the Islamic Republic of Iran] and others. Jo and I went there to undertake negotiation with all countries of Europe who participated in this meeting and finally all the European countries decided against joining the new region. And we could save and keep the European Region as it was before. Jo really demonstrated a lot of diplomacy and tact and even psychological understanding of how to speak to the people and how to put things across.*

## **Moving forward** (from interview 26.11.08)

### **The WHO Constitution and regional structure**

I have always felt, and I still do feel, strongly that WHO is not the staff, the individual persons who are the staff at any one moment. Although they are temporarily serving the Organization, of course, they are not the real WHO. Neither, and this may be even more controversial, are the persons who come to the governing bodies and decide on the policies, budgets, etc. There may be some good persons, even some excellent persons at a time, but at other times they are not so excellent. But they are not WHO. WHO is the WHO Constitution and the dream behind that Constitution. You constantly have to go back and check to see whether you are on course with the Constitution or not. Working at WHO, therefore, is a big responsibility.

You are not just working in any old kind of place. You are working in an organization that was given a global mandate not only to try to lift health, but to do it in a way that reflects a set of ethical principles. This should, of course, be reflected in the conduct of the management of WHO and in the way WHO behaves on the global scene.

As I have said before, there was a strong feeling at the end of the Second World War that we could not go back to where we were in 1939. One had to create a better world and the United Nations was the structure that could do that. Within the United Nations, WHO was going to be taking on the health sector. So WHO was not seen just as a technical organization; it was seen to be an important part in a bigger picture that was linked to some of the noblest aspirations of mankind.

The great public health leaders who helped shape the WHO Constitution – Andrija Štampar (Croatia), Karl Evang (Norway), İhsan Dođramacı (Turkey) and many others – were marked by their participation in different ways in the Second World War.

These people drew up a Constitution which is still today, in my view, up to date and extremely forward-looking. First, it is very clear in saying that WHO should be THE international organization coordinating, inspiring and leading public health developments around the world – a strong mandate. Second, it clearly builds all action on a strong ethical foundation: equity, solidarity, etc. Third, it provides a unique structure, which has been quite a good choice in my view, though many would disagree with me. Many people, particularly outside of WHO, came to see the balance between headquarters and the regions as problematic.

## The regional structure

WHO has the strongest regional structure of any United Nations organization because the regional directors are politically elected by Member States, just like the Director-General. This means that the Director-General does not appoint them. The Director-General cannot fire them. The Director-General is their administrative supervisor and they are his [*sic*] subordinates, but he [*sic*] is not in

charge of their contracts. This means that they are responsible to the Member States for what they do or don't do. This was not done by chance. I talked at length many years ago with Karl Evang when I had the pleasure of spending several weeks with him at the Twenty-sixth World Health Assembly held in Boston in 1969.

He said, "This matter was discussed a lot. We wanted to make an organization which was close to the countries, one that would be a proactive and an active organization, not just some 'philosophical' headquarters sitting somewhere. We wanted an organization that could give practical and useful advice to countries. Conditions around the world were different – Africa was not the same as Europe. Some of the basic problems were the same but the way resources were handled and the tactics to be chosen were different. And that's why we chose this rather special construction."

In my view, there are a number of examples in the history of WHO that show how this kind of checks and balance has been good, because being a political process, things may go wrong at times. If, for example, you do have a situation where a regional director is getting a bit out of line with regard to what WHO should really be doing, whatever it might be, the Director-General has considerable power to try to correct that situation. But on the other hand, if you should have a situation where perhaps there is a Director-General who may not be quite functioning in the way he or she should, the regions can continue to function, perhaps not independently but with considerable autonomy.

I think this structure has provided some kind of a safety valve. I think it shows that those persons who drew up the WHO Constitution were really thinkers of considerable stature.

## **Orienting and training staff**

I feel that more should be done in the Organization to brief new staff on these principles. I think, furthermore, that they should also be trained in other issues. When I joined WHO the first time in 1959, in the global malaria eradication programme, I was given a contract for half a year, which covered my training period.

I was sent to a training centre to learn all the techniques and the administration of the malaria eradication programme. It happened to be in Jamaica. After that I was sent for in-service field training in an operational programme in Mexico and to a second field training in Ecuador. After that I was sent back to Geneva for two weeks of exams and interviews and testing. Only after that was I, as well as my other colleagues on that course, told whether or not we would get a contract at all. There is nothing like that now in WHO. I think that it was an excellent preparation. You really knew what you were going to do. The Organization had a chance to observe people for a certain time to see whether or not they could function as necessary.

Many people who came to the Regional Office from Member States used to say we were not a university but a practical school of public health. I think first, there will always be some differences, depending on what job you have. There are some jobs in WHO which are very technical and perhaps very research-oriented but those are the great minority. The large number of staff should have a good background in public health. I have always felt that it ought to be mandatory for staff to have worked for some time in developing countries. You must know those problems so that you are forced to always think in terms of priorities. There is never time for all the things you would like to do. You have to choose all the time – how do you choose? If you have been working in developing countries, you learn to be practical and to know what things are the most important. What can in reality be done, not theoretically but with the resources, human and otherwise, that are available in the environment here? What are the resources that one can exploit? If I had had a say in the recruitment policies of WHO, I would give a high mark to persons who have worked in developing countries in their career.

## Getting staff to work together

How do you get staff to work together? First, one has to bring them together. One needs to use some resources in terms of time for that. It is fine to send out a lot of information – that is good and necessary. It is fine to give a video talk, but that doesn't replace a face-to-face encounter in a meeting. In the Regional Office during

Kaprio's time, whenever there had been a Regional Committee meeting or an Executive Board or a World Health Assembly, there would always be a staff meeting with everyone to report on the main issues and results of the meeting. Then everyone was free to discuss and raise questions.

More importantly, every second year we had the same kind of all-staff meeting during which we evaluated every programme – what had happened during the last two years and we discussed what should be the priorities for the next two years. So people were participating actively in the analysis and decisions in programmes outside their own field. In an area of activity like health, this is very good because you can often inspire each other. I remember vividly an evaluation session on the environment and health programme where they were really very happy and proud of the many new technical documents that had been developed. Then someone from another department said, “But what impact have they had?”

The staff member said, “Well, we have distributed 9000 copies to many institutions in the countries.”

He said, “Have they been read and have they been used?”

Well, how could you know that? We realized that we didn't know what was the impact of the programme – what happened in countries and how our programme affected (or didn't affect) policies in countries. That realization led to a total change of the programme. We started actively reaching out to more senior decision-making levels. We did not give up the technical aspect, but we added a whole new initiative to get to the ministers and to get to national policies in environment and health, and that approach became one of the strongest elements of that whole programme.

I think you have to ensure that people who work in WHO have a clear feeling that they are working with something bigger than just who they are themselves. It is important to understand how your input fits into the broader picture. If you are just going to get your satisfaction from what you are doing in your niche, you will not have so much gratification. If, on the other hand, you feel that you are part of a larger purpose, that gives you quite a different dimension.



Also, by having to discuss with your colleagues and defend what you are doing, you start an interesting discussion and you get a broader picture with regard to what you are doing. You think again next time am I really carrying on my work on these issues in a way that is linked to the policy?

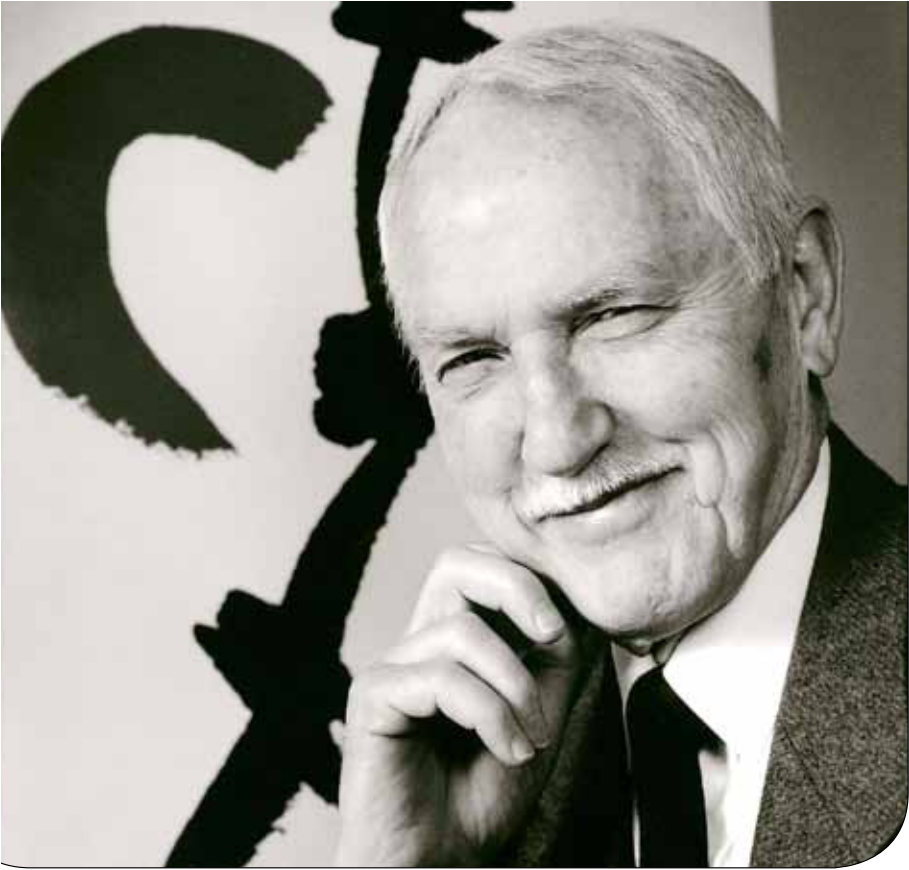
## An integrative policy

Finally, though, you must have a joint policy that explains clearly what the work is all about: that is, what do you want to solve, what are the goals, what are you aiming at, what strategies are you using to do so?

The Health for All movement was a huge thing. It did have that capacity to bring people together and give them a common understanding of what were the major problems in the health field, what strategies were available, what targets had been set, what priorities should be chosen to determine where we wanted to make major contributions. After the Health for All policy was adopted we immediately changed our programme budget structuring in the European Region to follow the new policy, so that for every target there was a programme response.

So people in planning had to go back and refer to the policy. They had to say, “Where are we? Why are we doing this and not that? How do we know that this contributes better to the result we want to achieve in the policy?”

I think WHO had the fantastic fortune of being linked to such a fundamentally worthwhile Constitution and design. The Health for All movement gave us a clear framework which was quite detailed, enough to say where we were going but open enough to give space to move on how we get there. There was a lot of discussion and possibilities of getting to the thing in different ways; you could therefore exploit your own thinking. You were not in a straightjacket. As WHO moves forward, these would be the main things I think I would protect.



Jo Asvall, Director, Danish Rehabilitation and Research Centre for Torture Victims (RCT), 2001-2005



Jo Asvall hosts visit by Princess Alexandra of Denmark to RCT

## After WHO

Following retirement from WHO, Jo Asvall took over directorship of the Danish Rehabilitation and Research Centre for Torture Victims (RCT) from April 2001 to January 2005.

### *Turning the institution around*

#### **Steen Bech, Denmark**

*In my opinion Dr Asvall, in spite of taking over an institution in the field of torture, a field with which he had no previous experience, very quickly grasped both RCT's problems and potential. His many management and leadership initiatives 'turned the institution around', set a clear future course and ensured a sound financial basis for many years to come.*

### *Brilliant and tough*

#### **Jan Ole Haagenesen**

*We at the RCT are very grateful to have had the good fortune to work under Jo Asvall's great leadership for nearly four years. They were tough, but great years! He was a brilliant and tough leader who demanded a lot from his employees, especially from the heads of the departments in the 'management group'; but he performed even more and was perhaps even harder on himself. These were fantastic years of hard work, but always full of laughter and learning.*

*A new review by the Danish International Development Agency has just been completed with a very positive result, focusing on prevention and especially the work of RCT's International Department. The foundation he helped us start is established: integrating research much more into the international work and enabling RCT to become a much better salesman of the good work performed. All of this has been made possible thanks to the solid foundation established under Jo's leadership.*

Over the last decade of his life, Jo continued to do missions for WHO.

## *Doing something about it*

### **Richard Alderslade**

*In 2009, Dr Asvall invited me to accompany him on a WHO fact-finding mission to Gaza related to health needs, human rights and social justice issues. Dr Asvall, as always, kept us focused on making recommendations that could really be implemented. He was intent on ensuring that we really help get something done, not just describe problems. Once again, I was amazed by his physical and intellectual energy.*

Jo reported on his findings and characterized the health and humanitarian needs in Gaza as a ‘complex, chronic disaster of catastrophic proportions’ and provided a plan for action.

## *Retained the old spark*

### **George Alleyne**

*I saw Jo last year on his return from a trip to Gaza and the thing that struck me was, he still retained that old fire, that old passion. He still retained it. I was very pleased to note that after a lapse of so many years he was still enthusiastic for what he was doing. He was still describing what the public health approach to some of the problems should have been, etc. I was very pleased about that.*

## **Last messages to Zsuzsanna**

18 October 2009

Dear Zsuzsanna,

I felt our meeting the other day was a very informative and productive one indeed! No one – you perhaps excluded! – has a stronger wish for you to succeed and I was pleased to see how much we agree on the issues. If there is anything I can do to help you, please tell me so!

I feel there are so many important issues to discuss and brief you about, so finding time to go through at least most of the things on this list would be important.

- The Constitution and WHO’s whole *raison d’être*

- The role and responsibilities of WHO's seven elected leaders
- Regional policy and strategies, programmes and ethics
- Programme priorities
  - Inter-country
  - Country level
  - Headquarters and other regions
- Dealing with governing bodies
- Organizational structure vs programme
- Planning/implementation/monitoring/evaluation
- Recruitment
- Staff relations
- Budget and raising voluntary contributions for longer sustainability

29 November 2009

Dear Zsuzsanna,

... I'm glad you found my comments to the transition paper useful and even more so that we seem to truly agree on the main changes needed in the Regional Office and the major priorities.

