EDITORIAL

Health promotion research: war on health, battle of bulge or conflict of confidence?

In 2012, we rejected about 85% of nearly 500 manuscripts submitted to *Health Promotion International*. The editorial team has rather mixed feelings about these numbers, as they signify a few developments in our field, both positive and negative.

For the first 20 years of our Journal’s existence the number of submissions very slowly grew to about 200 manuscripts per year. We could publish about half of these papers. We still publish about 100 articles annually in our print journal, and a few more in our Advance Access on-line area. But the vast majority of manuscript submissions are rejected or referred elsewhere. We suffer, like many of our sister journals, from a barrage of papers that aspiring but narrow-minded scholars spray through a multitude of ‘easy’ on-line submission systems. Fortunately, the technology also helps, and with iThenticate we filter out plagiarism easily (we recently found a paper that was virtually 99% glued together from other pieces).

But some of our publications have widely been disseminated mainstays of the scholarly body of work in health promotion: our most popular article has been Don Nutbeam’s piece on health literacy (*Nutbeam, 2000*). This was cited more than 700 times in other peer-reviewed papers, and had about 40 000 downloads from the Journal’s website at Oxford University Press.

Regrettably, though, a significant cohort of our papers has not been cited at all, not even by the original authors in other work they produced. The editors and publishers have now embarked on some deeper analysis of our publication policies. Most of the bibliographic metrics that are being used to describe the success and efficacy of scholarly publications seem to produce only haphazard information on publication success and efficacy. One should bear in mind that it is not our sole purpose to publish just the methodologically most astute and theoretically brightest research work in the health promotion field; we also intend to contribute to the current debates in health promotion development, as well as add significant value to policies and practices in the field. In some parts of the world (in particular driven by research and development programmes of the European Union), the latter objective is being described as ‘valorization’: ‘... the process of disseminating and exploiting project outcomes to meet user needs, with the ultimate aim of integrating and using them in training systems and practices at local, regional, national and European level’ (*Jansen and Ruwaard, 2012*). 

The process of ‘valorization’ (Jansen and Ruwaard, 2012) analyse the profound disconnect between scientific impact (that is, applying metrics such as citations, Impact Factors for journals and H values for individual researchers) and social impact (considering how research has influenced health, well-being and social development). They argue that fundamental and clinical research seems more easily ‘valorized’ than public health and health promotion research. Jansen and Ruwaard therefore suggest that the international (health promotion) research community needs to make an effort towards ‘... the development of a compound indicator to equally value scientific and societal impacts’. Indeed, the challenges are enormous: whereas it is relatively easy to track the 700 citations of Nutbeam’s paper, we have virtually no information how the 40 000 downloads of his work have actually influenced new and improved health literacy efforts around the world.
In our field, we face additional trouble. Few other disciplines rarely challenge their internal and external validity, consistency and conceptual boundaries. But some 30 years after its emergence onto the political and scholarly scene, ‘health promotion’ continually seems to face a need to re-assess and re-assert its perspectives. From the ivory tower of our editorial offices, our benchmarks seem simple and straightforward: we test every submission against the action areas of the Ottawa Charter, and the subsequent refinements, additions and reformulations that have taken place throughout the series of Global Conferences on Health Promotion. Thus, when we receive a submission on, for instance, health behaviour change intervention research we first and foremost test its health promotion validity against questions such as ‘Does this work add insight and value to health skills development and community action to control (social) determinants of health, and/or to the development of supportive environments for health, and/or the reorientation of health services and/or building healthy public policies/Health in All Policies?’ If the submission does not address such matters (and often this is most easily assessed through a review of the references that have been used), we recommend that authors submit their work elsewhere.