As for helping out with the policy work, there is nothing I would like more – that is truly the heart and soul of WHO in general and for the Regional Office's new image and drive even more! There is a lot of useful experience I can tell you about from the four Health for All policy documents that we made.

There are two very important, different but interlinked concerns to meet:

One is that the policy must – and must be seen to – rest on solid scientific ground; it cannot be a policy of general lofty principles only, as you see from many other organizations. Without it, it will be shot down. This means mobilizing ... staff and its best scientific partners. Needless to say, a kind of 'steering group' will be required ...

The second issue is the policy must be embraced by the Member States. This does not just mean saying yes in the Standing Committee of the Regional Committee and in the Regional Committee, but that the Member States truly embrace it with enthusiasm as their own joint effort, so they feel inspired by it, support its use in their countries and want to actively promote it.

24 January 2010

Dear Zsuzsanna,

... I have only one serious worry. Considering what I have said above about my own health status, I do believe it is urgent to start our talks. No one knows better than I the multitude of demands that will fall on you right now – but this may be a question of now or never.

I would be grateful if you kept the information regarding my medical condition strictly to yourself – once people know they look at you and treat you as a totally different person, and that's absolutely the last thing I would like to happen!

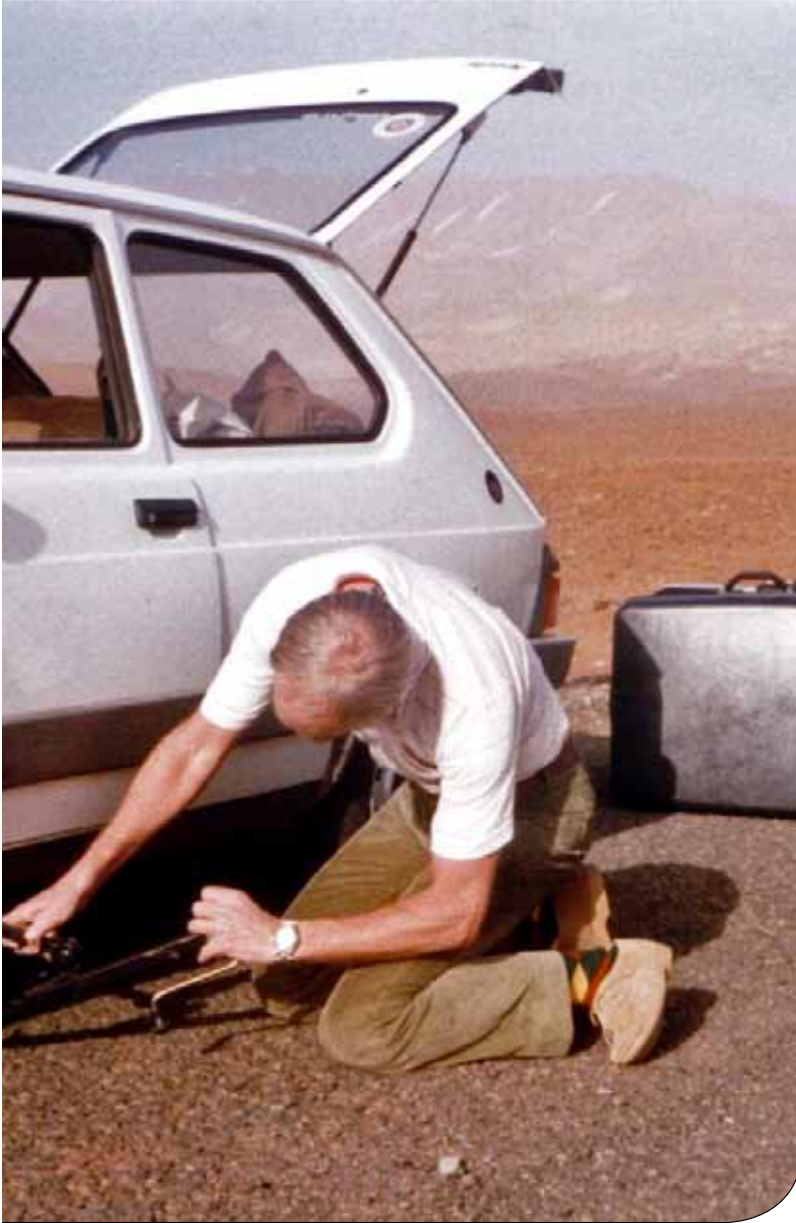
Warm Regards,

Jo

On 29 January 2010 Jo gave his last speech to WHO staff.



Jo Eirik Asvall died of cancer on 10 February 2010.



## Section 3.

# Ten rules of the road

## Rule 1. Be there, where and when you are needed

For Jo Asvall, the first public health leadership rule of the road was to ensure that he and the WHO Regional Office for Europe were always ready to play their role in responding to regional and global public health emergencies, whenever and wherever they occurred. He personally managed the Regional Office's response to major public health challenges, quickly travelled to emergency areas, delegated his authority as needed to designated representatives and arranged for creative solutions to assistance when political factors created obstacles.

“Jo Asvall was a Regional Director 24 hours a day, 365 days a year and did not differentiate between work and private life. He was always on duty!” says Thomas Zeltner.

Dr Concetto Guttuso recalls that preparing for the worst had long been a key concern of Asvall's. As Director, Programme Management in 1982, Asvall asked Guttuso to develop the first WHO Regional Office for Europe disaster preparedness plan and programme. Guttuso notes with pride that, after more than twenty years, that programme is still alive and well. Asvall, in talking about the European Region's response to disasters, credits that plan with providing a 'blueprint for action'. Guttuso remembers being called back from retirement by Jo on several occasions to help handle humanitarian crises over the years in Romania, Turkey and the former Yugoslavia.

“Jo was the first Director to bring the WHO Regional Office for Europe into a 'hot' war,” (see pages 126-131) says Carolyn Murphy. He overcame all objections to WHO taking action in the Yugoslavian war, with a simple challenge: “What will we do after the war if we haven't been there with them during the war? We have to help them now.” He delegated authority to Sir Donald Acheson and plans were drawn up for unprecedented public health assistance to all sides in a conflict.

Jo adapted WHO programmes to address needs, says Zsuzsanna Jakab: “He was devoted to the work in the countries and whether it was emergency or humanitarian or long-term policy development,



it did not matter. He supported everything. He gave very strong support when there was a war or any kind of emergency. He was personally very actively involved and worked to adapt WHO operations as needed. He believed in the role of WHO for that. We had strong offices and a presence and we were actually leading on the health impact of the conflict in the former Yugoslavia and coordinated it a lot with the other actors. And this was something these countries will never forget.”

He made decisions very fast, very quickly and delegated authority in a very effective way, recalls Serdar Savas: “If Dr Asvall saw that something should be done for the good of the country, for the good of the people, he would not avoid confronting politicians or international agencies. He followed up his ideas and, as a true leader, made things happen. His capacity for leadership was fascinating.

“I, for example, was asked to help out in my home country of Turkey when the 1999 earthquake struck, killing 20 000 people. I was sent by him and told to take whatever action I thought was necessary. Dr Asvall’s support and quick decision-making enabled WHO to establish a perfect infrastructure in the earthquake area. At that time the Turkish Ministry of Health was not ready to deal with such a big disaster. Dr Asvall and I communicated extensively by phone and acted quickly. We assisted the Ministry of Health to manage the situation and looked at the mental health situation, especially for children and families who had lost their relatives in the earthquake.”

Farman Abdullayev, former WHO Liaison Officer in Azerbaijan, explains how ‘being there’ was a principle which Asvall put into practice. “It was 1994, one of the hard periods for the independent republic of Azerbaijan. The economic status, the Karabakh war imposed upon us, a million refugees and displaced persons, health system breakdown occurred at that time. The number of cases of malaria, tuberculosis and other infectious diseases had increased. There were practically no means and strength to solve problems.

“And at this difficult period for my country, the Regional Office for Europe took a decision to open a liaison office to help solve these concrete health problems of the country.

“All this work was headed by Dr Jo Asvall. As Regional Director he often visited Baku, got personally acquainted with the work performed, had meetings with the head of the country and made amendments to the work on health system reform.”

When the EUROHEALTH programme started, notes Sergei Litvinov, “Jo was always interested and open to learn a lot about the countries so that he and we would better know how WHO could help. He immediately wanted to go and visit these countries and talk to the ministers there, and talk to the people there, trying to bring up the idea about what WHO is, how WHO could be useful for the countries, trying to provide information about what countries could gain from cooperation with WHO.”

## **Rule 2. Put international health first**

For Jo, putting international health first was about evidence-based decision-making, avoidance of vested interests and above all, independence. He fought for this throughout his career and on numerous occasions boldly stood up to Member States and other interest groups which tried to influence staff selection and behaviour. He felt that putting international health first was what made WHO and global public health practice special, credible and effective. Jo also saw international health as a bridge to peace and reconciliation. He was a master health diplomat.

### *Taking an oath*

Jo writes, “We made a change in the European Region around 1985 when I became Regional Director, because we wanted to highlight the fact that WHO is a special place compared to any other place of work. In the contract that a person signs when they come to work at WHO there is a statement to the effect that you pledge to work with the interest of the World Health Organization in view and not to seek or accept any undue pressure from any outside sources, including your national government.”

He took this very seriously and as Regional Director he would invite all new professional staff into his office, where they would read out

the pledge in front of him and the chief of personnel. Then they would all sit down and have a glass of sherry – the only drinking that ever went on in Jo Asvall’s Regional Director’s office – and would talk a little bit about what the pledge meant. General service staff did the same with the departmental directors.

David Macfadyen says: “It’s important that your primary loyalty in WHO is not to where you come from. Jo was very keen on us all being internationals and being loyal to the Organization. When he wrote letters to people thanking them for their service, the really important thing to him was loyalty to the Organization. He was a proud Norwegian but I know for a fact that his prime loyalty was to all Member States.”

### *Health diplomacy – health as a bridge to peace*

Keith Barnard recalls that during the 1990s, Asvall became increasingly concerned with promoting a role for health in peacemaking and conflict resolution. Barnard was involved in some episodes where this interest in international health was put into practice.

“Jo lent the support of the Regional Office to the Norwegian Medical Association, which had succeeded in bringing together delegations from the medical associations of the successor states to the republics of the former Yugoslav Federation to review the care received by victims of violence, and whether their ethnicity ever determined whether or how they were treated.

“The level of barely concealed hostility and mistrust was unmistakable, but the cool heads of the Norwegians and their diplomatic skill produced agreement at the end of the meeting and a transformation in the atmosphere. I think it confirmed for Jo that health should be seen as a bridge to peace.”

David Macfadyen wasn’t convinced that there would be anything positive from the process. “A lot of people were opposed to that, including myself. It wasn’t clear what good was going to come out of it and I feared they would all be shouting at each other. I felt that a lot of people who had lost close relatives, when faced with the

people they were in conflict with, would not be able to have civil discussion but that proved not to be the case. Jo enlisted the help of a Norwegian colleague, a psychiatrist, and he laid the ground rules for the meeting: we should pursue very limited objectives, such as child immunization and regular health meetings at Sarajevo airport. He advised Jo that as soon as he got these agreements, the Chairperson should end the meeting. He described the layout of the meeting so there would be three tables and on the central table there would be food and drink, so that if anyone wanted anything they would have to go to the central table and there would be interaction.”

Otto Steinfeldt-Foss recalls, “I was the Chair of the Norwegian Medical Association Committee on Human Rights and we initiated a programme of trying to re-establish contact between all the six conflicting republics of Yugoslavia. In this respect, Jo put the whole WHO resources into reorganizing and reconnecting health leaders of the six conflicting areas.

“During the ongoing conflict in Yugoslavia, Jo invited all the health ministers to a secret meeting in the Regional Office in Copenhagen in order to secure medical cooperation to reduce the suffering of the civil population during the war. That was a very strong experience. I was invited as an independent ‘reconciliator’ in this respect. This was enormously effective. The whole aim was to re-establish and reorganize contact and confidence. I think how Jo formulated the ways of and means of using public health measures in establishing peace was one of his greatest accomplishments.”

“These events,” recalls Keith Barnard, “showed Jo’s readiness to advance a values agenda, confronting people with the uncomfortable. He was quite often ready to raise issues that someone else in his position, more political and less principled, would have been happy to sidestep.”

### *The Bulgarian–Turkish dispute*

Serdar Savas describes the circumstances surrounding his first meeting with Jo Asvall. “Turkey and Bulgaria were almost at the brink of war in 1989 when 300 000 Turkish Bulgarians were expelled

from Bulgaria. At that time I was adviser to the Minister of Health in Turkey and was in charge of dealing with the health dimension of the situation. Tens of thousands of people were crossing the border every day. They were hungry, some of them had been tortured and they did not have access to health services. People were dying on trains, delivering babies on the street ...”

The problem ended up in the lap of WHO, recalls Constantino Sakellarides: “At a certain moment the Turkish government called and wrote to us and said, ‘You have to do something about this. This is discrimination about health, you are the World Health Organization, you have to intervene and convince the Bulgarian government.’”

“Asvall received the call and letter and talked with some of us, and we were thinking: ‘It’s a political issue. Of course there are health and health care overtones, but basically it’s a political issue. You know, it’s going to be a mess, try to avoid it.’”

That’s not what Jo thought.

“So what does our friend Jo do? He invited a delegation from Bulgaria and one from Turkey to Copenhagen. He let both delegations present their case. He then got both delegations to agree to a visit by a mission that would go to both countries and prepare a very detailed report. That report was taken to the Regional Committee in September but also to the United Nations Security Council.”

Otto Steinfeldt-Foss recalls that Jo used his public health ability to resolve conflict. Instead of having the Bulgarian authority deporting the Turkish minority, he managed to make the Bulgarian authority understand the psychology of the Turkish minority in keeping up their identity without having them deported.

The episode left a deep impression on Serdar Savas. “Using skillful diplomatic interventions that were respectful of the concerns of both sides, WHO, through Dr Asvall, was able to prevent a war between two countries.”

“We couldn’t believe how Jo had managed to sort that one out,” notes Constantino Sakellarides. “I discussed this with him and I

remember he told me: ‘The problem is that often many of us’ I had the impression I was included in that, too – ‘don’t believe enough in working in a truly democratic, open mode. People do have an enormous potential to negotiate, to communicate, to converge. One has to keep trying – you just have to keep working on it. You cannot give up on them. You have to truly believe in that.’”

### **Rule 3. Aim to influence systems and policies**

In whatever role or setting, Jo always seemed to get involved in constructively and methodically reviewing and enhancing the systems and policies which were shaping the perceptions, choices and behaviours of people and decision-makers.

He always worked to make systems more rational and accountable and to make it easier for clinicians, patients, institutions, communities and countries to make healthier choices. Jo was one of those rare people who could quickly see the missing links in systems and find ways to strengthen or develop new links where needed.

He writes, “I loved being an oncologist. Cancer I found fascinating from a technical and human social point of view. I felt that it was hugely rewarding but ultimately I left because I felt that what I did was rewarding for individual patients but it didn’t make any lasting improvement in the systems.”

Reflecting on relative states of poverty in developing countries in 1957, he writes, “In Africa people were poor but you didn’t have that huge difference between the rich and the poor. It was a poverty due to natural causes – the dry, poor soil, things like that. In Latin America the poverty was man-made, social inequity and injustice stemming from the old colonial times, racial differences; the Indians were treated like second-class citizens. So that made a deep impression on me – I was astonished. I hadn’t expected to find that in Latin America. So that showed me that it was the policies of countries that were the main obstacles to development.”

This capacity was evident from the beginning of Jo’s career. Professor Ole Berg interviewed Jo several times about how he

developed his approach to health (see pages 72-74): “Very early on, Jo discovered that he was systematically inclined. When he came to the cancer hospital he had the opportunity to watch his colleagues and see how they were working and he discovered they weren’t working in a very systematic way. Jo was given the go-ahead to do research and write a report on improving the hospital ... he then realized that if you really are systematically oriented, then to make a hospital function in a more rational way the hospital has to be an integrated part of a systematic health care system at a national level.”

Jo then worked for a year in the national directorate. Eventually that brought him to look at regional and global policies that could shape health systems at WHO. This policy change focus was central to his work as WHO Regional Director.

He helped spark a shift and a reframing from a technically focused Regional Office, reactive to the emerging needs of Member States, to a ‘change agent’ Regional Office, proactively advocating, with partners, for public-health-oriented policies in all sectors. He was particularly proud, and rightly so, that 43 countries in the WHO European Region passed Health for All policies, inspired by WHO regional frameworks, outlining specific actions to address equity, lifestyles, environment and health service challenges.

“Health for All, with its new strategic actions, represented a big shift from our technical focus and brought us, appropriately I believe, into the strategic policy-making area and initiated a process of proactive learning, engagement and advocacy that continues today,” he noted.

“It has helped move public health values and approaches off the margins of policy debates and onto mainstream economic, social and political development agendas. To a large degree, I believe it helped reframe the way people perceived the Office and the way staff perceived their responsibilities.”

## Rule 4. Turn vision into action

Ilona Kickbusch describes Jo Asvall as “a public health leader who combined vision with a very pragmatic and practical streak to get things done.”

“He did not accept the distortion of bureaucracy which led to impediment. He didn’t accept that at all,” adds George Alleyne.

According to David Macfadyen, Jo’s initial work in Africa on malaria prevention instilled in him a commitment to practical work on the ground.

“I have always felt that it ought to be mandatory for staff to have worked for some time in developing countries,” Jo said.

“You must know those problems so that you are forced to always think in terms of priorities ... as Hans Christian Andersen said, ‘The most important is the most important.’ There is never time for all the things you would like to do. You have to choose all the time – how do you choose? If you have been working in developing countries, you learn to be practical and to know what are the things that are the most important. What can in reality be done, not theoretically but with the resources, human and otherwise, that are available and exploitable in your local environment.”

Jo Asvall was a great manager and networker. He always looked for ways to link people and ideas that could result in enhanced public health actions.

Jo always tried to help staff find ways to overcome obstacles to action. “When he was Regional Director he always asked for full briefings from the staff,” remembers Zsuzsanna Jakab. “He always said that programme managers were the key building blocks of the Regional Office. Regional Directors come and go but the programme managers are the most important ones and he had a direct link to every programme manager. Whenever there was a technical issue, Jo would spend hours and hours being briefed and discussing ways to influence the developments and he was deeply concerned, involved and actively interested.”



Lowell Levin recollects Jo Asvall's days as WHO Director of Programme Management: "Jo knew what was going on so when he consulted with one of his programme managers, he talked from an informed status. He did not ask them, what are you doing? He knew what was going on but he wanted to find out two things: what were the barriers to achieving the goals? And then he would ask the second question of himself: how can I help as the manager of this place to facilitate the work of this programme manager?"

"For most of my work in the Regional Office, the relationship with Jo Asvall was quite positive," noted Mark Tsechkovski, "though it did not preclude his pointing out my mistakes and managerial shortcomings which were discussed very openly during the appraisal process. Then he offered a couple of short training periods to correct them."

### *Health for All*

"Health for All was the result of the leadership of Dr Mahler," notes Serdar Savas. "However, Health for All was an abstract notion in general in WHO until Dr Asvall made it a concrete tangible thing in our hands and it has had a great impact in countries."

Jo championed and shepherded the development of the WHO European Health for All strategies and targets from concept to practical application in local communities and institutions across the now 53 countries in the WHO European Region. This approach, supported by a new Health for All database which compared health system performance in all WHO European countries on a wide variety of common health indicators, inspired and catalysed health systems to look beyond health services and start addressing previously neglected social, lifestyle and environmental determinants of health.

"With Health for All," Jo writes, "we had a unifying concept which applied to the Region as a whole and which we then tried to get all the countries to embrace and to turn into realities in their own settings. In order to do that, we had to work at two different levels. One was to develop the tools or methods or strategies, whatever you like to call them, that countries could use in order

to promote and deliver Health for All. And the other thing was that we had to develop a mechanism whereby we could make the countries enthusiastic about using those tools, not only just formally embracing Health for All but turning it into a reality. That meant we had to think differently from before about how we tried to work with countries and how to stimulate work in countries.”

The Health for All targets and indicators were tools that made the European Health for All policy sharper and provided a model for the Region as a whole, which countries could adapt to their own contexts. They also provided public health advocates, professionals, academics and government decision-makers at grassroots with a lever to push for Health for All within countries.

Jo Asvall knew how to inspire, says Ainna Fawcett-Hennessy: “He taught us not to be self-absorbed but to think of the greater good. He was someone who inspired you and encouraged you to see the bigger picture and to think outside the box. He gave nurses credit for thinking beyond the patient and the bed.”

Keith Barnard notes: “Jo Asvall was a democrat in the sense that he believed in participation. He believed in collaboration. He did not believe in dictatorship. He believed if people were given the picture, they would come around to his point of view.”

When asked about his path to action, Jo replied, “The first general lesson concerns avoiding cynicism – it is quite widespread and leads to fear of trying to do things. This is often a major problem, I think.

“Over the years we have encountered people like that many times! When we said in 1982 that we would try to make common targets for the European Region, people believed that we were totally crazy. They said, ‘Come on, there is no cooperation between east and west and you want them to come together to embrace targets that are common for the USSR and Italy and Germany and Ireland. That is impossible. You are just dreaming.’

“But it was possible because ... we started with universally agreed upon outcomes that were backed with strategies and finally mutual actions. As one worked backward, there was more and more freedom

to choose the instruments to be used in each country. However, all actions used the same strategies that would lead to a common result. This approach functioned well, and it has functioned over a 25-year period.”

According to Constantino Sakellarides, “Jo made Health for All a platform that could be agreed by many different actors, including different political forces. Agreeing on outcome targets allowed people ‘room to disagree’ on how to implement them, according to their political beliefs or ideology. This created a win-win approach at the outset, while preserving differences of approach by stakeholders in contributing to the targets they were committed to help achieving. This was a major contribution to the democratic process in health policy.

“He was invited by John Major to the British Parliament to discuss Health for All. And I remember coming back beaming, because we all had a vivid recollection when, in the early days of the Health for All process, country delegations, particularly some of the larger, more influential countries, thought this was just a dangerous, theoretical, simplistic and far-fetched crazy idea. That’s why the invitation to present Health for All in a major European parliament generated such an amazingly pleasant feeling. Strong beliefs and perseverance had turned the tide.”

“We also had fantastic staff,” notes Jo, “they were very innovative good at exploring possibilities, at creating new possibilities. I mentioned that when we wanted to hold a conference on environment and health, we invited all environment ministers and health ministers in the regions to a planning session in Vienna. People said to us, ‘Forget about it. We can’t get the environment minister to meet with the health minister in our own countries. They will never come to the same international conference because they are fighting like cats and dogs.’

“The Chernobyl incident, however, was a huge awakening. The people in the European Region Environment and Health Department thought it was the right time because all of Europe had been shaken up by the accident. Environment and health had to get together because this environmental disaster had huge health

implications and also economic implications. So we had the First European Conference on Environment and Health, Frankfurt-am-Main, Federal Republic of Germany, 7-8 December 1989, chaired by the German Minister of Environment.

“There was the whole issue of trying to create a healthy city movement, where we worked with totally new partners that WHO had never worked with before. We had never worked with cities in WHO. This was a new initiative and it became one of the most powerful and self-sustaining, durable networks that the Health for All movement ever created.

“Another example is when we went to try to work directly with national medical associations that were totally opposed to the whole idea of Health for All, such as those in Germany, Austria, Switzerland and Italy. But when we then created the common forum and started to meet regularly and discuss with them face-to-face, it all changed. They started creating with us permanent working groups on smoking and quality of care, etc.

“To me, the most fascinating lesson of all was that so many things are possible which you wouldn’t think were possible. These things are not possible if people think they need a lot of money and staff to do things. We were 300 people total in the Regional Office and our regular budget decreased every biennium from 1979. We had cuts in the regular budget every second year. So we had to find other mechanisms to deal with that.

“One thing that struck me also was that we never got ‘No’ for an answer when we asked people. There is a lot of good will for WHO out there. That increased strongly with the Health for All movement. It really inspired people at many levels – at ministerial level, at local level and even in local communities, as well as professional levels like among nurses (who were really fascinated), medical associations and others. So it was a catalytic tool, which was fantastic. So without it you would never have thought about or done all these things. When I started working in the Regional Office, WHO was mostly dealing with individual programmes and individual projects. We did one thing one year and the next year we did something else. We did not have that broad, common view to see how things fit together

and how you could bring partners together, how you could create synergy.

“To me, that was an incredible discovery and the best of programme managers could get anyone they wanted to their meetings: Nobel prize winners, whomever – they could get them almost free of charge. We didn’t have to pay for them like we did in the past. We gave them a small contribution but asked them to cover the rest of their travel, hotel bills, etc. They came and they came gladly and they contributed a lot.”

## Rule 5. Opt for evidence over eminence

The ‘OMG’ syndrome was something that Jo often talked about. It described the “Oh my gosh!” reaction of clinicians, policy-makers and public health specialists when confronted with true data relating to the efficacy (or lack of efficacy) of their interventions. The ‘OMG’ often led to the requisite behavioural changes.

Throughout his career Jo was a strong champion of evidence-based policy-making. He was famous for his advocacy of the use of targets to stimulate policy action. He knew the critical importance of measuring outputs and impact as the only way to truly understand whether a policy or intervention made a difference.

Jo had an obsession about evaluation, recalls Claire Chollat-Traquet. “I would come up with an idea and he would say, ‘Has it been evaluated?’ – not to be critical of the ideas but to avoid wasting the resources of the Organization and above all to respect the people and not take them as subjects for pilot projects. At the time, in more scientific circles perhaps it was done, but it was not fashionable in public health. Jo systematized public health evaluation in the Regional Office and did a lot to strengthen it all over WHO.”

Talking about the Health for All targets, Jo said, “These targets and indicators made the European Health for All policy sharper and provided a model for the Region as a whole, which countries could adapt to their own contexts. They also provided public health advocates, professionals, academics and government decision-

makers at grassroots with a lever to push for Health for All within countries.”

Serdar Savas says that Jo Asvall would never support something simply because it was a good idea. Unless you could quantify what you were doing, it was meaningless.

“Dr Asvall’s dedication to quantifiable results put him at odds with representatives of the Member States. Politicians didn’t want to have targets – to reduce infant mortality 50 per cent in five years’ time, or tuberculosis 25 per cent in three years’ time. They didn’t want to put such goals for political reasons. If they were not able to reach these targets then they would be in a difficult position. But Dr Asvall would push the countries and the project owners to measure their results.”

Ainna Fawcett-Hennessy remembers, “When I went to see him, when I first joined, one of the key things he wanted me to work on was quality indicators and evidence-based practice. He wanted me to get data that would show that nurses were really making a difference in the country. To document how nurses could contribute to the health agenda.”

David Macfadyen said that Jo also worked to apply quality indicators to the political minefield of budgets. “Jo developed the Health for All database of indicators so that countries could assess whether or not their investments in health were achieving measurable improvements. He used the same HFA targets to monitor WHO’s own programme. His measurement of budget performance is a very simple concept but works exceptionally well in practice and was a profound change. Until Jo appeared on the scene, no one thought that the programme budget should be something that should be monitored, evaluated and reported on so specifically.

“He was very, very keen to be transparent, really showing that the secretariat was doing what the Member States asked it to do. When the Regional Committee was asked to approve the programme budget, he should be able to give Member States feedback on how their resources had been used in the previous biennium. To do that required a big internal change in the Office. A lot of people didn’t

like that, but it showed that every penny spent could be traced back to a Health-for-All-related item in the programme budget. In terms of internal organization this is probably one of the most important things he did. The budget performance report showed Member States that the money allocated to improve health was spent on what it was intended for.

“The second thing he did was to say that while you don’t improve health in the timescale of a biennial budget, you do improve health by framing budget decisions within a longer-term policy and this is what the 38 targets and 65 indicators were for. You then saw basically the pace of transformation of different societies, the outcome of each country’s own health investments and the purposes for which WHO resources had been invested.