However, we are not oblivious to the fact that health promotion quintessentially is a political endeavour. This means that, for reasons that have a perfectly fine validity in political rhetoric, ‘health promotion’ is redefined, compromised, challenged, snowed under, massaged and sometimes ridiculed. These are the processes and tactics described in the ‘epistemic communities’ thesis: perhaps nowhere more visible than in the international Healthy Cities movement (Heritage and Green, 2013). There are considerable global variations in the degree to which politics have embraced ‘Healthy Cities’. The idea was initially (in the second half of the 1980s) tremendously popular in many OECD countries. The tenets of ‘Healthy Cities’ seem to have reached validity and full political momentum in the Western Pacific Region of WHO only quite recently with the recognition that more people than ever before live in urban environments. This has caused the subsequent political prioritization of ‘healthy urbanization’ (World Health Organization Regional Office for the Western Pacific, 2011; Friel et al., 2012). It appears that urban health promotion in this part of the world has now acquired the same prominence as it continually has had in Europe (albeit with shifts from north-western to central and eastern parts of the region, cf. De Leeuw, 2012): clearly the evidence base and health promotion objectives for Healthy Cities have not changed, but rather the political support and momentum for the movement.

The pendulum swings in other directions in different parts of the world. Dennis Raphael, in this issue of the Journal, describes how Canada has moved from once being the vanguard of health promotion and being the proud delivering host of the Ottawa conference to an inward-looking, anxious and health inequity sustaining nation (Raphael, 2013a,b). The phenomenon Raphael describes is rather insidious, as all of the politically correct health promotion rhetoric is still in place in Canada. This is different in another hemisphere, where more blatantly backward rhetoric has confused the health promotion community. In Australia, the then Minister for Health and Ageing, Nicola Roxon, released the government’s 2010 policy document Taking Preventative Action in response to the report of the National Preventative Health Taskforce. It recommended the establishment of a national preventative health agency; fortunately, once confirmed, this organization had dropped the superfluous -ta- from its name and became the Australian National Preventive Health Agency (ANPHA). But Fran Baum (Baum, 2009) cautiously reminds us that it is not health that needs to be prevent(at)ed, but disease, and that the explicit goals of Australia’s national strategy are not toward salutogenesis but that it is merely looking, anxious and health inequity sustaining (Raphael, 2013a,b). The phenomenon Raphael describes is rather insidious, as all of the politically correct health promotion rhetoric is still in place in Canada. This is different in another hemisphere, where more blatantly backward rhetoric has confused the health promotion community. In Australia, the then Minister for Health and Ageing, Nicola Roxon, released the government’s 2010 policy document Taking Preventative Action in response to the report of the National Preventative Health Taskforce. It recommended the establishment of a national preventative health agency; fortunately, once confirmed, this organization had dropped the superfluous -ta- from its name and became the Australian National Preventive Health Agency (ANPHA). But Fran Baum (Baum, 2009) cautiously reminds us that it is not health that needs to be prevent(at)ed, but disease, and that the explicit goals of Australia’s national strategy are not toward salutogenesis but that it is merely aimed at the (conservative approaches of) prevention of disease. For scholars, activists and practitioners to keep their eye on the ball of health promotion and salutogenesis in such an environment is not always easy. Their resilience is particularly tested when governments do not just shift the rhetoric, but actually declare the health promotion and public health system entirely defunct (Daube, 2012a), even completely silencing activist voices (Daube, 2012b).

The ever so-balanced and objective scholarly health promotion community appears to criticize such developments by proposing new conceptual categories, such as ‘lifestyle drift’. But naming and shaming pernicious challenges to the integrity and evidence of the health promotion endeavour cannot be sufficient for Health Promotion International. In attempting to valorize the research and general body of knowledge
we funnel onto the pages and URLs of the journal, it is clear that we need to do more.

We are not the journal of obesity prevention, but we are happy to play our part in this battle of the bulge as long as the research that we publish in this area informs broader practical, conceptual and methodological approaches to health promotion (e.g. Ezendam et al., 2013; Kim et al., 2013; Scott et al., 2013, in this issue). We are not the journal of prevent(ative) health, and we feel an obligation to continue to identify unsavoury rhetoric and provide the means to analyse wicked problems and argue for effective action (e.g. Mantoura and Potvin, 2013; Signal et al., 2013, in this issue; Van Beurden et al., 2013). But most of all we feel we should empower activist scholarship and scholarly activism to continue to inspire true worldwide, genuine health promotion. This year will see two important health promotion gatherings: the Eighth Global Conference on Health Promotion in Helsinki and the 21st IUHPE World Conference on Health Promotion in Pattaya. Health Promotion International hopes to provide activism and scholarship as a foundation at both.

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REFERENCES