“Those are two enduring things. And he had a great talent for focusing on what was important. He was unremitting in making sure that these two things – monitoring Health for All progress and WHO budget performance – were done. He brought about the changes through a huge amount of persuasion with Member States and a very patient process of transformation within the Regional Office.”

Jo spoke about the all-staff meetings “during which we evaluated every programme – what had happened during the last two years and we discussed what should be the priorities for the next two years. So people were participating actively in the analysis and decisions in programmes outside their own field.”

Lowell Levin remembers that Jo Asvall “would throw any new idea against the Health for All screen and that was what his message was: whatever you want to do folks, do it but make sure you can relate it to the overall Health for All objective and show me how that is and how you’re going to measure it. How you’re going to know it made a difference.”

Jo Asvall’s attention to detail could appear, at first, quite narrow but as Carolyn Murphy discovered, there was usually a serious principle behind his approach. One of her first conversations with him concerned the high quality of the toilet rolls used in the head office.

“I said, ‘Jo, do you really care?’ and he laughed and said, ‘Well, yes I do because actually the other type, the cheap type, blocks the drains and there’s a special drainage system. It is right by the promenade and underneath the lawn, underneath where all the flags are, and it blocks up all the pipes so we have to have the very best.’ And so he was right, as per usual.”

## **Rule 6. Blend ethics and science with political know-how**

Jo learned early on that making system and policy changes required more than evidence and ethics; there was a need for political know-how.

Ole Berg remembers his work to smooth the passage for his proposed reorganization of the Norwegian health service.

“He realized that he could not just sit there and dictate how a hospital system should look in the future. This plan had to be presented to parliament and to be accepted he needed the support of politicians. So he travelled around the country and met with people in the hospitals and local politicians. He had not been that sensitive to politics before. Now he became much more sensitive to what politicians thought and meant and wanted and so on.

“Some of the other doctors tended to be a bit arrogant towards others. They tended to look down upon politicians as amateurs. Jo, he was able to develop good relations with politicians with his charming style, his sense of humour, his patient and pleasant way of behaving. He developed good relations with many local politicians. He was in close contact with the Committee for Social Affairs in parliament, which he needed to win over for his plan. In the long summer recess he made study tours. In one he took these politicians on a tour of European countries, such as the Netherlands, Germany and some other countries. The idea was to learn more about how to reform health services. They went out on a bus and that provided for a very close and personal atmosphere and they had a wonderful trip and after a few hours everyone had forgotten which parties they belonged to. They became so charmed by him. So this plan was sent



to parliament in the autumn of 1974 and voted on and discussed in spring 1975 and unanimously accepted.”

### *Know where power lies*

Thomas Zeltner recalls that Jo was “a man who understood what power is and where power lies and how to deal with power. He was not a servant of powers but a power player himself. His partners in the countries were at least the ministers of health, if not the heads of the governments or the heads of state. He learned to be an effective politician and how to use the instruments of international organizations to bring health to countries.

“In situations where he was not sure whether enough ministers or heads of delegations would vote for this or that, he might take a couple of key persons of the different parts of the region together for dinner and talk about it, asking them to convince the neighbouring countries to align to whatever the issue was. If he was in trouble in a debate, for example in the Regional Committee, he would actually go to all the heads of the delegations and say, if you don't do this or that then the whole region could get disrupted. He was good at making people feel something's very important and we have to follow him.”

Sandy Macara enjoyed watching Jo at work. “I recall the Regional Committee in 1984, when the targets were adopted. Jo and the Office, through an extensive process of consultation, had ‘proposed’ 80+ targets relating to different categories of action to be taken. He presented these and the reaction was predictable. What people didn't realize was that it was Jo's ... cunning would be a harsh word to use but Jo's sound common sense that he wanted to be able to give something away that didn't matter. There was apparently a battle in the Committee to get the commitments down to something in the 30s. I remember enjoying that — as a medical politician myself, I could see how Jo was playing it. Quite happy to agree to amalgamate one category with another or drop something when in fact he was giving nothing away at all. It was strengthening the core of his intention.”

Stan Tarkowski remembers how Jo finally decided to offer him a directorship position. “When Waddington left the director’s post Jo was delaying the nomination of the new director, but I was made responsible for the environmental health programme. One day, Jo says that we had to cut either food safety or occupational health. I said they were both needed. So in 1987 there was a Regional Committee meeting which discussed the budget and when it came to discussion on environmental health Jo Asvall was faced with strong voices of countries almost all criticizing his scheme to downplay occupational health. When discussion was finished, Asvall called me out of the room so I immediately thought that he was angry with me because he understood that the discussion from the countries on occupational health was manipulated by myself. The fact was that I simply talked to the countries and said, ‘Do you want occupational health?’ and they said, ‘Of course,’ so I thought, okay. He surprised me, though, because his question to me was, ‘Do you sustain your application for the Director of Environmental Health post?’ I asked him why and he said, ‘I want to be sure because if yes, I am going to the Polish minister to seek his support in my nominating you to the post of director.’ It was clear to me at that moment that if you could get the countries behind you, he thought, such a man or woman has enough political savvy to have as a director.”

Jo Asvall was also aware that it might be the little tricks and approaches which could help smooth potentially difficult negotiations. Carolyn Murphy remembers, “He was always terribly keen that staff should meet visitors at the airport with their own cars and bring them back and chat to them on the way, you know that sort of thing. Very keen. People said get taxis but no, it was much better if we met them ourselves, so we used to do that.”

Jo Asvall also understood that political know-how went beyond the formal settings. Ilona Kickbusch remembers, “Jo really understood how political the Regional Director’s job was and that you actually need to prepare the formal settings through social acts and occasions. He was very, very clever about that and created trust through social invitations. Member States thought it was very

important when they were invited to Jo's home. He often used those occasions to do pre-negotiations. Often his dinners were very well orchestrated. He would strategically invite certain staff and provided opportunities for informal discussions with key persons in Member States."

"Every time someone became minister of health," remembers Linda Topping, "they would be invited to the Regional Office. I would do the letter congratulating them and then draft a letter saying we realize that these are the main problems for the country and that the main priorities for the country were such and such. They may have other issues that they'd like to discuss. For that he would like to invite them to the Regional Office where he'd develop a programme for them about their priority issues and they would come. All of them came and he'd host a dinner for them at home, we'd have a luncheon for them in the office, often Denmark was funding some specific programme for one of these countries and we'd arrange a programme for them to go up to, to see somewhere else, whatever it was they were interested in. That was always high on his list, the minute we had a **sniffle** that somebody was going to be a minister or a new national health leader, then an appointment was confirmed. It was very important to him that they came to see the office, see who we are, who to talk to about what, face-to-face contact, that type of thing."

"I remember well my first visit and briefing at the Regional Office when I became Minister of Health in Armenia," notes Haik Nikogosian. "Right off, Jo Asvall invited me to be a panellist in a discussion happening in the Office that day! He immediately got me involved in WHO activities. He really was a great connector for me and many others to the international community. In those days our health system was very much health care oriented. Jo Asvall helped us broaden that view. Jo Asvall was a person with clear vision one could learn from. His knowledge of technical areas was outstanding. He was a charismatic advocate for public health who could talk and influence prime ministers and relate in a lively way with the people on the ground."

## Rule 7. Build movements for change    let a thousand flowers bloom

Throughout his tenure as WHO Regional Director for Europe, Jo repeatedly demonstrated the courage and capacity to involve and engage a broad range of stakeholders in WHO-related public health work. He repeatedly went beyond links with WHO's usual ministry of health counterparts. As Regional Director for Europe, Jo catalysed and supported the initiation of many new networks and new points of contact between the Regional Office and public health communities in all the countries of the WHO European Region. During his tenure, strong and lasting links were made with cities, schools, professional associations, regions, prisons, chronic disease programmes and others. All of these were bound together by the common Regional Health for All policy. Taken as a whole they formed a great 'public health army of collaborators' and significantly enhanced the power of the European public health movement.

These activities emphasized WHO's international health role as opposed to its intergovernmental role and at times got Jo into trouble with Member States. He was always very clear, however, about how such activities were the intention of the WHO Constitution and that WHO's role as a catalyst was key.

He writes, "WHO is a fantastic organization that has so many opportunities to work in a catalytic fashion — meaning to create movement without using up resources. The possibility to do that is much more than people think and say. There is a large body of partners out there in the countries who are very interested in working with WHO and who will gladly use their own resources and time to do that. These potential partners find working with WHO very interesting, particularly in the context of these interactive networks where they meet with their colleagues and peers from other countries in Europe. It becomes a very productive environment where the advice from WHO technical development work is then fed into the system and coming back is the experience from the practical application at local level, which then leads to further development of some of the strategies that we use. This has been a very fascinating process."

## *Know the stakeholders*

According to David Macfadyen, what Jo was good at was realizing who the stakeholders were and making sure they were involved. That might mean dealing with quite conservative organizations, but it was important to give them a role in making sure a project succeeded.

“It wasn’t just his own personal advocacy directly with the ministers sitting in his office in Copenhagen, it was working with nursing groups, medical groups, cities and regions to improve health through the cumulative influence of those groups.

“Jo created a space for the idea of Health for All as a movement that could blossom. Jo learned a lot from Ilona Kickbusch in this area. Healthy cities, healthy hospitals and healthy schools gave the Organization a high political profile with civic society.”

Building these coalitions meant working with nonmedical staff, which Jo didn’t have a problem with. Mikko Vienonen recalls that “Jo was very open to collaborations and listening to NGOs and others, rather than being restricted just to ministries of health.”

Ainna Fawcett-Henessy said, “When Jo went to countries and met with nurses, he always spoke to them of the valuable contribution that they could make to the public health agenda. It gave them a real boost. And my God, they really needed a boost in so many of the countries in the Region. The fact that someone of his stature, from the World Health Organization, acknowledged the profession in such a positive way was hugely important to them. This acknowledgement was all the more important as often those he was meeting in the ministries had little understanding of the profession at that time.

“He was a man of the people. He would meet up with, or ask to meet up with, nurses at local level. He would often return to Copenhagen with a good story to tell about the nurse or midwife he had met and what had impressed him, or not, as the case might be. That was what was different about him. I felt that he was as comfortable with the student nurse or midwife as he was with the minister of health. He made people feel comfortable in his company. My own

experience of him chatting away with people in their language was a joy to watch.”

## **Rule 8. Hire talented people and give them space to move**

Jo understood that creative and pioneering organizations, like WHO Regional Office during his tenure, are critically dependent on the quality and innovativeness of their staff.

His key advice to Zsuzsanna Jakab on Regional Director handover day was this: “Creative and innovative staff are not easy to manage! They tend to be anti-bureaucratic but they are the real ‘agents of change’. These staff can create quite a stir from the administration and will require firm support from the Regional Director. But I strongly advise you: give good leaders ‘space to move’ within the confines of the Health for All goals and you will see real professional developments come! It will require that you accept ‘some noise’ from such staff and be ready to support them. There will be some inter-staff bickering, but the goal is not a smoothly operating, unified behaviour in the office – it is the leadership quality of our programmes!”

172

### *Balance the formal and informal*

According to David Macfadyen, Jo wouldn’t have anything to do with a recruitment process based on favouritism. Yet for a man who wanted programmes measured and accountable, there was a bit of instinct involved when it came to hiring people.

Macfadyen said: “When I went for a director’s job, I was given psychometric tests by a recruitment agency and given feedback on my problem-solving skills and various other things. But when I was recruited as Director of Programme Management, I went for a walk in a forest where we spoke of various things and I got the offer of appointment after that.

“But Jo was never one who just relied on his instincts. He went through a formal process with input from staff and representatives and various other people and he used head-hunting firms and recruitment firms.

“But, at the end of the day, it was his own decision. I sat on lots of selection committees and he was really scrupulously fair.”

In return for this fairness, staff gave him their backing. Macfadyen said: “I knew I could count on being fully supported by Jo and I couldn’t have operated there [the Balkan countries] if I hadn’t had the back-up of the Regional Director.”

For Serdar Savas too, it was Jo’s trust in his staff which impressed him. “He always asked us to set our own targets. He would not set targets for us. The greatest professional freedom I’ve ever had was working with Dr Asvall.

“I think that he was ahead of his time in his managerial style. But in the way he treated people, his courteous behaviour and charming style made him a gentleman. He was a perfect gentleman, which might seem like an old-fashioned thing to be. Well, if you call that old-fashioned, then yes, he was old-fashioned, but he was a perfect gentleman.”

And for David Macfadyen, if someone had to lose their job, then Jo handled it professionally and sensitively. “When a person loses their job, it’s a terrible thing for the person and for the family. Jo was sensitive to that and dealt with people face-to-face, he didn’t leave it to personnel people to deal with. I thought that was a mark of really good leadership.”

There was a directness about his approach which many have remarked upon as refreshing and stimulating.

When the job for Dr Asvall’s personal assistant (PA) became available, Linda Topping recalls that “some colleagues pushed me to apply because I had been in personnel and I had worked in a technical unit and I’d got to know Dr Asvall a little bit through both jobs. Actually, the time in personnel was particularly memorable. As the head of personnel didn’t speak Danish, I was asked to serve as an information messenger between the police and Dr Asvall. The case involved a highly sensitive personnel issue and I was required to translate some very intimate details of the relationship in question! That was the first time I worked with him.

“And then the next time was when I applied for the job as his PA and had an interview with him and the interview lasted almost two hours. When I came into the office, you know he had that big map on the wall behind him, he said, ‘So, show me where you come from and show me where you’ve been in your life.’ He wanted to know a little bit of everything I’d done and who had meant a lot to me along the way, what had impressed me with different countries and different people and my background, educational background. He’d asked around about me a little bit and said, ‘Everybody has a good word to say about you, from the cleaning staff up to the directors.’ And I remember coming out of the interview and I was the lowest grade of person that applied for the job. All the rest were a couple of grades higher than me and I thought, ‘Well, I probably won’t get it but there’s not many people that can say I’ve had maybe two hours with the Regional Director just talking about myself,’ and that really impressed me. But to my surprise I got the job and I learnt a lot from him.

“He was always a gentleman. I wasn’t like just the sort of secretary who follows three paces behind. He made a point of including me when we were travelling if he was invited out for dinner. He was a very, very good man. He could be very frustrating when he focused on one thing and there were a load of other priorities piling up that he just didn’t want to deal with, and what you learnt as you went along was that he would deal with them just in his own time and he had his own list of priorities that weren’t necessarily other people’s but he would eventually get through.”

Isuf Kalo gives an example where Jo paid attention to work carried out and when asked for input didn’t stint in his response: “I was invited by WHO to work on a Mauritian diabetes programme. I wrote a report with proposals about what to do. This report was reviewed by six directors in the various departments of WHO. They approved it and stated that it needed to be seen by Jo as well. Jo was in Spain at that time and it had to be okayed urgently. So, Jo asked for the report to be faxed. Frankly speaking, I thought that it was just a bureaucratic system and felt Jo might not be interested in reading such a technical report on a specialized topic like diabetes. But I was



surprised to receive from him four pages of detailed comments on the report. He began in a very polite way. Then he suggested some corrections. After reading all his text, I felt ashamed as ‘diabetes expert’. I realized how superficial the report was and what he was proposing was great. I realized that Jo was not a simple bureaucratic director!

“The incident made me see Jo as a very knowledgeable health professional with huge expertise which allowed him to penetrate deeply even in such a narrow specialty as diabetes care. This lesson was repeated over the following years as I came to realize every report he received was scrutinized in a very correct, creative, positive and helpful way. He would not hurt you but correct you and guide you in a firm way. That Mauritius report was a fantastic lesson for me.”

Mikko Viononen commented, “He was able to get good staff and he did quite a lot of head-hunting himself during his travels. He was not jealous of the staff and their success. He highlighted the success and the persons who did it.”

Mark Tsechkovski gives another example of how Jo mixed the formal and informal when it came to recruitment. Having gone for a job as a divisional director more because he felt he should do it rather than because he believed he might get it, Mark recalls: “I was, therefore, absolutely quiet and relaxed. I do not remember whether questions presented any difficulty for me to answer and express my views. Asvall did not show any special interest during our more than half hour talk.

“I was deeply surprised when I was advised by Ministry of Health staff that Asvall wished to see me for an additional time in the evening the same day. We spent more than an hour in the restaurant of the hotel in which he was staying, talking not only about health matters but different aspects of my and my family life and interests and hobbies. Now he was another man, with a keen interest in his fellow man. We had an open and candid conversation.

“It was not that evening but some time later, I realized that Jo Asvall had a sort of positive skill, perhaps some psychological gift

or learned through life experience, to make people feel at ease, feel at one point in time equal with him, at the same level of knowledge and understanding of issues.

“In a month’s time, after a one-week working visit to Copenhagen, meeting with key staff of the Regional Office, Asvall offered me the position of Director of Health Systems.”

Anna Ritsatakis remembers how Jo Asvall allowed her to take risks. “In 1994, our unit was responsible for organizing the technical discussions at the Regional Committee in September and at the end of the year a ministerial level conference on health policy. In both cases what was unusual about him as a leader was that he gave us the freedom to try new things, even when there was no guarantee that we would succeed and he was advised by some of his top people not to let us try.

“For example, for the ministerial conference, which according to the regulations must be in the four official languages of the European Region, we proposed that instead of the many parallel groups reporting back to plenary, we would use a professional newscaster from Danish radio to feed back what happened in the groups, every morning, with the ‘9 o’ clock news’. Some of the directors said it couldn’t be done but Dr Asvall said go ahead.

“A similar thing happened with the technical discussions at the Regional Committee. Instead of the usual straightforward presentations on the issue, which was ‘equity in health’, we suggested calling in the top experts to do some role playing, pretending that in a country called Euroland the Minister of Health and the Minister of Finance were having a huge disagreement about an equity policy. Again, when we outlined the proposal some of the top management said, ‘No way at the Regional Committee’, but Dr Asvall again said ‘Go for it.’

“When I saw him by chance in the corridor the next day, he said ‘Congratulations, I hear that it all went very well.’ I said, ‘Well, I didn’t sleep the night before because I knew it would either be a huge success or a disastrous failure, we had no middle way.’ And he gave that funny little smile he had and said, ‘I know, I know.’ I

thought that was pretty remarkable, to give the staff the freedom even to risk failure.”

## Rule 9. Be courageous

To Regional Office staff his last message was: “I say this as strongly as I can: the Regional Office’s potential for action is almost limitless both for raising resources and for going into issues that are controversial, but where we can help our Member States! Our Constitution gives us that mandate – and in my own view also a strong responsibility for action. Be courageous and willing to take risks, but be sure you have the Constitutional mandate to lean on!”

Jo was very fond of quoting the Danish poet Piet Hein, who said: “Experts have their expert fun, telling you it can’t be done!” He cautioned staff to read the advice of experts, but don’t necessarily accept their recommendations if they will prevent you doing what you think is right.

In his last speech (see section 5) he points to many examples where he courageously took risks.

Mikko Vienonen said: “Jo Asvall did difficult things and did not avoid taking challenges. But he was not a typical risk-taking man. He did not jump into water without knowing what was there. In my view he was not really a risk-taker. He did his homework. But he would not say, let’s jump and see. He was not that sort of person. I am glad that he wasn’t.”

Lowell Levin agrees. “He took bold acts, there’s no doubt about that. He challenged old ideas as old fashioned, he stood his ground but he was not a risk-taker in the ordinary sense of sticking his neck out just to test the wind or to aggravate something.”

Vilius Grabauskas remembers when the President of Lithuania asked Jo’s advice: “We were in the process of negotiating the tobacco control laws with various parties and the President wanted to have Jo’s opinion because we were offered 30 million dollars by Philip Morris, which at that time was very big money for us, to support their ‘alternative text of the law’. Jo said: ‘Mr President,

I believe, judging from or based on what I know about your activities, everything you do is for the good of your people.’ And then he also said, ‘If you accept Philip Morris’s proposal, it will go against your people.’ This historical phrase has always been remembered by me.”

Vladimir Gusmari recalls a trip to Albania which was carefully stage-managed by the government. “My colleague and I were especially impressed when he urged us to stop the driver as he wanted to see something special at the top of the mountain which separated Tirana from the industrial city of Elbasan.

“One could see directly a big cloud and ash and rusty smoke covering the whole sky of the town. He became so troubled and concerned for that situation of such big pollution that he remained standing there for minutes, expressing his great worry for the environmental pollution and the consequences that it would bring to current and future generations.

“Although diplomacy was one of the strong aspects of his behaviour and character, he was determined to bring his worry to the attention of the Ministry of Health, asking them to take serious measures to improve the situation and offering the assistance of WHO to deal with it.

“At that time, the situation was delicate and bringing these aspects to the attention of the politicians was by far a strong step forward, to push the authorities despite their reluctance to deal with the situation ...”

Zsuzsanna Jakab remembers him as a courageous man of great integrity. “He always had the WHO oath in his pocket and I remember at a Regional Committee, when there was a lot of pressure on him from one of the delegations, and he took the oath out of his pocket and read it out to the Regional Committee and he said, ‘I’m not meant to accept any instructions from anyone, in particular not from national governments.’ And that was such a nice and courageous act. I was there in the Regional Committee and I will never forget this.”

## Rule 10. Lead by example, spread the glow

Jo was a great story-teller. His enthusiastic love of life, people and places, elephantine memory for details, often poignant observations of the ‘human condition’ and tireless ability to recollect and reflect made him truly a ‘treasure house’ of public health history. He was, indeed, always keen to share insights, inform, instruct, inspire and ignite us into action.

He understood the importance of people knowing about what has gone on before as they move into the future.

Jo’s meticulous dictation of his memoirs to the WHO history project and willingness and eagerness to pass on the history is a testament to his commitment to spreading the glow.

Ainna Fawcett-Hennessy was going through her papers when she came across two notes he had written to her. The glow is still there.

“They were two little cards from him, thanking me for the enormous contribution that I made in such a short space of time into my post. That was a very special personal note to me. People often did not realize the personal and very human side of Jo. When he retired I sent him a Christmas greeting to his home in France and he wrote saying ‘thank you for remembering me’ and a reference in the card which showed that he continued to take an interest in the profession and its development.”

Constantino Sakerallides remembers another time when he witnessed Jo saying thank you: “I visited Brazzaville with Jo in the 1980s to do some work at the WHO Regional Office for Africa. We arrived during a weekend and had a day for ourselves before doing our work on the Monday and Tuesday. Jo said to me, ‘You know, I was in Brazzaville 20-plus years ago, when I was doing the malaria eradication programme in Togo. At that time, I found this small shop on the outskirts of the city where they sold African art and sculptures. It was there that I bought that large, beautiful sculpture of the old African man I have in my flat in Copenhagen. You know, I would very much like to find that shop and the man who made that sculpture.’”

“And I said, ‘Come on Jo, it’s 20 years later, we’re in the outskirts of Brazzaville, ... kilometers ... with many shops. Do you really think you can find the shop and person that sold you that sculpture?’

“But, you know Jo! He was a very, very determined man! He says, ‘No, no, it’s not difficult, we’re going to find him!’ So next thing I know, we took a car and went around and around and around, and I was thinking to myself ‘Hmm ... this is the age-old game of trying to do the impossible!’ But after a while we stopped on a particular corner and Jo says, ‘I think it’s here!’ I couldn’t believe it. I said, ‘Come on Jo, how can you recognize it 20 years later?’ And he said, ‘It’s the style, I know it might not be the right shop, but it’s the same style, that I’m certain about.’

“So there was a young man sitting in the shop and Jo went up to him and in French told him the story. ‘I was here 20 years ago and I bought this sculpture and I think this is the shop where I bought it and I would like to talk with the person who sold me this sculpture. I know it’s 20 years and the man is older ...’

“The young man smiled and answered saying, ‘Oh, that man was probably my father. He is a sculptor.’

“Where’s your father now?” asked Jo.

“My father is blind now, so he doesn’t work anymore,” said the young man.

“Well, where is he?” Jo asked.

“Oh, he is close by actually,” said the young man, “he lives in the camp area behind the store, but he doesn’t go out much because he cannot see.”

“Please,” Jo asked, “Can I talk to him?”

“The young man went out and in a few minutes came back leading his father into the shop. He sat this old African gentleman down next to Jo. Jo took the old man’s hand in his and said the following:

“I am a person that came here 20 years ago and bought from you one of your beautiful sculptures and I took it to my home. Now,”

Jo continued, ‘because my home is visited by many people from many countries, many different sorts of people from many different backgrounds, rich and poor, workers, professionals and ministers, your sculpture has been seen by many, many people when they have visited my house. What I came here today to say and convey to you is a big thank you for the enormous pleasure you have given to all these people over these 20 years. We consider your sculpture a real treasure and a great masterpiece. Your beautiful sculpture has stimulated so much joy and has made many happy over these years.’



‘I was really amazed and moved (and I am still today, when I recall this experience) by this intimate and unique scene. The man was clearly touched by Jo’s words, as tears fell from his eyes.

‘Then Jo looked at his eyes and said, ‘I am also a doctor and you should know that your blindness is due to cataracts and can be treated.’

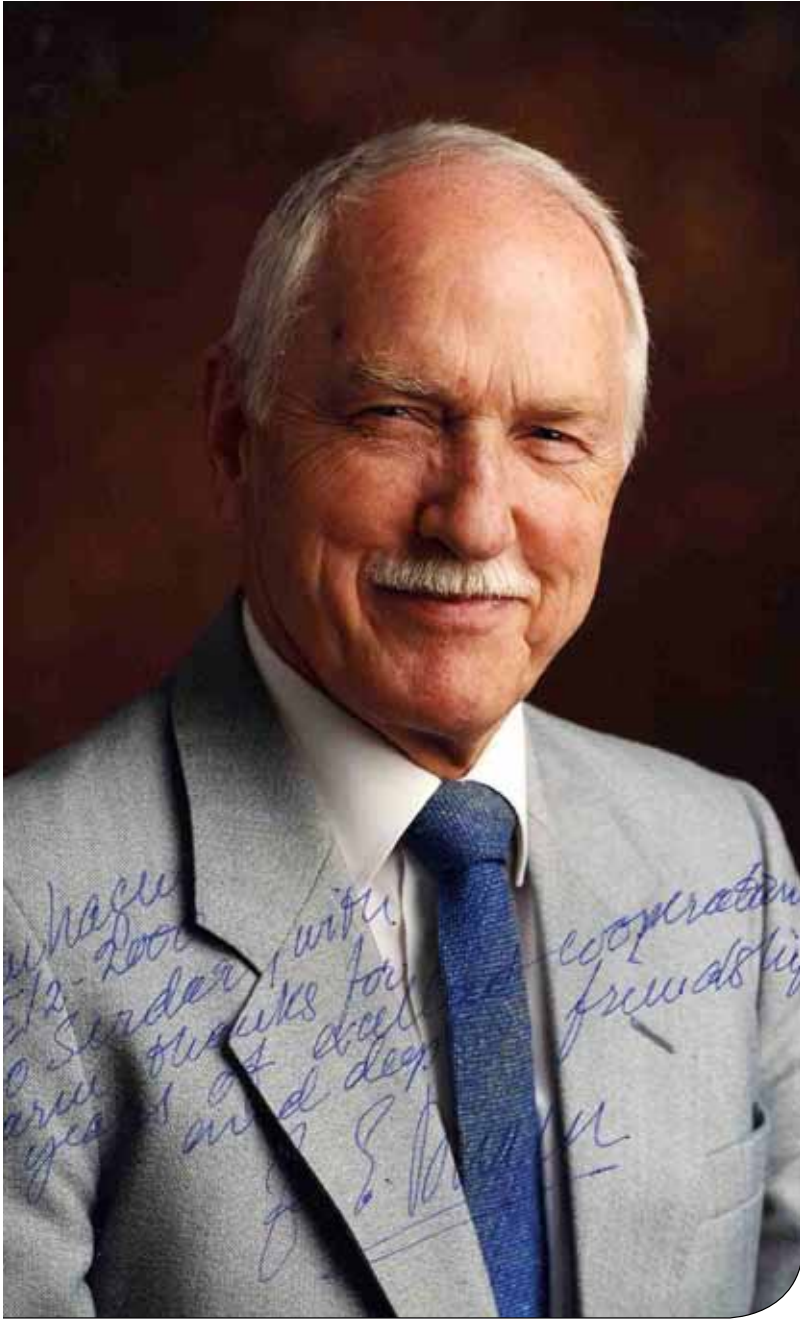
‘And then there were more thank yous and we said goodbye.

‘Next day, we went to the office and during lunch Jo told the Regional Director for Africa Dr Monakosso about this man and asked that he arrange for one of his assistants to take the man’s address, go and find the man and take him to hospital for a sight repairing operation. He explained that the man is a great artist and he needs to see. The Regional Director immediately told his

assistant to take care of it. The next day, the Regional Director and his assistant came to the airport with us to say goodbye. Just before entering the plane, Jo turned round to the assistant and said, ‘Hey, listen, don’t forget the old man with the eyes. Next Monday I’m going to call you to ask you how the trip to the hospital went,’ and so he did!”

*Editors’ final note: Let us all also remember the man with the eyes, the blue eyes. He is indeed watching us spreading the glow...*





**Thank you, Jo**

**Section 4.**

## If you could talk to Jo today, what would you say?

I would say it was very, very good knowing him. I would tell him about some of the things he would have wanted to see the European Region taking a very keen interest in noncommunicable diseases, for example. I would tell Jo that is indeed happening. I would tell Jo that there is now increased global interest in that area and I think he would be pleased to know this because this is one of the areas of public health on which he was always very keen.

### George Alleyne

Thanks, my dear Jo, for the loveliest years of my working life spent with you, to be a liaison officer working for you, as Regional Director, was not a job, but a joy.

### Marianne Szatmari

Well, I can honestly say that I would thank him for the good years we had together. I never got around to that. But I would. And sometimes now, when I sit and reflect a little bit on the many years (45) I worked there, and many with Jo Asvall, there were many good things. The many good things he did but I can't remember them all. I would definitely say, "Well, thank you very much Jo, we had a good time."

### Knud Thoby

Well, I would say to Jo that most of the things we fought for have been vindicated. Not directly, not immediately. Yes, many things were interrupted, many things were not easily accepted, some of the things seem to be forgotten, but the main message for public health work was that in the end we need to define our future, to believe in it, and to create a process of commitment with different actors, in order to achieve something durable that main message is very much alive in today's public health. In my country, Portugal, as we evolve from national plans to local health strategies that's where the action is Jo's contribution to modern public health thinking is at the very heart of our practice.

### Constantino Sakellarides

I wish we had more time together and thank you for having me almost like a close friend.

### **Dusan Bobarevic**

I would say to him now, thank you for not letting up on the profession and for giving us the courage to fight through and realize the potential of our contribution to the public health agenda. You will now witness nurses and midwives working in every possible sphere of public health, with the social determinants of health informing their practice in every possible way.

### **Ainna Fawcett-Henesty**

My dear friend, sleep peacefully. Your memory will remain in our hearts forever.

### **Archil Khomassuridze**

Really, thank you. He has formed the Region and he has formed a lot of people who are today in leading positions. He was extremely important for all of these people to get them trained, to get them to understand what public health is and so I think his merit was not only when he was there, but actually goes beyond. He saw the potential of people and what they needed to learn to become the leaders of the next generation. He gave them the chance to learn. He was an outstanding person.

### **Thomas Zeltner**

I miss you. Your legacy is unforgettable and I do hope that your successors in WHO will draw on it.

### **Mihály Kökény**

Thank you, yep, thank you. Thank you on behalf of myself, on behalf of Europe and I think on behalf of WHO. You were infuriating and you were stubborn and you weren't always right, but you were always terrific.

### **Carolyn Murphy**

Jo, I would like to know what you think of the current socioeconomic situation and how we could preserve public health

policies in the face of the economic downturn. How we could persuade the politicians and my clinical colleagues of the absolute importance of public health when they are desperately trying to retain those rescue and emergency services which are the stuff of electorates' expectations and demands. How do we keep reminding them that what matters is to stop people killing themselves through drinking and smoking too much and eating the wrong foods? It's not sexy, yet we know it's what matters and how in the present situation do we do this? I'd like to know how Jo thought we could do that. One has one's own ideas and I do work through various organizations to try to keep this going. I use my links with ministers and so on, but it's bloody difficult.

I'd ask him these things because I suppose to me, although we're very much of an age, I saw him as a kind of elder brother in public health. I always felt he was a step ahead of me in thinking something through or thinking how to deal with something. I always looked to him to give a lead.

### **Sandy Macara**

I felt that we were like twins because of professional, medical and public health values. We had a free flow of interaction. During the last year when he opened up his personal case history regarding his disease, it was a sort of depression, emotionally deeply felt weight. I think the last call was the day before he died. We talked for about an hour. It was a deep loss. He was a gentleman of high intellectual, professional and ethical standing and a real model for leaders of public health.

### **Otto W. Steinfeldt-Foss**

I would tell him he was absolutely an important person in my professional life. Being this young person, I was so lucky to have the support of people like himself, like Mahler and Kaprio. I was spoilt really, because they gave me lots of space to grow. I was able to grow also in part because of the conflicts I had with them — because obviously if you have a father figure, you have to fight it to establish yourself. That's what I would really thank him for: putting trust in me. In the end I did become the first female director in the Regional

Office. And Jo also supported my next career step, the position in headquarters that I moved on to. I have an immense thankfulness for everything he's done for me and I would never have had the career I've had without him.

### **Ilona Kickbusch**

Probably, as many people would say, to some extent I owe my career to him. And he must have done that to many. I dealt with him when he was the Director of Programme Management. He really encouraged you. I had written a book and I sent him a copy of it. The next time I was in Copenhagen and I walked into his office, he got up and pulled the copy of my book and said, "Listen, I have read this." He said, "On page 135, you have written this and you have quoted this and this. I think this is extremely interesting. But you have written just two or three pages on that. I think you should do this and this." He was a typical Norwegian and said "You should do this!" But he would do it in a way that is meant to encourage you. In that sense, he encouraged big time with my career. When I was young, he was the one who identified me. He said it is this guy who can do a couple of things. It was he who made me rapporteur for numerous committees. And I think he did this with several others. I would thank him for what he did for my career in public health and international health. I retired two months ago. If I were to mention my five key teachers and supporters, Jo definitely is one of them.

### **Ok Pannenberg**

I would say firstly, from my personal point of view, you taught me a lot. You taught me to see beyond my own specialty. You taught me that it is the team which matters. You taught me important lessons for my work in the Russian Federation. It was your spirit that inspired me to work there.

Secondly, from a more general perspective and from a historical point of view, I would state Jo's role in underlying primary health care and the determinants of health beyond medical concepts have been very important for Europe and the world. I would say that that was Jo's gift to the world. We hope to carry this on and can carry it

further. It is like a garden. If somebody has put the garden in good order and does not continue the work, gradually it gets wild. I would say to Jo that we are on track to get back his heritage and get it back to the place where it belonged.

### **Mikko Vienonen**

I will say that Jo, I miss you. All your friends, collaborators, Europe and the world miss you. You have been a treasure and will not be forgotten.

### **Isuf Kalo**

Instead of myself speaking now to Jo, I prefer to quote his words from a dedication on his own picture:

To Concetto from another African, with warm thanks for many years of fascinating professional work together but, above all, for a fine friendship! Copenhagen 2 Dec.1985 J

### **Concetto Guttuso**

We succeeded! After more than 20 years, specific country-based offices of the WHO Regional Office for Europe (known as geographically-dispersed offices) have been established in quite a number of countries and this trend is likely to continue to be a major subject in WHO. It seems to me that we could make the point that we were right to support such an undertaking.

### **Vittorio Silano**

Thank you, Jo. Just thank you. It was such an inspiration and so rewarding to have known someone like him. It was so interesting to work together. He was also a charming and very human friend, full of humour. I remember once we, with his wife Kirsten and my husband Keiji, went for a meal at one of the best fish restaurants in Geneva. It was very sophisticated and Jo asked the maître d' whether he could have potatoes with his fish. The maître d' said: "But we have so many other vegetables." And Jo replied: "I am a poor Norwegian and I always eat my fish with potatoes."

### **Claire Chollat-Traquet**

I learned a lot from him and in general he played an important role in my life and career development. So, after many years not having communicated, had the situation been hopefully conducive I would have thanked him for that and probably could not avoid the temptation to ask him if he did not regret his choice in Moscow in 1987.

### **Mark Tsechkovski**

“Heck, brother, you did a tremendous job.” He was a very competent colleague who became a friend.

### **Ingar Brueggemann**

Thank you for the strong public health legacy which you have left us and for your outstanding leadership.

### **Haik Nikogosian**

Thank you for the person you’ve been and for your strong leadership, which helped our Region a lot.

### **Marta di Gennaro**

We could use your leadership now. Europe is in great need of it. We need to join our efforts, not be closed down as we face our economic crisis. We could use your help and guidance. You were always the one who could join us.

### **Vilius Grabauskas**

Rest in peace, Jo. You worked hard. He did. He was a person who never stopped working. What would I say to him? I’d say that his Health for All ideals remain strong and a very high priority and at least in the Regional Office it was due to his implanting them so strongly in the Organization, its structure and its functions. He kept that thing going and also in terms of his later years, he’s broadened the perspective on health per se. Not on the management of health particularly, but in bringing together the social and environmental issues, for example. He began to work in that way. I would say Jo, you did a good job there, you planted the seeds, some of which died. Sorry to tell you that Jo, but they didn’t take. Others have been flourishing, actually, especially with the expansion of the Region from, what, roughly 30 plus to 50 plus. You prepared the way for

the integration of new countries, old countries — you prepared the way for growth of the European Regional Office of WHO. You laid the groundwork, you insisted on a strong Health for All orientation, you began to reach out to other sectors, policy sectors, so while you began the work I want to tell you Jo, it has flourished and it has flourished under some of the people that you hired.

**Lowell Levin**

## **A song for Uncle Jo**

**Halldor Asvall**

I would like to say a few words about a very special uncle.  
He was not like other uncles.

You see, some people are like this — when they begin to get close to their fiftieth or sixtieth year, everything starts to move a little slower. They shift down gear. They throttle back their engines.

They put their old documents into grey briefcases and settle down in the back seat of the train to town. They gradually become old, grey souls, sinking down into the tired, worn-out seats at the back of the coach, travelling to jobs they don't really want anymore.

With faces heavy as lead they stare out into the train compartment — with empty, cold gazes — calculating their pensions between each station.

And they think to themselves:

- How many more years until I can retire?
- What's the weather like now on that beach we visited in Spain?
- And why exactly did I marry my wife?

Their voices drip with bitterness and, with stories of their sad old age, they spread a dark fog over the dinner table, which slowly, inexorably, erodes the happy atmosphere of any family gathering.

And for those unhappy souls and unfortunate siblings and nephews sitting beside them, the whole world becomes the half-eaten shrimp sandwich on the plate in front of them — and Uncle Jack on their left, going on and on about his regrets over never taking up that early retirement.



It's at times like these I'm thinking:  
I'm glad that I am not related to an uncle like this.  
I couldn't bear to have such an uncle, even if you gave me one.  
But if you had given me an uncle, and I could have chosen for myself, I would have said:

Oh, give me an uncle  
that we all raise our glasses to,  
that flies between the countries  
and comes travelling back happily  
to us.

I'm just saying. There are exceptions. I know about one of them.  
- Lunch next weekend, you said? Well, you know, strictly speaking  
I'm flying in to Kazakhstan then. I'm meeting the Minister of Health  
there. Ivan, by the way, is the most magnificent health minister in the  
whole wide world. And then I'm going on to Gaza. But we can, of  
course, chat on Skype, if you like?

A tall, straight, white-haired figure stands looking at me, holding  
a bowl of freshly prepared crabs, leaving his boarding card on the  
kitchen table.

He's just finished serving tapas. And he's seventy-five years old.

Oh, give us an uncle  
that we all raise our glasses to,  
that flies between the countries  
and comes travelling back happily.  
Like Jo.

You see,  
All my girlfriends – I used to bring them on romantic holidays to  
Copenhagen – were always more charmed by Uncle Jo than by me.

We would sit in the little log cabin café on the pier in old Nyhavn.  
While the strong, Danish breakfast Schnapps had just started  
turning my head around.

My Uncle Jo gently leaned over the table and said:  
- Catherine, you have to understand. At that time, in Africa, we  
didn't have any car rescue company that we could pick up the phone

and call. There was no Norwegian Automobile Association. I remember that time we lay full length underneath our little 2CV, or *deux chevaux*, right in the middle of the national park in Zimbabwe.

- There we were with a broken-down car in the African sun. The lions were only half an hour away. and all we had to hand was a small piece of steel wire we had found in the trunk. And imagine. With that wire we managed to fix the mechanics of that little French wonder of a car. And you've also been to Zimbabwe, did you say?

Afterwards we sat quietly, alone on the ferry back to Norway, with Uncle Jo and all his stories left behind us.

She stared out of the window, longing to be back in that little café in Copenhagen.

I tried to finish up my cold meal, in that grey, dull restaurant.

And then she said:

- You know, you should be a bit more like Uncle Jo, Halldor. You have to remember to serve the wine to me first when we're having dinner.

Oh, give us an uncle  
who we all raise our glasses to,  
who flies between the countries  
and comes travelling back happily.  
Like Jo.

You see,  
Having Uncle Jo come to our house in Norway, when we were children, was like visiting three continents all at the same time.

Every time Jo left after spending a weekend with us and went back to Geneva, Beijing, Gaza or South Africa, we felt like we had been living between the pages of an encyclopaedia for three days.

If it had been normal practice at that time to hold competitions for 10-year olds to recite Ibsen's Peer Gynt in 80 languages, or to quote old student songs from the 1950s, at least we would have signed up.

If Norwegian fourth-graders had been questioned about their opinions on European health ministers, at least we could have provided answers. And good answers.

Standing on the porch, leaving our bicycles behind, we would have said:

- The best health minister through history in Europe was that guy from Portugal in the 1970s.

We would have leant over to the fridge, grabbing for more candies and birthday cake, saying:

- It's obvious. He made tough political decisions and built up local health stations all over the country, providing Health for All.

If you ask me, that's more fun than staring at a half-eaten shrimp sandwich and listening to uncle Jack complaining about never taking early retirement.

Yes, give us an uncle  
who we all raise our glasses to,  
who flies between the countries  
and comes travelling back happily.  
Like Jo.

One day, all journeys will end.  
Now, Jo has finished his travelling.  
And our travels have just begun.

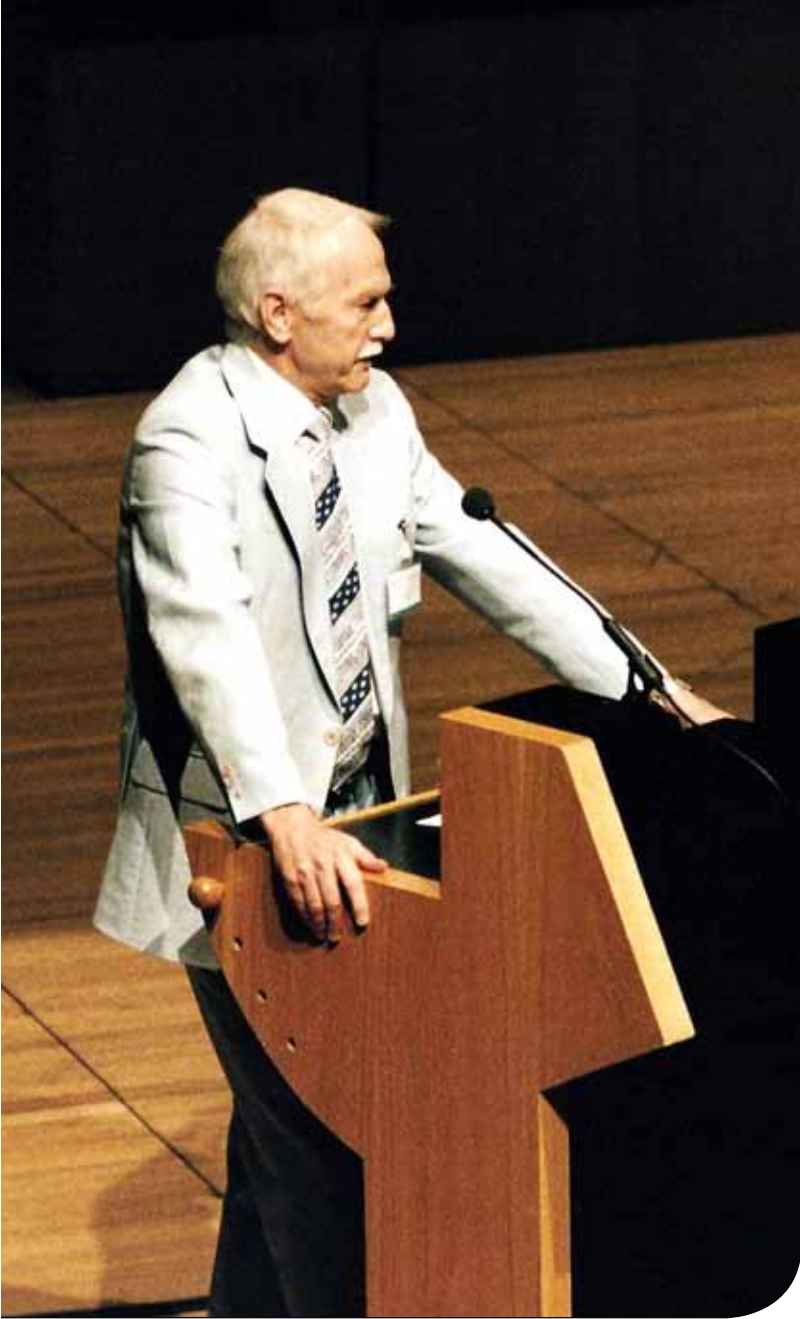
But some day, when we pour wicked Schnapps for our young nephews,  
And tell them swashbuckling tales from foreign parts  
Or we rush out to unexpected meetings, sending them out alone  
with the maid to the amusement parks  
We hope that one day, they too will say:

Yes, give us some uncles  
that we all raise our glasses to,  
that fly between the countries  
and come travelling back happily.

Yes, give us some uncles  
that can smile at our girlfriends  
that can make us believe again  
in life as it should be done.

Yes, give us some uncles  
that we all raise our glasses to,  
that fly between the countries  
and come travelling back happily.

**Like Jo.**



## His final words

### Section 5.

## Regional Director handover reception

### Regional Office for Europe, 29 January 2010

Speech by Jo E. Asvall MD, MPH, Regional Director Emeritus

Good evening everyone! It has been ten years since I was last here and it is nice to see so many of the ‘old-timers’ still around – and a nice crowd of new faces, people whom I look forward to getting to know ...

#### *EURO’s<sup>5</sup> mandate and freedom of action*

Looking out now at all your faces, I cannot help but think: Are you worried for the future? The money? The growing EU empire? The many new organizations dabbling in health in Europe? Your jobs and families?

As I look at you, I cannot help but worry about a fundamental question: *Is EURO’s organizational memory of its past way of working still present with you?* In particular, what does the new staff now know of how – in the 1970s and increasingly in the 1980s and 1990s – EURO became the undisputed leader and catalyst for public health in Europe?

To understand that, you must first start with the basics: *Why was WHO created?* The Second World War was such a catastrophe – touching virtually all countries and killing 50 million people, maiming many more for life and forcing many millions to flee their homes as refugees for a very bleak and uncertain future.

When it was all over, people and politicians all agreed: *Never again!* We must create a global body to help keep the peace and to help countries develop better systems for health, education, science, etc. – and for those reasons the *United Nations* and its seven *specialized agencies*, including WHO, were born in 1948.

WHO developed a fantastic Constitution, drafted in short time by a group of public leaders from all over the world who shared not only a common war experience, but also some far-sighted, fundamental

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<sup>5</sup> ‘EURO’ is the nickname for the WHO Regional Office for Europe within WHO and often used among staff.

values that allowed them to create a document which gave us clear guidance for difficult future decisions. *Read it and remember it!* It gives us such liberty for action; if you play it wisely, you can do almost anything that leads EURO to spearhead important developments and serve the needs of Member States!

Not that it will be easy; not that everyone will agree! As the Danish poet Piet Hein says: *Experts have their expert fun, telling you it can't be done!* Read the advice of experts, of course *but don't necessarily accept their recommendations if they will prevent you doing what you think is right.* Let me give you some examples:

- In 1984 Israel wanted to leave the Eastern Mediterranean Region and join the European Region. Legal HQ said *No, No, No!* It would be against United Nations policy due to the ensuing concerns regarding the membership of the Occupied Territories. Several European Member States (MS) were also nervous, for the same reasons. However, EURO said *We don't agree; the Constitution gives any Member State the right to try to change regional affiliation ... The Occupied Territories are HQ and EMRO concerns, not the Regional Committee for Europe's.* That argument prevailed, and we got a new MS eager to actively join our programmes and present many interesting models of relevance to our other MS.
- In 1986 *Chernobyl exploded*, but we were prepared. Dr Guttuso had done an excellent manual setting out how EURO should respond to major crises. Equally important, the dynamic Department Director of our Environment and Health department, Mr Ian Waddington and his excellent staff *with strong Belgian support* already had three working groups on nuclear power and health to hand. We immediately followed our crisis manual, Waddington recruited a team of top external experts (who worked within EURO for the coming months) and one week later a high-level group of experts from all over the world met in EURO to assess the situation and advise countries and EURO on what they should do. HQ EH Division wanted to take it all over but the Director-General, Halfdan Mahler, said *no* *EURO is up to the task!*

- In 1989 it was clear our financial and intercountry staff resources were dwindling due to Reagan, Thatcher and co. Should we just accept our fate? No, *our intercountry staff and programmes are EURO's life-blood.*

We looked for alternative solutions, but solutions that were long-term and where EURO kept total control on staff recruitment and programme developments. We found an excellent one: the EURO centres (Barcelona, Rome, Venice, Bonn, etc.).

HQ again was horrified – that did not fit with any existing WHO model! We went ahead, in spite of their objections, and you all know that has been a great success, more than doubling our intercountry resources.

- In 1991, *Yugoslavia and the USSR dissolved*, leading to a big increase in the number of EURO Member States – and *leading to some 13 'hot' wars* in our hitherto peaceful Region. The Balkan wars in particular were vicious; how could EURO sit passively by and not try to help? So we decided to take WHO into a 'hot' war. HQ again was horrified! Led by Sir Donald Acheson (a highly competent retired United Kingdom Chief Medical Officer) and strongly supported, financially and otherwise, by many of our Member States, we soon set up [an operational headquarters] in Zagreb, some ten field offices spread across all the fighting countries, seven specially designed programmes and fielded some 75 EURO staff to work in the area, crossing battle fronts and risking their lives almost daily. [Our work there was significant and] a true success ...

The reason I tell you all this is *to say as strongly as I can: EURO's potential for action is almost limitless – both for raising resources and for going into issues that are controversial, but where we can help our Member States!* Our Constitution gives us that mandate – and in my own view also a strong responsibility for action. *Be courageous and willing to take risks, but be sure you have the Constitutional mandate to lean on!*



## The way ahead

### *The European HFA policy*

You simply have no choice: You *must pick up on HEALTH21* [European health policy process] and go through the well established routines for its next update before you get the Regional Committee to adopt it as the Region's new policy. This must subsequently frame all EURO programmes directly and be *the* inspirational model for the Member States' own national policy-making (remember: there are 43 such examples, developed with EURO support during the 1985-2000 period!).

However, *you must not do that in a superficial way* – the Member States will quickly find out and *EURO will lose its biggest asset: being the scientifically most reliable and serious source of public health advice in Europe!* [Remember when doing] the update that:

- *A thorough analysis of the changes in health status in the Region is needed* – with essential indicators, disaggregated by at-risk and disadvantaged groups, etc. – at country level and for the Region as a whole. This should build upon EURO's periodic update of the Health for All database. The epidemiology/statistics unit has an urgent and challenging task to do!
- *An update will need to be done which identifies current global scientific evidence and knowledge on which strategies have been found to be better, or worse, than in 1998* (when HEALTH21 was finished) – a big and challenging task for EURO intercountry staff and their many scientific partners; it must be *thorough and well documented*.

### *The EURO intercountry programme*

*As already mentioned* – this is EURO's life-blood and most important asset. Working with its scientific partners and condensing its scientific evidence-based information into EURO advice on preventive and curative strategies and projects to implement them, *this is the most important work that EURO does*. That is what makes EURO relevant and interesting to our west European Member States – and *without their enthusiastic support, EURO can never attain its key role as the public health leader in Europe!*

### *The EURO country programmes*

These are, of course, a most important part of EURO's work! But there are three very important guiding principles [which we found in the past to be essential]:

- Country programmes must simultaneously address *WHO health policy priorities* – which in the case of EURO means Health for All (that is what the Regional Committee has agreed to and that is the clear mandate for EURO) – and on the other hand, *countries' own current health development priorities*; ...
- [Country offices should be encouraged to seek resources.] Finding resources for country work is not difficult, if our country programmes are good – and they will be, if it is the intercountry staff that advise on their developments, in cooperation with the country offices. Good country programmes will attract support from funders and partners: for example, ECDC, the Global Fund to fight TB, AIDS and Malaria, the Gates Foundation and many others.

### *EURO's networks*

These are a key EURO pioneering initiative. They have been very important and often highly successful. They were built on the concept that the EURO Health for All policy is not just for the national level. On the contrary – and the Regional Committee should, I believe, strongly support this – it should permeate and influence all levels in a country that can promote such development (regional and local administrations all the way down to individual institutions, ministries other than health, health professional organizations, etc.). Let me only mention one: the *Healthy City movement*.

I had the pleasure of participating in their last big conference in Zagreb a couple of years ago (an organization as complex as for a Regional Committee) and was utterly impressed by its development.

- Not only does it continue to expand to many new cities, do you know that it is the world's largest of its kind?
- Do you know that its scientific basis continues to grow through links with local universities and scientific institutions?

- Do you know that it is now self-sustainable financially, including support for its EURO-based staff?
- Do you know that EURO keeps a strong professional leadership in its development? Agis Tsouros and the other staff really merit admiration for how they have done it all!

### *The future*

I envy you! You are fantastically lucky to work in an organization with such noble goals and almost unlimited possibilities. Don't be afraid to grab them!

Now you have the chance, with a wonderful new Regional Director who is known east and west as a very competent leader and excellent with staff! You know her and her excellent work from her earlier EURO positions and you know her background as the Secretary of State for Health in her own country and most recently for her sterling leadership of the new EU ECDC centre in Stockholm. But don't worry; you will find the same old, warm Zsuzsanna and you will like her no less now!

### *Zsuzsanna*

We are all excited by your new appointment! You come with so many assets and I am very pleased to see, through the talks we have already had, that we broadly share the EURO development priorities.

I'd like to say one thing, however: *EURO is not ECDC!* EURO is a creative, pioneering public health leader that depends critically on the quality and innovativeness of its staff:

- Ilona Kickbusch and staff made EURO the undisputed world leader in health promotion and lifestyle programmes.
- Ian Waddington and then Stan Tarkowski and the fantastic Environment and Health department staff raised the profile of our Environment and Health programme from only producing technical guidance documents to grabbing the political environment and health policy development leadership for the health and environment sectors in Europe. They made the 1999 London conference the largest environment and health

conference ever in Europe, in terms of the number (and variety) of ministers participating and the courage and vision of the political decisions of the conference.

- Constantino Sakellarides and his colleagues made very thorough reviews of the key problems in the health care developments in the Region, and Kirsten Staehr Johansen started a revolution with regard to how to develop better systems for quality of medical care – all presented at the very successful European Conference on Health Care in Slovenia in 1996.
- Similar groundbreaking work was done by Marsden Wagner, Boris Velimirovic and other programme managers.

However, Zsuzsanna, they were not easy to manage! Innovative, anti-bureaucratic and creative, they were real *‘agents of change’* that created a stir from the administration and required firm support from the Regional Director.

Thus, I strongly advise you: *Give good leaders ‘space to move’* within the confines of the Health for All goals and you will see real professional developments come! It will require that you accept ‘some noise’ from such staff and must be ready to support them. There will be some inter-staff bickering, but the goal is not a smoothly operating unified behaviour in the office – it is the leadership quality of our programmes!

I know you understand that and I am very excited for the new era coming now. Enjoy it. I never had a dull day in my 15 years in that job and neither will you. You must feel the warmth coming to you both from EURO and the Member States! Let us all raise our glasses and give you a warm welcome as the new Regional Director of EURO!



**Invitation letter, questionnaire and witness list**

Date: 17 May 2010

REGIONAL OFFICE FOR EUROPE  
BUREAU RÉGIONAL DE L'EUROPE  
REGIONALBÜRO FÜR EUROPA  
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Notre référence:		reference:
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Dear Colleague,

## We need your help to tell Jo's Story

As you probably know, Jo Eirik Asvall, the European Regional Director Emeritus, died on 10 February this year. It was a great shock to all of us, especially as only 12 days before the staff had all met him in the Office here in Copenhagen. He was invited by Marc Danzon as the outgoing RD to witness the tradition of handing over the 'keys of the Office' to me as the new RD. Jo in his normal manner gave one of his wonderful speeches full of inspiration and history throughout which his deep love and affection for WHO shone through. You will not be surprised that many of the young WHO staff members, who had never met or heard him speak before, came and expressed their appreciation and thanks for his words of guidance and wisdom.

Now it comes to us to honour and acknowledge his contribution to strengthening public health in Europe and making his unique contributions more widely known. To this effect we are taking a number of initiatives, including holding a special memorial session in his honour at the WHO European Regional Committee meeting in Moscow in September. The aim of the session is not only to acknowledge Jo's great contributions to public health in Europe but to take this opportunity to reflect collectively on the values, approaches, policies, targets, actions and

public health leadership principles which he advocated throughout his life. Another initiative which is at an early stage is the possible setting up of a scholarship fund that will encourage and enable young health professionals from across the Region to enter public health.

Although Jo was a true international WHO visionary and inspirational advocate for the imperative of implementing its goal of health for all, he was at the same time the embodiment of Nordic values and goals and his spirit was forever Nordic. Therefore it is planned that the Regional Committee session will be organized together with the Norwegian Government and Ministry of Health.

For this session I have asked Franklin Apfel, EURO's head of communications during the last years of Jo's tenure as RD (who wrote the recent BMJ obituary), to coordinate on behalf of the Regional Office the writing of a reflective biographical booklet that tells 'Jo's story'.

With guidance from Jo's family, Franklin will use texts from Jo's memoirs, speeches and interviews and will complement them with reflections of key 'witnesses' who can provide first hand reflections on his life and times. He will also produce a short background video for the session. Our aim with this project is to include a wide variety of voices and perspectives: people from across the WHO European Region and beyond who have worked with Jo in different capacities, locations and times.

I am approaching you to join us as a key 'witness' to this process and am asking Franklin to contact you directly to explain in more detail the input and help we will need from you. I sincerely hope you will be able to contribute to telling 'Jo's story'.



**Zsuzsanna Jakab**  
*Regional Director*

# Questionnaire

## *'Witness' Questions*

Name of interviewee

1. In what capacity and when did you meet Jo Asvall?
2. How would you describe him to a classroom of new public health students?
3. Please reflect on a memorable project, meeting, activity or event that you shared with him.
4. What do you think was his greatest accomplishment?
5. Did you ever see him get in and out of trouble? Describe.
6. Did you ever see him 'get tough' with people? Tell story
7. Did you ever experience his skills as a negotiator? Tell story
8. Jo has been described as a European and a true Scandinavian, in the best sense of the words and concepts. Do you agree? Tell story.
9. Please reflect on a memorable travel experience or social event shared with Jo.
10. If you could speak directly to Jo now, what would you say?




## Witnesses

### **Farman Abdullayev**

*Former WHO Liaison Officer for Azerbaijan (1994–2005)*

### **Richard Alderslade**

*Former Regional Adviser, Humanitarian Assistance and Partnerships, WHO Regional Office for Europe; former Senior External Relations Officer at the WHO Office at the United Nations in New York*

### **George Alleyne**

*Director Emeritus, Pan American Health Organization (PAHO); United Nations Special Envoy for HIV/AIDS in the Caribbean Region; Chancellor, University of the West Indies*

### **Jean-Philippe Assal**

*Former Director, WHO collaborating centre for reference and research in diabetes education (1983–2008); professor of medicine, University of Geneva Medical School; former President and co-founder of the Diabetes Education Study Group of the European Association for the Study of Diabetes*

### **Halldor Asvall**

*Jo's nephew*

### **Keith Barnard**

*Formerly Principal Investigator, WHO collaborating centre and Head, Nuffield Centre for Health Services Studies, University of Leeds, United Kingdom; later guest professor in international health and consultant, Nordic School of Public Health, Gothenburg, Sweden; currently honorary lecturer, Nuffield Centre for International Health and Development, University of Leeds*

### **Steen Bech**

*Chairman of the Board, Danish Rehabilitation and Research Centre for Torture Victims (RCT)*

### **Ole Berg**

*Professor of Health Management at the University of Oslo, Faculty of Medicine, Department of Health Management and Health Economics*

### **Sali Berisha**

*Prime Minister of Albania*

### **Dusan Bobarevic**

*Former Director of the Department for International Cooperation of the Federal Ministry for Labour, Health and Social Policy of the former Republic of Yugoslavia*

**Ingar Brueggemann**

*Vice-Chair of the Board of the German Foundation World Population, Hanover (honorary); former Personal Representative of the Director-General of WHO to the United Nations headquarters in New York; former Director-General of the International Planned Parenthood Federation, Berlin*

**Claire Chollat-Traquet**

*Former WHO Director, Division of Development of Policy, Programme and Evaluation, WHO headquarters*

**Joshua Cohen**

*Former Chief Adviser, Director-General's Office, WHO headquarters*

**June Crown**

*Past-President of the United Kingdom Faculty of Public Health; former District Medical Officer, Bloomsbury Health Authority, London, United Kingdom*

**José Oltio Espinoza**

*Sanitary engineer; former Regional Adviser for Water and Sanitation, WHO Regional Office for Europe (1985–1992)*

**Ainna Fawcett-Henesty**

*Former Regional Advisor, Nursing and Midwifery for WHO Regional Office for Europe (1995–2006)*

**Marta di Gennaro**

*Head of the Department of Innovation, Ministry of Health of Italy*

**Hussein A. Gezairy**

*WHO Regional Director for the Eastern Mediterranean Region (1982–2011)*

**Vilius Grabauskas**

*Chancellor, Kaunas University of Medicine, Lithuania; former Director, Noncommunicable Diseases, WHO headquarters*

**Vladimir Gusmari**

*Medical Consultant; Head of the Quality & Accreditation Sector, National Centre of Quality, Safety and Accreditation of Health Institutions in Albania; former WHO Liaison Officer for Albania*

**Concetto Guttuso**

*Former Chief of Coordination, WHO Regional Office for Europe (1978–1985)*

**Jan Ole Haagensen**

*Director, International Development and Cooperation, Rehabilitation and Research Centre for Torture Victims, Copenhagen*

### **Danielle Hansen-König**

*Director-General of Health, Directorate of Health/Ministry of Health, Luxembourg*

### **Sverre Harvei**

*Former Head of the Hospital Division in the Ministry of Health, Norway*

### **Zsuzsanna Jakab**

*WHO Regional Director for Europe*

### **Kirsten Staehr Johansen**

*Former Regional Adviser for Quality of Care and Appropriate Technology; WHO Regional Office for Europe*

### **Isuf Kalo**

*Former Regional Adviser for Quality of Care and Appropriate Technology; WHO Regional Office for Europe; Director, National Centre of Quality, Safety & Accreditation of Health Institutions in Albania*

### **Harry Keen, CBE**

*Honorary President, International Diabetes Federation; Unit for Metabolic Medicine, Diabetes & Endocrine Clinical Unit, Guy's Hospital Campus, King's College London; Honorary Professor of Medicine, Warwick University Medical School*

### **Archil Khomassuridze**

*General Director of the Zhordania Institute of Human Reproduction, Georgia*

### **Iiona Kickbusch**

*Former Director, Department of Lifestyles and Health, WHO Regional Office for Europe (1990–1994); Director, Division of Health Promotion, Education and Communication, WHO headquarters (1994–1998); Director, Global Health Programme, The Graduate Institute of International and Development Studies, Geneva*

### **Mihály Kökény**

*Former Minister for Health of Hungary; current Chairman of the Executive Board of WHO (2010–2011)*

### **Maksut K. Kulzhanov**

*Rector, Kazakhstan School of Public Health*

### **Kimmo Leppo**

*Former Director-General, Health Department, Ministry of Social Affairs and Health, Finland*

### **Lowell Levin**

*Emeritus Professor of Public Health, Yale University; Consultant to the WHO Regional Office for Europe*

### **Sergei Litvinov**

*Former Director of Programme Management and Regional Adviser for the EUROHEALTH Programme, WHO Regional Office for Europe*

### **Alexander ‘Sandy’ Macara**

*President, National Heart Forum; former Chair, British Medical Association*

### **David Macfadyen**

*Fellow, Royal College of Physicians of Edinburgh; Director of Programme Management, WHO Regional Office for Europe (1993–1996); WHO staff member (1968–1996)*

### **Tilek Meimanaliev**

*Former Minister of Health of Kyrgyzstan*

### **Caroline Murphy**

*Former Director of Administration and Finance, WHO Regional Office for Europe*

### **Haik Nikogosian**

*Head of the Convention Secretariat to the WHO Framework Convention on Tobacco Control; formerly Head of Noncommunicable Diseases and Lifestyles, WHO Regional Office for Europe; served as Minister of Health and as Chairman of the National Institute of Health of Armenia*

### **Ok Pannenburg**

*Former official of the Netherlands Ministry of Health (1980–1985); official of the World Bank (1986–2010)*

### **P. Owe Petersson**

*Former Director of Programme Management and Director Lifestyles and Health, WHO Regional Office for Europe*

### **Anna Ritsatakis**

*Former Head, WHO European Centre for Health Policy, WHO Regional Office for Europe*

### **Constantino Sakellarides**

*Director of the National School of Public Health (Lisbon, Portugal); former Director-General of Health of Portugal; former President, European Public Health Association (EUPHA)*

### **Norman Sartorius**

*Former Director of the Division of Mental Health of WHO (1977–1993), WHO headquarters; former President of the World Psychiatric Association and the European Psychiatric Association; President of the Association for the Improvement of Mental Health Programmes*

### **Serdar Savas**

*Former Regional Adviser on Health Policies and Systems and Director of Programme Management, WHO Regional Office for Europe (1993–2000)*

### **Vittorio Silano**

*University Professor; Chairman of the Scientific Committee of the European Food Safety Authority; former consultant to WHO Regional Office for Europe*

### **Otto W. Steinfeldt-Foss**

*Former Director of Mental Health Services, Norway*

### **Marianne Szatmari**

*Former WHO Liaison Officer, Hungary*

### **Stanislaw Tarkowski**

*Former Director of Environment and Health, WHO Regional Office for Europe*

### **Knud Thoby**

*Former Administrative Support Officer, WHO Regional Office for Europe*

### **Linda Topping**

*Former Personal Assistant to Jo Asvall (1991–1999), then to Regional Director Marc Danzon, WHO Regional office for Europe; PA to WHO Director-General (1999–2005), WHO headquarters*

### **Mark Tsechkovski**

*Former Director of Health Systems and then Disease Prevention and Quality Care, WHO Regional Office for Europe (1987–1995); later Director, Noncommunicable Disease department and Assistant Director-General a.i. in WHO headquarters (1995–1998)*

### **Mikko Vienonen**

*Former Special Representative of WHO Director-General in the Russian Federation (1999–2006); Regional Adviser for Health Services Management, WHO Regional Office for Europe (1993–1999); Coordinating Chairman, Expert Group on Social Inclusion, Healthy Lifestyles and Work Ability (SIHLWA) under Ministry of Social Affairs & Health, Finland, Northern Dimension Partnership in Health and Social Well-being (NDPHS)*

**Meropi Violaki**

*Honorary General-Director of the Hellenic Ministry of Health and Solidarity;  
Advisor to the Health Minister, Greece*

**Marsden Wagner**

*Former Regional Adviser for Maternal and Child Health, WHO Regional Office  
for Europe*

**Thomas Zeltner**

*Advanced Leadership Initiative, Harvard University; former Head of the Swiss  
Federal Office of Public Health and Secretary of Health (1991–2009) and Head of  
the Swiss delegations to the Regional Committees and World Health Assemblies of  
WHO (1991–2009)*

**Herbert Zöllner**

*Former Regional Adviser, Future Fora, WHO Regional Office for Europe*











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**The WHO Regional  
Office for Europe**

The World Health Organization (WHO) is a specialized agency of the United Nations created in 1948 with the primary responsibility for international health matters and public health. The WHO Regional Office for Europe is one of six regional offices throughout the world, each with its own programme geared to the particular health conditions of the countries it serves.

**Member States**

Albania  
Andorra  
Armenia  
Austria  
Azerbaijan  
Belarus  
Belgium  
Bosnia and Herzegovina  
Bulgaria  
Croatia  
Cyprus  
Czech Republic  
Denmark  
Estonia  
Finland  
France  
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Latvia  
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Luxembourg  
Malta  
Monaco  
Montenegro  
Netherlands  
Norway  
Poland  
Portugal  
Republic of Moldova  
Romania  
Russian Federation  
San Marino  
Serbia  
Slovakia  
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